Behavioral Health for Asian American, Native Hawaiian, and Pacific Islander Males

Setting the Stage

In March 2015, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Behavioral Health Equity (OBHE) and the American Psychological Association co-sponsored a conference: "Pathways to Behavioral Health Equity: Addressing Disparities Experienced by Men and Boys of Color." The meeting, aligned with the Presidential initiative, My Brother's Keeper, focused on understanding behavioral health issues related to men and boys of color - namely Black/African Americans, Latinos, Native Americans, and Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPIs) - across the United States. At the convening, leaders of the AANHPI community noted that there was limited research on AANHPI men and boys, despite the recent report that Asian Americans (AAs) are the fastest growing ethnic group and are expected to be the largest immigrant group by 2055.[1] Further, although Southeast Asians (e.g., Hmong, Vietnamese, Laotians, and Cambodians) and Native Hawaiian and other Pacific Islanders (NHPIs) tend to experience similar educational and socioeconomic disparities as Black, Latino, and Native American men and boys, behavioral health programs or resources are limited for these populations.

In March 2016, SAMHSA's OBHE issued a brief entitled "A Snapshot of Behavioral Health Issues for Asian American/Native Hawaiian/Pacific Islander Boys and Men: An Overdue Conversation."[2] The issue brief provided a background on AANHPI communities – describing the diversity of ethnic groups, immigration histories, and current socioeconomic and political experiences in the US. The brief then highlighted research covering a spectrum of behavioral health issues related to AANHPI boys and men including:

- ***Behavioral health issues*** (e.g., depression, suicide, substance use, and schizophrenia)
- ***Ethnic and cultural factors*** affecting help-seeking behaviors
- ***Social determinants of health***, including educational factors, involvement in the criminal justice system, and racism and racial microaggressions.

The brief concluded with a call for local and national strategies to develop programs, services, and resources that specifically target behavioral health issues among AANHPI boys and men.

Clarifying the Purpose

Building on the initial brief, SAMHSA's OBHE contracted with leadership from the Asian American Psychological Association (AAPA) and the Okura Mental Health Leadership Foundation to develop this strategy brief to highlight the types of existing programs or services that address behavioral health disparities and promote equity for AANHPI boys and men. This brief summarizes "best practices" and expert consensus on culturally appropriate approaches, treatment modalities and effective tools in working with this population.

Collecting the Information

The leadership from AAPA and the Okura Foundation reached out to scholars, service providers, and community leaders in the AANHPI community who have been providing and developing effective interventions, services, and support systems for AANHPI boys and men. These experts represented various regions of the country (e.g., the East Coast, West Coast, Alaska, and Hawai'i), ethnic backgrounds (e.g., multiracial, Native Hawaiian, Filipino, Chinese, South Asian, Thai, Japanese, Hmong, and Korean), generational status (e.g., immigrants, second generation, and fourth generation), gender identities (e.g., men and women), sexual orientation (e.g., heterosexual and gay), and areas of expertise (e.g., psychologists, social workers, clinical directors, researchers, educators, and non-profit organization leaders). The information collected from these experts informed this strategy brief.

Reporting the Findings

This strategy brief highlights essential approaches for addressing behavioral health disparities and providing effective services for AANHPI boys and men. Seven practice strategies are highlighted for clinicians, substance abuse counselors, program coordinators, educators, and leaders of community groups. Four systemic and institutional strategies are provided for local, state and federal policy makers and staff, funding agencies, and other stakeholders. Examples of best or promising behavioral health practices (e.g., programs, therapeutic approaches, and supports, etc.) are provided from organizations and behavioral health practitioners who have successfully utilized these strategies.

Seven Strategies for Practitioners, Educators, and Community Leaders

1 Integrate Culturally-Based Strategies in Working with AANHPI Boys and Men

Integrating culturally-appropriate approaches in clinical interventions and behavioral health programs that promote behavioral health wellness and recovery is essential. While the actual approaches may vary based on individuals' ethnic background, acculturation level, and cultural identity awareness, there are several general approaches that experts deem as being effective. First, when utilizing Western therapy methods, it is crucial to integrate cultural traditions. Recent studies have supported that NHPI men prefer culturally congruent practices for coping with distress (e.g., family support, religiosity, or spirituality) rather than psychotherapy or substance abuse counseling.[3] Experts describe the importance of involving family – especially in culturally focused psychoeducation, treatment, and recovery programs. For NHPIs, key informants in Hawai'i describe how the traditional healing process (or *ho'oponopono*) involves the family- which can include both a *kupuna* (elder) and a licensed clinician; male clients specifically request this kind of healing session to bring the family together.

For educational or support programs promoting behavioral health, experts also recommend involving *kupunas* (or elders)**.** Elders can be instrumental in promoting interventions and healing because they have lived experience, life skills, wisdom, and knowledge. Several experts report that *kupunas'* intergenerational wisdom guide young men and boys in their development. Further, experts emphasize the importance of cultural education when promoting behavioral health. Many key informants describe how AANHPI boys and men need to be centered on their cultural identities, in order to develop healthy self-esteem and positive mental health. For instance, Hina Mauka Drug Treatment Program in Honolulu, Hawai'i offers a class on "Hawaiian Values" where a *kupuna* teaches Hawaiian history and cultural keys to the past and future. Similarly, the Hmong Youth and Family Program at Keystone Community Center in St. Paul, Minnesota offers afterschool enrichment programs including Hmong dance instruction, traditional Hmong cooking with parents, and holiday celebrations. Allowing young men and boys to learn about their cultural background can help increase self-esteem and ethnic identity, which may promote optimal mental health and coping behaviors.

