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Authors

Ro, Marguerite

Ho, Wendy

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Practitioners' Essay

Aligning Policy to the Mental Health Needs of Asian Americans and Pacific Islanders

Marguerite Ro and Wendy Ho

Abstract

This paper examines federal and California state mental health policy as related to Asian Americans and Pacific Islanders. A brief review of several pertinent issues is presented: the mental health status of Asian Americans and Pacific Islanders, culture and stigma, insurance coverage and utilization, and the mental health workforce. Recommendations are suggested to address issues of data and research, culturally competent services, and accountability of existing policies.

Introduction

The mental health of Asian Americans (AAs) and Pacific Islanders (PIs) has been a long overlooked issue within AA and PI communities and by the behavioral health and general health care system at large. Many opportunities to assure good mental health have been missed, resulting in lower quality of life and preventable poor health. Mental health policies at the federal and state level dictate what basic resources and services are available to the population at large. As such, it is critical to understand how mental health policies affect AAs and PIs.

In order to assess where progress has been made and where policy falls short, we present a brief review of several pertinent issues: the mental health status of AAs and PIs, culture and stigma, insurance coverage and utilization, and the mental health workforce. We then examine the existing federal and state policies that impact the mental health of AAs and PIs. Federal policies that we examine include the Mental Health Parity and Addiction Act and the Patient Protection and Affordable Care Act. For purposes of examining state-level policy options, we focus on recent develop-

ments in California, as it is home to a large population of AAs and PIs and has made notable advancements in mental health policy, namely the Mental Health Services Act (Proposition 63), and the Medicaid 1115 Waiver.

We conclude with recommendations to align policies with the needs of AAs and PIs. Towards that end, we frame recommendations that address the need to have a solid knowledge base that provides evidence for the development of programs and policies, services that are responsive to the diversity of AAs and PIs and address cultural barriers to mental health, and holds systems accountable for fully implementing existing policies.

Mental Health of AAs and PIs

The most recent national data on the mental health of AAs is from the National Latino and Asian American Study (NLAAS), a nationally representative community household survey that estimates the prevalence of mental disorders and rates of mental health service utilization by Latinos and Asian Americans in the United States, conducted in 2002-2003. Data from this study indicate an overall lifetime rate of any mental disorder is 17.3 percent and the twelve-month mental disorder rate is 9.2 percent among AAs. In comparison to the general population, the lifetime prevalence of any mental disorder was 46.4 percent (Kessler et al., 2005, 596) and the twelve-month mental disorder rate was 26.2 percent (Kessler et al, 2005, 620) for the U.S. adult population No major differences were found among Asian ethnic subgroups, with data available for Chinese, Filipino, Vietnamese, and "Other Asian" groups; however; U.S.-born AAs were more likely to experience a mental disorder when compared to foreign-born AAs (Takeuchi et al., 2007, 86). No national data are available on rates of mental disorder for PIs.

The data and research stemming from NLAAS extend the knowledge gained from previous epidemiological and community studies. Many previous studies have estimated need based on utilization rates, but these estimations neglect those individuals who do not seek services (Takeuchi, 2002, 225). Other community studies are often small and are not representative of the larger AA and PI populations. The low rates of mental disorders among Asian Americans from the NLAAS may be a research artifact as the validity of the NLAAS survey instrument has not yet been thoroughly

established and may not capture or account for the differences in cultural manifestations of mental disorders. More research and studies are needed given the lack of consistent and representative data on AA and PI populations

Culture, Language, and Stigma

Culture, language, and stigma have all been identified as major factors in the presentation and help-seeking of mental health conditions among AAs. There is cultural dissonance between the existing health care system and how AAs and PIs perceive mental health, particularly for those who are foreign-born. Stemming from culture and traditions, many AAs do not distinguish mental health from overall health and tend to express more physical or somatic symptoms of distress compared with the general U.S. population (Lin and Cheung, 1999, 774). Studies have found that Chinese Americans are more likely to exhibit somatic complaints of depression than African Americans and Caucasians (Chang, 1985, 295), and Chinese Americans with mood disorders exhibit more somatic symptoms compared with Caucasians (Hsu and Folstein, 1997, 382). Mental health professionals and paraprofessionals unfamiliar with somatic expressions of distress may fail to accurately diagnose and appropriately treat AA and PI clients (U.S. Department of Health and Human Services, 1999).

