

STATE OF THE STATE II: 2013
Reducing Disparities in Mental Health

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Acknowledgements

The California Mental Health Services Act Multicultural Coalition (CMMC) would like to express our appreciation to the many individuals who contributed to the completion of this *State of the State II: 2011-2012, Reducing Disparities in Mental Health* report which brings awareness to issues confronting the Armenian American and Deaf and Hard of Hearing communities. This report is one of the deliverables of the CMMC to be submitted to the former Department of Mental Health Office of Multicultural Services (now California Department of Public Health – Office of Health Equity). We would like to acknowledge our consultant and key writer Katherine Elliott and Measurement and Assessment Committee (MAC) members Gustavo Loera, Emma Oshagan, Jamila Guerrero-Cantor, and Masa Nakama for organizing and conducting the key informant interviews.

Finally, we would like to especially acknowledge the six key informants from the Armenian American and Deaf and Hard of Hearing communities who participated in this study. Through their dedication and tireless advocacy, they have developed a deep understanding of the critical issues that affect their communities. We are grateful for their willingness to share their time and wisdom.

Executive Summary

In this, the second “State of the State” report, the California Mental Health Services Act Multicultural Coalition (CMMC) takes a qualitative approach to exploring disparities. This State of State report aims to bring awareness to statewide and local policy makers, mental health service providers and community advocates about communities that have not been surveyed in previous efforts.

California is home to many diverse communities including new immigrant and refugee communities, and diverse cultural communities. The intent of this report is to present a qualitative study of two groups that may be replicated in future reports with other communities. These efforts are part of an ongoing process of connecting and building relationships with new communities throughout the state of California. The two groups selected for this report are Armenian Americans and the Deaf and Hard of Hearing community.

Key Findings: Armenian Americans

Interviews with three key informants from the Armenian American community revealed the following key themes related to community experiences, needs, assets, and recommendations:

- **Mental Health Needs and Key Experiences:** Armenian American key informants emphasized the prevalence of acculturation stress and exposure to trauma. These experiences contribute to depression and substance abuse in the Armenian community.
- **Community Assets:** Armenian Americans have a strong history of cultural pride and ethnic identity and of reliance on the community and the family as a central unit. Areas with high concentrations of Armenian Americans have established Armenian community based social service organizations and businesses. Furthermore, many Armenians have entered helping professions and are currently working as mental health providers.

- **Recommendations:** To improve access to care for Armenian Americans, programs should build on existing community resources. Given the importance of Armenian identity, and the tendency to look within the community for help, Armenians are more likely to seek services and to accept help from Armenian American providers. Participants recommended increased outreach and psycho-education to reduce stigma. Psycho-education and stigma reduction programs will have the most penetration into the Armenian community if delivered by Armenian providers and organizations.

Key Findings: Deaf and Hard of Hearing (DHH)

Two Key Informants for the DHH community identified critical issues, community assets and recommendations for improving access to care and effectiveness of services for the DHH community:

- **Mental Health Needs and Experiences:** Participants emphasized challenges for DHH persons related to access to services including: lack of access to community resources, a shortage of qualified mental health providers, and inadequate interpreting services. In addition, they described the isolation and frustration experienced by DHH clients in accessing care and advocating for their needs.
- **Community Assets:** A key strength identified by key informants was found within the family. Families' commitment to their children, their bond, and their persistent advocacy on behalf of their DHH family members was viewed as an important asset within this community. In addition, DHH culturally competent providers who have served as active and passionate advocates for their community were identified as an important resource.
- **Recommendations:** Increasing the ASL proficient workforce, providing additional funding for programs for DHH individuals with mental health problems, improving interpreting services and providing increased access to schools for the Deaf were viewed as key recommendations for improving the mental health of the DHH community. Further, it was recommended that programs build on existing assets, providing support for parents and caregivers in advocating for their DHH children.

The overall findings reveal significant mental health challenges for both groups including stress, isolation, substance abuse, family conflict, and identity development. Barriers to care include stigma, lack of linguistically and culturally appropriate services, and lack of funding prevent individuals from accessing needed services.

Despite these barriers, the informants reported that family, cultural, and community bonding and resiliency are fundamental to their communities. Family is particularly crucial for buffering individuals from stress and mental health stigma. Informants believed that mental health professionals, who understand the value and significance of family, tend to advocate for more programs that focus on educating and training family members. The informants also recognized the link between a resilient culture and mental health. According to the key informants, mental health professionals must be equipped with the cultural and historical knowledge of that community to be able to meet their mental health needs. A workforce that is not properly trained and prepared to adequately serve these communities, as an industry, we will miss opportunities to assess and address these communities mental health needs and eventually reduce mental health disparities for all. Key informants favor redirecting funding toward the community and building community capacity.

Background and Introduction

The Mental Health Services Act, passed in California in 2004, has provided increased funding to support the delivery of mental health services and the improvement of mental health programs. Since 2005, funding generated through the MHSA has been used to develop new, state-of-the-art mental health programs, to implement prevention and early intervention programs, to enhance the mental health workforce, to support innovation in mental health and to improve system infrastructure. Unfortunately, despite the increased funding for mental health services, many Californians with mental health problems continue to lack access to timely and appropriate care. In particular, ethnic and cultural minority communities are less likely to receive mental health services (Surgeon General, 2001), less likely to receive evidence-based and/or specialty mental health services (Garland, 2005; McGuire et al., 2008), and less likely to complete treatment (Saloner & Cook, 2013).

In 2009, the California Department of Mental Health in collaboration with the Mental Health Services Oversight and Accountability Commission (MHSOAC), the California Mental Health Directors Association (CMHDA), and the California Mental Health Planning Council launched the California Reducing Disparities Project (CRDP) to address these disparities. This policy initiative, supported by MHSOAC Prevention and Early Intervention funds applies a multi-pronged approach which includes: (1) the development of statewide workgroups to study effective approaches with minority communities and (2) the establishment of a statewide committee to represent the voice of multicultural communities in statewide policy: the California MHSOAC Multicultural Coalition (CMMC).

