Expanding Community-Based Behavioral Health Models to Support Asian American, Native Hawaiian, and Pacific Islander Communities: The Roles of Paraprofessionals

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Summary

Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPIs) are among the fastest-growing populations in the United States and are among the least likely to utilize behavioral health services. Organizations in the San Francisco Bay Area are utilizing unlicensed behavioral health paraprofessionals (e.g., peer support specialists, community mental health workers, lay counselors) to improve access to culturally and linguistically congruent services for AANHPIs. This report summarizes findings from interviews conducted with 15 of these organizations regarding their rationale for employing paraprofessionals, the roles paraprofessionals play, their training and compensation, their impact on clients, and the potential for scaling these models for meeting AANHPIs' behavioral health needs. By sharing language and lived experiences with clients, paraprofessionals foster trust, reduce stigma surrounding mental health, and improve clients' mental well-being and access to services.

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Table of Contents

Introduction

Background and Context

Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPIs)[1] are less likely to access behavioral health services than other racial/ethnic groups. According to the 2021 National Survey on Drug Use and Health, only 25.4% of Asian American adults[2] with any mental illness in the past year received mental health services, compared to 52.4% of White adults, 52.2% of Multiracial adults, 39.4% of Black/African American adults, and 36.1% of Hispanic/Latino adults (Substance Abuse and Mental Health Services Administration, 2022).

Several factors contribute to AANHPIs' hesitation to identify behavioral health needs and seek support, including:

- The compounding effects of intergenerational trauma
- Shame and stigma
- Systemic discrimination
- A complex healthcare system that is difficult to navigate and emphasizes reimbursable clinical diagnoses and treatment
- Misaligned definitions of wellness and well-being between providers and clients
- Lack of culturally responsive interventions
- Misaligned outcomes and expectations for behavioral health services
- Perceptions of AANHPI communities as a monolithic group despite cultural, political, economic, and religious differences

[1] Asian Americans include individuals with ancestral ties to Asia, which includes East Asia (e.g., Chinese, Japanese, Korean), Southeast Asia (e.g., Filipino, Vietnamese, Cambodian), and South Asia (e.g., Indian, Pakistani, Bangladeshi). Native Hawaiians are the indigenous people of Hawaii. Pacific Islanders include individuals from Polynesia (e.g., Samoan, Tongan, Tahitian), Micronesia (e.g., Chamorro, Palauan, Marshallese), and Melanesia (e.g., Fijian, Papua New Guinean, Solmon Islander).
[2] Data for Native Hawaiian and Other Pacific Islander adults were not reported.

- Lack of access to health insurance
  - According to 2024 estimates, 3.4% of Asian Americans and 5.2% of Native Hawaiians and Pacific Islanders in California did not have health insurance, while 5.9% of Californians overall were uninsured (U.S. Census Bureau, n.d.-c).
  - The number of AANHPIs who are uninsured is likely to increase in the coming years due to the expiration of Affordable Care Act (ACA) enhanced subsidies for coverage purchased through Covered California and other health insurance exchanges, the establishment of work requirements for Medicaid beneficiaries, and the enrollment cap for non-elderly undocumented adults in Medi-Cal (California's Medicaid program).
- Racial/ethnic, linguistic, and cultural discordance between behavioral health clinicians and clients
  - In California in 2024, 9.6% of behavioral health clinicians[3] were Asian American and 0.3% were Native Hawaiian/Pacific Islander, while 15.1% and 0.3% of the overall population in the state were Asian American and Native Hawaiian/Pacific Islander, respectively (California Department of Health Care Access and Information [HCAI], n.d.-b).
    - In the San Francisco Bay Area in 2024, 13.5% of behavioral health clinicians were Asian American and 0.3% were Native Hawaiian/Pacific Islander, while 27.8% and 0.5% of the overall population in the region were Asian American and Native Hawaiian/Pacific Islander, respectively (HCAI, n.d.-b).
  - In California in 2024, 4.1% of behavioral health clinicians spoke an Asian or Pacific Islander language, compared to 10.0% of overall population in the state (HCAI, n.d.-a).
    - In the San Francisco Bay Area in 2024, 5.8% of behavioral health clinicians spoke an Asian or Pacific Islander language, compared to 17.9% of overall population in the region (HCAI, n.d.-a).

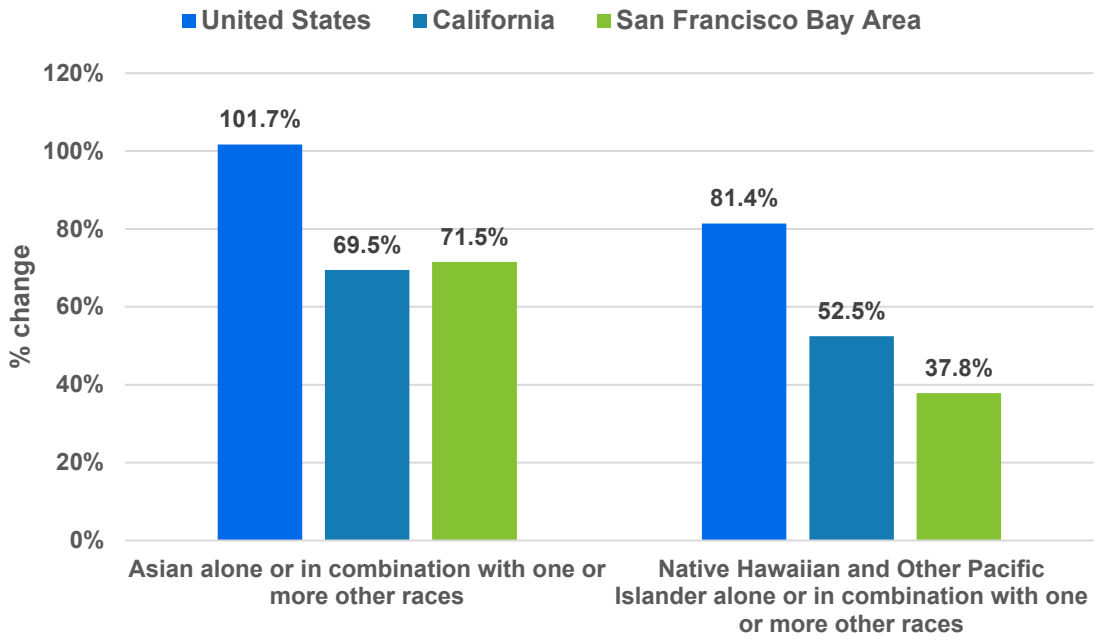
[3] Includes Associate Clinical Social Worker, Associate Marriage and Family Therapist, Associate Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Educational Psychologist, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, Psychiatric Mental Health Nurse, Psychologist, and Registered Psychological Associate.

These barriers are further exacerbated by the shortage of behavioral health clinicians. In 2022, California faced a 37.1% workforce shortage across three behavioral health roles[4] and the San Francisco Bay Area experienced a 31.4% shortage. By 2033, California is projected to face a behavioral health workforce shortage of 37.5%, requiring more than 88,400 additional clinicians to meet the forecasted demand. In the San Francisco Bay Area, the shortage is projected to be 36.2%, requiring more than 19,600 additional clinicians to meet forecasted demand (HCAI, n.d.-c). This shortage, coupled with the scarcity of licensed behavioral health clinicians who are racially, ethnically, linguistically, and culturally concordant with the client population, constrains AANHPIs' access to behavioral health services and negatively impacts their mental well-being.

These challenges are particularly significant when considering that the AANHPI population is one of the fastest growing populations at national, state, and regional levels (see Figure 1). Between 2000 and 2020, the number of Californians who reported their race/ethnicity as Asian alone or in combination with other racial or ethnic group(s) increased by 69.5%, and the number who reported their race/ethnicity as Native Hawaiian and Pacific Islander alone or in combination increased by 52.5% (U.S. Census, 2001; U.S. Census, n.d.-a). In the San Francisco Bay Area, there was a 71.5% increase in Asian Americans and a 37.8% increase in Native Hawaiians and Pacific Islanders during the same period (U.S. Census, 2001; U.S. Census, n.d.-a). This population growth is primarily driven by immigration. In California, the largest group of recently arrived immigrants were from Asia, constituting 46.4% of recently arrived immigrants as of 2022 (Perez & Johnson, 2024). Data from the 2021 American Community Survey (ACS) 5-year estimates for the San Francisco Bay Area indicate that 57.4% of Asian Americans and 24.7% of Native Hawaiians and Other Pacific Islanders were foreign-born (U.S. Census Bureau, n.d.-b).

[4] Includes Associate Level Clinicians, Non-Prescribing Licensed Clinicians, and Psychiatrists.

Figure 1. AANHPI Population Growth (2000 to 2020)



Note: Data extracted from U.S. Census data sources for 2000 and 2020 (U.S. Census Bureau, 2001; U.S. Census Bureau, n.d.-a).

Organizations providing community-based behavioral health services to AANHPIs have developed models of care that frequently utilize unlicensed behavioral health paraprofessionals (e.g., peer support specialists, community mental health workers, human services assistants, wellness coaches, lay counselors) to meet the needs of this growing and diverse population. The shortage of bilingual and bicultural AANHPI behavioral health clinicians makes the use of paraprofessionals vitally important in AANHPI communities. Paraprofessionals often speak the same languages as clients, function as effective cultural brokers, and provide important insights about AANHPI communities that facilitate outreach and treatment efforts. There is a need to describe these models of care, identify their similarities and differences, assess their effectiveness, and highlight opportunities for expanding these models to better serve AANHPIs.