The diverse languages found among AAs and PIs present significant challenges in assuring the availability of linguistically appropriate mental health resources and services. Over one hundred different languages are spoken by AAs and PIs. In California, 36 percent of AAs and 14 percent of PIs have limited English proficiency, whereas only 9 percent of the general population has limited English proficiency. Asian Americans in California have the highest levels of linguistic isolation (Asian Pacific American Legal Center, 2005), while Pacific Islanders have the third highest level of linguistic isolation in the state. More than one third of the AA population in California is *limited English proficient* (LEP). Six AA subgroups, including Vietnamese and Koreans, are predominately LEP (Asian Pacific American Legal Center, 2005).

Shame and stigma can have devastating effects on mental health problems. The Surgeon General's Report, "Mental Health: Culture, Race and Ethnicity," identifies stigma as the "most formidable obstacle" to making progress in mental health. A study

of Asian Americans in Los Angeles demonstrated how stigma was a major barrier to accessing mental health services (Zhang et al., 1998). Similar findings have been demonstrated among various Asian ethnic subgroups including Asian Indians, Vietnamese Americans, Chinese Americans, Korean Americans, and Filipino Americans (Conrad and Pacquiao, 2005; Fancher et al., 2010; Hsu et al., 2008; Jang, Chiriboga, and Okazaki, 2009; Sanchez and Gaw, 2007; Wu and Miller, 2009). Shame and stigma as experienced by the individual and the family often results in denial of mental health issues and lack of professional treatment.

Mental Health Coverage and Utilization of Services

Health coverage, or the lack thereof, continues to be a major systemic barrier to care. Coverage for mental health services is dependent upon having basic health coverage. Pacific Islanders (24%) lack health insurance at a rate higher than Asian Americans (17%). Among AA and PI ethnic subgroups, varying rates of health insurance reflect complex factors (i.e., citizenship status, age, gender, employment status) that determine access and availability to insurance coverage. The lack of health insurance coverage among AAs often is a result of not having available public or private options due to factors such as working for small businesses or being a new legal immigrant. For instance, more than half of the Korean Americans in the U.S. work for businesses with less than twenty-five employees. Yet only half of the employees in such firms receive coverage through their employer. As a result, Korean Americans have one of the lowest rates (49%) of employer-sponsored health coverage among AAs and PIs, compared to South Asians who have the highest rate at seventy-five percent (Kaiser Family Foundation and Asian & Pacific Islander American Health Forum, 2008). Overall, 31 percent of Korean Americans in the U.S. remain uninsured.

Public programs, such as Medicaid, are part of the safety net for low-income individuals needing health care. However, adult legal residents are barred from Medicaid for the first five years upon arrival. States have the option of lifting the five-year bar on Medicaid for children, yet few have done so (U.S. Census, 2008). Availability of Medicaid for Pacific Islanders is complicated due to the varying relations of the Pacific Islands with the U.S. government, which affects the rights and privileges of Pacific Islanders.

There is very low utilization of mental health services by AAs. NLAAS data reveal that, in a twelve-month period, only 3.7 percent of AAs utilize any formal mental health services, 2.9 percent use any informal mental health services, and 8.6 percent use any mental health-related services (Spencer et al., 2010, 2411). In comparison to other racial and ethnic groups, AAs appear to be the least likely to utilize specialty mental health services. Over a twelve-month period, 3.1 percent of AAs utilize specialty mental health services compared to 5.6 percent of African Americans, 5.9 percent of Caribbean Blacks, 4.4 percent of Mexicans, 5.6 percent of Cubans, and 8.8 percent of the general population (Spencer et al., 2010, 2411).

