BE HEARD

Community Voices About Mental Health and Wellness

Community Listening Project January 2025

King County Department of Community and Human Services
Behavioral Health and Recovery Division

King County
DCHS
Department of Community and Human Services

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Executive Summary

Background

Black, indigenous, and people of color (BIPOC), and refugee and immigrant people living in King County, as in many ethnic and culturally diverse communities nationwide, face a behavioral health model that is largely built around mainstream, Western-centric/white dominant medical service options that do not fit their cultural needs, so they remain unserved or underserved.[1] [2]The King County Behavioral Health and Recovery Division (BHRD) initiated the Be Heard Listening Project to partner with culturally centered community based organizations[3] to gather feedback focused on the behavioral health needs within their communities and learn about the strengths, challenges, and opportunities for improving behavioral health supports and programming in communities not always served well by the mainstream behavioral health system.

Project Summary

BHRD provided small grants through the MIDD Behavioral Health Sales Tax, a tax that supports services in King County for individuals with behavioral health needs. The small grants were allocated to 14 culturally centered, community-based organizations to conduct listening sessions and interviews within their communities. Together, they completed 106 listening sessions and interviewed 543 individuals. Seventy-three per cent of participants identified as first-generation immigrants to the United States and 63% identified a language other than English as their preferred language.

While agencies represented a diverse spectrum of the King County community, key themes emerged that transcend any one group. Learnings from this effort will elevate the needs and voices of under-recognized communities and will help guide efforts to improve County-directed behavioral health planning, programming, and service delivery.

Key Learnings

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[1] U.S. Maura J, Weisman de Mamani A: Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: a review. J Clin Psychol Med Settings 2017; 24:187–210.

[2] U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

[3] "Culturally centered community-based organizations" Per the Request for Application (RFA), a public or private non-for-profit organization that is representative of a community or significant segments of a community. For this project, culturally centered CBOs refers to organizations that are committed to a community's health, well-being, and empowerment and/or provides human services to individuals in the community within a culturally based context.

Key themes across the communities are summarized below. Implications for the publicly funded behavioral health system are included in the conclusion of this report.

1. **Culture and Context Matters**: Cultural backgrounds influence how mental health and substance use conditions are perceived and addressed by individuals and as a community. Culture influences whether an individual identifies a behavioral health need, seeks support to address the need, and the type of support the individual prefers. While some cultures may experience protective factors in sustaining community connections, some cultures have stigmas related to mental health and substance use that may prevent individuals from seeking help or sharing information with family or friends within their communities. Lack of behavioral health terminology in many cultures also contributes to a "culture of silence" around these issues. Fear of bringing shame to their families may influence whether young people hide their mental health concerns or do not seek support from their elders. In addition, spiritual and religious beliefs instilled within some cultures impact how individuals and communities approach mental health and substance use.
2. **Spirituality and Mental Health are Intertwined:** Spiritual beliefs and practices may impact mental health and sense of well-being, and an individual's interpretation of what shapes mental health is often tied to "spiritual practices," "supernatural causes," "ancestral displeasures," "karma," or other cultural practices across communities. Communities indicated that while spirituality and cultural practices can be a protective factor, it can also amplify the stigma that comes with the belief that poor mental health conditions are a consequence of an individual's own doing, tied to poor spiritual belief or practice, or resulting from a "curse" or evil spirits. Feelings of guilt or shame may further contribute to their mental health struggles.
3. **Mental Health Perceptions, Knowledge and Stigma Vary Across Communities:** Across communities, the concept of mental health is primarily interpreted in a negative way. Participants shared that people with mental health concerns are often perceived as weak, with no ability to control their emotions, or as having a personal failing, and may be perceived as "crazy," "unhealthy," or a problem. Community members shared that typical responses to mental health issues include denial, disbelief, and dismissal. Across communities, these perceptions and responses to mental health concerns contribute to the stigma related to seeking behavioral health supports. At the same time, having good mental health is also viewed more holistically, as "emotional and spiritual well-being."
4. **Common Mental Health Concerns include Anxiety, Loneliness, and Depression**: When asked about the mental health concerns and symptoms most prevalent in each community, three themes emerged.
    - Anxiety, Worries, and Stress: People recognized the anxieties, fears, and worries in themselves and others as a reflection of their well-being. Many people may not know the exact words for these conditions, but they share that these conditions are present in their bodies and minds.
    - Isolation and Loneliness: Isolation and loneliness were reported as common mental health concerns across communities, particularly among seniors. Several

immigrant and refugee communities emphasized that an intergenerational disconnect contributes to feelings of loneliness.
    - Underlying Depression: While the word "depression" was not often mentioned, examples of people experiencing chronic physical ailments with no clear treatment, lack of energy or interests, and emotional and physical exhaustion were mentioned.
5. **Trauma and Stressors Contribute to Mental Health Issues**: Trauma is a significant contributing factor to mental health issues across communities, even more so for refugees and immigrants, whose experience with trauma is often demonstrated through "intergenerational trauma." Participants mentioned trauma related to war and violence in their home countries, and trauma occurring during the displacement, migration, and adaptation process to a new country. Unresolved grief and loss from traumatic experiences was also noted including the loss of former relationships with family, friends, previous identities/roles in the community, home country customs, and an overall loss of stronger community connection. In addition, gender roles and experiencing poor social determinants of health presented as additional stressors for communities.
6. **Desire for Inter-generational Healing:** Participants expressed a tension between generations in their different approaches to addressing mental health issues. The approaches are often influenced by the older generations' experience in their home country. Participants indicated a desire to receive wellness support that helps them communicate more effectively within families and between generations to build stronger, healthier relationships between generations, and to heal the impacts of inter-generational trauma.
7. **Communities seek Education, Resources, and Support related to Substance Use:** While listening sessions and interviews tended to focus on mental health, substance use was also noted as a growing concern. Similar to how mental health is perceived, substance use is also enveloped in a strong "culture of silence." Across communities, the acceptable standards related to using substances varies widely and contributes to confusion around what level of substance use, for example when drinking alcohol, is considered problematic. Participants also indicated that current substance use treatment options do not integrate culturally relevant care. Concern about drug and alcohol access and use by youth was mentioned most consistently, along with recognition of the connection between poor mental health and the use of substances to escape or cope.
8. **Concerns about Youth Well-being Differ between Caregivers and Youth**: While participants shared concerns about every group in their communities, there is increased parental and caregiver concern about rising mental health needs of young people. Addressing youth mental health is a high priority across communities, particularly as it connects with substance use and ease of access to substances. Youth, on the other hand, expressed a need to communicate with family members about their mental health more effectively. Youth shared symptoms and feelings most related to anxiety and depression.

