



Culture of Access: Exploring AANHPI Youth Mental Health Access Barriers and Facilitators

A study on Asian American, Native Hawaiian, and Pacific Islander Youth Mental Health Access



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Background and Purpose

The Orange County Asian and Pacific Islander Community Alliance (OCAPICA) was established in 1997 with the mission to build a healthier and stronger community by enhancing the well-being of Asians and Pacific Islanders through inclusive partnerships in the areas of service, education, advocacy, organizing, and research. OCAPICA is a community based organization that serves over 80,000 community members a year in more than 20 different languages. The agency's program areas focus on health, mental health, workforce, youth leadership development and education, civic engagement, and housing. OCAPICA is the largest Asian American, Native Hawaiian, and Pacific Islander (AANHPI) behavioral health provider in Orange County (OC), providing culturally informed services for prevention and early intervention, mild to moderate needs, and serious mental illness.

AANHPIs have some of the highest rates of mental health needs, resulting in increasingly negative mental health outcomes (Benton et al., 2022; Keum et al., 2024). In 2022, suicide was the leading cause of death for Asian American youth and second leading cause of death for Pacific Islander youth, 15-24 years of age (Centers for Disease Control and Prevention, n.d.). Despite the need for mental health services in AANHPI youth, mental health service utilization rates have historically been lower than rates of other racial groups (Tan et al., 2024; Yang et al., 2020). AANHPI individuals face substantial individual-level and systemic barriers, including lack of culturally-appropriate care, lack of bilingual or bicultural therapists (Qi et al., 2025), cultural stigmatization of mental illness (Qi et al., 2025), and funding challenges for AANHPI-specific programs (Đoàn et al., 2019). Orange County has the third largest AANHPI population in the United States at more than 700,000 residents according to data from the U.S. Census' Population Estimation Program between 2020 and 2023 (U.S. Census Bureau, 2023). Within OC, AANHPI individuals make up a quarter of the population (Asian Americans Advancing Justice Southern California, n.d.). In addition, research has found that the pandemic exacerbated these barriers, especially with the rise of anti-Asian hate and discrimination (Huynh et al., 2023).

Asian American individuals were also found to be less likely than those in any other racial group to seek mental health treatment (Lee et al., 2021). Among AANHPI ages 12 and older with a substance use disorder, 93.1% did not seek treatment, and among those ages 18 and older with a mental illness, 76.7% did not seek treatment (Substance Abuse and Mental Health Services Administration, 2020). Without treatment, mental health outcomes among AANHPI youth will inevitably worsen. AANHPI youth were the only group in which suicide ranked as the leading cause of death, encompassing youth aged 15-19 and 20-24 (CDC/NCHS, 2017 as cited in Noor-Oshiro, 2021). In California, compared to all other ethnoracialized groups, AANHPI youth had the second-highest rate of suicidal ideation (17.5%), second only to multiracial youth (Lui et al., 2024).

OCAPICA was funded by AAPI Data through funds from the California AAPI Equity Fund to conduct community based participatory research regarding AANHPI youth and young adults' access to mental health care services. This report serves as a comprehensive overview of the study's research methodology, key findings, and policy recommendations. The study goals were to understand current mental health service utilization experiences, barriers to accessing care, and areas of improvement for making care more accessible to AANHPI youth. Additionally, this study aimed to identify service and policy opportunities to improve access to mental health services for AANHPI youth. Lastly, our study provides recommendations for the financial and programmatic resources from CA Department of Education, Mental Health Services Act, local education systems, and the resources impacting support for AANHPI youth.

Methods

This study utilized a mixed-methods approach through focus groups, key informant interviews, online surveys, electronic health records (EHRs) analysis, and sharing of analyses from other partner studies.

Secondary data analysis

Referral data was gathered from OCAPICA's youth mental health program for children, youth, and young adults with severe mental illness. After categorizing various referral sources, descriptive statistical analysis was used to identify how youth become connected to mental health services. Clients were between the ages of 14 and 25 when referred, identified as AANHPI, and were referred to OCAPICA between 2012 and 2023. Records without an age or date of birth listed were excluded. A total of 787 referral records were included in the analysis of referral sources.

Camillia Lui, Ph.D. provided a subset of data from her study of the California Healthy Kids Survey, a biannual health survey by the State of California of children and youth in California public schools. Dr. Lui's provided OCAPICA a summary from a disaggregated subset of data for students from Orange County schools. Descriptive statistical methods identified the demographic patterns amongst the survey respondents. Distribution of depression, suicidal ideation, and maladaptive coping behaviors were observed by ethnic identity and gender. These data are de-identified at the student level and clustered by school. Data from 9th and 11th grades from 48 Orange County high schools during the years 2017 to 2021 were included in the dataset. Of the 58,060 total survey respondents, 13,761 of the total surveys were from AANHPI youth.

Primary data collection and analysis

For this exploratory study, focus groups and interviews were utilized to gather qualitative insights from participants to better understand sources of stress and common trends relating to AANHPI mental health, AANHPI youth access to mental health services and resources, barriers to accessing services or resources, and improving access.

This methodology was chosen as it allows for open discussion and exploration of the research questions, giving insight the quantitative analysis may not provide (Zupančič, Pahor & Kogovšek, 2019).

The study conducted four focus groups of AANHPI mental health providers who work in prevention, early intervention, and crisis intervention settings (between 6-8 participants each) to a high percentage of AANHPI youth in Orange County. Providers identified as AANHPI and provided services in OC to AANHPI youth at the time of the study. A total of 31 providers participated in focus groups. Individuals with more than one race or ethnicity are counted in each category in the tables below, resulting in total counts higher than sample sizes.

Table 1. Provider Focus Group Demographics

Characteristics	Count	Percentage
Race		
Asian or Asian American	30	93.75%
White	1	3.13%
NHPI	1	3.13%
Ethnicity		
Vietnamese	19	52.78%
Korean	4	11.11%
Chinese	4	11.11%
Filipino	3	8.33%
Taiwanese	2	5.56%
Asian Indian	1	2.78%
Indonesian	1	2.78%
Japanese	1	2.78%
Tongan	1	2.78%
Level of Education		
Associate's	1	3.23%
Bachelor's	17	54.84%
Master's	12	38.71%
Unknown	1	3.23%

Nine key informant interviews were conducted with school and hospital/health care providers (5 school, and 4 hospital/healthcare) that serve a high percentage of AANHPI youth in Orange County. Participants provided services in OC to AANHPI youth at the time of the study.

