Photo courtesy of Ellen Ahn

CHAPTER 5

HEALTH CARE SERVICES

ASIAN AMERICANS ADVANCING JUSTICE ORANGE COUNTY

Culturally appropriate and linguistically competent education and services are of critical importance in addressing Asian American & Native Hawaiian and Pacific Islander (AA&NHPI) health disparities in each community. In Orange County, there are a number of AA&NHPI organizations and health care professionals that deliver linguistically and culturally competent services and education to AA&NHPI communities, particularly to low-income immigrants and refugees who are monolingual and limited English proficient, and even to non-AA&NHPI. While AA&NHPI contribute significantly to the county's health care services system, there are also continuing health service delivery needs as well as access to medical coverage that impact AA&NHPI. Providing timely and appropriate physical, behavioral, and mental health services to AA&NHPI ethnic groups is especially difficult as there are barriers both within the community and in the system. Ethnic organizations provide much-needed services that are not provided by most mainstream providers, but this fragile safety net for vulnerable AA&NHPI faces funding, capacity, and other challenges that threaten its ability to sustain quality care for the vastly diverse AA&NHPI community in the county.

ASSETS

Culturally and Linguistically Competent Workforce

AA&NHPI have been critical in contributing to both the mainstream health care system in Orange County and the development of culturally and linguistically competent services in the community. Linguistic competence is the ability to speak a client's preferred language, and cultural competency is understanding the cultural practices and behaviors, and even historical background, of the clients. Asian Americans make up 38% of the health care practitioners and technicians in the county, and over 36% of Filipino Americans work in health care and social assistance professions.[1] The top industries in which Native Hawaiians and Pacific Islanders in Orange County are employed are also health care and social assistance.[2] AA&NHPI work in a wide range of health care jobs that treat or provide services to patients and clients in hospitals, health care centers, and homes. However, given the increasing number of AA&NHPI populations, there is still a shortage of culturally and linguistically competent health care service providers (see Needs section).

Photo courtesy of Vattana Peong

The personal and family experiences of several community leaders motivated their health and social service work with AA&NHPI communities. Mary Anne Foo, who is of Chinese and Japanese ancestry and the founding executive director of the

Orange County Asian and Pacific Islander Community Alliance, says that growing up in Marysville, California, she faced anti-Asian racism that led her to depression and drug and alcohol abuse as a teenager "because I just wanted to fit in and I wanted to be White." Her post-college community work with the Association of Asian Pacific Community Health in the San Francisco Bay Area helped empower her to be proud of being Asian American and to work on Asian American issues: "That journey from self-hatred to kind of exploring and seeing, oh, the community is really diverse and interesting, to self-acceptance and self-love, was through that period."

Michael Matsuda, a third-generation Japanese American and superintendent of the Anaheim Union High School District, relates how he saw intergenerational trauma among his family and other Japanese Americans who experienced mass incarceration during World War II, an experience that had deep emotional impact on the community but is often not talked about within families: "It did take its toll when you think about the emotional trauma passed on generationally because we as adults now can look at the relationship between my mom and my dad, within the family, and how that trauma—even though you're trying to bear with it and have the guts to go through it—I think it did take an emotional toll on families generationally." As a leader of a large school district, Matsuda found his family's own experience with intergenerational trauma helpful in understanding the experiences and mental health needs of many of his students who are from refugee families.

Shikha Bhatnagar, who immigrated from India as a child and is the executive director of the South Asian Network, also talks about growing up and observing family trauma and domestic violence in the South Asian community and noticing the community's lack of response to such issues. This motivated her to work on gender justice issues in the community: "That also really sort of fueled my anger about the way that our community responds to domestic violence." The personal insights and commitments of these community leaders motivate them to address health care and its related issues from a culturally nuanced perspective.

Leadership of Culturally and Linguistically Competent Community Organizations

In addition to the contributions of AA&NHPI health care professionals and workers, AA&NHPI community-based service agencies and clinics have also played an important role since the 1990s in addressing health and social service needs of new immigrants and refugees in Orange County. They provide direct and indirect linguistically and culturally competent care to diverse AA&NHPI ethnic groups and address needs that may be overlooked by mainstream hospitals and health care providers. Ellen Ahn, executive director of Korean Community Services, remarks that even if mainstream organizations have staff with relevant language

skills, they "just don't have the reach that a community organization has. And that reach involves relationships, history, trust, reputation—all of those things that a couple of staff or a department just cannot do—and so we fill that gap."

Jane Pang, cofounder and board member of Pacific Islander Health Partnership (PIHP), explains how her organization has played an important role in translating materials for the Pacific Islander communities, which are often overlooked because of their relatively smaller population:

> Every time we have a new program coming out I'm asking, 'Can we get it done in Samoan and Tongan?'—at least two of my five languages. And they would get the Vietnamese, they would get the Korean, they would get all the other ethnicities. And I said, 'Could we just get one in Samoan, translate in Samoan?' The state could never get that [and would say] 'There wasn't enough resources.' So this is what part of the basic mission for PIHP is. . . . Let's find resources so then we can then take the information and do our own translation. And that way we can then help the small organizations who we network with some extra resources.

Shikha Bhatnagar of the South Asian Network echoes the same sentiment in serving the South Asian population—that the familiarity of the South Asian Network with the culture of the community allows it to be more effective in delivering services:

> Understanding how the experiences of a Bangladeshi American and their culture as a Bangladeshi Muslim . . . it's very specific. . . . We have this group of Punjabi aunties come in the other day, you know the way that you speak with them, . . . sometimes you have to be firm in a way that maybe a non–South Asian would be uncomfortable doing. But the person who's from that culture understands that the only way this person is actually going to make it to this appointment is if you're a little firm with them. . . . There's not only language, but it's the cultural nuances as well when we deliver these services.