A recent analysis of the 2005 California Health Interview Survey revealed similar racial and ethnic patterns in mental health use as seen in the national data—Asian immigrants (3%) and U.S.-born Asian Americans (7%) were among the least likely to report visits to a mental health professional compared to other racial and ethnic groups (Grant et al., 2010, 5). Similarly, analyses of NLAAS data reveal that limited-English-proficient individuals with mental disorders were less likely than English-proficient individuals to seek services (Bauer et al., 2010; Kang et al., 2010). The low utilization of mental health services is likely to result from a complex array of factors, including cultural factors (i.e., cultural manifestations of mental disorders and stigma), poor access to care due to systemic barriers (i.e., health insurance policies that limit or bar coverage to certain groups of individuals such as new legal immigrants, lack of affordable health insurance coverage options, and insurance policies that do not cover mental health services), and lack of culturally competent and linguistically appropriate services (U.S. Department of Health and Human Services, 1999).

Culturally Competent and Linguistically Appropriate Services

The lack of bilingual and bicultural mental healthcare staff presents an enormous barrier to providing effective services to AA and PI populations. As the Surgeon General found, "[n]early half of the Asian American and Pacific Islander population's ability to use the mental health care system is limited due to lack of English proficiency, as well as to the shortage of providers who possess appropriate language skills" (U.S. Department of Health and Human Services, 2001, 117). As of the 1990s, approximately 70 Asian

American providers were available for every 100,000 Asian Americans (U.S. Department of Health and Human Services, 2001, 117). This statistic does not account for language capability of these providers, nor does it provide any indication of how the needs of the diverse Asian American population are met.

The few studies that have sought to determine the effectiveness of mental health services to the AA and PI population demonstrate a correlation between bicultural and bilingual providers with positive outcomes. One study found that AA clients matched with AA therapists were less likely to leave treatment prematurely than AA clients who were matched with non-AA therapists. Another study found that AAs used services at a higher rate when AA-specific mental health outpatient services were available (Sue et al, 1991). Similarly, AA youth who attended Asian-oriented mental health centers fared better compared to AAs who had attended mainstream centers (Yeh, Takeuchi, and Sue, 1994).

Mental Health Policy

At the federal level, various legislative acts have sought to assure mental health parity, though there continues to be gaps even for those with health coverage. Prior to the mental health parity acts, mental health coverage was optional and what coverage that existed tended to be minimal and not equivalent to physical health coverage. A summary of the major federal legislative actions follows below.

Mental Health Parity Act of 1996 (MHPA)

MHPA requires health insurance issuers and group health plans that offer mental health benefits to have aggregate annual and lifetime dollar limits on mental health benefits that are no more restrictive than those for all medical/surgical benefits. However, MHPA does not apply to substance use disorders or chemical dependency.

Small businesses (those with fewer than fifty employees) and group health plans experiencing an increase in cost due to the mental health provisions are exempted from MHPA. While MHPA places limits on annual and lifetime benefits, it does not address limitations on number of visits.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted to address some of the gaps not addressed

in the MHPA. MHPAEA requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to all medical/surgical benefits. MHPAEA applies to plans sponsored by private and public sector employers with more than fifty employees, including self-insured as well as fully insured arrangements. MHPAEA also applies to health insurance issuers who sell coverage to employers with more than fifty employees.

Although MHPAEA provides significant new protections to participants in group health plans, it is important to note that MHPAEA does not mandate that a plan provide MH/SUD benefits. Rather, if a plan provides medical/surgical and MH/SUD benefits, it must comply with the MHPAEA's parity provisions. Also, MHPAEA does not apply to issuers who sell health insurance policies to employers with fifty or fewer employees or who sell health insurance policies to individuals.

Patient Protection and Affordable Care Act of 2010 (aka Affordable Care Act)

The Patient Protection and Affordable Care Act of 2010 provided an opportunity to lessen the gap in parity, making mental health coverage an essential benefit of all new basic health plans participating in Health Benefit Exchanges. The Affordable Care Act expands coverage for an estimated thirty-one million Americans. This expansion will occur through the expansion of Medicaid and the creation of Health Benefit Exchanges for individuals and small groups. Plans in the "Exchanges" will be required to cover MH/SUD as part of the basic/essential benefits packages. Exchange plans must comply with MHPAEA.