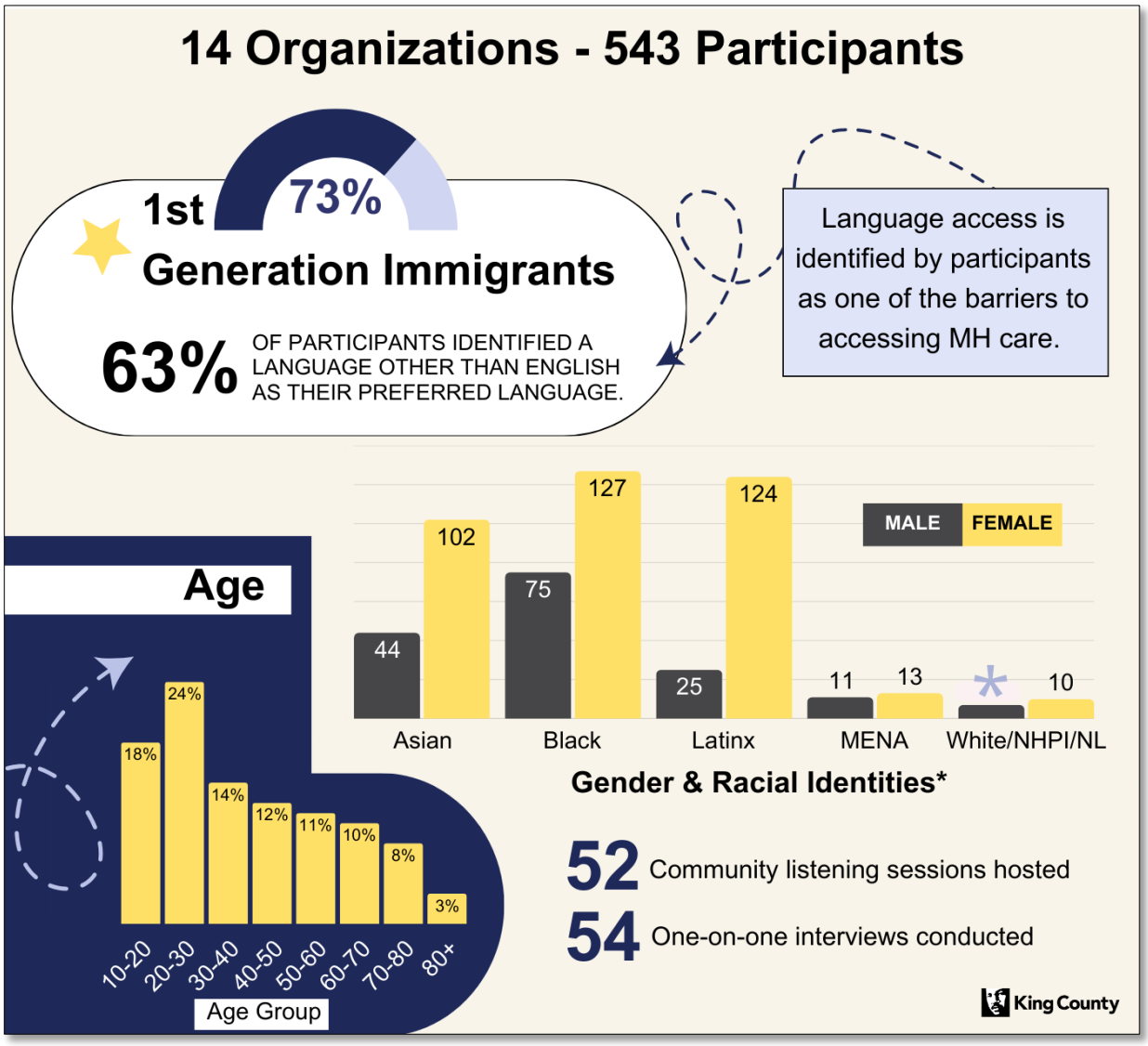
9. **Barriers to Care are Many:** Community participants experience many barriers to care, including accessing and receiving culturally relevant services. System barriers mentioned by participants include in-language services not widely available, lack of culturally respectful/relevant care or culturally responsive staff, lack of trust in providers, lack of information and knowledge about where to go for services, cost of services and insurance coverage issues, and transportation challenges.
10. **Culturally Responsive, Community-Driven Behavioral Health Education, Resources, and Treatment are Fundamental to Delivering Equitable and Quality Behavioral Care for Refugees, Immigrants, and other Marginalized Communities**: Across communities, participants emphasized, a need for more culturally responsive treatment, education, and resources for mental health and substance use both at the individual level and the community level. Participants also requested increased behavioral health education and support for staff within the trusted organizations serving them and expressed a desire and benefit in receiving the information from those trusted sources. Participants also noted the importance of creating safe spaces to discuss mental health openly with their communities and emphasized the desire for and wellness benefits of creating stronger relationships within their communities.

Conclusion

The findings above are valuable input from communities that have been historically marginalized by systems created largely by dominant white culture, including the existing behavioral health system we engage with today. Findings include a desire by many communities to receive culturally relevant behavioral health and wellness support designed and delivered by trusted, culturally centered, community-based organizations. Participants emphasized the value they found in coming together to have conversations within their community as a way of supporting their wellness. Participants also appreciated that sessions focused on sensitive and meaningful topics of mental health, wellness, and substance use. Feedback from the listening sessions will contribute to behavioral health materials, education, and resources to support the needs of the communities in the future. On a larger scale, key findings from this report will inform future behavioral health planning to create a behavioral health system that is more culturally responsive and effective for *all* King County residents.

Listening Sessions: Be Heard Participant Data

This project was implemented by community providers, from June – September 2024, in the form of Community Listening Sessions and individual interviews.



Background

According to the King County Community Health Needs Assessment 2018/2019, "People of Color and low-income residents are at disproportionate risk of being uninsured and having negative health and social outcomes." Extensive research has documented the disparities in health and other outcomes for historically marginalized groups. Racial and ethnic minority groups in the United States are shown to 1) have less access to and availability of care, 2) receive generally poorer quality of mental health services, and 3) experience a greater disability burden from unmet mental health needs, according to the U.S. Department of Health and Human Services.[2]

In King County, accessible and responsive behavioral health care can significantly improve people's quality of life, but such care remains inadequate for Black, Indigenous, and People of Color (BIPOC) and other individuals from marginalized communities in King County, as evidenced by continued disparities in health outcomes. Behavioral health services in the preferred language of the individual are another component of culturally- and linguistically responsive care that contributes to overall satisfaction with services, yet it remains a gap in the behavioral health system. A 2024 review of services funded by MIDD, King County's local behavioral health sales tax fund, found that MIDD underserves speakers of languages other than English[4] compared to the approximately 23% of individuals living under the 200% of the Federal Poverty Line in King County who primarily speak a language other than English.[5] Given the current state, it is also important to look beyond the data and engage in more in-depth dialogue to hear directly from communities most impacted to learn how King County can better serve the behavioral health and wellness needs of marginalized communities.

Project Summary and Purpose

The King County Behavioral Health and Recovery Division (BHRD) initiated this project to hear from BIPOC, immigrants and refugees, and other marginalized communities, to learn how to better serve individuals and communities related to their behavioral health and wellness. BHRD contracted with 14 culturally centered community-based organizations to gather feedback from their communities about their strengths, challenges and needs related to mental health and wellness. This report summarizes key themes and learnings from this project. Findings will be shared with participating organizations at a final community event and with the behavioral health system leaders and decision-makers to inform future program planning.

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[4] 2024 DCHS Data Review.

[5] *Steven Ruggles, Sarah Flood, Matthew Sobek, Daniel Backman, Annie Chen, Grace Cooper, Stephanie Richards, Renae Rogers, and Megan Schouweiler. IPUMS USA: Version 15.0 [dataset]. Minneapolis, MN: IPUMS, 2024. https://doi.org/10.18128/D010.V15.0.*

The goal of the Be Heard: Community Voices about Mental Health and Wellness Listening Project was to learn about strengths, challenges, and opportunities for improving behavioral health supports and programming in communities not always served well by the mainstream funded behavioral health system.

Uniqueness of Agencies and Terminology

The participating community organizations play an indispensable role in providing trusted and culturally responsive support and services to communities. While certain topic areas may serve as overarching summaries across communities, it is essential to recognize that each community organization brings its own unique set of perspectives, priorities, and challenges. These unique topics, often specific to individual agencies, may not be fully captured within the overall findings. It is also important to note that many cultures do not have terminology for terms like "mental health," "behavioral health" and "substance use." Facilitators were encouraged to use terminology that best fit the cultural and linguistic needs of the participants to facilitate an open and engaging dialogue about these sensitive topics.

Terminology of Behavioral Health and Mental Health: Behavioral Health is a term that refers to mental health, wellness, and substance use conditions. For this project, mental health is defined as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." Source: World Health Organization.

