IPP name: Korean Community Services (KCS)

CDEP name: Integrated Care Coordinators Project

Priority population: Asian & Pacific Islander

Local evaluation time period: August 15, 2018 – June 30, 2021

This report was made possible by the support of the California Department of Public Health - Office of Health Equity, through a California Reducing Disparities Project Phase 2 grant funded by the Mental Health Services Act (MHSA)

Table of Contents

Executive Summary

More than half (51%) of all Asians with a perceived need for mental health services experienced unmet need for mental health care in California in pooled data from California Health Interview Survey (CHIS), 2015-2019. Experiencing unmet need is even higher than the average for Korean and Vietnamese adults at 52% and 61%, respectively. More than two-thirds (68%) of all Asian adults with serious or moderate psychological distress experienced unmet need for mental health including three-quarters (75%) of Korean adults and more than three-quarters (78%) of Vietnamese adults, indicating the highest unmet needs among all Asian adults examined (Tse et al., 2021).

To address the ethnic/racial disparities in mental health care, Korean Community Services (KCS), in partnership with Southland Integrated Services ("Southland"), implemented a Community-Defined Evidence Practice (CDEP) of "Community Health Workers" (CHWs) that offered bilingual and bicultural "Integrated Care Coordinators" (ICCs). The CDEP employed ICCs with cultural and linguistic competence to address specific needs of Koreans and Vietnamese, two of the largest API communities within California, in navigating an integrated healthcare system. The Integrated Care Coordinators (ICC) project aimed to prevent or reduce trauma, anxiety, and depression among urban immigrants of Korean and Vietnamese ethnicities by decreasing self and social mental health stigma, strengthening cultural/spiritual/community protective factors, and increasing access/utilization of mental health services.

The ICC CDEP is a prevention and early intervention program for Korean and Vietnamese immigrants living in Orange County that includes three components: 1) Information and Referral; 2) Linkages and Follow-Up; and 3) Ongoing Integrated Care. Throughout the implementation of these components, the ICC project infused community-grounded core values and cultural elements that included: a) a "no wrong door" approach to needs assessment and linkages to services, b) a "whatever it takes" approach for types of assistance provided to support clients in accessing services, c) a "warm hand-off" to qualified providers to prevent clients from falling through the cracks, and d) "noon-chi" or a culturally-grounded relational focus as a form of emotional support, to ensure cultural and linguistic sensitivity.

This CDEP program was delivered by ICCs and the program manager with strong, trusted relationships with local Korean or Vietnamese communities. All ICCs were trained through the *promotoras* (community health worker) model with additional attention to cultural context that includes awareness and knowledge of heterogeneity within target ethnic groups, i.e., gender, age, religious affiliation, and sexual orientation. Moreover, ICCs were knowledgeable about the broad mental health system of delivery and vast network of resources in the mainstream communities in Orange County so that they were well prepared to make external linkages for their clients and advocate for necessary services.

The Ongoing Integrated Care program (core component #3) was the focus of the local evaluation using a mixed-methods approach. During the project period, 163 Korean and 107 Vietnamese clients completed the survey at KCS and Southland, respectively. The local evaluation was designed to explore program effectiveness by examining the extent to which participants

experienced changes in psychological, work/school, family, and social domains of psychological distress and functioning scores. The evaluation also included an assessment of satisfaction from participant perspectives and examined if the program was implemented as designed. The evaluation used a non-experimental pre- and post-test design for the quantitative component and an action research approach for the qualitative data.

The results showed statistically significant decreases in both psychological distress and functional impairment scores in Korean clients. Similarly, there were slight decreases in psychological distress and functional impairment scores in Vietnamese clients, but the changes were not statistically significant. Both sets of clients reported high satisfaction scores and very high general satisfaction ratings in both quantitative and qualitative data. The results also showed improvements in the clients' ability to deal with daily problems, to perform better at school and work, and to not allow symptoms and problems to bother them as much.

Utilizing a culturally sensitive framework and strategies, the Integrated Care Coordinators project contributed to the reduction of mental health disparities for Korean and Vietnamese communities. Services delivered by culturally and linguistically competent care providers improved access and removed the barriers to mental health service utilization, as well as reduced mental health stigma. Cultural and linguistic concordance as well as understanding the community and cultural aspects of noon-chi may have positively influenced the outcomes.

Despite its limitations such as the relatively small sample size and potential sampling bias, the findings of the ICC program evaluation can inform the planning and implementation of community-defined evidence projects in the future. Moreover, the action research approach is strongly recommended to enhance the practice and to investigate the effects of the actions taken. Finally, focusing on process outcomes and sharing the results of initial data analysis can help improve the community-defined evidence program, allowing for program refinements and improvements.

Introduction/Literature Review

The practice of '*promotoras*' or Community Health Workers (CHW) has been recognized as an effective community-defined intervention that contributes to the reduction of ongoing disparities in health equity in settings which require cultural and linguistic competence (Stacciarini et al., 2012). The role of the CHW is even more critical in the context of the current healthcare trend towards integrated care (SAMHSA, 2012). In California, leaders from primary care, mental health and substance abuse have been coming together to develop a model which addresses the integrated care of the whole person (California Institute for Behavioral Health Solutions, 2015). With multiple systems and modes of health care delivery, underserved populations are more than ever in need of a trusted community-based 'navigator' who can assist in finding the right levels of care. The Phase 1 work of the California Reducing Disparities Project (CRDP) identified gaping disparities (CRDP API Report, 2012) in individualized healthcare settings and these disparities are amplified in fragmented healthcare settings with the complex interaction of multiple systems of care. Integrated behavioral health care, a part of "whole-person care," is a rapidly emerging shift in the practice of high-quality health care. Integrated behavioral health care blends care in one setting for medical conditions and related behavioral health factors that affect health and well-being. Providers practicing integrated behavioral health care recognize that both medical and behavioral health factors are important parts of a person's overall health. The advantage is better coordination and communication, while working toward one set of overall health goals (AHRQ, 2021).

Utilizing the Community-Defined Evidence Practice (CDEP) of CHWs, Korean Community Services (KCS), in partnership with Southland Integrated Services ("Southland"), offered bilingual and bicultural "Integrated Care Coordinators" (ICCs) to address the ethnic/racial disparities in mental health care in Orange County. The CDEP employed ICCs with cultural and linguistic competence to address specific needs of Koreans and Vietnamese, two of the largest API communities within California, in navigating an integrated healthcare system. Both KCS and Southland are ideal settings as each agency has well-established primary healthcare clinics alongside a diverse spectrum of behavioral health and social services.

In the 2013 CRDP API Report ("Report"), 34% of the participating Korean-Americans, over the age of 60, were assessed with probable depression with an additional 8.5% reporting suicidal ideation. However, only 6.5% had sought professional help. Seventy-one percent (71%) considered depression as a sign of personal weakness and 14% stated mental illness would bring shame to the family. Similarly, compared to the state average of 5%, elderly Vietnamese reported 7% in mental disability. In addition, Vietnamese participants reported a higher frequency of mental distress than other API subgroups (CRDP Report, 2013).

In analyses of 2015-2019 California Health Interview Survey (CHIS) data (Tse et al., 2021), more than half (51%) of all Asians with a perceived need for mental health services experienced an unmet need for mental health care. The proportions experiencing unmet need for Korean adults and Vietnamese adults were 52% and 61% respectively. More than two-thirds (68%) of all Asian adults with serious or moderate psychological distress experienced an unmet need for mental health including three-quarters (75%) of Korean adults and more than three-quarters

(78%) of Vietnamese adults, indicating the highest unmet needs among all Asian adults examined (Tse et al., 2021).

To fully appreciate the needs addressed by the CDEP, a brief overview of the specific contextualization of mental health needs within the Asian worldview is in order. This worldview is particularly significant for both Korean and Vietnamese communities where there is often a deep-rooted cultural stigma associated with mental health. In contrast to the highly individualistic Western European cultures, collectivistic societies, characteristic of most API populations, value family cohesion, cooperation, solidarity and conformity (Choi & Han, 2008). In API cultures, individuals are constantly aware of how others are viewing them, leading to the concept of 'saving face' and a cultural stigma towards behavioral health services (Kramer et al., 2002). It is also important to note the strong influence of Confucianism in many Asian cultures where there is an emphasis on maintaining harmony within relationships (Park & Kim, 2008). Confucianism entails collectivistic thinking of the self ("we" vs. "me") along with more indirect forms of communication. For example, Koreans often use a communication strategy called '*noon-chi,'* which is the ability to infer the intention, desire, mood state, and attitudes of the other without having these inner states expressed explicitly to them (Park & Kim, 2008).

In light of these implicit nuances of collectivist mentality and modes of communication, mental illness remains an unspoken 'taboo' subject for many API communities (CRDP Report, 2013). In fact, there is no proper terminology of "mental health" in most API languages without a negative connotation attributed to it (CRDP Report, 2013). There is thus an increased need for cultural sensitivity and competence in dealing with these cultural nuances in an appropriate manner. ICCs who help navigate unfamiliar non-Asian systems of care will undoubtedly address some of the deep-rooted cultural stigma and need for heightened sensitivity to the cultural worldview in order to ensure accessible and culturally-responsive community services and resources for API populations.

The specific targeted populations of KCS's and Southland's CDEP are monolingual, multi-generational urban immigrants of Korean and Vietnamese ethnicities. Koreans and Vietnamese represent the top two API ethnic groups in Orange County with a population growth from 2000-2010 of 60% and 38%, respectively (AAAJ, 2014). The unique history of Korean and Vietnamese immigrants in America includes the intergenerational effects of war trauma. Both Korean and Vietnamese immigrant communities suffer from the trauma of a country divided by war and share similar cultural nuances and common post-traumatic stress disorder symptoms which require a depth of cultural and linguistic competence.

For Korean immigrants, the first influx of immigrants was tied to the Korean independence movement. Soon after Korea regained independence from the Japanese colonization, the country was again devastated by the Korean War, the outcome of which has divided the country and numerous families since 1953. After the passage of the 1965 Immigration and Nationality Act, there was an explosive growth in immigrants arriving in the United States and Los Angeles quickly hosted the largest population of Korean immigrants outside of Korea (Center for Immigration Studies, 1995). However, the 1992 Riots burned Koreatown to the ground and many Koreans began to question their place in Los Angeles (Bates, 2012). Indeed, almost 40% of total

damages from the rioting were incurred by Korean Americans (Ong & Hee, 1993). This led to a secondary migration of Korean immigrants to Orange County. The Korean community within Orange County began to grow steadily in the 1990s and has now become a primary locale of migration for new immigrants coming directly from South Korea.

For Vietnamese immigrants, the fall of Saigon led to one of the largest influxes of refugees in the history of the United States. 'Operation New Arrivals' settled in Camp Pendleton, California, where over 50,000 Vietnamese refugees came and built a 'tent city' (Tran, 2009). Geographically situated near Orange County, the birth of 'Little Saigon' took place in the city of Westminster and has now grown to be the largest ethnic enclave of Vietnamese immigrants outside of Vietnam (Orange County Register, 2015). A vast majority of Vietnamese American families have been affected by the multiple traumas wrought by war – imprisonment, torture in concentration camps – uprooting their families, fleeing by boat as they fended off pirates and braved turbulent seas, and eventually reestablishing their lives in a different country. This history is one reason why rates of mental health issues such as post-traumatic stress disorder, depression and anxiety are higher among Vietnamese Americans than other Asians, who typically immigrate for professional or familial reasons, not because of war.

Both KCS and Southland were borne out of the communities they serve. KCS started in a Korean church to respond to the influx of recent Korean Immigrants in Los Angeles and eventually moved alongside of the migration of Korean immigrants to Orange County. Similarly, Southland saw the influx of refugees coming into Orange County and initially started out as a makeshift storefront to meet the needs of refugees. Consequently, by their very nature, both Southland and KCS were supported by the communities they serve from the moment they were conceived. Indeed, both KCS and Southland were founded by trailblazing community leaders and have adapted and grown in order to meet the changing needs of the growing Korean and Vietnamese communities of Orange County.

In light of the unique history and worldview, common for many API cultures, but in particular, the Korean and Vietnamese communities, the existing issues and challenges identified by the "Report" were clearly addressed by the CDEP, with "the Integrated Care Coordinators"(ICC). The specific ways in which the ICC addressed the needs identified in the CRDP API Report are as follows:

1) The ICC addressed the lack of access to care, support for access to care and quality of care by providing a meaningful, culturally competent navigation of the systems of care by a trusted member of the community; and
2) The ICC addressed the lack of culturally appropriate services and the language barriers to care by utilizing a member of the community who was able to address the specific cultural and linguistic needs of the targeted population.

By addressing these needs, the ICC also implemented the following recommendations identified by the Report:

1) Increasing access, affordability, availability and quality of services by supporting culturally competent outreach, engagement and education to reduce stigma against mental illness and to raise awareness of mental health issues; and

2) Empowering the community by supporting capacity-building through efforts such as leadership development, technical assistance, inclusion of community participation in the decision-making process and establishment of infrastructures that maximize resources.

CDEP Purpose, Description & Implementation

CDEP Purpose

The Integrated Care Coordinators (ICC) project is a community health worker prevention and early intervention program that aims to prevent or reduce trauma, anxiety, and depression among urban immigrants of Korean and Vietnamese ethnicities in Orange County by decreasing self and social mental health stigma, strengthening cultural/spiritual/community protective factors, and increasing access/utilization of mental health services. It is designed to address the following Phase I Asian and Pacific Islander priority population strategy: a meaningful culturally competent navigation of the systems of care by a trusted member of the community as a means to increase access to mental health treatment and promote wellness.

Expected outcomes include:
1) Increased access, affordability, availability and quality of services.
2) Decreased stigmatization surrounding mental health issues.
3) Increased outreach opportunities and locations available for residents to receive support and education about mental health issues.
4) Improved health and wellness.
5) Improved spirituality.
6) Empowering the community through inclusion of community participation in the decision-making process.

CDEP Description & Implementation Process

The ICC is a prevention and early intervention program for Korean and Vietnamese immigrants that includes three components: 1) Information and Referral; 2) Linkages and Follow-Up; and 3) Ongoing Integrated Care. Throughout the implementation of these components, the ICC project infused CDEP core values/cultural elements: a) a "no wrong door" approach to needs assessment and linkages to services, b) a "whatever it takes" approach for types of assistance provided to assist clients to access services, c) a "warm hand-off" to qualified providers to prevent falling through the cracks, and d) "noon-chi" or a culturally-grounded relational focus, paying close attention to cultural and linguistic sensitivity.

Component #1: Information and Referral

For all inquiries for concrete services, whether that be by phone or walk-in, information and referral were provided. As comprehensive multiservice agencies, KCS and Southland provided a range of support in-house for community members including access to a food bank, housing information, transportation, caretaker information, free legal service, and support groups in addition to integrated health/behavioral health care. For inquiries that

needed external referral, each individual was provided with detailed information including 1) the name of the agency providing the particular service; 2) specific contact person at the agency; and 3) the best time of day to call. Each inquiry was responded to in a way that was culturally and linguistically sensitive with a personal touch. All information and referral services were provided by bilingual and bicultural staff at KCS and SIS with extensive knowledge of community resources.

Component #2: Linkages and Follow-Up

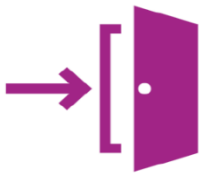
For all walk-in inquiries, an ICC utilized a brief screening tool specifically designed for the CDEP to assess the community member's need for primary care, behavioral health, or substance abuse services. Once ICCs at KCS and Southland assessed that a client was in need of primary care, behavioral health, or substance abuse services, they implemented the "warm hand-off" where a client was directly linked to a service provider to prevent falling through the cracks. Linkages involved a "whatever it takes" approach to ensure that the client was properly connected with the referral source and was indeed poised to receive services. Services included arranging transportation, providing translation, making phone calls and appointments, and providing cash assistance. Once confirmation was received that the client was receiving services, ICCs followed up within two weeks to make sure the person was connected to the appropriate agency for needed services. Ongoing follow-up also occurred to confirm that the client was not encountering barriers to services.

Component #3: Ongoing Integrated Care

ICCs assisted in the navigation of a wide spectrum of health services ranging from primary healthcare services and behavioral health services to traditional forms of Asian acupuncture and medicine. The underlying approach of this CDEP was to address the deeply rooted 'trust' issue by elevating peer specialists and trusted community members into a more active community health worker role. This approach incorporated the trust and sensitivity to cultural stigma issues which often acted as significant barriers in addressing the mental health needs of API populations. The ICC program was delivered in a client-centric model; ICCs delivered care coordination in a manner that was specifically tailored to the client's unique needs in a culturally appropriate manner. There was 'no wrong door' and program barriers within the agency were eliminated by the ICCs who were bilingual and bicultural. ICCs 1) assisted clients with navigating the integrated healthcare system and accessing services they were referred to; 2) provided ongoing peer and emotional support via weekly contacts; 3) monitored medication compliance; and 4) provided practical forms of assistance such as making arrangements for rides to appointments. As trusted community members who acted as the bridge between the Korean/Vietnamese culture and the mainstream culture within which the systems of care operated, ICCs were able to demonstrate sensitivity to the cultural/linguistic/historical experiences of the clients.

The cultural values, practices, and beliefs of priority communities are reflected in the ICC programs as follows:

a) "No wrong door" approach to needs assessment and linkages to services:



This approach clarifies that the responsibility of providing care addressing a range of health and social needs is the responsibility of the ICCs. It requires the ICCs to provide care and/or facilitate access to service delivery that falls beyond their specific focus. It removes the onus of negotiating different services and providers from the client and thereby aims to reduce the incidence of people 'falling through the cracks' of a complex service delivery system. This approach also reflects cultural understanding of the help-seeking behaviors of Asian immigrants where there is a great reluctance to seek help for mental health problems. Instead, individuals with mental problems are more likely to seek help from their primary physicians or religious leaders and consider professional mental health services as a last resort. The "no wrong door" approach embraces these cultural values and practices and offers alternative paths to mental health services without individuals' having to "lose face" in the help-seeking process.

b) "Whatever it takes" as far as types of assistance provided to assist clients to access services:

This approach reflects the holistic perspective where the client is seen as a human being with multiple needs, e.g., health, mental health, social, financial, vocational, etc. and the belief that all these needs are intertwined. In order to help the client with mental health problems, the ICC may need to first address other areas of the client's needs such as housing, legal status, and finances. By addressing these other needs, the ICC established credibility and trust, which in turn led to clients' accessing mental health services. Services may include arranging transportation, providing translation, making phone calls and appointments, and providing cash assistance.

c) "Warm hand-off" to qualified providers to prevent falling through the cracks:

Once ICCs at KCS and Southland assess that a client is in need of primary care, behavioral health, or substance abuse services, they implement the "warm hand-off" where a client is directly linked to a service provider to prevent falling through the cracks. Linkage will involve a "whatever it takes" approach to ensure that the client is properly connected with the referral source and is indeed poised to receive services. Once confirmation is received that the client is receiving services, the ICC followed up within two weeks to make sure the person was connected to the appropriate agency for needed services. Ongoing follow-up also occurred to confirm that the client was not encountering barriers to services.

d) "Noon-chi" or culturally-grounded relational focus as far as emotional support, checking in cultural and linguistic sensitivity:

"Noon-chi" is a Korean concept signifying the subtle art and ability to listen and gauge others' moods. Akin to the concept of emotional intelligence in Western culture, "**noon-chi"** is of central importance to the dynamics of interpersonal relationships. This cultural value is reflected in the ICC-client relationships where the ICC utilizes their noon-chi to respond to the client's moods and/or unspoken wishes. For example, the expectation to complete client assessments in the first few sessions, which is typical of mainstream mental health services, may be antithetical to the beliefs of the Asian immigrant communities. Instead the ICCs use noon-chi and take their time to build trusting relationships with their clients first before completing assessment forms. Being aware of the hierarchical relationships that exist in Asian culture based on age, gender, socioeconomic status, etc., the ICC gauges the client's level of discomfort in relation to ICC and addresses the matter in a sensitive and respectful manner.

The program was delivered by ICC's and the program manager with strong, trusted relationships with local Korean or Vietnamese communities. All ICCs were bilingual and bicultural, trained in the *promotoras* (community health worker) model, and received additional training in cultural competency that included awareness and knowledge of heterogeneity within target ethnic groups in terms of gender, age, religious affiliation, sexual orientation, etc. Moreover, ICCs were knowledgeable about the broad mental health system of delivery and vast network of resources in the mainstream communities so that they were well prepared to make external linkages for their clients and advocate for them for needed services. The ICC program was time-limited: The ICC program at the KCS provided a maximum of three months of services, while Southland provided one month.

Demographic Characteristics

We intended to serve mostly monolingual Korean and Vietnamese immigrant adults. According to the staff at KCS and Southland, clients at KCS and Southland are likely to have the following characteristics: Mostly non-native English-speaking cisgender heterosexual individuals with recent immigration history and varying income and education levels. While the majority of KCS clients are expected to be affiliated with Christianity (Protestant and Catholic), the majority of Southland clients are expected to be Buddhist or Catholic. KCS clients are likely to be uninsured or underinsured while the majority of Southland clients have insurance.

At KCS, 207 clients were served by Component 3 (Ongoing Integrated Care) during the project period. All clients self-identified as Korean and ranged in age from 18 to 81. About 70% of the clients were female. The majority of clients were low income, two-thirds were affiliated with Christianity, and almost all of them were cisgender heterosexual individuals. The majority of participants (71%) immigrated longer than 10 years ago, about half of them were able to speak both English and Korean, and about 60% of the participants had bachelor's degrees. These characteristics were somewhat different from the population the CDEP intended to serve.

However, these demographics reflect the need for navigation supports among broad Korean immigrant populations, not just for low-income, low educational attainment, more recently immigrated, or monolingual Koreans. In addition to 207 individuals served in Component 3 at KCS, 3,021 individuals were served in Component 1 (Information and Referral) and 1,542 individuals were served in Component 2 (Linkages and Follow up).

At Southland, 194 clients were served by Component 3 (Ongoing Integrated Care) during the project period. All clients self-identified as Vietnamese and ranged in age from 18 to 83. About 70% of the clients were female. All but one respondent had health insurance and almost all of them were cisgender heterosexual individuals. About 23% of them were able to speak both English and Vietnamese. These characteristics were somewhat similar to the population the CDEP intended to serve. In addition to 194 individuals served in Component 3 at Southland, 227 individuals were served in Component 1 (Information and Referral) and 173 individuals were served in Component 2 (Linkages and Follow up).

It is difficult to calculate overall ICC program attrition rates as this information was not consistently collected across ICC providers and sites (KCS and Southland). However, according to the service and discharge date records, several people received services only once, making it difficult to assess whether this should be considered as program dropout or termination for other reasons (e.g., needs were met with one session).

Local Evaluation Questions

There were six main questions for this evaluation as shown in Table 1 below. Data sources and key outcome measures are also listed.

Table 1.

Local Evaluation Questions and data sources

Local Evaluation Question	Data Source(s)	Key Outcomes/Measures
1. What types of ICC services were provided for participants and how many?	Internal program records (service log)	
2. To what extent are ICC participants satisfied with the ICC program?	SWE Post-test ICC program participant interviews	General satisfaction from MHSIP - 3 items Satisfaction rating – 1 item
3. How does each cultural element of the ICC program look like? What cultural element(s) of the ICC program reached clients as intended and for which clients?	SWE Post-test ICC program participant interviews ICC provider interviews	CBCCI - 11 items
4. To what extent did ICC program participants show reduction in psychological distress and functional impairment?	SWE Pre and Post-tests SWE Pre and Post-tests SWE Post-test	Kessler-6 Psychological Distress Sheehan Disability Score

		MHSIP perceived outcomes - 3 items
5. To what extent did ICC program participants strengthen spiritual wellness, and cultural and social connectedness?	SWE Pre and Post-tests	Cultural connectedness- 4 items Holistic health – 1 item Social connectedness - 2 items
6. To what extent did the ICC program increase participants' ability to navigate the integrated healthcare system?	ICC program participants interviews ICC provider interviews	MHSIP Access- 3 items

Note. CBCCI = Consumer-Based Cultural Competency Inventory. MHSIP = Mental Health Statistics Improvement Program. SWE = Statewide Evaluation. Questions 1-3 are process evaluation questions and questions 4-6 are outcome evaluation questions.

Six open-ended questions were added in the post-survey. This decision was based on our preliminary review of a small number of post-surveys completed by clients at KCS. This review demonstrated that we were able to measure changes in terms of clients' mood and functioning in various aspects of life. However, it was not clear what helped clients change (mostly for better). By adding these six short-answer questions, we wanted to identify factors directly related to clients' change. We decided to add only six essential questions in order to minimize any possible survey fatigue among the participants. Appendices A-C represent the SWE pre- and post-surveys in each language (English, Korean and Vietnamese), while Appendix D represents the qualitative interview guide.

Local Evaluation Design & Methods

Design

The local evaluation used a mixed-method design. A non-experimental pre-and post- with single-group design was used for the quantitative component, while an action research approach was used for the qualitative component of the local evaluation. The action research design fits well with the ICC program, as implementation of solutions occurs as a part of the research process without any delay. Utilizing a community-based participatory research strategy, the evaluation engaged community advisory boards of each site (KCS & Southland) throughout the evaluation process by soliciting feedback on evaluation planning, implementation, and dissemination. ICCs were also integral in discussing CDEP implementation processes and data collection experiences to inform slight adjustments to the local evaluation (data capture procedures) to strengthen the opportunity to capture outcomes data. This evaluation research was approved by Institutional Review Boards of the California Department of Public Health and California State University, Fullerton.

Sampling Methods and Size

The Ongoing Integrated Care program (core component #3) was the focus of the local evaluation. Both KCS and Southland accepted clients into the ICC program on a rolling basis. All adult clients receiving the Ongoing ICC program were invited to participate in the evaluation and those who voluntarily agreed to participate were included in the evaluation (convenience sampling).

Initially, the program aimed to collect data from 200 Korean clients and 110 Vietnamese clients. However, we were unable to meet these target numbers largely due to the impact of COVID-19: we had to pause data collection while discussing and modifying the consent process and data collection method (For details, see the data collection procedures section below). While the ICC program served 207 Korean clients, only 163 service recipients (78.7%) participated in the pre-survey. According to ICC program providers, the survey was typically completed during the second session, and some clients did not continue after the first session, therefore they were not included in the evaluation. The final matched sample size for KCS is 102 with 163 pre-surveys and 102 post-surveys (collected from August 2018 to June 2021). However, the number of analytical samples may differ in analyses below as some participants refused, skipped or did not answer one or more items. All pre- and post-surveys from KCS were conducted in Korean. The proportion of pre-surveys collected in-person before COVID pandemic was 79.75% (n=130).

