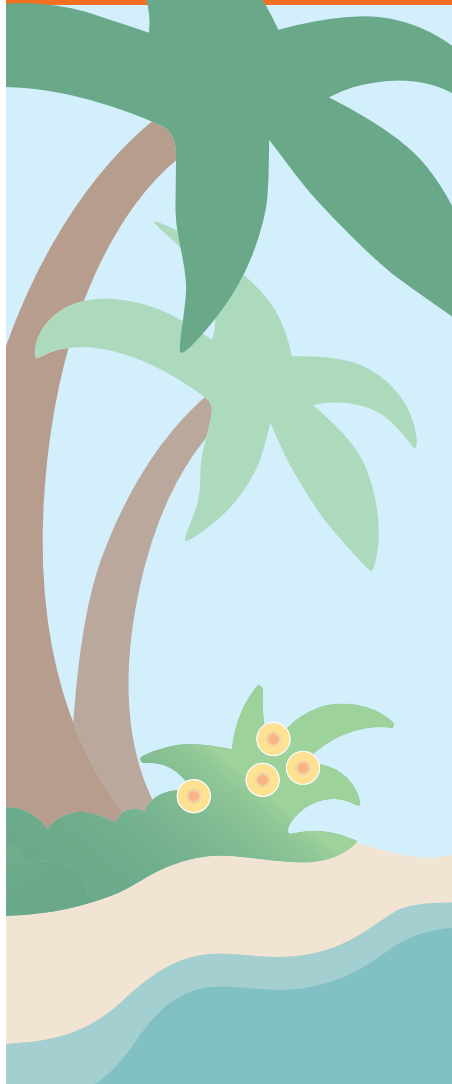


# Services for Asian and Pacific Islander Children and Families

SUMMARY OF THE SPECIAL FORUM HELD AT THE  
2006 GEORGETOWN UNIVERSITY TRAINING INSTITUTES

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## Introduction

A series of Special Forums were held at the Georgetown University Training Institutes in July 2006 to provide opportunities for dialogue about critical issues in order to contribute to the development of future policy and technical assistance. The Special Forums were designed as interactive discussions about communities and populations with unique service needs, requiring specialized planning and service delivery approaches within systems of care. Specifically, the goals of the Special Forums were to:

- Summarize issues and challenges related to each topic
- Identify effective service delivery strategies for local systems of care
- Develop recommendations for policy and technical assistance that will support communities in implementing these effective service delivery strategies

Each Special Forum began with brief framing presentations summarizing issues and challenges related to the topic and offering examples of effective service delivery strategies. The remainder of the forum consisted of facilitated discussion among forum participants focusing on recommendations for services, financing, policy, advocacy, information development and dissemination, and training and technical assistance. The Special Forums were tape recorded and transcribed, and additional input was collected from participants through worksheets completed at the conclusion of each forum. These materials were used to prepare a paper summarizing the issues and recommendations resulting from each Special Forum.

This paper presents the issues and recommendations from the Special Forum on Services for Asian and Pacific Islander Children and Families. Presenters included:

- Rachele Espiritu, Ph.D., *Director of Evaluation, National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, Washington, DC*
- Ming Wang, M.S.W., *Program Manager, Utah Division of Substance Abuse and Mental Health, Salt Lake City, UT*
- Sai-Ling Chan Sew, L.C.S.W., *Director, Children's Mental Health Services, San Francisco Department of Public Health, CA*

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## Issues and Challenges

### Culturally Competent Services for Asian Americans

Sai-Ling Chan Sew shared some lyrics from an old song by Chris Ijima from the 1983 album “Back to Back”:

*Mr. Woo works in the laundry.*

*His wife sews in the shop*

*And each and every wrinkle tells a tale*

*A survivor of the hard times and a fighter all his life*

*But the twinkle in his eye has never failed*

*He puts a kettle on the table, and he leans against the wall.*

*He says, “Excuse my English,” but his words speak for us all*

*He says...*

*These hands*

*Have washed the clothes*

*These hands have served the food*

*Heaven knows*

*And this neck has felt a mob's rope*

*And it's been behind barbed wire*

*These arms have built the railroad track*

*This back has been for hire*

*And these hands have fought injustice*

*And this soul has been on fire...*

*But I'm still here*

*I'm going strong*

*And I'm getting tired of proving I belong*

Chan Sew presented statistics to describe Asian Americans in the United States. Asian Americans are the fastest growing of all major racial ethnic groups. According to census data, in 1999 and 2000, the Asian population grew by 63.24%, while

Whites grew by 5.08%, Blacks by 15.26%, American Indians by 14.42%, and Latinos by 39.42%. Asian Americans currently comprise 4% of the United States population. Two-thirds (66%) of Asian Americans live in five states—California (12.1% of the state's population), New York (5.6%), Hawaii (63.3%), Texas (2.9%), and Illinois (3.4%). More than half (55%) live in six metropolitan areas—Los Angeles, New York, San Francisco, Honolulu, Washington, DC, and Chicago.

