Health Issues: Mental Health

CONTEXT

Santa Clara County and its Mental Health Department have been active in policy-making, program implementation and service delivery or mental health services to all in need. The Board of Supervisors has consistently and generously allocated more funding for mental health services than mandated by the State. For the fiscal year 2000-2001, nearly $40 million of the $150 million Department budget, or 27%, comes from the County general fund (the mandatory minimum matching rate is 10%). The Department provides services through its county-operated programs and many contract programs by both non-profit and for-profit corporations.

The Department has high standards for developing cultural competence mental health services, as well as assuring consumer and community participation through various arenas to give inputs on policies, programs and service delivery. Recently, the County Mental Health Intern Collaborative was formed with the purpose of "creating and implementing strategies for system-wide collaboration of internship programming with specific attention to training, recruitment and retention of clinically and culturally competent mental health professionals." Finally, immigration status is not a barrier when it comes to accessing mental health services, e.g., the Department and its contract programs provide services to undocumented clients.

Despite these efforts and accomplishments, the County and the Mental Health Department still have not met the mental health service needs of many immigrants in the County. According to the Summit survey, immigrants show much higher mental health needs but have received fewer services for such problems, compared to the general population. Their specific mental stressors include refugee experiences, language barriers, cultural shock and conflicts, intergenerational differences, familial role reversal, homesickness, loneliness, unemployment, career changes and poverty.

The mental health services targeted to various immigrant groups, specifically the more recently arrivals, are insufficient. Currently, immigrants do not have adequate culture-specific information about health/mental health services, resources and treatment services for their particular groups. Also, outreach, education and prevention efforts targeted at mental health problems experienced by immigrants are inadequate.

FINDINGS AND RECOMMENDATIONS

Finding 1: There are not enough mental health services targeted to immigrant communities.

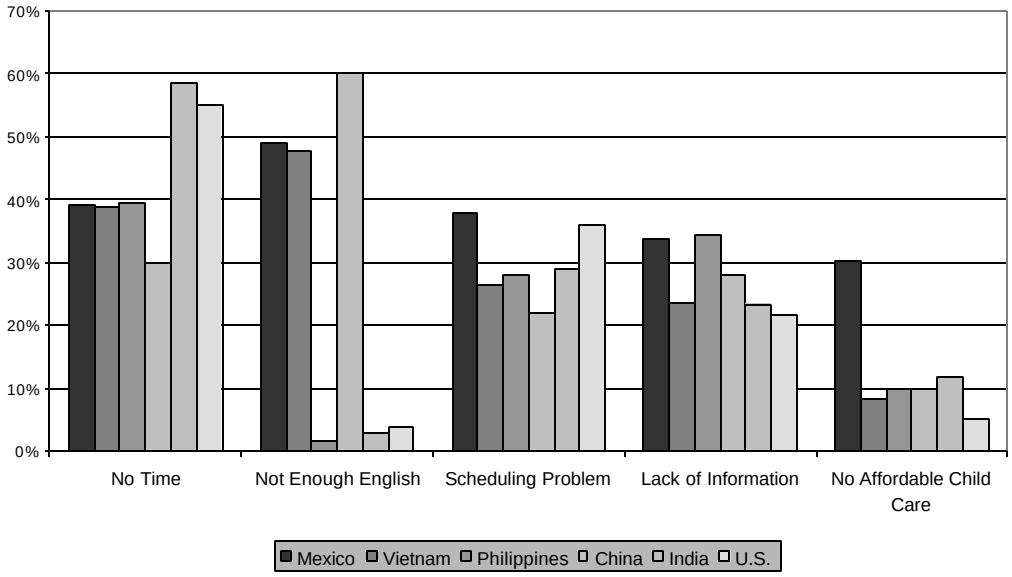
Bosnians participating in Immigrants Building Community (IBC) feel that there is a need for translated materials on many health issues and transportation is a major barrier for them to get the services they need.

The Lao focus group participants listed the need for physical and mental health services as their second priority. They feel that promotion of the health education and awareness is needed in their own language.

During the Latino group discussion of IBC, the participants expressed that there is a lack of information about where to get mental health services and which services are being offered, especially for the undocumented.

Approximately 50% – 60% of immigrants from Mexico, Vietnam and China who answered the question in the random survey said that having limited English prevents them from obtaining services.

What prevents you from obtaining education, services, or public benefits? (Random Survey)



The Somali Focus Group indicated that mental health services are needed for individuals who were victims of the Somali Civil War. They talked about family members being injured or missing and the fact that some parents have children left behind in their country who they constantly worry about.