Having cultural understanding is especially critical for many refugees from Vietnam, Cambodia, and Laos who may not only be monolingual or limited English proficient but also traumatized by war and displacement. Tricia Nguyen, the CEO of Southland Integrated Services, formerly the Vietnamese Community of Orange County (VNCOC), describes how the organization was created in 1979 in response to Vietnamese refugees settling in the county:

> It started out because of the influx of Vietnamese [who] immigrated here when we lost our country. So a group of volunteers got together and [said], 'We need to have a nonprofit to help the community.' So we started out as [providing services for] immigration, citizenship, offering

> job skills in our classes. And then about 10, 12 years after that, they say, 'We need a clinic.' So that's how they started the Asian Health Center [which was part of VNCOC].

Southland Integrated Services now has over 60 staff and continues to expand to address the evolving health needs of the Vietnamese American community, including dental and mental health services.

Vattana Peong, executive director of The Cambodian Family, which was founded in 1982 by Cambodian refugees to help other newly arrived Cambodians in Santa Ana, explains how the community has difficulty talking about its past history and how its staff spends time to build trust with each client who is dealing with "all those kind of stories of war, of genocide. So the clients are most likely not [going] to disclose that information or tell that client information to providers who [do] not really understand what [is] happening—the root cause behind immigration and refugee experiences."

Before these community-based organizations and clinics that developed in recent decades, many AA&NHPI in Orange County had to rely on organizations in Los Angeles County for assistance. Mainstream organizations in Orange County were not providing linguistically and culturally competent health care services, resulting in high levels of disparities when it came to health care access. In response to this, community-based organizations saw the dire need and began delivering services to the underserved, becoming a critical safety net. Remarking on the impressive growth of Korean Community Services, which now has 80 staff and has expanded its social services to include a medical clinic, Ellen Ahn of Korean Community Services says that "We used to, 10 years ago, literally advise our clients to move to LA because the services are better there, and we no longer have to do that." These ethnic community organizations have been critical in developing a health care and social service infrastructure that addresses the health care needs of Orange County's AA&NHPI populations.

Collaborations to Deliver Effective and Impactful Services

Responding to Orange County's demographic growth, organizations such as the Orange County Asian and Pacific Islander Community Alliance (OCAPICA) formed and emphasized collaboration across ethnic groups to more effectively deliver services. Drawing upon her previous experience working with pan-Asian coalitions in Los Angeles and San Francisco, founder and executive director Mary Anne Foo of OCAPICA brought together other emerging AA&NHPI community leaders in 1997 to work on health care issues. The vision of a multiethnic collaboration was an important aspect that second-generation AA&NHPI community leaders brought to the table:

> It was young, new leaders who built a good reputation that could help us build trust. Because there was so much fighting in Orange County among first generation and between the different Asian American and Pacific Islander ethnic groups that I really thought about this. It has to be 1.5 or second generation who sees the whole Asian American and Pacific Islander [community], who aren't saying 'I'm Vietnamese, I'm fighting for Vietnamese' or 'I'm fighting for Koreans' or 'I'm fighting for Chinese,' . . . but that the board would see themselves as '[I'm] Asian American' or 'I'm Pacific Islander' or 'I'm API' [Asian Pacific Islander] . . . because we need to fight for everybody.

Michael Matsuda, a U.S.-born Japanese American who supported Foo to form OCAPICA, adds, "You put the sticks together and you're a lot stronger. And that's where I think Mary Anne Foo, her vision of creating this cross–Asian Pacific organization that would be much stronger together rather than isolated and being pitted against each other [was effective]." Today, OCAPICA has approximately 100 staff who speak 24 languages and provide programs in addition to health, including employment, education, and civic engagement.

Holistic and Inclusive Approaches to Health Care Services

Leaders of AA&NHPI organizations also expressed a broad vision of their role in the Orange County community. Their holistic view of health includes comprehensive services that address the different aspects of health while also creating healthy communities that address language barriers to education, workforce development, and political engagement. Michael Matsuda speaks about OCAPICA's vision as "grounded in social justice and a deeper understanding of not just sort of giving services but also empowering with education and empowering with a voice, so we can empower more of our community to come forward and articulate that in a way that is going to impact the larger system." OCAPICA, Korean Community Services, and Southland Integrated Services serve senior citizens, families, and youth, and all three organizations provide mental health services, while the latter two also provide medical services. These organizations also provide wraparound services for families to deliver mental health services for the children as well as for their parents and to improve relationships within the family. The California passage of Proposition 63 in 2004 was critical in allocating funding for many ethnic communities to provide these mental health services. To meet growing client populations, some groups have multiple sites and conduct off-site outreach and education at schools, businesses, and faith institutions, to ensure that AA&NHPI communities are being served where they live, work, and pray.

Although many of these organizations may have started with a focus on AA&NHPI, many now serve other communities in Orange County facing similar issues. Since these organizations work with low-income clients, many who

are immigrants or refugees, they have been able to apply their knowledge and experiences to serve other underserved populations. After they received their first funding in 1983, The Cambodian Family employed a diverse staff that served not only Cambodian Americans but also Latinos and Eastern European and African refugees who, like them, had escaped war and famine. With budget cuts, they were forced to downsize; however, executive director Vattana Peong describes how the organization serves both Cambodian Americans and Latinos, and emphasizes how they are able to serve both communities because they have shared experiences:

> That has always been a question asked to our agency: How can you work with Latino populations or other populations? . . . So that is the key thing. So when we have, for example, health education together, we try to be inclusive, so we have a translator for them. . . . We have ethnic food for them as well to make sure that we are diverse. And for our after-school program, it's very important because our after-school program is a mixture of Latino and Cambodian youth in the same room. How are they going to be working together? So we have a very skilled staff member who is able to work with them by having them share their experiences because . . . 95% of our clients are immigrants or refugees, so they were able to share their experiences, their experiences of resiliency, their experiences of struggle with their parents. So they were able to listen to each other.