Table 2. Key Informant Demographics

Characteristics	Percentage	Count
Education		
Bachelor's degree	11.11%	1
Master's degree	66.67%	6
Professional degree (e.g., MD, JD)	22.22%	2
Race		
Asian or Asian American	70.00%	7
White	10.00%	1
Hispanic/Latino	10.00%	1
Unknown	10.00%	1
Setting		
Hospital	33.33%	3
Private Practice	11.11%	1
School	55.56%	5

Two transitional age youth (18 - 25 years old) focus groups and two adolescent youth (14 - 17 years old) focus groups were conducted. Youth identified as AANHPI (including multiracial youth), were between the ages 14 to 25 at the time of the study, and resided in OC. A total of 32 youth participated in focus groups.

Table 3. Youth Focus Group Demographics

Characteristics	Count	Percentage
Age		
14-18	19	59.38%
19-25	13	40.63%
Gender		
Female	20	62.50%
Male	8	25.00%
Other	4	12.50%

Table 4. Youth Focus Group Demographics (continued)

Characteristics	Count	Percentage
Multiple Race/Ethnicities		
True	4	12.50%
False	28	87.50%
Ethnicity		
Vietnamese	14	33.33%
Chinese	8	19.05%
Korean	6	14.29%
Japanese	5	11.90%
Asian Indian	2	4.76%
Chamorro	1	2.38%
Filipino	1	2.38%
Indo-Fijian	1	2.38%
Native Hawaiian	1	2.38%
Okinawan	1	2.38%
Taiwanese	1	2.38%
Thai	1	2.38%
Immigrant Generations		
First Generation	3	9.38%
Second Generation	25	78.13%
Third Generation and above	4	12.50%
Languages Spoken at Home		
Both API languages and English	18	56.25%
English Only	11	34.38%
API Languages Only	3	9.38%

The research team used an inductive, open coding method to create a codebook. This method was utilized to allow for additional codes to be added throughout the study process, as focus groups and interviews were occurring concurrently with the qualitative analysis. Once coding of each transcription was completed, the final list of codes was established. Codes were then categorized based on the frequency of their appearance in all transcriptions and their relationship to one another. The research team then categorized codes into broader themes that addressed the research questions.

An online survey was then developed by the research team using the preliminary focus group findings and pre-existing literature on barriers and facilitators of access for AANHPI and other populations. The survey was published using Survey Monkey and administered from August to September 2024. Survey respondents identified as AANHPI, were between the ages 14 to 25 at the time of the study, and resided in OC. A total of 47 participants were included in the analysis.

Table 5. Online Survey Demographics

Ethnicity	Count	Percentage
Asian Indian	3	4.55%
Cambodian	1	1.52%
Chamorro	1	1.52%
Chinese	12	18.18%
Filipino	5	7.58%
Japanese	3	4.55%
Korean	10	15.15%
Maori	1	1.52%
Native Hawaiian	2	3.03%
Pakistani	1	1.52%
Samoan	1	1.52%
Taiwanese	2	3.03%
Thai	1	1.52%
Vietnamese	23	34.85%

Ethical Approval

The study was approved by the Public Health Institute's Institutional Review Board Human Subjects Review Committee (application ID #I23-030) through Dr. Camillia Lui. The study team accessed secondary data records through data-sharing agreements between OCAPICA and their clients, or clients' parents or guardians if the client was younger than 18 years old. Verbal consent was approved for AANHPI provider focus groups and key informant interviews, and written consent was utilized for AANHPI youth focus groups, receiving consent from parents or guardians if the youth participant was below the age of 18 at the time of the study. Considering the sensitive nature of the study topic, protocols were implemented to ensure youth participants' mental wellbeing was top priority. For all focus groups and interviews, the research team reviewed the study activities, confidentiality, and guidelines for the participants.

Mental health providers capable of intervening in case of emergencies were present in youth focus groups in case any participant needed mental health care. Links to resources were also provided at the end of the online survey in case participants experienced any discomfort or needed additional mental health resources as a result of completing the survey. Participants were also made aware that they could reach out to anyone on the study team if they felt any discomfort. In addition, all research materials including scripts and the online survey notified participants they could end their participation at any time. All participants were compensated for their time, with compensation varying based on study activity.

Results

Secondary Data Analysis

Other & Community Referral was the largest category from which referrals originated (27.7%), followed by Mental Health (19.7%), and Hospital/Medical Referral (17.8%) as seen in Table 6. Other & Community referrals were predominantly from individuals with a connection to OCAPICA such as previous clients or their family members, previous staff, and individuals in the community who are aware of OCAPICA's services.

When distributed by age, most referrals were for adolescents, ages 14 - 17 (66.1%). For adolescents, referral sources varied more across categories, with most referrals coming from Hospital/Medical referrals (24.23%), followed by Mental Health referrals (22.31%), and Other & Community referrals (21.35%). For those above 18, the majority of referrals came from Other & Community (40.07%). Transitional age youth more frequently researched and found services on their own compared to adolescents (10.49% vs. 2.12%). Table 6 provides the referral categories by age group.

Table 6. Referral Demographics

Referral Category	Adolescent (14 - 17)	Percentage	TAY (18 - 25)	Percentage
Education Referral	96	18.46%	35	13.11%
Government Referral	29	5.58%	26	9.74%
Hospital/Medical Referral	126	24.23%	14	5.24%
Insurance Referral	3	0.58%	0	0.00%
Internal Referral	28	5.38%	17	6.37%
Mental Health Referral	116	22.31%	39	14.61%
Other & Community Referral	111	21.35%	107	40.07%
Religious Referral	0	0.00%	1	0.37%
Self Referral	11	2.12%	28	10.49%
Total	520		267	

Primary Data Analysis

Attitudes and Behaviors

1. A majority of youth were more **likely to keep mental health struggles to themselves** (53%) rather than reach out to friends (34%) or other people close to them (13%).
2. If youth were to look for information on mental health services, it would likely be through **online means** (72%) or **word of mouth from close friends** (63%).
3. If youth were to talk with anyone, they most commonly felt **comfortable talking with friends** (79%) over parents (23%) or mental health care professionals (30%).
4. **Youth are split** when it comes to how much they prioritize their mental health. 47% generally consider mental health a high priority while **49% of participants only consider mental health a priority in crisis.**

Access Barriers: Most Common Barriers to Accessing Mental Health Services

Based on the youth survey responses, the following were identified as the top five most frequent barriers for AANHPI youth to access mental health services. Additional context for each barrier is provided through key findings from focus groups and interviews.