2 Address Masculinity and Gender Roles

Masculinities have different attributions in different cultures; some assigning more aggression to masculinity; others more receding, passivity. AANHPI men and boys are often emasculated or desexualized in American media and in American society in general. Experts described how gender role expectations and masculinity affected behavioral health. For different ethnic groups, cultural pressures manifest differently. For East Asian American (e.g., Chinese, Japanese, and Korean Americans) and Southeast Asian American men, the pressure to appear more masculine is motivated by a need to negate stereotypes of AA men as weak, asexual, or submissive. For Filipino Americans, the pressure to appear more masculine is shaped by a need to abide by the *machismo* gender role expectation that was embedded into Filipino culture through Spanish colonialism.

Previous research has found that when AANHPI men believe their masculinity is being threatened or questioned, they may develop lower self-esteem and other mental health issues; they may also engage in unhealthy and harmful coping mechanisms and behaviors (e.g., intimate partner violence or substance abuse).[4] Research has also supported how AA men uniquely experience masculinity in negative ways – due to the intersection of their racial and gender identities; often, the pressures to conform to Westernized masculine ideals may result in AA men's psychological stress[5] and substance abuse.[6] It is recommended for practitioners and educators to discuss masculinity with AANHPI male clients, in order to understand how racism and gender role expectations have influenced their self-concepts and other presenting problems.

3 Discuss Coping Strategies and Promote Help-Seeking Behaviors

Related to masculinity, experts identified how AANHPI boys and men are less likely to seek help for their psychological or behavioral issues, drop out of mental health services or substance use disorder treatment, or seek services only after symptoms have worsened or functioning has deteriorated. AANHPI boys and men tend to have a difficult time seeking help due, in part, to cultural expectations and gender norms.[1] While seeking support for mental health issues is stigmatized across AANHPI ethnic groups and genders, AANHPI boys and men often face additional pressure to be viewed as smart, successful, and emotionally strong.

It is important for practitioners, counselors, and educators to discuss coping mechanisms with AANHPI men and boys. Experts recommend facilitating discussions on cultural and gendered expectations on coping, while encouraging AANHPI men and boys to seek professional help when they need it. Specific to counseling and other clinical therapy services, providing psychoeducation about the therapy process may be especially important for AANHPI male clients, as they are often unfamiliar with the process or may not be inclined to discuss emotional or psychological hardships with others. For substance abuse counselors, discussing how alcohol or drug use has been a primary way of coping with life stressors or traumatic events can assist AANHPI men to understand the need to change or minimize such behaviors.

Further, because of cultural shame and the stigma in seeking behavioral health care, some researchers have supported the use of internet outreach and online support groups to promote behavioral health among AANHPI men.[7] Because AANHPI men are less likely to seek mainstream psychotherapy or substance abuse counseling than AANHPI women, practitioners may utilize the internet to provide psychoeducation or outreach services to AANHPI men. Clinicians may also consider monitoring online support groups, in addition to promoting in-person support groups. While promoting behavioral health online alone may not be ideal, such methods can be the first step that AANHPI men and boys need to attaining information or addressing any problematic psychological or behavioral issues. It may be a first critical step of engagement.

4 Acknowledge Experiences of Racism and Microaggressions

Experts described how AANHPI men and boys experience racism- in both overt and subtle ways. One example of overt discrimination that AANHPI men and boys encounter is bullying- which the U.S. Department of Education reports AANHPI youth are experiencing at increasing rates.[8] In 2015, 19 percent of Native Hawaiian students and 17 percent of Filipino students reported being bullied in Hawai'i high schools, and 60 percent of Native Hawaiians and Filipinos reported being bullied in Hawai'i middle schools. AANHPI students report being bullied for a number of cultural reasons, such as their racial characteristics, immigration status, or family background and history. When AANHPI men and boys experience discrimination, they may turn to substance use (e.g. alcohol, nicotine, illicit drug use) to cope with their problems.[9]

Subtle forms of discrimination often come in the forms of microaggressions- which are covert acts of discrimination that are often unintentional by the perpetrator or appear to be harmless or innocuous.[10] For instance, experts who worked with NHPI young men cited how others (e.g., police officers, teachers, store clerks, and others) often perceive and treat NHPI men as dangerous or criminal due to their darker skin color and typically larger physical stature. As a result of this, some NHPI young men learn to expect these stereotypes as commonplace or truthful which affects their self-efficacy, their assessment of their potential, and their ability to succeed. AA men, particularly East Asian American men, often experience gendered, racial microaggressions in the forms of demasculinization - or acts of discrimination in which AA men are viewed as weak, effeminate, asexual, or not masculine enough. Again, such racialized and gendered experiences may result in lower self-esteem, potential mental health issues, and other behavioral concerns. Recent studies with AA samples have found that racial microaggressions can predict depression[10] and lower academic self-efficacy.[11]

Clinicians and other practitioners may address racism and microaggressions by directly asking about discrimination with clients, particularly since many AANHPI men and boys may not initiate conversations about racism or microaggressions. Experts recommend providing education about the different

forms of racism, including both subtle and overt racism, since many clients may not be aware of how even subtle racism may affect their lives. Further, developing support groups or other programs that encourage AANHPI men and boys to discuss discriminatory experiences with each other can be especially effective in normalizing and validating others' experiences with overt racism and racial microaggressions. Moreover, discussing how individuals may turn to substance use as a way of coping with discrimination may help AANHPI men gain insight into their problematic behaviors.