"There's not only language, but it's the cultural nuances as well when we deliver these services."

Southland Integrated Services CEO Tricia Nguyen says that the organization changed its name from the Vietnamese Community of Orange County to better reflect its clientele and to be more inclusive of those who need the services provided by the center, regardless of their ethnic background:

> So I changed [the health clinic that had been called] Asian Health Center to Southland Health Center, and it was received very well from the non-Vietnamese population because we serve everybody. And they say, 'Oh my god, we're so glad you changed your name because we feel like when we see Asian Health Center, we feel like we don't belong there or you don't want to focus on us.' And then after that, about a year, a year ago, I said, 'You know what? Let's just be brave and let's just close our eyes and change [the organization's] name.'

These community organizations and clinics have grown and built trust beyond their own ethnic communities. They are addressing gaps in service delivery that mainstream institutions fail to address, not just for their own ethnic groups, but for other underserved populations as well.

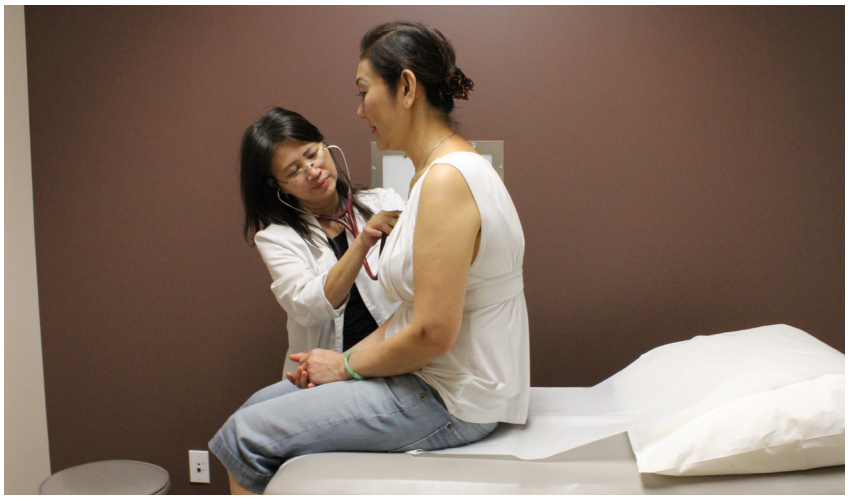

Photo courtesy of Tricia Nguyen

NEEDS

Improve Access to Health Insurance

Health insurance continues to be an important health access issue for AA&NHPI. Enacted in 2010, the federal Patient Protection and Affordable Care Act (ACA) significantly increased health insurance options for many Californians through the creation of the Covered California marketplace and the expansion of Medicaid (Medi-Cal in California). This expanded coverage to over 4.7 million Californians by 2016, including many lower-income families and individuals. Nationally, Asian Americans were among the greatest beneficiaries of the ACA, purchasing health insurance coverage at higher rates than other groups.[3] In California, 21% of enrollees were Asian Americans, well above the Asian American population statewide (15%).[4] In Orange County, the uninsured rate decreased from 17% to 12% from 2013 to 2014, and the uninsured rate for Asian Americans in the county dropped from 15% to 8% during this time.[5]

Since the November 2016 presidential election, the ACA and other federal health care programs have been under repeated attack in Congress and by the current administration. If the ACA is repealed, many AA&NHPI are at risk of once again becoming uninsured or spending more money on health coverage. Community leaders working in social services shared that their clients have expressed fear about how federal policy changes will impact their access to health care. Korean Americans may be particularly affected by changes to the ACA. With a high concentration of small business owners, Korean Americans have had especially high rates of uninsurance and often have to purchase health insurance independently. In 2008, prior to the ACA, Korean Community Services estimated that one-third of Korean Americans in Orange County were uninsured.[6] Ellen Ahn explains:

> There are going to be some huge changes to Medicaid and Covered California. . . . That's what's been promised by the new administration. And it's particularly jarring for Korean Americans. . . . But I've seen some Covered California numbers, and Asian Americans enrolled in much higher rates in Covered California than other ethnic communities, and Korean Americans in particular. Which means if there are changes to Covered California, that means we're going back to what we were before the Affordable Care Act, which is the high number of uninsured. Our Medicaid enrollments have been very, very, very high. So our Medicaid expansion population, if that goes away, that will leave many, many, many uninsured.

Health insurance has made access to both physical and behavioral health services a reality. Without it, access will be financially prohibitive for many AA&NHPI. Ahn notes how the ACA helped to expand coverage to address a wide range of health issues:

> And Medicaid expansion and Covered California not just meant more insured, it also meant more benefits. . . . So it opened up new mental health care benefits, psychiatric benefits. It's much more complex than just 'insured' per se. And so what that meant for the immigrant who either bought their insurance through their exchange or who received Medicaid through the expansion, what that meant is the ability to access some very basic preventive services or addressing mental health medication, it meant not going to the emergency room for basic needs. And if this goes away, that's a huge blow to the safety net [for the] population.