As shown in Table 2 below, ICC program participants at KCS were 23.3% male and 76.7% female. Almost all participants (97.5%) were foreign-born, and on average, they have lived in the United States for 18.46 years (range: 1-44, SD = 9.99). About half of the participants responded that they speak English fluently (18.4%) or somewhat fluently (35.6%). About one-third of the participants (32.5%) indicated that they cannot speak English very well, know some vocabulary but can't speak in sentences (11%) or cannot speak at all (2.5%).

Table 2.

Sociodemographic Characteristics of KCS ICC Program Participants at Pre-survey (N = 163)

Characteristics	*n*	%
Gender		
Male	38	23.3
Female	125	76.7
Age		
18-29	20	12.3
30-39	24	14.7
40-44	19	11.7
45-49	15	9.2
50-64	73	44.8
65 or older	12	7.4

Nativity		
Inside the US	4	2.5
Outside the US	159	97.5
Length of stay in US	*M* = 18.46	*SD = 9.99*
Proficiency in English		
Fluently	30	18.4
Somewhat fluently; can make myself understood but have some problems with it	58	35.6
Not very well; know a lot of words and phrases but have difficulties communicating	53	32.5
Know some vocabulary, but can't speak in sentences	18	11
Not at all	4	2.5

For Southland, the program aimed to collect data from 110 Vietnamese clients. However, due to COVID, target numbers were not met. While the ICC program served 194 Vietnamese clients, only 107 service recipients (55.2%) participated in the pre-survey. According to the ICC staff and the service log, the low participation rate appears to be related to several factors: Several people denied the invitation to the survey due to lack of time to complete the survey; Some clients started to receive the ICC program services before the evaluation started, therefore, they were not eligible to participate in the evaluation; Others were discharged too early (less than two weeks) for ICC staff to administer the survey. The final matched sample size is 79 with 107 pre-surveys and 79 post-surveys (collected from January 2019 to June 2021). However, the number of analytical samples may differ as some participants refused, skipped or did not answer one or more items. Less than 10% of the surveys were completed in English (7 pre-surveys and 6 post-surveys). The proportion of pre-surveys collected in-person before the COVID pandemic was 53.27% (*n*=57).

As shown in Table 3 below, participants of the Southland ICC program included 31.4% male and 67.6% female. Almost all participants (91.4%) were foreign born, and on average, they have lived in the United States for 22.99 years (range: 3-51, *SD* = 11.76). About one-third of the participants responded that they either speak English fluently (16.5%) or somewhat fluently (12.6%). Another one-third of the participants (30.1%) indicated that they cannot speak English very well, know some vocabulary but can't speak in sentences (31.1%), or do not speak it at all (9.7%). The largest age group was between 50 and 64 years of age (43.4%), followed by 65 or older (27.4%).

While we were not able to run statistical analysis to see whether the final sample are representative of the total number served by ICC program component 3, we are fairly confident that survey participants at KCS and Southland are representative of the ICC program participants by the description above and comments from ICC program staff.

Table 3.

Sociodemographic Characteristics of Southland ICC Program Participants at Pre-survey (*N* = 107)

Characteristics	*n*	%
Gender		
Male	33	31.4
Female	71	67.6
Age		
18-29	9	8.5
30-39	9	8.5
40-44	5	4.7
45-49	8	7.5
50-64	46	43.4
65 or older	29	27.4
Nativity		
Inside the US	9	8.6
Outside the US	96	91.4
Length of stay in US	*M* = 22.99	*SD = 11.76*
Proficiency in English		
Fluently	17	16.5
Somewhat fluently; can make myself understood but have some problems with it	13	12.6
Not very well; know a lot of words and phrases but have difficulties communicating	31	30.1
Know some vocabulary, but can't speak in sentences	32	31.1
Not at all	10	9.7

Qualitative data collected for KCS included six individual client interviews, four group interviews with ICC staff, and one group interview with non-ICC staff from September 2018 to June 2021. For Southland, qualitative data were collected from four individual client interviews and three group interviews with ICC staff during the period between April 2019 to June 2021. Participants for individual interviews were selected among those recommended by the staff based on the following eligibility criteria: they must have completed the ICC program prior to the interview; and they should be capable of articulating their experiences with the ICC program. Additionally, some of those who initially agreed to participate in the interviews were no longer reachable or available by the time the local evaluator tried to schedule an interview. Moreover, there were service gaps and abrupt transitions due to the coronavirus pandemic with a new focus on COVID testing and vaccines, which delayed the process of referring clients for individual interviews. All these barriers resulted in a very small sample size for participants of the qualitative data collection and may also have led to potential sampling bias.

Data Collection Procedures

Quantitative Data

Both pre- and post-surveys were collected through in-person survey administration, following an in-person consent process. These processes were put in place to meet the needs of participants for language consideration and to build rapport via in-person interactions. Pre-survey was collected mostly during the first session of the ICC program, and post-survey at the end of the ICC program or as early as feasible after termination. Surveys were completed by participants in Korean, Vietnamese and English based on language preference identified by the program participant.

For KCS, self-administration was used initially for pre-survey, as most participants of the pilot study were able to answer survey items without much difficulty. During the brief review of the collected pre-surveys in early September, 2018, we found a potential problem with items about one's sexual orientation/gender identity (SOGI). SOGI questions are open-ended in the self-administered version. Two respondents answered all open-ended questions (sex at birth, gender identity, sexual orientation) as the same as their "sex at birth" (e.g., female respondent answered all questions as "female"). After a consultation with the Asian and Pacific Islander Technical Assistance Provider (API TAP), we decided to ask ICCs to explain SOGI questions to clients in order to help them understand the concepts and differences between "sex at birth," "gender identity," and "sexual orientation," using the wordings in the staff-administration version of the pre-survey. However, a continued review and feedback from the ICC staff showed that some participants still had difficulties understanding and using the self-administered pre-survey. Therefore, we decided to have the ICC staff administer the pre-survey using a staff-administered version of the survey. In total, 20.86% of the surveys were self-administered. For Southland, staff-administration methods were used for both pre- and post-surveys; Southland had a delayed intervention timeline, starting five months later than KCS.

In addition to the variation of survey administration method (self- vs. staff-administered), there were variations in survey versions for Korean participants. The initial version was used for 46 pre-surveys and 24 post-surveys, and the second version with adjusted wordings were used with the rest of the surveys. For the second version of the post-surveys, we added six open-ended questions about possible contributing factors for indicated positive outcomes in dealing with daily problems, performing in school/work, and managing symptoms/problems better. For the third version of the pre-survey, skip logic pattern designs using blue arrows or text boxes were implemented to draw attention of survey administrators and to clarify the logic patterns.

The versions of the English pre- and post-surveys led to multiple translated versions of the surveys in Korean. Fortunately, unlike the Korean survey, only one version of the Vietnamese pre- and post-surveys were used for the entire sample at Southland. The open-ended questions for the post-survey were used by Southland from the beginning of the data collection, as data collection started five months later than KCS.

Due to the COVID-19 pandemic and the “shelter in place” order for the State of California, as of March 2020, all in-person program activities and data collection for evaluation were paused for approximately three months (mid-March to early June 2020). This inability to have in-person contact between ICC staff and participants presented difficulties for data collection. Therefore, we discussed and consulted with API TAP, SWE and ICC staff and came up with modifications for data collection. According to the approved protocol, the informed consent process and data collection were conducted using mostly phone, and phone/email. The timing for administering the pre-survey was adjusted so that the pre-survey could be completed during the initial or second meeting. The amount of time for completing the survey increased from "about 20 minutes" to "about 30 to 50 minutes,” considering the use of a phone or other virtual formats. Additionally, instead of requiring a signature, survey administrators received verbal consent. KCS staff collected surveys by phone and email, whereas Southland staff collected all data via phone.

Qualitative Data

At the completion of the ICC program, selected participants were recommended for individual interviews by staff based on the client’s ability to articulate their ideas and opinions as well as their capacity for insights. The participants engaged in a semi-structured individual interview, which included questions about the presence and quality of the implementation of each core element in the ICC program as well as their overall experiences with the ICC program. Similar questions were asked in the informant interviews with ICCs to get their perspectives on implementing the CDEP. Interviews with non-ICC staff centered on the referral decision and processes, in component 1 and 2 of the CDEP. Each interview took place at KCS or Southland at a time that was convenient for the clients or the staff, and interviews lasted from 45-75 minutes. During the pandemic from March 2020 to June 2021, the interviews were conducted virtually using the Zoom platform. Individual interviews with clients were conducted in Korean or Vietnamese based on the client’s preference. None of the Korean or Vietnamese clients chose English for the interview. Group informant interviews with KCS staff were conducted in Korean while the interviews with Southland staff were done in English. All interviews except for individual interviews with Vietnamese clients were conducted by one of the co-local evaluators (Kim-Goh). Individual interviews with Vietnamese clients at Southland were conducted by a graduate-level research assistant who was bilingual and bicultural in Vietnamese. All interviews were digitally recorded with the participants’ permission, and they were later transcribed and then translated into English for analysis.

Measures

Selection of Measures

The SWE core measures were used in pre-survey (58 questions) and post-survey (43 questions) for the local evaluation not only to measure the program outcomes reliably, but also to avoid the testing burden to the participants. The providers at KCS and Southland raised such concerns, as the majority of monolingual Koreans and Vietnamese cannot complete a long survey without distress, especially when they finally come in to receive services.

After several months of data collection, we added six open-ended questions to the post-survey to collect more detailed and contextualized information about outcomes and contributing factors for any positive outcomes.

Procedures of Measure Translation

The measures in pre- and post-surveys were initially developed in English for the Statewide Evaluation and later translated into the Korean and Vietnamese languages by the ICC staff at KCS and Southland. For each language version, a second bilingual, bicultural clinician independently reviewed the initial translation comparing them with the English version. Any disagreements in translation or word choices were discussed and reconciled to create a final version for each language.

Quantitative Measures

Psychological distress was measured with the 6-item Kessler Psychological Distress Scale (K6; Kessler et al., 2002). This scale measures the frequency of general psychological distress experienced during the past 30 days (e.g., "During the last 30 days, about how often did you feel depressed?). Each item was measured on a 5-point scale ranging from *none of the time* (5) to *all of the time* (1). Items were reverse-coded with 0-4 range so that higher scores reflect higher psychological distress. The possible range of total scores was 0 -24. We also used a standard cut-off score of 13 points to identify individuals with serious psychological distress (i.e., Furukawa et al., 2003; Kessler et al., 2003; Kim et al., 2012) and score between 5 and 12 points to examine individuals with moderate psychological distress (Prochaska et al, 2012).

Modified Sheehan Disability Scale was used to assess the impact of impairment in four areas of life (CHIS, 2016). Participants were asked to think about one month, within the past 12 months, when they were at their worst emotionally and the frequency that their emotions interfered in performance at work/school, household chores, social life and relationship with family and friends. Responses ranged from *a lot* (1) to *not at all* (3). Items were reverse-coded (in 0-2 range) so that higher scores reflect higher functioning impairment. The possible range of total scores was 0-8.

Mental Health Statistics Improvement Program (MHSIP) adult consumer satisfaction survey was used to measure two domains: general satisfaction and access to services (Eisen et al., 2001). For general satisfaction with services received, participants were asked to answer the degree of agreement on the following three statements: "I like the services that I received here," "If I had other choices, I would still get services from this agency," and "I would recommend this agency to a friend or family member." For access to services, participants were asked to rate the degree of convenience of the location of services, availability of staff and frequency of access. All six items were measured on a 5-point scale ranging *strongly agree (1)* to *strongly disagree (5)*.

Nine items from the Consumer-Based Cultural Competency Inventory (CBCCI) were used to measure participants' perception of the ICC providers' cultural competence focused on valuing diversity (Cornelius et al., 2004). Two new items were added to the post-survey to capture the

providers' competence in respectful behavior and acceptance of within-group differences in terms of gender identity and/or sexual orientation. In total, 11 items were included in the post-survey with four different dimensions: respectful behaviors (5 items), understanding indigenous practices (2 items), acceptance of within-group differences (3 items) and one item of patient-provider organizational interaction.

Among eight cultural connectedness items in the SWE core measures, four items of cultural connectedness were used to capture the role of culture in maintaining and improving mental health at present time. Participants were asked to rate their agreement with the following statements: Your culture gives you strength; your culture is important to you; your culture helps you to feel good about who you are; and you feel connected to the spiritual/religious traditions of the culture you were raised in. Each item was measured on a 5-point scale ranging from *strongly agree* (1) to *strongly disagree* (5). Holistic wellness was measured using a single item, the frequency of feeling balance in mind, body, spirit and soul. Different time frames were used in the post-survey to align it with the length of each ICC program: Time frame for this question in the pre-survey was '30 days' for both KCS and Southland; the time frames in the post-survey were three months for KCS and 30 days for Southland. This item was measured on a 5-point scale ranging from *all of the time* (1) to *none of the time* (5). This item was reverse-coded so that higher scores indicate higher levels of wellness. Social connectedness was measured using two items: feeling marginalized or excluded from society and feeling isolated and excluded from society. Each item was measured on a 5-point scale ranging from *all of the time* (1) to *none of the time* (5). These items were reverse-coded so that higher scores indicate higher levels of social marginalization/isolation.

Also, the following sociodemographic variables were included in the presurvey: Gender at birth, age, nativity, length of stay in the United States, gender identity and sexual orientation.

Qualitative Questions

In the individual interviews, client satisfaction was assessed using the following questions: 1) Was the reason/concern for visiting KCS/Southland resolved to your satisfaction? 2) On a scale of 1 to 10, with 10 being the most satisfied and 1 being not satisfied at all, how would you rate your experience of the overall ICC program? 3) Can you tell me what aspect of the program was satisfying? As to each of the core cultural elements, the following questions were asked to assess its implementation and effectiveness: 1) How was this principle applied in your situation? Could you give an example? and on a scale of 1 to 10, with 10 being very much and 1 not at all, how would you rate the level of helpfulness of this principle in addressing/resolving your concern? Could you tell me why you chose that number?

For the group informant interviews with ICC staff, the following questions were asked: 1) How has each cultural element been implemented? 2) While implementing cultural elements, what challenges have you encountered? How did you respond to the challenges? 3) While implementing cultural elements, what successes have you encountered? 4) What cultural element(s) of the ICC program and to what extent did the ICC program increase participants' ability to navigate the integrated healthcare system? and 5) What cultural element(s) of the ICC

program and to what extent did the ICC program change participants' ability to deal with daily tasks and specifically to solve their primary concern for the visit?

Interviews with non-ICC staff centered on the referral decision and processes. Sample questions include the following: 1) What made you decide to refer the client to ICC? and 2) Could you describe the referral process, i.e., What happened after you contacted ICC for your clients? What were unique cultural elements that you observed during the ICC referral process, if any? What were challenges/barriers in the ICC referral process, if any?

Fidelity and Flexibility

The following Table 4 notes indicators to assess the fidelity and flexibility of the program:

Table 4.

Fidelity and Flexibility of the ICC program

Dimensions	Criteria	Measurement Tool	Protocol
Adherence	CDEP delivered as it was designed	Program documentation (case file and/or progress notes), focus group (ICC) and individual interviews (participants)	At the end of ICC program, select participants engaged in a semi-structured individual interview, which included questions about implementation of core elements. Participants were asked about the presence and quality of each core element of the ICC program. Similar questions were asked in the informant interviews with ICCs to get their perspectives on adherence.
Participant responsiveness	Participants' Satisfaction; completion of ICC program as planned without dropping out of service	Satisfaction (SWE core measure), Individual interviews (participants), Program documentation (case file and/or progress notes)	Participants' satisfaction of the ICC program was measured using SWE core measures at post-survey. At the end of ICC program, select participants engaged in a semi-structured individual interview, which included questions about their experiences with the ICC program. At the end of ICC program, the relevant program documents will be reviewed by evaluation team to explore reasons for termination/completion of the program.

Data Analyses

Quantitative Data Analysis

For descriptive analyses, frequency, percentage, and/or mean and standard deviation were calculated for each variable and measures for all participants. To compare pre- and post-surveys, dependent t-test (paired sample t-test) was used to compare the means of two repeated measures of the same participants at different time points (pre-survey and post-survey) of psychological distress and functional impairment among participants with matched data. SPSS version 27 was used to conduct both descriptive and inferential analyses.

Qualitative Data Analysis

Text transcribed from the recorded interviews served as the data for the qualitative analysis with a general inductive approach. Data analysis involved a thorough review of all transcripts by the local evaluators to gain an overarching familiarity with the entire body of data. Data was analyzed using coding consensus, co-occurrence, and comparison (Willms et al., 1990). Transcripts were independently coded based on the interview questions and emergent themes. Triangulation was used to check and establish validity in the qualitative data. In-depth interviews were conducted with a group of stakeholders such as clients, ICC staff, and non-ICC staff to gain insight on what the stakeholders perceive as outcomes of the program. We then triangulated by looking for outcomes that were agreed upon by all stakeholder groups.

Results

Results are presented separately for KCS and Southland as data from the two sites were collected and analyzed separately. Although there were some shared cultural values and norms across clients at KCS and Southland, each agency served clients with unique ethnic/cultural backgrounds and needs and allowed differing length of services (maximum three months for KCS and approximately one month for Southland).

KCS

Evaluation Question 1: What types of ICC services were provided for participants and how many?

About half of the ICC program participants received counseling services (n=80, 49.08%): 42 participants received primary care, nine acupuncture, six chiropractic services, and six dental services. About 16% (n=26) of the participants used more than one service.

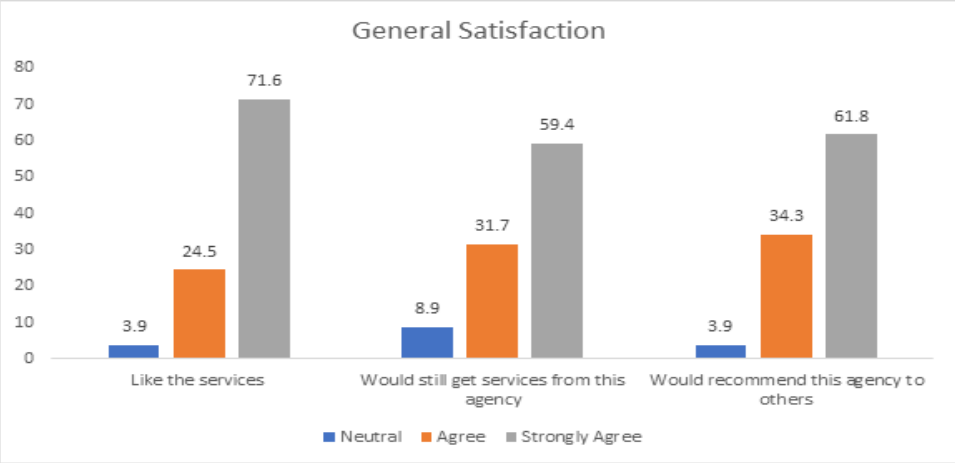
Evaluation Question 2: To what extent are ICC participants satisfied with the ICC program?

As shown in Figure 1, the vast majority of participants reported general satisfaction with services they received from the ICC program. About 96% of respondents positively indicated that they liked the services that they received. Over 90% of respondents positively indicated that they

would still get services here if they had other choices; and 96% of participants would recommend KCS to a friend or family member.

Figure 1.

General Satisfaction with Services Received



All client participants who were interviewed expressed high satisfaction with the ICC program, providing satisfaction scores of 9 or 10, with 10 being the most satisfied. One participant explained that he gave a rating of 9 because the services were shifted to tele-health due to the pandemic and that he would have preferred in-person services. Another participant said the program duration was too short and that was the reason for giving a score of 9 instead of 10. Participants appreciated the integrated care model, i.e., receiving counseling and case management services as well as medical care on site. They pointed out that appointments were easy to set up with the help of staff and they felt listened to by their providers. The participants also explained how the program providers paid close attention to symptoms; therefore, "that was how everyone received high quality treatment." The participants' overall satisfaction was reflected in the following quotes:

"My son's problems are still there but I learned how to respond to his problems. I learned how to interact with my son better. I was even advised to receive legal protection if necessary."

"Through counseling, I learned to love myself and to take care of myself, something I didn't know before."

Evaluation Question 3: How does each cultural element of the ICC program look like? What cultural element(s) of the ICC program reached clients as intended and for which clients?

For 11 items asking about cultural competency of the staff (See Table 5), 97.6% of participants positively indicated that the staff treated them with respect in general and in regards to other

aspects of diversity, such as race and/or ethnicity, religious and/or spiritual beliefs, gender identify and/or sexual orientation, and cultural health-related beliefs. Participants strongly agreed or agreed that ICC providers understand their indigenous practices, and that staff were aware of within-group heterogeneity (e.g., "Staff here understand that people of my racial and/or ethnic group are not all alike"). Also, almost all participants (98%) strongly agreed or agreed that it was easy to talk to the staff when they first contacted the staff. These results show some evidence that ICC providers' beliefs and attitudes of culturally competent practice are apparent in the participants' perception of services.

Table 5.

Cultural Competency of ICC Providers

	Strongly Agree	Agree	Neutral
Respectful Behaviors			
The staff here treat me with respect	77 (76.2)	23 (22.8)	1(1.0)
The staff here don't think less of me because of the way I talk	79 (78.2)	21 (20.8)	1(1.0)
The staff here respect my race and/or ethnicity	80 (80.8)	19 (19.2)	
The staff here respect my religious and/or spiritual beliefs	75 (75.0)	25 (25.0)	
The staff here respect my gender identity and/or sexual orientation	62 (73.8)	20 (23.8)	2 (2.4)
Understanding Indigenous Practices			
Staff are willing to be flexible and provide alternative approaches or services to meet my needs	77 (76.2)	23(22.8)	1(1.0)
The people who work here respect my cultural beliefs, remedies, and healing practices	69 (70.4)	29 (29.6)	
Acceptance of Within-group differences			
Staff here understand that people of my racial and/or ethnic group are not all alike	69 (70.4)	29 (29.6)	
Staff here understand that people of my gender and/or sexual orientation group are not all alike	62 (70.5)	24 (27.3)	2 (2.3)
Staff here understand that people of my religious and spiritual background are not alike	67 (71.3)	25 (26.6)	2 (2.1)
Patient-Provider-Organizational Interaction			
When I first called or came here, it was easy to talk to the staff	70 (70.0)	28 (28.0)	2 (2.0)

Note. Numbers in the column shows frequency (percentage). "Disagree" and "Strongly Disagree" categories were omitted from this table due to no responses.

No wrong door. This approach also reflects a cultural understanding of the help-seeking behaviors of Asian immigrants, where there is great reluctance to seek help for mental health problems. Instead, individuals with mental health problems are more likely to seek help from their primary physicians or religious leaders and consider professional mental health services as a last resort. The "no wrong door" approach embraces these cultural values and practices, and offers alternative paths to mental health services without individuals' having to "lose face" in the help-seeking process.

For example, a middle-aged couple initially came for counseling because of their son's drug use. Through the ICC program, they applied for Medi-Cal for their son, and now the son is receiving medical services from KCS.

Another female client stated, *"I don't have any health insurance. I was receiving medical services from KCS at first because of high blood pressure… And then I saw that they were providing a counseling service, so that's how I started counseling."*

Whatever it takes. This approach reflects the holistic perspective where the client is seen as a human being with multiple needs, e.g., health, mental health, social, financial, vocational, etc. and the belief that all these needs are intertwined. In order to help the client with mental health problems, the ICC may need to first address other areas of the client's needs such as housing, legal status, and finances. By addressing these other needs, the ICC established credibility and trust, that in turn led to clients' accessing mental health services. Services may include arranging transportation, providing translation, making phone calls and appointments and providing cash assistance. The following examples illustrate how this principle was applied in the ICC program shared by ICC staff and the client participants.

A husband brought in his wife to KCS Health Clinic for post-stroke treatment. Although his wife was the primary patient, the husband was referred to the ICC program for counseling and support that he needed as a caregiver. Eventually his children were also included in the program.

One client was on the verge of eviction. ICC helped this client register for housing, foodbank, and Medi-Cal. Once their basic needs were met, they began to reflect on themselves and their lives.

Warm hand offs. This principle refers to where a client is directly linked to a service provider to prevent falling through the cracks. Linkage will involve a "whatever it takes" approach to ensure that the client is properly connected with the referral source and is indeed poised to receive services.

For example, ICC staff provided information, made a referral, helped make appointments, and followed up. ICC connected clients to acupuncture or even to dental treatment. Additionally, ICC program followed their patients' transfers closely to ensure the patient was able to receive additional services outside of the ICC program.

"Noon-chi." This is a Korean concept signifying the subtle art and ability to listen and gauge others' moods. Akin to the concept of emotional intelligence in Western culture, "noon-chi" is of central importance to the dynamics of interpersonal relationships. This cultural value is reflected in the ICC-client relationships where the ICC utilizes her noon-chi to respond to the client's moods and/or unspoken wishes. The concept of "noon-chi" reflects culturally-grounded relationships and its application is related to cultural and linguistic sensitivity. The following quotes represent select examples shared by participants:

"The staff told me that my son smelled like marijuana. We had no idea before, and we didn't believe it. We never thought my son would do that but we began to think that it might be a possibility… Using Noon-chi, the staff didn't say he was smoking. Instead she said he smelled like marijuana."

*"[One of the staff]at KCS [belongs to the same organization]as I. I was concerned about other people finding out that I was getting services from here. IPP staff asked me whether I knew her, and I told her yes. Right away my [organization]member approached me and told me not to worry. She assured me of confidentiality even before I brought it up."(*We replaced specific terms with vaguer descriptors to keep the anonymity of the participants. The replacement of identifying details in the text was indicated using the text with [brackets]).

"Both of us being Korean, the counselor and I were able to empathize with each other. We are both mothers. There was shared understanding. Given that I am in my mid 60's, my communication with my son tends to be one-way, curt, and just giving him an order, and not much of listening. So in the initial counseling session, the counselor focused on parent-child communication, different ways of communicating with children. That was the most challenging thing."

ICC staff also shared their understanding of "noon-chi" as follows:

"People are reluctant to reveal their undocumented status. Using noon-chi, I let people know there are services available in case they need them."

"In cases of financial or emotional abuse, the elderly is reluctant to share. When their son has alcohol or gambling problems, they don't want others to know about that. We just let them know the resources are there regardless of legal status."

"In Korean culture even if people need help, they would deny or decline the help at first. Using Noon-chi, ICC staff approach potential clients cautiously and assess their readiness for services. Some will flatly refuse or deny that they need any help but there are others who cautiously open up and feel relieved that someone approached them first before they had to seek help. That way, ICC staff are 'saving' the client's 'face'".