The CMMC brings together community advocates representing various diverse cultural groups and provides leadership and recommendations for the enhancement of cultural and linguistic competence in the mental health system. The Coalition has several programs including a leadership initiative that provides mentoring and support to emerging ethnic and cultural minority professionals. In addition, the CMMC produces a yearly report exploring disparities in mental health.

The State of the State report serves as a tool for advocacy and for the identification of approaches for addressing mental health disparities. Last year, the CMMC completed the first of five reports: *State of the State 2012: Reducing Disparities in Mental Health*. This report examined statewide penetration rates as a measure of access to care and found persistent disparities in access to care. However, the report also found significant flaws in penetration rates as a measure of disparities. The report called for renewed emphasis on data collection approaches that would reflect the complex experiences of diverse communities.

In this, the second “State of the State” report, the CMMC takes a qualitative approach to exploring disparities. This State of State report aims to bring awareness to statewide and local policy makers, mental health service providers and community advocates about communities that have not been surveyed in previous efforts. California is home to many diverse communities including new immigrant and refugee communities, and diverse cultural communities. While the State of the State II report will focus on two groups, the CMMC recognizes that there are several communities that could be a focus of these efforts. Many groups are historically underserved, are marginalized or vulnerable, and experience social and civic exclusion due to their race, ethnicity, sexual orientation, or

culture. The current report will not survey all groups, instead the intent of this report is to conduct a qualitative study of two groups that may be replicated in future reports with other communities. These efforts are part of an ongoing process of connecting and building relationships with new communities throughout the state of California. The two groups selected for this report are Armenian Americans and the Deaf and Hard of Hearing community.

Armenian Americans

Background and History:

Originating from the region of Eurasia, which currently includes Turkey, the Republic of Armenia, and Nagorno-Karabakh Republic, Armenians have survived genocide, war, earthquakes, and a diaspora. In April of 1915, Armenians were subjected to mass deportation and massacre in what is now known as one of the worst genocides in world history. Armenians who escaped the genocide fled to various countries including the US, the Soviet Union, Iran, and other Middle Eastern countries. It is estimated that in the years directly following the genocide, approximately 25,000 Armenians immigrated to the US.

The initial wave of immigration precipitated by the genocide was followed by continued stream of immigration to the US by Armenians from all over the world. Political unrest in Iran in the 1950s and in Lebanon in the 1970s created a surge in immigration from these countries. In the 70's Armenians from Soviet Armenia immigrated to the US as refugees seeking political asylum. In addition, the earthquake that hit the Republic of Armenia in 1988 resulted in the displacement of hundreds of thousands of families. Many of these families immigrated to the US. In recent years, there has been an influx of refugees from Iran, Iraq, and Syria.

The US Census 2010 estimates indicate that approximately half a million Armenians currently reside in the US. Many scholars suggest that this number is an underestimate and that, in fact, the number of Armenians residing in the US most likely is between 1,200,000 and 1,500,000. The Census 2000 estimates that about half of Armenian Americans live in California, primarily in Los Angeles.

The variety of the backgrounds of the Armenian immigrant community in California and the US has led to cultural diversity within the Armenian population, but Christianity, the church, the language, unique cultural experiences and historical events such as the Genocide are strong uniting factors for all Armenians. Many Armenian Americans have experienced war, human rights violations, and exposure to natural disasters (the 1988 earthquake). These traumatic experiences contribute to stress, anxiety, loss, and fear. Despite these challenges, Armenians have endeavored to maintain a robust sense of Armenian identity and to build strong communities in their respective host countries. The unique and diverse experiences of Armenian Americans prior to immigration contribute to their experiences as they settle in the US. In the interviews that follow, participants connect their rich history to their current social and economic conditions.

Deaf and Hard of Hearing

Background and History:

The National Center for Health Statistics estimates that approximately 37 million DHH currently live in the United States, 2.2 million of whom are considered deaf. California is home to about 3 million DHH individuals. Approximately 800,000 DHH live in the Los Angeles area. The National Deaf Children's Society estimates that 90% of deaf newborns are born to hearing families.

In reviewing DHH population figures, it is important to note that US Census does not provide estimates for the DHH population. Instead, it presents figures on all people with disabilities; data on the DHH is not disaggregated. Thus, data on DHH demographics must be culled from other surveys. In addition, the manner in which a person identifies themselves in terms of their hearing loss is personal. While some may identify with the Deaf community, others may consider their hearing loss only in relation to their ability to communicate (Greater Los Angeles Agency on Deafness).

The history of the DHH community in the US is characterized by incredible diversity and advocacy for basic rights, particularly in the areas of education and communication. In 1817, Thomas Hopkins Gallaudet and Laurent Clerc, a deaf educator from France, established the first school for the deaf in the US. Schools opened across the US that specialized in the

education of deaf students. The last school for the deaf was established in Riverside, CA in 1953. A significant milestone that affected the DHH community was a conference of educators for the deaf in Milan, Italy in 1880. A decree was issued that banned the use of sign language in favor of oral communication for the education of deaf children. This infamous resolution is considered to have sparked a significant struggle for the DHH community in attaining their rights for education through the use of sign language for DHH children. Several advocates opposed the ban, including the president of the National Association of the Deaf, George Veditz who championed the use of sign language in the US. *"As long as we have deaf people on earth, we will have signs. And as long as we have our films, we can preserve signs in their old purity. It is my hope that we will all love and guard our beautiful sign language as the noblest gift God has given to deaf people."*—(George Veditz, President of the National Association of the Deaf, 1913). Since then, both sign language and the oral method have been used in the education of DHH children.

Another landmark event for the DHH community was the passage of the Americans with Disabilities Act in 1990. The Act made it illegal to discriminate in employment, and required that public services be accessible to individuals with disabilities and public places have accommodations for individuals with disabilities. As a result of the ADA, the DHH community (including DHH children and their families) have more choices in education such as attending mainstream school environments (both K-12 and post-secondary) with accommodations such as American Sign Language (ASL) interpreters and real time captioning, and state schools for the deaf, such as California School for the Deaf, Fremont and California School for the Deaf, Riverside who embrace teaching methods in ASL.