Limited Capacity and Funding for Community Organizations

Community organizations and health clinics have provided an important service for AA&NHPI communities, especially first-generation immigrants. Some of these centers, such as Southland Integrated Services and Korean Community Services, provide preventive health services to many low-income communities that are supported through federal funding. If there are any cuts to Medicaid or community health center funding, or if further attempts to repeal and replace the ACA succeed, it will mean less funding to these centers and a shift away from key services like preventive care, mental health care, and women's health services. Such changes would remove a safety net for many of these communities, which depend on these community centers for basic services. Tricia Nguyen relates how this impacts the stability of her organization:

> In terms of the clinic, as a leader, I worry about the funding. We don't know if the federal funding . . . if it's going to get cut. How is that going to play out? What are the regulations and inconsistency? Like one day it's like, 'Oh we're doing this!' And the next day, 'Oh we're doing that.' Because that's our struggle with the county level as it is before. It's like they're changing on us, you know, on a weekly basis. And so that's our concern. It's a lot of uncertainty. It creates a lot of stress.

As these organizations continue to fill these needs, they all face similar funding and political uncertainty that may jeopardize their capacity to provide quality care to these communities.

In addition to questions about funding stability, nonprofit leaders raised concerns about the excessive compliance and reporting requirement for the foundation

Photo courtesy of Asian Americans Advancing Justice – Orange County

and government grants that support their organizations. Although accountability and transparency are necessary, community agencies have limited administrative capacity and need a more streamlined and simplified grant-reporting process that is less cumbersome and time-consuming. Many of them rely on multiple national and regional grants that require inordinate amounts of time to complete the paperwork for both small and large grants. Shikha Bhatnagar notes that nonprofits "spend really ridiculous amounts of time reporting on money, which hinders our ability to serve our populations. And frankly, the funds that we're getting are really just Band-Aid solutions to much deeper issues." Simplifying these tasks would give the organizations more capacity to provide much-needed services to the AA&NHPI community.

Providing culturally and linguistically competent services is an additional burden on the limited capacity of community organizations. Although community organizations have played a critical role in filling that gap, there are still major challenges. Vattana Peong asserts that this becomes a major gap in the continuum of care for many Cambodian Americans in Orange County: "About 80% of the time a lot of clients that we refer out got referred back to us because they [the mainstream organizations] didn't have the capacity, especially on language and cultural understanding . . . so that puts challenges back on our back." Many community leaders view language assistance as more than the mechanics of interpretation and translation and involves a deeper cultural understanding that comes from being a part of the community. Ellen Ahn explains:

> Cultural competency is much more than language. Cultural competency involves a cultural inclusion, which means you need to really bring in folks who are a part of the community into the process, the service provision process. And we fill that need. But it also means understanding the culture well, and you can't do that with one staff. If you hire a Korean, that doesn't [necessarily] happen. You really need to be embedded in the community, understand the community, the nuances of the community. You can't teach that in a training. I'm not belittling training. Training is important. Cultural competency training is critical and it helps to a certain degree, but it's best served by folks who are embedded in the community.

According to cofounder Victor Pang, Pacific Islander Health Partnership uses an intergenerational approach to translate materials in the Pacific Islander communities so that it is culturally appropriate: "We use a two-step process. First everyone

translates it literally. But then we give it to an elder, and the elder translates . . . to their thinking of what the message should be."

The need to ensure culturally and linguistically competent care makes AA&NHPI cases more complex and time-consuming, and the additional work required is often uncompensated or undercompensated. Tricia Nguyen's team expends extra effort to ensure terms are properly translated:

> There's always a lot of terminologies that we don't have on the medical side, like for example, *nurse practitioner*, *occupational therapist*. We don't have those terminology [in Vietnamese]. So a lot of time it's really a struggle for us. . . . There could be 10 people translating one thing totally different. So that's the hard part, is being culturally competent. But it's very hard to do translation. I feel like they're so limited . . . folks that are really, really good at translating English to Vietnamese and vice versa. 'Cause a lot of them [organizations], they do Google translate. . . . The brochures we came across and we're like, 'What is this? It is just not good.' So we end up doing a lot of the translation for a lot of the folks locally if they need help.

"95% of our clients are immigrants or refugees, so they were able to share their experiences, their experiences of resiliency, their experiences of struggle."

AA&NHPI community organizations have played a crucial role in the collection of disaggregated health data and can do more with additional funding and resources. AA&NHPI have historically been lumped together as a monolithic group, leading to misperceptions that AA&NHPI as a whole have better health outcomes than other racial groups, and in some cases, the general U.S. population. However, the use of AA&NHPI aggregated data often masks specific health issues that AA&NHPI experience, including significant differences between Asian American populations and Native Hawaiian and Pacific Islander populations. Cancer is the leading cause of death for Asian Americans, while heart disease is for Native Hawaiians and Pacific Islanders.[7] AA&NHPI comprise over half the deaths associated with chronic hepatitis B infection and are 8 to 13 times more likely to develop liver cancer compared with other groups.[8] Southeast Asian women also face high rates of breast cancer and low rates of breast cancer screening.[9] While medical conditions are not addressed directly in this report, further research is needed about the prevalence of these health disparities, which include the collection and analysis of disaggregated data to understand specific causes, patterns, and treatments.

Underrepresentation of Health Care Professionals

While Asian Americans make up over one-third of the health professionals in Orange County, and many Native Hawaiians and Pacific Islanders work in health care jobs, there is still an underrepresentation of specific ethnic groups in health occupations. Communities that have the most need for bicultural and bilingual services are also the ones with the highest poverty levels and lowest educational

attainment rates. There are thus fewer individuals in the pipeline to become health professionals (see chapter 3, "Economic Development and Disparities," and chapter 4, "K–12 and Higher Education"). Some community leaders also expressed that the comparatively lower salary in nonprofit occupations may discourage individuals from working at community organizations.