"In Korean culture, there used to be a lot of stigma around mental health. But during the COVID, people were a lot more receptive and open to receiving mental health services. People began to think that there was nothing wrong with getting mental health services. They either

came voluntarily or were referred by others but they were more willing to receive treatments for mental health problems. They no longer think that it is abnormal to get counseling. Just today, I got a phone call from a Korean man who wanted to come for counseling to prevent his suicidal ideations. I think more and more people are making decisions for themselves rather than caring too much about what others think (남의 눈치 안봄*) – silver lining of COVID"*

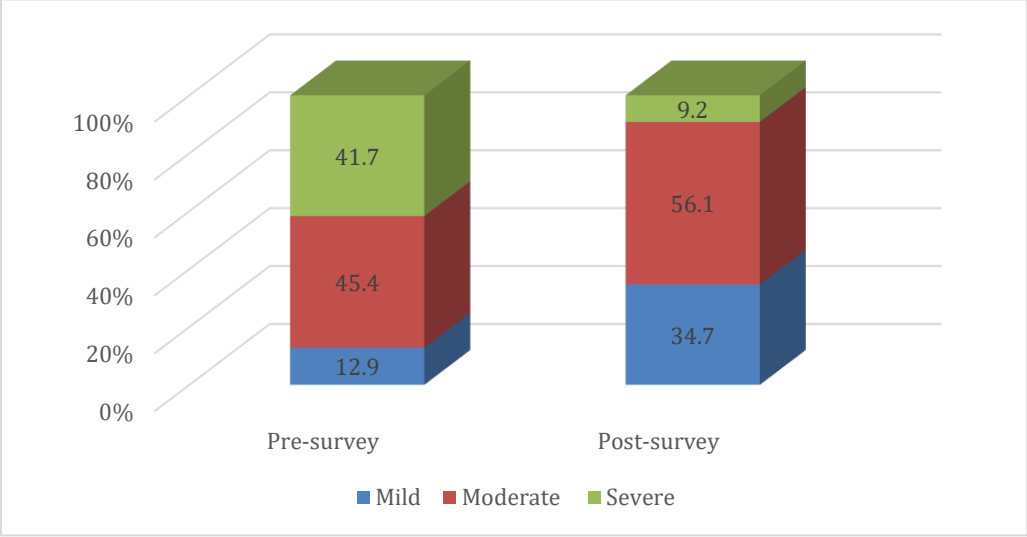
"People are giving some of the clients "noon-chi" and encouraging them to seek help for mental health issues. Noon-chi = pressure. For example, a mother-in-law calls the agency and says her daughter-in-law needs treatment, giving "noon-chi" to the daughter-in-law."(알게 모르게 주는 압력*)*

Evaluation Question 4: To what extent did ICC program participants show reduction in psychological distress and functional impairment?

Psychological Distress. We examined psychological distress in two ways, using the cut-off points (descriptive) and the total scores (inferential). When the cut-off points were applied, the proportion of participants who met the criteria for past-month psychological distress decreased tremendously after participating in the ICC program: While 41.7% of participants met past-month serious psychological distress at pre-survey, only 9.2% of participants met the same category at post-survey (See Figure 2).

Figure 2.

Levels of Psychological Distress Among KCS ICC participants

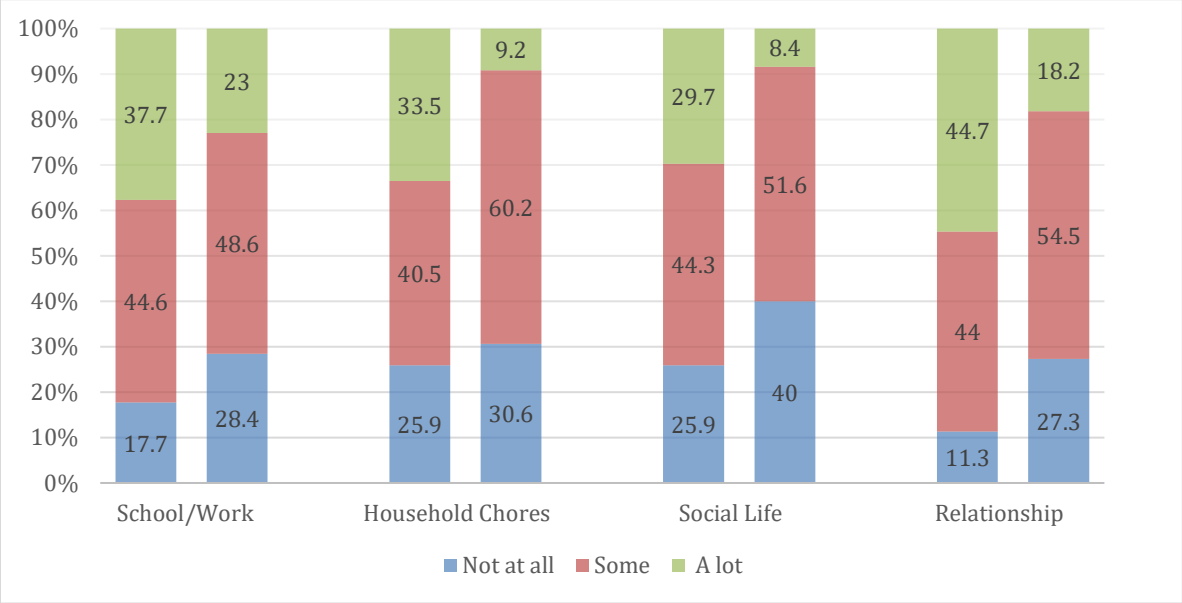


The second examination using the total scores and t-test showed the same result: On average, psychological distress scores of participants were significantly decreased at post-survey (M = 7.00, SD = 4.38) than at pre-survey (M =11.10, SD = 5.50). This improvement in score by 4.1 points was statistically significant, t (97) = 6.98, p < .001.

Functional Impairment. Figure 3 shows the proportion of the frequency of functional impairment on each of four life domains. It is clear that the proportion of "A Lot" (in green) has decreased from pre-survey (left column) to post-survey (right column) for all four domains.

Figure 3.

Functional Impairment on Four Life Domains Among KCS ICC Participants



Note. Pre-survey result is displayed on the left and the post-survey result on the right for each life domain.

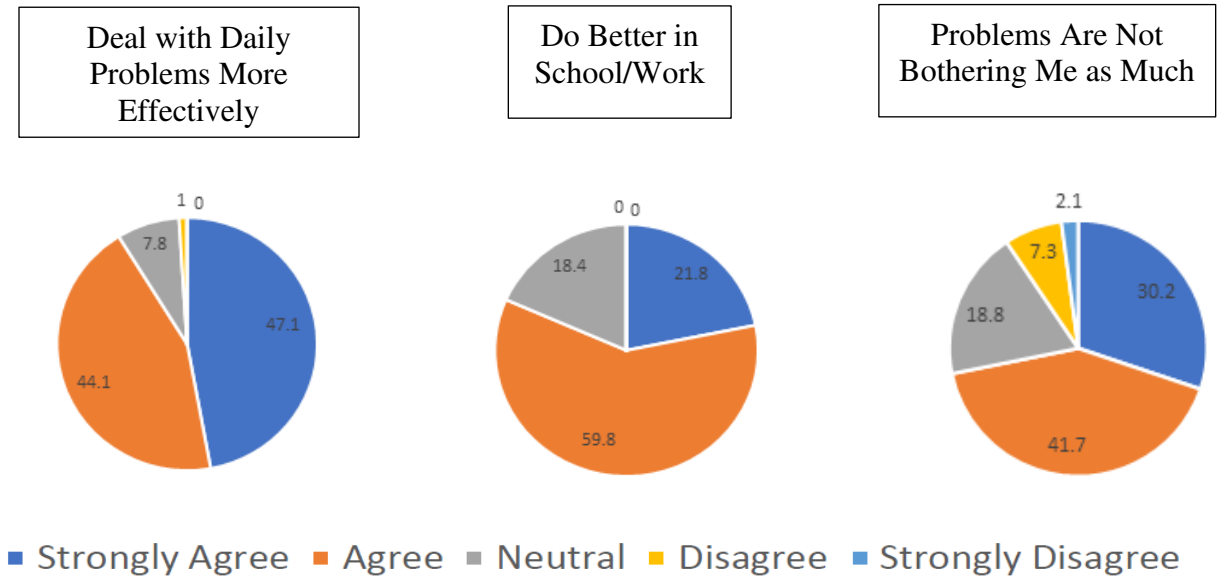
In order to assess the changes in impact of impaired functioning, the overall impairment score was calculated using 4 items. Those who responded as "not working or at school" (n =26 at pre-survey) skipped the question about functioning at school/work and therefore, were excluded in this analysis. Results showed that the overall functional impairment score was also significantly decreased among participants. On average, the functional impairment score of participants was significantly decreased at post-survey (M = 3.37, SD = 1.92) than at pre-survey (M =4.63, SD = 2.04). This improvement by 1.27 points was statistically significant, t (59) = 3.55, p= .001.

Perceived Outcomes. Another measure is perceived outcomes, or improved functioning due to ICC program participation ("As a direct result of my involvement in the program:"). As shown in the Figure 4 below, the majority of participants endorsed that they either agree or strongly agree to each of the statements. Participants identified that they deal more effectively

with their daily problems (91.2%), do better in school and/or work (81.6%), and symptoms/problems are not bothering them as much (71.9%).

Figure 4.

Perceived Outcomes



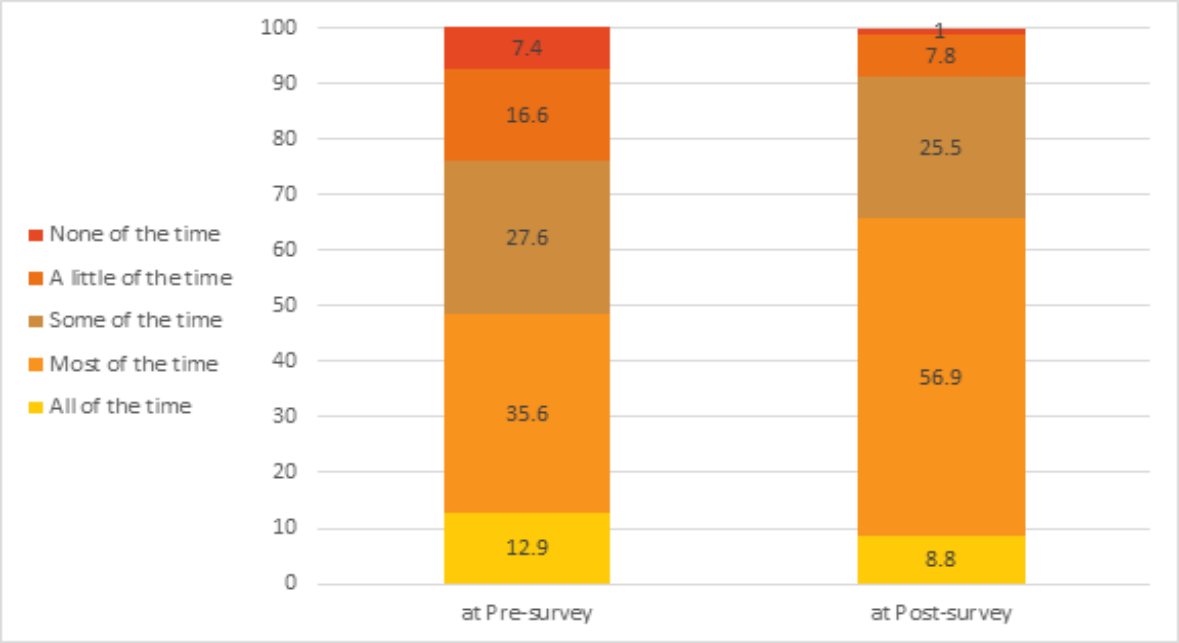
Although we cannot establish causality between program participation and the three outcomes addressed here, we have data indicating the ICC program's effectiveness through participants' accounts on what elements/aspects of the ICC program helped to achieve the outcome.

Evaluation Question 5: To what extent did ICC program participants strengthen spiritual wellness, and cultural and social connectedness?

Feel Balanced in mind, body, spirit, and soul. Figure 5 reflects holistic wellness, which was measured using one item. The proportion of participants who reported holistic well-being increased at post-survey, compared to pre-survey: 65.7% of the participants reported that they felt balanced in mind, body, spirit and soul either all of the time or most of the time at post-survey, while less than half of the respondents (48.5%) belonged to those categories at pre-survey.

Figure 5.

Holistic Well-being



Cultural Connectedness. Table 6 below shows the proportion of participants who responded to each of the four items about cultural connectedness at pre- and post-surveys. In general, the majority of participants either strongly agreed or agreed that culture has positive impacts on them (culture gives strength - 68.1%; helps to feel good about oneself - 68.3%). An even larger proportion of participants reported that culture is important to them (73.6%). A little bit more than half of the participants (56.2%) acknowledged that they felt connected to the spiritual/religious tradition of the culture they were raised in.

At the post-survey, compared to the pre-survey, approximately 10% more participants either strongly agreed or agreed that culture has positive impacts on them (culture gives strength - 78.5%, helps to feel good about oneself - 77.2%). Also, a larger proportion of participants reported that culture is important to them (84.3%), and acknowledged that they felt connected to the spiritual/religious tradition of the culture they were raised in (59.8%).

Table 6.

Cultural Connectedness

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
At pre-survey					
Your culture gives you strength	41 (25.2)	70 (42.9)	41 (25.2)	8 (4.9)	3 (1.8)
Your culture is important to you	54 (33.1)	66 (40.5)	36 (22.1)	6 (3.7)	1 (0.6)
Your culture helps you to feel good about who you are	43 (26.7)	67 (41.6)	38 (23.6)	10 (6.2)	3 (1.9)
You feel connected to the spiritual/ religious traditions of the culture you were raised in	29 (17.9)	62 (38.3)	40 (24.7)	19 (11.7)	12 (7.4)
At post-survey					
Your culture gives you strength	33 (32.4)	47 (46.1)	18 (17.6)	4 (3.9)	0 (0)
Your culture is important to you	30 (29.4)	56 (54.9)	14 (13.7)	2 (2.0)	0 (0)
Your culture helps you to feel good about who you are	21 (20.8)	57 (56.4)	17 (16.8)	6 (5.9)	0 (0)
You feel connected to the spiritual/ religious traditions of the culture you were raised in	20 (19.6)	41 (40.2)	29 (28.4)	11 (10.8)	1 (1.0)

Note. Numbers in the column shows frequency (percentage).

Social Connectedness (Social Acceptance). Feelings of marginalization and isolation from society were measured at pre-survey and again at post-survey. As shown in the Figure 6 and 7, no participant reported feeling marginalized and isolated all of the time at post-survey, which was slightly decreased from pre-survey (1.2% and 3.7%, respectively). A similar pattern was observed as fewer participants reported feeling marginalized (10.4% to 9.9%) or isolated (7.4% to 5%) at post-survey, compared to pre-survey.

Figure 6.

Social Acceptance at Pre-survey

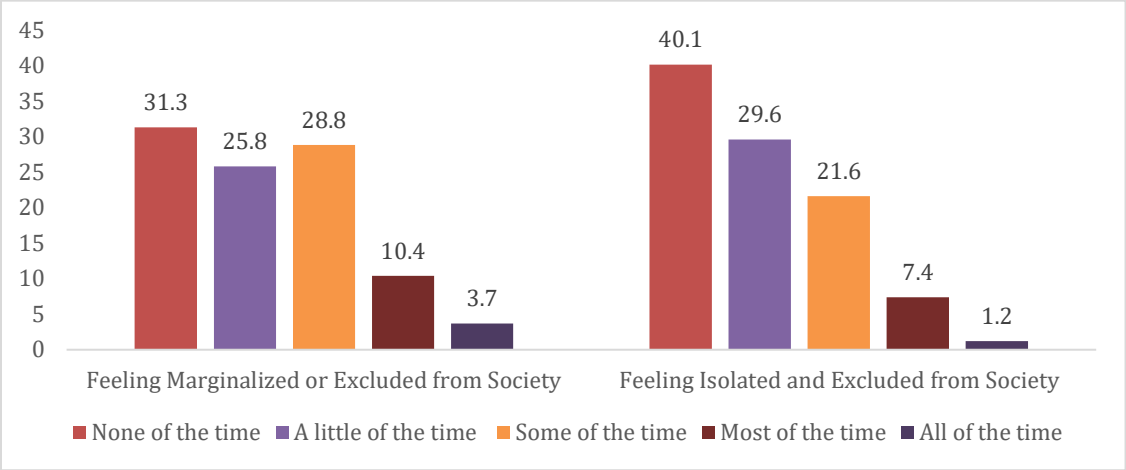
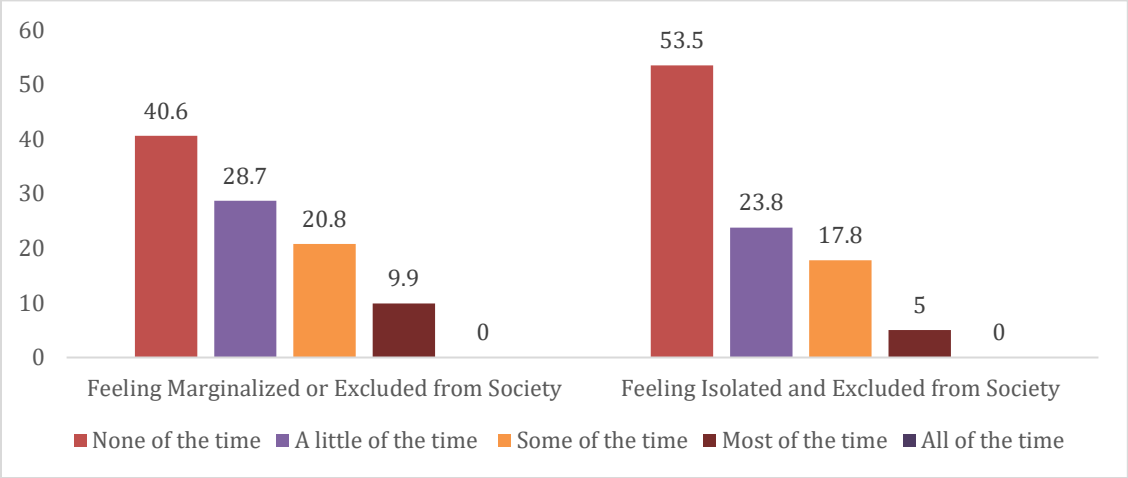


Figure 7.

Social Acceptance at Post-survey

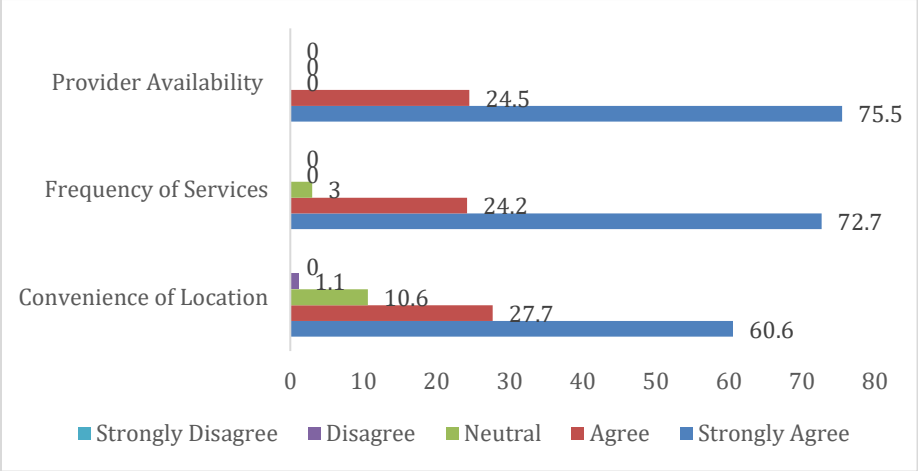


Evaluation Question 6: To what extent did the ICC program increase participants' ability to navigate the integrated healthcare system?

The following three items here show the general access to the ICC program (See Figure 8). The majority of participants strongly agreed or agreed that the location of the agency was convenient (88.3%), staff were willing to see them as often as necessary (97%), and staff were available at times that were good for them (100%).

Figure 8.

Access to Services



Once participants start to receive services, it seems they have access to other services: Administrative data showed that many participants used different combinations of services, including counseling services (*n*=80), primary care (*n*=42), acupuncture (*n*=9), chiropractic services (*n*=6), and dental services (*n*=6). About 16% (*n*=26) of the participants used more than one service. From the answers to the open-ended question and individual interviews, participants mentioned ease of getting other types of services in-house.

Southland

Evaluation Question 1: What types of ICC services were provided for participants and how many?

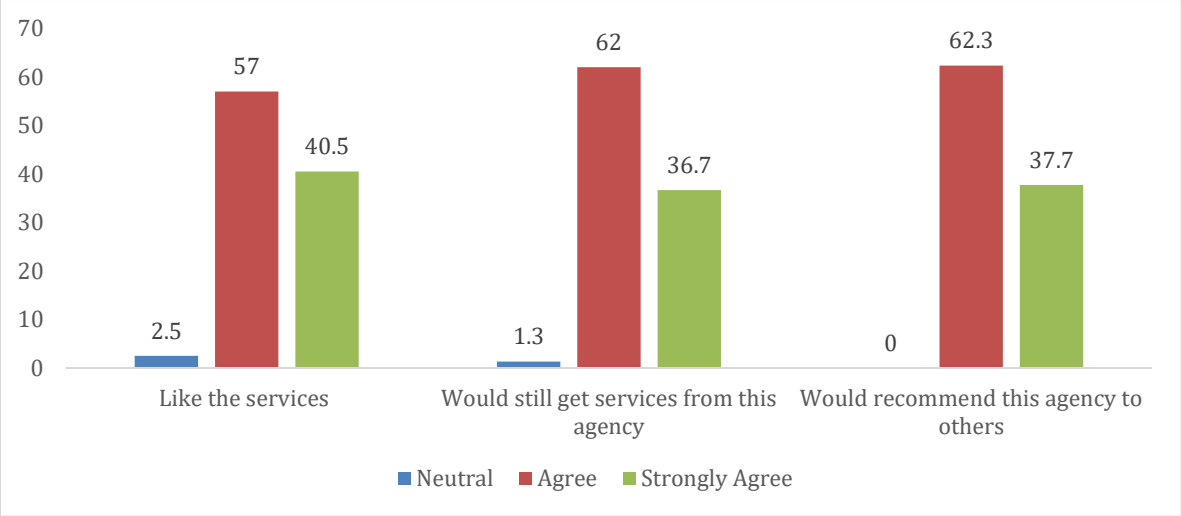
The data are available for 98 out of 107 pre-survey participants (91.6%). More than half of the participants received mental health services (*n*=67, 68.4%). Among 98 participants, 37 received primary care, 22 food service, nine transportation, and ten senior wellness. Overall, 52% (*n*=51) of the participants used more than one service, and number of different types of services used ranged from one to eight.

Evaluation Question 2: To what extent are ICC participants satisfied with the ICC program?

As shown in Figure 9, the vast majority of participants reported general satisfaction with the Southland ICC program. Over 97% of respondents positively indicated that they liked the services that they received from Southland; over 98% of respondents positively indicated that they would still get services here if they had other choices; and all participants would recommend Southland to a friend or family member.

Figure 9.

General Satisfaction with Services Received



All client participants from Southland who were interviewed expressed high satisfaction with the ICC program, providing satisfaction scores of 9 or 10, 10 being the most satisfied. Participants appreciated the integrated care model, i.e., receiving counseling and case management services as well as medical care on site. They pointed out that appointments were easy to make with the help of staff and they felt listened to by their providers. The participants also explained how the program providers paid close attention to symptoms; therefore, "that was how everyone received high quality treatment." The participants' overall satisfaction was reflected in the following quotes:

"The doctors and the staff members have been helpful, caring, and kind. They really do care about their patients here at this office [Southland]. They treat us as if we are a part of this big family… It is the interactions I have had with the people in this program that has been satisfying. They treat us as human beings. They try their best to be flexible with my schedule, so I am able to attend my appointment."

"This program feels like a family and it does not feel like I am going into a doctor's visit, but as if I am going on a fun trip. I am able to have conversations with them and share my life with them. They help make the experience less intimidating."

"Although not everything has changed, counseling planted in my heart the motivation to change. Sometimes things seem to be better, but other times it still feels like hell. Through the ICC program, I got to have some hope and organize my thoughts."

"[At the beginning], every time when I arrived at the office, my body was very tense and even when I discussed my problems out loud, I did not have a lot of confidence in myself. I was sad.

There were times when I talked about my story, tears welled up in my eyes…. However, in recent appointments when I talked to my therapist, I no longer feel the weight pulling down on my self-confidence, and I do not feel sad anymore."

Evaluation Question 3: How does each cultural element of the ICC program look? What cultural element(s) of the ICC program reached clients as intended and for which clients?

For 11 items asking about cultural competency of the staff (See Table 7), over 96% of participants positively indicated that the staff treated them with respect in general, and in regards to other aspects of diversity, such as race and/or ethnicity, religious and/or spiritual beliefs, gender identify and/or sexual orientation, and cultural health-related beliefs. Participants strongly agreed or agreed (97.5%) that ICC providers understand their indigenous practices, and that staff were aware of within-group heterogeneity (95% or higher; e.g., "Staff here understand that people of my racial and/or ethnic group are not all alike"). Also, the vast majority of participants (94%) strongly agreed or agreed that it was easy to talk to the staff when they first contacted the staff. These results show some evidence that ICC providers' beliefs and attitudes of culturally competent practices are apparent in the participants' perception of services.

Table 7.

Cultural Competency of ICC Providers

	Strongly Agree	Agree	Neutral	Disagree
Respectful Behaviors				
The staff here treat me with respect	47 (59.5)	32 (40.5)		
The staff here don't think less of me because of the way I talk	38 (48.1)	40 (50.6)	1 (0.9)	
The staff here respect my race and/or ethnicity	37 (46.8)	42 (53.2)		
The staff here respect my religious and/or spiritual beliefs	28 (35.4)	45 (57.0)		
The staff here respect my gender identity and/or sexual orientation	26 (33.3)	47 (60.3)	3 (3.8)	
Understanding Indigenous Practices				
Staff are willing to be flexible and provide alternative approaches or services to meet my needs	27 (34.2)	49 (62.0)	2 (2.5)	
The people who work here respect my cultural beliefs, remedies, and healing practices	25 (31.6)	51 (64.6)	2 (2.5)	
Acceptance of Within-group differences				
Staff here understand that people of my racial and/or ethnic group are not all alike	23 (29.1)	48 (60.8)	3 (3.8)	
Staff here understand that people of my gender and/or sexual orientation group are not all alike	23 (29.1)	46 (58.2)	4 (5.1)	
Staff here understand that people of my religious and spiritual background are not alike	24 (30.4)	46 (58.2)	3 (3.8)	

Patient-Provider-Organizational Interaction				
When I first called or came here, it was easy to talk to the staff	24 (30.4)	46 (58.2)	4 (5.1)	5 (6.3)

Note. Numbers in the column shows frequency (percentage). "Strongly Disagree" category was omitted from this table due to no responses.