The largest ethnic groups among Asian Americans are Chinese (22%), Filipino (18.3%), Asian Indians (16.4%), Vietnamese (10.9%), and Koreans (10.6%). However, these are not the fastest growing groups. The fastest growing groups of Asian Americans are Bangladeshi (who grew by 350.3%), Pakistani (124.7%), Asian Indian (113.4%), Hmong (88.8%), and Vietnamese (80.7%). Each group came to the U.S. under different circumstances, with vastly different cultural roots, religious orientations, customs, and beliefs. Many Asian countries are either historically or currently at war with each other. Thus, Asian Americans are not a homogeneous population, though there are some similarities among the groups that we call Asian Americans. There are “push” factors from the countries of origin, such as war, political instability, famine, poverty, and family reunification. There also are “pull” factors from the United States, including relative political stability, opportunity for growth, the “American Dream,” and employment opportunity. There are many common positive stereotypes about Asian Americans. They are considered to be the model minority, hardworking, overachievers, agreeable, nonconfrontational, and “almost white”. There also are common negative stereotypes—they

are mysterious, secretive, not trustworthy, easy targets for victimization, and “the yellow peril.”

Chan Sew suggested six areas to think about when building culturally competent community services for Asian Americans:

- *Alliance and coalition building*—It is important to build alliances beyond human service providers to identify and address social concerns. For example, business owners would be concerned about curbing juvenile delinquency. Additionally, educators, health providers, Asian providers, and other Third-World coalitions (such as Latinos and African Americans) must be included in alliances to support the development of systems of care. It also is important to elicit support and buy-in from elected officials through quantitative data and qualitative stories.
- *Needs assessment*—Careful needs assessment is needed to identify needs and gaps in services. For needs assessment purposes, the specific Asian American subpopulations in the community must be identified. This can be accomplished by involving the community in gathering data on needs and service gaps. For example, in San Francisco, youth are hired during the summer to go out into the community and collect information for needs assessments in the Service & Advocacy for Asian Youth (SAAY) program. This provides ethnic-specific information about service needs and reveals dramatic differences among the Asian population groups. Further, data on Asian Americans must be disaggregated. Without looking at sub-groups, information might be obtained only on Chinese,

Japanese, and Southeast Asians, but not on other ethnic Asian groups. This is important because Asian American groups are not all the same and have very different stages of acculturation and assimilation. For example, in looking more closely at subgroups in the San Francisco area, it was found that Cambodian youth are disproportionately arrested, adjudicated, and re-arrested. They received institutional placement in 71% of adjudicated cases, as compared with 22.6% of African Americans and 44.3% of Asian Pacific Islanders—a dramatic difference.

- *Program planning*—In addition to doing assessments of the individual, family, and peer group, it is also critical to do an ethno-cultural assessment, which explores the level of acculturation, migration history, generational standards, and home-school gap. This is needed to explore all of the different factors that impact both

the child and the family’s functioning when planning services. Evelyn Lee outlined assessment guidelines, as shown on Table 1. Program planning also involves staffing and the need to increase the recruitment and retention of bilingual, bicultural staff. Attention to the location of services is important in program planning; services should be placed close to the community to be served. Additionally, program models that are culturally responsive should be used to ensure relevancy and “fit” with cultural expectations. For example, the Chinatown Child Development Center, in San Francisco’s Chinatown, provides a drop-in program offering education for young children. For Chinese parents, it is very important for children to learn, so they come and are engaged. When they come, that provides the opportunity to offer a range of services, including mental health services.