The DHH community in California – like the larger DHH community in the US, has a deep-rooted history and diverse culture. The DHH community represents people from every racial, ethnic, religious and cultural background, including LGBTQ, African American, Latina/o, Native American, Asian Pacific Islander, deaf plus (deaf plus other disabilities), deaf-blind, and deaf from hearing families and deaf from deaf families. Individuals who identify with Deaf culture often share common values, behavioral norms, experiences, and communication styles (like sign language). Many DHH people value their Deaf cultural heritage, their history and institutions and show strength and resiliency through a common movement on a national and global level to attain equal rights and recognition of their unique experience and language (like ASL).

Methods and Participants

To select the two groups that are the focus of the current study, the CMMC convened the Measurement and Assessment Committee (MAC). During a brainstorming session, the MAC committee compiled a list of potential groups to be surveyed (see appendix A). As this was the first time the CMMC had embarked on this kind of survey, it was decided that groups would be selected for whom there was a pre-existing relationship with a committee member. The presence of a pre-existing relationship enabled MAC committee members to reach out to and engage community members from these groups with greater facility. The groups chosen were 1) Armenian Americans and 2) the Deaf and Hard of Hearing population.

To gather information on the socio-cultural background, history, mental health needs, cultural strengths and assets, and barriers to care of the two selected communities the MAC committee conducted a brief qualitative study. For each group, 2-3 key informants were interviewed for approximately one hour. Two members of the MAC who are familiar with these two populations made initial contact by telephone and/or email to participants who had indicated an interest in participating in the study. Prior to the interviews, the interviewers and researcher discussed the protocol and techniques to ensure interviewers were consistent in their approach to the interviews. During the telephone and face-to-face interviews, the interviewer thanked the participants, briefly described the purpose of the project, the interview, and the benefits of their participation. The participant chose the type of interview (e.g., telephone, face-to-face, or in one case, written response), location, and time of the interview. Each interview took approximately 60 minutes to complete and a note taker took extensive notes. All telephone, face-to-face, and written interview sessions were conducted entirely in the preferred language of the participant and all non-English sessions were later translated into English by the interviewer. Interview sessions were audio recorded for accuracy. Each participant who agreed to be audiotaped provided a verbal consent. According to Stringer (1999), in qualitative research, it is essential to first build rapport with the participants before engaging in interviews and taping. Therefore, prior to asking the questions related to the study, the interviewer engaged in casual

discussion in order to build trust or used open-ended questions that started with “Tell me about your community...”

Mindful that the key informants from the DHH community predominantly use sign language, the interviewer, who is fluent in American Sign Language, ensured that the interview content was transmitted in sign language. It should be noted that the DHH participants were given a choice of whether or not they wanted to use an interpreter as a facilitator during the interview. All interviews that used sign language were videotaped as well as recorded with digital voice recorder. These two methods allowed the researcher to use voice recordings and video recorded footage for accuracy purposes.

Interview Questions

The interview questions were designed specifically for the project’s purpose, yet broad enough to capture unexpected but related concepts (Strauss & Corbin, 2007). The seven key open-ended questions were intended to explore the views, opinions, and experiences of communities that have historically been unserved/underserved. These key questions were: (1) Tell us about your community. (Consider asking about history, geographic distribution, socioeconomic issues, acculturation, etc.). (2) What are some of your community’s greatest concerns? (3) What do you think are your community’s greatest concerns around mental health? (4) Where do people in your community go for help when they have emotional concerns or are worried about a family member with a emotional, relationship, or social issues? (5) What services or programs are available in your community for social and emotional issues (mental health problems)? (6) What barriers exist to accessing services for your community? (7) If we had the opportunity to develop programs and services to prevent or treat mental health problems, what recommendations would you give us to do this? (8) What are some assets, strengths, or resources for your community?

Participants

The participants in the current study included three individuals who identified themselves as representatives of the Armenian community and three individuals who identified themselves as Deaf and Hard of Hearing

(DHH). Our primary interest focused on the experiences of these individuals and their knowledge of mental health issues and concerns within each community respectively. This was a purposeful sample, reflecting the desire to interview participants with significant experience working with the Armenian and DHH communities, as well as with an in-depth understanding of community needs and concerns.

The three Key Informants for the Armenian community included a lawyer, a mental health provider (LCSW), and a psychiatrist (Appendix B provides biographical statements for Armenian participants). All three are Armenian American and have worked extensively with the Armenian community providing professional services as well as leadership and advocacy for their communities. Two of the participants hold prominent leadership positions in Armenian advocacy organizations.

The DHH participants include a DHH counselor with eight years of experience providing mental health services for the DHH community at a school for the DHH. The second participant is a clinical psychologist with over 26 years of experience working with the DHH community. She has appointments with the California School of Professional Psychology and Gallaudet University. In addition, she is co-founder of Cultural Intersections in Oakland, CA, a non-profit community based program that offers diversity training and consultation. The third DHH participant is a mental health provider.

Data Analysis

Data analysis followed immediately after each interview session. After transcribing the notes of each interview session, the researcher and MAC member began coding the transcript/notes to identify themes or patterns in the data. Specifically, when analyzing the data, the researcher and MAC members extracted significant viewpoints and opinions from the transcripts/notes and began looking for categories through a process called open coding, which means forming initial categories of information about the phenomenon being studied by segmenting information (Creswell, 1998). Then using axial coding, the author was able to organize the data in order to obtain a holistic picture of participants' views and opinions. Creswell describes axial coding as a process used to establish themes and patterns in order to build a meaningful story. After the researcher and MAC

members read all the individual transcripts/notes marking meanings and themes, each developed a list of possible themes. The team met to discuss the possible themes representing the six participants and stopped when consensus was reached.