5 Discuss Immigration and Generational Issues

Key informants reported that generational issues were salient for AANHPI men and boys that they had worked with, particularly for American-born young men and boys who experienced generational conflicts with their immigrant parents. For instance, one clinician described their psychotherapy experience with a second-generation AA young man whose parents had emigrated from countries in East Asia and Southeast Asia. The client presented with symptoms of depression and anxiety- stemming from his internalized notions that he was "not good enough." Despite his near perfect grades, his parents pressured him to be perfect and even punished him when he received anything less than 100% on assignments. When he developed mental health symptoms, he reported that his family viewed him as "not trying hard enough" or that he just needed to "be stronger." Experiences like these match previous literature which cites how excessively strict parenting in AA families may result in social, developmental, and emotional issues for AANHPI children.[12] While AANHPI girls and young women may also face parental pressures, the gendered and cultural expectations of being a man (e.g., carrying the family name, being a provider for one's family, etc.) may result in unique psychological and behavioral health issues for AANHPI boys and men.

Experts also described the need for targeted behavioral health services for AANHPI boys and men who are recent immigrants and refugees. Previous research has found that AANHPI immigrants and AANHPIs who are less acculturated are less open to seeking mental health services than those who are American-born or are more acculturated.[13] For instance, studies with South Asian Americans report that American-born individuals are more likely to turn to social support, while immigrants are more likely to internalize negative emotions.[14] Accordingly, immigrants and less acculturated populations are often in need of specialized, targeted services which are difficult to find across the country. Further, for behavioral programs that do provide linguistically competent clinicians or therapists, key informants reveal that funding usually makes it difficult to be specifically focused on only boys and men. Given this, it is crucial for programs to make efforts to hire practitioners who can provide culturally and linguistically appropriate services, to hire translators when necessary, and to provide training in gender- or male-specific services.

6 Be Knowledgeable of Ethnicity-Specific Concerns

Because the AANHPI community consists of over 40 distinct ethnic groups, it is crucial to recognize that there is a spectrum of experiences that AANHPI may encounter. Within each of these groups, there is a range of socioeconomic statuses, languages, religions, and other cultural factors which may result in even more nuanced experiences. Key informants identified several ethnicity-specific concerns that they encountered when working with AANHPI boys and men. While there are many unique ethnic variables that can influence behavioral health, we list a few examples to demonstrate some of the potential experiences among AANHPI men and boys.

Some experts shared that male suicides among Native Hawaiians were disproportionately high, particularly for Native Hawaiian men who were transitioning back to normal life after incarceration, drug treatment, or both. Spaces where they felt safe and accepted in the community were needed for them to get continued help, support and hope. While the research on Native Hawaiians and behavioral health is scarce, existing research has found that Native Hawaiians have a higher prevalence of substance abuse, depression, and delinquency than their AA counterparts. However, Native Hawaiians are unlikely to seek treatment unless they are involved in the criminal justice system.[15] Another expert described how suicide is also prevalent among Micronesian boys and men, aligning with previous literature which finds that Micronesian boys and young men were

11 times more likely to die by suicide than their female counterparts.[16] This expert also described how Micronesian boys and men in Hawai'i have insufficient human services and resources, which increases health disparities for this population.

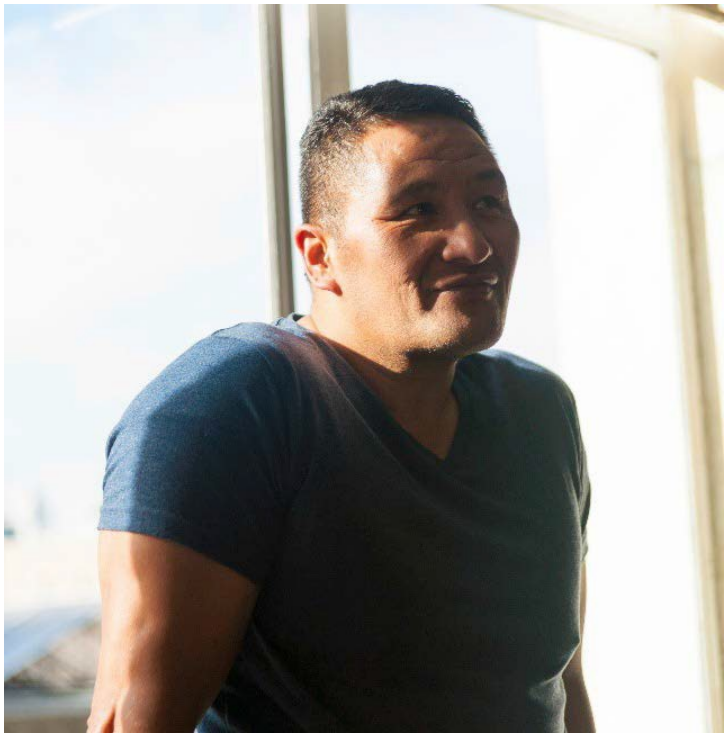
The experts described how some South Asian American males may struggle with domestic partner violence. While the literature on intimate partner violence in South Asian communities tends to focus on experiences of South Asian American women, it is important to create programs that address male dominance and abusive behaviors of the male perpetrators.[17] Further, the expert shared how coronary heart disease and diabetes are also serious health problems for South Asian communities, which often result in psychological distress and other mental health problems. Hindu temples are used for health education for the whole community, including boys and men, but often do not focus specifically on mental health issues. Finally, one expert described how Filipino American boys and men are often perceived as Asian American, Pacific Islander, and other racial and ethnic groups due to unique experiences with colonialism and racialization in the US. Aligning with previous literature, psychotherapy and behavioral health programs for Filipino American men should focus on the Filipino cultural values of *kapwa* (shared identity between self and others) and *utang ng loob* (reciprocity and connectedness with loved ones), instead of framing mental health from Western perspectives.[18]