- *Data collection and evaluation*—Collection of data is essential for accountability and evaluation. Most data systems, however, only have one field for Asian Americans and, therefore, do not track information for the various Asian groups. There are many additional data collection challenges and barriers, such as data collection instruments and evaluation tools that are not translated into any Asian languages. Alliances are needed between researchers and community service providers to obtain better data on Asian American communities, as there is little information on what is effective.
- *Sustainability and advocacy*—Many programs start as pilot programs to meet the special needs of an emerging special population, but they must be sustained over time. There are different ways to sustain Asian-focused programs. The Chinatown Child Development Center, for example, was absorbed into a public health structure and became part of the city and county human service system. Other agencies or programs become private, nonprofit entities, such as the Richmond Area Multi-Service Center, the Asian Women’s Shelter, and Wu Yee Children’s Services. Some services have become part of networks of private practice providers, who provide services on a fee-for-service basis.
- *Human resource development*—There is a need for minority training programs to encourage Asian Americans to enter the mental health field and the helping professions in general. In addition, the personnel structure is needed to recognize the specialty in Asian American languages and cultures and to

TABLE 1

**Assessment Guidelines for Chinese American Immigrant and Refugee Families**

- Family’s ethno-cultural heritage
- Family migration stress and relocation history
- Degree of loss and traumatic experience
- Post-migration experience and cultural shock
- Acculturation level of each family member
- Work and Financial stresses
- Family’s place of residence and community support
- Family dynamic, problems and strengths
- Physical health and medication history
- Family concept of presenting problem, help-seeking behavior and treatment expectation

EVELYN LEE

provide incentives for the specialty of working with Asian Americans, including bilingual pay, bicultural pay, and the opportunity of career development rather than the “glass ceiling.” In-service training and activities to enhance the retention of Asian American professionals and paraprofessionals also are needed.

Chan Sew presented data from a youth survey conducted in San Francisco. Findings revealed that in San Francisco middle schools, Filipino and Pacific Islanders have the second-highest percentage of youth (24%) who have had thoughts of suicide. In high school, the same group had the third-highest percentage reporting depression, 29.7%. Nationally, suicide was the leading cause of death for Asian/Pacific Islander youth, second to unintentional injuries. Suicide is a major concern for this population.

In California, Asian youth had the highest percentage of use of stimulants among youth admitted to a treatment facility as compared to other ethnic groups (16%). More than half (54%) of Asian youths surveyed reported that they see drug dealers in their neighborhood at least once a week; 88% of Cambodian youth reported seeing drug dealers at least once a week. In San Francisco in 1999, Asian and Pacific Islander youth were ordered by the court to be taken out of the family home and placed in an institutional setting at a higher rate (44.3%) than any other group. The number of Asian females referred to probation between 1990 and 2000 increased by 169%, with Vietnamese, Chinese, and Filipino females having the highest number of referrals. Cambodian youth had the highest six-month recidivism rate for felonies (38%) than any other racial

group in San Francisco, and Samoan youth had the highest 24-month recidivism rate for felonies than any other racial group in San Francisco in 1998. A closer look at Samoan youth revealed an extremely high rate of involvement with the juvenile justice system for a subset of older adolescents and young adults, nearly 50%.

In conclusion, Chan Sew emphasized the need for Asian Americans to be at the table and to be included from the beginning in discussions about funding services, data collection, and human resource development—moving from exclusion to inclusion. A deeper understanding of intra-group differences among Asian Americans is needed, as well as culturally competent service models that incorporate cultural considerations in assessment, treatment, evaluation, and program design. Further, coalitions across professional and ethnic groups must be built and politicians reminded that Asians comprise the fastest growing minority. Investment in research and data collection are needed, along with investment in the training and retention of culturally competent staff. Asian Americans must refuse to be the “silent minority” and demand inclusion.

### Service System Challenges

Ming Wang explored the challenges from a service system viewpoint:

- *Disease concept*—The first challenge is that people have different understandings of mental health and different expectations about services. Asian populations start with different cultural interpretations of mental illness and the behaviors that result from mental illness or substance abuse—the disease concept is different. The interpretation may

be more spiritual, it may not be as medically or biologically based. For example, some may believe that certain behaviors result from a sin that you committed in the last life or that someone put a curse on you.

- *Symptom expression*—Because the disease concept is so different, the way that symptoms are expressed also is different. For example, few Asians will come in and say, “I’m depressed.” Rather, the first expression is typically, “I have a bad headache.” So, at first glance, Asians are likely to present a physical symptom which influences the way they function. The challenge is to dig deeper to tease out what the symptom truly represents.
- *Behaviors that conflict with mainstream values*—Another challenge stems from behaviors of Asian and Pacific Islanders that are ingrained in their culture, but may conflict with the mainstream values. For example, disciplinary behavior that is culturally acceptable to many Asian American groups may be seen as totally unacceptable in the American culture. In many Asian cultures, there is a sense of fate, or that things are beyond one’s individual capacity to control, leading to a more passive approach to health care. That can be a conflict in a culture where self-management of illnesses and self-help increasingly is valued.
- *Values, spiritual, and religious beliefs and practices*—Asian and Pacific Islander cultures are highly spiritually based, and spiritual and religious beliefs among Asian Americans influence the view of illness and the practice of health care. A participant shared an example of a woman in Guam who goes into the jungle and survives