Participating Organizations, Participants, and Project Team

In early Spring 2024, BHRD initiated a Request for Applications (RFAs) from small, culturally centered community-based organizations interested in facilitating community listening sessions about mental health and wellness within their communities. Thirty organizations submitted applications. A review panel scored applications and recommended agencies based on RFA criteria. A total of 15 organizations were initially awarded but one organization withdrew their participation due to a lack of staff capacity, resulting in 14 organizations being funded.

Participating Organizations

The following small, culturally centered organizations were selected for the project from over 30 community-based applicants. BHRD defined "small" organizations as having less than 20 full-time equivalent staff and less than $4 million in the previous fiscal year. Community-centered organizations have built trust within their respective communities and were thus able to offer safe spaces for participants to share their perspectives openly.

- Alimentando al Pueblo (AAP)
- Association of Zambians in Seattle (AZS)
- Ayan Maternity Health Care Services (AMHS)
- CHARMD Behavioral Health (CHARMD)
- Communities of Rooted Brilliance (CRB)
- Congolese Integration Network (CIN)
- Ethiopian Community in Seattle (ECS)
- Filipino Community of Seattle (FCS)
- Indian American Community Services (IACS)
- Korean Community Service Center (KCS)
- NAMI Eastside (NAMI)
- New Americans Alliance for Policy and Research (NAAPR)
- Vietnamese Health Board (VHB)
- Therapy Fund Foundation (TFF)

Participants

Seventy-three percent of participants identified as first-generation immigrants to the United States. Sixty-three per cent identified a language other than English as their preferred language. The organizations recruited participants using myriad methods including outreach to existing contacts and to the broader community. While many of the listening sessions included a diversity of community members, others were focused on specific groups, including youth, elders, parents, gender-specific groups, and others. Organizations communicated in the preferred languages of their communities. Organizations reported that listening sessions and interviews were conducted in Amharic, Arabic, Dari, Farsi, Filipino, French, Korean, Lingala, Portuguese, Somali, Spanish, Swahili, Vietnamese, and English. BHRD funded translation of materials at the discretion of organizations to compensate for the additional funds needed to engage all participants in their preferred languages. BHRD funding also enabled organizations to offer stipends to compensate participants for their time to demonstrate that their time and experiences are valued by the organizations and King County.

Project Team

BHRD contracted with an external consultant, Dr. Diem Nguyen, who is a Clinical Assistant Professor in the Department of Global Health at the University of Washington (UW) as well as an officer of the Vietnamese Health Board. Dr. Nguyen was contracted to assist BHRD project staff in the development of the interview content, the data coding and analysis, and identification of key findings. BHRD also enlisted three students enrolled in the UW Master of Public Health Program as support staff for this project; the project, in turn, fulfilled course requirements for the students' academic program. The students served as the primary contacts for participating organizations, performed extensive data coding, and provided critical feedback on qualitative data analysis.

Methodology

Listening Session Implementation Plans

Selected organizations developed a Community Listening Session Implementation Plan to facilitate group listening sessions and key informant interviews. Each organization was required to conduct a minimum of three group listening sessions, with a minimum of ten participants per session, with the option to conduct three additional key informant interviews. There was no limit required for the total number of sessions or participants per organization. The listening sessions centered around a County-designed questionnaire to ensure general consistency of behavioral health topics across listening sessions. Organizations could modify language or terminology while maintaining the core topics, to meet their community's needs. Collectively, the project had a "participant count" goal of conducting a minimum of 42 community listening sessions, excluding optional key informant interviews, which would result in a minimum of 420 participants in the project.

Awarded organizations conducted community listening sessions and interviews with community members between June and September of 2024. Organizations then provided the information to BHRD for analysis in fall 2024.

Data Collection

Organizations collected data during the group listening sessions and individual interviews using the same questionnaire. See Appendix A for the full questionnaire. Staff from each organization along with community volunteers and student interns from BHRD facilitated and took notes during the interviews. Demographic information was collected from participants prior to the sessions. Financial stipends were provided to participants at the discretion of the organizations. Facilitators clarified with all participants that participation was voluntary and no personal health information was collected during the interview process. Although not included in the total listening sessions and participant counts, a final listening session was hosted by King County with community organizers to create space for agency staff to provide their own input on mental health and wellness.

In total, 52 community listening sessions and 54 key informant interviews were conducted over a three-month period.

A total of 543 attendees participated in either group listening sessions or key informant interviews – well over the project's goal of 460 participants. The awarded organizations went above and beyond throughout this project, including exceeding the minimum number of sessions, interviews, and participants.

Data Analysis

Student interns, led by Dr. Nguyen, with support from BHRD's Performance Measurement and Evaluation Team staff, coded and analyzed data over a six-week period.

Thematic analysis was conducted via creation of codes using the Dedoose application, a qualitative analysis software. The data was input and analyzed by the project team for all group and individual notes. Coders collectively identified emerging themes to better understand the behavioral health perceptions, understandings, and needs of the communities. Key learnings were then identified by the project team with Dr. Nguyen's stewardship and summarized in this report.

Key Learnings

The following information highlights key themes across participating organizations along with notable quotes that demonstrate participant perspectives. Not all elements provided by each agency are captured in these findings; rather, this report summarizes key learnings that emerged across participating communities. Quotes have been provided by participants from each of the organizations to recognize community-specific needs, to reflect that communities are unique, and that they have a complexity of needs rather than a "one size fits all" approach for future consideration in planning.

This report provides participant perspectives on a variety of topics including spirituality and religion, stigma, common mental health concerns, trauma, generational approaches, substance use, concern for youth, barriers to care, and the request for culturally responsive community driven behavioral health care. At the center of all these behavioral health topics is how culture intersects and influences behavioral health and wellness and, therefore, culture should be considered and prioritized when developing and designing systems planning by and for marginalized communities.

1. Culture and Context Matters

Responses by a majority of participants demonstrated that culture, beliefs, values, race, language, and the impact of one's cultural identity can affect social relationships and shape everyday actions and experiences. Taken together, these, in turn, can affect a person's perspective on mental health and substance use conditions, which influences whether an individual seeks support. Culture can also influence what types of treatments and supports may work best, as it relates to the individual and the collective community experience. Participants stressed the critical need to provide services that are culturally responsive, developed by and for their community and provided by individuals from similar cultures, to provide care that is both meaningful and effective. When serving marginalized communities, participants indicated that it is essential to

> *"Communities are not static. They are multi-faceted, diverse, and ever-changing, creating complex social and cultural contexts that shape the varying perspectives on mental health and substance use." (VHB)*

center cultural approaches within behavioral health services and to have services provided by individuals who share similar cultural backgrounds or have an in-depth understanding of their background, as participants often noted that the current system is not accessible and does not resonate with their needs.

Opportunity #1: Understanding and incorporating culturally responsive approaches is critical when addressing mental health and substance use conditions in marginalized communities. Centering cultural needs of communities when planning systems and providing stable funding to culturally centered organizations to support wellness will help ensure that culturally responsive care is recognized and supported by the publicly funded behavioral health system.

2. Spirituality and Mental Health Are Intertwined

Typically, in the United States, mental health and substance use issues are viewed in a secular context, but for many of the communities participating in this project, a cultural or spiritual component is present. Spiritual beliefs heavily influence interpretations of mental health. Some participants equated spiritual health with mental health. Participants often noted spiritual leaders as a trusted source to turn to when dealing with mental health issues. They also suggested that that the County should offer spiritual leaders education and training to address their community's behavioral health concerns since people often go to them already for these concerns.

Spiritual Context

Participants from a variety of cultural backgrounds shared that people with mental health issues may be viewed as "cursed" or possessed by evil spirits. Religious or spiritual beliefs are often regarded as a protective factor for well- being and religion was often mentioned by participants as the first place people turn for support. However, participants also reported that some cultural beliefs may add a layer of shame on the individual related to their mental health needs, in addition to their existing mental health concerns. Participants indicated that, among multiple communities, if the religious or spiritual remedy recommended by spiritual leaders doesn't work, it can further isolate and shame the individual for believing they are not worshipping or praying enough to resolve the condition.