Within the Cambodian American community, only 4% have a graduate school education and, of those, very few return to work in community organizations. According to Vattana Peong, "We don't have enough [of a] culturally, linguistically [capable] workforce to provide services to our population. And we're still going to go back to square one. We never will get out of this cycle unless we address that high school–college career pipeline in terms of the allied health, like public health professional, therapist, or things like that, or other medical fields." Currently in Orange County there is only one Khmer-speaking medical provider and physician assistant and no Khmer-speaking mental health providers for a population of 7,471 Cambodian Americans.[10]

Gender is also a factor in providing culturally and linguistically competent services. Trained female professionals are essential in contexts such as assisting a female victim of domestic violence and sexual abuse. Having someone whom a victim can ethnically or racially relate to—and of the same gender—is particularly critical for these types of services because of the high levels of stigma experienced by community members and the corresponding reluctance of community members to identify themselves as someone in need of mental health services and/or a victim of domestic violence.

Photo courtesy of Ellen Ahn

Several community leaders also mentioned the need for more AA&NHPI males in the behavioral and mental health care professions. Recalling his experience attending Chapman University to receive a degree in counseling, Jei Garlitos, a Filipino American principal and coordinator of Alternative Education with the Anaheim Union High School District, notes the lack of AA&NHPI males: "I was one. There were two female Asian Americans. One was Japanese American and the other one was Chinese American. And then, I believe, one of them is still in the profession. The other is no longer. And I'm no longer, at least not, in counseling. . . . That was the one thing that I saw was still a need in that area for us, is the need for mental health services and counselors, I think, that our population can relate to."

In Garlitos's experience working in education, "there's not enough Asian Americans, not enough Asian American males in the [counseling] profession I think to be able to address some of those students." Jane and Victor Pang, cofounders of Pacific Islander Health Partnership, assert that in order to respect Pacific Islander cultural norms, there is a need to have both male and female health advocates. Victor

Pang's leadership has helped to further health education among males in the Pacific Islander communities, including issues that are not easily recognized such as male breast cancer, which he personally battled.

Behavioral Health Services and Addressing Stigma

One of the major AA&NHPI health care needs identified by community leaders was the need for more culturally competent behavioral health services, which include mental health and substance abuse. There is still a major stigma within most ethnic communities to acknowledge mental health problems, and when AA&NHPI do seek help, culturally and linguistically appropriate services are limited. Many AA&NHPI cultures emphasize the concept of "saving face," meaning not bringing shame on one's family, and seeking mental health counseling or accepting professional assistance to resolve family problems is often viewed as shameful. One report found that 34% of Korean Americans over the age of 60 were diagnosed with probable depression and an additional 8.5% reported suicidal ideation; however, only 6.5% had contacted professionals.[11] Approximately 71% of them considered depression as a sign of personal weakness, and 14% stated mental illness would bring shame to the family. Compared with the state average of 5%, elderly Vietnamese Americans reported suffering from mental disability or symptoms associated with mental illness at 7%, and more Vietnamese American participants reported a higher frequency of mental distress than other AA&NHPI groups. Immigrants and refugees, even those who have been in the United States for a long time, may not know U.S. laws or the U.S health care system, including where to get health coverage and services, what mental health services are available to them and their families, or how to find information in their native language.

According to Suzie Xuyen-Dong Matsuda, a clinical social worker who is the Pacific Asian Unit service chief at the Orange County Health Care Agency, when culturally and linguistically appropriate mental health services are made available, members of the community use them. However, mainstream institutions often do not have the resources or staffing, or they neglect to provide culturally and linguistically appropriate services to these populations.[12] As a result, nonprofit ethnic organizations have filled the gap in providing these services, even though the lack of capacity and onerous administrative requirements often limit their ability to meet the need for such services. These organizations receive federal, state, or county grants, or funding through foundations; however, during the economic recession or shifts in the political climate, their funding has been cut. Often underfunded, they have had to lay off valued staff and curtail their services, knowing that the needs of the community will be unmet.

Disparities in behavioral health services are amplified for populations such as Vietnamese, Cambodian, and Laotian Americans who have experienced the trauma of civil war, displacement, postwar survival, and escape as refugees. Vattana Peong explains how he and his staff at The Cambodian Family must make extra effort to identify possible mental health issues and advocate for the community:

> When I go out and advocate for our population, we usually talk about the unique needs of the population we serve. I always talk about the experiences that they went through, not just a war, a civil war, but a genocide. It's about a population that witnessed a lot of killing, a lot of torture, a lot of starvation, a lot of family separations. So a story of immigration experiences and a story of resiliency—that's usually what I tell other people about our population. But talking about mental health, that has already been a challenge for our community because there are very, very limited resources for the Cambodian community, especially those who are still suffering from PTSD [posttraumatic stress disorder] and depression.

Impacted Cambodian Americans find it difficult to share their history, so they often internalize their problems, and behavioral and mental health conditions often manifest themselves in physical health symptoms:

> And there was so many things I was not able to find out what happened. For example, they come to complain that 'I have a lot of headaches,' 'I have a stomach ache.' And I thought that [it was] a physical complaint, but actually sometimes [it's] emotional and mental health things. But they didn't want to talk about that. So I had to work with my staff who are the case managers to really identify [the real problem]. So that was a challenge for me to really put extra time to really work on one client with different staff members.