Results for Armenian Americans:

Review of the interview notes for the three Armenian American Key Informants yielded themes related to barriers to care in individual, community, and social domains *Table I. Armenian American Respondents: Key Themes and Quotes* provides examples of quotes from the key informants that express these themes.

Individual Level Factors:

On the level of the individual, all three respondents discussed the impact of cultural identity, acculturation, and adjustment issues.

Cultural Identity: Many Armenian Americans experience a struggle to maintain their cultural affiliation while adjusting to a new culture and fear the loss of their language, institutions, and cultural heritage. Armenians typically feel a strong sense of pride in their heritage and in Armenian traditions. In fact, Armenians are often somewhat insular, preferring to do business with and socialize with other Armenians. One key informant suggested that perhaps because of the history of genocide and diaspora, the desire to maintain a robust Armenian identity is particularly compelling. While Armenians often have a strong sense of pride and belonging, for many second generation Armenians Americans, the affiliation to their culture of origin may be somewhat diminished. This gradual erosion of culture is a source of grief and depression for older generation Armenian Americans.

Acculturation Stress: Key informants discussed the difficulty experienced by Armenian Americans in adjusting to life in the US. Many immigrants, even those with thriving careers or businesses in their countries of origin, face the challenge of “starting from the bottom” and finding work to support their families and to send their children to college. This challenge can be extremely stressful particularly for immigrants with limited English proficiency. While immigrants with refugee status may have government assistance, those who came without refugee status must overcome these

challenges with very little assistance. Much of this stress leads to loss of trust in surroundings.

In addition, many Armenian American families experience conflict as family members acculturate at different rates. Children often learn to speak English more quickly and begin to adopt values and behaviors of the new culture. Parents may feel alienated from their children and children often feel disconnected from both their parents and their culture of origin. The resulting acculturation gaps may be a source of conflict and stress, and may also hamper parents' ability to manage their children's behavior or to support them effectively.

Family: An important theme that emerged in the interviews was the importance of family as an asset and strength for Armenian Americans as well as a barrier to recognizing mental health problems. Key informants suggested that for Armenian Americans family bonds and loyalty are critical and family support often serves to buffer individuals from the stresses of poverty and acculturation. However, this reliance on family also prevents individuals from seeking help for mental health problems outside of the family. Respondents suggested that parents tend to minimize behavioral or mood problems to avoid the stigma associated with mental illness.

Trauma: Key informants discussed the history of trauma experienced by the Armenian community, particularly prior to immigration. Many Armenian Americans have been exposed to political strife and persecution. Others were witness to the devastation of the earthquake in 1988. These experiences cause trauma in older generation Armenian Americans which may affect children. One key informant referred to the intergenerational transmission of trauma as a factor affecting the mental health of Armenian American children and young adults.

Substance Use: A common problem identified by key informants for the Armenian American community is substance abuse. Key informants pointed to the intergenerational transmission of trauma, intergenerational acculturation gaps, and the erosion of cultural pride as key factors contributing to substance use.

Community Level Factors

Participants identified several community level factors that affect the mental health of Armenian Americans. The themes that emerged most consistently were related to stigma, lack of outreach and engagement, and lack of education and awareness about mental health issues. Respondents suggested that for many Armenian Americans mental illness is considered shameful and family members try to hide it from others. This stigma prevents individuals and families from seeking help for mental health problems. Instead, help is sought within the family or through the extended family.

In addition, key informants suggested that outreach, engagement, and psycho-educational services are lacking for the Armenian American community. Many Armenian Americans do not have an understanding or awareness of mental health problems, causes, and treatments. This lack of awareness contributes to the stigma associated with mental illness and to the reluctance of many Armenian Americans to obtain needed services. Participants suggested that effective outreach, engagement, and psycho-education, particularly if conducted by Armenian American providers would significantly increase individuals' willingness to reach out and obtain mental health services.

Social Factors

Key informants discussed the social and economic factors that affect mental health care. In particular, they noted that a lack of funding and resources, as well as a dearth of trained professionals limit access to care. As noted above, Armenians often prefer to conduct business with other Armenians and to obtain mental health care from Armenian American providers. For this reason, the few Armenian community based agencies that are currently equipped to provide services are often overtaxed. Waiting lists are long for Armenian speaking providers due to workforce shortages, particularly for bilingual psychiatrists. Furthermore, community based agencies have limited budgets to expand their services.

Table I. Armenian American Respondents: Key Themes and Quotes

Themes	Quotes
Individual Factors	
Cultural Heritage/Identity	<p>“... there is an issue with balancing [our] Armenian identity and culture along with the new immersion of the US culture, especially for new immigrants. These major issues that have not been explored and addressed”</p>
Acculturative stress	<p>“Issues trusting the new system/mainstream culture, language barriers ...become a problem for the new immigrant. These issues eventually become mental health issues (i.e., depression or anxiety).”</p>
Family	<p>“Parents want to keep their children more traditional and follow the customs/traditions of the Armenian culture. Children are more interested in exploring the new [US] culture. This creates conflict between parent and child.”</p> <p>“...seeking help against the wishes of the family is viewed as betrayal. Mental health issues are not being addressed in the family.”</p>
Trauma	<p>“Family does not want the community to know that they are receiving mental health services... [during] visitations, parents request that providers not wear badges, or carry briefcases so to not call attention.”</p>
Substance Abuse	<p>“They came with a lot of emotional stress and hardships they had to overcome. They had to start their life from scratch. Whether they were exposed to traumatic events or had to endure losses. They are already traumatized and are carrying that in their background.”</p> <p>“Substance abuse is another area that we don’t have enough resources. We are very limited in this area. We need more support in addressing this issue. Also, it is not</p>

	just youth who are abusing, parents themselves are abusing drugs too.”
Community Factors	
Stigma	“It is the stigma that is attached to mental health that becomes an issue in the Armenian community.”
Lack of outreach and engagement	“Outreach and engagement is a key factor in educating the community. Increasing awareness and education is important.” “...mental health issues are not addressed in schools. Basically, parenting sessions, outreach and engagement, schools do not have these services in place.”
Education	“... lack of awareness that mental health issues creates obstacles in accepting and receiving services or understanding the reasons for a referral for their children.”