- "In the Somali community, our views on mental health, wellness, and substance use are deeply influenced by cultural and religious values. There's often a lot of stigma, and misconceptions

"Religious and spiritual leaders often play a crucial role in guiding discussions about mental health. Some communities might prefer seeking help from spiritual or traditional healers rather than mental health professionals." (CHARMD)

surrounding mental health, and people might not be fully aware of the conditions or available treatments." (NAAPR)

- "So many things impact wellness in the Vietnamese community. People's wellness is tied to their environment, their food, relationships, religion, etc. There is also a strong belief that our past lives (karma) can impact our health and wellbeing – that what you did in your past lives can have an effect in your current life." (VHB)

Opportunities to Incorporate and Collaborate with Spiritual Leaders

> *"I think the community would prefer to go to their religion for solutions. I think the religious leaders need to get trainings on how they can educate people to open up about mental health and how they can treat people." (ECS)*

Spiritual leaders, of which there were two who took part in the key informant interviews, and participants with spiritual backgrounds from various groups, expressed a desire for future mental health programming that incorporates spirituality. Participants reported that although some spiritual leaders already discuss mental health with their community members, they don't have an adequate knowledge of behavioral health to do so skillfully and supportively for community members who need more intensive support that the behavioral health system could provide, in addition to support from their trusted spiritual leader. Some participants want to see spiritual leaders educated on behavioral health resources and trained to have effective mental health conversations with community members, as they are having these discussions already.

- "At the mosque, an imam will often talk to you, remind you to pray and recite the Quran. However, most imams are not trained to handle someone experiencing a [significant] mental [challenge]. (AMHS)

Opportunity #2: Integrate spirituality in behavioral health supports to align with community members' values and beliefs by 1) building organizations' expertise to support spiritual leaders, 2) educating spiritual leaders on basic behavioral health support and resources, and 3) providing funding models that provide flexibility to support the integration of spirituality into behavioral health services, as requested by individuals and communities.

3. Mental Health Perceptions, Knowledge and Stigma Vary Across Communities

Many communities shared that stigma, and a culture of silence exists around mental health and substance use issues, and that this culture of silence partially stems from communities not having language or tools to talk about mental health. Participants recognized that the culture of silence commonly results in, or is a result of, mental health being stigmatized by communities.

Additionally, some participants noted a culturally based emphasis on maintaining resilience and perseverance as members of a marginalized group. While this emphasis may be seen as a protective factor in some circumstances, it can also contribute to the culture of silence, a lack of acknowledging mental health conditions, or a reduced willingness to seek help. Some participants expressed a desire to learn more about mental health and stated that mental health education, both at an individual level and as a collective community, is needed for communities to be able to discuss it more openly.

- "In many Indian families, the concept of mental health is almost nonexistent. For my South Asian classmates, especially, mental well-being is hard for them to talk about–many don't seek necessary help." (IACS)
- "Another factor is that people don't know about mental health. There are [many] types of mental disorders, and we don't know about them. So sometimes when you feel lazy or moody, you don't know whether you're experiencing [depression or] mental illness." (ECS)

"For me when my doctor sent me to a therapist, I was almost offended …. I also thought, how am I supposed to talk to a complete stranger about my problems at home?" (NAMI Eastside)

"The community is not aware of mental health or [has] much knowledge about what mental health illness is." (AMHS)

Negative Perceptions and Stigma

For many participants, mental health was interpreted in a negative way, often equating one experiencing mental health issues to being "crazy," "weak," or having a "personal failing" or problem. Additionally, participants pointed out that community members often deny mental health as a valid concern and do not believe that it exists. For many communities, poor mental health is taboo, and people do not feel comfortable or open to discussing it. This stigma can contribute to feelings of guilt, shame, fear, and isolation among communities, which prevents community members and families from seeking care. Many participants report that community members prefer to handle mental health issues privately.

> *"When it comes to [using] the term mental health, I think it's kind of taboo … in our culture and not really talked about, because everyone struggles with it, even if there's a lot of neglecting it too. I have a lot of family members, Vietnamese friends, that neglect their mental health just because it's taboo and it takes a toll on them." (VHB)*

- "In our culture, mental health is often overlooked. Unfortunately, almost everyone experiences some sort of mental health issue, but these issues are not being addressed or treated. Many people are unable to manage the stress they face, which prevents them from slowing down or healing their mental health problems." (NAAPR)
- "Individuals with mental health issues might internalize negative societal attitudes, leading to feelings of shame, low self-esteem, and reluctance to seek help." (CHARMD)

Holistic and Culturally Centered Services

While most of the responses related to perception of mental health were negative, participants also indicated that mental health is connected to social, emotional, and psychological health. Views of mental health as holistic, related to overall well-being, and necessary for daily functioning were also mentioned. The value of self-care, wellness and supporting well-being were also common responses from participants. Culturally centered wellness services, including community events to build relationships and have discussions about mental health, along with community-led mental health education, was perceived as needed and important to the health of the whole community.

> *"We must take a holistic approach, considering mental health as part of overall well-being. This aligns with the idea that mental health is not just about the absence of disorders but also about positive mental states, resilience, and functioning." (CHARMD)*

Opportunity #3: Support and expand ways to normalize and de-stigmatize mental health dialogue and treatment in communities by working with culturally-centering organizations to expand discussions about mental health, in preferred languages, and with approaches that resonate within each community.

4. Common Mental Health Concerns include Anxiety, Loneliness, and Depression

Throughout the group and individual interviews, community members brought up a myriad of mental health concerns. The top three mental health topics discussed included anxiety and worries, isolation and loneliness, and depression.

Anxiety and Worries

Participants often noted that community members don't have the words to describe anxiety, and instead describe symptoms or feelings related to anxiety like worries, fear, nerves, overthinking, etc., due to stressors like finances, work, the immigrant experience, housing, and other social determinants of health. Participants said the fear of judgement from others in the community has often kept them and others from seeking help for mental health struggles.

- "Anxiety disorders are prevalent, characterized by excessive worry, fear, and nervousness, especially regarding financial security, job stability, and integration into a new culture. Many immigrants may feel anxious about their immigration status or their ability to support their families." (CIN)

Isolation and Loneliness

Across community listening sessions, participants reported that community is extremely important to them, and they view community as an essential part of their maintaining health and wellness. Communities were very concerned about isolation and loneliness, especially among elders in first- and second-generation immigrant families. Isolation and loneliness often occur because of the cultural differences between Western culture and the community member's home culture. In Western culture, individualism is emphasized more than community, which puts a strain on many BIPOC and other culturally specific communities. The feelings of isolation and loneliness felt throughout communities is exacerbated by the stigma connected to mental health which prevents people from seeking help.

- "[Mental health issues are] ignored. People aren't taken seriously and when it reaches an extreme, they're blamed for not reaching out. They become isolated from their community and support system." (AAP)
- "Isolation is a big problem because our community is a very participatory community. Here [in the US] you don't really talk to your neighbors and there is a language barrier. This also leads to depression." (ECS)

Depression

Underlying depression was discussed, although indirectly, throughout the interviews. Many participants noted that communities may tend to dismiss or ignore signs of depression due to not knowing the language to discuss it openly. This is exacerbated by the stigma placed on depression among communities because it is often seen as a "curse" or people fear judgement from others in their community if they seek help. Because of the tendency to dismiss or minimize concerns related to mental health and depression, community members often go untreated until their mental health struggles get to extremes.