No wrong door. This approach also reflects cultural understanding of the help-seeking behaviors of Asian immigrants, where there is a great reluctance to seek help for mental health problems. Individuals with mental health problems are more likely to seek help from their primary physicians or religious leaders, and consider professional mental health services as a last resort. The "no wrong door" approach embraces these cultural values and practices, and offers alternative paths to mental health services without individuals' having to "lose face" in the help-seeking process. For example, three out of the four clients interviewed initially sought services from Southland Integrated Services for physical or dental problems, and later, got referred to the ICC program for additional services and resources.

Whatever it takes. This approach reflects the holistic perspective where the client is seen as a human being with multiple needs, e.g., health, mental health, social, financial, vocational, etc., and the belief that all these needs are intertwined. In order to help the client with mental health problems, the ICC may need to first address other areas of the client's needs such as housing, legal status, and finances. By addressing these other needs, the ICC established credibility and trust, that in turn led to clients' accessing mental health services. Services may include arranging transportation, providing translation, making phone calls and appointments and providing cash assistance. The following examples illustrate how this principle was applied in the IPP program shared by ICC staff and the client participants.

"Yes, this principle has been applied to my situation. For example, I am Vietnamese, so my culture is Vietnamese. I speak Vietnamese and even though the majority of the staff speaks English, they try their best to help me understand what they are saying. Another example is when the doctors refer me to an outside service and the doctors are Caucasian or only speak English. The doctors here try their best to get me a Vietnamese translator to accompany me during these visits. Having a Vietnamese translator helps me understand the outside doctors better."

Warm hand offs. This principle refers to where a client is directly linked to a service provider to prevent falling through the cracks. Linkage will involve a "whatever it takes" approach to ensure that the client is properly connected with the referral source and is indeed poised to receive services. For example, ICC staff provided information, made a referral, helped make appointments, and followed up. The ICC staff connected clients to acupuncture or even to dental treatment. Additionally, the ICC program followed their patients' transfers closely to ensure the patient was able to receive additional services outside of the ICC program. The following quotes offer an example of this principle:

"The doctors [providers] follow up with me on the next visit to ask how the referral was and if the care was of high quality. If the referral source did not provide the care I needed, then the doctors would pick a different referral that is better suited for my needs. Even though they referred me out to other services, they still have concerns and care for my health." (client)

"A lot of resources I provide, I google search first, do advanced research to confirm their addresses, and reach out to resources. I call ahead and update my resource list on an Excel sheet. I give specific instructions to clients. Getting to know the community and I am going out there more often to collaborate with other agencies." (Southland ICC)

"Noon-chi." This is a Korean concept signifying the subtle art and ability to listen and gauge others' moods. Akin to the concept of emotional intelligence in Western culture, "noon-chi" is of central importance to the dynamics of interpersonal relationships. This cultural value is reflected in the ICC-client relationships, where the ICC utilizes her noon-chi to respond to the client's moods and/or unspoken wishes. The concept of "noon-chi" reflects culturally-grounded relationships and its application is related to cultural and linguistic sensitivity. All four Vietnamese participants agreed that the ICC program provided culturally-grounded relationships by having Vietnamese translators readily available as well as Vietnamese staff and medical professionals. The majority of the participants wanted to come back to this ICC program because of their Vietnamese speaking staff who understands what their medical needs are. However, there was one Vietnamese participant who did not agree with her provider's asking her to "throw away" her medication and thought it was unprofessional and culturally disrespectful.

The following quotes represent selected examples shared by ICC staff describing how they applied the concept of "Noon-chi" in their CDEP work:

"Knowing proper Vietnamese terms that are culturally appropriate and sensitive. Some Vietnamese words may trigger memory of the communist regime so we have to be careful. Literal translation from English to Vietnamese may not work. For example, instead of saying breast exam, we have to say "chest exam" with Vietnamese clients. Otherwise, clients will get offended." (Southland ICC)

"In Vietnamese, 'Dong Huong' means we are from the same home, place, or community. This concept especially resonates with the older generation. They trust us. They bring personal letters and ask us to read to them. Within the Vietnamese community, there is a sense of family, calling one another aunties and uncles although we are not blood-related."

"With the ICC program, we had to ask a lot of questions. ICC staff ask questions to get to know the client better, not just focusing on the medical condition. Patients know that we are asking the questions out of concern and care. Actually, we are training all other staff to do it too.... The client knows that even if we may not have the answers to all their questions, they know we will find the answers for them. Having that type of trust is very powerful."

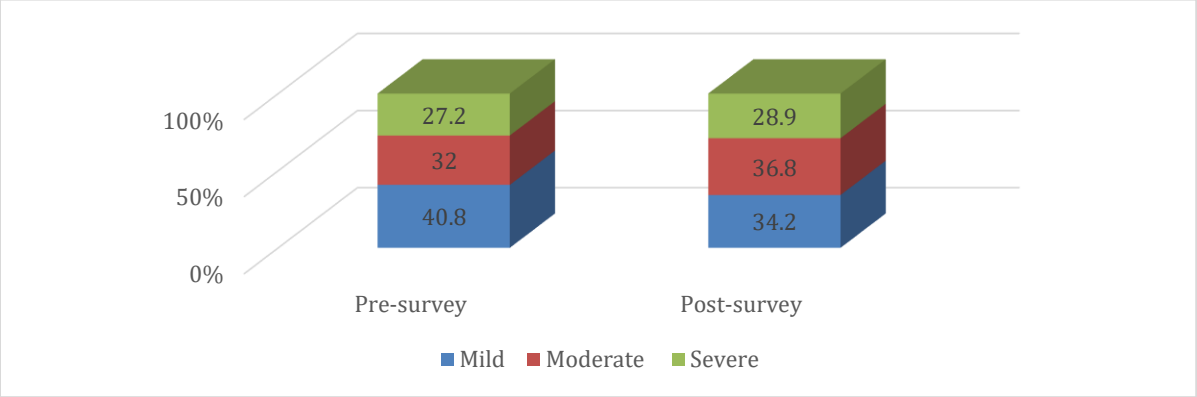
Evaluation Question 4: To what extent did ICC program participants show a reduction in psychological distress and functional impairment?

Psychological Outcomes. We examined psychological distress in two ways, using the cut-off points (descriptive) and the total scores (inferential). Figure 10 shows the changes in the proportions of participants belonging to each group that is categorized using the cut-off points. The proportion of participants who meet past-month psychological distress slightly increased at post-survey: While 27.2% of participants met past-month serious psychological distress at pre-survey, 28.9% of participants met the same category at post-survey. Participants who met past-month moderate psychological distress also increased from 32% to 36.8%.

The second examination using the total scores and t-test showed similar results. On average, psychological distress scores of participants were not significantly decreased at post-survey (M =8.26, SD =6.21) than at pre-survey (M =8.51, SD =6.70). This improvement, .26, was not statistically significant, t (73) =.35, p =.73.

Figure 10.

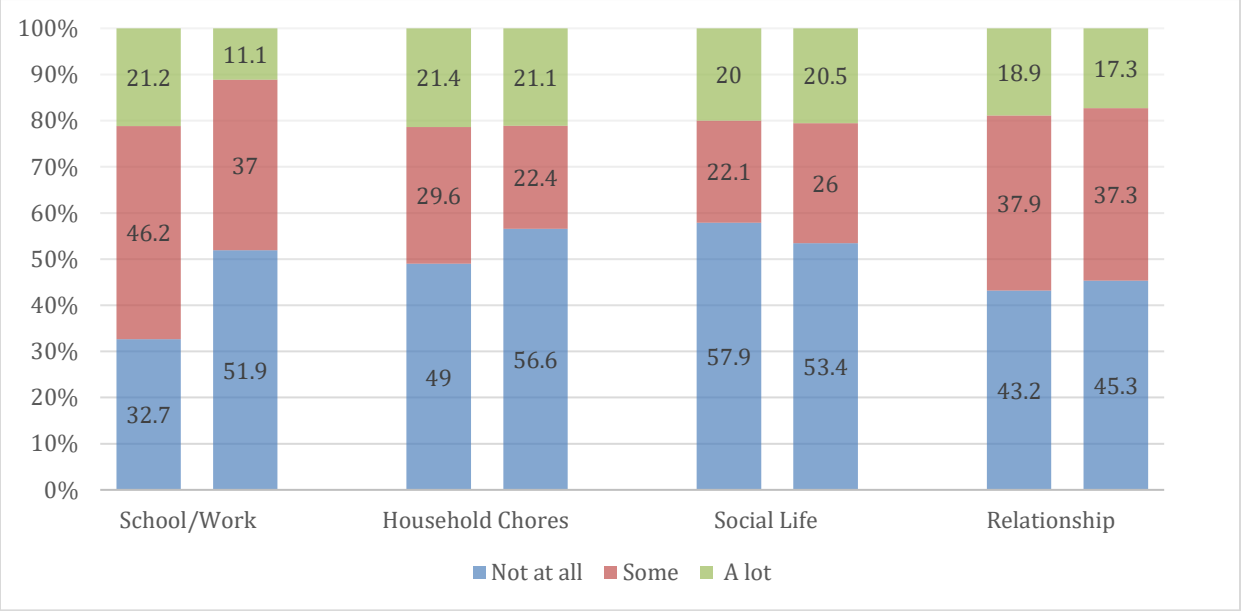
Levels of Psychological Distress Among Southland ICC participants



Functional Impairment. Figure 11 shows the proportion of the functional impairment interfering with each of the four life domains. In the school/work domain, data showed that the proportion of "A Lot" (in green) has decreased approximately 10 percent from pre-survey (left column) to post-survey (right column). The interference of emotion on functioning in other areas of life, household chores, social life and relationship with family and friends, changed very slightly.

Figure 11.

Functional Impairment on Four Life Domains among Southland ICC Participants



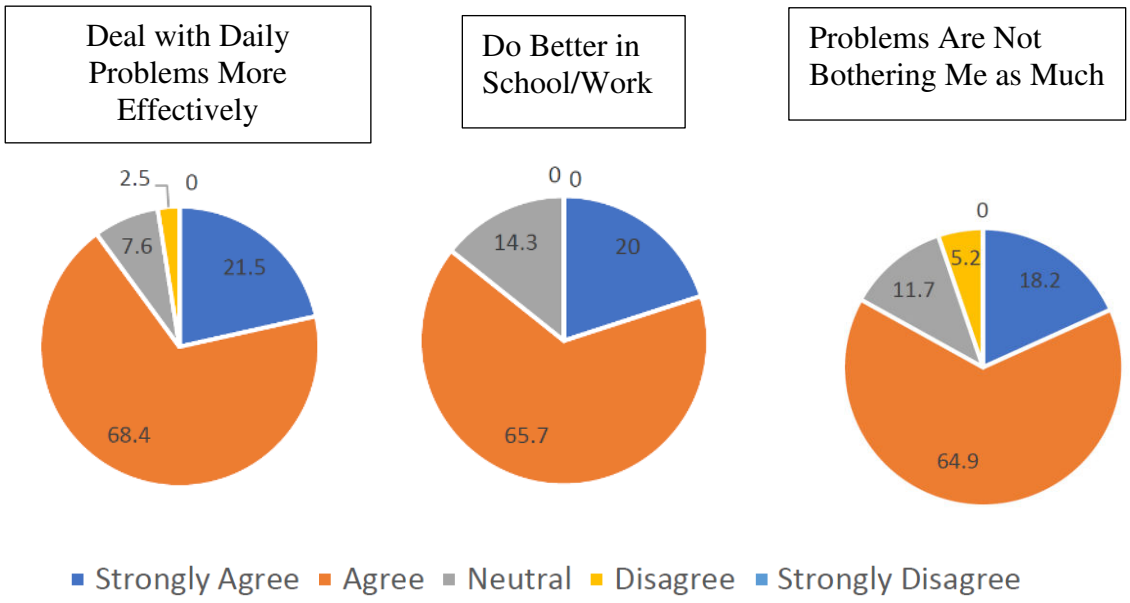
Note. Pre-survey result is displayed on the left and the post-survey result on the right for each life domain.

In order to assess the changes in impact of impaired functioning, the overall impairment score was calculated using four items. Those who responded as not working or at school (n =45 at pre-survey) were excluded in this analysis, leaving only 20 cases for this analysis. Self-reported functioning in four life domains was not significantly improved among participants who were either working or at school (n = 20). On average, the overall functional impairment score of participants was slightly decreased at post-survey (M = 2.85, SD = 2.46) than at pre-survey (M =3.8, SD = 2.28). This decrease in functional impairment, however, was not statistically significant, t (19) = 1.39, p= .18.

Perceived Outcomes. Another measure is perceived outcomes, or improved functioning due to ICC program participation ("As a direct result of my involvement in the program:"). As shown in Figure 12, the majority of participants endorsed that they either agree or strongly agree with each of the statements. Participants identified that they deal more effectively with their daily problems (89.9%), do better in school and/or work (85.7%), and symptoms/problems are not bothering them as much (83.1%). There was no participant who strongly disagreed with any of the statements.

Figure 12.

Perceived Outcomes



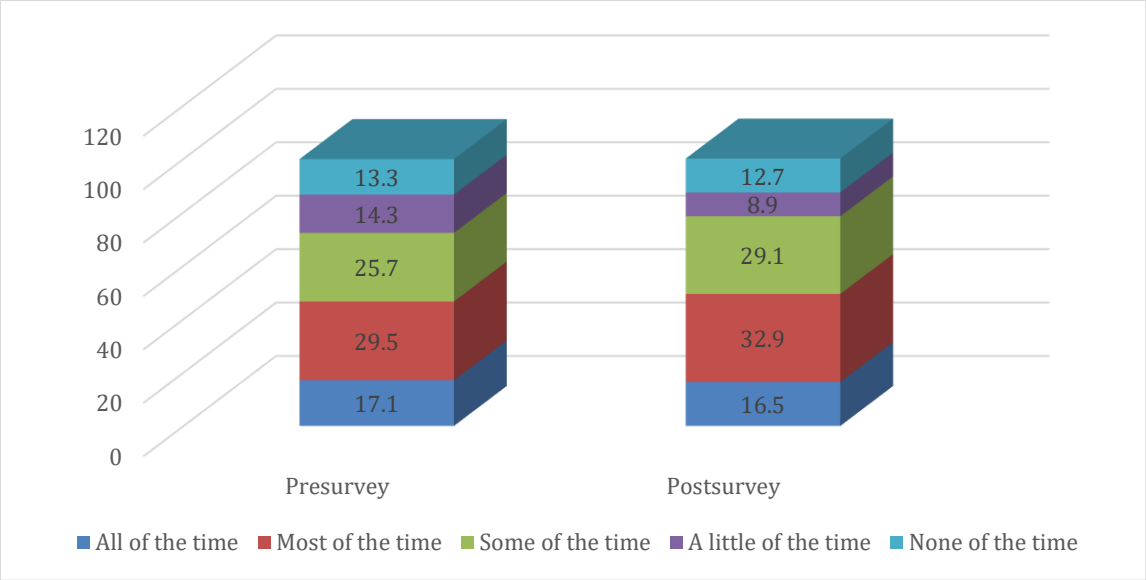
Although we cannot establish causality between program participation and the three outcomes addressed here, we have data indicating the ICC program's effectiveness through participants' accounts on what elements/aspects of the ICC program helped to achieve the outcome.

Evaluation Question 5: To what extent did ICC program participants strengthen spiritual wellness, and cultural and social connectedness?

Feel Balanced in mind, body, spirit, and soul. Holistic wellness was measured using one item, noted in Figure 13. There was a slight increase in the proportion of participants who reported holistic well-being at post-survey, compared to pre-survey: While less than 46.6% of the participants reported that they felt balanced in mind, body, spirit, and soul either *all of the time* or *most of the time* at pre-survey, 49.4% belonged to those categories at post-survey.

Figure 13.

Holistic Well-being



Cultural Connectedness. Table 8 below shows the proportion of participants who responded to each of the four items about cultural connectedness at pre- and post-surveys. In general, the majority of participants either strongly agreed or agreed that culture has positive impacts on them (culture gives strength - 67%; helps to feel good about oneself – 80.1%). An even larger proportion of participants reported that culture is important to them (86.7%). A majority of the participants (78.3%) acknowledged that they felt connected to the spiritual/religious tradition of the culture they were raised in.

At the post-survey, compared to the pre-survey, a large proportion of participants either strongly agreed or agreed that culture has positive impacts on them (culture gives strength – 76.9%; helps to feel good about oneself – 83.4%). While a similar proportion of participants reported that culture is important to them (87.2%), a larger proportion of participants acknowledged that they felt connected to the spiritual/religious tradition of the culture they were raised in (84.9%).

Table 8.

Cultural Connectedness

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
At pre-survey					
Your culture gives you strength	23 (21.7)	48 (45.3)	27 (25.5)	5 (4.7)	3 (2.8)
Your culture is important to you	30 (28.6)	61 (58.1)	10 (9.5)	3 (2.9)	1 (1.0)
Your culture helps you to feel good about who you are	24 (22.6)	61 (57.5)	16 (15.1)	3 (2.8)	2 (1.9)
You feel connected to the spiritual/religious traditions of the culture you were raised in	22 (20.8)	61 (57.5)	12 (11.3)	9 (8.5)	2 (1.9)
At post-survey					
Your culture gives you strength	17 (21.8)	43 (55.1)	15 (19.2)	3 (3.8)	0 (0)
Your culture is important to you	27 (34.6)	41 (52.6)	9 (11.5)	1 (1.3)	0 (0)
Your culture helps you to feel good about who you are	19 (24.4)	46 (59.0)	10 (12.8)	3 (3.8)	0 (0)
You feel connected to the spiritual/religious traditions of the culture you were raised in	19 (24.1)	48 (60.8)	6 (7.6)	5 (6.3)	1 (0.9)

Note. Numbers in the column shows frequency (percentage).

Social Connectedness. Feelings of marginalization and isolation from society was measured at pre-survey and again at post-survey. While there was no overall drastic change reported on feelings of marginalization and isolation from society between the pre- and post-surveys, there were changes in two groups: As shown in Figure 14, participants who reported feeling marginalized and excluded from society *some of the time* increased approximately 7% from pre-survey (18.7%) to post-survey (25.6%). Participants who felt isolated and alienated (Figure 15) from society *all of the time* increased slightly from pre-survey (2.8%) to post-survey (6.5%).

Figure 14.

Feeling Marginalized or Excluded from Society

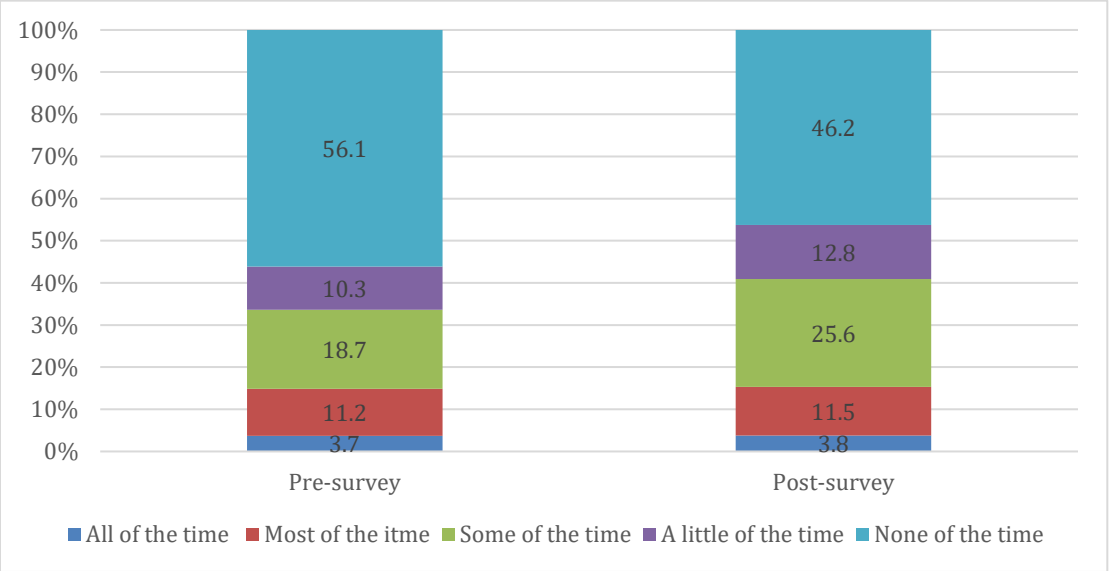
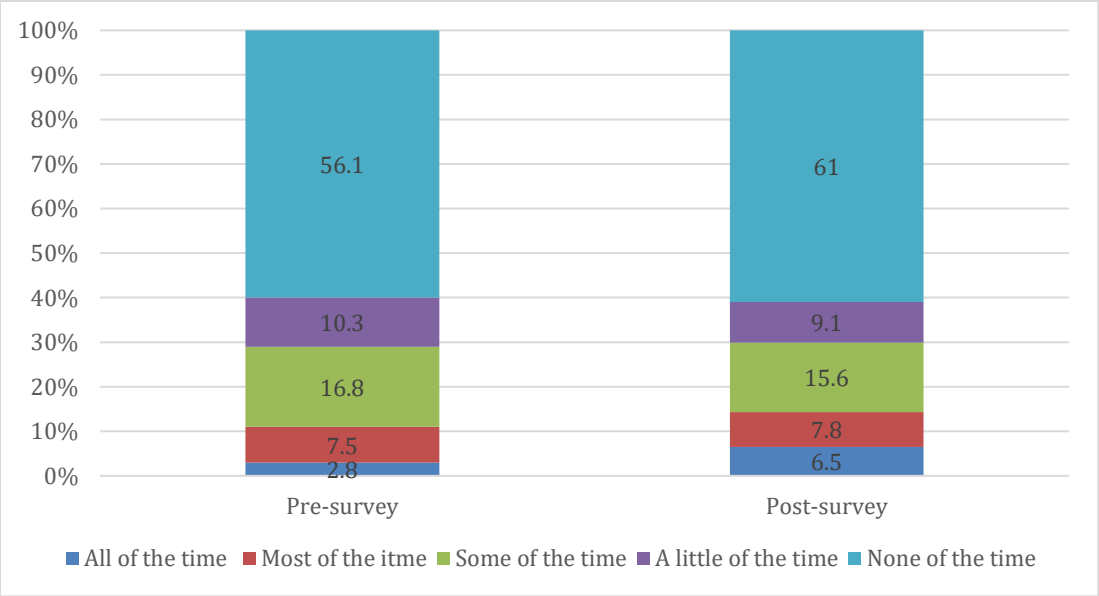


Figure 15.

Feeling Isolated and Alienated from Society

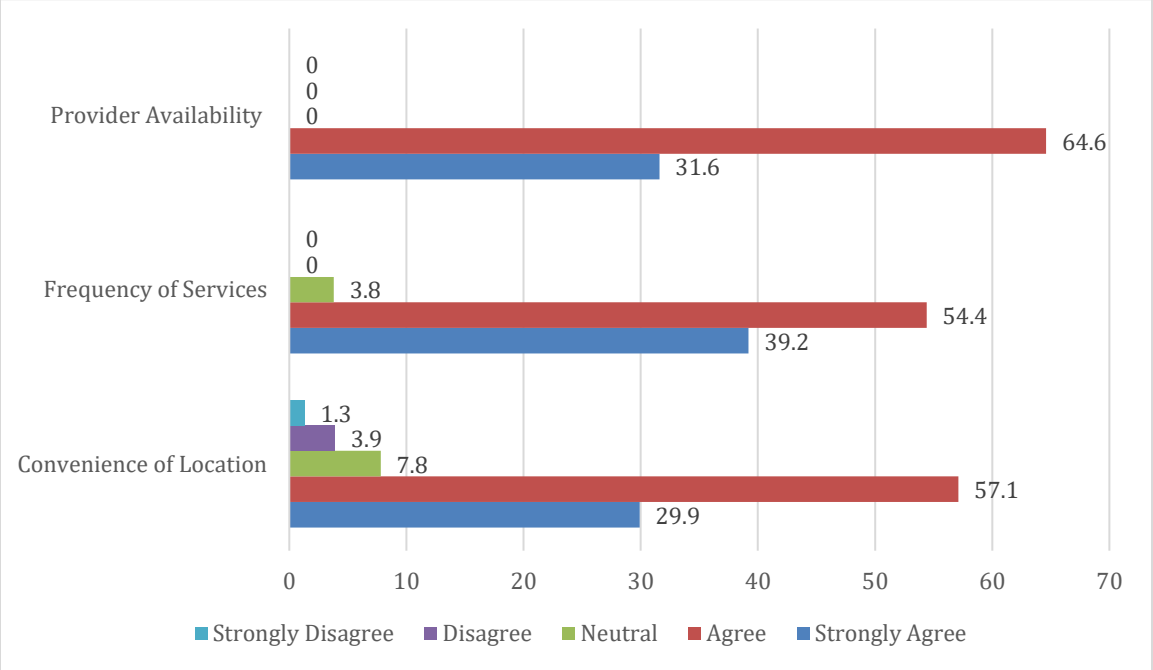


Evaluation Question 6: To what extent did the ICC program increase participants' ability to navigate the integrated healthcare system?

The following three items here show the general access to the ICC program (See Figure 16). The majority of participants strongly agreed or agreed that location of the agency was convenient (87%), staff were willing to see them as often as necessary (93.6%), and staff were available at times that were good for them (100%).

Figure 16.

Access to Services



Once participants start to receive services, it seems they have access to other services, especially referral to physical health care.

Other Qualitative Data Findings: Recommendations for Improving the ICC Program.

The following recommendations are shared by client participants, ICC staff, and non-ICC staff.

1. Most clients including the elderly quickly adapted to tele-health through the help of their children or community resources such as churches. Given the advantages of tele-health such as flexibilities in arranging the location and time, some clients may continue to prefer tele-health over in-person visits.

2. The maximum duration of the ICC program was 12 weeks, although an extension was allowed in some cases. Several participants and ICC staff expressed the need for increasing the duration of the program.
3. There is a need to increase publicity and community outreach since "there are so many people who don't know about the services." In spite of numerous community outreach events and activities that both KCS and Southland engaged in during the grant period, there seem to be large segments of these communities that are not aware of the ICC program. There is a lot more communications and programs in Korean media about mental health these days which will potentially lead to less stigma and more positive attitudes towards mental health and services.
4. Through exposure to Korean mass media and social media, Korean Americans are now more familiar with counseling. Some see conditions similar to theirs being portrayed on YouTube and want to get checked by professional counselors.

Discussion and Conclusion

Overall, the ICC program appears to be an effective intervention program for Korean American participants. We found that one of the main outcomes, psychological distress and functional impairment, decreased significantly at the time of post-survey. Participants' comments from the open-ended questions and individual interviews also echoed the same sentiment. While the proportion of participants who met the past-month serious psychological distress at post-survey (9.2%) was still larger than the 5.7% of Korean-Americans who met the same criteria from the California Health Interview Survey (CHIS; AskCHIS, 2021), this difference makes sense if we consider the participants of CHIS are the general public, not those who have identified needs and sought services.

