

PROJECT ACCESS

Identifying Factors that Influence Access and Use of Mental Health Services for African Americans, Latinos, and Asian-Pacific Islanders in San Bernardino County

Presented to the San Bernardino County

Department of Behavioral Health

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1. Foreword and acknowledgments

It has been widely documented that racial and ethnic minority groups have less access to mental health services than do their white counterparts, are less likely to receive needed care, and are more likely to receive poor quality of care when treated (U.S. Department of Health and Human Services [USDHHS], 1999). It is important to note that this study proposes an intentional differentiation between *use* of mental health services and *access* to mental health services. Access is determined by the availability, acceptability, and cultural appropriateness of services, as well as location, hours of operation, transportation needs, and cost (USDHHS, 2009). Conversely, this study confirms that service utilization can be affected by factors not commonly associated with the above definition of accessibility of services such as cultural beliefs and explanatory models of health or illness. This study represents the most comprehensive community-based evaluation of factors that impact use of mental health services in the County of San Bernardino. We trust that the findings and recommendations will serve to improve access, use, and quality of mental health care for African Americans, Latinos/Hispanics, and Asian Pacific Islanders.

This landmark study was made possible through a collaborative effort between the San Bernardino County Department of Behavioral Health (DBH), Loma Linda University, the Latino Health Collaborative, and community partners. The community-based research was coordinated by Dr. Edward McField and Dr. Juan Carlos Belliard with the valuable assistance of Rupinder Cheema (research coordinator), Holly Schuh, Adriana Arzate, and Kelly Winjum. We recognize the extraordinary effort of the research assistants, Melissa Preciado, Rebecca Medina, Marina Anwuri, Tehani Mundy, Atinuke Shittu, Lisa Pham, Kathryn Pham, Duc Nguyen, Hovi Nguyen, Sophie Hung, Sarena Cha, Myung Me Cho, Luong Nguyen, and Lisandra Perez. Additionally, we thank Michael Batech and Sherma Charlemagne for their support with statistical analysis, and Dr. Susanne Montgomery of the Loma Linda University Center for Health Disparities for the valuable support with the study design. A special gratitude goes to Alex Fajardo of El Sol Neighborhood and Educational Center and the *promotores de salud* as well as the African American, Latino, and Asian Pacific Islander cultural coalition chaired by Gwen Knotts, Maribel Gutierrez and John Pi respectively. We are grateful to the staff and representatives of the Department of Behavioral Health. The Director, Mr. Allan Rawland, and Deputy Director and Chief Compliance Officer, Ms. CaSonya Thomas, are to be commended for their support of this landmark study. We also recognize, Dr. Keith Harris, Veronica Kelly, Maribel Gutierrez, Michael Knight, Bob Sudol, Manuel Gomez and other DBH staff who were instrumental in the success of this study. Last but not least, we acknowledge the individuals that were involved in the study, whether collecting data or as focus group participants, key informants, or survey respondents, consumers of mental health services or not, without your valuable input, the study would not have been completed.

While we value the input and participation of all the partners involved in this study, the contents of this report represent the authors' perspective and do not necessarily reflect the position of the San Bernardino County Department of Behavioral Health or of the organizations that the authors are affiliated with.

2. Ethics

The study obtained Institutional Review Board (IRB) approval from the San Bernardino County Department of Behavioral Health (DBH) and from Loma Linda University (LLU) and complied with ethical and professional standards to protect human subjects. All members of the research team completed IRB certification. Team members were recruited on the basis of either their professional experience as interviewers or their experience with the population concerned. All study team members received additional training in the study's community-based participatory techniques and survey protocols before initiation of the study.

During the study, identifiable information was not collected and individual responses were kept anonymous. Moreover, once all study goals, aims, and procedures, as well as risks and benefits, were verbally explained, study participants were given an information sheet which included facts on the subject under study, purpose of the study, methods used, participant inclusion criteria, benefits from the study, time commitment required, reward or compensation issues, and assuring complete confidentiality. Before any interviewing occurred potential study participants were informed that the completion of the anonymous survey was completely voluntary and would not affect their ability to access services or the quality of the services. Only aggregate data was used to present average responses or generalizations about the responses as a whole.

