A Novel Virtual Partnership to Promote Asian American and Asian International Student Mental Health

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In 2018, the Massachusetts General Hospital Center for Cross-Cultural Student Emotional Wellness (CCCSEW) developed the CCCSEW Consortium, a year-long virtual program for secondary schools, colleges, and universities, to support campus staff in promoting the mental health of Asian American and Asian international students. The program shares similarities with the Extension for Community Healthcare Outcomes model, including the hub-and-spoke virtual learning environment, development of self-efficacy, and peer learning. The program is in its second year of operation and has been well received by participants. The Consortium, a nonprofit entity, has achieved financial sustainability through support of annual membership fees.

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Relative to White students, high school and college students from racial-ethnic minority groups have lower rates of mental health diagnoses and mental health care utilization but higher rates of suicidal ideation, suicide attempts, and suicide (1–3). In particular, Asian American and Asian international high school and college students report higher rates of hopelessness and depression than White students and have among the highest rates of suicidality of all racial-ethnic groups (1, 3, 4). Although Asian American and Asian international students represent a large and growing portion of the student body on U.S. university and high school campuses (4, 5), many educational institutions struggle to provide culturally effective care or to address psychiatric disparities in these communities (6, 7).

In this column, we describe the development and operationalization of a virtual program to support educational institutions in promoting the mental health of minority students, with a focus on Asian American and Asian international high school and college students. The program represents the evolution over several years of an ongoing partnership between a nonprofit group at a large academic hospital and clinicians, educators, and researchers based at other institutions around the world. The program shares many features with the Extension for Community Healthcare Outcomes (ECHO) model (8, 9), although it was not initially developed with an ECHO framework in mind. The program is currently in its second year of operation. We briefly describe the program's development, current functions, and preliminary outcomes.

Program Development

The Center for Cross-Cultural Student Emotional Wellness (CCCSEW) at Massachusetts General Hospital was founded in 2014 as a group of mental health clinicians, educators, and researchers to promote the mental health of students from diverse cultural backgrounds. The three founders, all psychiatrists of Asian descent, had observed a rising number of Asian American and Asian international university and high school students in their clinical practices, along with a dearth of clinical guidelines for bridging cultural barriers to mental health care among this population. The CCCSEW expanded as psychiatrists, other mental health practitioners, educators, and researchers across the country with an interest in Asian American and Asian international student mental health joined. Today, the majority of CCCSEW

HIGHLIGHTS

- A partnership between a nonprofit group at a large academic hospital and several educational institutions was developed to promote the mental health of Asian American and Asian international students.
- The program has been positively rated by participants and has reached full financial sustainability in its second year.
- The program shares similarities with the Extension for Community Healthcare Outcomes model, originally developed for the treatment of the hepatitis C virus.

collaborators are based outside of Massachusetts General Hospital.

Partnership with educational institutions has been central to the CCCSEW since its inception. U.S. secondary schools, colleges, and universities advised the CCCSEW's three founders of a need for clinical and nonclinical campus staff to be trained to address the mental health needs of the growing Asian American and Asian international student body. Initially, the CCCSEW faculty, which consisted of mental health clinicians with experience in cross-cultural psychiatry, primarily responded by developing and delivering one-time presentations and training sessions to a range of stakeholders, including students, faculty, and families. However, educational institutions continued to seek a greater level of partnership with the CCCSEW. Moreover, a greater number of educational institutions were contacting the CCCSEW for such services.

Thus, the CCCSEW Consortium was launched in fall 2018 as a year-long virtual program for secondary schools, colleges, and universities. The program's primary goal is to deliver clinical education to the staff at participating institutions, and the Consortium model is intentionally communal (fostering connections among educational institutions as well as between each institution and the CCCSEW) rather than dyadic (fostering connections only between each institution and the CCCSEW). The program was developed by the authors throughout 2018, in part by gathering input on unmet needs and potential novel program models from staff at four educational institutions (two secondary schools and two universities) with which the CCCSEW had previously partnered. At the time of this writing, the CCCSEW is planning the Consortium for the 2020–2021 year.