For Vietnamese American participants, we found that psychological distress and functional impairment slightly decreased but failed to reach statistical significance. There could be several possible explanations for these findings: For example, the ICC program may not seem effective in reducing psychological distress and functional impairment among a group of participants who completed both pre- and post-surveys during the pandemic or completed the pre-survey before the pandemic and the post-survey during the pandemic. Possible explanations can be related to the elevated level of psychological distress (due to fear of infection, unemployment/financial insecurity, social isolation, uncertainty) during the intervention period, which offset the improvement. Also, the uncontrollable nature of the problems (e.g., unemployment, financial strain) are likely to influence the outcomes. Indeed, approximately half of the pre-surveys (53%) and most of the post-surveys were completed during the pandemic (82.3%).

Another main finding of this evaluation is that ICC providers were not only linguistically but culturally competent. As most participants preferred to use the language from their country of origin and identified as not very fluent in English, providing all ICC services in Korean/ Vietnamese removed a basic barrier for most monolingual participants. In addition, participants reported their perceptions of ICC providers' high level of understanding of diversity, including within-group diversity. Stigma, culturally unresponsive services, and conflicts between Asian values and Western treatment (Kwok, 2013; Leung et al., 2010; Phan, 2000) as well as limited

English proficiency (Kim et al., 2011) were cited as major barriers to mental health service utilizations. Therefore, receiving services from culturally competent providers may remove additional barriers to service utilization for our participants. Participants of the qualitative interviews also reported cultural and linguistic concordance, as well as the cultural aspects of noon-chi and understanding community and culture.

Limitations of the Evaluation

The evaluation was limited by several factors which may impact the generalizability of the findings:

Convenience sampling: As this study used convenience sampling, some of the study findings may not be generalizable to the other Korean Americans in the community. However, based on the providers' comments and the master logs of the agencies, survey participants appeared to have similar demographical characteristics as non-survey participants. It is probably because our convenience samples are limited to one ethnic group which is strongly related to certain shared characteristics (e.g., immigrants, non-native English speakers).

Small sample size: The COVID pandemic influenced the program implementation and data collection methods in the middle of the project and data collection. Interruption of data collection for three months as well as switching the data collection method from in-person to phone/email resulted in a smaller sample size than we originally had planned for KCS (200 surveys) and Southland (110 surveys), and relatively small, matched cases for both agencies (62.6% for KCS and 73.8% for Southland). The relatively small, matched sample size, in turn, limited the scope of our quantitative analysis. Also, there is a possibility that the positive outcomes are slightly overestimated as those who see/feel their improvement stayed in the program and completed the post-surveys, resulting in positive outcomes.

While the survey consisted of validated questions, we found that participants did have difficulty in understanding a handful of the questions, which may affect survey findings. Concepts validated in English did not translate equally in-language and left room for interpretation. Surveys were administered by staff to help clarify questions, but may have affected survey findings.

Internal validity: While the possible impact of COVID-19 on evaluation outcomes cannot be directly assessed, this historical event is likely to influence the internal validity of the evaluation. Therefore, the findings need to be interpreted with caution. Also, changing data collection methods from in-person to phone/email may have impacted how participants understood and answered survey questions.

Similar to the quantitative data collection, there was a small sample size for the qualitative data collection. Recruiting clients for the semi-structured individual interviews was more challenging than expected for a variety of reasons. Participants for individual interviews were selected among those recommended by the staff based on the following eligibility criteria: they must have completed the ICC program prior to the interview; and they should be capable of articulating their experiences with the ICC program. Additionally, some of those who initially agreed to

participate in the interviews were no longer reachable or available by the time the local evaluator tried to schedule an interview. Moreover, there were service gaps and abrupt transitions due to the coronavirus pandemic with a new focus on COVID testing and vaccines, which delayed the process of referring clients for individual interviews. All these barriers resulted in a very small sample size for participants of the qualitative data collection and may also have led to potential sampling bias. As a result, the qualitative study sample was a convenient sample and may have reflected individuals who were more likely to engage, and therefore, more likely to have had positive experiences and/or feedback.

Lessons Learned

The CDEP has provided lessons learned to strengthen the existing program and for consideration with future programs. Three key lessons were the importance of communication, providing ongoing staff training, and establishing clear instructions and processes for data collection/program implementation.

Communicate with ICC providers regularly: We used an action research approach to enhance the practice and to investigate the effects of the action that was taken. Steps and cycles have been used to improve the ICC program to yield desirable outcomes. While we evaluated and shared the outcomes of previous steps to improve the program, oftentimes we were not timely enough to provide useful feedback. More focus on process outcomes and sharing the results of initial data analysis could have been used to improve the ICC program and data collection process. The local evaluation team communicated regularly with ICCs and heard their experiences, however establishing a more structured process to capture, analyze, consider and implement changes from learnings could be more fruitful and ensure timely program refinements and improvements.

Importance of ongoing staff training: High turnover rate in nonprofit organizations is often inevitable. While we provided research training (e.g., human subject research, data collection procedures, survey administration) for new ICC providers, there could be variations in how each ICC provider approached data collection. Establishing protocols for ongoing trainings and check-ins on implementation of protocols can help to ensure fidelity. Adjustments and flexibility are also inevitable in a real-world setting, being aware of contextual changes and being able to adapt and to train all staff on adjusted protocols can also ensure stronger fidelity and consistency in program implementation.

Establish clear instructions in data collection and follow-through: We set up a data tracking log to collect information about each participant (e.g., timing of the survey, difficulties in consenting process/questions, lengths of survey, difficulties administering survey). However, it was not implemented consistently across different ICC providers and sites. The main lesson here: have a clear guideline and follow-through and check-in.

Next Steps

Despite its limitations, the main findings of the ICC program evaluation can inform the planning and implementation of future ICC programs and other similar programs.

The findings of this evaluation inform the planning of a further evaluation looking at the impact of the ICC programs on participants' outcomes using advanced statistical analysis. Some demographic and clinical characteristic factors that are likely to impact program outcomes will be used for sub-group analysis.

As CRDP received funding for extension of the current program, we anticipate there will be a larger sample of evaluation data for the outcome evaluation. Future evaluation with a bigger sample may provide an in-depth understanding of within-group variation among participants for the analysis, which we were not able to do at this time due to small matched-sample size.

References

Agency for HealthCare Research and Quality accessed on October 25, 2021 https://integrationacademy.ahrq.gov/about/integrated-behavioral-health, 2021

Asian American Advancing Justice. A Community of Contrast: Asian Americans and Pacific Islanders in Orange County, 2014 available at https://advancingjustice-la.org/wp-content/uploads/2021/06/CommunityofContrasts_OC2014.pdf

Bates, K. (April 27, 2012). How Koreatown Rose from the Ashes of the LA Riots. National Public Radio < http://www.npr.org/2012/04/27/151524921/how-koreatown-rose-from-the-ashes-of-l-a-riots> accessed October 11, 2015

California Institute for Behavioral Health Solutions (nd). The Business Case for Bidirectional Integrated Care. http://www.cibhs.org/pod/business-case-bidirectional-integrated-care

California Reducing Disparities Project, Asian Pacific Islander Report (2013) Office of Health Equity, California Department of Health, p. 26.

California Reducing Disparities Project, Asian Pacific Islander, Strategic Planning Work Group: The API Population Report, *In Our Own Words,* 2012 available at https://cultureishealth.org/wp-content/uploads/2021/01/API-Population-Report.pdf

Center for Immigration Studies (1995). Three Decades of Mass Immigration: The Legacy of the 1965 Immigration Act < http://cis.org/1965ImmigrationAct-MassImmigration> accessed October 10, 2015

Choi, S. C., & Han, G. (2008). Shimcheong Psychology: A Case of an Emotional State for Cultural Psychology. *International Journal for Dialogical Science*, *3*(1), 205-224.

Cornelius, L. J., Booker, N. C., Arthur, T. E., Reeves, I., & Morgan, O. (2004). The validity and reliability testing of a consumer-based cultural competency inventory. *Research on Social Work Practice*, *14*(3), 201-209.

Eisen, S. V., Shaul, J. A., Leff, H. S., Stringfellow, V., Clarridge, B., & Cleary, P. D. (2001). Toward a national consumer survey: evaluation of the CABHS and MHSIP instruments. *The journal of behavioral health services & research*, *28*(3), 347-369.

Furukawa, T. A., Kessler, R. C., Slade, T., & Andrews, G. (2003). The performance of the K6 and K10 screening scales for psychological distress in the Australian National Survey of Mental Health and Well-Being. *Psychological medicine*, *33*(2), 357-362.

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S.-L.T., Walters, E. E., & Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological medicine*, *32*(6), 959-976.

Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., Howes M. J., Normand, S.-L. T., Manderscheid, R. W., Walters, E. E., & Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. *Archives of general psychiatry*, *60*(2), 184-189.

Kim, G., Bryant, A. N., & Parmelee, P. (2012). Racial/ethnic differences in serious psychological distress among older adults in California. *International Journal of Geriatric Psychiatry*, *27*(10), 1070-1077.

Kim, G., Loi, C. X. A., Chiriboga, D. A., Jang, Y., Parmelee, P., & Allen, R. S. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research*, *45*(1), 104-110.

Kramer, E. J., Kwong, K., Lee, E., & Chung, H. (2002). Cultural Factors Influencing the Mental Health of Asian Americans. *Western Journal of Medicine*, *176*(4), 227-231.

Kwok, J. (2013). Factors that influence the diagnoses of Asian Americans in mental health: An exploration. *Perspectives in Psychiatric Care*, *49*, 288-292.

Leung, P., Cheung, M., & Cheung, A. (2010). Vietnamese Americans and depression: A health and mental health concern. *Social Work in Mental Health*, *8*(6), 526-542.

Orange County Register (2015, April 24). The History of Little Saigon and the Vietnamese in Orange County. http://www.ocregister.com/articles/vietnamese-659434-saigon-little.html

Park, Y.S., & Kim, B. (2008). Asian and European American cultural values and communication styles among Asian American and European American college students. *Cultural Diversity and Ethnic Minority Psychology*, *14*(1), 47-56.

Phan, T. (2000). Investigating the use of services for Vietnamese with mental illness. *Journal of Community Health*, *25*(5), 411-425.

Prochaska, J. J., Sung, H. Y., Max, W., Shi, Y., & Ong, M. (2012). Validity study of the K6 scale as a measure of moderate mental distress based on mental health treatment need and utilization. *International journal of methods in psychiatric research*, *21*(2), 88-97.

Stacciarini, J. M. R., Rosa, A., Ortiz, M., Munari, D. B., Uicab, G., & Balam, M. (2012). Promotoras in mental health: A review of English, Spanish and Portuguese literature. *Family & Community Health, 35*(2), 92-10285.

Substance Abuse and Mental Health Services Administration (2012). *Understanding Health Care Reform: Integrated Care and Why You Should Care*. http://www.integration.samhsa.gov/integrated-care-models/2012-07-23UnderstandingHealthReform.pdf

Tran, M. T. (April 30, 2009). Orange County's Vietnamese Immigrants reflect on historic moment. *Los Angeles Times.* http://articles.latimes.com/2009/apr/30/local/me-saigon-memories30

Tse, H. W., Padilla-Frausto, D. I., Wolstein, J., & Babey, S. H. (2021). *Uncovering Unique Challenges: Variation in Unmet Mental Health Needs Among Asian Ethnic Groups in California*. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2021/UnmetMentalHealthNeeds-AsianEthnicGroups-policybrief-jul2021.pdf

US Census Bureau, American Community Survey (2011) http://www.census.gov/acs/www/data_documentation/documentation_main/

UCLA Center for Health Policy Research. (2016). California Health Interview Survey (CHIS) 2016 Adult Questionnaire. https://healthpolicy.ucla.edu/chis/design/Documents/2015-2016%20Questionnaires/CHIS%202016%20Adult%20Questionnaire%20(FINAL).pdf

Willms, D. G., Best, J. A., Taylor, D. W., Gilbert, J. R., Wilson, D. M. C., Lindsay, E. A., & Singer, J. (1990). A systematic approach for using qualitative methods in primary prevention research, *Medical Anthropology Quarterly*, *4*(4), 391-409.

APPENDICES

ID:
2 - 4 - __ __ - __ __ __
Priority Pop Code *IPP Code* *Agency Code* *CDEP Participant Code*

ADULT VERSION (18+)
PRE

Instructions for Staff Administrator/Program Staff

Staff administration

If the questionnaire is staff-administered (instead of self-administered by the program participant), staff should remind participants that all questions are voluntary and they can refuse to answer anything they do not wish to. If the participant refuses to answer a question, staff will ask if the participant would like to share why. The staff administrator will document the reason and any observations in the "staff administrator section" on the questionnaire itself. If the participant does not want to share why, staff administrator should not push the participant, but will document any observations in the "staff administrator section" on the questionnaire.

General Instructions

The California Reducing Disparities Project (CRDP) is a statewide project that is working across five historically unserved, underserved, and/or inappropriately served population groups: the African American; Asian and Pacific Islander; Latino; Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ); and Native American. In order to collect data to address the disparities for these multiple populations, a set of standard questions have been developed for all populations. Since these are standard questions, some of the questions may not feel applicable or relevant for you to answer.

All information that you share on this questionnaire will be confidential. The data will be shared with the State, but your name will not; and whatever you share cannot be connected back to you. As you answer, you may feel that one or more of the questions below do not apply to you or make you feel uncomfortable. If there are questions that you do not feel comfortable answering, you do not have to answer them. Your participation in this questionnaire is completely voluntary. Any level of participation is appreciated, because any information that you provide will be useful in helping us understand the disparities for and across multiple populations. If you have any questions, please ask the program staff who gave you this questionnaire.

ADULT VERSION PRE

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. The next questions are about your culture.

At present…	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
1. Your culture gives you strength.	☐	☐	☐	☐	☐
2. Your culture is important to you.	☐	☐	☐	☐	☐
3. Your culture helps you to feel good about who you are.	☐	☐	☐	☐	☐
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.	☐	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 30 days

About how often during the past 30 days did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
5. …connected to your culture?	☐	☐	☐	☐	☐
6. …balanced in mind, body, spirit and soul?	☐	☐	☐	☐	☐
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)	☐	☐	☐	☐	☐
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond your family, school, and friends.*)	☐	☐	☐	☐	☐

9. Do you currently have health insurance coverage? (check one)

☐ **Yes (GO TO Q10)** ☐ **No** ☐ **Refused (GO TO Q11)** ☐ **Don't Know (GO TO Q11)**

Did you have health insurance coverage in the past 12 months?

☐ Yes ☐ No ☐ Refused ☐ Don't Know **(GO TO Q11)**

	Yes	No	Refused	Don't Know
10. Does your insurance cover treatment for mental health problems, such as visits to a psychologist or psychiatrist?	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
11. During the past 12 months, did you take any prescription medications, such as an antidepressant or an antianxiety medication, almost daily for two weeks or more, for an emotional or personal problem?	☐	☐	☐	☐

	Yes	No	Refused	Don't Know	NA
12. Because of problems with your mental health, emotions, nerves or your use of alcohol or drugs, was there ever a					

ADULT VERSION PRE

	Yes	No	Refused	Don't Know	NA
time during the past 12 months when you FELT LIKE YOU MIGHT NEED to see a…					
a. Traditional helping professional like a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐	☐
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐	☐
c. Primary care physician or general practitioner	☐	☐	☐	☐	☐
d. Mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker	☐	☐	☐	☐	☐

	Yes	No	Refused	Don't Know	NA
13. In the past 12 months, because of problems with your mental health, emotions or your use of alcohol or drugs					
a. HAVE YOU SEEN a traditional helping professional like a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐	☐
b. HAVE YOU SEEN a Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐	☐
c. HAVE YOU SEEN a Primary care physician or general practitioner	☐	☐	☐	☐	☐
d. HAVE YOU SEEN a Mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker	☐	☐	☐	☐	☐

If YES to Q13c OR 13d GO TO Q14. Otherwise, GO TO Q19

GO TO Q19

	Yes Mental/Emotional Health Problem	*Yes Alcohol-Drug Problem*	*Yes Both Mental & Alcohol-Drug Problems*	*Refused*	*Don't Know*
14. Did you seek help for your mental or emotional health or for an alcohol or drug problem? (*Circle one*)					

15. In the past 12 months, how many visits did you make to a mental health professional (counselor, therapist, psychologist, psychiatrist or social worker) for problems with your mental or emotional health, alcohol-drug problem, or both? Do not count overnight hospital stays.

_____ # of visits

ADULT VERSION PRE

	Yes	No	Refused	Don't Know
16. Are you still receiving treatment for these problems from one or more of these providers?	☐	☐	☐	☐
	GO TO Q19	GO TO Q17	GO TO Q19	
17. Did you complete the full course of treatment? In other words, you ended treatment when your counselor, therapist, psychologist, psychiatrist or social worker told you it was ok to end?	☐	☐	☐	☐
	GO TO Q19	GO TO Q18	GO TO Q19	

18. What is the **MAIN REASON** you are no longer receiving treatment? (Circle ONE only)
    - ☐ Got better/No longer needed
    - ☐ Not getting better
    - ☐ Wanted to handle the problem on own
    - ☐ Had bad experiences with treatment
    - ☐ Lack of time/transportation
    - ☐ Too expensive
    - ☐ Insurance does not cover
    - ☐ Other (Specify) _____
    - ☐ Refused
    - ☐ Don't Know

Instructions: Here are some reasons people have for NOT seeking help from a mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker, even when they think they might need it.

	Agree	Disagree	Refused	Don't Know
19. You were planning to or already getting help from a…				
a. Traditional helping professional such as a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐
20. You did not know of or have never heard of these types of mental health professionals (e.g. counselor, therapist, psychologist, etc.)	☐	☐	☐	☐
	GO TO Q34	GO TO Q21	GO TO Q34	

	Agree	Disagree	Refused	Don't Know
21. You didn't feel comfortable talking with them about your personal problems.	☐	☐	☐	☐
22. You didn't think you would feel safe and welcome because of your…				
a. limited English	☐	☐	☐	☐
b. race/ethnicity	☐	☐	☐	☐
c. age	☐	☐	☐	☐
d. religious or spiritual practice	☐	☐	☐	☐
e. gender identity	☐	☐	☐	☐
f. sexual orientation	☐	☐	☐	☐

ADULT VERSION PRE

	Agree	Disagree	Refused	Don't Know
23. You were concerned about the cost of treatment.	☐	☐	☐	☐
24. You didn't have time (because of job, childcare, or other commitments).	☐	☐	☐	☐
25. You had no transportation, or the program was too far away, or the hours were not convenient.	☐	☐	☐	☐
26. You didn't think you needed mental health counseling or treatment at the time.	☐	☐	☐	☐
27. You thought you could handle the problem on your own.	☐	☐	☐	☐
28. You didn't think mental health counseling or treatment would help.	☐	☐	☐	☐
29. You were concerned that getting mental health treatment or counseling might cause your neighbors or community to have a negative opinion of you.	☐	☐	☐	☐
30. You were concerned that getting mental health treatment or counseling might have a negative effect on your job.	☐	☐	☐	☐
31. You were concerned that the information you gave the counselor might not be kept confidential.	☐	☐	☐	☐
32. You were concerned that you might be admitted to a psychiatric hospital.	☐	☐	☐	☐
33. You were concerned that you might have to take medicine.	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 30 days.

About how often during the past 30 days did you feel…	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
34. … nervous?	☐	☐	☐	☐	☐
35. … hopeless?	☐	☐	☐	☐	☐
36. … restless or fidgety?	☐	☐	☐	☐	☐
37. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
38. … feel that everything was an effort?	☐	☐	☐	☐	☐
39. … worthless?	☐	☐	☐	☐	☐

40. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q34-Q39) match how you would describe those experiences? (Check one)

☐ **A Lot** ☐ **Somewhat** ☐ **Not At All**

NOW, think about the one month, within the past 12 months, when you were at your worst emotionally.

Did your emotions interfere a lot, some, or not at all with your…	**A Lot**	**Some**	**Not At All**	**Refused**	**Don't Know**
41. …performance at work or school?	☐	☐	☐	☐	☐
⇒ *Check here if not working and not in school during the past 12 months* ☐					
42. …household chores?	☐	☐	☐	☐	☐
43. …social life?	☐	☐	☐	☐	☐
44. …relationship with friends and family?	☐	☐	☐	☐	☐

45. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q41-Q44) match how you would describe the negative effect of emotions on your life? (Check one)

☐ **A Lot** ☐ **Somewhat** ☐ **Not At All**

46. How old are you?

☐ between 18 and 29 years of age
☐ between 30 and 39 years of age
☐ between 40 and 44 years of age
☐ between 45 and 49 years of age
☐ between 50 and 64 years of age
☐ 65 or older years of age

47. **VERSION 1**

What is your race and ethnic origin? ***Select only one race category and specify your ethnic origin.***

☐ American Indian or Alaska Native
☐ Black or African American**:** Please specify your ethnic origin(s):_____
☐ Latino, Hispanic, or Spanish: Please specify your ethnic origin(s):_____
☐ Asian: Please specify your ethnic origin(s): _____
☐ Native Hawaiian or Other Pacific Islander: Please specify your ethnic origin(s): _____
☐ White: Please specify your ethnic origin(s):_____
☐ Other Race: Please specify your race and ethnic origin(s):_____
☐ Multi-Racial: Please specify your origin(s):_____
☐ Refused
☐ Don't Know

48. How well can you speak the English language?
    ☐ Fluently
    ☐ Somewhat fluently; can make myself understood but have some problems with it
    ☐ Not very well; know a lot of words and phrases but have difficulties communicating
    ☐ Know some vocabulary, but can't speak in sentences
    ☐ Not at all

49. What is your preferred language? _____

50. Were you born:
    ☐ Inside the U.S.
    ☐ Outside the U.S.
    ☐ Refused
    ☐ Don't Know

51. What are the first 3 digits of your ZIP Code? _ _ _ ☐Unstable housing/ no ZIP code ☐ Refused ☐ Don't Know

52. Have you ever spent time in a temporary settlement area for refugees or displaced persons or been held at ICE facilities?
    ☐ Not Applicable
    ☐ Yes
    ☐ No
    ☐ Refused
    ☐ Don't Know

53. About how many years have you lived in the United States? [*For less than a year, enter 1 year*]
    Number of years_____ ☐ Not Applicable

54. Thank you for taking the time to answer all these questions. We wanted to remind you that all of your responses are confidential. We want to ask one more question. Did any of the previous questions upset you or make you feel uncomfortable?
    ___No
    ___Yes (If yes, which ones? Please specify #'s: _____)

Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals encompass all races and ethnicities, religions, and social classes. Discrimination against LGBTQ persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide. Yet, the LGBTQ community faces greater difficulties in accessing mental health care due to stigma.

Sexual orientation and gender identity questions are not asked on most national or State surveys, making it difficult to estimate the number of LGBT individuals and their health needs. In order to effectively address LGBT health issues, it's important to ask these questions in surveys. This will allow researchers and policy makers to accurately understand LGBT health and disparities.

ADULT VERSION PRE

As you answer, you may feel that one or more of the questions below do not apply to you or make you feel uncomfortable. If there are questions that you do not feel comfortable answering, you do not have to answer them. Your participation in this questionnaire is completely voluntary.

55. My sex at birth was…

Staff-Administered:
**Staff Administrator Step 1:*
Write in participant's response (in language):_____
If applicable, write in translation of participant's response:_____

**Staff Administrator Step 2:*
Select one of the following that best fits the participant's response:

☐ Male/Boy
☐ Female/Girl
☐ Intersex (they were unsure about my sex at birth)
☐ I am not sure about my sex assigned at birth
☐ My assigned sex at birth (please specify):_____
☐ I do not wish to answer this question

Gender identity is how individuals perceive themselves and what they call themselves, whether male, female, a blend of both or neither. A person's gender identity can be the same or different from their sex assigned at birth.

56. When it comes to my gender identity, I think of myself as….

Staff-Administered:
**Staff Administrator Step 1:*
Write in the participant's response (in language):_____
If applicable, write in translation of the participant's response:_____

**Staff Administrator Step 2:*
Check all of the following that best fit the participant's response:

☐ Man/Male
☐ Woman/Female
☐ Transgender/Trans
☐ Trans man/Trans male
☐ Trans woman/Trans female
☐ Genderqueer/Gender non-conforming
☐ I do not wish to answer this question
☐ Non-binary (not exclusively male or female)
☐ Two Spirit
☐ Intersex (between male and female)
☐ I am not sure about my gender identity
☐ I do not have a gender/ gender identity
☐ My gender identity is (please specify):_____

Sexual orientation is different from gender identity and is about whom you're attracted to and want to have romantic relationships with. Examples of sexual orientation are gay, lesbian, bisexual, asexual, and heterosexual. Some people are straight and are attracted to people of another gender. Other people are gay or lesbian and are attracted to people of the same gender.

57. What is your sexual orientation?

Staff-Administered:
**Staff Administrator Step 1:*
Write in the participant's response (in language):_____
If applicable, write in translation of the participant's response:_____

**Staff Administrator Step 2:*
Check all of the following that best fit the participant's response.

☐ Straight/heterosexual
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Asexual (I am not attracted to anyone sexually)
☐ I am not attracted to anyone romantically
☐ I am not sure who I am attracted to sexually
☐ I am not sure who I am attracted to romantically

☐ Queer ☐ Something else: _____
☐ Pansexual/Non-monosexual (I am attracted to all genders) ☐ I do not wish to answer this question

***For Staff Administrators Only:**

In your opinion, were any of the above items confusing or difficult for the participant to understand?
___No
___Yes (If yes, which ones? Please specify #'s: _____)

In your opinion, did any of the above items cause the participant to feel uncomfortable or upset?
___No
___Yes (If yes, which ones? Please specify #'s: _____)

At present…

	Very Good	Good	Fair	Poor
Would you say your health is Very Good, Good, Fair, or Poor?	☐	☐	☐	☐

ID:
02 - 04 - - __ __ __
Priority Pop Code *IPP Code* *Agency Code* *CDEP Participant Code*

ADULT VERSION (18+)
POST

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. The next questions are about your culture.

At present…	**Strongly Agree**	**Agree**	**I am Neutral**	**Disagree**	**Strongly Disagree**
1. Your culture gives you strength.	☐	☐	☐	☐	☐
2. Your culture is important to you.	☐	☐	☐	☐	☐
3. Your culture helps you to feel good about who you are.	☐	☐	☐	☐	☐
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.	☐	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 3 months.

