



API Connections – MHSA Prevention & Early Intervention

Supporting Immigrant & Refugee Communities in Alameda County

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Why we love PEI so much

- **Visionary approach:** ACBHCS intentionally connecting with **more diverse communities** through targeted Underserved Ethnic and Language Populations (UELPP) programs: APIs, South Asians, Native Americans, Afghan, Latinos/Hispanics
- UELPP is helping **fill gaps** in the system: Reaching new, small and emerging communities
- Collection of **disaggregated data** (ethnicity and language)
- Community wellness advocates address mental health **workforce gap**
- **API Connections** has been a powerful platform for identifying and elevating the visibility of immigrant and refugee mental health issues in Alameda County
- **UELPP is generative-** we have identified **new areas of need** that have resulted in new programs and efforts

Unserved API Communities

CHAA's TARGET COMMUNITIES:

- ❑ Refugees from **Bhutan** – speak Nepali, live in Oakland and Alameda
- ❑ Refugees, asylees and Immigrants from **Burma – diverse communities, refugees in Oakland mostly, others in South County:** Karen, Karenni, Chin, Kachin, Rakhaing, Burman, other ethnicities
- ❑ **Mongolian** – mostly in Oakland, many undocumented
- ❑ **Nepali** – throughout the County, many undocumented
- ❑ **Pacific Islanders:** Tongan, Chamorro, Fijian, Hawaiian Native, Samoan, other Pacific Islanders, many undocumented
- ❑ **Thai** – throughout the County, temples in Berkeley and Fremont, many undocumented
- ❑ **Tibetan** – Oakland, Albany, Berkeley, also El Cerrito and Richmond
- ❑ CHAA's 6 Community Wellness Advocates speak **14 languages**

CHAA's Model



- ❖ **IDENTITY & EXPERIENCE: Community Wellness Advocates**
- ❖ **REDUCE STIGMA: Integrate mainstream mental health concepts with cultural wellness practices**
- ❖ **MEET COMMUNITIES WHERE THEY ARE: Community engagement strategies based on readiness**

Challenges faced by Newcomer Immigrant and Refugee Communities



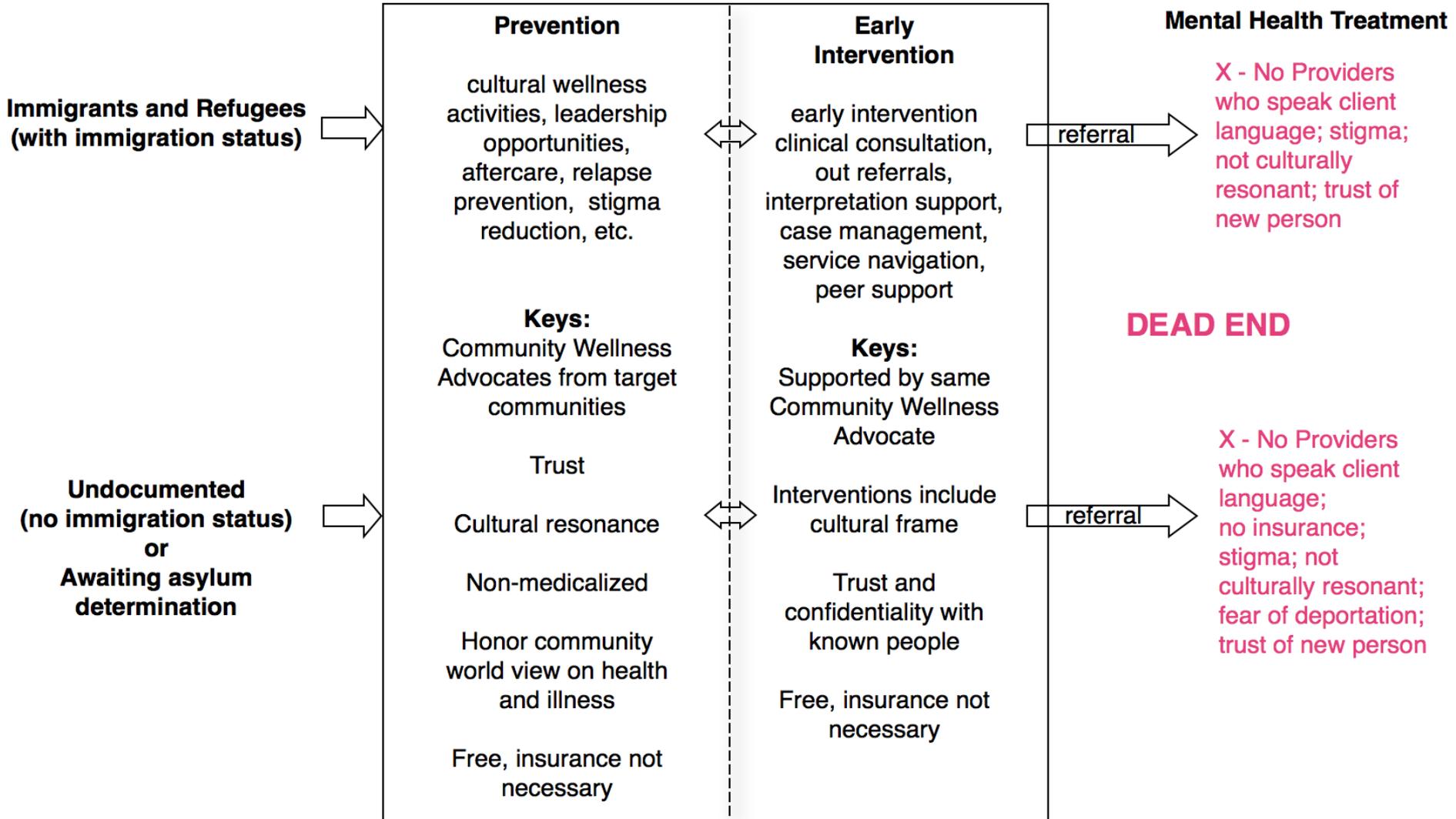
Building community, connection and leadership are keys to mental health and overall well-being,