Purpose of This Report

This report aims to inform stakeholders about the critical role of paraprofessionals in expanding community-based behavioral health models that are culturally tailored to support the unique needs of AANHPI communities. It summarizes findings from focused interviews conducted with managers and behavioral health providers at organizations providing community-based care for AANHPIs throughout the San Francisco Bay Area. Although not all organizations engaged in this work are included, the report discusses a selection of these organizations that represents a diversity of types of organizations, populations served, and community-based behavioral health models.

Primary Audiences for This Report

The primary audiences for this report are philanthropic foundations, donors, and organizations investing in initiatives that address behavioral health disparities among AANHPI communities, as well as policymakers and government entities.

Limitations

Although disaggregating data among the different racial and ethnic subgroups within the AANHPI diaspora is important to fully understand the unique experiences and needs of these communities – especially in regard to behavioral health and well-being – this report does not do so due to limitations in the available data, which often combine AA and NH/PI subgroups. Findings from the focused interviews discussed below are also not disaggregated, as the majority of the organizations interviewed served diverse client populations across many AANHPI subgroups, and subgroup-specific information was limited primarily to organizations that focused on a specific racial/ethnic group or other subgroups (e.g., LGBTQ+).

Most organizations interviewed conducted client satisfaction surveys to gauge their overall experience with the behavioral health services provided but did not systematically assess the impact of paraprofessionals on clients' mental health and well-being. The capacity of these organizations to assess impact was limited due to resource constraints, such as a lack of funding and limited staff availability or expertise.

Focused Interviews

Methodology

The Healthforce Center at UCSF research team conducted 20 semi-structured interviews with 21 representatives from 15 organizations.[5] Organizations were identified through recommendations by the Advisory Group[6] established for this phase of Asian Pacific Fund's community-based behavioral health initiative and through web searches. Three criteria were used to select the organizations interviewed:

- Located in the San Francisco Bay Area
- Utilized paraprofessionals to provide community-based behavioral health services
- Predominately served AA and/or NHPI clients

Particular attention was given to selecting organizations that served diverse cultures within the AANHPI diaspora, as well as considering factors such as age of the client population and focus on a specific segment of the AANHPI community (e.g., LGBTQ+). Information about the primary client populations served can be found in Appendix A.

Table 1 describes key characteristics of the organizations that participated in the focused interviews.

[5] One interview had two participants. One organization did not utilize paraprofessionals at the time of the interviews but was sending staff through a paraprofessional training course and intended to utilize paraprofessionals to provide community-based behavioral health services in the future. See Appendix A for a full list of the organizations included in the focused interviews.
[6] The Advisory Group is composed of 10 leaders from exemplar organizations that utilize paraprofessionals to deliver community-based behavioral health services in the San Francisco Bay Area, or from organizations with expertise in this field. See Appendix B for a full list of the organizations included in the Advisory Group.

Table 1. Characteristics of Organizations that Participated in the Focused Interviews

Characteristic	Description
Type of Organization	3 behavioral health organization 6 community-based organization (CBO) 3 domestic violence support organization 3 federally qualified health center (FQHC)[7]
Interaction with Licensed Behavioral Health Clinicians	7 collaborative model 2 complementary model 5 consult external clinicians model
Preferred Educational Qualifications	2 bachelor's degree 12 no preferred educational credentials
Opportunities for Advancement	10 advancement within paraprofessional role and/or to different roles (e.g., program manager) 4 no opportunity for advancement
Compensation	8 paid staff 2 volunteers 4 paid staff and volunteers
Source of Funding for Paraprofessionals	1 California Opioid Settlement Funds 2 county government funding 9 grants 1 Medi-Cal 1 organizational revenue

Note: In total, 15 organizations participated in the focused interviews. However, one organization did not utilize paraprofessionals at the time of the interviews but was sending staff through a paraprofessional training course and intended to utilize paraprofessionals to provide community-based behavioral health services in the future. Characteristics for this organization are omitted from the table where appropriate.

After identifying eligible organizations, the UCSF research team reached out to a representative of the organization, typically someone in a leadership or program management role, to invite them to participate in a focused interview. The representative then nominated a licensed behavioral health clinician and/or paraprofessional from their organization to participate in a separate interview. In some cases, interviewees held dual

[7] A community-based organization is a nonprofit organization that provides services to a specific community or geographical area to address its needs. A domestic violence support organization is a nonprofit agency that offers resources, shelter, advocacy, and support to survivors of domestic violence. A federally qualified health center is a federally funded community-based clinic that delivers care to underserved communities.

roles, such as a licensed behavioral health clinician also holding a program management role. Interviewees included:

- 8 program managers
- 2 licensed behavioral health clinicians
- 3 paraprofessionals
- 6 program manager and licensed behavioral health clinicians
- 2 program manager and paraprofessionals

Interviews were approximately one hour long and were conducted via Zoom between March and May 2025 using an interview guide developed with input from Asian Pacific Fund and the Advisory Group. For managers of community-based behavioral health programs, interview questions focused on what led the organization to utilize paraprofessionals, how these paraprofessionals were utilized and compensated, opportunities for career growth, and impact on organizational and client well-being. For licensed behavioral health clinicians and paraprofessionals, interview questions focused on paraprofessionals' work, training, and impact.

The study was approved by the UCSF Institutional Review Board (IRB). Data collection adhered to ethical guidelines, with informed consent obtained from all interviewees and confidentiality maintained. Each interviewee received a $50 gift card as compensation for their time. Interviews were recorded using Zoom and transcribed verbatim using Rev. The qualitative analysis involved coding and thematic analysis of interview transcripts using Dedoose to identify recurring themes and patterns related to paraprofessionals and community-based behavioral health services.

Findings

The interview findings revealed key insights into the role of paraprofessionals in community-based behavioral health models. Interviewees shared diverse perspectives, reflecting variations in their types of organizations, paraprofessional models, and populations served. Findings were synthesized into high-level themes, including:

- Reasons for hiring paraprofessionals
- Roles paraprofessionals played in serving AANHPI clients and how they interacted with licensed behavioral health clinicians
- Impact of paraprofessionals on the well-being of AANHPI clients
- Recruitment, education, and training of paraprofessionals
- Compensation and retention of paraprofessionals
- Mitigating risk of re-traumatization
- Opportunities for scaling models that utilize paraprofessionals

Why Organizations Hire Paraprofessionals

Organizations hire paraprofessionals to meet the demand for culturally competent behavioral health care. All interviewees noted that their organizations believe paraprofessionals can better connect with and relate to clients because they share similar backgrounds (e.g., from the same culture), lived experiences, and languages. Moreover, paraprofessionals provided additional support and extended services beyond what licensed behavioral health clinicians could offer alone, increasing the organization's capacity to provide clients with behavioral health services and other resources. In some cases, paraprofessionals were hired due to challenges with finding qualified licensed behavioral health clinicians of the same racial/ethnic, linguistic, and/or cultural background as the client population, reflecting the statewide and regional shortage of AANHPI clinicians (HCAI, n.d.-b) and clinicians who speak an Asian or Pacific Islander language (HCAI, n.d.-a).

> "A lot of times, peer work is necessary; [paraprofessionals are] the ones who better relate with folks on the street. We connect better, understand better, and help them navigate, because **a lot of the time we relate to them, and they relate to us. [We] help them and support them in actually accessing services**."
> — Paraprofessional at a behavioral health organization

The Role of Paraprofessionals

Paraprofessionals held a variety of job titles across different organizations, including Advocates, Behavioral Health Linkage Workers, Case Managers, Peers, Peer Counselors, Peer Mentors, Peer Support Specialists, Trusted Messengers, and Wellness Coordinators. Regardless of their job titles, paraprofessionals shared many similarities in their core job functions. They played a vital role in helping clients access behavioral health services and used three strategies to engage clients.

- Destigmatizing mental health by engaging community members in non-traditional activities
- Serving as a bridge to behavioral health services
- Helping clients address social drivers of health

Paraprofessionals used one, several, or all of these strategies depending on clients' needs. The process of engaging clients, while sometimes linear, was often iterative.

Using Non-Traditional Activities to Destigmatize Mental Health

Paraprofessionals engaged community members through building trust and a sense of belonging. One organization serving unhoused individuals with mental health issues and substance use disorders explained that trust building was particularly valuable in their work because many clients were distrustful of the government and/or had bad experiences with systems. They surmised that this lack of trust led clients to be less willing to share or less candid about their behavioral health needs. Paraprofessionals built trust and rapport with clients, helping them access different resources and services.

The importance of trust-building extends to fostering trust and credibility in behavioral health services themselves. A study by Kim and Zane (2016) found that Asian Americans perceived less benefit from seeking help for behavioral health needs due to cultural differences in how distress is manifested, understood, and addressed, which contributed to their lower willingness to seek support. For example, many Asian cultures tend to place greater emphasis on a holistic mind-body view that considers both physical and emotional symptoms

of distress, making approaches focused solely on cognitive symptoms of distress appear less credible.

Paraprofessionals also engaged community members through cultural connection. For example, one organization hosted a youth book club featuring authors with the same cultural background as participants as a mechanism for promoting mental wellness and building resilience through cultural pride and seeing oneself represented in literature. Another organization hosted frequent lunches for seniors, providing them with a space to converse in their native language.