Pressures from societal expectations

Related Themes:

- Cultural factors relating to emphasis on academic and financial success
- Model minority myth

“Having other more pressing priorities” was the most common barrier identified to accessing mental health care according to the youth survey. Pressing priorities shared during the focus groups typically encompassed maintaining good grades in school and preparing for a successful career, which stem from societal and familial expectations.

The model minority myth also adds external pressure on AANHPI youth to perform well academically. The model minority myth is a harmful stereotype that portrays Asian individuals as well-assimilated because of their success in academics and higher socioeconomic status (Walton & Truong, 2022). In the context of this study, this stereotype paints AANHPI experiences as a monolith, and overlooks the health, economic, and educational disparities within the AANHPI populations. For example, NHPI youth do not have the same levels of access to higher education or traditionally defined academic success compared to certain Asian American groups. Lastly, the model minority myth portrays AANHPIs as a group that does not need help - further exacerbating AANHPI youth’s inclination to internalize their struggles, and making it easier for school staff and service providers to overlook AANHPI student needs. Perpetuating harmful stereotypes can lead to isolation and bullying of AANHPI students and cause these youth to experience depression and anxiety (Huang & Hall, 2020).

The immigrant bargain also contributes to the high academic and financial pressures youth face. “The immigrant bargain” is a term that describes the pressures and expectations placed on children of immigrants to validate the sacrifices of immigrant parents. One way for youth to offset the immigrant bargain is to achieve academic and financial success. These pressures make it difficult for youth to find the time to care for their mental health. In addition, school staff may find it challenging to identify AANHPI youth who may need mental health services if standards such as falling grades are used as indicators of mental health challenges.

Both youth and service providers discussed AANHPI youths' tendencies to internalize struggles rather than expressing them as a result of not wanting to burden others.

"If I were to prioritize sleep over doing homework, my grades would start dropping, and then I'm not going to get into college. It's kind of hard to prioritize yourself when you have all these pressures, like expectations of you from your family, or maybe even friends' expectations as well. Maybe because there is a stereotype for Asian kids to be smart and to be able to uphold yourself, but it's hard when you're going through a mental problem and you have to decide what to prioritize."

~ Youth Focus Group

"There's this thing called the immigrant bargain - your parents gave up everything to come to the US so you feel like now you have to make a lot of money for your family. My clients have to take care of their family, and that in turn affects their mental health."

~ Provider Focus Group

Policy Recommendations:

- Educators and providers must learn about harmful stereotypes and stressors among AANHPI youth to be able to identify mental health struggles stemming from cultural factors. Doing so can address the underreporting of mental illnesses in AANHPI youth and increase culturally appropriate linkages to care. Part of this learning can be done by requiring providers to complete racial trauma healing and cultural humility courses to meet their continuing education credits for licensure renewals.
- The disaggregation of data is critical to seeing the full picture of AANHPI mental health. Often, AANHPI subgroups are combined into a single racial group, which can mask the unique needs of distinct ethnic communities. Analysis of data by ethnicity allows for more tailored behavioral health services, opportunities to advocate for additional funding, and an avenue to address public health inequities.

Funding and Affordability Constraints of Quality Mental Health Care

Related Themes:

- Dependence on caregivers to obtain mental health care
- Lack of knowledge or awareness of free resources
- Lack of culturally competent providers in community programs
- Lack of funding for AANHPI community programs

“Concerns over the affordability of mental health care” was the second most common survey response to barriers that AANHPI youth face when accessing services. Mental health care was perceived as expensive and most youth were not aware of free resources outside of school-based services. In addition, youth were concerned over the quality of free or low cost services. For example, school-based services were negatively associated with long wait times, poor quality, limited sessions, and insufficient staffing. Youth who wanted long-term care, often did not have the knowledge or tools they needed to navigate the healthcare system and insurance.

Youth under the age of 18 heavily rely on caregivers to obtain mental health care. Many youth remain on their parents’ health insurance until they are 26 and depend on parents insurance or pay out of pocket. However, youth often are met with another hurdle because they are hesitant to disclose to their parents that they need to seek mental health services. Even if parents were supportive of youth seeking mental health services, families could still face language barriers and financial barriers when navigating the healthcare system.

Lastly, the underinvestment in AANHPI-serving community mental health services leaves fewer culturally informed and affordable mental health services to choose from. Finding a culturally competent provider added another layer of complexity when seeking quality mental health services. Youth discussed they were tired of having to explain cultural nuances relating to family dynamics or stressors. They appreciated being able to talk to AANHPI providers who had lived experience and already understood the subtleties and cultural factors they wanted to discuss. However, many AANHPI providers choose to go to private practice rather than community organizations due to low wages and high workload. Youth who are receiving community mental health services experience frequent interruptions in their treatment such as provider changes due to high turnover or program closures. Providers and program administrators at AANHPI-serving organizations face multiple hurdles in securing funding opportunities for community mental health services that adequately address AANHPI youth needs.

“You were just talking about how it costs like \$100 to see a therapist, but you could just talk to your friends for free. I know you say that as a joke, but it's so real. The only reason I'm able to afford therapy is because I got a scholarship. My financial aid pays for my tuition and my health insurance. But once I graduate, where am I going to get the money for this? It's like \$50 a session and I go every week. It's like \$250 to see my psychiatrist once a month, and I need to save money because I'm a first generation immigrant. My parents barely have money to send me to college, let alone therapy.”

~ Youth Focus Group

“[In community mental health,] you have to go through a million and one red tape to get funding opportunities. There are a lot of people that are passionate and want to help people, but the cost of living is high, and that's the reality of where we're currently living right now. It becomes hard when you're given a choice. You are going to choose the opportunity that is going to benefit you and your family more. Unfortunately, finances are a big factor not just in mental health, but in any field. You don't want to lose people that have the heart because they cannot afford to stay in this job.”