7 Consider Sexual Orientation Issues

Key experts who worked with AANHPI men who identified as gay, bisexual, or queer (GBQ) reported that the men's cultural backgrounds negatively affected their ability to connect to their sexual orientation identities. While our expert panelists reported that many of these GBQ men accepted their sexual orientation identities, some reported working with young men who lived "double lives" (i.e., they were closeted when with their families and they were open about their sexualities in other aspects of their lives). Previous researchers have described the psychological distress of feeling unable to connect to one's sexual orientation due to family pressures, cultural expectations, and homophobia in some AANHPI families and communities.[19]

Related to sexual orientation issues, two mental health practitioners reported how their GBQ clients also developed body image issues or symptoms of Body Dysmorphic Disorder. These AANHPI male clients reported not feeling attractive enough, often comparing themselves to White male standards of beauty. While there is a dearth of literature examining this trend, there is a substantial amount of literature that has supported how GBQ men of all racial groups tend to have more body image issues than their heterosexual counterparts.[20] Thus, it is important for future researchers to examine this phenomenon, while practitioners can discuss body image issues with the AANHPI boys and men that they work with.

One expert also described how GBQ AANHPI men and boys were often affected by intimate partner violence (IPV). While research on intimate partner violence is limited, one study found that 29% of GBQ AANHPI men reported being the victim of IPV by a male partner in the past year, with 62.5% reporting physical abuse in the past 5 years and 64% reporting multiple victimizations in their lifetimes.[21] Accordingly, practitioners and educators need to recognize that while men are falsely presumed not to be targeted by IPV, GBQ AANHPIs may be at risk.



Four Strategies for Policy Makers and Funding Agencies

I Create Funding Opportunities for Programs for AANHPI Boys and Men

There are very few mental or substance use prevention/treatment programs across the United States created specifically for AANHPI boys and men. While there have been increasing programs addressing the needs of other men and boys of color (e.g., Black/African American, Latino, and Native American boys and men), programs addressing behavioral health among AANHPI boys and men are scarce. Experts report that such programs are needed, but that there are few funding opportunities for AANHPIs in general. Key informants described some of the major obstacles in funding programs for AANHPI boys and men. First, public funding policies rarely provided targeted and/or gender-specific services for AANHPI behavioral health programs, indicating that this is not seen as a need in the AANHPI community. Second, funding tends to be granted to larger, older, established organizations, instead of localized, newer and more recently established organizations. Third, funding tends to be temporary or project-focused, making maintaining or achieving long-term goals unpredictable or difficult.

Despite this limited funding, many practitioners described how a sizable amount of their treatment population was AANHPI and many are AANHPI boys and men. Yet, there were few or no services targeted specifically for them. For instance, the director of Adult Outpatient Treatment at Hina Mauka in Kaneohe (on Oahu, HI) shared that in 2014, over 40% of the clients in their program were Native Hawaiian or part-Hawaiian, but that ethnicity-specific programs were limited. Other practitioners described how AANHPI boys and men might over-utilize certain services that are open for all, but that the programs do not recognize cultural or gender-specific approaches, often due to funding restrictions or minimal resources. For example, a practitioner from the South Asian Network described how mental health services are largely utilized by men over women. Similarly, the clinical supervisor at City of Fremont described how many psychotherapy groups for children with symptoms of Asperger Syndrome tend to be majority AANHPI boys. Despite these observations, such programs are not adjusted or tailored specifically for AANHPI men or boys.

II Increase Culturally Competent Training and/or AANHPI Practitioners

The experts identified the lack of linguistically or culturally competent providers as another major systemic barrier to addressing behavioral health for AANHPIs. Experts who resided in areas with larger AANHPI populations especially viewed this as problematic, given that their clientele were majority AANHPI and other people of color, while their service providers were overwhelmingly White. While many experts affirmed that there are more AANHPI women who enter mental health related careers, they observe the lack of male AANHPI providers in psychology, counseling, social work, and other fields. When asked about this trend, experts described that stigma often prevented AANHPI men from entering the helping professions. Some experts described how psychology graduate programs are not training their students to work effectively with AANHPI clients. While students may learn about multicultural competence, programs often neglect to teach students specifically about AANHPI experiences – in part, due to the presumption that AAs do not have mental or substance use issues. Due to a lack of cultural competence training, it is common for AANHPI men and boys to be misdiagnosed, without considering cultural components that may influence behavioral health. For instance, scholars describe how gender role socialization in Vietnamese men may result in male bonding rituals of binge drinking, also known as *nhau*.[22] Without having this type of cultural knowledge or awareness, clinicians may pathologize or shame Vietnamese men who engage in alcohol use, without understanding the cultural and gendered meanings of such behaviors. Instead, culturally competent clinicians should provide a safe space for AANHPI men to discuss culture and gender expectations, which can validate their clients' experiences, while allowing clients to assess their own health behaviors and change on their own accord.