> "We understand **as collectivist culture folks that storytelling is a big thing in our culture**. So, with this program, we focus on reading through wellness or wellness through reading, [specifically] stories by Pacific Islander authors about Pacific Islander people."
> — Program manager at a CBO

In many AANHPI cultures, relationships are built through "gestures of caring," such as providing food or meeting other material needs. These gestures align with the concept of gift giving in therapy and reflect gift-giving rituals commonly found in interpersonal relationships among AANHPIs (Sue & Zane, 1987; Namkoong, 2004).

Community engagement was often facilitated through linguistic concordance between paraprofessionals and clients. Research has shown that limited English proficiency among Asian Americans and Pacific Islanders is associated with lower use of behavioral health services (Sentell et al., 2007; Nguyễn et al., 2024). While English proficiency is not the sole factor contributing to differences in service utilization – for instance, stigma remains a significant barrier – eliminating language barriers between providers and clients is important for improving access to behavioral health services and empowering non-English speaking individuals to express their mental health needs more openly and in their native language. One organization described how beneficial it was to have a paraprofessional workforce fluent in various South Asian dialects, illustrating the impact of language capacity.

> "When they know that there is a person on staff or a volunteer who can speak their language, it changes dramatically for them…**they're able to lift up their head and say, 'Yes, I can talk to somebody who can understand me.'"**
> — Program manager at a domestic violence support organization

Serving as a Bridge to Behavioral Health Services

Paraprofessionals are trusted members of their communities and are able to better empathize with clients' mental health challenges because they navigate similar cultural, systemic, and social barriers (Barnett et al., 2018). They are non-native English speakers, immigrants, first-generation parents, targets of microaggressions, caretakers of other family members, and more – factors that enhance their cultural competence and ability to provide appropriate care. These shared lived experiences and cultural backgrounds enable paraprofessionals to serve as effective bridges between clients and other members of the behavioral health care team.

Interviewees noted that the ability of paraprofessionals to relate to clients on a more personal and less clinical level allowed them to gradually introduce behavioral health concepts in communities where mental health is highly stigmatized. For example, one organization discussed gradually introducing behavioral health concepts and encouraging open discussion during organized group activities like hiking, fruit picking, and beach trips. These community activities provided clients with ways and methods to restore or improve their social and occupational functioning.

> "...Having wellness activities, things like going for hikes or doing yoga together... brings folks into the agency. And then **as they just get more and more comfortable, they're more likely to tell their story**, which then leads to like, 'Oh yeah, well, do you want someone to talk to?'"

> — Program manager and licensed behavioral health clinician at a behavioral health organization

Interviewees also indicated that paraprofessionals identified client needs, made referrals to appropriate services, and assisted with systems navigation. For example, they conducted warm handoffs to licensed behavioral health clinicians or provided emotional support on a hotline to ensure clients were connected to additional behavioral health resources. In one organization, paraprofessionals helped clients with severe mental illnesses access specialty mental health services provided by county behavioral health agencies. Paraprofessionals also played an active role in clients' treatment plans, such as participating in interventions (e.g., role playing), and they frequently provided interpretation during appointments when there was linguistic discordance between clients and licensed behavioral health clinicians.

> "We brought in a paraprofessional that speaks Cantonese…to rehearse SST – social skills training – in Cantonese, utilizing the language skills of this paraprofessional. So **that is another way we utilize paraprofessionals… to practice communicating and overcoming social anxiety**."
> — Program manager and licensed behavioral health clinician at a CBO

Addressing Social Drivers of Health

Paraprofessionals helped clients meet their needs related to social drivers of health (SDOH), such as housing, food, and transportation. They advocated for clients and provided cultural and linguistic assistance, such as language interpretation and translation, when helping clients navigate different resources. Addressing these fundamental needs is known to improve overall mental well-being (Faruque et al., 2025). Interviewees noted that, at times, more pressing SDOH challenges may take precedence over addressing behavioral health needs. For example, obtaining safe housing for clients and their children was a top priority for organizations that served people experiencing domestic violence. By prioritizing SDOH needs, paraprofessionals enhanced their stature and credibility as care providers who could

help their AANHPI clients cope with major life stressors. This credibility supported continuity of care so that treatment could address and focus on behavioral health issues.

> "If there were, for example, social services that they needed to navigate, such as financial assistance, housing assistance, or food assistance, those all [require interactions] with different social service agencies... And so our job is to evaluate what those needs are... making sure that when they're going through, let's say, the Social Security benefits aspect, **we're still checking in and making sure their mental health and emotional health through this process is okay** so that they are able to commit and adhere to the appointment systems and the resources."
> — Program manager and paraprofessional at a FQHC

How Paraprofessionals Interact with Licensed Behavioral Health Clinicians

Three common models emerged from the focused interviews regarding paraprofessionals' interactions with licensed behavioral health clinicians:

- Collaborative Model
- Complementary Model
- Consult External Clinicians Model

Collaborative Model

The collaborative model was the most commonly used model among interviewees. All behavioral health organizations and FQHCs interviewed utilized it. In the collaborative model, paraprofessionals were integrated into the behavioral health care team and participated in case management meetings and development of clients' treatment plans. In some organizations, paraprofessionals also made referrals and conducted warm handoffs to licensed behavioral health clinicians on staff at the organization. Additionally, some conducted client intakes by administering behavioral health assessment tools and participated in the

implementation of client treatment plans. For example, if a licensed behavioral health clinician taught certain social skills in therapy, the paraprofessional would practice those skills with the client via role play. At one FQHC, paraprofessionals accompanied clients to practice social skills at public places in the community, such as shopping centers.

Complementary Model

Among interviewees, the complementary model was utilized by organizations of varying types and sizes. Under the complementary model, paraprofessionals provided separate services from licensed behavioral health clinicians and only made referrals and conducted warm handoffs to licensed behavioral health clinicians who were on staff at the organization. In two organizations, paraprofessionals facilitated support groups and afterschool programs for children and youth. If a client indicated need for and expressed interest in receiving behavioral health services, the paraprofessional would refer the client to a licensed behavioral health clinician who worked for the organization and would conduct a warm handoff, which helped build trust and ensure continuity of care.

Consult External Clinicians Model

The consultation model operated without any licensed behavioral health clinicians on staff. Instead, paraprofessionals consulted with external licensed behavioral health clinicians contracted by the organization and then made referrals to external behavioral health services when needed. Among interviewees, domestic violence support organizations and smaller CBOs with 10 or less employees used this model. These CBOs tended to rely primarily on volunteer paraprofessionals rather than employ them as paid staff.[8]

Impact of Paraprofessionals

The focused interviews explored the perceived impact of paraprofessionals on access to behavioral health services and on behavioral health broadly. As previously discussed, paraprofessionals were able to improve access to behavioral health services through various functions of their role, such as engaging community members in non-traditional approaches

[8] Compensation models are discussed in more detail in a subsequent subsection.

that destigmatized mental health, serving as a bridge to behavioral health services, and helping clients address social drivers of health needs. Paraprofessionals developed trusting relationships with clients which led clients to be more open about their behavioral health challenges and more receptive to therapy.

> **"[Paraprofessionals] are the bridge to connect our community members if they need care**. We know that mental health stigma is a huge thing for many of our Asian community [members]. When they come through the door…they're going to share their stressors, but they're not going to identify their mental health distress in any way. Our case manager will work to respond to what their current needs are… They're going to have conversations with them with regards to [what] they're going through, a stressful experience or so on, and then [suggest] 'Maybe right now you need someone who you can talk to…about these problems and issues and needs. I know someone at our agency, how about I connect you to that individual and see if this is something that you can get care [for]. However, I'm still going to be here to support you as your case manager, but you'll have an additional person to provide social and emotional support for you. How would you feel about that?'"
>
> — Program manager and licensed behavioral health clinician at a CBO

Not only do paraprofessionals add a unique perspective to the care team given their lived experiences, but they also extend clinical capacity. The impact of paraprofessionals on licensed behavioral health clinicians' workloads varies depending on the model of interaction between the two roles (collaborative, complementary, or consulting with external clinicians). In organizations that deployed the collaborative model, paraprofessionals took on some responsibilities that would have otherwise been carried out by licensed behavioral health clinicians, such as case management. As one interviewee noted, addressing clients' basic needs was imperative before discussions about behavioral health could begin. By helping clients navigate different resources to secure basic needs (e.g., housing, food,

transportation), paraprofessionals allowed licensed behavioral health clinicians to focus on clinical services.

One interviewee observed that clients smiled more as they became more engaged with community events, developed new friendships, and progressed along their behavioral health journey. Common client outcomes after engaging with a paraprofessional included reduced isolation, improved sleep, and decreased anxiety and stress.

> **"[They're] just more connected to community, less isolated. The isolation goes down, the joy goes up, all of that**. When they first come in the door…they're looking down, they're slumped over, they have a lot of physical health issues, and in six to nine months they're dancing at Zumba. They're in groups – they're crying with groups, they're laughing with groups. They're going on our field trips. They have a therapist, and they're hanging out with a trusted messenger."
> — Program manager and licensed behavioral health clinician at a CBO

Recruitment of Paraprofessionals

Organizations faced moderate difficulty in recruiting paraprofessionals. Two major challenges were a limited number of qualified candidates and an inability to offer competitive compensation. Interviewees expressed that their organizations did not have the financial resources to pay competitive salaries, leading candidates to seek opportunities elsewhere or outside the field. Common recruitment strategies included website and job board postings, internal recruitment (e.g., volunteers or past clients), community connections, and word-of-mouth referrals.