~ Provider Focus Group

Policy Recommendations:

- Public investments in the recruitment of bilingual and bicultural individuals from AANHPI communities into Master of Social Work (MSW), Marriage and Family Therapist (MFT) and other professional counseling programs. While an increase in AANHPI providers is needed, the mental health system and post-secondary education system lack mechanisms to engage AANHPI individuals to see the mental health field as a viable career path. Without proper channels to increase the number of AANHPI individuals in the mental health education system, the gap in care for AANHPI youth will continue to grow especially for NHPI individuals.
- School-based services and healthcare systems can build a stronger referral pipeline and partnerships with free community-based organizations and provide more healthcare navigation guidance tailored to AANHPI youth and their families.
- Policymakers must adopt an equity funding framework for community-based organizations and providers. Applications for government funding should be easy to understand and access.

Policy Recommendations (continued):

- The passage of Prop 1 in March 2024 adds additional complexity as the state and local counties begin to phase out some Mental Health Services Act (MHSA) programs to comply with Behavioral Health Services Act's (BHSA) new requirements beginning in 2026.
 - State and county behavioral health agencies, advisory board members, and commissioners must actively engage with community-based organizations currently or previously funded through MHSA's Prevention and Early Intervention (PEI) component. Most PEI fund recipients are not Medi-Cal behavioral health providers but provide culturally and linguistically appropriate programs that are tailored to reduce stigma, discrimination, and mental illness among youth and families. In Orange County, an estimated 21% of individuals served by PEI-funded programs in FY 2022-23 were Asian or Pacific Islander, a much higher utilization rate compared to other MHSA-funded programs and services (OC Health Care Agency, n.d.). With the elimination of PEI in BHSA, counties must work with PEI programs to help transition the current service populations and integrate community-based organizations into the BHSA early intervention model.

Reluctance to Share With Family

Related Themes:

- Differing understanding of mental health between parents and youth
- Parents' lack of awareness of what mental health struggles can look like in youth
- Language gaps between parents and youth preventing fluid and effective conversations on mental health
- Lack of knowledge on confidentiality laws for protected health information
- Impact of parents' beliefs of mental health on youths' ability to successfully access services

The third most commonly identified access barrier for youth was “not wanting family members to know” they were struggling with mental health issues. Multiple contributing factors were identified in the qualitative data regarding youths' resistance to discussing matters of mental health.

Youths' reluctance to share mental health struggles with parents is often due to vastly different lenses through which youth and parents viewed mental health. Mental health literacy is defined as knowledge and beliefs affecting one's ability to recognize, manage, and seek care for mental health concerns. Youth tended to have more mental health literacy through peers and knowledge shared on social media. On the other hand, parents were reportedly less likely to pick up on signs of mental illness or were more likely to be dismissive of mental health struggles. Participants felt that a parent's perspectives and experiences often caused them to label mental illness as a weakness or something that reduces the family's reputation in the community. Many parents were said to equate mental illness to symptoms of psychosis such as hearing voices or seeing ghosts. Some associated mental illness only with events that cause great distress such as war, famine, and persecution.

Language gaps add an additional layer of complication when discussing mental health within AANHPI families. Bilingual or monolingual English youth who need to speak with parents with limited English capabilities have a hard time finding the words to describe their symptoms and stressors. Mental health terms do not always translate well into AANHPI languages and are unfamiliar to parents, are not colloquially used as they are in American society, or have a different connotation in the translated language.

Many also had concerns about potential repercussions of receiving mental health services due to a lack of knowledge on health confidentiality laws. Some were unsure as to whether receiving mental health services would be documented on their personal records or whether the information they share with mental health professionals would be shared with parents or colleges.

“When I was in high school, I tried to go to the counselor and they said I needed my parents' permission. I was like ‘Oh god, now I have to tell my parents,’ and they'd ask, ‘What, are you psycho?’ No, mom, I just want to see a counselor. But that's how parents view it, like, ‘Why are you going to a mental health counselor? What's wrong with you? You're fine.’”

~ Youth Focus Group

“I think sometimes mental health or mental illness is seen as something to be ashamed of so I've seen students who are afraid to share that they are struggling with their mental health with their parents. I've heard things like, ‘Please don't tell my mom, please don't tell my dad.’ The students themselves might be more open to talking but I find that they don't want their parents to know or they feel like their parents may not follow through with mental health services.”

~ Provider Focus Group

Policy Recommendations:

- Educators and mental health providers should inform AANHPI youth about privacy and confidentiality laws when seeking any health service and more specifically regarding minor consent to mental health in California (National Center for Youth Law et al., 2024).
- Service providers should be aware of differences in how mental health is perceived and understood within AANHPI cultures. Research has shown AANHPI individuals do not want to burden others and their preference for family-centered decision making (Wecht et al., 2024; Qin et al., 2024). Family members need to be engaged in a culturally informed manner throughout the care process to provide support for the AANHPI youth.
- Access to timely, quality language services including interpretation and translation services are essential to providing quality care. While some students may communicate with non-English speaking family members in another language, they often are not trained or have the vocabulary to translate or interpret medical terms causing a critical gap in communication.

Minimizing Mental Health Struggles

Related Themes:

- Misconceptions about qualifications and benefits of mental health services
- Stigmatization decreases help-seeking
- Importance of community-building and sense of community-belonging to decrease mental health stigmatization
- Effects of acculturation on mental health literacy

The fourth most common barrier to accessing care on the youth survey was “minimizing mental health struggles.” Conversations with youth revealed they often compared their struggles to others with seemingly more severe issues before deciding not to seek mental health care. As a result, they commonly seek services only during a time of crisis or at a point they cannot deal with their issues on their own. In provider focus groups it was noted that referrals often come from hospitals after self-harm or suicide attempts.

One potential explanation for AANHPI youths’ tendencies to minimize mental health issues and avoid receiving services is their inherited views on help-seeking as a sign of weakness. AANHPI cultures valued the ability to endure struggles and persevere through difficulties without asking for help. Despite youth acculturating to mainstream, Western values on mental health, reaching out for help can still be attached to a sense of shame. Many AANHPI youth viewed themselves as a representation of their family and do not want to reflect badly on their parents. Minimizing issues enables one to save face and maintain a good public-facing image. This ultimately leads to underreporting of mental illnesses in AANHPI populations.