Table I (cont.) Armenian American Respondents: Key Themes and Quotes

Themes	Quotes
<p>Social/Economic Factors</p> <p>Lack of resources</p> <p>Lack of funding</p> <p>Lack of trained professionals</p>	<p>“Families have difficulty following through with referral services because most of the services are English-only and families feel out of place.”</p> <p>“...long waiting list...because most of the people on the waiting list rather see a provider who speaks Armenian, they stay on the waiting list regardless of the severity of their condition.”</p> <p>“We need more providers and resources that are specific to the Armenian community to address the mental health and substance abuse issues.”</p> <p>“Our staff is overwhelmed and as an agency, we feel like our hands are tied because of the lack of resources within and outside of the Armenian community.”</p>

Community-Defined Recommendations

Key informants recommended building on cultural strengths and existing assets, providing outreach, engagement, and education to combat stigma, and increasing workforce and resources for mental health services. Armenian Americans have a strong history of cultural pride and ethnic identity and of reliance on the community and the family as a central unit. Areas with high concentrations of Armenian Americans have established Armenian community based social service organizations and businesses. Furthermore, many Armenians have entered helping professions and are currently working as mental health providers. It is critical that these existing resources be tapped to effectively serve the Armenian community. Given the importance of Armenian identity, and the tendency to look within the community for help, Armenians are more likely to seek services and to accept help from Armenian American providers.

In addition, key informants stressed the importance of conducting outreach and educating community members about mental illness. As many Armenian Americans are reluctant to obtain needed mental health services due to the stigma of family and cultural values associated with mental illness, interventions are needed to educate the community about mental health problems, signs, symptoms, and treatments. Respondents suggested that psycho-education and stigma reduction programs will have the most penetration into the Armenian community if delivered by Armenian providers and organizations. Additionally, providing these services through schools with high percentage of Armenian American students may enhance reach into this community. *Table 2. Armenian American Respondents: Quotes for Recommendations/Solutions* displays quotes related to these themes.

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Table 2. Armenian American Respondents: Quotes for Recommendations/Solutions

Themes	Quotes
<p>Individual Factors</p> <p>Cultural Heritage/Identity</p> <p>Recognize Armenians as an ethnicity</p> <p>Family</p>	<p>“... Armenian people have a rich history of standing up to and surviving historical tragedies. These lived experiences builds resiliency.”</p> <p>“Armenians hold a strong belief in the culture and the belief that Armenian is a unique culture.”</p> <p>“Armenian people have a sense of moral resolve having survived war to keep their Christianity...essential in strengthening the culture.”</p> <p>“...[Armenians are viewed as] “white” or “other” and doing this limits affirmative action opportunities [for young Armenians]. It is important for people to identify where they immigrated to the US.”</p> <p>“...the family is a support system when it comes to mental health services.”</p> <p>“Family and extended family are strength. Grand parents play a key role, they are the voices of reason, and the expertise and they have the knowledge, historical knowledge.”</p>
<p>Community Factors</p> <p>Community leaders</p>	<p>“ Community leaders, people who know the community are assets [to ending stigma].”</p> <p>“Armenian leadership is key to getting mental health services to the community. Get the leadership on board and one will be successful in making mental health services acceptable.”</p>

Outreach and engagement	“...Improve education and educate the community about mental health...work on helping people feel comfortable asking for help...starting with youth, we need to get them the help that they need early on.”
Schools	<p>“ [Parents] communicating and engaging with other parents can help. Outreach and engagement is a key factor in educating the community. Increasing awareness and education is important.”</p> <p>“The Armenian schools are a great place to discuss identity issues and mental health issues.”</p> <p>“[Increase immersion programs for] Armenian youth when they go to college. They are not prepared to enter a new environment that they are not familiar with.”</p>

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Table 2 (cont.) Armenian American Respondents: Quotes for Recommendations/Solutions

Themes	Quotes
<p>Social/Economic Factors</p> <p>Resources</p> <p>More funding for existing programs</p>	<p>“[Resources in] Armenian language is key to reaching out to parents and community at large...any outreach information to engage community must be in Armenian.”</p> <p>“[Increase funding for best practices]...Hye-Wrap, for example, emphasizes education and awareness [of mental health] resources. [Hye-Wrap] have Armenian clinicians who are Armenian-culturally sensitive for clients who need services.”</p> <p>“[Increased funding] to support continued education seminars to combat stigma... Increase outreach and engagement. Increase...programs for elderly Armenians who are isolated and suffering from depression...and LGBTQ youth coming out to their families.”</p>

Results for the Deaf and Hard of Hearing:

Review of the interview notes and transcripts for the two DHH key informants yielded themes related barriers to care in individual, community, and social domains. *Table 3. DHH Respondents: Key Themes and Quotes* presents quotes from key informants in these areas.

Individual Level Factors:

DHH Identity and Culture: On the level of the individual, respondents emphasized the challenges faced by DHH persons in expressing their needs and concerns, creating a sense of identity, and fitting in in hearing contexts. One informant put it succinctly, “Issues that come up because of crisis, cultural identity (LGBTQ, racial), etc. are often met with a lot of feelings of frustration because their family’s culture – the hearing culture – is different. The low expectations that hearing parents sometimes have for their DHH children is more about their ignorance and limited access to

unbiased and appropriate information that they need to know for their DHH children. The DHH child often feels left out, frustrated, and misunderstood culturally – their deaf culture, and their specific needs.”