Preferred Qualifications for Paraprofessionals

Paraprofessional positions typically require minimal, if any, formal education compared to positions for licensed behavioral health clinicians. While some employers preferred

candidates with a bachelor's degree in relevant fields such as Psychology or Social Work, the emphasis was often placed on other qualities. Characteristics that organizations sought when recruiting paraprofessionals included compassion, cultural and linguistic concordance with the client population, dedication to the organization's mission and values, empathy, and strong interpersonal skills. Employers also prioritized candidates who were members of the local community, had experience working with the population of interest, and had lived experience with behavioral health challenges – whether firsthand or through supporting a loved one. For candidates seeking positions at domestic violence support organizations, an understanding and awareness of domestic violence issues was required.

Education and Training of Paraprofessionals

Paraprofessionals are not expected to enter their roles fully equipped with the necessary skills. All interviewed organizations reported that they provided on-the-job training to prepare paraprofessionals for the unique demands of their position. These trainings were tailored to the specific needs of the organization and the populations served. Internal trainings hosted by the organization included topics such as conflict resolution, mental health first aid, motivational interviewing, nonviolent communication, risk assessment, substance use, and trauma-informed care.

In addition to internal training, some organizations provided paraprofessionals with opportunities to participate in external training programs to further develop their skills and expertise. Examples included the Lay Counselor Academy, a 14-week course that prepares participants to provide mental health counseling, and the Richmond Area Multi-Services (RAMS) Peer Specialist Mental Health Certificate Program, which offers three levels of training to help peer providers develop their competencies. Paraprofessionals working with individuals experiencing domestic violence were required to attend a state-mandated 40-hour domestic violence advocacy training.

Compensation of Paraprofessionals

The compensation model of paraprofessionals varied, though distinct patterns emerged during the focused interviews. Behavioral health organizations, mid-sized CBOs with 11 to 50

employees, and FQHCs tended to hire paraprofessionals as paid staff. In contrast, smaller CBOs with 10 or less employees tended to rely on volunteers. Larger CBOs with more than 50 employees and domestic violence support organizations tended to have both paid staff and volunteers.

Organizations generally were not reimbursed by Medi-Cal or other health insurance plans for the services that paraprofessionals provide.[9] Most of the organizations interviewed depended on grant funding to cover expenses associated with employing paraprofessionals, which constrained salaries, benefits, and professional development opportunities.

Retention of Paraprofessionals

The tenure of paraprofessionals varies based on individuals' desired career pathways and interests. While working as a paraprofessional is a career for some, for others it can be a steppingstone to higher education in behavioral health or other healthcare fields. For the latter – typically recent college graduates – the paraprofessional position is an opportunity to explore the behavioral health field, gain hands-on experience working with a diverse client population, and learn more about providing behavioral health services at the community level. Some of these individuals return to the organization as licensed behavioral health clinicians after degree completion. In other cases, individuals are long-time volunteers at the organization before transitioning into a paid staff role. Interviewees stated that their organizations were usually unable to offer financial support for further education (e.g., tuition reimbursement), but they typically offered non-financial support such as flexible scheduling, practicum opportunities, mentorship, and clinical supervision to meet licensure requirements.

Among interviewees, the behavioral health organizations and FQHCs, most of which had larger staff sizes than the CBOs and domestic violence support organizations, were most likely to offer advancement pathways for paraprofessionals to managerial positions or different roles within the care team. CBOs were less likely to offer opportunities for advancement due to funding constraints and the limited availability of open positions.

[9] At the time this report is published, some organizations are actively seeking pathways to expand Medi-Cal reimbursements to cover some services provided by unlicensed paraprofessionals, such as case management, outreach, and engagement.

Domestic violence support organizations, which often relied on both paid and volunteer paraprofessionals, offered volunteer paraprofessionals the opportunity to apply for paid positions when openings arose.

Mitigating Risk of Re-Traumatization

Many paraprofessionals have lived experiences similar to those of the client population, which, while beneficial for relationship-building and understanding the client, can also create emotional triggers and a risk of re-traumatization. Organizations took several measures to address these risks. These measures included regular supervision and check-ins to address work-related issues and assess how staff were doing emotionally; providing time away from work for self-care; holding group processing sessions facilitated by an external therapist so paraprofessionals could feel safe and process their feelings, thoughts, and experiences; and comprehensive training on topics like boundary setting and well-being practices.

Opportunities Scaling Community-Based Models with Paraprofessionals

Although paraprofessionals are recognized as effective members of the behavioral health care team, there are challenges to broader implementation of the models of care implemented by AANHPI-serving organizations in the Bay Area. The recruitment and retention of qualified individuals remain a barrier because of a limited pool of qualified candidates and limited funding. Organizations that provide behavioral health services to AANHPIs face serious resource constraints that have become more severe due to cuts in federal funding and California's state budget crisis. They may not be able to offer competitive salaries or pathways for career advancement, which may lead paraprofessionals to seek opportunities elsewhere.

The lack of funding for services provided by paraprofessionals is in part due to reimbursement barriers. Although Medi-Cal reimburses services provided by community health workers and peer support specialists (California Department of Health Care Services [DHCS], 2025a, 2025b, 2025c), only one of the organizations interviewed currently bills Medi-Cal for paraprofessionals' services. Most organizations financially support paraprofessional

services through other funding mechanisms, such as grants, contracts with county government, and organizational revenue.

There are several reasons why organizations interviewed for this project have not sought Medi-Cal reimbursement. In some cases, Medi-Cal reimbursement policy plays a role. Medi-Cal only reimburses organizations for enhanced community health worker or peer support services provided to beneficiaries who are eligible for the Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), or Drug Medi-Cal Organized Delivery System (DMC-ODS) programs (DHCS, 2025a and 2025b). Some clients served by community health workers or peer support specialists have mental health needs that negatively affect their well-being but do not meet the eligibility criteria for SMHS (e.g., significant impairment, probability of significant deterioration) (California Department of Health Care Services, 2021). These clients may be eligible for the Medi-Cal community health worker benefit available to all Medi-Cal enrollees, but some of the organizations interviewed cannot bill for these services because they are FQHCs (DHCS, 2025c). Enhanced community health worker services are also a new benefit that first became available in April 2025 (DMC-ODS) (DHCS, 2025b). Organizations need time to assess whether the services their paraprofessionals provide are consistent with Medi-Cal's requirements (i.e., health education, navigation, screening and assessment, client support, and advocacy).

In other cases, organizations currently do not bill Medi-Cal for any services because their primary mission is not to provide clinical services. Examples include organizations whose primary mission is youth or community development or providing services to survivors of domestic violence. Meeting the requirements to become a Medi-Cal provider may not be practical for these organizations.

In addition, under the Behavioral Health Connect Initiative, the Medi-Cal program is directing providers to implement practices that are considered "evidence-based," such as Assertive Community Treatment. While such practices can benefit AANHPI clients, they reflect a Western orientation to behavioral health services that often require working with licensed behavioral health clinicians. Empirical evidence regarding the impact of community-based models that involve paraprofessionals is limited, making it difficult for organizations to persuade Medi-Cal that these services should be reimbursed.

Conclusion and Future Directions

Organizations that provide behavioral health services to AANHPIs are turning to paraprofessionals to help them meet the behavioral health needs of the rapidly growing AANHPI population and address the numerous, persistent disparities found in these communities. Paraprofessionals address social drivers that affect clients' mental health, enhance AANHPIs' access to culturally tailored behavioral health care, and improve their mental well-being. Because paraprofessionals often share lived experiences and language with client communities, they effectively destigmatize mental health and foster trust in ways that licensed behavioral health clinicians often cannot, particularly given the severe shortage of bilingual and bicultural AANHPI behavioral health clinicians.

Expanding community-based behavioral health models that utilize paraprofessionals will require organizations to conduct robust evaluations of these models to assess their effectiveness, including cost-effectiveness, and impact. Recognizing this need, Healthforce Center at UCSF has developed an Evaluation Framework to provide a structured approach to evaluation (see Appendix C).

Organizations utilizing paraprofessionals or those that wish to utilize paraprofessionals for community-based behavioral health services, could also benefit from a learning collaborative that addresses topics such as how to secure Medi-Cal reimbursement for services delivered by paraprofessionals and best practices for mitigating burnout and re-traumatization.