Having discussions on mental health helped to normalize the act of receiving help for their struggles. Help-seeking behaviors were reportedly improved after being able to talk to others about their emotions and experiences that normally would be suppressed. A common misconception among AANHPI youth was that mental health services were for people with “more serious problems” than themselves. However, hearing stories and positive experiences of accessing mental health care from others played a key part in youths’ willingness to seek resources. Even within this study, youth noted one of the benefits of participating in the focus groups was being able to discuss experiences regarding mental health.

These findings emphasize the importance of creating a sense of community-belonging as a preventative intervention to mental illness. Focusing on community-building, establishing trust with teachers, counselors, parents, and community members, as well as promoting dialogue around validating and normalizing mental health struggles could potentially be a means of prevention and early intervention.

“I wish it wasn’t that you need to have the most extreme form of mental illness before you get help, especially with how mental illness is portrayed in movies and social media. People might be like, ‘Oh, I just have depression, I’m not gonna go see a therapist.’ There is this kind of comparison, ‘I’m not as bad as them,’ but it shouldn’t be a comparison. It should be like ‘You deserve help, everyone deserves this kind of help.’ So it should be focused on the individual, not this comparison game.”

~ Youth Focus Group

“Another thing that I hear a lot is, ‘But I don’t think it’s bad enough that I need therapy or I need mental health services.’ Or I even hear like, ‘Well, I think other people need it more than I do.’ I hear that disproportionately more from AANHPI folks. I find that I have to do a lot of psychoeducation – that there’s services available for everyone who needs it. And that it’s not taking away from anybody else’s needs for you to take up space, and ask for what you need, and get the support that you need. But I do hear a lot of that.”

~ Provider Focus Group

Policy Recommendations:

- School districts should partner with AANHPI-serving community-based organizations to provide alternative models to therapy that encourage cultural connection and trust-building. AANHPI students may avoid traditional counseling or therapy models but may be drawn to environments that encourage peer-to-peer support and leadership development through culturally relevant programming or activities.
- Policymakers must continue to fund public surveys and provide publicly funded research opportunities to collect and analyze detailed demographic student data from the California Healthy Kids Survey and other youth surveys. Data collection and research on AANHPI youth mental health must also center community experiences and actively engage youth perspectives as we have done in this study.

Apprehension Towards Receiving Services

Related Themes:

- Decreased help-seeking from negative past experiences accessing mental health services
- Provider search fatigue from a lack of culturally sensitive services and providers
- Lack of trust in the mental health system, individual providers, or effectiveness of services
- Social medias impacts on help-seeking behavior

“Knowing where to go but not feeling comfortable receiving services” was the fifth most common survey response to barriers accessing mental health. While AANHPI youth were aware of resources their schools provided, many felt an apprehensiveness to seek help for mental health struggles. Help-seeking behavior was impacted by negative past experiences navigating and receiving mental health services and not having faith in the effectiveness of the current mental health care system.

Directly experiencing a negative encounter or hearing from others who had negative experiences is likely to deter future attempts to access mental health services. Youth described the process of seeking services as having too many requirements or steps, making it feel exhausting and inefficient. This process can be made more challenging if youth are experiencing depressive symptoms and are lacking the motivation to seek services. Youth also discussed the insufficient number of counselors at schools, creating long waits before they could receive services. Every additional step introduces an increased risk of individuals not following through.

Youth reported greater treatment success when able to choose providers with diverse backgrounds that fit their needs. For example, youth recounted feeling fatigue from searching for culturally congruent providers. Having an AANHPI provider allowed youth to feel more comfortable sharing their struggles and life experiences and improved client-therapist rapport. AANHPI youth were described as being more protective or reserved about disclosing family matters to mental health providers in comparison to youth of non-AANHPI ethnicities. However, due to the lack of AANHPI providers, youth often had limited options. Many AANHPI providers are in high-demand and have long waitlists. Some youth reported giving up on seeking culturally competent services after facing fatigue from unsuccessful searching. If youth are able to establish a connection with a provider, they are likely to return and continue their treatment. Whereas, if the youth feel they are incompatible with their care provider, they may feel mental health services are ineffective.

Discussions around social media highlighted fears of judgement, especially when specific mental health conditions are excluded from online discourse. Youth felt they were aware of symptoms of stress and anxiety because of social media, but they lacked understanding of other mental health conditions that were not addressed online. This further stigmatizes these conditions, as youth may feel that their mental health issues are not worth dealing with if it is not "validated" by others online. While youth discussed feeling comfortable using social media to find resources on mental health, potential misinformation was a critical issue. Some youth reported social media as a replacement for traditional services. This can result in maladaptive coping mechanisms and a deterrent from seeking professional care. Often it is up to the youth to determine the trustworthiness or effectiveness of different resources, coping strategies, and treatments they find on social media, which can be daunting without proper mental health literacy. Coupled with their own or others' negative past experiences and the invalidation they may experience from non-AANHPI providers, seeking effective services can be seen as an extremely difficult and uncomfortable process.

"My friends told me they tried going to the counseling center, but it doesn't really work because they have to wait forever for an appointment, so what's the point of going? It kind of defeats the purpose and it's only for 10 weeks. I spoke to the counseling center once for depression and anxiety and the person on the phone said, "This resource is mostly for academic stress... Have you considered finding an outside therapist?" and I was like, "I don't have money."

~ Youth Focus Group

"There are some shared experiences but I think there's a lot of differences that the ANHPI community faces because I think there's this sense of distrust of providers in our cultures that may make it really difficult for youth to be open to the idea of talking to somebody. Whereas my non-AANHPI clients feel more comfortable talking to me or like they're really able to self-advocate and find resources and not feel shame as much as my other clients would."

~ Provider Focus Group

Policy Recommendations:

- Institutions must recruit, hire, and retain more bilingual and bicultural ANHPI clinical and non-clinical providers. Having a provider workforce that reflects the diverse patient and student populations in our communities will help overcome some of the cultural barriers to mental health in hospitals and clinics (Schlossberg, 2023).