Furthermore, language barriers make Cambodian Americans reluctant to seek help from government programs, and they may be less likely to apply for Medi-Cal, which covers both physical and mental health. Additionally, they may lack knowledge of how the health care system functions and need help to navigate its complexities.

Tricia Nguyen says that some immigrants and refugees may not necessarily have diagnosable conditions, but the adjustment of learning a new language and culture on top of everyday stresses can accumulate and contribute to emotional strain. She points out how "saving face" and stigma with mental health illness make it difficult for them to ask or receive help: "And I don't think nobody really knows, like the recognizing of the stress [of] . . . marriage, having kids, acculturation, not having the financial day-to-day, not having a roof over [your head], . . . food, . . . transportation, childcare. So there's so much that our community struggled [with], but because they're saving face, they don't want to come forward to get our help."

Stigma continues to be a major challenge to accessing mental health for youth and family counseling services. Jei Garlitos of Anaheim Union High School District describes his experiences working as a Filipino American school counselor reaching

out to Asian Americans as well as Native Hawaiians and Pacific Islanders and their reluctance in seeking services:

> As a counselor, the biggest thing that I saw was the reluctance to receive help. . . . Families just didn't go seek counseling. It was this big taboo for them. And so the minute I would go 'I'm a counselor. I'm a counselor here to help your child,' the family says, 'No, no thank you. We'll take care of it ourselves.' You got a lot of that from [the] Pacific Islander community. . . . As soon as I realized that, I tried to approach it more as 'I'm a fellow Pacific Islander trying to reach out to help.' They were a lot more open to it. But the minute the word *counseling* or *counselor* or *intervention* was brought up, they didn't want any of that. What I learned from those particular families was they liked to keep it within their family, . . . whether it was discipline . . . they would handle it internally. And then working with Asian Americans outside of the PI [Pacific Islanders], so, you know, Korean Americans, Japanese Americans, Chinese Americans, similarly, they did not want help.

The stigma and inability to access mental health services can lead to violence toward themselves or others. Michael Matsuda relates that this can lead to intergenerational trauma within families, which he has seen in both the Japanese and Vietnamese American communities:

> Especially in the Vietnamese, where you have a large refugee population, there's a lot of issues that are transferred generationally. There's a lot of issues of self-hate or shame that are deep, that can manifest itself, and family dynamics and other relationships that can be very harmful. So the issue now with mental health is so important to address in the schools, with all kids, but especially those who have these roots that have a lot of trauma generationally.

Caroline Hahn, a criminal defense attorney and past president of the Orange County Korean American Bar Association, shares that in her experiences working criminal cases with Korean American clients, many are associated with unaddressed mental health issues: "People don't want to talk about it. They want to brush it under the rug. And then if it's not treated, what ends up happening is it gets to a point where you could've treated it at this level, but it gets to a point, if they're not on medication or something happens, and they commit a really big crime. So many of my current Korean clients, the reason why they're in criminal court is because there's a mental illness that was either undiagnosed or untreated."

"Medicaid expansion and Covered California not just meant more insured, it also meant more benefits. . . . And if this goes away, that's a huge blow to the safety net [for the] population."

Raising Awareness about Domestic and Family Violence

Dealing with domestic violence cases is a concern for many AA&NHPI communities. Like mental health, the issue of domestic violence is a taboo subject for AA&NHPI communities as it involves both personal and family dynamics that many feel should not be publicly aired in order to "save face" or avoid bringing shame on their family. The sensitivity of this topic further highlights the importance of having community organizations and bilingually and biculturally trained AA&NHPI professionals who understand how to educate the community about available counseling or legal services and to assist those affected.

Shikha Bhatnagar explains that the South Asian Network operates an anti–domestic violence program, and that publicizing domestic violence is a problem among South Asians since it presents a negative view of their community. Some feel that because they are a racialized minority or predominantly an immigrant community, highlighting these problems can lead to negative repercussions. Community education on this issue needs to be handled with care and cultural sensitivity, so it does not alienate community members nor create racial stereotypes: "A lot of the work that we need to do as an organization is internally. . . . The challenges of being so diverse internally is that we all come from different experiences and we may not mean to say things in certain ways, but we might accidentally do it in a way that offends or makes somebody feel isolated, and we have to be very careful about that."

Caroline Hahn further describes how her identity as a Korean American and being raised in an immigrant family helps her to better understand domestic violence court cases with Korean American clients, which she notices have been increasing in Orange County:

> In the Korean community, there's a lot of DUIs [driving-under-the-influence violations]. There's a lot of alcohol-related cases. . . . Say you're dealing with someone who is middle-aged or older than middle age, say 50s or 60s, [a] Korean man drinks alcohol, goes home, gets into [a] fight with his wife, ends up hitting her, pushing her, shoving her, whatever. [The] police get called out. [The] man's arrested. . . . A protective order is issued. [The] man can't go back to his wife, his own home, because he can't be near his wife.
>
> There's so much cultural implications that go along with that. For instance, drinking is really big in the Korean community, with Korean men. Domestic violence is big. Sometimes you'll have both of them come in at the same time, maybe the alleged victim and the defendant. And I mean in a sense, sometimes, I counsel both of them. . . . [I have an] understanding as to how their relationship works. . . . I understand because I grew up in a [Korean] household. . . . I understand the dynamics. . . . There's just a sense of familiarity and understanding that

> they don't have to express with me and so it makes me understand my clients a lot better, deeper, and I can speak Korean, which helps.