> *"Being an immigrant and not being in a place where you were born and raised, the changes in your life, losing your friends, depression sets in. And so, if you don't get out and make friends, then you can become isolated. The more isolated you get, the more depressed you are, and if you don't earn any money, you can't get a hold of your friends, and you cannot just go to a computer and talk to friends because some of them don't have any means whatsoever of communication, not even a cell phone, so severe depression [can develop]." (FCS)*

- "I would also say [my community experiences] depression and stress, but they don't know about [terminology for] depression as much. Also, the acting out of stress, like verbal abuse or physical abuse adding to that stress." (VHB)

Opportunity #4: Work with communities to identify culturally adapted language and terminology to empower individuals to describe their mental health symptoms and experiences so that communities can create awareness and openness to dialogue.

5. Trauma and Stressors Contribute to Mental Health Issues

Trauma was a common theme repeated across listening sessions. Trauma is "an event or experience that results in physical and/or emotional harm that [if left untreated] has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being."[6] During listening sessions, the topic of trauma presented at an individual level and was also recognized as a community-wide concern. Participants throughout communities shared different

> *"[King County should] provide more opportunities for community members to train as mental health therapists/professionals and how to handle trauma." (AZS)*

[6] Substance Abuse Mental Health Services Administration (SAMHSA) website, Trauma and Violence, November, 2024.

aspects of trauma, including trauma from war in their home countries, displacement, grief, violent encounters, gun violence, and more. In addition, adapting to changing gender roles and struggles with social determinants of health in the U.S. presented as significant stressors across communities.

Adaptation Stressors

Immigrants face unique life circumstances that include adapting to a whole new culture and often includes significant trauma history. Many participants noted the impact this can have on their mental health as they struggle with language barriers, cultural differences, navigating the institutions of the U.S. (i.e. Western health institutions), finding work, financial struggles, and more. Understanding the trauma immigrants have faced is crucial to understanding their mental health needs. This is sometimes difficult to do because a large portion of mental health providers don't come from culturally diverse backgrounds or have experience as a refugee or immigrant themselves or working with immigrant and refugee communities. Even if the mental health provider can speak the person's preferred language, participants said they aren't always comfortable sharing or they don't feel fully heard or understood if the staff doesn't share their cultural background or identity.

- "Many community members have experienced traumatic events, either from their home country or during their journey to the U.S. This can lead to PTSD and other trauma-related issues, affecting their ability to function in daily life." (CIN)
- "[Common mental health concerns are] trauma people experience back home, for example, imprisonment, beating, rape, trauma around civil war or personal experiences. Everybody in our family has been exposed to a tremendous amount of trauma." (ECS)

Gender Roles

Some immigrants and refugees experience stress related to customary gender roles when they immigrate to this country. Men may experience loss in status as they are often not able to find work comparable to what they did in their home countries. Women may have access to a wider range of jobs, though these tend to be lower-paying positions. In some cases, women become the main income earners for their families. Many men feel a sense of loss, guilt, and shame that they can no longer support their families. Further, across many communities, the cultural expectations related to masculinity prevent some men from acknowledging their stress or seeking support.

- "It's "unmanly" or a sign of weakness to admit or face up to mental health challenges one may be experiencing." (AZS)

- "Women are burdened with a lot of care responsibilities, which means we have more mental load than men, and this deteriorates our mental health. On the other hand, men are not socially allowed to talk about their emotions because they are the ones in charge of the family; they are the providers. So, I believe that this disparity between genders, which is very accepted in our Latino culture, really does affect all of us in the end." (NAMI Eastside)

Opportunity #5: When working with BIPOC and other marginalized communities, it is important to understand the significance of the trauma people have experienced, as well as the added stress that struggling to meet their basic needs (social determinants of health) has on their mental health. Funding for trauma-informed mental health support is needed to focus on collectively addressing trauma from a community-based and culturally-relevant approach, as determined, and delivered, "by and for" communities. Trauma-informed approaches should include support to address unmet basic needs as a means of building physical, emotional, and psychological safety.

6. Desire for Inter-generational Healing

Participants expressed that a tension exists between generations in their communities. This affects mental health perceptions, interactions among family members and between community members, and the unique experiences of each generation. Multiple community members indicated a desire to communicate across generations more effectively. In addition, intergenerational trauma is often passed down in communities of color and other marginalized communities.

There was a general sentiment that younger generations have different understandings of mental health due to being more immersed in mainstream U.S. culture through school, social media, etc. Among younger participants, there is a desire to discuss mental health with their older family members, but they reported feeling dismissed or criticized. Because of the culture of silence that is apparent particularly in older generations, it is difficult for younger generations to discuss mental health openly because it may be perceived as disrespectful or bringing shame to the whole family or community. This often results in isolation by the younger generations

" Young people talk about it more openly than older people. In my family, for example, my younger siblings talk about mental health and the things that impact their mental health. They talk about going to counseling and treatments for their depression. But our older siblings don't even though they experience a lot of stress and pressure in their daily activities. They are just not used to talking about these things. They may say, 'I feel stressed' or 'under a lot of pressure' but never use the phrase 'mental health'." (VHB)

from parents and grandparents, as well as perpetuating continued silence surrounding mental health.

- "Older generations tell young adults today that we complain too much because, back then, they weren't allowed to express their feelings or else it would come off as weak." (CHARMD)

Intergenerational Trauma

Participants of younger generations expressed a desire to discuss their mental health with family members, but they did not know how, did not want to be disrespectful, or feared family member's reactions. In addition, the unique experiences many BIPOC and other cultural groups face often results in intergenerational trauma (trauma that is passed down from generation to generation, if left unaddressed.) Community participants expressed a need for different programming for each generation, as well as multi-generational healing groups and events to create a safe space to openly discuss, share, and receive support related to trauma.

- "I think it's really a generational gap, in essence. I think in certain communities we can be very open to talk about [mental health] ...the progressive spaces and among the younger, you know, more aware generation. But when talking with elders it is more of a leap for them, like, it'll take more time to explain what mental health is before actually talking about, 'how is your mental health?'" (FCS)
- "I've noticed that the challenges of displacement, trauma, and the generational differences in how mental health is understood have shaped my perspective. For instance, younger people in my community might be more open to discussing mental health and seeking help, while older generations might still view it as a taboo topic. This has made my experience both connected to the traditional views of mental health but also somewhat distinct, as I navigate these differing perspectives within my community and my personal life." (NAAPR)

Opportunity #6: Prioritize intergenerational trauma when supporting marginalized communities, including communities of color. Mainstream mental health support can and should incorporate a multi-generational service approach that includes 1) distinct services and groups for peers within the same generation to connect with each other (i.e. youth groups, adult groups, elder groups, etc.) and 2) inter-generational support groups and events that bridge the divide between generations with a collective approach to cultural healing.

7. Communities seek Education, Resources, and Support related to Substance Use

Many participants noted a link between substance use and mental health in their communities. Participants also reported a lack of knowledge about when substance use is considered problematic. Some participants shared that substances are sometimes being used in their communities as a form of escape, to de-stress, or to cope with life stressors and perceive a lack of practical and feasible alternatives.

Alcohol Use is Normalized and Unclear When It's a "Problem"

Some communities differentiated between drugs and alcohol due to the normalization of alcohol in their communities. Because alcohol is legal and commonly used throughout society, participants shared that they don't necessarily know when use of alcohol is "normal" and when it is considered a substance use problem. The lack of knowledge about the threshold for problematic drinking contributes to a lack of recognizing the problematic behaviors as well as the need to seek support. A few participants said they sometimes feel pressured to drink alcohol at social events or they will be judged by other community members.