- ❖ **Access to quality care/services**
- ❖ **Limited systems navigation knowledge**
- ❖ **Language barriers**
- ❖ **Immigration and/or Citizenship challenges**
- ❖ **Un/Under-employment**
- ❖ **Limited Educational Advancement Opportunities**
- ❖ **Social Isolation**

Mental Health Needs

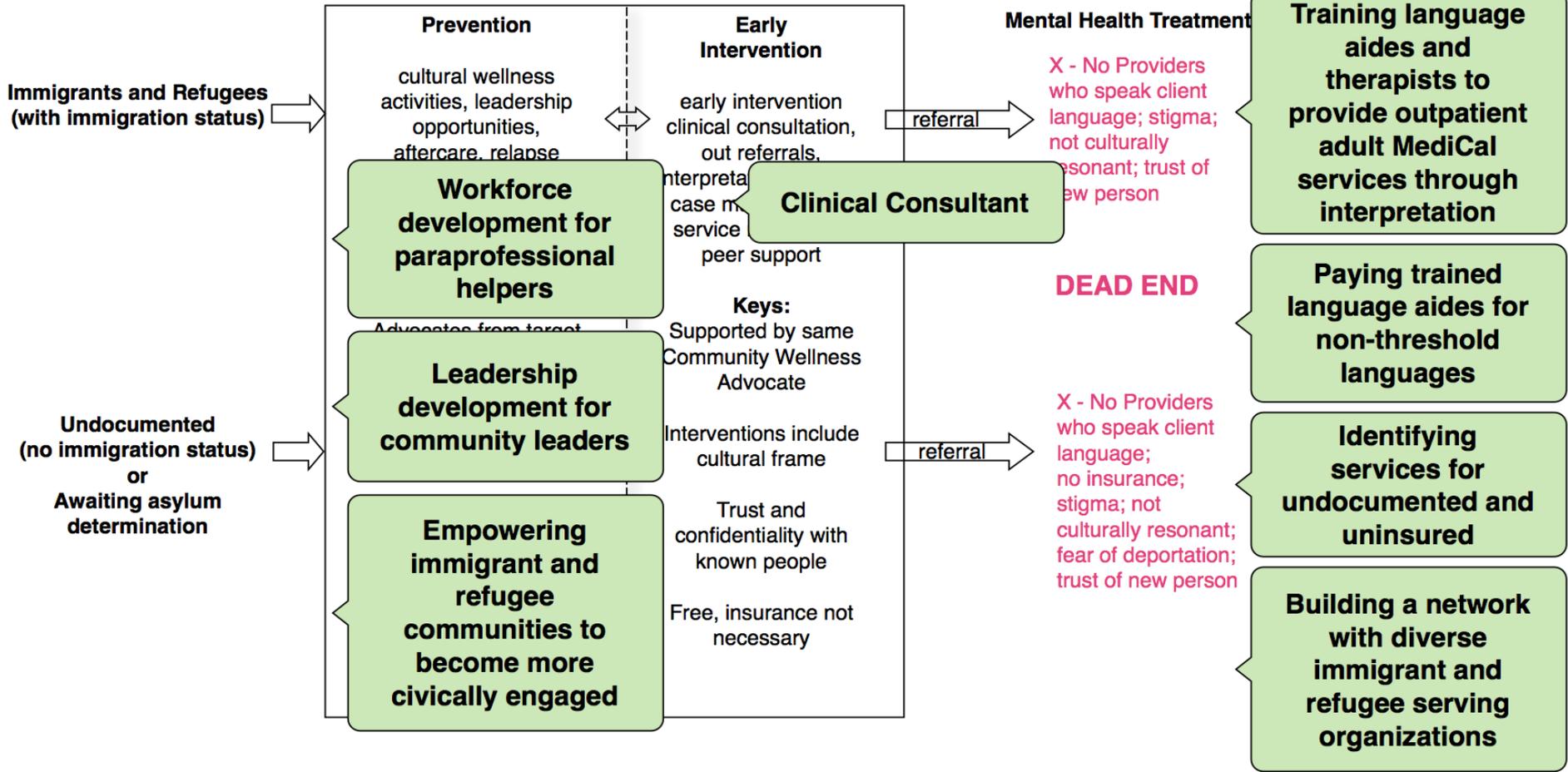
- ❁ **PTSD, Depression, Anxiety**
- ❁ **AOD, Gambling, Domestic Violence**
- ❁ **Histories of trauma, exposure to violence**
- ❁ **Different conceptions of mental health and illness than mainstream Western framework**
- ❁ **Stigma around mental health & help-seeking**
- ❁ **Virtually no mental health services or providers (language & cultural challenges)**