Appendix A

Organizations Interviewed

Organization	Organization Type	Primary Populations Served	Examples of Services Provided
Asian American Recovery Services	Behavioral Health Organization	Asian Americans and Pacific Islanders	- Behavioral health services - Case management - Prevention and education - School-based and youth programs - Substance use recovery programs - Support groups
Asian Americans for Community Involvement	Federally Qualified Health Center	Asian American refugees and immigrants	- Behavioral health services - Health and social services resource navigation - Primary care - Youth programs
Asian Health Services	Federally Qualified Health Center	Asian Americans	- Behavioral health services - Community and youth programs - Dental care - Primary care - Support groups
Asian Refugees United	Community-Based Organization	Asian American refugees and immigrants	- Advocacy and empowerment - Community-building programs - Mental health support and healing practices
Asian Women's Shelter	Domestic Violence Support Organization	Survivors of domestic violence and human trafficking, including refugees and immigrants	- Advocacy and legal support - Case management - Community building - Crisis intervention and safety planning - Emergency shelter and housing
Center for Empowering Refugees & Immigrants	Behavioral Health Organization	Southeast Asian refugees and immigrants	- Clinical counseling - Complementary and alternative healing - Medication management - Support groups - Workforce development and advocacy

Organization	Organization Type	Primary Populations Served	Examples of Services Provided
			- Youth programs
Korean Community Center of the East Bay	Community-Based Organization	Korean and other Asian Americans	- Case management for seniors - Health and social services resource navigation - Immigration support - Mental health services
Lavender Phoenix	Community-Based Organization	Queer and transgender Asian Americans and Pacific Islanders	- Advocacy and leadership development - Community organizing - Peer counseling program
Maitri	Domestic Violence Support Organization	South Asian survivors of domestic violence and abuse	- Crisis intervention and safety planning - Economic empowerment - Emergency shelter and housing - Legal support - Mental health services - Outreach and education - Peer counseling - Policy advocacy - Support groups
Narika	Domestic Violence Support Organization	South Asian survivors of domestic violence and abuse	- Case management - Crisis intervention and safety planning - Economic empowerment - Emergency shelter and housing - Legal support - Peer counseling - Mental health services - Support groups
North East Medical Services	Federally Qualified Health Center	Asian Americans and Pacific Islanders	- Behavioral health services - Complementary and alternative healing - Dental care - Primary care
Richmond Area Multi-Services, Inc.	Behavioral Health Organization	Asian Americans and Pacific Islanders	- Mental health counseling - Outreach and education - Peer support services - Workforce development

Organization	Organization Type	Primary Populations Served	Examples of Services Provided
Samoan Community Development Center	Community-Based Organization	Samoans and other Pacific Islanders	- Advocacy and outreach - Behavioral health services - Cultural and community programs - Youth development
Community Youth Center of San Francisco	Community-Based Organization	Asian American and Pacific Islander youth	- Behavioral health services - Community engagement - Enrichment and advancement - Health and wellness programs
Taulama for Tongans	Community-Based Organization	Tongans and other Pacific Islanders	- Health and social services resource navigation - Prevention and education - Senior programs - Translation and interpretation

Appendix B

Organizations Represented in the Advisory Group

1. Asian Americans for Community Involvement
2. Asian Health Services
3. Center for Empowering Refugees & Immigrants
4. Community Youth Center of San Francisco
5. Korean Community Center of the East Bay
6. Ohana Center of Excellence
7. Richmond Area Multi-Services, Inc.
8. Regional Pacific Islander Task Force
9. Taulama for Tongans
10. University of California, Los Angeles Center for Health Policy

Appendix C

Evaluation Framework

Introduction

As described in the main body of this report, organizations serving Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPIs) in the San Francisco Bay Area have developed innovative models for providing behavioral health services that utilize unlicensed personnel with limited post-secondary education, such as community health workers, lay counselors, and peer support specialists (hereafter referred to as paraprofessionals). In some of these organizations, paraprofessionals collaborate directly with licensed behavioral health clinicians to meet clients' needs by participating in case conferences, helping clients practice skills learned in therapy, or providing interpretation or translation. In other cases, paraprofessionals provide outreach, case management, or peer counseling services that complement the work of licensed behavioral health clinicians. Paraprofessionals also help clients navigate multiple resources to secure basic needs (e.g., housing, food, transportation), which allows licensed behavioral health clinicians to focus on providing clinical services to clients. Program managers, licensed behavioral health clinicians, and paraprofessionals interviewed for this project reported that paraprofessionals formed trusting relationships with clients, which led clients to share their mental health challenges and be more open to receiving therapy. Interviewees also perceived that clients who engaged with paraprofessionals were less isolated, slept better, and had reduced anxiety and stress.

These perceptions are important and reflect the expertise of the interviewees. To build on this foundation and effectively advocate for funding to scale and sustain these innovative, community-based, culturally attuned models of care for AANHPIs with behavioral health needs, it is essential to systematically evaluate their impact on access to services and the mental well-being of AANHPI clients. This requires consideration of the unique cultural context and, to the extent they are available, distinct indicators of mental well-being for AANHPIs, which differ from standard (i.e., Western) indicators of mental health. Utilizing culturally relevant indicators, and appropriate assessment tools, is critical for measuring mental well-being in this population, as they can more accurately capture the cultural values, beliefs, and experiences that shape AANHPI clients' behavioral health.

This document presents a framework designed to guide the development of evaluations that assess the impact of behavioral health service models that involve paraprofessionals and are tailored to meet the unique needs of AANHPI communities. The framework was developed as part of a multi-phase community-based mental health initiative of the Asian Pacific Fund. The framework is intended as a resource for philanthropic foundations, donors, organizations, and county-level stakeholders investing in programs that address mental health disparities among AANHPI communities. It may also be useful to organizations that provide behavioral health services to AANHPI communities.

Development of the Evaluation Framework

The evaluation framework was developed by Healthforce Center at UCSF in consultation with staff of the Asian Pacific Fund and members of the project's Advisory Group.[10] A landscape scan was conducted to identify organizations in the San Francisco Bay Area that utilize paraprofessionals to provide behavioral health services to AANHPIs. Key informant interviews were conducted with program managers, licensed behavioral health clinicians, and paraprofessionals to learn about the roles that paraprofessionals play in these organizations. A second set of interviews was conducted to learn about the tools that these organizations use to identify clients' behavioral health needs and assess the impact of the services they receive from paraprofessionals and other staff members. A list of the organizations that participated in the landscape scan can be found in Appendix A.

Evaluation Considerations

Cultural Considerations

Culturally responsive or culturally informed evaluation is defined as an evaluation approach that "recognizes that demographic, sociopolitical, and contextual dimensions, locations, perspectives, and characteristics of culture matter fundamentally in evaluation" (Hopson, 2009). It is an approach that integrates cultural context, values, and perspectives into every stage of an evaluation to advance equity and enhance the social validity of outcomes. Culturally informed evaluation engages evaluators who have requisite knowledge of the

[10] The Advisory Group is composed of 10 leaders from exemplar organizations that utilize paraprofessionals to deliver community-based behavioral health services in the Bay Area, or from organizations with expertise in this area. See Appendix A for a full list of the organizations included in the Advisory Group.

client's culture (cognitive competence), are proficient in the home language of the AANHPI clientele, can empathize with the client's experiences (affective competence), and can conduct the evaluation in a manner that is considered acceptable and appropriate by the client (role competence). The evaluation also uses measures that address symptom domains that are meaningful and important to AANHPI clients. Finally, the evaluation incorporates data collection and interview procedures that are considered appropriate and acceptable to AANHPI clients and their families.

Community-based organizations serving AANHPI communities with behavioral health needs can be well-situated to do this work, given that they are attuned to the cultural background and lived experiences of their clients and have developed their programs with specific cultural or demographic groups in mind. However, existing evaluation tools may not be appropriately tailored for the specific AANHPI community members served. For example, while there may be a linguistically accurate translation of a behavioral health screening questionnaire available online, that specific translation may not be validated in the population that the organization serves. The reading level of the tool may not fit the education level of the community members, the use of technical jargon may not be understood by lay audiences, or certain cultural expressions of distress may not be adequately captured. Some AANHPI behavioral health service providers may already recognize this and go a step beyond by informally adjusting the tools based on the cultural context of the participants served. However, these adjustments may not be documented or may be inconsistently applied, and this in turn may lead evaluations to miss critical insights (Around Him et al., 2021).

One challenge in data collection involves the use of paraprofessionals as interviewers in the assessment because they are proficient in AANHPI clients' native language. In such situations, AANHPI clients may not disclose important information that carries with it great social stigma in many AANHPI communities (e.g., suicidal thoughts, intent, or attempts, gambling problems, severe learning disabilities). To offer up such information may create great loss of face and shame among AANHPI clients and their families. Paraprofessionals can mitigate this risk by first developing trusting relationships with clients before formally collecting data about clients' mental well-being.

A recent scoping review of the literature on culturally responsive evaluation recommends that evaluators must move beyond surface-level cultural adaptations to embed equity principles throughout the evaluation process – from design to dissemination (Kushnier et al., 2023). The review identifies three core practices: 1) engaging communities as partners in defining evaluation questions and interpreting findings; 2) acknowledging and addressing power dynamics between evaluators and participants; and 3) incorporating cultural knowledge systems and values as sources of evidence. Together, these practices ensure that evaluation findings are contextually valid, promote mutual learning, and contribute to the dismantling of structural inequities within traditional evaluation paradigms.

Ethical Considerations

Many AANHPI communities face significant stigma associated with behavioral health care, as well as concerns related to immigration status and public systems (e.g., the public charge rule). Program evaluation could contain sensitive information, so it is important to think through some of the ethical considerations involved, including: 1) informed consent, 2) privacy protections, and 3) data security.

Evaluators should obtain informed consent from participants in a program evaluation, such that participants know about the risks and benefits of participating in the evaluation activities. For example, if the evaluators plan to collect interview data from participants, one risk may be that participants may feel uncomfortable answering certain interview questions. Participants should be told that they may skip any questions they do not want to answer. A benefit may be that the participant contributes to improving services at the organization but may not personally benefit.