> *"Education on how you know you have a problem and how it actually affects a person is needed. This is because they might not know the full extent of which these topics can affect them." (CRB)*

- "We also must realize… we normalize drinking. We can't go to a social event or watch a TV show or movie or attend an event without there being booze or alcohol. Think about that for someone who is struggling or in recovery. I think there are just some things we need to not normalize." (TFF)
- "People just don't want to talk about [substance use]. I think there's a lot of silencing. There's a lot of backpedaling, and moving away, and changing the subject, and not being as open. It's hard to talk about." (FCS)

Substances Are Used as an Escape

Participants across communities indicated substances are used to cope with life stressors or as an "escape." Mental health issues like anxiety, and depression contribute to substance use issues because people do not know where else to turn to for relief. In addition, the "culture of silence" and stigma surrounding mental health often leads people to use substances to cope with their feelings.

- "Drug use is seen as a solution. They see it as an "out" but what they need is emotional support." (AAP)

- "Substance use is often linked to escape. People use it to forget their problems." (CHARMD)

Opportunity #7: Partner with culturally centered organizations to develop and disseminate culturally responsive education and support related to substance use including how to recognize when drinking or use of substances is considered problematic and what options are available for support.

8. Concerns about Youth Well-being Differ between Caregivers and Youth

Parental Concerns

Older participants showed increasing concern for the youth in their community. Some participants noted that the youth must mature a lot faster in the U.S., as compared to their country of origin, and are concerned that youth are susceptible to peer pressure. Concerns by youth about their own mental health include facing judgement from their peers as well as navigating the complexities of meeting the social and academic expectations from elders. Many parents and adult participants felt that the youth have easy access to substances, and youth alcohol and drug use is a big concern among adult participants. While substance use was less of a concern presented by youth, some younger participants did feel they were becoming desensitized to drinking and drug use due to normalization within the school culture.

"Young people are in a stage of finding their identity and independence. Also, many times they don't have the support or guidance, and they turn to substance use to cope with their emotions. Nowadays, anyone is vulnerable, but even more so those who lack information, which is almost nonexistent in our language." (NAMI Eastside)

- "I believe schools mislabel kids which sets them on a path of low self-esteem or self-worth, judgment and prevents them from getting the help they need. I have family members who were placed into special needs classes when they had lost their parents to drugs or prison and were experiencing grief and massive loss. Kids who didn't have proper nutrition and support at home shoved into these labels instead of having their needs met. A lot of them became adults with chronic mental health issues, in and out of prison, self-medicating, drug addiction or alcohol abuse." (TFF)
- "A lot of these children are facing adult problems; they mature a lot faster." (AAP)
- "I believe many teenagers and young adults are prone to mental health issues and substance use disorder as they're living in this time where there is a lot of competition and fitting in social life, social media, and school problems. I believe there is a lot of destruction in the world right now for teenagers and young adults and that leads them to unstable mental health and substance use. "(ECS)

Youth Concerns

Younger participants often shared that they wish they could communicate with older family members and parents about their mental health, but report experiencing a generation gap and worry the older generations do not adequately understand the culture of younger generations. Some participants felt that when they have tried to open up about their mental health in the past to their family, they have been met with dismissal and disbelief. Some youth noted a lack of parental support as a barrier to care and others felt that mental health is not important to adults. This not only exacerbates mental health struggles but also contributes to the culture of silence and stigma surrounding mental health.

Participants expressed a desire for programming that brings generations together and that opens up discussions of mental health.

- "I can certainly talk about mental health with some of my closer relatives mostly, the ones living in America. I would choose to avoid talking to older relatives, however." (IACS)
- "In our families, we don't talk about trauma. We don't talk about anything with kids, even if people are dying. We shelter children from trauma, so I still don't know how to deal with people who are mourning or anything in general that is trauma related. We avoided it in my family. When a close friend has a loss in their family, I don't know how to talk about it with them." (ECS)

"We want to create connections across the generations. In the past, I noticed some people felt hesitant about interacting with people across the generations, but now they see the senior programs and find joy in talking and interacting with people of all ages…now we try to encourage a feeling of family and forgiveness, so people seem more open. We encourage these kinds of interactions, which can really help to support mental well-being. ...So, creating space for people to talk with each other in a fun and safe way can support mental health." (VHB)

Younger participants commonly mentioned anxiety and depression to describe their own mental health concerns. Some participants said this results from the pressure they feel from older family members to succeed as first- and second-generation family members in the U.S., from peer pressure in their communities and in mainstream youth culture, and from school stressors. Because some of the stress the youth face stems from family relationships, it is hard to discuss their mental health with those family members. Some youth shared that knowing they wouldn't be judged would encourage them to seek care for mental health issues, but overall, they felt there is currently nowhere to go for mental health care.

- "There's this disconnect because parents are from a very different culture than their first-generation children and they do not feel part of any community. That can lend itself

to substance abuse or mental suffering. We can do better to make first generation youth feel more connected." (ECS)

Opportunity #8: Recognize and fund youth and family-centered culturally responsive programming to support open dialogue within families from marginalized communities about mental health and substance use prevention and support.

9. Barriers to Care are Many

Language Access Needs: Education, Resources and Materials, and Treatment

Language access was identified as one of the biggest barriers to getting support for behavioral health needs. Language access includes the availability of outreach and educational materials in preferred languages to create awareness of mental health and substance use conditions, as well as providing resources, support, and treatment in preferred languages. Language barriers significantly impact care because they create challenges for community members who speak languages other than English (LOTE). The result is people are not aware of the resources available, or they aren't able to access services because they are not routinely offered in their preferred language. Additionally, the terminology used in care settings can be difficult for non-English speakers to comprehend, further preventing effective communication and engagement in treatment. As a result, individuals may not be able to navigate complex systems of care, resulting in unmet needs and inequities in mental health and substance use treatment and outcomes. Ensuring language accessibility through increased availability of culturally appropriate services and providers who speak their language is crucial in addressing these barriers and encouraging equitable care for all community members.

- "In my opinion, language is the first barrier. There are no mental health services in the clinics in our language." (NAAPR)
- "We feel helpless to go out due to language barrier." (IACS)

Lack of Culturally Responsive Providers and Programming

"I need someone I can see myself in. Coming in to see a white person in therapy – it spikes my nervous system." (TFF)

In addition to the language barrier, a lack of culturally responsive services is another barrier to care. Participants mentioned the lack of culturally responsive providers and services as a hindrance to care. Culturally responsive care includes having a provider who speaks the same language *and* shares a similar background. Culturally responsive programs include, but are not limited to, offering individual and group-based services that encourage cultural identity and stronger community connections. Research has demonstrated having a provider who comes from the same background and speaks the same language helps build trust and allows the patient to be better understood.

- "I really think that lack of professionals who can understand the community, the culture and language. There is not a lot of trust. Also, the information about help and treatment is so hard to find. They don't know where to start looking and sometimes there is no information in Vietnamese. And sometimes, they call the number provided on resources, but they cannot speak English. This makes people give up. They feel very discouraged." (VHB)

> "[There aren't] *a lot of culturally competent therapists-therapists who know our backgrounds and know how to connect. [This gap] can make many people turn away. Even though I am a therapist, it took me a while to find a therapist who I connected to." (CRB)*

Social Determinants of Health

Across communities, participants expressed worries about the cost of living, meeting basic needs, stable housing, safety, job security, and other social determinants of health. This reflects a wider concern for how the social determinants of health impact the mental health of BIPOC and other marginalized communities. Participants report challenges with securing employment which leads to stress and anxiety. Many communities support multiple generations of families within one household. Due to the high costs of living in King County, elder family members are often burdened with household work or childcare responsibilities, contributing to their own isolation. In other instances, participants said they must juggle multiple jobs just to meet basic needs which adds significantly to their mental health stress.