III Disaggregate Data based on Ethnicity, Gender, and other Intersectional Identities

One common theme among most of the key informants' input was the need for data to be disaggregated among AANHPI boys and men. Because AANHPI boys and men are still treated as a homogenous group, there is limited knowledge regarding the differences that can exist among groups. When data is actually disaggregated, rich and salient information emerges, often countering the narratives of the lack of behavioral problems or providing new knowledge about certain AANHPI subgroups. For instance, studies of schizophrenia find that there is a lower prevalence among AANHPIs; however, when the data is disaggregated, one study found that (a) Native Hawaiians tend to be hospitalized more than Chinese, Japanese, and Filipinos, (b) Filipinos and Japanese report higher severity of symptoms, and (c) Chinese, Japanese, and Filipinos tend to have longer hospital stays than Whites.[23] Without disaggregating such data, it might be presumed that schizophrenia is not problematic among AANHPIs or that the psychiatric disorder affects AANHPI ethnic groups similarly. Relatedly, if researchers do not disaggregate by ethnicity, they will likely also fail to examine differences in gender, immigration status, sexual orientation, or other salient intersectional identities.

Regarding substance use, disaggregated data is necessary to understand the experiences of AANHPI men and women from different ethnic groups. For instance, one study reported that NHPIs and multiracial people were two times more likely than AAs to be diagnosed with two or more substance use disorders (e.g., alcohol use, tobacco use, illicit drug use).[24] Another study found that there were no gender differences between Filipino, Chinese, and Vietnamese men and women; however, Filipinos reported higher mean scores for drinking patterns than both Chinese and Vietnamese.[25] The study also revealed that reasons for drinking differ between the ethnic groups, in that Chinese drank more when they had family conflict and Vietnamese drank more when they experienced everyday discrimination.[20]

Disaggregating data based on gender is also important, as findings also reveal behavioral differences between AANHPI men and women. For instance, one study found that while Hmong men and women may report similar levels of family conflict, higher levels of family conflict predicted less smoking and higher completion rates for the first year of college for Hmong men. Meanwhile, higher levels of family conflict increased alcohol consumption among Hmong women.[26] For AANHPI college students living in Guam, men were significantly more likely to exhibit depressive symptoms, but both men and women reported equal levels of anxiety and stress.[27]

It is also necessary to disaggregate data regarding treatment effectiveness, based on ethnicity, gender, and other identities. In general, most studies that examine the effectiveness of substance use treatment programs for AANHPI people do not examine differences in ethnicity, gender, or the interaction of ethnicity and gender.[28] A program that evaluated school-based mental health program for AA adolescents found that Cambodian youth were less likely than Chinese youth to access such services.[29] Accordingly, when educators and practitioners create programs for AANHPI boys and men, they must recognize that programs may not be applicable to all AANHPI ethnic groups or to AANHPI people of different genders.

IV Create, Implement, and Assess Programs for AANHPI Boys and Men

Scholars have reported that evidence-based treatment for AANHPIs in general (and AANHPI men and boys specifically) is rare because most evidence-based treatment programs are not culturally- or linguistically-based.[30] Experts cite how culturally-based programs are less funded because they are not grounded in conventional empirical evidence. Consequently, practitioners must create and implement behavioral health programs for AANHPI men and boys, and researchers must assess the effectiveness of such programs.

First, in order for programs with AANHPI men and boys to be effective, they must be grounded in cultural values of the specific ethnic groups. One way to create culturally effective programs is to utilize cultural experts who can provide insights into how psychological and behavioral health is conceptualized within certain groups. When working with Samoan people, some scholars recommend using a culturally derived method, referred to as *Fa'afaletui,* which gathers gender-specific focus groups of elders who

discuss and consensually agree upon culturally effective ways to address health within their communities. In utilizing their own cultural knowledge and experiences, the groups develop culturally appropriate services that they consider to be effective – instead of relying on Western methods to be applied or replicated with their groups.[31]

As it stands, there are very few empirical studies regarding the effectiveness of programs that address behavioral health concerns among AANHPI boys and men. Some researchers have found that group therapy with Korean men can be effective in reducing tobacco dependence with one pilot study finding that two-thirds of participants reported abstinence from smoking after participating in a clinical tobacco dependence program.[32] A similar study with a majority Chinese male sample found that a culturally and linguistically competent intervention program also resulted in two-thirds of the participants quitting smoking.[33]

Many experts report that some programs have been effective in addressing mental health issues (e.g., depression, self-esteem) and substance abuse issues specifically in AANHPI boys and men. Experts shared that the most effective approaches were programs that were culturally-centered and directly addressed disparities affecting these populations. In Table 1, we highlight some of the community-based, community-developed enduring and promising programs and services that promote behavioral health among AANHPI boys and men. While not an exhaustive list, experts identified programs that they believed to demonstrate cultural effectiveness or that showed promise in addressing the needs of AANHPI boys and men. It is hoped that these programs can provide a sampling of the types of work that is being done, while generating ideas for new programs that can be created.