Evaluators should communicate clearly how participant confidentiality will be guarded, for example, no names or personal identifiers will be shared outside of the evaluation team, and data will only be used for evaluation purposes. Many AANHPI clients immigrated from countries in which personal information is widely shared among governmental agencies and personnel, which may make them hesitant to participate in an evaluation. Evaluators need to make sure that participating in evaluation activities will not impact privacy or safety. In settings where interpretation is needed, confidentiality agreements and training for

interpreters are also essential for maintaining trust. Evaluators should be mindful that distrust in systems, including healthcare systems, may be prevalent among some community members.

Similarly, evaluators should communicate how evaluation data will be securely stored. For example, paper forms will be locked in a filing cabinet in a locked office and then shredded after the evaluation is completed, or electronic data will be password-protected in a secure, encrypted database and then deleted after the evaluation is completed. Evaluators should explain the administrative safeguards put into place to restrict access to the data. Because of the potential lack of credibility concerning privacy and confidentiality, evaluators may need to rely on trusted community leaders to endorse and sanction these procedures.

Feasibility and Resource Constraints

Evaluation must be feasible for organizations that often operate with limited staffing, time, and infrastructure. Funding proposals should include funds earmarked for evaluation in addition to service delivery when possible. Additionally, evaluators can rely on existing program data whenever appropriate, reducing the need for new and time-intensive data collection efforts. It is also more effective to focus on a small number of meaningful indicators rather than attempting to measure every possible outcome. Providing staff with clear training and data collection scripts can help ensure that information is gathered consistently and reliably across the organization. Finally, embedding evaluation activities into regular program workflows – rather than treating them as separate or additional tasks – helps sustain evaluation efforts over time and minimizes the burden on staff. For example, if an organization is already routinely collecting depression screening (i.e., PHQ-9 questionnaires), an evaluation metric could be whether or not depression screening was completed for a certain percentage of clients.

Ensuring that data is collected consistently across staff and time points helps strengthen the reliability of evaluation findings. Although comparison groups are often recommended in formal evaluations, they may not be realistic in community-based settings. Alternative approaches such as documenting changes over time, collecting qualitative narratives, or using pre- and post-self-assessments can still produce meaningful evidence of impact.

Key Components of an Evaluation

Conducting a robust and responsive evaluation of the impact of paraprofessionals on AANHPIs with behavioral health needs and the organizations that serve them requires an evaluation design that encompasses several key components that are outlined below.

Evaluation Goals

The goals of an evaluation must be identified in advance so that the evaluation can be designed to meet them. Possible goals for an evaluation of the impact of paraprofessionals on AANHPIs with behavioral health needs include:

- To assess the impact of paraprofessionals on use of behavioral health services
- To assess the impact of paraprofessionals on the mental well-being[11] of clients
- To assess the impact of paraprofessionals on the cost of behavioral health services (e.g., savings associated with reduction in hospitalizations)
- To assess how the different roles of paraprofessionals impact access to behavioral health services and client outcomes

To ensure that the goals for an evaluation align with the needs of clients, providers, and other interested parties, entities undertaking an evaluation should solicit input from these parties and modify goals as needed to respond to feedback. Engagement with clients and other interested parties should follow guidelines for Community-based Participatory Research.

Evaluation Questions

Once the goals for an evaluation are identified, evaluators should develop evaluation questions that reflect the evaluation's goals. Developing questions in advance helps ensure that an evaluation will yield information of interest to the entity sponsoring an evaluation and other interested parties. Evaluation questions guide evaluators in selecting the outputs and outcomes they will assess. The questions also affect the methods used to collect information

[11] Mental well-being focuses on the subjective, positive aspects of psychological health and emotional states like happiness and sense of purpose (Gautam et al., 2024; Burns et al., 2022).

for an evaluation. For example, if the evaluation questions ask for information about clients' perceptions of paraprofessionals, the evaluation plan may encompass surveys, focus groups, or interviews with clients. If the evaluation asks questions about impact on sleep or other somatic symptoms, the evaluation plan may include administering standardized questionnaires that measure these symptoms and conducting quantitative analysis of the data collected.

Examples of evaluation questions for each of the evaluation goals described in the preceding section are presented below.

- To assess the impact of paraprofessionals on use of behavioral health services:
  - Are clients who interact with paraprofessionals more likely to seek therapy for behavioral health challenges?
  - Are clients who receive assistance from paraprofessionals less likely to drop out early (usually defined as termination of treatment after one session)?
  - Are clients who interact with paraprofessionals less likely to perceive barriers to obtaining behavioral health services?
  - Are clients who receive services from paraprofessionals more likely to refer family or community members with behavioral health needs to the organization where the paraprofessional is employed?
  - Does collaborating with paraprofessionals enable licensed behavioral health clinicians to devote more time to providing clinical behavioral health services relative to case management?
  - Does having paraprofessionals on staff improve access to linguistically and culturally congruent providers?

- To assess the impact of paraprofessionals on the mental well-being of clients:
  - Are clients served by paraprofessionals more satisfied with the outcome of treatment and overall quality of service?
  - Are clients served by paraprofessionals more likely to have their social needs met (e.g., housing, food, transportation)?
  - Are clients served by paraprofessionals less socially isolated?

  - Do clients served by paraprofessionals experience a reduction in symptoms of anxiety, depression, or other behavioral health conditions?
  - Are clients served by paraprofessionals more likely to experience improved social, occupational, educational, and family functioning?
  - Are clients served by paraprofessionals more likely to experience a reduction in the burden of mental illness (usually measured in days of work or school lost)?
  - How do paraprofessionals' knowledge of culture and ability to speak clients' languages contribute to clients' mental well-being?

- To assess the impact of paraprofessionals on the cost of behavioral health services
  - What are the costs associated with operating models of care that involve paraprofessionals?
  - Are clients who receive services from paraprofessionals less likely to be hospitalized or visit an emergency department for behavioral health services?
  - Are clients who receive services from paraprofessionals less likely to delay seeking behavioral health services?
  - How cost-effective are models of care that involve paraprofessionals relative to standard models of care?

- To assess how the different roles of paraprofessionals impact access to behavioral health services and client outcomes
  - How do different roles assigned to paraprofessionals (e.g., care coordination, outreach, peer support, administrative tasks) impact clients' ability to access behavioral health services?
  - Does the model by which paraprofessionals interact with licensed behavioral health clinicians (i.e., collaborative, complementary, consult external clinicians) impact access and outcomes for clients?
  - Do clients respond differently to paraprofessionals depending on whether they are utilized in direct care roles (e.g., peer counseling) versus administrative or support roles (e.g., care coordination)?
  - How does the manner of paraprofessional utilization (e.g., direct care roles versus administrative or support roles) impact overall system efficiency and the ability to serve more clients?

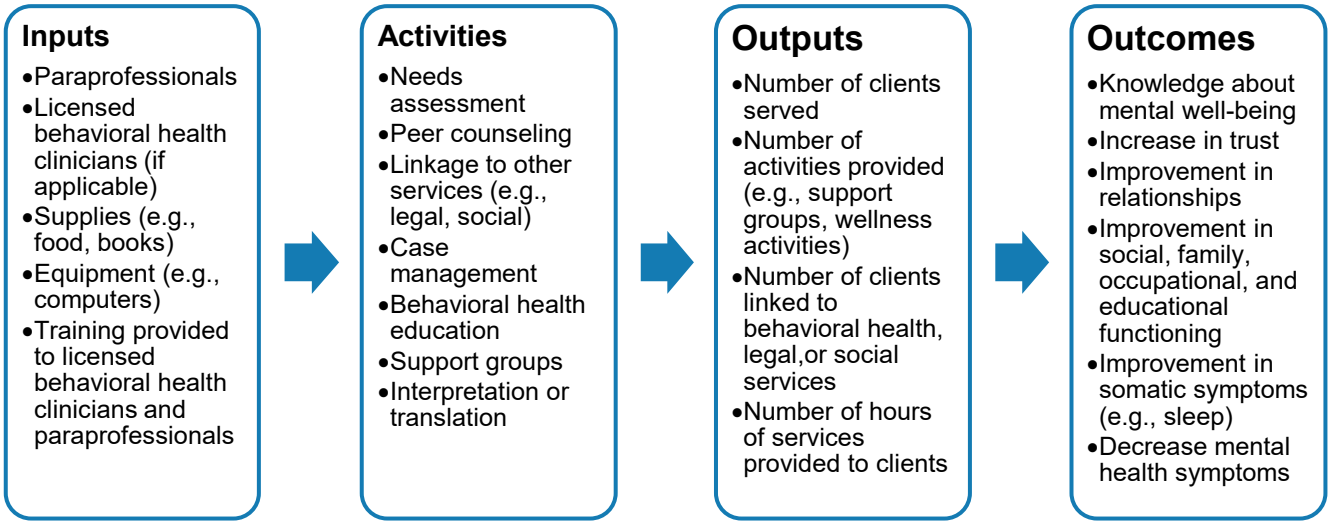
- Are different communities within the AANHPI population more effectively served by paraprofessionals in specific roles or utilization models, and how does this impact access to behavioral health services and client outcomes?

Logic Model

A logic model is a visual representation that clearly and systematically describes how an intervention will be implemented and the results it is expected to achieve. It visually maps a series of "if-then" statements that explain how and why a program is expected to work.

Figure 2 provides an illustration of how a logic model can be used to describe the services that paraprofessionals provide to AANHPIs with behavioral health needs and how they are hypothesized to impact their mental well-being.