API Connections



For the communities we serve, our program is often the ONLY AVAILABLE SERVICE addressing mental health concerns. The program is their ACCESS TO THE MENTAL HEALTH SYSTEM.

API Connections



Even if we do all this....

- ❑ **No therapists.** It will be years, perhaps decades, before there are therapists from the communities we serve in places where our communities can access their services. **Diversity will be, increasingly, our growing challenge.** 34% of Alameda County's residents are foreign born, and growing.
- ❑ **“If we build it, will they come?”** MediCal-funded treatment service models make it difficult to provide services for our communities— revenue model, modality, diagnoses, stigma in small communities, cultural fit. Our language aide-supported model is an experiment that we're not sure will work or survive because of these challenges.
- ❑ There has been **almost no investment in the future mental health work force for the communities we work with and those like them;** most is investment in what is the mainstream workforce, people at the latter stages of the pipeline.
- ❑ The system is **conceived with mainstream consumers in mind first,** rather than designed with vulnerable cultural communities in mind first. Addressing the needs of the most vulnerable creates a better system for everyone.

Collection of Duration of Undiagnosed Mental Illness Data

- The impact of **stigma**
- The impact of **immigration status**
- The impact of **community readiness for our mainstream mental health definitions** on whether to seek out a service
- Don't understand how "talking" can help, look for more **concrete support** like support in getting work
- **Who will do the assessment?** Paraprofessionals need clinical supports to move a client to and through assessment
- Paraprofessional staff share many of the same stigmas as their community members, and can face pressures to minimize, downplay the mental health issues their clients present.
- Referral should include **non-treatment options, including prevention activities** within the same organization

Data Collection and Evaluation

□ Community Trust:

- **Histories of trauma and oppression:** Many of our communities come have long relationships with authorities (undocumented, asylee, refugee) that make them reluctant to and traumatized by requests to share information
- **Resentment:** Communities feel they are being used to help providers receive government funding
- **Survey-fatigue:** Individuals who are high need clients are asked about their personal data throughout all systems they encounter and do not understand why they are being surveyed so many times

□ Staff Challenges:

- Burdensome for part-time paraprofessional staff
- Staff carry same beliefs as communities around data collection and mental health stigma
- Burden for translating and explaining data collection to community members can more timely and take away from programs

Conclusions

- ❑ There is still a lot of work to do to level the playing field.
- ❑ The expectations in the regulations are easier to adopt for some communities and providers than for others. The regulations project an assumption that referral for treatment services and identifying duration of undiagnosed mental illness are easy uniformly for all communities
- ❑ New barriers and challenges are often caused by planning based on poor understandings or no consideration of issues that impact vulnerable communities most acutely
- ❑ By placing PEI in service of the medical model, **the regulations drive PEI programs towards the medical model, rather than allowing PEI to contribute to the transformation of the mental health system that MHPA promised**

The logo features a stylized green leaf icon to the left of the word "chaa" in a lowercase, rounded font. Below this, the text "COMMUNITY HEALTH FOR ASIAN AMERICANS" is written in a smaller, uppercase font.

chaa
COMMUNITY HEALTH FOR ASIAN AMERICANS



Building
Home
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