Table 1: Sample Programs Promoting Behavioral Health for AANHPI Boys and Men

Organization Name	City, State	Description of Services
Aha Kane www.ahakane.org	Honolulu, HI	Aha Kane aims to nurture a healthier Native Hawaiian male population by eliminating psychological, health, and educational disparities through activities founded on traditional cultural practices that build sustainability in the community. Its Hale Mua Initiative has created men's houses for Native Hawaiian men to gather and learn the ways of successful fathers, husbands, and warriors through cultural activities that aim to reestablish intergenerational traditions in contemporary Hawaiian communities.
APICHA Community Health Center www.apicha.org	New York, NY	APICHA offers comprehensive and integrated services for underserved and vulnerable people with opportunities for medical and mental health treatment, as well as programs focusing on education and social justice. The Men's Health Project is a program to support and educate men to reduce their risk for HIV infection. The GAYME Youth Mentorship program connects LGBTQ youths with peers and adult mentors for support and growth.
Asian & Pacific Islander (API) Wellness Center www.apiwellness.org	San Francisco, CA	API Wellness provides comprehensive and integrated services for LGBTQ and people of color that includes medical, mental health, educational, and social justice components. Its TRANS: THRIVE is a drop-in center for transgender individuals to engage in daily activities, which includes a biweekly group dedicated to transmasculine people.
Asian Counseling and Referral Service (ACRS) www.acrs.org	Seattle, WA	ACRS provides a comprehensive, multicultural, and multilingual set of services for various AA populations. Services include medical care, mental health counseling, employment and training support, civic engagement, and recreational activities. Its Southeast Asian Youth Men's Group particularly focuses on boys from immigrant or refugee families of Cambodian, Cham, Filipino, Hmong, Lao, Khmu, Mien, or Vietnamese heritage. The program supports this group of young men by improving their academics, familial relationships, peer relationships, vocational plans, and various mental health aspects.
Asian Pacific AIDS Intervention Team (APAIT) www.apaitonline.org	Los Angeles, CA	APAIT aims to improve the lives of medically underserved communities living with or at risk for HIV/AIDS or other health disparities by providing multiculturally competent services in Southern California. It offers two support groups for LGBTQ API and Latinx men. VIBE provides a space for LGBTQ API and Latinx men to become aware of HIV and available resources for prevention, along with other social support. VIBE+ provides a space for LGBTQ API and Latinx men who are HIV+ to gather and find social support.
Chinatown Service Center www.cscla.org	Los Angeles, CA	Chinatown Service Center provides economic assistance, medical/ dental/behavioral services, and social support to all age groups in the local and greater community. The Men's Health Care program specifically targets prostate cancer education and screening.

Organization Name	City, State	Description of Services
Desis Rising up and Moving (DRUM)	New York, NY	DRUM's mission is to build the power of South Asian low wage immigrant workers, youth, and families in New York City to win economic and educational justice, and civil and immigrant rights. DRUM hosts an annual summer leadership program for young men and women, as well as "liberation caucus" support groups based on gender. These liberation caucuses focus on personal and emotional development, relationship building, and communication skills. The organization hosts one young men's liberation caucus group which comprise 6-12 members at any given time and meet monthly to discuss issues related to young South Asian men.
Richardson Ocean Center Educational Curriculum Project	Hilo, HI	Supported by the City and County of Hilo, HI, the program focuses on boys and young men in Hilo. The instructor involves the boys in a hands-on ocean experience where they learn to be the crew for the voyage, share the work and responsibilities and experience many valuable lessons in life through the voyage. The program has been effective in decreasing substance use symptoms and helping men develop a new direction for their lives.
Waianae Men in Recovery	Waianae, HI	The support group was created in 2000 for boys and men on Oahu, especially for those returning to the community from incarceration. The group holds an Annual Waianae Men and Keiki (children) Camp Out on the beach in Waianae in September. In the past, the group also participated in a statewide celebration of recovery from substance use called "Hands Across the State" as part of National Recovery Month. Waianae Men in Recovery made the members feel they were not alone and helped them deal with the stigma of being in recovery. Waianae Men in Recovery helped the members move on with their lives and overcome the challenges and barriers they faced.

Conclusions and Next Steps

Based on expert panel discussions, key informant interviews and research reviews, this brief highlighted seven strategies critical to service provision and four strategies to consider in policy and practice development addressing behavioral health for AANHPI boys and men. Providing effective services for AANHPI boys and men requires bringing together cultural, ethnic, racial and gender-specific knowledge and practice to an understanding of behavioral health. It draws upon and requires integrating clinical, service, system and social justice perspectives and interventions. In this sense, it is not easy work. This brief has provided some guideposts for this work and a compilation of programs that have demonstrated effective and innovative work with this population. Much works remains to implement these strategies and to continue to garner support to serve and strive for behavioral health equity and wellness for the underserved population of AANHPI boys and men. As this brief clearly indicates, it is not that we don't know what works, rather it is knowing how best to move what we know works into practice and policy.