Frustration, Stress and Isolation: In addition, participants discussed the frustration DHH persons experience living in environments which marginalize the Deaf culture. Key informants described the feelings of frustration, anger, isolation, and despair that many DHH when their opinions, needs, and rights are ignored by those in the hearing population. In seeking mental health services, DHH individuals often encounter significant barriers. Even in initial encounters with the mental health system, DHH individuals often do not obtain adequate interpreting services and are thus unable to communicate their experiences effectively. A long history of struggling with these barriers and experiencing deep frustration contributes to a reluctance to seek services. Feelings of isolation are exacerbated as the DHH community is often not included in social events. One DHH informant depicted her frustration with this lack of inclusivity due to lack of familiarity and sensitivity: “Sadly, most cities and states...are not familiar or sensitive to the needs of the deaf-blind community and are not able to provide deaf-blind interpreter services, appropriate lighting...They [deaf-blind individuals] end up isolated and this often leads to serious mental health issues...”

Diversity within the Community: Finally, Key Informants emphasized cultural, ethnic, racial, and socioeconomic diversity within the community. The DHH community has significant diversity that often goes unrecognized. For example, one participant reported that DHH clients in her program come from various different countries and speak several languages. The life experiences and mental health needs of DHH individuals who are LGBTQ, immigrant, refugee, and from various racial and cultural backgrounds may differ widely. Further, stigma may be a major barrier between the deaf Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth and his/her family. One informant noted, “Deaf LGBTQ youth of deaf parents...often worry about ruining their family’s reputation if they come out as an LGBTQ individual.” Again, this highlights the lack of resources and programs for DHH LGBTQ youth and their families.

Community Level Factors

On the community level, participants discussed challenges for DHH persons related to access to services including: lack of access to community resources, a shortage of qualified mental health providers, and inadequate interpreting services. In terms of community resources, DHH participants reported that not all DHH children have the opportunity to obtain educational services in ASL. Many California communities do not have schools for the Deaf and thus, many DHH children do not have the opportunity to be educated in ASL in a culturally affirmative context. This can be detrimental to the DHH child's learning as well as to the development of a healthy sense of identity.

In addition, participants emphasized the difficulty obtaining culturally and linguistically appropriate mental health services for DHH clients. Because of the shortage of mental health professionals proficient in ASL, waiting lists for individual and family therapy and psychiatric services for DHH clients are lengthy. Furthermore, obtaining adequate and timely interpreting services can be challenging. ASL interpreters are often not fully proficient or may lack mental health training. Often DHH consumers go undiagnosed or are misdiagnosed due to communication barriers. Key informants described incidents in which clients who needed crisis intervention were not able to receive help due to a shortage of ASL proficient providers and interpreters. One participant described an incident in which a DHH client who had repeatedly sought mental health services for depression committed suicide.

One informant further suggested that ASL proficiency is not enough to ensure cultural competency. She noted that many of her DHH consumers are immigrants, refugees, and ethnic, cultural, and of diverse racial backgrounds. These individuals may have cultural beliefs and values that differ from those of a DHH (or DHH culturally competent) therapist. To address cultural competence with a DHH client, the complex interplay of cultural identities must be taken into account.

Social Factors

Among the social factors that were barriers to care identified by DHH informants were: 1) a sense of isolation and disconnection and 2) a lack of funding to sustain effective and critical services. In some DHH families both parents and children may be DHH, however in many families only one

member is DHH. The manner in which the individuals experience their Deaf culture may differ based on presence or absence of DHH family members, close friends, or community members. Some DHH individuals feel supported and connected to the DHH community and their family. In contrast, other DHH individuals may feel marginalized, ignored, or isolated from family and community. If family members are not DHH and do not make efforts to validate and engage in Deaf culture with their DHH family members, DHH individuals may feel isolated and alone. Thus, the extent to which the DHH individual's proximate social environment, family, friends, neighbors, classmates, and teachers validate and support their Deaf cultural identity may affect the individual's ability to cope with stress and challenges. Further, recent budget cuts have drastically reduced the availability of mental health services to DHH individuals and families.

Table 3. DHH Respondents: Key Themes and Quotes

Themes	Quotes
Individual Factors	
Struggle/Frustration	“...we feel frustrated about expressing our voice, we do have a voice! And we have to speak up for our rights and it's still a struggle for us.”
Individual rights	“We've been fighting for a long time about these issues of language access, education, etc. and it is still a struggle.”
Diversity	“...for multicultural, multilingual families with DHH children-- especially for those families with DHH children with additional disabilities-- neither "hearing" or deaf serving agencies (from our experience) could serve these youth adequately, or simply not at all...”

Table 3 (cont.) DHH Respondents: Key Themes and Quotes

<p>Community Factors</p> <p>Lack of access to community resources</p>	<p>“The biggest concerns in our community right now I would say are around access to education, especially the right for us to use our own language – American Sign Language (ASL).”</p>
	<p>“As a Deaf person myself, and also as a person who works as a Counselor at a school for the deaf I see that there is virtually “no access” to mental health services...really...Not nearly enough...We have no access, really, to service providers who have the background, knowledge, and understanding of how to serve the DHH community.”</p>
<p>Shortage of qualified professionals</p>	<p>“Many really struggle to ask for help because they know that there are going to be many barriers to prevent them from getting the services they need.”</p>
<p>Interpreter/translation</p>	<p>“...there is a severe shortage of quality, appropriate, and accessible mental health services for the DHH community in the entire country (United States), let alone California.”</p> <p>“...mental health issues are not addressed in schools. Basically, parenting sessions, outreach and engagement, schools do not have these services in place.”</p> <p>“...Often we see that the ‘cheaper rate’ at an interpreter agency provides less qualified and lower skilled interpreters...during a therapy session, often the low skilled interpreter will have trouble understanding what is being said by they DHH person.”</p> <p>“So a lot of gaps in communication impact the diagnosis and mental health services that the DHH community gets.”</p>

Social/Economic Factors	<p>“...a huge gap in feeling connected with therapy services...[DHH people] feel a huge disconnect culturally [especially DHH people who come] from another country.”</p>
<p>Sense of being disconnected</p>	<p>“[DHH individuals] really STRONGLY wanted to be able to see a therapist who could sign fluently and who could also understand their other culturally needs.”</p>
<p>Lack of funding</p>	<p>“A real change in how funding is dispersed. Every year we have seen funding cuts go deeper and deeper...too many have shut down in recent years due to funding cuts and the need is greater than ever.”</p>

Community Defined Recommendations

A key strength identified by key informants was found within the family. Families’ commitment to their children, their bond, and their persistent advocacy on behalf of their DHH family members was viewed as an important asset within this community. It was recommended that parents and caregivers receive support in advocating for their children.