About how often during the past 3 months did you feel…	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
5. …connected to your culture?	☐	☐	☐	☐	☐
6. …balanced in mind, body, spirit and soul?	☐	☐	☐	☐	☐
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)	☐	☐	☐	☐	☐
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond of your family, school, and friends.*)	☐	☐	☐	☐	☐

Instructions: During the past 3 months how often did you feel…

	All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
9. … nervous?	☐	☐	☐	☐	☐
10. … hopeless?	☐	☐	☐	☐	☐
11. … restless or fidgety?	☐	☐	☐	☐	☐
12. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
13. … feel that everything was an effort?	☐	☐	☐	☐	☐
14. … worthless?	☐	☐	☐	☐	☐

15. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q9-Q14) match how you would describe those experiences? (Check one)

☐ **A lot**	☐ **Somewhat**	☐ **Not At All**

ADULT VERSION POST

Think about the one month in the past 3 months when you were at your worst emotionally.

Did you emotions interfere a lot, some, or not at all with your…	A Lot	Some	Not At All	Refused	Don't Know
16. …performance at work or school?	☐	☐	☐	☐	☐
Check here if not working or in school during the past 12 months ☐					
17. …household chores?	☐	☐	☐	☐	☐
18. …social life?	☐	☐	☐	☐	☐
19. …relationship with friends and family?	☐	☐	☐	☐	☐

20. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q16-Q19) match how you would describe the negative effect of emotions on your life? (Check one)

☐ **A lot** ☐ **Somewhat** ☐ **Not At All**

Instructions: Please answer the following questions based on the services you have received so far. Indicate if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each of the statements below. If the question is about something you have not experienced, check the box for Not Applicable to indicate that this item does not apply to you. <u>Please note: the word "service" stands for any program activities or events connected to the program.</u>

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
21. I like the services that I received here.	☐	☐	☐	☐	☐	☐
22. If I had other choices, I would still get services from this agency.	☐	☐	☐	☐	☐	☐
23. I would recommend this agency to a friend or family member.	☐	☐	☐	☐	☐	☐
24. The location of services was convenient (parking, public transportation, distance, etc.).	☐	☐	☐	☐	☐	☐
25. Staff were willing to see me as often as I felt it was necessary.	☐	☐	☐	☐	☐	☐
26. Services were available at times that were good for me.	☐	☐	☐	☐	☐	☐
27. When I first called or came here, it was easy to talk to the staff.	☐	☐	☐	☐	☐	☐
28. The staff here treat me with respect.	☐	☐	☐	☐	☐	☐
29. The staff here don't think less of me because of the way I talk.	☐	☐	☐	☐	☐	☐
30. The staff here respect my race and/or ethnicity.	☐	☐	☐	☐	☐	☐
31. The staff here respect my religious and/or spiritual beliefs.	☐	☐	☐	☐	☐	☐
32. The staff here respect my gender identity and/or sexual orientation.	☐	☐	☐	☐	☐	☐
33. Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	☐	☐	☐	☐	☐	☐
34. The people who work here respect my cultural beliefs, remedies and healing practices.	☐	☐	☐	☐	☐	☐
35. Staff here understand that people of my racial and/or ethnic group are not all alike.	☐	☐	☐	☐	☐	☐
36. Staff here understand that people of my gender and/or sexual orientation group are not all alike.	☐	☐	☐	☐	☐	☐
37. Staff here understand that people of my religious and spiritual background are not all alike.	☐	☐	☐	☐	☐	☐

ADULT VERSION POST

As a direct result of my involvement in the program:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
38. I deal more effectively with my daily problems.	☐	☐	☐	☐	☐	☐
a. If you *strongly agree* or *agree*, what specific aspect(s) of the program contributed to this change?_____						
39. I do better in school and/or work.	☐	☐	☐	☐	☐	☐
a. If you *strongly agree* or *agree*, what specific aspect(s) of the program contributed to this change?_____						
40. My symptoms/problems are not bothering me as much.	☐	☐	☐	☐	☐	☐
a. If you *strongly agree* or *agree*, what specific aspect(s) of the program contributed to this change?_____						

	Yes	No	Refused	Don't Know
41. Were the services you received here in the language you prefer?	☐	☐	☐	☐
42. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available in the language you prefer?	☐	☐	☐	☐

43. Was there anything about the program/service that was particularly helpful to you that you have not mentioned earlier?

44. Was there anything about the program/service that could be improved that you have not mentioned earlier?

45. Do you have any other comments about the program/service that you received?

Thank you for compleitng the survey.

ID:
02 - 04 - A - __ __ __ __
Priority Pop Code *IPP Code* *Agency Code* *CDEP Participant Code*

ADULT VERSION (18+)
PRE (Korean)

담당직원에 의한 설문조사 유의점 (담당직원 시행)

프로그램 참여자가 직접 설문을 작성하지 않고 직원이 실행하는 경우, 실행자는 모든 응답이 자발적 의사에 따라 이루어지는 것이며 원치 않을 경우 응답을 거부할 수 있다는 점을 참여자에게 상기시켜 주어야 합니다. 참여자가 특정 문항에 응답을 거부하는 경우, 실행자는 그 이유를 질문합니다. 그런 뒤 그 이유와 더불어 실행자의 관찰 내용을 설문지의 "실행기록란"에 보고합니다. 만일 참여자가 그 이유를 밝히기 거부하는 경우, 참여자에게 압력을 행사해서는 안되며 대신 실행자의 관찰 내용을 "실행기록란"에 보고합니다.

설문조사 개요

캘리포니아 주정부에서 지원하는 CRDP 는 아프리카계 미국인, 아시아태평양계 동양인, 라티노, LGBTQ 로 통칭되는 성소수자(레즈비언, 게이, 양성애자, 트랜스젠더, 소수성애자), 아메리칸인디언(아메리칸원주민)을 포함하는 다섯 개 집단이 오랫동안 적절한 서비스를 받지 못하거나 부적절한 방식으로 서비스를 받았다는 문제의식에서 출발한 프로젝트입니다. 여기서 이들 집단의 서비스 불평등 문제를 해소하기 위한 자료를 수집하고자 설문지가 개발되었습니다. 이 설문지는 위 다섯 집단에 공통적으로 적용되는 것이므로 일부 질문은 귀하와 관련이 없거나 응답의 필요성을 느끼지 못할 수 있습니다.

귀하가 응답한 모든 정보는 비밀이 유지됩니다. 수집된 자료는 귀하의 이름이 삭제된 상태에서 주정부와 공유되기 때문에 귀하의 응답과 신상을 서로 연결시킬 수 없습니다. 설문에 응답하는 과정에서, 귀하에게 해당되지 않거나 불편감을 주는 질문들이 나올 수 있습니다. 혹시 응답하기 불편하면 하시지 않아도 됩니다. 귀하의 설문 참여는 전적으로 귀하의 자발적 의사에 따라 이루어지는 것입니다. 참여의 정도를 떠나 서비스 불평등 문제를 해소하려는 노력에 큰 도움이 될 것입니다. 본 설문조사에 대한 궁금한 사항은 담당 직원에게 문의하시기 바랍니다.

02-04-A- **ADULT VERSION PRE**

문화가 무엇인지에 대한 이해는 사람마다 다릅니다. 일반적으로는 규모가 큰 집단의 구성원들이 공유하는 어떤 것을 의미하지만 풍습이나 전통, 문화유산이나 생활방식을 떠올리는 이들도 있습니다. 또한 문화는 신념, 가치, 태도, 개인의 정체성, 해당 집단의 역사와 구성원 지위를 가리키기도 합니다. 다음 질문들은 귀하의 문화적 배경에 관한 질문입니다.

현재...	**매우 동의**	**동의**	**중립**	**동의 안함**	**전혀 동의 안함**
1. 우리문화는 나에게 힘이 된다.	☐	☐	☐	☐	☐
2. 우리문화는 나에게 중요하다.	☐	☐	☐	☐	☐
3. 우리문화는 나 자신에 대해 자부심을 느끼게 해준다.	☐	☐	☐	☐	☐
4. 나는 우리 문화의 영적/종교적 전통에 연결되어 있는 느낌을 갖고 있다.	☐	☐	☐	☐	☐

다음은 지난 30 일 동안 어떻게 느끼셨는지에 대한 질문입니다.

지난 30 일 동안 ...라는 느낌을 얼마나 자주 경험하셨습니까?	**항상**	**대부분**	**약간**	**조금**	**전혀**
5. 귀하가 한국 문화와 연결되어있다고...	☐	☐	☐	☐	☐
6. 정신적, 육체적, 종교적, 영적 균형을 유지하고 있다고...	☐	☐	☐	☐	☐
7. 사회에서 주변적이고 배제된 존재라고... (즉 나 자신이 중요한 존재가 아니라거나 내 생각, 느낌, 의견이 별 의미가 없다는 느낌)	☐	☐	☐	☐	☐
8. 사회로부터 고립되고 소외당했다고... (즉 가족, 학교, 친구를 넘어 사회로부터)	☐	☐	☐	☐	☐

9. 현재 의료보험이 있으십니까? (해당 사항에 응답해주십시오)

☐ 예 **(10 번으로 가십시오)**

☐ 아니오

→ 지난 1 년동안 건강보험을 가지고 있었습니까? ☐ 네 ☐ 아니오 ☐ 거절 ☐ 잘 모르겠음

(11 번으로 가십시오)

☐ 답변 거절**(11 번으로 가십시오)**

☐ 잘 모르겠음**(11 번으로 가십시오)**

10. 현재 귀하가 갖고 있는 의료보험은 정신건강서비스에 대한 비용을 보장합니까? (예: 심리학자 또는 정신과 의사 방문/상담)
    - ☐ 예
    - ☐ 아니오
    - ☐ 답변 거절
    - ☐ 잘 모르겠음

11. 지난 12 개월 동안 본인의 정서적/개인적 문제를 해결하기 위해 항우울제 또는 항불안제와 같은 처방약을 거의 매일 2 주, 혹은 그 이상 복용하신 적이 있습니까?
    - ☐ 예
    - ☐ 아니오
    - ☐ 답변 거절
    - ☐ 잘 모르겠음

12. 지난 12 개월 동안 본인의 정신건강, 정서, 신경쇠약, 술, 마약사용과 관련된 문제로 인해 아래와 같은 이들의 도움이 필요하다고 생각하신 적이 있었습니까?

	예	아니요	답변 거절	잘 모름	해당없음
a. 연장자, 무당, 종교 관련 지도자, 조언가	☐	☐	☐	☐	☐
b. 보건의료분야 종사자, 동료 상담사, 사례 관리자 등 지역의 전문가	☐	☐	☐	☐	☐
c. 주치의 또는 1 차 진료 의사	☐	☐	☐	☐	☐
d. 상담사, 치료사, 심리학자, 정신과의사, 사회복지사 등 정신건강전문가	☐	☐	☐	☐	☐

13. 지난 12 개월 동안 본인의 정신건강, 정서, 술, 마약사용과 관련된 문제로

	예	아니요	답변 거절	잘 모름	해당없음
a. 연장자, 무당, 종교 관련 지도자, 조언가를 만나신 적이 있습니까?	☐	☐	☐	☐	☐
b. 보건의료분야 종사자, 동료 상담사, 사례 관리자 등 지역의 전문가를 만나신 적이 있습니까?	☐	☐	☐	☐	☐
c. 주치의 또는 1 차 진료 의사를 만나신 적이 있습니까?	☐	☐	☐	☐	☐
d. 상담사, 치료사, 심리학자, 정신과의사, 사회복지사 등 정신건강전문가를 만나신 적이 있습니까?	☐	☐	☐	☐	☐

13c 또는 13d 의 대답이 "예"일 경우, **14 번으로 가십시오. (그 외 응답은 19 번으로 가십시오.)**

19 번으로

14. 본인의 정신적, 정서적, 술, 마약 문제를 해결하기 위해 관련 전문가의 도움을 받은 적이 있습니까? (다음 중 한가지만 선택해 주십시오)
☐ 예, 정신적/정서적 문제로 도움받음
☐ 예, 술, 마약 문제로 도움받음
☐ 예, 정신적, 술, 마약문제로 도움받음
☐ 답변 거절
☐ 잘 모르겠음

15. 지난 12 개월 동안 본인의 정신적, 정서적, 술, 마약 문제를 해결하기 위해 해당 전문가 (상담사, 치료사, 심리학자, 정신과의사, 사회복지사)를 얼마나 많이 찾아가셨습니까? (입원일 수 제외)
_____ 번 (방문횟수)

16. 귀하는 정신건강 문제를 해결하기 위해 현재 정신건강 전문가의 도움을 받고 계십니까?
☐ 예 → **(19 번으로)**
☐ 아니오 → **(17 번으로)**
☐ 답변 거절 → **(19 번으로)**
☐ 잘 모르겠음 → **(19 번으로)**

17. 귀하는 전문가가 권유한 치료프로그램을 다 마치셨습니까? (상담사, 치료사, 심리학자, 정신과 의사, 사회복시사 등 전문가가 더 이상의 치료가 필요 없다고 할 때 치료를 종료함)
☐ 예 → **(19 번으로)**
☐ 아니오 → **(18 번으로)**
☐ 답변 거절 → **(19 번으로)**
☐ 잘 모르겠음 → **(19 번으로)**

18. 치료를 중단한 **가장 큰 이유**는 무엇입니까? (다음 중 한가지만 선택해 주십시오)
☐ 더 나아짐/더 이상 치료가 필요 없어짐
☐ 더 나아졌다는 느낌을 받지 못함
☐ 스스로 해결하고 싶어서
☐ 좋지 못했던 치료 경험
☐ 부족한 시간/교통편
☐ 너무 비싸서
☐ 보험이 정신건강 치료를 보장하지 않아서
☐ 기타(구체적으로) _____
☐ 답변 거절
☐ 잘 모르겠음

02-04-A- ADULT VERSION PRE

사람들은 자신이 겪는정신건강문제에 대해 전문가 (상담사, 치료사, 심리학자, 정신과의사, 사회복지사)의 도움이 필요하다는 것을 알면서도, 도움을 받지 않는 경우가 있습니다. 다음은 당신이 정신건강 전문가를 찾지 않는 이유에 관한 질문입니다. (현재 전문가의 도움을 받고 있더라도 설문에 응답해 주십시오)

	동의	동의 안함	답변거절	잘 모르겠음
19. 아래의 전문가들에게 도움을 받고 있거나 받을 예정이다.				
a. 연장자, 무당, 종교 관련 지도자, 조언가	☐	☐	☐	☐
b. 보건의료분야 종사자, 동료 상담사, 사례 관리자 등 지역의 전문가	☐	☐	☐	☐
20. 정신건강 관련 전문가가 있다는 사실을 몰랐다.	☐	☐	☐	☐
	(34 번으로)	(21 번으로)	(34 번으로)	

	동의	동의 안함	답변거절	잘 모르겠음
21. 정신건강 문제에 대해 전문가와 상담하는 것이 불편해서	☐	☐	☐	☐
22. 아래와 같은 이유때문에 안전하거나 환영받는 기분을 느끼지 못할 것 같아서				
a. 부족한 영어 실력	☐	☐	☐	☐
b. 인종/민족	☐	☐	☐	☐
c. 나이	☐	☐	☐	☐
d. 종교생활이나 영적활동	☐	☐	☐	☐
e. 성 정체성	☐	☐	☐	☐
f. 성적 성향/취향	☐	☐	☐	☐
23. 치료 비용에 대한 걱정 또는 부담감 때문에	☐	☐	☐	☐
24. 부족한 시간 (직장, 자녀, 기타 이유) 때문에	☐	☐	☐	☐
25. 교통편이 없거나, 치료 프로그램이 너무 멀리 있거나, 프로그램 시간이 나와 맞지 않아서	☐	☐	☐	☐
26. 정신건강 상담/치료가 필요없다는 생각이 들어서	☐	☐	☐	☐
27. 전문가 도움없이 스스로 해결할 수 있을 것 같아서	☐	☐	☐	☐
28. 정신건강 상담/치료가 크게 도움이 되지 않을 것 같아서	☐	☐	☐	☐
29. 정신건강 상담/치료 사실이 이웃이나 주변에 알려지면 그들이 나를 부정적으로 보게 될까 걱정이 되어서	☐	☐	☐	☐
30. 정신건강 상담/치료 이력이 직장에 부정적 영향을 끼치게 될까봐	☐	☐	☐	☐
31. 정신건강 전문가와 상담 시, 비밀이 지켜지지 않을 수도 있기 때문에	☐	☐	☐	☐
32. 정신 병원에 입원을 할 수도 있다는 걱정 때문에	☐	☐	☐	☐
33. 약을 복용하게 될 수도 있다는 걱정 때문에	☐	☐	☐	☐

02-04-A- **ADULT VERSION PRE**

다음 질문들은 지난 30 일 동안 당신이 느낀 증상에 관한 질문입니다.

지난 30 일 동안...

	항상	대부분	약간	조금	전혀
34. 신경이 예민했던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐
35. 희망이 없다고 느꼈던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐
36. 안절부절하며 가만히 있을 수가 없었던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐
37. 너무 우울해서 뭘해도 기분이 좋아지지 않았던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐
38. 모든 게 다 힘겹다는 생각이 들었던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐
39. 내가 쓸모없는 존재란 생각이 들었던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐

40. 위 문항들(34 번-39 번)은 귀하의 정신적, 정서적 스트레스 경험을 파악하기 위해 종종 사용되는 질문들입니다. 귀하가 보시기에 위 질문들이 귀하의 그러한 경험을 파악하는데 얼마나 적합하다고 생각하십니까? (해당되는 곳에 X 표시를 해주십시오)

☐ **많이**	☐ **다소**	☐ **전혀**

지난 12 개월 중, 정서적으로가장 힘들었었던 한 달에 관한 질문을 드립니다.

정서적 어려움이 귀하의 일상생활에 얼마나 많은 영향을 끼쳤습니까? (많이, 약간, 전혀)

	많이	약간	전혀	답변 거절	잘 모름
41. ...직장/학교 생활에 있어서?	☐	☐	☐	☐	☐
→ *지난 12 달 동안 특정 직업 (학교 포함)을 가진 적이 없습니다* ☐					
42. ...가사 활동을 수행함에 있어서?	☐	☐	☐	☐	☐
43. ...사회 생활을 수행함에 있어서?	☐	☐	☐	☐	☐
44. ...친구/가족 관계에 있어서?	☐	☐	☐	☐	☐

45. 위 문항들은 정서가 우리의 일상생활에 어떤 영향을 끼치는지 알아보기 위해 종종 사용됩니다. 귀하가 보시기에 위 질문(41 번-44 번)들이 정서가 귀하의 일상생활에 끼친 부정적인 영향을 파악하는데 얼마나 적합하다고 생각하십니까? (해당되는 곳에 X 표시를 해주십시오)

☐ **많이**	☐ **다소**	☐ **전혀**

46. 귀하의 나이는 몇 살입니까?

☐ 18 세 에서 29 세 사이
☐ 30 세 에서 39 세 사이
☐ 40 세 에서 44 세 사이
☐ 45 세 에서 49 세 사이
☐ 50 세 에서 64 세 사이
☐ 65 세 이상

47. 귀하의 인종/민족은 어떻게 되십니까? **(해당 사항 한 곳에 X 표시를 하고 빈칸에 구체적으로기입해 주십시오).**

☐ 아메리칸 인디안 또는 알라스카 원주민
☐ 흑인 또는 아프리카 계 미국인**:** (구체적으로):_____
☐ 라티노, 히스패닉, 또는 스페니쉬: (구체적으로):_____
☐ 아시안: (구체적으로): _____
☐ 하와이 원주민/기타 남태평양 원주민: (구체적으로): _____
☐ 백인: (구체적으로):_____
☐ 기타: (구체적으로):_____
☐ 다민족 또는 복합 인종: (구체적으로):_____
☐ 답변 거절
☐ 잘 모름

48. 귀하의 영어 실력은 어느 정도 되십니까?

☐ 유창함
☐ 어느 정도 능통하지만, 때로 어려움을 겪음
☐ 잘 하지 못함. 상당 수의 영어 단어들과 문장들을 알고 있지만, 대화시 어려움을 겪음
☐ 단어들을 알고 있고 사용하지만, 문장을 만들어서 사용하지는 못함
☐ 전혀 못함

49. 귀하에게 편한 언어는 어떤 것입니까?_____

50. 귀하의 출생지는 어디입니까?

☐미국
☐ 미국 외 국가
☐ 답변 거절
☐ 잘 모르겠음

51. 귀하의 거주지 우편번호 첫 3 자리는 무엇입니까? __ __ __

☐ 거주지가 일정하지 않습니다/ 우편번호가 없습니다
☐ 답변 거절
☐ 잘 모르겠음

52. 귀하는 난민이나 실향민을 위한 임시정착지, 혹은 미국 이민세관단속국(ICE)에서 운영하는 시설에서 생활한 적이 있습니까?

☐ 해당 사항 없음
☐ 네
☐ 아니오
☐ 답변 거절
☐ 잘 모르겠음

53. 미국에 얼마나 오랫동안 거주 하셨습니까? (1 년 미만인 경우, "1"을 기입해 주십시오)

총 거주 연 수_____
☐ 해당 사항 없음

54. 귀중한 시간 내주셔서 감사합니다. 귀하의 응답은 철저히 비밀유지가 됨을 알려 드립니다. 이제까지 나온 질문 중에 특별히 불편하거나 거부감을 주는 질문이 있었습니까?

__아니오
__네 (있다면, 그 질문의 번호를 써주십시오: _____)

02-04-A- **ADULT VERSION PRE**

미국사회에서 LGBTQ 로 불리는 레즈비언, 게이, 양성애자, 트랜스젠터, 퀴어는 인종, 민족, 종교, 사회계층을 막론하고 존재합니다. LGBTQ 에 대한 차별은 이들의 정신질환, 물질남용, 자살 비율이 일반인에 비해 높은 것과 관련이 있습니다. 그럼에도 낙인 때문에 이들은 정신건강서비스에 접근하는 과정에서 일반인 보다 더 큰 장벽을 경험합니다.

성적취향이나 성정체성에 관한 질문은 연방정부나 주정부가 주관하는 설문조사에는 대부분 포함되지 않기 때문에 LGBTQ 인구의 규모나 건강관련 요구를 예측하는데 어려움이 있습니다. 이 분들의 건강관련 요구를 보다 효과적으로 조명하기 위해서는 설문조사에 다음과 같은 내용이 포함될 필요가 있습니다. 이러한 조사는 연구자와 정책입안자가 LGBTQ 인구의 건강관련 요구와 불평등 문제를 보다 정확하게 예측하는데 도움이 됩니다.

설문지에 응답하는 동안, 귀하에게 해당되지 않거나 불편감을 주는 질문들이 나올 수 있습니다. 혹시 응답하기 불편하면 하시지 않아도 됩니다. 귀하의 설문 참여는 전적으로 귀하의 자발적 의사에 따라 이루어지는 것입니다.

55. 출생 시 나의 성별은:

참여자 응답을 그대로(한국어):_____

해당시 참여자 응답을 번역하여(영어) : _____

참여자의 응답에 가장 적절한 것을 하나만 선택하시오.

☐ 남성
☐ 여성
☐ 간성(남성과 여성 사이)
☐ 출생 시 성별이 명확하지 않음
☐ 출생 시 성별은 (구체적으로):_____
☐ 답변 거절

성 정체성은자기 자신을 어떤 사람으로 인지하는지, 자신을무어라 부르는지, 즉 남성인지, 여성인지, 둘다인지, 둘다 아닌지 등을 일컫는 것입니다. 성 정체성은 출생시에 지정된 성별과 같을 수도 있고, 다를 수도 있습니다.

56. 내가 생각하는 나의 성 정체성은:

참여자 응답을 그대로(한국어):_____

해당시 참여자 응답을 번역하여(영어) : _____

참여자의 응답에 해당하는 모든 사항에 표시를 해 주십시오.

☐ 남성
☐ 여성
☐ 성 전환자/트랜스 젠더
☐ 남성 성 전환자 (**여자에서 남자로)**
☐ 여성 성 전환자 (**남자에서 여자로)**
☐ 특정 성별 없음
☐ 답변 거절
☐ Non-binary (완전히 남성도 여성도 아닌)
☐ 두 개의 영혼
☐ 간성 (남성과 여성 사이)
☐ 어떤 성 정체성을 가지고 있는지 명확하지 않음
☐ 특정 성 정체성을 가지고 있지 않음
☐ 나의 성 정체성은 (구체적으로):_____

성적 취향은 성 정체성과는 다른 것이며, 어떤 성에게 끌리고, 어떤 사람과 낭만적인 관계를 맺기 원하는지에 관한 것입니다. 성적 취향의 예로는 게이, 레즈비언, 양성애자, 무성별자, 이성애자가 있습니다. 어떤 사람들은 이성애자로, 반대 성별의 사람(이성)에게 끌립니다. 다른 사람들은 게이나 레즈비언으로, 같은 성별을 가진 사람(동성)에게 끌립니다.

57. 당신의 성적 취향은 어떻게 되십니까?

참여자 응답을 그대로(한국어):_____

해당시 참여자 응답을 번역하여(영어) : _____

참여자의 응답에 해당하는 모든 사항에 표시를 해 주십시요.

☐ 이성애자
☐ 게이
☐ 레즈비언
☐ 양성애자
☐ 퀴어
☐ 다성애자 (모든 종류의 "성"에 끌립니다)
☐ 무성욕 (아무에게도 "성"적으로 끌리지 않는다)
☐ 아무에게도 끌리지 않는다.
☐ "성"적으로 끌리는 대상이 누군지 잘 모르겠다
☐ 내가 누구에게 끌리는지 모르겠다
☐ 기타: _____
☐ 답변 거절

*** 담당직원 응답란:**

귀하의 생각으로는, 위의 질문 중에 참여자가 헛갈리거나 이해하기 어려운 질문이 있었습니까?

__아니오

__예 (있다면, 그 질문의 번호를 써주십시오: _____)

귀하의 생각으로는, 위의 질문 중에 참여자를 불편하게 하거나 거부감을 주는 질문이 있었습니까?

__아니오

__예 (있다면, 그 질문의 번호를 써주십시오: _____)

58. **현재...**

	매우 좋음	**좋음**	**보통**	**나쁨**
귀하는 자신의 건강상태가 어떻다고 보십니까?	☐	☐	☐	☐

ID:
02 - 04 - A - ___ ___ ___
Priority Pop Code *IPP Code* *Agency Code* *CDEP Participant Code*

ADULT VERSION (18+)
POST (Korean)

문화가 무엇인지에 대한 이해는 사람마다 다릅니다. 일반적으로는 규모가 큰 집단의 구성원들이 공유하는 어떤 것을 의미하지만 풍습이나 전통, 문화유산이나 생활방식을 떠올리는 이들도 있습니다. 또한 문화는 신념, 가치, 태도, 개인의 정체성, 해당 집단의 역사와 구성원 지위를 가리키기도 합니다. 다음 질문들은 귀하의 문화적 배경에 관한 질문입니다.