ACKNOWLEDGMENTS

This document was prepared by Kevin L. Nadal, Ph.D. (President of the Asian American Psychological Association) with the assistance of Ford Kuramoto, DSW (Executive Director of Okura Mental Health Leadership Services) and Patrick Lin, Ed.M. (Research Assistant). We also would like to acknowledge the Expert Panel members and Key Informants who provided their time and expertise for shaping this brief: Ana Liza Caballes, Deputy Director of Desis Rising Up and Moving (DRUM; New York, NY); Keola Chan, Executive Director, Aha Kane (Honolulu, HI); E. J. R. David, Ph.D., Associate Professor of Psychology at University of Alaska at Anchorage (Anchorage, AK); Gregory Desierto, Psy.D., Outpatient Clinical Psychotherapist, West Coast Children's Clinic (Oakland, CA); Helen Hsu, Clinical Supervisor/Department Manager of Youth and Family Services for Human Services (Fremont, CA); Saima Hussein, Deputy Director, South Asian Network (Artesia, CA); Chai Jindasurat, Former National Coalition of Anti-Violence Programs Coordinator of New York City Anti-Violence Project (New York, NY); Francis Lu, M.D., Professor Emeritus of UC Davis, Department of Psychiatry and Behavioral Sciences (Davis, CA); Bill Mousser, MA, Director, Clinical Services, Hina Mauka Drug Treatment Program (Honolulu, HI); Alan Shinn, MSW, Executive Director of Coalition for A Drug- Free Hawai'i (Hilo, HI); Antony Stephen, Ph.D., President/Chair, New Jersey Asian American Association for Human Services (Belleville, NJ); and Mike Watanabe, MSW, Executive Director, Asian American Drug Abuse Program (Los Angeles, CA)

This publication was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by A-G Associates, Inc. under contract number HHSS2832012000731/HHSS28342001T, with SAMHSA, U.S. Department of Health and Human Services (HHS). Larke Huang, Ph.D., and Roslyn Holliday Moore, M.S., served as the Government Task Leaders.

DISCLAIMER

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS.

Non-federal resources are included in this publication as additional information for readers and do not constitute an indirect or direct endorsement by the Substance Abuse and Mental Health Services Administration or the U.S. Department of Health and Human Services of any non-federal entity's products, services, or policies.

PUBLIC DOMAIN NOTICE

HHS Publication No. (SMA) 17-5032

NON-DISCRIMINATION NOTICE

SAMHSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SAMHSA cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

REFERENCES

[1] Pew Research Center (2015). Modern Immigration Wave Brings 59 Million to U.S., Driving Population Growth and Change Through 2065: Views of Immigration's Impact on U.S. Society Mixed. Author: Washington, D.C.

[2] Substance Abuse and Mental Health Services Administration, A Snapshot of Behavioral Health Issues for Asian American/Native Hawaiian/Pacific Islander Boys and Men: Jumpstarting an Overdue Conversation. HHS Publication No. (SMA) 16-4959. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[3] Allen, G. K., Kim, B. S., Smith, T. B., & Hafoka, O. (2015). Counseling attitudes and stigma among Polynesian Americans. *The Counseling Psychologist*, 44, 6-27.

[4] Iwamoto, D. K., & Kaya, A. (2016). In. Y. J. Wong, & S. R. Wester, S. R. (Eds.). *APA handbook of men and masculinities* (pp. 285- 297). Washington DC: American Psychological Association.

[5] Lu, A., & Wong, Y. J. (2013). Stressful experiences of masculinity among US-born and immigrant Asian American men. *Gender & Society*, *27*, 345-371.

[6] Liu, W. M., & Iwamoto, D. K. (2007). Conformity to masculine norms, Asian values, coping strategies, peer group influences and substance use among Asian American men. *Psychology of Men & Masculinity*, *8*, 25-39.

[7] Chang, T., & Wong, R. P. (2010). Using the internet to provide support, psychoeducation, and self-help to Asian American men. In W. M. Liu, D. K. Iwamoto, & M. H. Chae (Eds.) *Culturally responsive counseling with Asian American men* (pp. 259-278). New York, NY: Routledge.

[8] U.S. Department of Education (2016). *Asian American and Pacific Islander Bullying Prevention Task Force Report 2014–2016.* Authors: Washington DC. Retrieved from http://sites.ed.gov/aapi/files/2015/02/AAPI-Bullying-Prevention-Task-Force-Report-2014-2016.pdf

[9] Gee, G. C., Delva, J., & Takeuchi, D. T. (2007). Relationships between self-reported unfair treatment and prescription medication use, illicit drug use, and alcohol dependence among Filipino Americans. *American Journal of Public Health*, *97*, 933-940.

[10] Nadal, K. L., Wong, Y., Sriken, J., Griffin, K., & Fujii-Doe, W. (2015). Racial Microaggressions and Asian Americans: An Exploratory Study on Within-Group Differences and Mental Health. *Asian American Journal of Psychology, 6*, 136-144.

[11] Forrest-Bank, S. S., & Jenson, J. M. (2015). The relationship among childhood risk and protective factors, racial microaggression and ethnic identity, and academic self-efficacy and antisocial behavior in young adulthood. *Children and youth services review*, *50*, 64-74.