In addition, informants noted that within the Deaf community there are knowledgeable and committed professionals who espouse a sense of cultural bonding and support that is critical in buffering the DHH individual from stress. DHH providers (and DHH culturally competent providers) were described as loyal, passionate, and dedicated. Further, within the DHH community there is significant resiliency. A long history of struggling to obtain basic rights within education and other systems has brought the community together. To more effectively address the needs of the DHH, providers should consider building on the resiliency that exists within the community, on the strength of advocacy, and closeness of families.

Finally, informants recommended that increased resources be devoted to improving access to education and mental health care. Informants suggested that many DHH children are denied access to education in ASL.

Improving access to ASL education would enable many children to learn in an environment that validates their Deaf culture.

Furthermore increased resources are needed to improve the ASL proficient workforce, train providers that are DHH (and DHH culturally competent), and provide adequate and timely interpreting services. Interpreters should be trained in mental health issues and should be proficient in ASL. The key to providing high-quality care and treatment to DHH communities lies in training and research. In other words, training providers to be more competent in the deaf culture, and increase research about the DHH culture. Expanding the skills set of counselors and their ASL fluency and research will help to increase the mental health care and treatment needs of the DHH community. Table 4 presents quotes related to these themes.

Table 4. DHH Respondents: Quotes for Recommendations

Themes	Quotes
<p>Individual Factors</p> <p>Family</p> <p>Advocacy and training</p>	<p>“...the families' commitment and love for their DHH child.”</p> <p>“Families...have their cultural knowledge and insights that they bring to the table.”</p> <p>“...their indigenous and ‘within’ cultural supports and resources...that we (professionals) often disregard, discount, minimize, and overlook...We need to be tapping into these resources from our families...asking them what works and partner ‘with’.. rather than criticizing and work against.”</p> <p>“...parents need more resources and structural supports from the healthcare professionals and system, and special education system...we can't simply expect [the family] to know how to</p>

	advocate in the ways that are meaningful and effective in our American system.”
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Table 4 (cont.) DHH Respondents: Quotes for Recommendations

Themes	Quotes
<p>Community Factors</p> <p>Committed professionals</p>	<p>“...commitment and dedication to their child manifests in how once a relationship is established with the professional...the relationships is a "forever" one...loyal, committed...”</p>
<p>DHH-appropriate services</p>	<p>“[I] can call on the parent-guardian all the time...and they'll have my back as I have theirs...that relationship is viewed and valued differently due to the cultural differences.”</p> <p>“...professionals need to adopt a stance of cultural humility foremost...and come in with the attitude of "not knowing" and being willing to learn from and exchange with our families.”</p>
<p>Community resiliency</p>	<p>“...[professional and family] relationships are interdependent oriented...emphasis on the "relational" or relationship between each other...how they interact with others is a strength.”</p> <p>“...[in Riverside County] the second largest county in the state...and has a huge deaf population, there is one licensed therapist in this</p>

	<p>county who can sign ASL fluently.”</p> <p>“...we do have a voice! And we have to speak up for our rights and it’s still a struggle for us. We’ve been fighting for a long time about [our] issues of language access, education, etc.”</p> <p>“The DHH community so often has to fight and fight just to have even the most minimal mental health services.”</p>
<p>Social/Economic Factors</p> <p>More funded ASL schools</p> <p>Increase access to programs</p>	<p>“...a much broader and mixed approach to teaching in our school system for the DHH community...have made a big impact on issues of education in the DHH community, and an impact on so many other issues we face such as job opportunities and issues of mental health.”</p> <p>“There’s only really one...option in our community called CODIE (Center On Deafness Inland Empire) [to refer DHH individuals] but they are severely understaffed...They are really completely overwhelmed!”</p> <p>“If a child at CSDR (CA School for the Deaf Riverside) needs help in situations of crisis, there are really few places I can refer them to.”</p>

Summary and Conclusions:

In this report, we explored the perceptions and experiences of key informants from the Armenian American and the Deaf and Hard of Hearing (DHH) communities regarding community needs, access to mental health services, and community assets. The results revealed barriers to care as perceived by the informants through experiences and interactions with

individuals, families, and community at large. Informants for both communities emphasized a need for additional community-appropriate resources and workforce qualified to serve these communities. One informant stated, “We need more providers and resources that are specific to the Armenian community to address the mental health and substance abuse issues.” Another one said, “There is a severe shortage of quality, appropriate, and accessible mental health services for the DHH community in the entire country, let alone California.” These statements indicate that both communities are faced with the challenge of overcoming a financial and workforce burden in serving people in need.

Furthermore, adequate funding matters. Informants described the negative impact of inadequate funding on staff and the community. “Long waiting lists...because most of the people on the waiting list rather see a provider who speaks Armenian, they stay on the waiting list regardless of the severity of their condition.” This raises the question, if MHSA funding is to recognize and address the disparities of underserved communities, why is there still a shortage of well-trained professionals? Informants favor redirecting funding toward the community and building community capacity. As noted by this informant, “A real change in how funding is dispersed. Every year, we have seen funding cuts go deeper and deeper...too many [programs] have shut down in recent years due to funding cuts and the need [for DHH] is greater than ever.” The need for more qualified professionals and funding resources is evident, yet only a handful of programs (i.e., Hye-Wrap and CODIE) serving the Armenian and DHH communities respectively exist in California.