> *People that don't a have job, this person is responsible to support back home, they have many bills. Losing their job is a huge stressor." (AMHS)*

Many participants feel that their community members don't have the knowledge or resources to seek out care. Some participants felt there are mostly unrealistic options when it comes to care seeking. For example, many community members work 9-5 jobs, which is typically also when behavioral health care is available, so care is inaccessible especially among those who cannot take time off. Additionally, it is time consuming to find a provider and navigate the health system, and some participants noted that their communities don't have the time for this due to caring for elders or children, work, and other responsibilities. While some participants did note that Washington has some good laws to help with insurance coverage, participants still reported insurance as a barrier to care. Some participants can't get insurance while others can't afford the costs of services even with insurance. Many participants often expressed worries over finances and work which only exacerbates cost as a barrier to care.

Some participants shared transportation and location as a barrier to care. For community members who don't drive, finding transportation to and from health centers can be a challenge. Many providers will only accept certain insurance coverage, which makes finding a convenient location even harder.

- "There are several factors that affect the community's ability to seek care for mental health, such as: Poor information about available resources, financial problems, medical insurances

not accepted at private health clinics, lack of doctors who speak Persian or Pashtu, and most community members are not able to speak English proficiently." (NAAPR)

- "Lack of housing and good shelters where we can cook pose as barriers to care. Additionally, no transportation limits access to essential services, including mental health and substance use programs." (CIN)

Opportunity #9: Center cultural and linguistic needs in behavioral health planning, funding, and service delivery. Require program budgets to maintain set aside funds *solely* to address barriers to access such as interpretation services, translation of materials, transportation, etc.

10. Culturally Responsive, Community-Driven Behavioral Health Education, Resources, and Treatment are Fundamental to Delivering Equitable and Quality Behavioral Care for Refugees and Immigrants, and other Marginalized Communities

Across communities, participants emphasized a need for more education and resources about mental health particularly designed and delivered by trusted sources. Many participants felt that their community members don't seek mental health support due to a lack of knowledge about resources and where to turn. Culturally responsive mental health education is not widely available to the public, especially among immigrant and low-income families. An additional challenge noted by participants is a lack of mental health education and resources in languages other than English. This is exacerbated by a lack of trusted providers to turn to that understand participants' language and culture. Some participants brought up a desire to not only receive mental health education from trusted culturally centered organizations, but also from religious leaders to whom they already go to for support.

Mental Health Awareness and Education in Preferred Languages by Trusted Organizations

"A lot of people don't even know what services are available. There's a big gap in communication." (CIN)

Participants expressed a need for targeted mental health public awareness campaigns for their communities. A prime barrier to care seeking is a lack of educational materials produced in different languages and that are culturally relevant. Participants across communities indicated a need for more culturally responsive programming. Additionally, a gap in mental health awareness exists due to the lack of availability of mental health resources or educational materials in languages other than English. Participants also seek providers who speak their preferred languages and who come from, or understand, their culture.

- "I think setting up a flyer with the time place and date maybe at a local park or church where people can have a [shorter] commute. Where people can just talk about their issues

or just basically is somewhere where they can find information and resources that they might need for any kind of crisis, whether physical or mental." (CRB)

- "There is a big lack of knowledge in the community about where to go and how to approach your mental health problems." (IACS)

Wellness Programs in Safe 'Third' Spaces that Build Strong Community Connections

Participants recognized the importance of creating safe spaces to discuss mental health openly among their peers and within their trusted communities. Participants connected mental health to having social supports and a sense of belonging through community groups as a healing practice. Many community members throughout the listening sessions were excited about the opportunity to connect with each other on the topic of mental health and wanted to learn more*, together as a community,* about mental health resources. Some participants asked if the community listening sessions could be continued because they felt the experience of having someone facilitate a community conversation about mental health and substance use was helpful to them and their communities. Surprisingly to the facilitators of the project, this was a request that arose across multiple communities.

"More places to meet to be in community with one another. Covid was challenging. But then during Covid we lost the "third place" community that supported them, across generations. We want more community gathering." (KCS)

Ideas like community green spaces, dance, art, cultural celebrations, cooking together, and more types of wellness programming were suggested by participants as ways to improve their well-being. Other participants highlighted a need for wellness programming like healing circles that address the whole person, not just their mental health needs. This could include workshops that focus on nutrition, physical fitness, and stress management. Programs offering free or low-cost fitness classes, cooking workshops, and mindfulness sessions can significantly improve overall wellbeing and serve as a bridge to mental health services. Integrating these wellness components can encourage individuals to view mental health care as part of a comprehensive approach to health.

- "We do classes to the community, but we are missing spaces specific [for sharing] our community resources. For example, where they can get resources or connect with a consultant who can speak their language?" (AMHS)

- "To better support the community and increase access to mental health and substance use services, several key policy changes are necessary. For example, free access to recreational facilities, such as soccer fields. Implementing policies that allow for free or low-cost access to community sports fields would promote physical activity and provide safe spaces for youth and families to engage in healthy activities. This could help reduce stress and foster community connection, ultimately contributing to improved mental health outcomes." (CIN)
- "Since 2017 we've been running soccer activities to stop the school to prison pipeline, and it has been very successful. Having access to soccer fields is hard because they cost a lot of

money and the process to acquire them is difficult. We would like to not be the only provider of those activities, but we want kids to be engaged that would keep them away from making bad decisions." (TFF)

Culturally Centered Organizations Design and Deliver Behavioral Health Supports By and For Communities They Serve

Culturally centered organizations play a significant part in supporting the behavioral health needs of their community, often without formal training, since they are rooted in the communities they serve and are a trusted source of support. To support this programming, funding should be focused on building a skilled, knowledgeable, and trusted behavioral health clinical as well as "lay" workforce to effectively address the unique needs of their communities. Support is also needed for culturally relevant training that encourages community members from within the community to become behavioral health providers. Programming that centers community organizations as program providers would help foster trust, reduce stigma, and ensure that behavioral health services are both culturally appropriate and sustainable. Multiple communities noted an interest in having their community members and leaders trained to support their communities when behavioral health support is needed.

> *"Targeting the communities and listening to them is crucial. Not just listening but giving the resources. If not giving the resources, then what is the point? We did this kind of thing before, but nothing changed." (NAAPR)*

- "Provide more opportunities for community members to train as mental health therapists and professionals and to how to handle trauma." (AZS)
- "Teach or share ideas on how communities can create Peer Support Groups." (AZS)
- "Key policy is not to aggregate data, be respectful of the need of each community. Don't take a mainstream (approach) of mental health to the community. Be respectful of their needs. Notions of mental health need to be approached [for] refugees in the context of their resettlement. They need to have a trusted mental health therapist, trained and speaking the same language." (NAAPR)

Opportunity #10:

- **Build behavioral health capacity at culturally centered community organizations with:**
  - Technical assistance, including finance, IT, program and staff development, etc.
  - Create a pipeline of licensed and non-licensed behavioral health staff, including peers within organizations, through training and support.
  - Fund organizations to design and deliver (not limited to): 1) Educational materials that normalize mental health and substance use conditions, address stigma, and begin to break the culture of silence within communities; 2) Materials in different languages with terminology that is culturally relevant; and 3) Public awareness campaigns in coordination with community leaders.
  - Support interested organizations in becoming licensed behavioral health agencies who can bill Medicaid to access sustainable funding.
- **Adapt current mainstream services to develop more culturally responsive programs within allowable funding parameters.**
  - Begin by establishing a joint exploratory workgroup with BHRD and community organizations.
  - Examples of adapted mainstream services to explore include: 1) Culturally based support groups (both licensed and non-licensed), delivered by community organizations; 2) Peer support (individual and group) by agency-trained behavioral health peers; 3) Prevention funds towards monthly or quarterly culturally focused community events and gatherings; and 4) Culturally based “alternative” programming not billable through Medicaid.

Policy and Funding Recommendations

This section recaps opportunities and policy recommendations for each section. Organizations recommend that any future planning allow for the greatest amount of flexibility and autonomy for communities to determine and deliver mental health and substance use supports that are most relevant and requested by and for their communities.