Other critical improvements in coverage include remedying denial of coverage to pre-existing conditions, expansion of dependent coverage for children up to age twenty-six, and prohibiting lifetime limits on coverage. However, the Affordable Care Act does not allow for Medicaid coverage for new legal residents within the first five years upon arrival and prohibits undocumented residents from federally funded coverage and obtaining coverage through an Exchange.

Other notable access related provisions, as identified by the Bazelon Center for Mental Health Law, include:

> 1. Improvements in access to home- and community-based services. The state plan option to cover home- and community-based services (Section 1915(i) of the law) has been amended to raise the income level for eligibility so it is the same as under home- and community-based waivers (i.e., 300 percent of the Supplemental Security Income level in the state). This is potentially very beneficial for individuals with severe mental illness.
>
> 2. A new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition, to designate a provider as a health home. Community mental health centers are listed among eligible entities that can be designated as a health care home.
>
> 3. Workforce and pipeline incentives to increase the pool of mental health providers. This includes new mental health behavioral health education training grants and support for loan repayment programs.

Despite these tremendous advances in federal legislation toward mental health parity, there are still some policy limitations. Most federal and state parity legislation exempts individual plans and small business (i.e., companies with fewer than fifty employees) plans from mental health parity requirements. In addition, the recent Affordable Care Act does not mandate that *all* plans provide mental health benefits, leaving considerable room for policy improvement at the state level.

State parity laws vary by illnesses covered, type of insurance policies and plans that are affected, and co-pays/co-insurance. For instance, three states (Colorado, Texas, and Montana) have "bare-bones" exception laws that allow small employers to purchase a basic health plan that does not include coverage of mental health or substance abuse disorders. For larger employers, plans must cover severe mental illness, but do not have to cover other mental health disorders. In those instances, insurers must offer at least one policy with state-mandated health benefits (National Conference of State Legislatures, 2010).

Existing and new plans must be in accordance to both federal and state mental health parity laws. Clarification and coordina-

tion of federal and state laws will have to be addressed, given the enactment of the Mental Health Parity and Addiction Equity Act and the passage of the Affordable Care Act. Federal mental health parity does not replace state parity laws when the state parity laws are stronger.

State Policy: California's Mental Health Services Act of 2004 (aka Proposition 63)

California, home to the largest proportion of AAs and PIs, is also a leader in innovations to address mental health services at the state level. The centerpiece of California's efforts to improve mental health services is the Mental Health Services Act of 2004, which, if fully implemented, presents a tremendous opportunity to increase culturally appropriate mental health services.

In 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). The MHSA provides increased funding, personnel, and other resources to support county mental health programs and monitor progress toward statewide mental health goals. The MHSA addresses a broad continuum of prevention, early intervention and service needs, and the necessary infrastructure, technology, and training elements that will effectively support the mental health system. The Act imposes a one-percent income tax on personal income in excess of $1 million. This funding may not be used to supplant existing services without voter approval.

The six key components of MHSA to expand community mental health services include: Community Planning, Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovative Programs, Capital Facilities and Technology, and Workforce Education and Training.

There is a strong emphasis in MHSA on culturally competent services for underserved populations. The statute's "Purpose and Intent" notes that the state should expand its cadre of successful and innovative programs, inclusive of "culturally and linguistically appropriate approaches for underserved populations." Additionally, there must be an emphasis in PEI programs on improving access for underserved populations in a timely fashion. Likewise, services to adults and seniors with severe mental illnesses must include planning that reflects "the cultural, ethnic and racial diversity of mental health consumers"(California Welfare and Institution Code 5813.5(d)(3)).

The California Department of Mental Health (DMH) issued a "Vision Statement and Guiding Principles" document to guide its implementation of MHSA, further reaffirming DMH's commitment to creating a culturally competent mental health system. In the document's section on cultural competence, DMH emphasizes the need to conduct outreach and to expand services in order to create accurate prevalence estimates and eliminate disparities in access and accessibility. Additionally, the DMH suggests that assessments should be more culturally and linguistically appropriate, bearing in mind "a client's and family's culture, race, ethnicity, age, gender, sexual orientation and religious/spiritual beliefs"(California Department of Mental Health, 2005, 4).