Program Components

The CCCSEW Consortium is a year-long virtual institute for educational institutions; participating institutions have the option to rejoin each subsequent academic year. Member institutions identify several delegates to participate in the Consortium program for the full year. The program is centered around hour-long monthly meetings during which a Consortium faculty member delivers a 45-minute presentation on a predetermined topic relevant to cross-cultural student mental health. Topics have included cross-cultural approaches to depression and anxiety, discrimination, cultural assimilation, and cultural perspectives on perfectionism. The presentation is designed to be highly interactive; delegate participation is strongly encouraged. The final 15 minutes of the session are reserved for delegate questions and deidentified case discussions.

In addition, several sessions are scheduled throughout the year as "office hours" devoted entirely to deidentified cases and delegate questions. For example, in early 2020, multiple delegates raised concerns about the impact of COVID-19 on student mental health. Given the profound societal impact of COVID-19, multiple sessions were dedicated to this topic, and monthly meeting curricula were modified to incorporate didactic topics relevant to the virus, such as stigma directed at Asian American and Asian international individuals.

Consortium faculty are all practicing clinicians who specialize in cross-cultural mental health care. At the time of this writing, the faculty included six M.D. psychiatrists and one Ph.D. psychologist. All identify as being of Asian American or Asian international background.

All Consortium sessions are held through Zoom, a videoconferencing platform that is free for members. Because Consortium membership is offered to educational institutions across the country and the world, the Consortium is generally unable to offer direct clinical services; case discussions represent clinical guidance rather than the direct provision of care or comanagement of patient cases.

An online forum is available throughout the year for delegates to post questions, ideas, and deidentified clinical case material; this forum is hosted through Google Groups. All forum posts are visible to all Consortium faculty members and delegates, and anyone may respond. Finally, individual on-campus sessions led by Consortium faculty remain available to participating institutions for more extensive campus-specific needs.

The program places a strong emphasis on peer-to-peer learning and sharing of experiences. Peer relationships are cultivated in the Consortium itself; most participating institutions enter the Consortium without preexisting relationships with other member institutions. Consortium faculty are coached by Consortium leadership on how to foster peer-to-peer learning in meetings. Delegates across institutions become familiar with and increasingly supportive of one another over the course of the year.

The Consortium model is not copyrighted at this time. The program is financed through annual membership fees from participating institutions. Membership fees have ranged from $1,000 to $3,000 per year, covering participation for all institutional delegates. Massachusetts General Hospital, the CCCSEW, and the Consortium are all nonprofit entities. Consortium faculty are compensated at an hourly rate for preparing for and presenting at monthly meetings and for hosting office hour sessions. In addition, the Consortium has a paid part-time program coordinator who manages meeting facilitation, technology, membership issues, and other administrative needs. Any year-end surpluses are retained by the CCCSEW and invested in the following year's program; for example, the surplus from the first year's program allowed for the addition of the office hour sessions in the second year.

Preliminary Outcomes

The CCCSEW Consortium had six participating institutions and 24 delegates in its first year and eight participating institutions and 41 delegates in its second year. Three of the institutions from the first year rejoined for the second year,

representing 50% retention. Of the 11 unique participating institutions, eight were secondary schools, two were educational agencies working with international students based in the United States, and one was a university. Eight of the institutions were based in the United States, and three were based in China. All were private institutions. Delegates represented a broad range of institutional roles, including general administration, student services, diversity or multicultural affairs, counseling, and physical and mental health care.

All participating China-based institutions to date have been institutions that use English as a primary language. Many of the staff at these institutions are native to English-speaking countries, and many of the students plan to relocate to English-speaking countries after graduating. As a result, issues of acculturation, cultural conflict, and cultural perspectives on mental health are relevant for these institutions.

Delegate experience was assessed annually with an online survey. Because the purpose of all member- and delegate-level data collected was to inform program changes rather than to conduct a systematic investigation to develop generalizable knowledge, we designated delegate responses as a quality improvement effort and did not seek approval from an institutional review board.