Speaking about child abuse cases, Hahn's experience shows that immigrants who were raised in their homeland where physical punishment is more acceptable can find themselves suddenly facing criminal child abuse charges without clearly understanding why:

> Say there's a case where dad gets frustrated with child, and he spanks the child or whatever. [The] child calls the police. And now the client, the dad, is facing criminal charges for child abuse. But not only that, he's facing maybe termination of his parental rights because Social Services has now gotten involved and removed the child from the home.
>
> And you're talking about someone, if he has been in the United States for a very long time, even if he's a citizen, this is the first time this has ever happened to him. He doesn't understand the American legal process. So I know where he's coming from because if he says, 'I was so frustrated because he wasn't listening," . . . I understand that coming from a Korean family with a Korean perspective. I get it.

These examples do not present a cultural justification for criminal or negligent behavior; rather, they highlight how cultural competency can place the crisis in context and aid in intervention. While tension between parents and children during the teenage years is commonplace, this is compounded for immigrant families that are raising children in a very different environment than the ones in which they grew up in addition to language and cultural barriers between generations. Furthermore, these concerns may be specific to behavioral health issues, but they ultimately speak to the social and institutional barriers AA&NHPI communities generally face in accessing social services to address different health needs.

"In terms of the clinic, as a leader, I worry about the funding. We don't know if the federal funding . . . if it's going to get cut. … It's a lot of uncertainty. It creates a lot of stress."

Improving Health Care Services and Programs for Native Hawaiians and Pacific Islanders

Native Hawaiian and Pacific Islander (NHPI) populations face particular health disparities that are often overlooked because of the lack of disaggregated data and their relatively smaller population. In 2012, the death rate for NHPI in Orange County was 864 per 100,000 people, which was the highest for all racial groups. Health education and access to culturally and linguistically appropriate services remain a huge barrier for a number of NHPI communities. An understanding of the culture and history of the different NHPI groups is especially critical in the delivery of services to the different communities.

Heart disease is the leading cause of death for NHPI, and the proportion of NHPI deaths attributable to diabetes is also highest among all racial groups.[13] Pacific Islander Health Partnership, in collaboration with Pacific Islander community

groups and University of California, Riverside, created the Navigating Pacific Hearts program to help educate the different ethnic groups about heart disease through culturally relevant interventions. Cofounder Jane Pang relates their efforts to improve dietary habits:

> Our Tongans at last year's Heart Health event took their most popular dish, which is taro leaf with corn beef, and they used coconut or mayonnaise and tried to make it healthier. So it's trying to challenge the community to think about how you can do the same dish but make it a little healthier, less high in calories and less high in cholesterol. And that's the reward we are able to appreciate because the volunteers that we work with are willing to take the extra step, after learning what their options are, to really be creative . . . and help build their community.

Eating greens and salads is not necessarily part of the culture of Pacific Islander groups due to environmental concerns tied to a history of American military presence in their homeland: "Think about it. After you nuke the Marshall Islands, where can they plant salad or anything from their island? We wonder about what the fish they're eating, consuming, because that pollution and that nuclear waste is still there within the area."

Cancer is the fastest-growing cause of death for NHPI.[14] According to Pang, stigma toward the disease can make it difficult to treat and can impact the mental health of many NHPI:

> [The] Chamorro community won't even talk about cancer. We used to say "the big C." They won't even say that and won't share. . . . Last year when we did our heart health, one of our leaders, she just turned 40, said from the period of time from when her grandmother died, had a massive attack at age 40, she always kept it in the back of her mind and in her heart, 'Will I ever get to 40?' And carrying that burden, and not even sharing it with her aunts or the other family members, by not talking about it or sharing that. . . . She made it to 40 and she celebrated. . . . We need to share.
>
> Some of the community feels by sharing that, if you're young, it affects your eligibility for partnership and future marriage and your future life. And that in some circles is a great burden and double the burden. Number one, the lack of information. Number two, the fact that they can't share it. And so much of it, if we understand there are things we could do to help prevent heart disease and all the other chronic diseases, but to carry that burden without sharing, to me I thought that . . . had great impact.

Similar to Asian ethnic groups, they also face language barriers as many Pacific Islander ethnic groups have their own native language, but linguistically and

culturally competent materials can be even more scarce given their smaller populations. Pang notes that having these materials available would help NHPI combat high rates of cancer and obesity: "These are basic things, basic 101, that Hispanics have, that African Americans have, all the other ethnic groups, and our Pacific Islanders are basically struggling." Pacific Islander Health Partnership has had to correct translated health materials from mainstream institutions:

> Susan G. Komen gave us these steps for self–breast exam. And so I don't know who did it, but nationally it came down in Marshallese, so I gave it to the minister's wife to look at it. She said, 'Oh that's very interesting. The word they use for *step 1*, *step 2*, *step 3*, was the "step" they used for marching and was not [referring to] the first thing you do, the second thing you do.' So the literal translation was done, but no one did the cultural context and so that was missing. And so she laughed and couldn't understand why. And it was really terrible because it came from national, Komen national. And so again they gave it to someone who was well educated and knew the language but didn't have the cultural context.