The scope and potential impact of the MHSA has been and is subject to the economic downturn and the state budget deficit. To relieve the budget deficit in early 2010, the Governor's Budget proposed a reduction of $452.3 million from the General Fund and a substitution with MHSA funding for the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program and a portion of the Mental Health Managed Care program. This proposal was rescinded in the Governor's May revision of the budget, which restored $452.3 million from the General Fund to the EPSDT program. The program remains fully funded in the Governor's final budget. As it stands, estimates of the MHSA allocations suggest that there will be between a fifteen percent and twenty percent decrease in MHSA funding in fiscal years 2011/2012 and 2012/2013.

State policy: California's Medicaid Waiver

Medicaid is the single largest payer for mental health services in the U.S.. Waivers allow states to use federal Medicaid dollars in ways other than that dictated by federal standards and

Table 1. MHSA County Planning Estimates
Conservative Estimate (Dollars in Millions)

	FY 10/11	FY 11/12	FY 12/13	FY 11/12	FY 12/13
CSS	$783.6	$691.8	$588.9	-12%	-15%
PEI	$216.2	$172.9	$147.2	-20%	-15%
INN	$119.6	$45.3	$38.7	-62%	-15%
Total	$1,119.4	$910.0	$774.8	-19%	-15%

Source: Ryan, 2010.

options. California's Medicaid 1115 waiver for hospital financing and uninsured care expired in August 2010. California successfully pursued a new 1115 waiver to "create more accountable coordinated systems of care, strengthen the health care safety net, reward health care quality and improve outcomes, slow the long-term expenditure growth of Medi-Cal (California's Medicaid program), and expand coverage to uninsured Californians" (California Mental Health Directors Association et al., 2010). The development of a new 1115 waiver provided an opportunity to address unmet mental health needs of vulnerable populations. One of the four vulnerable populations that the Department of Health Care Services had identified as a focus of the 1115 waiver are adults with several mental illness and/or substance abuse disorders. Stakeholders also recommended that pilot projects be targeted towards the elimination of racial and ethnic disparities. California's Medicaid 1115 waiver was approved in November 2010 and the state will receive approximately $10 billion in federal funding to invest in health system delivery reforms (Department of Health Care Services, 2010).

Workforce Policies

The Annapolis Coalition on the Behavioral Health Workforce (Annapolis Commission) was commissioned by the Substance Abuse and Mental Health Services Administration (SAMHSA) in conjunction with other federal agencies to develop a national action plan for strengthening the behavioral health workforce. In their report, "An Action Plan on Behavioral Health Workforce Development", the Annapolis Coalition noted the lack of cultural diversity in the behavioral health workforce and plainly stated, "the workforce at large cannot be characterized as culturally or linguistically competent" (The Annapolis Coalition on the Behavioral Health Workforce, 2007, 12). The recommended objectives for future action are: establishing a clearinghouse for dissemination of culturally competent practices; increasing staff development on such practices across all levels of the workforce; ensuring a critical mass of culturally competent faculty, trainers, and mentors; and developing standards and adequate reimbursement for interpreters who are trained to work in behavioral health.

As noted above, the Affordable Care Act will provide for new training grants, though it is not clear to what degree this will enhance the diversity of the mental health workforce. Given the

increasing diversity of the AA and PI population, and the U.S. population as a whole, an action plan that focuses specifically on assuring the culturally and linguistic competency of the mental health workforce may be needed.

In addition, the American Recovery and Reinvestment Act of 2009 included $500 million in funding to expand the health professions workforce. This included funds for loan forgiveness programs for mental health professions (licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors).