Immigrants from China and Mexico are less likely than all other groups to think that children between 12 and 18 have a support system in their community. A full 37% of respondents from China and 38% from Mexico believed their communities had such a support system, compared to a range from 66% to 73% for other groups.

According to results from the random sample survey, only 2.7% of immigrants said they would talk to a mental health specialist if they had emotional problems. They would, however, talk to their spouses (55%), friends (42%), relatives (26%), a religious advisor (7%) or a doctor (6%). About 16% said they would talk to no one.

Recommendations for Finding 1:

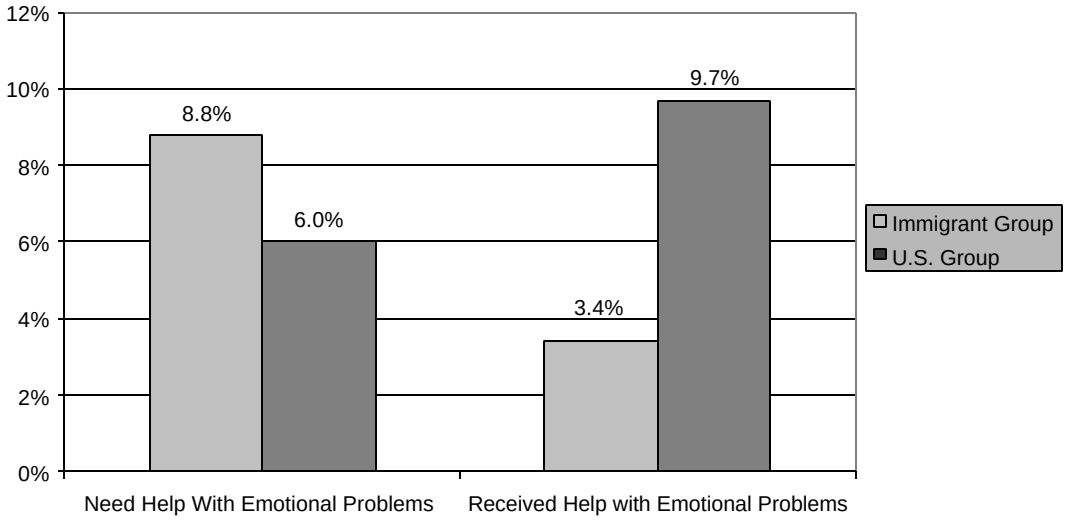
- The Mental Health Department and mental health providers should provide more materials translated into Bosnian, Chinese, Spanish, Vietnamese and other languages representative languages in the Santa Clara County.
- Staff should also be trained to be more linguistically and culturally proficient along with providing translated materials and services.
- Youth programs should be developed for people from 12-18 years old from China, Mexico and other representative groups.
- There should be more programs and support groups for people who are victims of war (especially from Somalia and Vietnam) and mental health providers should be trained on these issues.

One way to address culturally based reluctance to go to a professional mental health specialist is to conduct school visits by counselors and to sponsor family support groups. These have been effective practices for some agencies in Santa Clara County. Another agency also does most of their counseling in the home, enabling the extended family to participate and those involved tend to feel much more secure. Treatment mental health programs for immigrants must involve their social and familial natural support systems, which will help to identify mental health needs earlier, refer for services appropriately, and provide needed support for immigrants.

Finding 2: Immigrants show higher mental health needs but have received fewer services for such problems, compared to the general population.

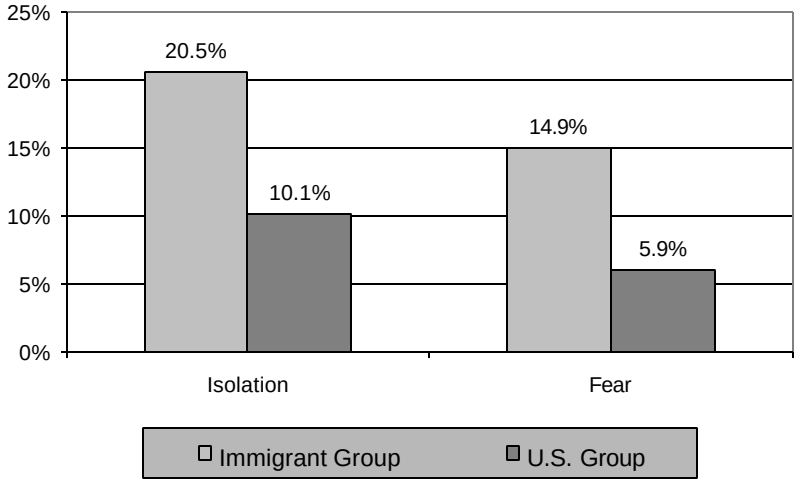
According to the random survey, 9% of immigrant respondents who answered the question reported that they have a current need for assistance with personal and/or emotional problems, compared to 6% of the US-born. However, only 3.5% of immigrants reported having ever received help for such problems, compared to 10% of the US-born.