Figure 2. Sample Logic Model for Evaluating the Impact of Paraprofessionals on AANHPIs with Behavioral Health Needs



Although logic models are typically represented as a linear progression, the real-world implementation of programs often involves feedback loops, for example outcomes can inform adjustments to inputs or activities.

Inputs

Inputs consist of funding, staff, partnerships, training, technology, materials, and other resources needed to implement an intervention. In the case of models for providing behavioral health services to AANHPIs that involve paraprofessionals, the paraprofessionals are key inputs, as are other staff or external contractors with whom they interact. Funds and informed managerial staff are necessary to recruit and hire appropriate paraprofessionals who can best serve the needs of the agency and the surrounding AANHPI communities. Training in evidence-based outreach, case management, and cultural competence practices can enhance the effectiveness of paraprofessionals. Additional inputs may include computers used to identify resources to meet clients' social needs and help them apply for benefits (e.g., CalFresh, Medi-Cal) or books, art supplies, sports equipment, or other materials used for group activities with clients.

Activities

The activities are the specific actions, strategies, or interventions implemented using the inputs. For example, in several organizations interviewed for this project, paraprofessionals screen clients to identify their needs and assist them in obtaining the resources they need either directly through the organization or through referral to other organizations (e.g., food banks, specialty behavioral health agencies). Others host meals for their clients to meet one another and provide social support and, in some cases, basic counseling. Interviewees also indicated that paraprofessionals provide interpretation and translation.

Outputs

Outputs are the direct results of the services provided. Examples of direct results of the work of paraprofessionals include the number of clients served, the number of referrals, the number of outings led, and the number of clients for whom paraprofessionals provided interpretation or translation.

Outcomes

Outcomes are the effects of an intervention on clients. They are often grouped based on the length of time within which an outcome can be measured. Short-term outcomes consist of outcomes that can be measured soon after a client receives an intervention. For clients served by paraprofessionals, examples of short-term outcomes may include increased awareness about mental well-being and increased knowledge about services for people with behavioral health needs. Intermediate outcomes may include strengthening of trust between clients and paraprofessionals and increased willingness to engage in therapy. Long-term outcomes include improvement in behavioral health outcomes.

Metrics for Assessing the Impact of Paraprofessionals

The impact of paraprofessionals can be assessed across multiple dimensions, including use of services, client satisfaction, client outcomes, and economic evaluation. Data should be collected at multiple time points to evaluate impact over an extended period (e.g., pre- and post-engagement with paraprofessionals). Examples of metrics that can be used to assess effects of paraprofessionals across each of these dimensions are listed below.

Use of Services

Multiple metrics exist for assessing the effects of paraprofessionals on use of behavioral health services and services that meet clients' social needs (e.g., food, housing, transportation).

- Service availability
  - Number of clients served by paraprofessionals
  - Number of clients served by licensed behavioral health clinicians
  - Number of clients served by linguistically and culturally congruent providers
- Utilization rates
  - Number of clients served, by type of service provided
- Continuity of care
  - Rate of follow-up after intake
  - Rate of service discontinuation

- Connecting clients with other services
  - Number of referrals
  - Number of clients obtaining assistance with social needs
  - Number of clients engaged in therapy with a licensed behavioral health clinician

Client Satisfaction

Assessment of client satisfaction provides a means for clients to participate directly in an evaluation and for their input to be incorporated into the implementation of paraprofessional services. Clients' input can be especially useful during the implementation period because their feedback can be used to adapt the paraprofessional intervention to better meet their needs.

- Quantitative ratings of experiences with paraprofessionals that include satisfaction with the overall service provided, progress in treatment (e.g., perceived impact on mental health and mental well-being), access to services, the therapist (e.g., communication, professionalism), and cost of services
- Net Promoter Score (i.e., percentage of clients who would recommend paraprofessional services to others)
- Qualitative data on clients' experiences with paraprofessionals collected via interviews or focus groups

Client Outcomes

When deciding how to evaluate the impact of paraprofessionals on client outcomes for AANHPIs with behavioral health needs, evaluators need to consider the indicators they will use to assess impact and the tools they will use to collect information.

Typically, outcome measures address two domains, one involving psychiatric symptoms and the other relating to types of psychosocial functioning. This dual emphasis is important because decreases in symptoms are considered important but not sufficient if the intervention cannot restore or improve an individual's ability to perform or carry out important roles in their life. The impact on functioning essentially reflects the effect of the burden of mental illness

(e.g., the number workdays lost or school absences attributable to the mental illness). Measures that assess functioning in one's family, occupation, education, and extra-familial relationships help provide a more comprehensive appraisal of an intervention's impact.

Indicators of Mental Well-Being

Standard indicators used by behavioral health services providers in the United States tend to emphasize functioning, coping, and the absence of specific clinical diagnoses. In contrast, mental well-being indicators focus more on the subjective, positive aspects of psychological health and emotional states like happiness and sense of purpose (Gautam et al., 2024; Burns et al., 2022). Mental health and mental well-being are distinct concepts but there are interconnection and cross-influence. For example, the likelihood of experiencing poor mental health decreases when mental well-being is high but mental well-being can still exist despite mental distress (Gautam et al., 2024).

Specifically, focusing on the impact of paraprofessionals on indicators of mental well-being instead of indicators of mental health better aligns with AANHPI cultural values like holistic health and well-being. These indicators are also more appropriate for evaluating alternative (i.e., less clinical), more culturally relevant strategies to improving the mental health and well-being of community members. Considering that paraprofessionals are trusted members of the community and who often share the language, cultural background, and lived experiences of clients, they are likely to affect behavioral health outcomes among AANHPI populations through their impact on mental well-being.

Although there is some overlap between standard indicators of mental well-being and those relevant to AANHPIs, standard frameworks tend to focus on individuality and symptoms associated with mental health conditions (e.g., anxiety, depressed mood). In contrast, mental health in AANHPI populations tends to focus on collectivist values and somatic symptoms. Differing culture-based perspectives about health, mental health, and mental well-being, may influence these differences in indicators.

In addition, AANHPIs may report experiencing culture-bound syndromes. These syndromes can impact how individuals experience, understand, express, cope with, and seek treatment

for mental distress. Some examples of culture-bound syndromes in AANHPI communities include:

- Hwa-byung – loosely translated as “an illness of fire;” an anger syndrome in Korean culture (Jackson, Y., 2006)
- Kaumaha – a heavy, oppressive feeling of sadness or despair in Native Hawaiian culture, documented as stemming from a loss of land, governance, health, education, cultural identity, and family members (Riley et al., 2022)
- Shenjing shuairuo (i.e., neurasthenia) – loosely translated as “a weakness of nerves;” a depressive-like syndrome in Chinese culture (Jackson, Y., 2006)
- Taijin kyofusho – translated as “the fear of interpersonal relations;” a social phobia unique to Japanese culture (Jackson, Y., 2006)

Evaluators should consider examining the impact of paraprofessionals on the incidence and severity of symptoms of these syndromes, provided these syndromes are prevalent within the AANHPI communities served by paraprofessionals and validated tools are available.

It is important to note that the various ethnic groups within the AANHPI diaspora may define mental well-being differently, especially when considering other factors such as but not limited to age, gender, nativity, religion, socioeconomic status, and geographical location.

Overall, research specifically focusing on indicators of mental well-being for AANHPIs remain limited. The available research from 2014 to present is summarized in Appendix D. Some examples of mental well-being indicators that have been studied for AANHPIs include:

- **Attitudes towards seeking help** (Kim & Lee, 2022; Tummala-Narra et al. et al., 2018)
- **Connection to community and culture** (Choi et al., 2020; Jara & Phan, 2024; Mossakowski & Darrah-Okike, 2024; Wyatt et al., 2015)
- **Quality of relationships** (Ai et al., 2015; Ai et al., 2021; Choi et al., 2020; Iyer et al., 2023; Li et al., 2024; Lui, 2015; Miyawaki et al., 2022; Park et al., 2024; Park et al., 2025; Sharma et al., 2020; Tran et al., 2015; Wyatt et al., 2015)
- **Self-confidence** (Ahn et al., 2025; Iyer et al., 2023)
- **Somatic health** (Li et al.; 2024; Yeung et al., 2021)

Assessment Tools

Use of standardized, validated assessment tools to measure psychiatric symptoms, mental well-being, and psychosocial functioning helps ensure reliability, consistency, and the use of evidence-based practices, which is especially important when evaluating the impact of behavioral health service models that involve paraprofessionals. Commonly used and validated assessment tools are described in Table 2 below. This is not intended to be an exhaustive list of assessment tools. Some tools are validated for both child/adolescent and adult populations. However, it is important to note that these tools may not be validated for AANHPI populations, including those with limited English proficiency.