Aligning Policy with Needs

In order to align policy with the mental health needs of AA and PI populations, a critical first step is to build the knowledge base on the mental health needs and use of mental health services by AAs and PIs in the aggregate, as well as disaggregated by ethnic subgroup. With the advent of health information technology and federal efforts to implement electronic health records, there is a unique opportunity to collect standardized data on race/ethnicity and primary language that can be used to dissect mental health needs and use of mental health services. Two of SAMHSA's strategic priority areas are: Health Information Technology for Behavioral Health Providers, and Data, Outcomes and Quality—Demonstrating Results.

Recommendations for data collection:

- SAMHSA, in conjunction with the Department of Health and Human Services (DHHS), should follow the recommendations in the Institute of Medicine's report on *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* (2009) in its national surveys and surveillance efforts (Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement & Institute of Medicine, 2009).
- Health Information Technology policy should follow the recommendations in the Institute of Medicine's report on *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* (2009) on using data collection and monitoring to ensure cost-effective and efficient quality care for limited English proficient individuals and minorities.
- SAMHSA working with the National Center for Health

Statistics should explore strategies to oversample AAs and PIs to assure that national surveys and surveillance efforts adequately capture data on AAs and PIs.

- States, in developing and monitoring their behavioral health contracts, should also require adoption of standardized data collection and reporting by race, ethnicity, and primary language that allow for AA and PI use of services to be determined.

Beyond data collection is the need for research that accounts for the diverse ethnicities and the diverse social contexts of AAs and PIs. Developing the evidence-base that accounts for the diversity of AA and PI populations in terms of ethnicity, culture, nativity, and exposure to environmental factors that influence behavioral health is greatly needed to support the allocation of resources and development of programs and services. The National Institutes of Health (NIH) should support and increase trans-disciplinary research that seeks to fill in the knowledge gaps related to the behavioral health of AA and PI ethnic subgroups. NIH should also increase its support for behavioral and social sciences research to fill the large knowledge gap on the social and environmental factors that impact the behavioral health of AAs and PIs.

There is a critical need to increase culturally and linguistically appropriate mental health services. This is true in general, but also in times of extreme circumstances, such as natural or man-made disasters, such as Hurricane Katrina and the Gulf Coast oil disaster which resulted in mental health crises for Asian Americans living in the effected regions. With the exception of psychiatrists, AAs and PIs are very underrepresented in the workforce with only 1.5 percent of psychologists, 2 percent of social workers, 0.01 percent of marriage family therapists and 0 percent of psychiatric nurses (Center for Mental Health Services, 2006, 261). There is no data that indicates what percentages of these providers are also bilingual. Given the shortage of AA and PI mental health professionals, pilot programs are needed to explore promising strategies to ensure that culturally appropriate services are provided. This may include the use of community health workers, patient navigators, and other lay workers who can act as a bridge between diverse ethnic communities and mental health providers and systems. Developing pipelines of mental health professionals that reflect

the diverse ethnic subgroups within the AA and PI population is needed in the long run. Until there is an adequate supply of bicultural and bilingual mental health professionals, the use of trained interpreters is needed.

Recommendations for workforce development:

- DHHS should ensure that at least one representative on the National Workforce Commission is a recognized expert on diversity in the health and behavioral health care workforce.
- Federal and state policies should incentivize the use of trained and qualified interpreters. This should include adequate federal and state reimbursement for language access services.
- Public and private funders should support pilot programs of culturally appropriate mental health programs and services.
- The Health Resources and Services Administration, SAMHSA, and academic institutions should develop pipeline programs that aim to increase the diversity of the mental health workforce.
- States should require training on cultural and linguistic competence as part of the certification of providers.
- Primary care and behavioral health systems should support culturally relevant team-based care that supports an integrated care approach.
- DHHS, working with other Departments, should continue to develop behavioral health response systems for crises that are culturally and linguistically appropriate. DHHS should seek input from AA and PI health organizations and community leaders to assure the viability and quality of these systems.

Stigma is a major issue in addressing the mental health of AAs and PIs. California has developed a ten-year strategic plan to reduce mental health stigma and discrimination that may serve as a model for other states and localities. The plan offers a comprehensive range of strategies, starting from changing attitudes, beliefs, and practices; to promoting awareness and accountability; to enforcing the laws; and to increasing knowledge through research and evaluation. It adopts a community tailored approach and incorporates community-wide strategies and responsive practices.