Help Needed and Received with Emotional/Personal Problems (Random Sample)



In addition, the survey data indicates that immigrants are more likely than the US-born group to frequently experience a series of distressing symptoms or maladaptive behaviors, which put them at high risk for psychiatric disorders. These include: sadness (32% to 25%), isolation (20% to 10%), fear (15% to 6%), anger (25% to 22%), self-destructive behaviors (3.3% to 2.6%), nightmares (6% to 1.7%), flashbacks (7.1% to 2.6%) and hallucinations (6% to 1%).

Isolation and Fear Experienced (Random Sample)



A questionnaire of mental health providers identifying gaps in mental health services indicated that people who have private insurance could not get bilingual and bicultural providers.

Recommendation for Finding 2:

Government and private agencies must increase efforts to address mmigrants' mental health services needs, to develop mental health resources, and to help them receive access to those resources.

Finding 3: There are insufficient culture-specific outreach, education and prevention efforts targeted at mental health problems experienced by immigrants.

According to the survey conducted by the Mental Health Work Group, some immigrants believe that if they are identified as mentally ill, they will be sent back to their homeland. There is a severe stigma associated with using mental health services. Immigrants are not aware of how to identify their own or others' mental health problems. Also according to that survey, there is a lack of education to reduce substance abuse, domestic violence, gambling, and gang related activities. There is also a lack of knowledge among immigrants about the availability of mental health services.

The Bosnian IBC group expressed that there is a need for translated educational materials on many health issues as well as a need for education, e.g., not to use emergency rooms for regular health care issues.

The Iranian IBC group expressed that it had insufficient information about health care topics. The group further confirmed the taboo surrounding mental illness and said that Iranian cultural norms consider mental illness a shameful sin. The group recommended raising public awareness and outreach to their community.

The Latino IBC group expressed that there is a lack of information about mental health services, such as where to get services and whether services are available to undocumented people. The group confirmed that its community faces taboos about mental illness.

The Vietnamese IBC group discussed that there is a lack of knowledge about mental health in their community and that its community views mental health as a sin rather than an emotional illness. The group also agreed that people do not know where to get help in the community. They recommended more information in their native languages.

The Lao focus group suggested promotion of mental health education and awareness.

The statistics above indicate that although more immigrants reported a current need for assistance with personal/emotional problems than the US-born respondents (9% versus 6%), a small percentage of immigrants ever received help for those problems (3.4%

versus 9.9%). This could indicate a fear of stigma from receiving mental health services and/or an unawareness of those services.

Immigrants who answered the question in the random survey are less likely to talk to mental health specialist about emotional problems than the US-born group (2% versus 10.6%).

Additionally, 27.1% of immigrants who answered the question said that lack of information prevents them from obtaining services, compared to 21.8% of the US-born group.

A final barrier to receiving mental health services is immigration status: 31.5% of immigrants from Mexico and 19.3% from India who answered the question indicated that immigration status prevents them from receiving services.

Recommendations for Finding 3:

The survey of mental health providers regarding best practices highlights the effectiveness of utilizing local foreign language media for the purpose of educating immigrants about mental health services. Another effective practice in this area is to conduct outreach to health care providers, social service agencies, law enforcement, parks and recreation departments, churches, and educational and vocational services. Culturally-specific and sensitive information and translated materials should be provided. Informal engagement and education of family members within their cultural framework was also cited as a best practice. The Mental Health Department and mental health providers should increase their outreach, education and prevention services to immigrants. Information is better disseminated to immigrants through immigrant-focused media and communities. Additionally, there should be education to de-stigmatize mental health and build awareness to all immigrant communities.

WHAT IMMIGRANTS SAY ABOUT MENTAL HEALTH

During the Latino discussion of IBC, the participants expressed that there is a lack of information about mental health services as to where to get services and which services are being offered, especially for undocumented immigrants.

The Lao focus group participants listed physical and mental health services as their second priority and felt that health education and awareness is needed in Laotian.

For the Iranian IBC group, there is a rise in the number of untreated mental health patients due to social taboos on mental health and economic problems. Mental health is not validated in their society and families tend to ignore it and treat it as a shameful sin.

The Vietnamese IBC group shared that the Vietnamese community views mental health as a sin rather than an emotional illness. People do not know where to get help in the community. They recommended more information in their native languages.