Despite these barriers, the informants seemed to agree that family and cultural and community resiliency are the core of their community. Key informants described both their experiences and observations regarding the powerfully positive role of family in promoting strength and resilience. Family is particularly crucial to reducing disparities and mental health stigma. In fact, mental health professionals who understand the value and significance of family, advocate for more programs that focus on educating and training family members about mental health issues and giving them a

voice. The informants recognized the link between a resilient culture and mental health. One informant stated, “Armenian people have a sense of moral resolve having survived war to keep [our] Christianity...[this] is essential in strengthening the culture.” Another said, “We [DHH] do have a voice! And we have to speak up for our rights and it's still a struggle for us. We've been fighting for a long time about [our] issues of language access, education, etc.” This indicates that mental health professionals must be equipped with the cultural and historical knowledge of that community to be able to meet their mental health needs. However, if the system and current workforce is not properly trained and prepared to adequately serve these communities, as an industry, we will miss opportunities to assess and address these communities mental health needs and eventually reduce mental health disparities for all.

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Appendix A State of the State II

Selecting Groups

The CMMC was charged with the task of producing a yearly State of the State report on disparities. The first report focused on summarizing statewide data on disparities. The second report will build awareness about groups that have not been surveyed in previous reports and provide information on the history, culture, and mental health needs of these communities.

While the State of the State II report will focus on a few communities, the CMMC recognizes that there are several communities that could be a focus of these efforts. Many groups are historically underserved, are marginalized or vulnerable, and experience social and civic exclusion due to their race, ethnicity, sexual orientation, or culture. The current report will not survey all groups, instead the intent of this report is to conduct a qualitative study that may be replicated in future reports with other communities. These efforts are part of an ongoing process of connecting and building relationships with new communities throughout the state of California.

Group Selection:

The first task in this process is to select 2-3 groups to be the focus of this report. The CMMC MAC conducted a brainstorming process which resulted in a list of communities. The CMMC may consider the following factors in selecting the groups to be the focus for the first report:

1. Un/underserved populations (and historically marginalized or vulnerable groups) not in the first CRDP phase BUT are current CMMC members
2. Un/underserved populations (and historically marginalized or vulnerable groups) not in the first CRDP phase AND are not current CMMC members

3. Un/underserved populations (and historically marginalized or vulnerable groups) from the first CRDP phase (5) BUT could benefit from additional planning resources
4. Special “needs”

In addition, the committee may consider the following factors:

1. Does the group experience high levels of risk (exposure to trauma or war, exposure to violence, discrimination, high rates of homicide, suicide, or out of home placement for children)
2. Does the community experience high rates of uninsurance, underinsurance and poverty?
3. Does the community lack access to services?
4. Does the community experience significant barriers to care?

Preliminary list of groups from brainstorming session:

CMMC MAC committee members conducted a brainstorming process in which they proposed the following groups. The MAC committee recognizes that this list is not comprehensive, and hopes that it will be viewed as a “living document” and that CMMC members will add to this list as they identify new and emerging groups.

1. Deaf and Hard of Hearing
2. Armenian Community
3. Russian Community
4. Arabic-speaking Community
5. Individuals with Disabilities (including developmental and cognitive disabilities, and autism spectrum disorder)
6. Blind
7. Rural/Isolated Urban
8. Refugees/Immigrants
9. Women
10. Older Adults, (including aging who do not identify as “older”, and aging single males)

Appendix B State of the State II

Armenian American Participant Biographical Statements

Raffi Tashjian, MD

Dr. Tashjian is a board certified psychiatrist who had a private practice in the Pasadena, Montebello, and West Covina areas between 1981 and 2000. Throughout those years he treated Armenian patients, lectured in Armenian schools, participated in Armenian TV programs, and provided educational articles in Armenian newspapers. He is currently a medical consultant for the California Department of Social services.

Dr. Tashjian is one of the founders of the Armenian American Mental Health Association (AAMHA) and currently the Vice President of its Board. AAMHA is a non-profit organization established in California in 2009. Its mission is to provide support to individuals, agencies, and organizations that offer mental health services to the Armenian community, and, to promote utilization of mental health services to those who need it. Its goals are to provide leadership in assessing the mental health needs of the Armenian community in Southern California, to develop educational programs about mental health for the Armenian community, to inform the Armenian community about available mental health resources, to promote training of mental health professionals, and to help initiate the development and organization of mental health services to meet the needs of the Armenian community. AAMHA's membership is composed of different levels of Armenian mental health providers including Psychiatrists, Psychologists, LCSWs, MFTs, RNs, and students enrolled in a doctoral or master's degree program in this field. AAMHA is the only such organization in California and has been growing since its recent inception thanks to its volunteer workforce and dedication of its members. AAMHA's website and web-mail list reaches over 225 Armenian mental health providers in Southern California.

Nyree Derderian, PhD

Dr. Nyree Derderian has a Ph.D. in Political Science and a Law Degree from Stanford University. She has her own practice in Los Angeles as a consultant to non-profit organizations. Dr. Derderian is the Past Chair of the Armenian Relief Society Western Region which includes 27 chapters on

the West of the Mississippi. It covers the states of Utah, Colorado, California, Arizona, Nevada, and Texas. The Armenian Relief Society is a US based organization founded in New York in 1910. Among its several services to the Armenian community, ARS maintains a Social Services Unit and a Counseling Center completely funded by the Armenian community. All services are offered free of charge.

Stella Petros, LCSW

Stella Petros, LCSW has been a Team supervisor/Clinical supervisor at Child and Family Specialty Division, Hye-Wrap program since 2006. Pacific Clinics has been providing behavioral and mental health care services to families in the greater San Gabriel Valley area since 1926. It has more than 75 service locations in Los Angeles, Orange, San Bernardino, Riverside, and Ventura Counties. Hye-Wrap is a program developed in 1996 for the Armenian community by Pacific Clinics. Hye-Wrap is a school and community based program specializing in serving Armenian children, youth, adults and older adults. The program is funded in part by the Los Angeles County Department of Mental Health, and accepts Medi-Cal insurance. It also provides specialized services funded by the California Mental Health Services Act (MHSA).