POLICY RECOMMENDATIONS

- Collect and report disaggregated data for AA&NHPI to identify disparities in health coverage, conditions, and access, with a special focus on underserved populations such as NHPI ethnic groups.
- Research issues impacting health access and health care service delivery to AA&NHPI communities (e.g., impact on client operations of significant administrative responsibilities, use of interpreter and other ancillary services).
- Provide culturally and linguistically accessible education, outreach, and assistance for AA&NHPI on health and health care services, e.g., health care rights; eligibility for Covered California, Medi-Cal, or other health coverage; other types of health care such as dental care, mental health services, substance abuse treatments.
- Fund community-based programs that provide culturally and linguistically competent interpreters and translators who are also knowledgeable about health and health care.
- Fund existing health programs and services provided by AA&NHPI-serving agencies, including preventive and specialty care, behavioral health (mental health and substance abuse), oral health, and other essential health care benefits. Recognize that AA&NHPI clients may require more resources to receive equitable services due to cultural and linguistic barriers (e.g., need for longer visits, use of interpreters).

- Provide AA&NHPI cultural competency training for all health care students and professionals to ensure culturally appropriate health care delivery to community members, especially by mainstream institutions (e.g., migration histories and experiences, cultural stigmas in seeking services, proper use of trained health care interpreters and translated materials).
- Create or expand health career pipeline programs and expand outreach and recruitment for positions in the health care field in order to increase the number of health care professionals from underserved AA&NHPI communities (especially from Southeast Asian and NHPI ethnic groups).
- Create or support community health worker programs that can provide AA&NHPI communities with basic health education and assist with accessing and navigating the health care system (e.g., *promotores* training programs in the Latino community).
- Work with NHPI community organizations to address NHPI disparities in health services.
- Expand culturally and linguistically accessible behavioral health services for AA&NHPI, from the first point of contact and throughout the entire pathway of care.
- Counter the low number of AA&NHPI seeking mental health or family violence interventions by educating AA&NHPI communities on the need for and value of mental health services and services for survivors of domestic or other family violence.
- Maintain and expand local, publicly funded safety net programs and providers (e.g., community clinics, hospitals, Federally Qualified Health Centers).
- Improve overall access to health care by supporting efforts to move toward a single-payer and/or universal health care system for all Californians.

INTERVIEWED COMMUNITY LEADERS

Ellen Ahn	Executive director of Korean Community Services
Shikha Bhatnagar	Executive director of the South Asian Network
Mary Anne Foo	Founder and executive director of the Orange County Asian and Pacific Islander Community Alliance (OCAPICA)
Jei Garlitos	Principal and coordinator of Alternative Education with the Anaheim Union High School District
Caroline Hahn	Past president of the Orange County Korean American Bar Association
Michael Matsuda	Superintendent of the Anaheim Union High School District; founding member of the Orange County Asian Pacific Islander Community Alliance (OCAPICA)
Tricia Nguyen	CEO of Southland Integrated Services, formerly known as the Vietnamese Community of Orange County (VNCOC)
Jane Pang	Cofounder and board member of Pacific Islander Health Partnership (PIHP)
Victor Pang	Cofounder of Pacific Islander Health Partnership (PIHP)
Vattana Peong	Executive director of The Cambodian Family

The quotes from these interviews are represented verbatim in this report, with some shortened for space considerations, shown by an ellipsis. The only other modifications are to help provide context, shown in brackets.

NOTES

1. U.S. Census Bureau, 2011–2015 American Community Survey Selected Population Tables, Table C24030.

2. Ibid.

3. Austin, Algernoon. 2016. "Asian-Americans Could Lose the Most from an Obamacare Repeal." *Huffington Post*, last modified May 25, 2017, http://www.huffingtonpost.com/algernon-austin/asian-americans-could-los_b_10115250.html.

4. Ramakrishnan, Karthick, and Farah Z. Ahmad. 2014. *State of Asian American and Pacific Islanders: A Multifaceted Portrait of a Growing Population*, Washington, DC: Center for American Progress (September).

5. Children & Families Commission of Orange County. 2016. *OC Community Indicators 2016.* Santa Ana, CA: Orange County Community Indicators Project.

6. California State University, Fullerton; Children and Families Commission of Orange County; and Korean Community Services Inc. 2008. *Profiles of the Korean American Community in Orange County* (December).

7. California Department of Public Health Death Public Use Files 2005–2010. Information taken from Asian Americans Advancing Justice, and Orange County Asian and Pacific Islander Community Alliance. 2014. *A Community of Contrasts: Asian Americans, Native Hawaiians and Pacific Islanders in Orange County*. Los Angeles: Asian Americans Advancing Justice.

8. "Asian Americans and Pacific Islanders and Chronic Hepatitis B." n.d. Centers for Disease Control and Prevention. Accessed September 5, 2017, https://www.cdc.gov/hepatitis/Populations/api.htm.

9. Nguyen, Tu-Uyen, et al. 2011. "A Qualitative Assessment of Community-Based Breast Health Navigation Services for Southeast Asian Women in Southern California: Recommendations for Developing a Navigator Training Curriculum." *American Journal of Public Health* 101 (1): 87–93.

10. U.S. Census Bureau, 2011–2015 American Community Survey 5-Year Estimates, Table B02015.

11. California Reducing Disparities Project Asian Pacific Islander Strategic Planning Workgroup. 2013. *The CRDP API Population Report: In Our Own Words.* Sacramento, CA: California Department of Public Health (March).

12. Vo, Linda Trinh. 2003. "Managing Survival: Economic Realities for Vietnamese American Women." In *Asian/Pacific Islander American Women: A Historical Anthology*, edited by Shirley Hune and Gail Nomura, 237–252. New York: New York University Press.

13. California Department of Public Health Death Public Use Files 2005–2010. Information taken from Asian Americans Advancing Justice, and Orange County Asian and Pacific Islander Community Alliance. 2014. *A Community of Contrasts: Asian Americans, Native Hawaiians and Pacific Islanders in Orange County*. Los Angeles: Asian Americans Advancing Justice.

14. Ibid.