Full implementation of the plan will require the engagement of diverse stakeholders from multiple disciplines working together.

The plan is based upon six core principles (Schwarzenegger, Belshe, and Mayberg, 2009):

- Implement culturally and linguistically competent strategies and programs that reduce disparities and reflect the values and beliefs of diverse populations.
- Employ a lifespan approach to effectively meet the needs of different age groups.
- Involve a broad spectrum of the public, including mental health consumers, family members, friends, caregivers, mental health and allied professionals, advocates, and agencies that interact with children, youth, adults, and older adults.
- Address all types of stigma and anti-discrimination laws.
- Build upon promising practices and proven models.
- Recognize that individuals experiencing mental health challenges are resilient and have the capacity for recovery, and that the best results in treatment for those experiencing mental health challenges come from voluntary programs that offer choice and options

To combat institutional stigma and, to some degree, individual stigma, anti-discrimination laws serve to protect the rights of individuals assuring them of their civil rights, access to fair housing options, opportunities for employment, education, and full civic participation. Federal and state efforts are needed to enforce existing policies and to assure full implementation and enforcement of these policies.

Recommendations for addressing stigma:

- SAMHSA's Office of Minority Health should address mental health stigma among racial and ethnic minorities as one of their priorities.
- State and local health jurisdictions should develop and implement plans to address mental health stigma and discrimination that include culturally tailored anti-stigma campaigns.
- Federal and state offices of civil rights should promote compliance, enforcement, and enhancement of current anti-discrimination laws and regulations across all sectors (housing health, education, etc).

Conclusion

Mental health care is fundamental to the overall health and well-being of AAs and NHPIs, and indeed all populations. To assure that AAs and PIs can fully participate in their families, communities, and society, targeted efforts and policies are needed to ensure access to culturally and linguistically appropriate mental health and substance abuse disorder services, and to overcome negative cultural perceptions of mental illness. This will require acknowledging the cultural and ethnic diversity of AAs and PIs, and shaping mental health systems to respond appropriately.

This paper presents a basic policy framework with broad recommendations for addressing the mental health needs of AAs and NHPIs. There is great need for research that disaggregates AAs and PIs to account for cultural and ethnic differences; research that incorporates Western and Eastern perspectives on prevention, treatment, and care; outreach and education that is tailored and directed towards AA and PI communities; and support for the development of community-based services.

Progress will require efforts at federal, state, and community levels. With the advent of the Affordable Care Act, the implementation of MHPAEA, and continuing state efforts to address mental health and substance abuse disorders, there are opportunities to include AA and PI perspectives in the design of federal and local mental health policies and systems.

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Marguerite Ro, DrPH is the Chief of the Assessment, Policy Development, and Evaluation (APDE) Section of the Public Health Seattle-King County health department. She is the former Deputy Director of the Asian & Pacific Islander American Health Forum

Wendy Ho, MPA, is the Research and Policy Analyst for the Asian Pacific Islander American Health Forum

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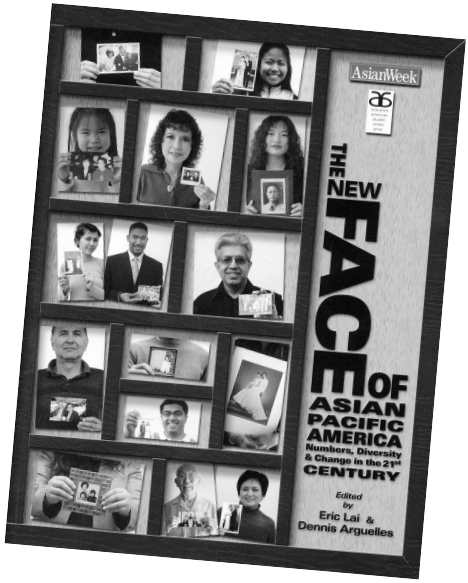

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