현재...	**매우 동의**	**동의**	**중립**	**동의 안함**	**전혀 동의 안함**
1. 우리문화는 나에게 힘이 된다.	☐	☐	☐	☐	☐
2. 우리문화는 나에게 중요하다.	☐	☐	☐	☐	☐
3. 우리문화는 나 자신에 대해 자부심을 느끼게 해준다.	☐	☐	☐	☐	☐
4. 나는 우리 문화의 영적/종교적 전통에 연결되어 있는 느낌을 갖고 있다.	☐	☐	☐	☐	☐

다음은 지난 3 개월동안 어떻게 느끼셨는지에 대한 질문입니다.

지난 3 개월동안 ...라는 느낌을 얼마나 자주 경험하셨습니까?	**항상**	**대부분**	**약간**	**조금**	**전혀**
5. 귀하가 한국 문화와 연결되어있다고...	☐	☐	☐	☐	☐
6. 정신적, 육체적, 종교적, 영적 균형을 유지하고 있다고...	☐	☐	☐	☐	☐
7. 사회에서 주변적이고 배제된 존재라고... (즉 나 자신이 중요한 존재가 아니라거나 내 생각, 느낌, 의견이 별 의미가 없다는 느낌)	☐	☐	☐	☐	☐
8. 사회로부터 고립되고 소외당했다고... (즉 가족, 학교, 친구를 넘어 사회로부터)	☐	☐	☐	☐	☐

지난 3 개월간 ...

	항상	대부분	약간	조금	전혀
9. 신경이 예민했던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐
10. 희망이 없다고 느꼈던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐
11. 안절부절하며 가만히 있을 수가 없었던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐
12. 너무 우울해서 뭘해도 기분이 좋아지지 않았던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐
13. 모든 게 다 힘겹다는 생각이 들었던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐
14. 내가 쓸모없는 존재란 생각이 들었던 때가 얼마나 됩니까?	☐	☐	☐	☐	☐

15. 위 문항들(9 번-14 번)은 귀하의 심리적, 정신적인 스트레스 경험을 파악하기 위해 종종 사용되는 질문들입니다. 귀하가 보시기에 위 질문들이 귀하의 그러한 경험을 파악하는데 얼마나 적합하다고 생각하십니까? (해당되는 곳에 X 표시를 해주십시오)

☐ **많이**	☐ **다소**	☐ **전혀**

지난 3 개월 중, 정서적으로가장 힘들었었던 한 달에 관한 질문을 드립니다.

정서적 어려움이 귀하의 일상생활에 얼마나 많은 영향을 끼쳤습니까? (많이, 약간, 전혀)

	많이	약간	전혀	답변 거절	잘 모름
16. ...직장/학교 생활에 있어서?	☐	☐	☐	☐	☐
지난 12 달 동안 특정 직업 (학교 포함)을 가진 적이 없습니다 ☐					
17. ...가사 활동을 수행함에 있어서?	☐	☐	☐	☐	☐
18. ...사회 생활을 수행함에 있어서?	☐	☐	☐	☐	☐
19. ...친구/가족 관계에 있어서?	☐	☐	☐	☐	☐

20. 위 문항들은 정서가 우리의 일상생활에 어떤 영향을 끼치는지 알아보기 위해 종종 사용됩니다. 귀하가 보시기에 위 질문들(16 번-19 번)이 정서가 귀하의 일상생활에 끼친 부정적인 영향을 파악하는데 얼마나 적합하다고 생각하십니까? (해당되는 곳에 X 표시를 해주십시오)

☐ **많이**	☐ **다소**	☐ **전혀**

ADULT POST (Korean)

다음은 이 기관에서 받은 서비스에 대해 귀하가 어떤 생각을 갖고 계신지 질문하겠습니다. 여기서 서비스란 귀하가 이용하는 프로그램과 관련된 모든 활동을 말합니다. 매우 동의, 동의, 중립, 동의 안함, 매우 동의 안함 중 한 가지에 답변해 주시고, 귀하와 관계없는 문항의 경우 "해당 없음"에 x 표시를 해주십시오.

	매우 동의	동의	중립	동의 안함	매우 동의 안함	해당없음
21. 이 기관에서 받은 서비스에 만족한다.	☐	☐	☐	☐	☐	☐
22. 내게 선택의 여지가 있다 해도 이 기관을 이용할 것이다.	☐	☐	☐	☐	☐	☐
23. 이 기관을 가족이나 친구에게 추천하겠다.	☐	☐	☐	☐	☐	☐
24. 이 기관의 위치는 나에게 편리했다 (주차, 대중교통, 거리 등)	☐	☐	☐	☐	☐	☐
25. 직원들은 내가 도움을 요청할 때 항상 도와줬다.	☐	☐	☐	☐	☐	☐
26. 서비스는 내가 가능한 시간에 제공되었다.	☐	☐	☐	☐	☐	☐
27. 처음 방문 했을 때, 담당 직원과 이야기하기가 수월했다.	☐	☐	☐	☐	☐	☐
28. 이 기관의 직원들은 나를 존중해 주었다.	☐	☐	☐	☐	☐	☐
29. 직원들은 내 말투 (말하는 방식) 때문에 나를 무시하거나 하지는 않았다.	☐	☐	☐	☐	☐	☐
30. 직원들은 나의 이민자 배경(지위)을 존중해 주었다.	☐	☐	☐	☐	☐	☐
31. 직원들은 나의 종교적/영적 가치관을 존중해 주었다.	☐	☐	☐	☐	☐	☐
32. 직원들은 나의 성 정체성과 성적취향을 존중해 주었다.	☐	☐	☐	☐	☐	☐
33. 직원들은 내가 필요로 할 때 적절한 대안을 제공해 주었다 (예: 예약 시간 변경)	☐	☐	☐	☐	☐	☐
34. 직원들은 나의 한국적 가치관이나 내가 사용하는 전통적 치료 방법들을 존중해 주었다.	☐	☐	☐	☐	☐	☐
35. 이 기관 직원들은 한국인이라 해서 모두 같지는 않다는 점을 잘 이해하고 있다.	☐	☐	☐	☐	☐	☐
36. 이 기관 직원들은 같은 성 정체성과 성적취향을 가졌다고해서 모두 같은 것은 아니란 점을 잘 이해하고 있다.	☐	☐	☐	☐	☐	☐
37. 이 기관 직원들은 같은 영적, 종교적 배경을 가졌다고해서 모두 같은 것은 아니란 점을 잘 이해하고 있다.	☐	☐	☐	☐	☐	☐

프로그램 참석의 결과로 :

	매우 동의	동의	중립	동의 안함	매우 동의 안함	해당 사항 없음
38. 나의 문제를 전보다 더 효과적으로 해결할 수 있게 되었다.	☐	☐	☐	☐	☐	☐
a. **매우 동의**하거나 **동의**한다고 응답한 경우, 이용하신 서비스나 프로그램 가운데 특히 어떤 점이 그러한 변화를 가져오는데 도움이 되었나요?						
39. 학교나 직장 생활을 전보다 더 잘 할 수 있게 되었다.	☐	☐	☐	☐	☐	☐
a. **매우 동의**하거나 **동의**한다고 응답한 경우, 이용하신 서비스나 프로그램 가운데 특히 어떤 점이 그러한 변화를 가져오는데 도움이 되었나요?						
40. 정신건강상의 문제나 증상이 이전에 비해 큰 영향을 미치지 않게 되었다.	☐	☐	☐	☐	☐	☐
a. **매우 동의**하거나 **동의**한다고 응답한 경우, 이용하신 서비스나 프로그램 가운데 특히 어떤 점이 그러한 변화를 가져오는데 도움이 되었나요?						

	네	아니오	답변 거절	잘 모르겠음
41. 귀하는 이 기관의 서비스를 이용하는 과정에서 귀하가 선호하는 언어로 도움을 받으셨습니까?	☐	☐	☐	☐
42. 귀하가 받은 서면 정보는 귀하가 선호하는 언어로 작성된 것이었습니까? (이용 가능한 서비스, 소비자 권리, 정신건강 교육자료)	☐	☐	☐	☐

43. 귀하가 이용한 프로그램이나 서비스 가운데, 귀하가 위에서 언급하지 않은, 특히 도움이 되었던 점은 무엇이라 생각하십니까?

44. 귀하가 이용한 프로그램이나 서비스 가운데, 귀하가 위에서 언급하지 않은, 개선의 여지가 있는 점은 무엇이라 생각하십니까?

45. 귀하가 이용한 프로그램이나 서비스에 대해 추가적 의견이 있으시면 말씀해 주십시오.

46.

	매우 좋음	**좋음**	**보통**	**나쁨**
귀하는 자신의 건강상태가 어떻다고 보십니까?	☐	☐	☐	☐

설문에 참여해 주셔서 감사합니다.

ID:
02 - 04 - B - __ __ __
Priority Pop Code *IPP Code* *Agency Code* *CDEP Participant Code*

ADULT VERSION (18+)
PRE (Vietnamese)

Hướng dẫn chung cho nhân viên giúp điền đơn/và nhân viên của chương trình

Nhân viên giúp điền đơn

Nếu các nhân viên giúp người tham gia điền đơn (thay vì tự trả lời bởi người tham gia chương trình), nhân viên nên nhắc nhở người tham gia rằng tất cả các câu hỏi đều là tự nguyện và họ có thể từ chối trả lời bất cứ điều gì họ không muốn. Nếu người tham gia từ chối trả lời câu hỏi, nhân viên sẽ hỏi xem người tham gia có muốn chia sẻ lý do không. Nhân viên điền đơn sẽ ghi lại lý do và bất kỳ quan sát nào trong phần "quản trị viên nhân viên" trên bản câu hỏi. Nếu người tham gia không muốn chia sẻ lý do tại sao, người nhân viên không nên ép buộc người tham gia, nhưng sẽ quan sát lưu lại mọi bình luận của người tham gia trong phần "Nhân viên giúp điền đơn" trên bảng câu hỏi.

Hướng dẫn chung:

Dự án của California nhằm giảm thiểu sự khác biệt về quyền lợi là một dự án toàn tiểu bang, được làm việc trên năm nhóm dân số không được phục vụ, bị hạn chế phục vụ, và/hoặc không được phục vụ phù hợp một cách thích đáng, bao gồm những sắc dân: người Mỹ gốc Phi, Châu Á và Đảo Thái Bình Dương, người gốc Tây Ban Nha, Đồng tính nữ, Đồng tính nam, Người lưỡng tính, Người chuyển giới, Người có giới tính khác biệt (LGBTQ); và người Mỹ bản địa. Để thu thập dữ liệu nhằm giải quyết sự chênh lệch cho nhóm cộng đồng trên, một số các câu hỏi tiêu chuẩn đã được tạo ra cho những nhóm cộng đồng trên. Vì đây là những câu hỏi tiêu chuẩn, sẽ có một vài câu hỏi không phù hợp hoặc liên quan đến quý vị.

Tất cả thông tin mà quý vị chia sẻ sẽ được bảo mật. Dữ liệu sẽ được chia sẻ với Tiểu bang, nhưng danh tánh của quý vị sẽ không được chia sẻ; và tất cả những gì quý vị đã chia sẻ sẽ không ảnh hưởng gì đến quý vị. Trong quá trình trả lời những câu hỏi này, quý vị sẽ gặp một số câu hỏi có thể làm quý vị không thoải mái hoặc không phù hợp, hay liên quan tới quý vị. Quý vị có thể không trả lời những câu hỏi đó. Sự tham gia của quý vị là hoàn toàn tự nguyện. Mức độ tham gia nào từ quý vị cũng được đánh giá cao, bởi vì những thông tin mà quý vị cung cấp đều rất hữu ích cho chúng tôi để hiểu được sự khác biệt giữa các nhóm dân tộc khác nhau. Nếu quý vị có bất kỳ câu hỏi nào, xin vui lòng hỏi nhân viên chúng tôi, người đã đưa cho quý vị mẫu câu hỏi này.

02-04-B- **ADULT VERSION PRE**

Văn hóa có ý nghĩa khác nhau cho mỗi người nhưng nó là cái gì đó thường được chia sẻ bởi một nhóm đông người. Đối với một số người thì nó đề cập đến phong tục và truyền thống. Đối với người khác, văn hóa mang ý nghĩa của sự thừa kế từ những người đi trước và hướng những người đi sau theo cách sống đó. Nó có thể đề cập đến niềm tin, giá trị tinh thần và cái nhìn, bản sắc của bạn, lịch sử chung và đặc tính của thành viên trong một nhóm. Những câu hỏi tiếp theo là những câu hỏi về văn hóa của bạn.

Tại thời điểm này…	**Hoàn toàn đồng ý**	**Đồng ý**	**Trung lập**	**Không đồng ý**	**Hoàn toàn không đồng ý**
1. Văn hóa của bạn cho bạn sức mạnh.	☐	☐	☐	☐	☐
2. Văn hóa của bạn quan trọng đối với bạn.	☐	☐	☐	☐	☐
3. Văn hóa của bạn giúp bạn cảm thấy bạn là người tốt.	☐	☐	☐	☐	☐
4. Bạn cảm thấy nối kết với tâm linh/tôn giáo truyền thống theo văn hóa mà bạn được nuôi dạy từ nhỏ.	☐	☐	☐	☐	☐

Hướng dẫn: Những câu hỏi tiếp theo là những câu hỏi bạn cảm thấy thế nào trong 30 ngày qua.

Trong 30 ngày qua bạn thường cảm thấy…	**Luôn luôn**	**Thường xuyên**	**Thỉnh thoảng**	**Lâu lâu**	**Không lúc nào**
5. …gần gũi với văn hóa của bạn?	☐	☐	☐	☐	☐
6. …có sự cân bằng trong tâm trí, cơ thể, tinh thần và tâm hồn?	☐	☐	☐	☐	☐
7. …bị đẩy lùi hoặc bị loại khỏi xã hội? (Nói cách khác, *cảm thấy bản thân không có quan trọng, hoặc những thứ như suy nghĩ, cảm xúc, hay quan điểm của bạn không quan trọng đối với người khác.*)	☐	☐	☐	☐	☐
8. …bị xã hội cô lập và xa lánh? (Nói cách khác, *cảm thấy cô độc, xa cách, bị cắt đứt khỏi thế giới bên ngoài gia đình, trường học và bạn bè.*)	☐	☐	☐	☐	☐

9. Hiện tại bạn có bảo hiểm y tế hay không? (chọn một)

☐ Có **(Nếu có thì trả lời câu hỏi số 10)**
☐ Không
→ *Bạn có bảo hiểm sức khỏe y tế trong 12 tháng qua không?* ☐ Có ☐ Không ☐ Từ Chối ☐ Không Biết **(Nếu không thì trả lời câu hỏi số 11)**
☐ Từ Chối Trả Lời **(Nếu từ chối thì trả lời câu số 11)**
☐ Không Biết **(Nếu không biết thì trả lời câu số 11)**

	Có	Không	Từ Chối Trả Lời	Không Biết
10. Bảo hiểm y tế của bạn có bao gồm chữa trị cho sức khỏe tâm lý, chẳng hạn như các lần gặp bác sĩ tâm lý và bác sĩ tâm thần?	☐	☐	☐	☐
11. Trong 12 tháng qua, quý vị đã có dùng thuốc theo toa, chẳng hạn như thuốc giảm trầm cảm hoặc thuốc giảm lo âu hàng ngày từ hai tuần trở lên, vì một vấn đề về tâm lý, cảm xúc hay về vấn đề cá nhân?	☐	☐	☐	☐

12. Do có những vấn đề về sức khỏe tâm lý, tình cảm, hay vì việc dùng rượu hoặc nghiện thuốc, có khi nào trong suốt 12 tháng qua bạn <u>CẢM THẤY CÓ THỂ BẠN CẦN</u> gặp…	Có	Không	Từ Chối Trả Lời	Không Biết	Không áp dụng
a. Chuyên gia trợ giúp truyền thống như đông y sĩ, những nhà lãnh đạo về tôn giáo/ tinh thần	☐	☐	☐	☐	☐
b. Chuyên gia trợ giúp từ cộng đồng như chuyên viên về sức khỏe, người quảng bá, những người cố vấn đồng bệnh, hoặc những người hướng dẫn viên về sức khỏe.	☐	☐	☐	☐	☐
c. Bác sĩ gia đình	☐	☐	☐	☐	☐
d. Chuyên gia về sức khỏe tâm lý như cố vấn tâm lý, bác sĩ tâm thần hoặc nhân viên xã hội	☐	☐	☐	☐	☐

13. Trong 12 tháng qua, bởi vì những vấn đề của quý vị về sức khỏe tâm lý, tình cảm, hay vì việc dùng rượu hoặc nghiện thuốc	Có	Không	Từ Chối Trả Lời	Không Biết	Không áp dụng
a. <u>CÓ BAO GIỜ BẠN ĐÃ GẶP</u> chuyên gia trợ giúp truyền thống như đông y sĩ, những nhà lãnh đạo về tôn giáo/tinh thần	☐	☐	☐	☐	☐
b. <u>CÓ BAO GIỜ BẠN ĐÃ GẶP</u> chuyên gia trợ giúp từ cộng đồng như chuyên viên về sức khỏe, người quảng bá, những người cố vấn đồng bệnh, hoặc những người hướng dẫn viên về sức khỏe.	☐	☐	☐	☐	☐
c. <u>CÓ BAO GIỜ BẠN ĐÃ GẶP</u> bác sĩ gia đình	☐	☐	☐	☐	☐
d. <u>CÓ BAO GIỜ BẠN ĐÃ GẶP</u> chuyên gia về sức khỏe tâm lý như cố vấn tâm lý, bác sĩ tâm thần, bác sĩ tâm lý, hoặc nhân viên xã hội	☐	☐	☐	☐	☐

Q13c hoặc 13d, nếu trả lời <u>CÓ</u> thì **TRẢ LỜI CÂU Q14** (nếu trả lời <u>KHÔNG</u> **ĐI ĐẾN Q19**)

TRẢ LỜI CÂU Q19

14. Bạn có tìm kiếm sự giúp đỡ về sức khỏe tâm lý, tình cảm hay về việc dùng rượu hoặc nghiện thuốc không? (*Chọn một*)

☐ Có, Vấn đề về sức khỏe/tình cảm
☐ Có, Dùng rượu hoặc chất nghiện
☐ Có, Vấn đề về sức khỏe tâm lý, dùng rượu và chất nghiện
☐ Từ chối trả lời
☐ Không biết

15. Trong 12 tháng qua, có bao nhiêu lần quý vị đã gặp những chuyên gia về chăm sóc sức khỏe (cố vấn tâm lý, bác sĩ tâm thần hay nhân viên xã hội) cho vấn đề về sức khỏe tâm lý, tình cảm hay vì việc dùng rượu hoặc nghiện thuốc, hoặc cả hai? Xin đừng tính những ngày phải ở lại bệnh viện

_____ # số lần gặp

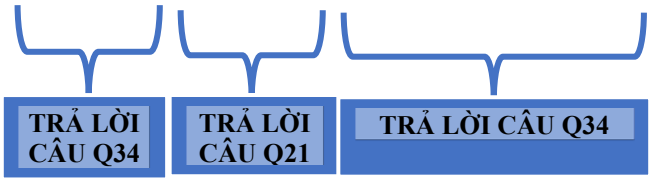
	Có	Không	Từ Chối Trả Lời	Không Biết
16. Có phải quý vị vẫn đang được điều trị cho những vấn đề này từ một hoặc nhiều nhà cung cấp dịch vụ?	☐ → TRẢ LỜI CÂU Q19	☐ → TRẢ LỜI CÂU Q17	☐ → TRẢ LỜI CÂU Q19	☐
17. Quý vị đã hoàn thành quá trình điều trị đầy đủ chưa? Nói cách khác, quý vị chấm dứt điều trị khi người cố vấn tâm lý, bác sĩ tâm thần hoặc nhân viên xã hội của quý vị đã nói với quý vị rằng sự chữa trị của quý vị đã chấm dứt rồi.	☐ → TRẢ LỜI CÂU Q19	☐ → TRẢ LỜI CÂU Q18	☐ → TRẢ LỜI CÂU Q19	☐

18. Đâu là **LÝ DO CHÍNH** làm quý vị không còn nhận được sự điều trị này nữa? (*Chọn một*)

☐ Khỏe hơn/Không còn cần thiết
☐ Không được khỏe hơn
☐ Muốn tự giải quyết vấn đề
☐ Đã có kinh nghiệm xấu với sự điều trị
☐ Thiếu thời gian/Phương tiện
☐Quá tốn kém
☐ Bảo hiểm không chi trả cho việc trị liệu
☐ Lựa chọn khác (Ghi cụ thể) _____
☐ Từ chối trả lời
☐ Không biết

Hướng dẫn: Dưới đây là một số lý do khiến mọi người KHÔNG tìm kiếm sự giúp đỡ từ cố vấn tâm lý, bác sĩ tâm thần hoặc cán sự xã hội ngay cả khi họ nghĩ họ có thể cần đến nó. Ngay cả khi bạn đang nhận được trợ giúp ngay bây giờ, bạn có đồng ý hoặc không đồng ý với những lý do sau đây khiến có lúc bạn không muốn tìm sự trợ giúp từ một chuyên gia về sức khoẻ tâm lý?

	Đồng ý	Không đồng ý	Từ chối trả Lời	Không biết
19. Bạn đang có dự định hoặc đã lên kế hoạch để được giúp từ…				
a. Chuyên gia trợ giúp truyền thống như đông y sĩ, những nhà lãnh đạo về tinh thần	☐	☐	☐	☐
b. Chuyên gia trợ giúp từ cộng đồng như chuyên viên về sức khỏe, người quảng bá, những người cố vấn đồng bệnh, hoặc những người hướng dẫn viên về sức khỏe.	☐	☐	☐	☐
20. Bạn không là biết có những chuyên gia về tâm bệnh này	☐	☐	☐	☐



	Đồng ý	Không đồng ý	Từ chối trả Lời	Không biết
21. Bạn không cảm thấy thoải mái khi nói chuyện với người chuyên môn về các vấn đề cá nhân của bạn	☐	☐	☐	☐
22. Bạn nghĩ rằng bạn sẽ không cảm thấy an toàn và được chào đón trong những lần gặp mặt với các chuyên gia vì bạn …				
a. Anh ngữ hạn chế	☐	☐	☐	☐
b. Sắc tộc	☐	☐	☐	☐
c. Tuổi tác	☐	☐	☐	☐
d. Tôn giáo và Hành đạo	☐	☐	☐	☐
e. Bản sắc giới tính	☐	☐	☐	☐
f. Khuynh hướng tính dục	☐	☐	☐	☐
23. Bạn lo ngại về chi phí chữa trị.	☐	☐	☐	☐
24. Bạn không có thời gian (vì công việc, chăm sóc trẻ em, hoặc có việc bận khác).	☐	☐	☐	☐
25. Bạn không có phương tiện đi lại, hoặc chỗ điều trị quá xa, hoặc giờ giấc không thuận tiện	☐	☐	☐	☐
	☐	☐	☐	☐

26. Bạn nghĩ rằng bạn không cần tư vấn sức khoẻ tinh thần hoặc điều trị vào thời điểm đó.				
27. Bạn nghĩ bạn có thể giải quyết vấn đề mà không cần điều trị.	☐	☐	☐	☐

	Đồng ý	Không đồng ý	Từ chối trả Lời	Không biết
28. Bạn nghĩ rằng tư vấn sức khoẻ tinh thần hoặc điều trị sẽ không giúp mình đỡ hơn.	☐	☐	☐	☐
29. Bạn lo ngại rằng việc điều trị hoặc tư vấn sức khoẻ tinh thần có thể khiến hàng xóm hoặc cộng đồng của bạn có cái nhìn xấu về bạn.	☐	☐	☐	☐
30. Bạn lo ngại rằng việc điều trị hoặc tư vấn sức khoẻ tinh thần có thể có ảnh hưởng tiêu cực đến công việc của bạn.	☐	☐	☐	☐
31. Bạn lo ngại rằng thông tin quý vị cung cấp cho nhân viên tư vấn có thể không được giữ kín.	☐	☐	☐	☐
32. Bạn lo lắng rằng bạn có thể bị đưa vào bệnh viện tâm thần.	☐	☐	☐	☐
33. Bạn lo lắng rằng bạn có thể phải uống thuốc.	☐	☐	☐	☐

Hướng dẫn: Những câu hỏi tiếp theo là về cảm xúc của bạn trong 30 ngày vừa qua. Thường bao lâu thì bạn cảm thấy như vậy trong 30 ngày qua...

	Luôn luôn	Thường xuyên	Thỉnh thoảng	Lâu lâu	Không lúc nào
34. ... lo lắng?	☐	☐	☐	☐	☐
35. … vô vọng?	☐	☐	☐	☐	☐
36. … bồn chồn đứng ngồi không yên?	☐	☐	☐	☐	☐
37. … chán nản đến nỗi không có gì có thể làm bạn vui lên?	☐	☐	☐	☐	☐
38. … cảm thấy rằng mọi thứ đều là một sự gắng gượng?	☐	☐	☐	☐	☐
39. … vô dụng?	☐	☐	☐	☐	☐

40. Các mục trên đây thường dùng để mô tả kinh nghiệm với những đau khổ về tâm lý hoặc tình cảm. Những mô tả này (từ Q34 đến Q39) có giống với trải nghiệm của bạn không? (Chọn một)

☐ **Nhiều** ☐ **Có một chút** ☐ **Hoàn toàn không**

BÂY GIỜ, hãy nghĩ về một tháng trong 12 tháng qua, khi nào bạn cảm thấy cảm xúc ở mức tồi tệ nhất.