[12] Juang, L. P., Qin, D. B., & Park, I. J. (2013). Deconstructing the myth of the "tiger mother": An introduction to the special issue on tiger parenting, Asian-heritage families, and child/adolescent well-being. *Asian American Journal of Psychology*, *4*, 1.

[13] Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., Appel, H., Nicdao, E., & Alegría, M. (2007). Use of mental health-related services among immigrant and US-born Asian Americans: results from the National Latino and Asian American Study. *American Journal of Public Health*, *97*, 91-98.

[14] Tummala-Nara, P., Inman, A., & Ettigi, S. (2011). Asian Indians' responses to discrimination: A mixed-method examination of identity, coping, and self-esteem. *Asian American Journal of Psychology, 2,* 205-218.

[15] Wu, L. T., & Blazer, D. G. (2015). Substance use disorders and co-morbidities among Asian Americans and Native Hawaiians/Pacific Islanders. *Psychological medicine*, *45*, 481-494.

[16] Hezel, F. X. (2001). *The New Shape of Old Island Cultures: A Half Century of Social Change in Micronesia.* Manoa, HI: University of Hawaii Press.

[17] Jordan, A., & Bhandari, S. (2016). Lived experiences of South Asian women facing domestic violence in the United States. *Journal of Ethnic & Cultural Diversity in Social Work: Innovation in Theory, Research & Practice, 25,* 227-246.

[18] Nadal, K. L. (2011). *Filipino American psychology: A Handbook of theory, research, and clinical practice.* New York: John Wiley & Sons, Inc.

[19] Chung, Y. B., & Singh, A. A. (2009). Lesbian, gay, bisexual, and transgender Asian Americans. *Asian American psychology: Current perspectives* (pp. 233-246). New York: Taylor and Francis.

[20] Drummond, M. J. (2005). Asian gay men's bodies. *The Journal of Men's Studies*, *13*, 291-300.

[21] Tran, A., Lin, L., Nehl, E. J., Talley, C. L., Dunkle, K. L., & Wong, F. Y. (2014). Prevalence of substance use and intimate partner violence in a sample of A/PI MSM. *Journal of interpersonal violence, 29,* 2054–2067.

[22] Nghe, L. T., Mahalik, J. R., & Lowe, S. M. (2003). Examining Traditional Gender Roles, the Refugee Experience. *Journal of Multicultural Counseling and Development*, *31*, 245-261.

[23] Sentell, T., Unick, G. J. Ahn, H. J., Braun, K. L., Miyamura, J., Shumway, M. (2013). Illness severity and psychiatric hospitalization rates among Asian Americans and Pacific Islanders. *Psychiatric Services, 64*,1095-1102.

[24] Wu, L. T., Blazer, D. G., Gersing, K. R., Burchett, B., Swartz, M. S., Mannelli, P., & Workgroup, N. A. (2013). Comorbid substance use disorders with other Axis I and II mental disorders among treatment-seeking Asian Americans, Native Hawaiians/Pacific Islanders, and mixed-race people. *Journal of psychiatric research*, *47*, 1940-1948.

[25] Park, S. Y., Anastas, J., Shibusawa, T., & Nguyen, D. (2014). The impact of acculturation and acculturative stress on alcohol use across Asian immigrant subgroups. *Substance use & misuse*, *49*, 922-931.

[26] Lee, R. M., Jung, K. R., Su, J. C., Tran, A. G., & Bahrassa, N. F. (2009). The family life and adjustment of Hmong American sons and daughters. *Sex Roles*, *60*, 549-558.

[27] Ran, M. S., Mendez, A. J., Leng, L. L., Bansil, B., Reyes, N., Cordero, G., ... & Tang, M. (2016). Predictors of Mental Health Among College Students in Guam: Implications for Counseling. *Journal of Counseling & Development*, *94*, 344-355.

[28] Ta, V. M., & Chen, T. (2008). Substance abuse among native Hawaiian women in the United States: a review of current literature and recommendations for future research. *Journal of psychoactive drugs*, *40*, 411-422.

[29] Anyon, Y., Ong, S. L., & Whitaker, K. (2014). School-based mental health prevention for Asian American adolescents: Risk behaviors, protective factors, and service use. *Asian American Journal of Psychology*, *5*, 134-144.

[30] Hall, G.C.N., Hong J.J., Zane, N.W., & Meyer, O.L. (2011). Culturally-competent treatments for Asian Americans: The relevance of mindfulness and acceptance-based therapies. *Clinical Psychology: Science and Practice, 18,* 215-231.

[31] Tamasese, K., Peteru, C., Waldegrave, C., & Bush, A. (2005). Ole Taeao Afua, the new morning: a qualitative investigation into Samoan perspectives on mental health and culturally appropriate services. *Australian and New Zealand Journal of Psychiatry*, *39*, 300-309.

[32] Kim, S. S., Kwon, M. S., Klessig, Y. C., & Ziedonis, D. (2008). Adapting tobacco dependence group therapy treatment for Korean Americans: a case report of pilot treatment program. *Journal of Groups in Addiction & Recovery*, *3*(1-2), 93-108.

[33] Wu, D., Ma, G. X., Zhou, K., Zhou, D., Liu, A., & Poon, A. N. (2009). The effect of a culturally tailored smoking cessation for Chinese American smokers. *Nicotine & Tobacco Research*, *11*, 1448–1457.