- Mental health systems should integrate AANHPI social workers into the care delivery team. Social workers can provide support to individuals and families throughout the care process and assist with care coordination and case management. AANHPI youth and their families may feel more at ease communicating with a social worker with a similar cultural and/or linguistic background.
- State policymakers should consider expanding the scope of Medi-Cal services to include community-defined evidence practices (CDEPs) as an outpatient behavioral health service (Cītlali et al., 2021). Many community-based organizations already offer programs and services that are culturally tailored to specific populations including AANHPI youth. Codifying CDEPs would allow community-based providers to seek Medi-Cal reimbursement and create a more sustainable funding model.

Access Barriers: Additional Key Findings

The following describe other major themes relating to systemic barriers identified through the focus groups and interviews.

Strict Funding Requirements

Although there has been an increase in AANHPI-focused programs, funding requirements limit the activities these programs can facilitate. Many organizations depend on funding that comes with significant administrative burdens that fall on both program administrators and direct service providers. For example, programs using Medi-Cal funding have time-consuming and strict documentation requirements, taking time away from providing care to clients. In addition, necessary services may not be covered by Medi-Cal reimbursement, thus preventing providers from having flexibility needed to address a wide variety of client needs.

Funding requirements also limit the populations that mental health programs can serve based on age, severity, diagnosis, and length of stay. Youth expressed frustrations due to only having access to short-term services through their school, which may not address more severe mental health needs. Providers also noted that youth who age-out of community mental health services or do not meet severity requirements are often in limbo with nowhere to go for free or low-cost services. As a result, providers lacked the capacity or ability to continue services and youth struggled to find a program that fit their needs.

“I had a client who had sought mental health treatment twice before being referred to my program and each time he was told he was too high functioning. He was not severe enough, basically. And what ended up happening to him is he got into a very severe psychotic break. Then he got hospitalized, and then a few months after that he jumped off a building. He's still alive, but I feel very strongly about his situation. I think about the limits of the severity scale. If he had that support before, none of that would have had to happen.”

~ Provider Focus Group

Provider Burnout

The emphasis on fulfilling programmatic requirements such as high productivity, high caseloads, and billing expectations prevents providers from focusing on quality client care and exacerbates burnout. Another cause for burnout in AANHPI providers was emotional burden from transference and countertransference while working with AANHPI youth and family members. For some providers, dealing with clients' family members reflected their own experiences and difficulties as an AANHPI youth. Coupled with high caseloads, providers lack the time to care for themselves despite the emotional toll this work can have.

Burnout contributes to higher provider turnover rates and a shortage of culturally competent mental health professionals in community organizations. Inadequate funding in community mental health also makes it difficult to retain mental health professionals due to lower compensation rates. Insufficient AANHPI providers creates a barrier hindering youths' ability to access culturally informed services. Providers reported clients being negatively affected by the high turnover, with some clients quitting services due to the frequent changes in providers.

"I get that we have quotas to meet and our supervisors are trying to communicate that to us, but when I hear, 'Just cut your sessions to 50 minutes and do your documentation in 10 minutes and then go see the next person,' it feels dehumanizing. That's when I feel really burnt out and just question, 'Why am I in community mental health? Should I just go somewhere else where the notes are easy and I can have a personal life?' So I think about that a lot. And that 10 minute documentation is just unrealistic."

~ Provider Focus Group

Curriculum and Training

Providers noted that most education programs lack curriculum on how to care for diverse populations in a culturally and historically informed way. While cultural diversity may be mentioned in their training, it is rarely a topic that is dealt with in-depth. Rather, on-the-job experience filled these gaps in knowledge. As a result, non-AANHPI providers are often ill-equipped to deal with the unique needs of varying ethnic cultures within the AANHPI umbrella. AANHPI providers reported feeling like they had to pioneer their own culturally-appropriate interventions because their curriculum did not adequately prepare them to work with AANHPI populations.

"One of the biggest gaps I experienced in my Master's in Social Work program is how white-centered the material is. All of the vignettes we study are with white clinicians or white clients. I felt very disconnected from the material I was learning. And then I would go to my current job where I primarily serve AAPI clients. It felt like I had to just figure it out. They're not teaching you about the nuances in different Asian communities. Maybe they'll say to be aware that there are different cultures and that you should learn about them. But they're not really teaching us about them."

~ Provider Focus Group

Discussion

Study Purpose:

The reason for this study was to address the silent health crisis that AANHPI youth currently face. Suicide is one of the leading causes of death for AANHPI youth but they often only seek help in crisis. Better strategies need to be developed and utilized to engage AANHPI youth and family members in addition to more avenues to culturally competent treatment, community, and easy access to care early-on into their mental health journey. Another reason for this study was to confront the model minority myth stereotypes that AANHPI youth do not need help when in reality, AANHPI youth need access to life-saving mental health care.

Study aims:

This study sought to better understand 1) AANHPI youth's access to mental health services and 2) whether the current system of care meets AANHPI youth needs. Key findings confirmed many barriers, beliefs, and perspectives we have heard throughout our work as a community-based, AANHPI-serving organization. Many of the findings are already informally known to AANHPI youth and mental health providers and this study contributes to the emerging literature around this topic. Both youth and providers noted that the current system of care does not adequately meet the unique needs of AANHPI youth because there are not enough AANHPI providers, not enough resources in both K-12 schools and colleges, and not enough funding.

Cultural Barriers

Cultural factors such as valuing perseverance or not wanting to be a burden to others explained where the barriers in accessing care are, and why youth are underutilizing resources. At home, explicit discussions around mental health and wellness are not encouraged, making it difficult for youth in need of services to access care. However, some youth reported being able to have open discussions with their parents. Typically, these youth had parents who were US-born or had previous experience seeking mental health care for other family members. Some parents may have had more exposure to Western perspectives on mental health. Literature notes the benefit of having a trusted adult to mitigate negative effects of stressors on mental health (Park et al., 2023; Office of the Surgeon General (OSG), 2021). However, the current study's findings suggest that youth are more likely to lean on peers for support rather than mental health professionals or family members. Transitional age youth more frequently found services through their own efforts in comparison to adolescents. Those over the age of 18 who no longer require parental consent can make their own health decisions whereas adolescents need formal referrals from schools and hospitals first before finding culturally appropriate mental health services. Further research is needed on the relationship between parental mental health literacy and youths' mental health outcomes.