Cảm xúc của bạn có bị trở ngại thường xuyên, thỉnh thoảng, hay không hề bị trở ngại đến…	**Thường xuyên**	**Thỉnh Thoảng**	**Không Có**	**Từ chối trả Lời**	**Không biết**
41. …hiệu quả làm việc tại chỗ làm hoặc trường học?	☐	☐	☐	☐	☐
➡ *Đánh dấu ở đây nếu không đi làm hoặc không đi học trong 12 tháng qua* ☐					
42. …việc hoàn thành công việc nhà?	☐	☐	☐	☐	☐
43. …cuộc sống xã hội?	☐	☐	☐	☐	☐
44. …mối quan hệ với bạn bè và gia đình?	☐	☐	☐	☐	☐

45. Các mục trên đây mô tả cảm xúc tiêu cực ảnh hưởng như thế nào đến cuộc sống của con người. Những mô tả này từ Q41 đến Q44) có giống như trải nghiệm về sự tiêu cực của cảm xúc này trong cuộc sống của bạn? (Chọn một)

☐ **Nhiều** ☐ **Có một chút** ☐ **Hoàn toàn không**

46. Bạn bao nhiêu tuổi?

☐ từ 18 đến 29
☐ từ 30 đến 39
☐ từ 40 đến 44
☐ từ 45 đến 49
☐ từ 50 đến 64
☐ từ 65 tuổi trở lên

47. Sắc tộc và nguồn gốc của bạn là gì? ***Xin ghi rõ nguồn gốc sắc tộc.***

☐ Người Thổ Dân Mỹ Da Đỏ hoặc Thổ Dân Alaska: Xin ghi rõ nguồn gốc sắc tộc: _____
☐ Người da đen/Mỹ gốc Châu Phi: Xin ghi rõ nguồn gốc sắc tộc: _____
☐ Người Mỹ Latino, hoặc Tây Ban Nha: Xin ghi rõ nguồn gốc sắc tộc: _____
☐ Người Á Châu Xin ghi rõ nguồn gốc sắc tộc: _____
☐ Người bản địa/ đảo Thái Bình Dương: Xin ghi rõ nguồn gốc sắc tộc:_____
☐ Người Mỹ Trắng: Xin ghi rõ nguồn gốc sắc tộc: _____
☐ Sắc tộc khác: Xin ghi rõ nguồn gốc sắc tộc: _____
☐ Đa sắc tộc: Xin ghi rõ nguồn gốc sắc tộc: _____
☐ Từ chối trả lời
☐ Không biết

48. Bạn có thể nói tiếng Anh tốt như thế nào?

☐ Lưu loát
☐ Trôi chảy; có thể tự hiểu nhưng vẫn gặp một vài trở ngại
☐ Không tốt lắm; biết rất nhiều từ và nhiều câu nhưng vẫn gặp khó khăn khi giao tiếp
☐ Biết một số từ vựng, nhưng không thể nói thành câu
☐ Không nói được hoàn toàn

49. Ngôn ngữ bạn chọn là gì? _____

50. Bạn được sinh ra tại:

☐ Tại Hoa Kỳ
☐ Ở nước khác
☐ Không muốn trả lời
☐ Không biết

51. 3 con số đầu tiên theo mã bưu điện (Zip Code) của bạn là gì? _ _ _

☐ Không có nhà cửa ổn định/ không có mã bưu điện
☐ Không muốn trả lời
☐ Không biết

52. Bạn đã bao giờ ở tại khu vực định cư tạm thời dành cho người tị nạn hoặc người đi di tản hoặc người bị giữ tại các cơ sở của ICE (Sở Di Trú)?

☐ Không áp dụng
☐ Có
☐ Không
☐ Không muốn trả lời
☐ Không biết

53. Bạn đã sống ở Hoa Kỳ khoảng bao nhiêu năm? *[Nếu ít hơn một năm, tính là 1 năm]*

Tổng số năm ở Hoa Kỳ_____
☐ Không áp dụng

54. Cám ơn bạn đã dành thời gian để trả lời những câu hỏi này. Chúng tôi muốn bạn biết rằng tất cả những câu trả lời của quý vị sẽ được bảo mật. Chúng tôi muốn hỏi thêm một câu hỏi nữa. Những câu hỏi ở trên có làm bạn khó chịu hoặc khiến bạn cảm thấy không thoải mái?

___Không
___Có (Nếu có, là câu nào? Vui lòng ghi rõ câu số mấy: _____)

Các cá nhân đồng tính luyến ái nữ, đồng tính luyến ái nam, lưỡng tính, chuyển giới, và người có giới tính khác biệt (LGBTQ) được bao gồm trong các chủng tộc và dân tộc, tôn giáo, và các tầng lớp xã hội. Sự phân biệt/kỳ thị đối với người đồng tính luyến ái có ảnh hưởng đến tỷ lệ rối loạn tâm thần, lạm dụng thuốc và xác suất tự tử. Tuy nhiên, vì những thành kiến sai lệch này, cộng đồng đồng tính luyến aí LGBTQ đã đối mặt với nhiều khó khăn trong việc tìm kiếm giúp đỡ về vấn đề sức khỏe tâm thần.

Các câu hỏi về định hướng giới tính và nhận dạng giới tính không được hỏi trong hầu hết các cuộc điều tra quốc gia hoặc tiểu bang, đã gây khó khăn trong việc ước tính số lượng người đồng tính luyến ái LGBT và nhu cầu hữu dụng cho sức khỏe của họ. Những câu hỏi định hướng giới tính và nhận dạng giới tính rất cần thiết trong các cuộc khảo sát. Điều này sẽ giúp các nhà nghiên cứu và các nhà hoạch định chính sách hiểu rõ về sức khỏe và sự chênh lệch của giới đồng tính luyến aí LGBT.

Khi quý vị trả lời, quý vị có thể cảm thấy rằng một hoặc nhiều câu hỏi dưới đây không áp dụng cho quý vị. Nếu có câu hỏi mà quý vị không cảm thấy thoải mái để trả lời, quý vị không cần phải trả lời chúng. Sự tham gia của quý vị trong bảng câu hỏi này là hoàn toàn tự nguyện.

55. Giới tính lúc được sinh ra của tôi là…

**Staff Administrator Step 1:*
Write in participant's response (in language): _____
If applicable, write in translation of participant's response: _____

**Staff Administrator Step 2:* Select <u>one</u> of the following that best fits the participant's response:

☐ Đàn ông/Con trai **[Male/Boy]**
☐ Phụ nữ/Con gái **[Female/Girl]**
☐ Lưỡng tính (họ đã không chắc về giới tính của tôi lúc tôi được sinh ra) **[Intersex (they were unsure about my sex at birth)]**
☐ Tôi không chắc về giới tính của tôi lúc tôi được sinh ra [**I am not sure about my sex assigned at birth]**
☐ Giới tính của tôi được xác định lúc sinh ra (vui lòng ghi rõ) [**My assigned sex at birth (please specify)]:_____**
☐ Tôi không muốn trả lời câu hỏi này **[I do not wish to answer this question]**

Nhận dạng giới tính là cách mọi người nhận thức được bản thân họ và cách họ đặt cho mình, cho dù là nam, hay nữ, hoặc là kết hợp của cả hai giới tính hay không chắc là mình thuộc giới tính nào. Bản sắc giới tính của một người có thể giống hoặc khác với giới tính được chỉ định khi sinh ra.

56. Khi phải xác định giới tính, tôi nghĩ giới tính của tôi là: Chọn tất cả những lựa chọn mà bạn thấy thích hợp với bạn.

**Staff Administrator Step 1:*

02-04-B- **ADULT VERSION PRE**

Write in participant's response (in language): _____
If applicable, write in translation of participant's response: _____

**Staff Administrator Step 2:*
Check all of the following that best fit the participant's response:

- ☐ Đàn ông/Nam giới **[Man/Male]**
- ☐ Phụ nữ/Nữ giới **[Woman/Female]**
- ☐ Người chuyển giới **[Transgender/Trans]**
- ☐ Một người chuyển từ nam sang nữ **[Trans man/Trans male]**
- ☐ Một người chuyển từ nữ sang nam **[Trans woman/Trans female]**
- ☐ Genderqueer:người không theo định nghĩa của xã hội về giới tính rằng họ là nam hay nữ hoặc cả hai /Gender non-conforming: cách sống và liên hệ với người mà hành vi và sắc diện không theo chuẩn mực khẳng định của xã hội **[Genderqueer/Gender non-conforming]**
- ☐ Vô tính (không là nam cũng không là nữ) **[Non-binary (not exclusively male or female)]**
- ☐ Two Spirit: Hai Tâm Hồn – từ để nói về những người thổ dân da đỏ có đa giới tính và được người da trắng hiểu như vậy **[Two Spirit]**
- ☐ Lưỡng tính (nam và nữ) **[Intersex (between male and female)]**
- ☐ Tôi không chắc về giới tính được xác định của tôi **[I am not sure about my gender identity]**
- ☐ Tôi không có xác định giới tính **[I do not have a gender/ gender identity]**
- ☐ Diễn tả khác về giới tính (Vui lòng ghi rõ) **[My gender identity is (please specify)]: _____**
- ☐ Tôi không muốn trả lời câu hỏi này **[I do not wish to answer this question]**

Khuynh hướng tình dục khác với nhận dạng giới tính. Khuynh hướng tình dục là cách qúy vị bị thu hút bởi một người mà quý vị muốn có mối quan hệ lãng mạng với. Ví dụ về khuynh hướng tình dục là đồng tính nam, đồng tính nữ, lưỡng tính, vô tính và không phải đồng tính. Một số người không phải đồng tính và bị thu hút bởi những người thuộc giới tính khác họ. Một số khác là đồng tính nam hoặc đồng tính nữ và bị thu hút bởi những người cùng giới tính với họ.

57. Khuynh hướng tính dục của bạn là gì? Chọn tất cả những lựa chọn đúng với bạn.

**Staff Administrator Step 1:*
Write in participant's response (in language): _____
If applicable, write in translation of participant's response: _____

**Staff Administrator Step 2:* Check all of the following that best fit the participant's response:

- ☐ Khuynh hướng tính dục khác giới **[Straight/heterosexual]**
- ☐ Đồng tính nam **[Gay]**
- ☐ Đồng tính nữ **[Lesbian]**
- ☐ Lưỡng tính **[Bisexual]**
- ☐ Người có giới tính khác biệt **[Queer]**
- ☐ **Pansexual/Non-monosexual** (Tôi bị thu hút bởi tất cả các giới tính)
- ☐ Tôi là người vô tính (Tôi không bị thu hút bởi bất cứ ai) **[Asexual (I am not attracted to anyone sexually)]**
- ☐ Tôi không bị thu hút bởi bất cứ ai **[I am not attracted to anyone romantically]**
- ☐ Tôi không chắc người mà tôi có sự hấp dẫn về giới tính là ai **[I am not sure who I am attracted to sexually]**
- ☐ Tôi không chắc người mà tôi có sự hấp dẫn một cách lãng mạn là ai **[I am not sure who I am attracted to romantically]**
- ☐ Lựa chọn khác **[Something else]:** _____
- ☐ Tôi không muốn trả lời câu hỏi này **[I do not wish to answer this question]**

02-04-B- **ADULT VERSION PRE**

*** For Staff Administrators Only:**

In your opinion, were any of the above items confusing or difficult for the participant to understand?

___No

___Yes (If yes, which ones? Please specify #'s: _____)

In your opinion, did any of the above items cause the participant to feel uncomfortable or upset?

___No

___Yes (If yes, which ones? Please specify #'s: _____)

58. Ở thời điểm hiện tại…	**Rất Tốt**	**Tốt**	**Trung Bình**	**Tệ**
Bạn có thể nói sức khỏe của bạn là …	☐	☐	☐	☐

ID:
2 - 4 - B - _____
Priority Pop Code *IPP Code* *Agency Code* *CDEP Participant Code*

ADULT VERSION (18+)
POST (Vietnamese)

Văn hóa có ý nghĩa khác nhau cho mỗi người nhưng nó là cái gì đó thường được chia sẻ bởi một nhóm đông người. Đối với một số người thì nó đề cập đến phong tục và truyền thống. Đối với người khác, văn hóa mang ý nghĩa của sự thừa kế từ những người đi trước và hướng những người đi sau theo cách sống đó. Nó có thể đề cập đến niềm tin, giá trị tinh thần và cái nhìn, bản sắc của bạn, lịch sử chung và đặc tính của thành viên trong một nhóm. Những câu hỏi tiếp theo là những câu hỏi về văn hóa của bạn.

Tại thời điểm này…	**Hoàn toàn đồng ý**	**Đồng ý**	**Trung lập**	**Không đồng ý**	**Hoàn toàn không đồng ý**
1. Văn hóa của bạn cho bạn sức mạnh.	☐	☐	☐	☐	☐
2. Văn hóa của bạn quan trọng đối với bạn.	☐	☐	☐	☐	☐
3. Văn hóa của bạn giúp bạn cảm thấy bạn là người tốt.	☐	☐	☐	☐	☐
4. Bạn cảm thấy gắn kết với tâm linh/tôn giáo truyền thống theo văn hóa mà bạn được nuôi dạy từ nhỏ.	☐	☐	☐	☐	☐

Hướng dẫn: Những câu hỏi tiếp theo là những câu hỏi bạn đã cảm thấy thế nào trong thời gian30 ngày qua

Trong 30 ngày qua bạn thường cảm thấy	**Luôn luôn**	**Thường xuyên**	**Thỉnh thoảng**	**Lâu lâu**	**Không lúc nào**
5. …gần gũi với văn hóa của bạn?	☐	☐	☐	☐	☐
6. …có sự cân bằng trong tâm trí, cơ thể, tinh thần và tâm hồn?	☐	☐	☐	☐	☐
7. …bị đẩy lùi hoặc bị loại khỏi xã hội? (Nói cách khác, *cảm thấy bản thân không có quan trọng, hoặc những thứ như suy nghĩ, cảm xúc, hay quan điểm của bạn không quan trọng đối với người khác.*)	☐	☐	☐	☐	☐
8. …bị xã hội cô lập và xa lánh? (Nói cách khác, *cảm thấy cô độc, xa cách, bị cắt đứt khỏi thế giới bên ngoài gia đình, trường học và bạn bè.*)	☐	☐	☐	☐	☐

Hướng dẫn: Trong 30 ngày qua qua bạn thường cảm thấy …

	Luôn luôn	**Thường xuyên**	**Thỉnh thoảng**	**Lâu lâu**	**Không lúc nào**
9. ... lo lắng?	☐	☐	☐	☐	☐
10. … vô vọng?	☐	☐	☐	☐	☐
11. … bồn chồn đứng ngồi không yên?	☐	☐	☐	☐	☐
12. … chán nản đến nỗi không có gì có thể làm bạn vui lên?	☐	☐	☐	☐	☐
13. … cảm thấy rằng mọi thứ đều là một sự gắng gượng?	☐	☐	☐	☐	☐
14. … vô dụng?	☐	☐	☐	☐	☐

15. Các mục trên đây mô tả kinh nghiệm với những đau khổ về tâm lý hoặc tình cảm. Những mô tả này (từ Q9 đến Q14) có giống với những trải nghiệm của bạn không? (Chọn một)

☐ **Nhiều** ☐ **Có một chút** ☐ **Hoàn toàn không**

Hãy nghĩ về 1 tuần trong 30 ngày qua khi cảm xúc của bạn ở mức tồi tệ nhất.

Cảm xúc của bạn có bị trở ngại thường xuyên, thỉnh thoảng, hay không hề bị trở ngại đến…	**Thường xuyên**	**Thỉnh Thoảng**	**Không Có**	**Từ chối trả Lời**	**Không biết**
16. …hiệu quả làm việc tại chỗ làm hoặc trường học?	☐	☐	☐	☐	☐
Đánh dấu ở đây nếu không đi làm hoặc không đi học trong 12 tháng qua ☐					
17. …việc hoàn thành công việc nhà?	☐	☐	☐	☐	☐
18. …cuộc sống xã hội?	☐	☐	☐	☐	☐
19. …mối quan hệ với bạn bè và gia đình?	☐	☐	☐	☐	☐

ADULT VERSION POST

20. Các mục trên đây mô tả cảm xúc tiêu cực ảnh hưởng như thế nào đến cuộc sống của con người. Những mô tả này từ (Q16 đến Q19) có giống như trải nghiệm về sự tiêu cực của cảm xúc này trong cuộc sống của bạn? (Chọn một)

☐ **Nhiều**	☐ **Có một chút**	☐ **Hoàn toàn không**

Hướng dẫn: Căn cứ vào những dịch vụ mà bạn đã nhận, xin trả lời những câu hỏi dưới đây. Trả lời Trung Lập, Không Đồng Ý, hoặc Hoàn Toàn Không Đồng Ý với mỗi câu dưới đây. Nếu câu hỏi là về một điều gì đó mà bạn không có trải nghiệm, hãy đánh dấu vào ô Không Áp Dụng để cho biết rằng điều này không áp dụng cho bạn. Xin lưu ý: từ "dịch vụ" là viết tắt của bất kỳ hoạt động chương trình hoặc các sự kiện đả có liên quan với chương trình.

	Hoàn Toàn Đồng Ý	**Đồng Ý**	**Tôi Trung Lập**	**Không Đồng Ý**	**Hoàn Toàn Không Đồng Ý**	**Không Áp Dụng**
21. Tôi thích những dịch vụ tôi nhận ở đây.	☐	☐	☐	☐	☐	☐
22. Nếu tôi có những lựa chọn khác, tôi vẫn chọn để nhận những dịch vụ ở đây.	☐	☐	☐	☐	☐	☐
23. Tôi muốn giới thiệu cơ quan này với bạn bè hoặc thành viên gia đình.	☐	☐	☐	☐	☐	☐
24. Địa điểm của những dịch vụ là thuận tiện (chỗ đậu xe, phương tiện giao thông công cộng, quãng đường, vân vân...).	☐	☐	☐	☐	☐	☐
25. Nhân viên sẵn sàng gặp tôi vào những lúc tôi thấy cần.	☐	☐	☐	☐	☐	☐
26. Dịch vụ hiện có vào những thời gian thuận tiện cho tôi.	☐	☐	☐	☐	☐	☐
27. Khi tôi gọi hoặc đến đây lần đầu tôi thấy dễ dàng.	☐	☐	☐	☐	☐	☐
28. Nhân viên ở đây đối đãi với tôi một cách trân trọng.	☐	☐	☐	☐	☐	☐
29. Nhân viên ở đây không coi thường tôi qua cách mà tôi nói chuyện.	☐	☐	☐	☐	☐	☐
30. Nhân viên ở đây tôn trọng sắc tộc và nguồn gốc của tôi.	☐	☐	☐	☐	☐	☐
31. Nhân viên ở đây tôn trọng tôn giáo và sinh hoạt tôn giáo của tôi.	☐	☐	☐	☐	☐	☐
32. Nhân viên ở đây tôn trọng giới tính và khuynh hướng tính dục của tôi.	☐	☐	☐	☐	☐	☐
33. Nhân viên ở đây linh động và dùng những phương cách khác nhau để đáp ứng những nhu cầu của tôi.	☐	☐	☐	☐	☐	☐
34. Những người làm việc ở đây tôn trọng quan điểm và cách nhìn về văn hóa của tôi, biện pháp khắc phục và sinh hoạt chữa lành của tôi.	☐	☐	☐	☐	☐	☐
35. Nhân viên ở đây hiểu rằng những ngườicùng thuộc nhóm sắc tộc và/hoặc dân tộc như tôi không giống nhau mà đa dạng,	☐	☐	☐	☐	☐	☐
36. Nhân viên ở đây hiểu rằng những người cùng thuộc giới tính và/hoặc khuynh hướng tính dục như tôi không giống nhau mà đa dạng.	☐	☐	☐	☐	☐	☐
37. Nhân viên ở đây hiểu rằng những người cùng có nguồn gốc tôn giáo và tâm linh như tôi không giống nhau mà đa dạng.	☐	☐	☐	☐	☐	☐

ADULT VERSION POST

Kết quả trực tiếp của sự tham gia của tôi vào chương trình:

	Hoàn Toàn Đồng Ý	Đồng Ý	Tôi Trung Lập	Không Đồng Ý	Hoàn Toàn Không Đồng Ý	Không Áp Dụng
38. Tôi giải quyết vấn đề hàng ngày một cách hiệu quả hơn.						
a. Nếu bạn hoàn toàn đồng ý hoặc đồng ý, phần nào của chương trình đã gây ra sự thay đổi này? _____	☐	☐	☐	☐	☐	☐
39. Tôi học/hoặc làm việc hiệu quả hơn.						
a. Nếu bạn hoàn toàn đồng ý hoặc đồng ý, phần nào của chương trình đã gây ra sự thay đổi này? _____	☐	☐	☐	☐	☐	☐
40. Triệu chứng/vấn đề của tôi không làm phiền tôi nhiều.						
a. Nếu bạn hoàn toàn đồng ý hoặc đồng ý, phần nào của chương trình đã gây ra sự thay đổi này? _____	☐	☐	☐	☐	☐	☐

	Có	Không	Từ Chối Trả Lời	Không Biết
41. Những dịch vụ mà bạn nhận ở đây có được cung cấp theo ngôn ngữ mà bạn muốn không?	☐	☐	☐	☐
42. Những thông tin bằng văn bản (chẳng hạn như bản thông tin mô tả những dịch vụ cung cấp, quyền của khách hàng, và những thông tin về sức khỏe tâm lý) có sẵn bằng ngôn ngữ mà bạn muốn không?	☐	☐	☐	☐

43. Có phần nào của chương trình/dịch vụ hữu ích với bạn mà bạn chưa đề cập trước đây không?

44. Có phần nào của chương trình/dịch vụ có thể tốt hơn mà bạn chưa đề cập trước đây không?

45. Bạn có ý kiến nào khác về chương trình/dịch vụ mà bạn nhận được không?

46. Ở thời điểm hiện tại…	Rất Tốt	Tốt	Trung Bình	Tệ
Bạn có thể nói sức khỏe của bạn là …	☐	☐	☐	☐

Appendix D

Qualitative Interview Guide (English)

Individual Interview

Please use the following questions to assess client satisfaction:

1) Was the reason/concern for visiting KCS/Southland resolved to your satisfaction?
2) On a scale of 1 to 10, with 10 being the most satisfied and 1 being not satisfied at all, how would you rate your experience of the overall ICC program?
3) Can you tell me what aspect of the program was satisfying?

Please use the following questions to assess the implementation and effectiveness of each core cultural element:

1) How was this principle applied in your situation? Could you give an example?
2) On a scale of 1 to 10, with 10 being very much and 1 not at all, how would you rate the level of helpfulness of this principle in addressing/resolving your concern? Could you tell me why you chose that number?

ICC Staff

1) How has each cultural element been implemented?
2) While implementing cultural elements, what challenges have you encountered? How did you respond to the challenges?
3) While implementing cultural elements, what successes have you encountered?
4) What cultural element(s) of the ICC program and to what extent did the ICC program increase participants' ability to navigate the integrated healthcare system?
5) What cultural element(s) of the ICC program and to what extent did the ICC program change participants' ability to deal with daily tasks and specifically to solve their primary concern for the visit?

Non-ICC Staff

1) What made you decide to refer the client to ICC?
2) Could you describe the referral process, i.e., What happened after you contacted ICC for your clients?
3) What were unique cultural elements that you observed during the ICC referral process, if any?
4) What were challenges/barriers in the ICC referral process, if any?

Appendix D

질적 면담 가이드 (한국어)

개인 면담

내담자의 만족도를 측정하기 위해서 다음과 같은 질문을 사용하십시요:

1) KCS 에 오시게 된 원인이 만족스럽게 해결되었습니까?
2) ICC 프로그램에서 경험의 만족도를 1 부터 10 까지의 숫자로 점수를 매긴다면 몇점을 주시겠습니까? 10 이 제일 만족도가 높고 1 이 제일 만족도가 낮은 것입니다.
3) ICC 프로그램의 어떤점이 만족스러웠는지 말씀해 주시겠습니까?

핵심적인 문화적 요소의 이행과 유효성을 평가하기위해 다음과 같은 질문을 사용하십시요:

1) 이 문화적 요소가 당신의 상황에 어떻게 적용되었습니까? 예를 들어 주십시요.
2) 1 부터 10 까지의 스케일에서 10 이 아주 많이, 1 이 전혀 없음을 의미할 때 이 문화적 요소가 당신의 문제를 해결하는데 얼마나 도움이 되었다고 보십니까? 그 점수를 주신 이유는 무엇입니까??

ICC 스태프

1) 문화적 요소 하나 하나가 어떻게 이행되었습니까?
2) 문화적 요소들을 이행하면서 어떤 힘든점이 있으셨습니까? 그 어려움을 어떻게 대처하셨습니까?
3) 문화적 요소들을 이행하면서 겪으신 성공담이 있으십니까?
4) ICC 프로그램의 어떤 문화적 요소가 얼마나 참여자로 하여금 통합 의료 시스템을 잘 이용 할 수 있도록 해 주었습니까?
5) ICC 프로그램의 어떤 문화적 요소가 얼마나 참여자가 일상 일들을 처리하는데, 구체적으로 KCS 에 오시게 된 이유를 해결하는 능력에 변화를 주었습니까?

ICC 이외의 스태프

1) ICC 에게 내담자를 의뢰하기로 결정한 이유는 무엇입니까?
2) 의뢰과정을 설명해 주십시요. 다시 말하면 당신이 내담자를 위해서 ICC 한테 연락을 취한 후 그 다음에 무슨 일이 있었습니까?
3) ICC 에게 의뢰하는 과정에서 관찰한 고유한 문화요소가 있었다면 무엇입니까?
4) ICC 에게 의뢰하는 과정에서 혹시 장애물이 있었다면 어떤것들이 있었습니까?

Appendix D

Hướng Dẫn Phỏng Vấn định Tính (Tiếng Việt)

Phỏng Vấn Cá Nhân

Vui lòng sử dụng các câu hỏi này để kiểm tra mức độ hài lòng của khách hàng:

1) Lý do / mối quan tâm đến thăm KCS / Southland có giải quyết thỏa mãn cho bạn không?
2) Trên thang điểm từ 1 đến 10, với 10 là hài lòng nhất và 1 là không hài lòng chút nào, bạn đánh giá thế nào về sự phục vụ của chương trình ICC?
3) Bạn có thể cho tôi biết khía cạnh nào của chương trình ICC đã làm được tốt nhất?

Vui lòng sử dụng các câu hỏi này để kiểm tra việc thực hiện và hiệu quả của nền văn hóa cốt lõi:

1) Nguyên tắc này đã được áp dụng như thế nào trong tình huống của bạn? Bạn có thể cho một ví dụ?
2) Trên thang điểm từ 1 đến 10, với 10 là rất nhiều và 1 là không có, bạn kiểm tra mức độ hữu ích của nguyên tắc này đã được giải quyết như thế nào? Bạn có thể cho tôi biết tại sao bạn chọn số đó không?

Nhân Viên ICC

1) Mỗi yếu tố văn hóa đã được thực hiện như thế nào?
2) Trong khi thực hiện các yếu tố văn hóa, bạn đã gặp phải những thử thách gì? Bạn đã ứng phó với những thử thách đo như thế nào?
3) Trong khi thực hiện các yếu tố văn hóa, bạn đã làm được những thành công nào?
4) (Các) yếu tố văn hóa của chương trình ICC là gì? Chương trình ICC đã làm tăng khả năng của người tham gia trong việc điều hướng hệ thống chăm sóc sức khỏe tổng hợp như thế nào?
5) (Các) yếu tố văn hóa của chương trình ICC là gì? Chương trình ICC đã thay đổi khả năng của người tham gia như thế nào trong việc giải quyết các công việc hàng ngày và cụ thể là để giải quyết mối quan tâm chính của họ cho chuyến thăm?

Nhân Viên Không Phải Của ICC

1) Điều gì khiến bạn quyết định giới thiệu khách hàng đến ICC?
2) Bạn có thể nói về quy trình giới thiệu sau khi bạn liên hệ với ICC cho khách hàng của mình?
3) Các yếu tố văn hóa đặc biệt mà bạn quan sát được trong quá trình giới thiệu ICC, nếu có là gì?
4) Những thử thách / rào cản nào trong quá trình giới thiệu ICC, nếu có là gì?