Mean±SD member satisfaction in the first year was 6.5±0.5 on a scale ranging from 0 to 7, with higher scores indicating greater satisfaction; the mean likelihood of recommendation to a colleague at a peer institution was 8.8±1.2 on a scale ranging from 0 to 10, with higher scores indicating greater likelihood (N=8 of 24 delegates surveyed, response rate=33%). Qualitative feedback from delegates has included themes such as gaining cultural and family systems perspectives, dedicating time to learning and thinking about minority student experiences, and acquiring practical tools to work with students.

Discussion

The CCCSEW Consortium has successfully engaged and retained member institutions and achieved financial sustainability. Several parallels can be drawn to the ECHO model. ECHO was initially developed in New Mexico for the treatment of patients with hepatitis C virus infection and demonstrated noninferior viral response rates compared with a university hepatitis C clinic (9). ECHO has since been studied across multiple subspecialties within psychiatry (10). Both the CCCSEW Consortium and ECHO leverage a virtual platform to create a hub-and-spoke longitudinal learning environment that includes both didactic teaching and case presentations. In addition, both the Consortium and ECHO seek to build a sense of self-efficacy among participants and to encourage peer-to-peer learning (9).

The programs have several key differences. The Consortium is not limited to a single U.S. state and is an international program. Whereas the original ECHO model for hepatitis C provided comanagement of specialty-level clinical cases (8, 9), the Consortium does not offer direct clinical services because of issues pertaining to licensing and medicolegal risk. As a result, in contrast to ECHO's focus on case discussions, the Consortium emphasizes the didactic teaching component. In addition, whereas ECHO relies on external funding such as grants and public or pharmaceutical funding, the Consortium is funded by membership fees, which cover the cost of the Consortium faculty and administrative coordination. Although annual membership fees may be a substantial investment by participating institutions, a single membership offers the opportunity for multiple delegates to participate in the year-long program, with ongoing contact via an online forum and e-mail.

In addition to achieving financial solvency, the Consortium program also represents an improvement in sustainability and an effective investment of time from CCCSEW faculty. Before the launch of the Consortium, CCCSEW clinicians were visiting campuses around the United States to deliver presentations, spending several hours to days on travel. By uniting interested institutions within a single, virtual community, the CCCSEW has been able to support more campuses in a more substantive, longitudinal manner. In-person training sessions and faculty workshops are still offered but are now limited to Consortium member institutions.

The Consortium faces several important challenges. First, despite the program's financial sustainability, the membership fee represents a barrier to participation for some interested schools, including nonprivate institutions. Potential future strategies include a sliding scale for membership fees or scholarships for applicants. Second, although the Consortium explicitly does not provide direct clinical care to patients, participating institutions have continued to express interest in such services, especially because some campuses are located in parts of the country with limited access to specialized mental health care. As one solution, the CCCSEW is working to build a nationwide referral network of providers with expertise in cross-cultural care. Finally, an important goal is to measure the Consortium's impact on delegate familiarity with cross-cultural topics and clinical outcomes on participating campuses.

Conclusions

The CCCSEW Consortium demonstrates that the design and launch of a financially sustainable hub-and-spoke model of clinical education is possible within a short time frame. The critical element of this program is the use of technology to support an international, longitudinal experience. A flexible approach to the program components has enabled the Consortium to adapt to meet members' needs, such as advising on the impact of the COVID-19 pandemic on student mental health. Although several challenges to optimizing the program remain, the Consortium has to date been acceptable to and well reviewed by participating institutions.

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The Integrated Care column publishes overviews of emerging issues at the mental health/general medical interface. Submissions may describe new clinical models or policy innovations affecting delivery of mental health care in primary care settings or delivery of general medical care in specialty mental health care settings. Submissions that address care integration at the local, state, or federal level in U.S. settings are encouraged, as are submissions addressing care integration in non-U.S. settings..

Benjamin G. Druss, M.D., M.P.H., and Gail Daumit, M.D., M.H.S., are the editors of the column. Prospective authors should contact Dr. Druss to discuss possible submissions (bdruss@emory.edu; gdaumit@jhmi.edu). Column submissions should be no more than 2,400 words.