Without open channels of discussion on mental health, youth sometimes refuse or delay treatment due to the fear that their parents will find out they are receiving mental health services.

Systemic Barriers

Barriers relating to policies, protocols, and systems were broadly categorized as systemic barriers. Systemic barriers affecting youth included an overall lack of knowledge on how to obtain necessary mental health services as a result of insufficient education on these topics. Participants indicated a lack of awareness about who might be able to benefit from mental health services and what low-cost resources are available outside of school-based services. The lack of flexibility of mental health programs also made it difficult for youth to receive the treatment they needed. School-based services were often short-term services and students would be referred to another program if their needs exceeded the number of appointments available to them. The current healthcare system requires multiple steps before being able to receive care, contributing to the underutilization of mental health services. While there are resources available, they may be difficult to get into because of long waitlists or the programs only work with specific populations. There also is a lack of AANHPI providers available to youth. Mental health providers were negatively affected by high workloads, low wages, and burnout as a result of the lack of funding in community organizations.

Our findings were consistent with previous literature on mental health access. Overall, many of the barriers identified were common barriers for all youth, not just AANHPI populations. Barriers to accessing care including geographic access (Damian et al., 2018), financial barriers (Damian et al., 2018), and lack of health literacy or knowledge to navigate the system (Arora & Khoo, 2020) were common themes in previous studies. The system barriers we identified were also discussed by previous research including the lack of appropriate mental health personnel for programs, insurance requirements preventing care (Qi et al., 2025), and lack of coordination among mental health services (Damian et al., 2018).

Specifically related to AANHPI youth, our research echoed the attitudinal and social factors that previous studies on AANHPI mental health also found. Stigma and lack of trust in the mental health system are key barriers that drive AANHPI youth's unwillingness to seek services, with both being prevalent in our findings and existing knowledge on this issue (Arora & Khoo, 2020; Wang et al., 2020). In a recent UCLA report on AANHPI mental health in California, researchers utilize the term "survivor mentality", capturing the idea that although perseverance and resilience has helped AANHPI groups when faced with oppression and trauma, it can also prevent them from seeking mental health support (Tan et al., 2024). This mentality was reflected throughout our findings, especially in relation to generational

differences and cultural attitudes towards seeking care. Findings from our study also confirmed youths' access to care is dependent on parents' attitudes and beliefs (Arora & Khoo, 2020; Wang et al., 2020), which was a critical theme in our findings as well.

A Need for More Investment and NHPI Providers

This study calls for further investment in recruiting, retaining, and sustaining AANHPI providers in the mental health field. There also needs to be more programs that target AANHPI youth, be it an increase in mental health services provision or expanding the capacity of current AANHPI-serving youth programs. There is also a need for more curriculum and training integrated into mental health professional development that train providers on how to work with AANHPI communities. In particular, we need more targeted investment in NHPI communities to increase the representation of NHPI providers in the field.

A Need for More Community

Lastly, we can also look to AANHPI culture as an access facilitator. Knowing that youth are facing isolation more than ever, collectivism provides a strong support system and a sense of belonging. Providers can utilize collectivism as strength to improve mental health outcomes of AANHPI youth. Rather than tackling mental health challenges through solely Westernized treatment, creating approaches informed by collectivist values can bridge the gap between AANHPI cultures and mental health care.

Many youth shared appreciation and gratitude that they were given the space to openly discuss mental health, and wished that they had more opportunities to discuss their struggles with peers. This signifies a need for more youth-centered spaces as a part of community care and healing, and as a preventative intervention that aligns with collectivist AANHPI values. While youth face loneliness and isolation, having a sense of cultural community nurtures their well-being. In conclusion, we hope these findings create more cultural community spaces for youth to engage in preventative care, encourage youth to seek services, and destigmatize mental health.

References

Arora, P. G., & Khoo, O. (2020). Sources of Stress and Barriers to Mental Health Service Use Among Asian Immigrant-Origin Youth: A Qualitative Exploration. *Journal of Child and Family Studies*, 29(9), 2590–2601. <https://doi.org/10.1007/s10826-020-01765-7>

Asian Americans Advancing Justice Southern California. (n.d.). About Orange County. Retrieved September 27, 2024, from <https://www.ajsocal.org/orange-county/about-oc/>

Benton, T., Njoroge, W. F. M., & Ng, W. Y. K. (2022). Sounding the Alarm for Children’s Mental Health During the COVID-19 Pandemic. *JAMA Pediatrics*, 176(4), e216295. <https://doi.org/10.1001/jamapediatrics.2021.6295>

Centers for Disease Control and Prevention (n.d.). WISQARS Leading Causes of Death Visualization Tool. WISQARS Leading Causes of Death Visualization Tool. Retrieved March 27, 2025, from <https://wisqars.cdc.gov/lcd/?o=LCD&y1=2022&y2=2022&ct=10&cc=ALL&g=00&s=0&r=4&ry=2&e=0&ar=lcd1age&at=groups&ag=lcd1age&a1=0&a2=199>

Ciřlali, R. K. T., Masotti, P., King, J., Aadam, S. Y., Harvey, L. O. C., Bahrami, A., White, T., Ubozoh, K., Kakishiba, D., & Hiramoto, S. (2021). Policy Options for Community-Defined Evidence Practices (CDEPs) [Concept Paper]. California Pan-Ethnic Health Network. <https://cpehn.org/assets/uploads/2021/04/CDEPs-Concept-Paper-April-2021.pdf>

Damian, A. J., Gallo, J. J., & Mendelson, T. (2018). Barriers and facilitators for access to mental health services by traumatized youth. *Children and Youth Services Review*, 85, 273–278. <https://doi.org/10.1016/j.chilyouth.2018.01.003>

Đoàn, L. N., Takata, Y., Sakuma, K.-L. K., & Irvin, V. L. (2019). Trends in Clinical Research Including Asian American, Native Hawaiian, and Pacific Islander Participants Funded by the US National Institutes of Health, 1992 to 2018. *JAMA Network Open*, 2(7), e197432. <https://doi.org/10.1001/jamanetworkopen.2019.7432>