for long periods of time and then returns home and wanders the streets. Her parents did not want her to get medicated, as their idea of what was going on was what is called “Gai Tau Tau,” meaning that she has a spirit within her. She has never hurt herself or anyone else, but entered the mental health system when someone else thought she was a danger to herself and to others. There are many different religions within Asian cultures, all of which have different belief systems that influence how care should be designed and implemented.

- *Traditional healing practices*—Traditional healing practices should be incorporated, such as Chinese acupuncture, exercise to achieve harmony, diets and herb medications, coin rubbing, and others.
- Tolerance of symptomatology by natural support system.

Wang noted that a number of factors must be considered when providing care, including communication patterns, cultural differences, family structure, common family/individual problems, religious and spiritual beliefs, cultural strengths, and history of immigration and acculturation. The mode of communication is different from the American system. Asian Americans do not come in and report mental health problem. Eye contact also is something we need to consider when we provide care.

Cultural differences include family structure and the way family is defined. For example, Wang explained that a Pacific Islander identified numerous people as “my cousin,” but later explained that cousin does not necessarily mean that it is a blood-related cousin.

When providing direct care, Wang related that her clients referred to her as “Sister Ming,” demonstrating that the concept of that family goes beyond blood relationships. Clients see providers as “family” and see them as part of their natural support system, not just as a therapist.

According to Wang, cultural strengths should be incorporated into designing and providing care, though this typically is not done. A significant cultural strength is in the identity of family and the responsibility in family members’ lives. However, this is not recognized and incorporated in service delivery in today’s society, which is more individualized.

There are risk factors for mental health problems that are influenced by culture, including the acculturation process, family breakdown, experience with trauma, economic hardship, and limited English proficiency. How we acculturate and how well we adjust to this society must be recognized as a risk factor. Some cultural adjustment is needed for the sake of survival in the United States. How adults acculturate and how children acculturate is different, contributing, in some cases, to family breakdown. Females may take on more of a leadership role in the family than they were used to, causing a family breakdown due to reversal of role definition. Another risk factor is that many Asian groups coming to the United States may have experienced trauma, possibly war trauma or domestic violence, which may have been more tolerated in some cultures than in American culture. Economic hardship and limited English proficiency also comprise risk factors for mental illness or substance abuse.

However, there also are protective factors to be considered and promoted, including respect, interdependence, cooperation, fatalism, and the emphasis on family. Wang stated: “The respect we have for each other; the respect we have for authority; and the way we see each other as interdependent, rather than as independent. We cooperate. We negotiate. The way we see things as fate, which makes us more tolerant of the inconveniences and disappointments in life... There is greater acceptance, and sometimes, with acceptance comes less struggle with life.”

## Recommendations

### Service Delivery

- *Consider “practice-based evidence” as an alternative to evidence-based practice for diverse populations*—The vast body of research needed to provide an evidence base for an intervention may not be possible with ethnically diverse population groups. An alternative may be to look at “practice-based evidence” that exists in communities and to document the impact and efficacy of ethnic-specific interventions.
- *Involve families with cultural activities*—One challenge is getting families to participate. There is so much cultural variation that families often do not come to community events; they stay within their own culture. One approach is to organize community events that are directed towards their cultures. For example, potlucks with ethnic foods can feature different countries and culturally appropriate recreational activities can provide a forum for mixing and for offering some training.

### Policy and Advocacy

- *Increase advocacy for Asian American populations*—There are stronger voices for other ethnic populations (such as Latinos and African Americans) in systems of care and in mental health in general. Increased advocacy on behalf of Asian Americans at national, state, and local levels is needed. One of the challenges around advocacy is that none of the sub-groups in the Asian American population is sufficiently large to do the kind of advocacy that other groups have accomplished. The various cultures need to work together to build a coalition to advocate on behalf of their needs. In addition, effective advocacy at the national level can occur only when a group of Asian Americans come together and take a confrontational route, which is probably foreign to many Asians. The role of the National Asian American Pacific Islander Mental Health Association (NAAPIMHA) is to advocate for Asian and Pacific Islander mental health issues.
- *Reduce stigma*—Stigma impacts whether people ask for services. At the policy level, it is important to address, in culturally competent ways, reducing the stigma around seeking mental health services.
- *Distinguish immigrant and refugee status and its effect on acculturation and assimilation*—How people come into this country makes a difference in their life experiences. It is important to understand immigrant versus refugee status and what happens by the second and third generation. This knowledge would improve the ability to provide appropriate services.