Table 2. List of Commonly Used and Validated Assessment Tools

Assessment Tool	Screens For/Measures	Notes
Adverse Childhood Experiences (ACEs)	Exposure to traumatic childhood events	Validated for adults; adapted for children/adolescents (PEARLS)
Alcohol Use Disorders Identification Test-Consumption (AUDIT-C)	Substance use	Validated for adults and adolescents
Beck Anxiety Inventory (BAI)	Anxiety	Validated for adults; adapted for children/adolescents (Beck Youth Inventory)
Behavior Assessment System for Children, Third Edition (BASC-3)	Behavior and emotions	Validated for children/adolescents
Center for Epidemiologic Studies Depression Scale (CES-D)	Depression	Validated for adults and adolescents; adapted for children (CES-DC)
Child and Adolescent Needs and Strengths (CANS)	Client and family needs	Validated for children/adolescents
Collective Self-Esteem Scale (CSES)	Social identity	Validated for adults and adolescents
Ethnic Identity Scale (EIS)	Ethnic identity	Validated for adults
General Anxiety Disorder-7 (GAD-7)	Anxiety	Validated for adults and adolescents
Geriatric Depression Scale (GDS)	Depression in older adults	Validated for older adults
Multidimensional Scale of Perceived Social Support (MSPSS)	Perceived social support	Validated for adults and adolescents
Patient Health Questionnaire-9 (PHQ-9)	Depression	Validated for adults and adolescents

Assessment Tool	Screens For/Measures	Notes
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	Social drivers of health	Validated for adults
Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)	Trauma-related symptoms	Validated for adults
Psychological Sense of Community Scale (PSCS)	Belonging	Validated for adults and adolescents
Quality of Relationships Inventory (QRI)	Perceptions of social support, conflict, and depth	Validated for adults and adolescents
Refugee Health Screener-15 (RHS-15)	Health screener for refugees and asylum seekers	Validated for adults and older adolescents
Screening Assessment for Children with Emotional Risk Disorders (SACRED)	Anxiety	Validated for children/adolescents
Short Mood and Feelings Questionnaire (SMFQ)	Depression	Validated for children/adolescents
Social Connectedness Scale-Revised (SCS-R)	Social connectedness	Validated for adults and older adolescents
Somatic Symptom Scale-8 (SSS-8)	Somatic symptoms	Validated for adults and adolescents

Economic Evaluation

Organizations sponsoring evaluations of the impact of behavioral health paraprofessionals on AANHPIs may also want to complete an economic evaluation of the costs and benefits associated with these models of care. These analyses typically involve comparison of different interventions to one another. To assess the impact of paraprofessionals on costs associated with providing behavioral health services to AANHPI clients, comparisons can be made between models for providing behavioral health services that involve paraprofessionals to models that do not involve paraprofessionals. For example, organizations in which paraprofessionals partner with licensed behavioral health clinicians to provide case management services to clients could compare costs for personnel and other expenses associated with this model of care to costs associated with models in which licensed behavioral health clinicians provide both case management and therapy to clients.

In addition to comparing costs, evaluators can compare the net benefits associated with different models of care. Cost-benefit analyses quantify benefits in monetary terms and can

be used to estimate the net monetary benefits associated with utilizing paraprofessionals, such as an increase in number of billable services provided to clients or a reduction in the percentage of personnel costs for licensed behavioral health clinicians associated with completing tasks that a paraprofessional could complete. Often the use of paraprofessionals may help reduce the client's need to use more intensive and costly care such as emergency and urgent care services. Such analyses must account for the overall cost of service that extends beyond the client's use of outpatient mental health care.

Evaluators can also examine the cost-effectiveness of models of care that involve paraprofessionals. Studies of the cost-effectiveness of behavioral health services typically examine impact on mental health outcomes, such as the number of symptom free days. To compare cost effectiveness, evaluators can estimate the incremental cost associated with each unit of benefit by calculating an incremental cost effectiveness ratio (i.e., dividing the difference in cost between two models of care by the difference in their effect). Cost-effectiveness analyses should be conducted by evaluators with expertise in the methods used to carry out this type of analysis.

Practical Applications for Evaluation Findings

The value of evaluation lies not just in collecting data for the sake of data, but in using findings to inform action. There should be a clear plan for how data will be used before data collection begins. For organizations and funders focused on strengthening community-based behavioral health services for AANHPI communities, evaluation results can serve multiple purposes. Findings can demonstrate how paraprofessionals and culturally and linguistically tailored service models impact access, engagement, and mental health well-being. These results can help organizations understand where the program is having the most meaningful effects and where additional support or adaptation may be needed. Evaluation results can guide iterative program refinements. For example, if data indicates that clients are more likely to remain engaged when sessions are held in familiar cultural spaces or facilitated by staff with shared lived experiences, organizations may choose to expand those approaches. Furthermore, evaluation findings can be a powerful tool for communicating the importance of community-based behavioral health services to policymakers, philanthropic foundations, and healthcare systems. The possible applications of the findings are diverse and complex. It is

critically important that the specific goals of the evaluation be made explicit to AANHPI clients and communities at the very beginning of the evaluation.

Sharing findings with stakeholders, including staff, clients, and community partners, reinforces collective ownership of the program's success. Highlighting strengths and progress is particularly critical for maintaining morale, especially in organizations working with underserved populations. By fostering a culture of learning, organizations become better equipped to adapt, sustain, and grow their programs.

Appendix D

Findings from Studies of Indicators of Mental Well-Being

Attitudes Towards Seeking Help

In a study of Asian American college students, Tummala-Narra et al. (2018) found that a stronger sense of ethnic identity is negatively associated with help-seeking attitudes, particularly among male participants. However, no association was observed between perceived subtle and blatant racism and help-seeking attitudes.

Kim & Lee (2022) found that predisposing factors influence help-seeking attitudes among Chinese, Korean, Asian Indian, Filipino, and Vietnamese Americans. Chinese Americans are more likely to seek formal mental health support from a health professional (e.g., physician, psychiatrist) or non-health professional (e.g., teacher, religious leader) if they have a history of mental health concerns and/or higher acculturation level. Chinese Americans are also more likely to seek informal mental health support from family and friends if they have mental health concerns. Korean Americans' formal help-seeking behaviors are influenced by socioeconomics, knowledge, and beliefs about mental health. Korean Americans may seek informal support from family, friends, church community, and online. Asian Indian American mothers are more likely to seek formal mental health support for their children than fathers. Filipino Americans are more likely to seek formal mental health support if they are older, have a history of mental health concerns, or experience somatic symptoms. Higher levels of acculturation and social support also increase formal help-seeking attitudes. Additionally, Filipino Americans with high religiosity are more likely to seek formal mental health support from religious clergy. Those who are single, born in the US, and have mental health concerns are more likely to seek informal support from family and friends. Vietnamese Americans are more likely to seek formal support from educators and mental health professionals if they have severe mental health conditions and established careers. They are more likely to seek informal support from family, friends, and religious or spiritual leaders if they believe the problem will be resolved and if they have family support.

Connection to Community and Culture

Wyatt et al. (2015) reported that ethnic belonging buffers against depression among AANHPI youth. Among Native Hawaiian young adults, collectivist values and connections to community are associated with lower stress, and community engagement is associated with greater confidence in coping with stress (Jara & Phan, 2024). Similarly, a greater sense of local identity and cultural values protects against depressive symptoms among Hawaiian college students (Mossakowski & Darrah-Okike, 2024).

While ethnic identity is a protective factor against depressive symptoms and suicidal ideation for Filipino American and Korean American youth, American identity only provides some protective effects against depressive symptoms (Choi et al., 2020).

Quality of Relationships

Young Adults and Adults

Iyer et al. (2023) reported that greater family cohesion during adolescence is significantly protective against poor mental health outcomes in adulthood among Asian Americans and protects against general anxiety disorder (Ai et al., 2021). Although a strong family-centered support system is not associated with a reduction in depressive symptoms among older Vietnamese adults, it is associated with lower levels of loneliness (Miyawaki et al., 2022). Ai et al. (2015) found that social support from family and friends is a significant protective factor against major depressive disorder for Chinese and Vietnamese Americans but not for Filipino Americans. Social support from family, friends, and peers is a protective factor against suicidal thoughts and behaviors among Asian American young adults (Li et al., 2024) and college students (Tran et al., 2015).

Children and Adolescents

Strong family and peer relationships buffers against depression and suicide among AANHPI youth (Wyatt et al., 2015). A study by Park et al. (2024) found that different sources of support impact mental health among Filipino American and Korean American adolescents differently and across developmental stages. For example, family support has been shown to protect both groups throughout adolescence, religious support protects Filipino Americans in early

adolescence (defined as middle school), and school support protects both groups in early adolescence (Park et al., 2024). Another study found that parent-child and peer relationships were associated with better mental health outcomes, namely reduced depression and suicidal ideations, among Filipino American and Korean American adolescents and young adults (Choi et al., 2020).

Immigrant parents with limited English proficiency and knowledge of American culture may rely on their children for help with tasks like translating and interpreting – this responsibility, which often starts at a young age, may increase the risk of mental health concerns among youth, especially for those who have adapted to American culture and value autonomy (Park et al., 2025). Such conflicting levels of acculturation between parents and children, especially in cultures that emphasize beliefs like filial piety, may contribute to mental distress in youth (Park et al., 2025; Ai et al., 2021; Choi et al., 2020; Sharma et al., 2020; Lui, 2015).

Self-Confidence

Iyer et al. (2023) reported that higher self-esteem during adolescence is significantly protective against poor mental health outcomes in adulthood among Asian Americans. Among Asian American college students, Ahn et al. (2025) found that internalized racism, and perceptions of mothers maintaining their heritage culture, may be associated with greater conflict with mothers and lower self-esteem.

Somatic Health

Research on somatic symptoms as an indicator of mental well-being among AANHPIs is limited. One study by Li et al. (2024) found that sufficient sleep is a protective factor against suicidal thoughts and behaviors among Asian American young adults. Another study found that Chinese Americans with major depressive disorder are more likely to present with psychological symptoms, a departure from the belief that Asian Americans tend to present with somatic symptoms (Yeung et al., 2021).

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