Huang, E. R., & Hall, G. C. N. (2020). The Invisibility of Asian Americans in the United States: Impact on Mental and Physical Health. In L. T. Benuto, M. P. Duckworth, A. Masuda, & W. O’Donohue (Eds.), *Prejudice, Stigma, Privilege, and Oppression: A Behavioral Health Handbook* (pp. 91–106). Springer International Publishing. https://doi.org/10.1007/978-3-030-35517-3_6

[Huynh, J., Chien, J., Nguyen, A. T., Honda, D., Cho, E. E., Xiong, M., Doan, T. T., & Ngo, T. D. \(2023\). The mental health of Asian American adolescents and young adults amid the rise of anti-Asian racism. *Frontiers in public health*, 10, 958517. <https://doi.org/10.3389/fpubh.2022.958517>](https://doi.org/10.3389/fpubh.2022.958517)

Keum, B. T., Oh, S., & Sheftall, A. H. (2024). National Trends in Suicide Among Asian American or Pacific Islander Youth. *JAMA Network Open*, 7(7), e2422744–e2422744. <https://doi.org/10.1001/jamanetworkopen.2024.22744>

Lee, M., Bhimla, A., Lu, W., & Ma, G. X. (2021). Correlates of Mental Health Treatment Receipt Among Asian Americans with Perceived Mental Health Problems. *The Journal of Behavioral Health Services & Research*, 48(2), 199–212. <https://doi.org/10.1007/s11414-020-09704-6>

Lui, C. K., Ye, Y., Gee, J., Cook, W. K., Tam, C. C., Sun, S., Miranda, R., Subica, A., & Mulia, N. (2024). Unmasking Suicidal Ideation for Asian American, Native Hawaiian, and Pacific Islander Youths Via Data Disaggregation. *JAMA Network Open*, 7(11), e2446832. <https://doi.org/10.1001/jamanetworkopen.2024.46832>

National Center for Youth Law, National Health Law Program, The Children’s Partnership, & California School-Based Health Alliance. (2024, June 4). *FAQ - Minor Consent for Mental Health Care—Implementing Assembly Bill 665 | California Alliance of Child and Family Services*. <https://www.cacfs.org/news/faq-minor-consent-mental-health-care-implementing-assembly-bill-665>

Noor-Oshiro, A. (2021, April 23). Asian American young adults are the only racial group with suicide as their leading cause of death, so why is no one talking about this? *The Conversation*. <http://theconversation.com/asian-american-young-adults-are-the-only-racial-group-with-suicide-as-their-leading-cause-of-death-so-why-is-no-one-talking-about-this-158030>

OC Health Care Agency. (n.d.). *Mental Health Services Act Annual Update for FY 2024-2025 (p. 72) [Plan Update]*. OCHCA. https://ohealthinfo.com/sites/healthcare/files/2024-06/MHSA_2024-25_UpdatePlan_FINAL.pdf

Office of the Surgeon General. (2021). *Protecting Youth Mental Health—The U.S. Surgeon General’s Advisory*. US Department of Health and Human Services. <https://ccfwb.uw.edu/resource/protecting-youth-mental-health-the-u-s-surgeon-generals-advisory/>

Park, I. Y., Walls, N. E., Atteberry-Ash, B., & Kattari, L. (2023). Trusted Adults as a Protective Factor for Bullying and Suicide Attempts Among Youth Across Differences in Race, Sexual Orientation, and Gender Identity. *Journal of the Society for Social Work and Research*, 14(2), 313–336. <https://doi.org/10.1086/716241>

Qi, H. V., Huo, H., & Mikami, A. Y. (2025). Barriers to mental health help-seeking among Asian American adolescents: A systematic review. *Asian American Journal of Psychology*. Advance online publication. <https://doi.org/10.1037/aap0000373>

- Qin, S., Corrigan, P., & Lee, E.-J. (2024). Family-centered decision making: A culturally responsive collaborative approach among Asians living in the United States. *Psychiatric Rehabilitation Journal*, 47(2), 94–105. <https://doi.org/10.1037/prj0000603>
- Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (Annual Report HHS Publication No. PEP20-07-01-001; NSDUH Series H-55). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/report/2019-nsduh-asiansnative-hawaiians-and-other-pacific>
- Tan, C., Lo, F., Ocampo, C., Galán, M. & Ponce, N. A. 2024. *Piecing the Puzzle of AANHPI Mental Health: A Community Analysis of Mental Health Experiences of Asian Americans, Native Hawaiians and Pacific Islanders in California*. Los Angeles, CA: AAPI Data and UCLA Center for Health Policy Research.
- U.S. Census Bureau. "Vintage 2023 Annual Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2023" Population Estimates, PEP Demographic Characteristics, Table PEP_ALLDATA, -1, https://data.census.gov/table/PEPCHARV2023.PEP_ALLDATA?q=PEP_ALLDATA: Accessed on January 13, 2026.
- Walton, J., & Truong, M. (2022). A review of the model minority myth: understanding the social, educational and health impacts. *Ethnic and Racial Studies*, 46(3), 391–419. <https://doi.org/10.1080/01419870.2022.2121170>
- Wang, C., Barlis, J., Do, K. A., Chen, J., & Alami, S. (2020). Barriers to Mental Health Help Seeking at School for Asian– and Latinx–American Adolescents. *School Mental Health*, 12(1), 182–194. <https://doi.org/10.1007/s12310-019-09344-y>
- Wecht, S., Hendrixson, M., & Radović, A. (2024). A Mixed Method Investigation of Parent-Adolescent Communication About Mental Health. *Journal of Adolescent Health*, 75(6), 904–911. <https://doi.org/10.1016/j.jadohealth.2024.07.012>
- Yang, K. G., Rodgers, C. R. R., Lee, E., & Lê Cook, B. (2020). Disparities in mental health care utilization and perceived need among Asian Americans: 2012–2016. *Psychiatric Services*, 71(1), 21–27. <https://doi.org/10.1176/appi.ps.201900126>
- Zupančič, V., Pahor, M. & Kogovšek, T. Focus Group in Community Mental Health Research: Need for Adaption. *Community Ment Health J* 55, 168–179 (2019). <https://doi.org/10.1007/s10597-018-0271-7>

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