### Information Development and Dissemination

- *Collect evaluation data on Asian and Pacific Islander populations*—Capitalize on opportunities for collaboration across system of care communities to translate evaluation tools into various Asian languages and to develop effective approaches for data collection among ethnically diverse populations. For evaluation, consider grouping sites with large Asian and Pacific Islander populations and devoting time and resources to ensuring that data are collected and analyzed for ethnic subcategories, as well as assessing the relevance of various questions and instruments. A viable way to obtain good information on Asian American populations is through the national evaluation of the federal system of care program.
- *Disaggregate data for Asian and Pacific Islanders groups*—Most data collected about children served is aggregated. It will take much work to obtain information about population groups that are smaller and less visible in this society because they tend to be marginalized.
- *Share data across federal child-serving systems*—Federal agencies may have a great deal of data on Asian American children, including the education and child welfare systems. Tapping into cross-departmental information may provide data that would also inform mental health.
- *Increase research on Asian and Pacific Islander children*—This population is under-researched. More resources for quality research are needed to provide more information. Communities with populations of Asian and Pacific Islander children might collaborate in research projects and assist in data collection.

## Recommendations

- *Develop fact sheets explaining mental health services for ethnic groups*—Develop fact sheets and materials for the various groups explaining what mental health services are to provide some knowledge and expectations of what occurs when they interact with mental health systems.
- *Develop resource lists of organizations providing services to various Asian American subgroups in local areas*—Resource lists of agencies and organizations serving various Asian, Pacific Islander subgroups would be helpful. These organizations can provide inroads into the community.
- *Translate documents and evaluation instruments and tools*—Publishers may offer a source of assistance in translating some of the copyrighted instruments used in evaluations. For most instruments in the evaluation of the federal system of care communities, only translation into Spanish is mandated, and they are not available in other languages. Some concepts in evaluation instruments do not translate well, presenting significant challenges to using these instruments in Asian and Pacific Islander communities. Some new tools may be needed or the current tools need to be adapted.
- *Increase resources for research and services to emerging populations*—Emerging populations that are coming to the United States (such as Micronesians, Bangladeshis, and Hmong) often are not understood and are neglected and ignored. Resources are needed for research to better understand these populations and their needs and to learn more about services and supports. For example, thousands of people have come from the Federated States of Micronesia and little is known about this group and its needs. The National Institute of Mental Health (NIMH) is conducting a study in Palau because there is a high incidence of schizophrenia there. Funds for research on these groups should be a high priority amongst national and state advocacy groups, such as NAAPIMHA, and researchers should be encouraged to apply for funds to do this kind of research. There needs to be some kind of vigilance to ensure that the right questions are being asked and the right issues are being studied. Asian and Pacific Islanders are not just subjects to be studied, but there are important questions to ask that have implications for services and supports. Some potential areas for research include suicide prevention, acculturation stress, inter-generational stress, issues for recent refugees, trauma, human trafficking and sexual exploitation, and evidence-based and promising practices within Asian and Pacific Islander communities, and culturally defined or culturally specific healing practices.
- *Provide information and education about the various Asian American populations*—Materials (such as a pamphlet) with information about the different subgroups and brief explanations would be helpful to avoid grouping all Asian Americans into one group without distinguishing among the various sub-populations.

### Training and Technical Assistance

- *Incorporate culturally competent service approaches in training for mental health professionals*—Incorporate cultural knowledge, culturally competent service approaches, and culturally defined health practices in pre-service education programs for mental health professionals across disciplines.
- *Build an affinity group of system of care communities*—An affinity group of sites with large Asian populations should be created.
- *Establish a community of practice*—A community of practice could have a listserv, regular conference calls, email exchanges, etc. to disseminate information and share resources quickly and easily on services to Asian and Pacific Islander children and their families.
- *Develop a resource bank of experts and consultants with expertise in the various Asian and Pacific Islander populations to provide training and technical assistance*—Pulling resource information together with experts would provide communities with expertise to call upon when trying to meet the needs of specialized populations. The NAAPIMHA website has resources and a consultant database; this needs to be expanded and kept updated so that people can access information on Asian American, Pacific Islander groups. It is the responsibility of individuals and organizations to give information to NAAPIMHA.

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