1. **Culture and Context Matters**

   Incorporating culture is critical when addressing mental health and substance use conditions in marginalized communities. Perceptions about wellness and treatment are influenced by culture and have a significant impact on whether an individual seeks care and the types of care they prefer; namely, behavioral health care that is provided within the context of the individual and community's culture.

2. **Spirituality and Mental Health is Intertwined**

   Integrate spirituality in behavioral health supports to align with community members' values and beliefs by 1) building organizations expertise to support spiritual leaders, 2) educating spiritual leaders on basic behavioral health support and resources, and 3) provide funding models that provide flexibility to support the integration of spirituality into behavioral health services, as requested by individuals and communities.

3. **Mental Health Perceptions, Knowledge and Stigma Vary Across Communities**

   Support and expand ways to normalize and de-stigmatize mental health dialogue and treatment in communities by working with culturally centering organizations to expand discussions about mental health, in preferred languages, and with approaches that resonate within each community.

4. **Common Mental Health Concerns include Anxiety, Loneliness, and Depression**
   Work with communities to identify culturally adapted language and terminology to empower individuals to describe their mental health symptoms and experiences, so that communities can create awareness and openness to dialogue.

5. **Trauma and Stressors Contribute to Mental Health Issues**

   Fund trauma-informed mental health support that focuses on collectively addressing trauma from a community-based and culturally relevant approach, delivered "by and for" the community. Include support to address unmet basic needs as a means of building physical, emotional, and psychological safety.

6. **Desire for Inter-generational Healing**

   To prioritize intergenerational trauma, incorporate a multi-generational service approach with 1) distinct services for peer groups and 2) inter-generational support groups and events that bridge the divide between generations with a collective approach to cultural healing.

7. **Communities seek Education, Resources, and Support related to Substance Use**

   Partner with and fund culturally centered organizations to develop and disseminate culturally responsive education and support related to substance use, including how to

recognize when drinking or substance use is problematic and what options are available for support.

8. **Concerns about Youth Well-being Differ between Caregivers and Youth**

   Recognize and fund youth and family centered programming to support open dialogue within families from marginalized communities about mental health and substance use prevention, resources, and treatment.

9. **Barriers to Care Are Many**

   Center cultural and linguistic needs in behavioral health planning, funding, and service delivery. Require program budgets to maintain set aside funds *solely* to address barriers to access such as interpretation services, translation of materials, transportation, etc.

10. **Culturally Responsive, Community-Driven Behavioral Health Education, Resources, and Treatment are Fundamental to Delivering Equitable and Quality Behavioral Care for Refugees and Immigrants and other Marginalized Communities**

    - **Build behavioral health capacity at culturally centered community organizations with:**
      - Technical assistance including finance, IT, program and staff development, etc.
      - Create a pipeline of licensed and non-licensed behavioral health staff, including peers within organizations through training and support.
      - Fund organizations to design and deliver (not limited to): 1) Educational materials that normalize mental health and substance use conditions, address stigma, and begin to break the culture of silence within communities; 2) Materials in different languages with terminology that is culturally relevant; and 3) Public awareness campaigns in coordination with community leaders.
      - Support interested organizations in becoming licensed behavioral health agencies that can bill Medicaid.
    - **Adapt current mainstream services to develop more culturally responsive programs within allowable funding parameters.**
      - Begin by establishing a joint exploratory workgroup with BHRD and community organizations.
      - Examples of adapted mainstream services to explore include: 1) Culturally based support groups (both licensed and non-licensed) delivered by community organizations; 2) Peer support (individual and group) by agency-trained behavioral health peers; 3) Prevention funds towards monthly/quarterly culturally focused community events and gatherings; and 4) Culturally based "alternative" programming not billable through Medicaid.

Conclusion

This report amplifies the voices of historically marginalized communities and highlights opportunities to shape future behavioral health programming in King County. The key learnings presented underscore that culturally diverse individuals face systemic disparities in both accessing and benefiting from behavioral health services. The current system, rooted in the mainstream, Western-centric, white dominant, medically based model, frequently overlooks the social, cultural, and historical contexts of marginalized communities, leading to unmet needs and inequitable behavioral health care. Participants in community listening sessions emphasized the centrality of stigma, trauma, and spirituality of behavioral health problems, in understanding and addressing behavioral health concerns in their communities. Participants also highlighted a lack of culturally and linguistically relevant care, which further compounds feelings of isolation and distrust toward existing services. Across listening sessions, communities expressed a strong desire to continue community conversation about mental health and the importance of connection—both with each other and with mental health resources.

As we look toward the future, these learnings serve as a call to action to build a behavioral health system where every King County resident feels valued, understood, and encouraged to seek care that is accessible and individualized for their needs. With sustained commitment and collaborative efforts, King County is well-positioned to serve as a model for an equitable behavioral health system, reflective of the rich and diverse communities it serves.

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- Filipino Community of Seattle (FCS)
- Indian American Community Services (IACS)
- Korean Community Service Center (KCS)
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Appendix A. Listening Session Questionnaire

BE HEARD LISTENING SESSION QUESTIONS

A. The following questions are focused on common beliefs or perceptions of mental health and substance use in the community.

1. When you think of or hear the phrase mental health, what ideas or thoughts come to mind? (For reference, a definition of mental health is provided below.)

> Mental Health is defined as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community."
>
> Source: World Health Organization

   a. What about substance use?
   b. How do you feel about this definition of mental health? Does it capture your thoughts and feelings about mental health? How's your experience connected or not connected to this?
   c. Do people in the community use the phrase mental health? If not, what other words are used to describe mental health?

2. Can you share some cultural beliefs around mental health, wellness in your/our community?
   a. What about substance use?

3. Are you or people you know in your/our community able to talk openly about mental health or wellness?
   a. If not, what are some things that make it difficult to talk about mental health or wellness?
   b. What are some things that are helpful to discuss these topics?

4. Is there stigma connected with mental health or wellness?
   a. What does this stigma look like?
   b. Can you give an example of how stigma surrounding mental health unfolds or is displayed?
      i. What about substance use?
   c. Can you share a little bit about where this stigma comes from?

5. Are there other thoughts or ideas you would like to share about perceptions or understanding of mental health, wellness, or substance use in your/our community?

B. The following questions focus on who in the community has the most need for mental health or substance use services.

1. Who in your/our community are you most concerned about needs related to mental health and substance use disorder? *(older adults, youth, first generation immigrants, second generation immigrants, homeless individuals)*
   a. What are some things that you can share about why these particular groups are most affected by mental health and/or substance use?

2. What are some common mental health concerns in your/our community? *(depression, trauma, isolation, stress, giving space for people to share, physical/somatic symptoms (physical pain, unexplained pain that comes up often))*

C. These next questions focus on community access to and support for mental health and/or substance use issues.

1. In your/our community, what factors affect decisions to seek care for mental health or substance use issues? *(lack of culturally responsive staff and services; geographic restriction; lack of transportation and translation/interpretation, etc.)*

2. If you, someone in your family, or someone in the community needed help with a mental health or substance use issue, where would you/they turn for help? *(A community leader, hospital/doctor, church/mosque, community center, friend, etc.)*
    a. If the person was experiencing a mental health crisis, how would you respond and where would you take them?
    b. What support is needed to help people in crisis?

3. What are some things that can help to improve your/our community's well-being?
    a. What types of programs do you think would be most helpful in our community to increase utilization of mental health and substance use services? *(Community building and connection, wellness programming, etc.)*
    b. What policy changes are needed?
    c. What would be helpful for people to talk more openly about mental health or access mental health services?

4. What are the barriers or challenges to access for mental health and substance use services in your/our community?

5. Are there other thoughts, experiences, or ideas you would like to share with us about ways to support a healthy and thriving community?

Please share any additional information you think would be helpful for us to know.

Thank you for your time.

Community Listening Project January 2025

Thank you to all of our partners in this work