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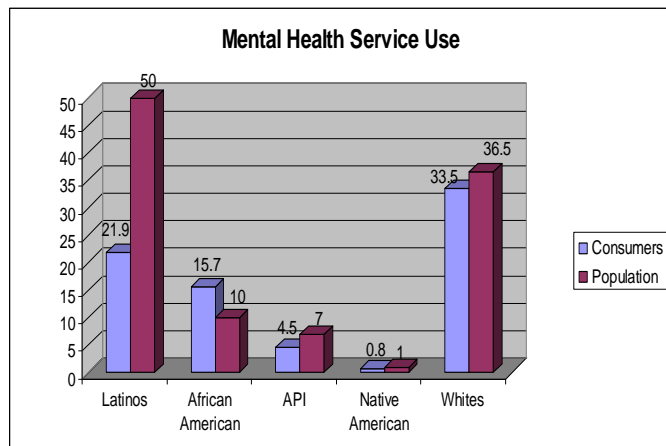
Identifying Factors that Influence Access and Use of Mental Health Services for African Americans, Latinos, and Asian-Pacific Islanders in San Bernardino County

Introduction to Study

3. Introduction to study

Former Surgeon General David Satcher reminded the public in the landmark report *Mental Health: Culture, Race, Ethnicity*, that racial and ethnic minority groups have less access to mental health services than do their white counterparts, are less likely to receive needed care, and are more likely to receive poor quality of care when treated (U.S. Department of Health and Human Services [USDHHS], 1999). In fact, minorities suffer from disparities in mental health care despite having, in general, equal or better mental health than white Americans (McGuire & Miranda, 2008). The debate on health care reform in the 1990s resulted in the re-emergence of access to mental health care services as a major concern (Pandiani, 2002). However, despite advances in behavioral health policies, the mental health systems continues to be plagued with barriers to equal access and treatment for persons with mental illness (Braithwaite, 2008). Unfortunately, the mental health needs of minority racial/ethnic groups have largely remained unmet, and the mental health care system continues to provide less care to persons in Asian/Pacific-Islanders, African-American and Latino/Hispanic minority groups than to whites, suggesting the need for policy initiatives to improve services for these minority groups (Cook, McGuire, & Miranda, 2007).

A comprehensive evaluation of mental health in California found that San Bernardino County did 'lower than expected' in comparison with other counties in California in regards to adult mental health (Eisenberg, 2005). The County of San Bernardino is estimated to have a population of 2,083,640 with 50% identified as Latinos (1,048,708), 10% African Americans (215,734), and 7% identified as Asian-Americans (136,725) (California Department of Finance, 2008).



An analysis of county data shows that during fiscal year 2007-2008, there were 36,980 unduplicated clients served in the mental health program. Latinos accounted for 28% of consumers while Asian Americans accounted for only 2% of consumers. Furthermore, African Americans accounted for 28% of consumers, almost 2 times their proportion in the county's population (DBH Research and Evaluation, 2008). It is also worth noting that 87% of consumers preferred to communicate in English, while only 5% had a preference for Spanish, 1% Vietnamese, and other languages accounted for 8% (DBH Research and Evaluation, 2008). Although Spanish is the county's "threshold language", it appears that the percentage of consumers that preferred Spanish (5%) is below what would be expected. These penetration or utilization rates do not correspond to the census breakdown and population distribution for the county, which confirms disparities in access for ethnic populations.

In light of these disparities in the use of mental health services, the County of San Bernardino Department of Behavioral Health (DBH) sought to determine what barriers exist for each of these populations as it relates to their utilization of mental health services.

3.1. Objectives

Project Access proposed the development of a comprehensive socio-ecological analysis of access and use of mental health services trends among African-Americans, Latino/Hispanic Americans, and Asian-Pacific Islander in the County of San Bernardino. Specific questions that were studied included:

- How and to what extent are residents of selected minority ethnic/racial communities in San Bernardino able to obtain behavioral health services?
- What factors are associated with better or worse access/utilization of mental health services?
- What social and cultural beliefs about mental illness and treatment influence how people of different racial and ethnic groups seek mental health care?
- What are strengths of the current mental health system and how can they be harnessed to improve accessibility, usability, and sustainability of mental health services in culturally diverse populations?

3.2. Methods

The study was designed based on principles of *appreciative inquiry* (AI) and *community-based participatory research* (CBPR). *Project Access* utilized a dynamic social ecological systems model to identify the social context, perceptions of, access to, and use of services for behavioral health among Latino/Hispanics, African Americans, and Asian-Pacific Islanders.

Furthermore, the study is based on a participatory research paradigm and uses a mixed methods design (Creswell, 2002; Johnson, 2004). The qualitative phase included focus group discussions and key informant interviews, whereas the quantitative phase consisted of secondary data analysis of admission/intake records (database provided by the San Bernardino County Department of Behavioral Health), and surveys with consumers of mental health services and non-consumers. This mixed methods approach is especially suited for research on access to care because it allows researchers to uncover the links between different dimensions of cultural factors (e.g. culture, worldviews/beliefs, etc) to construct a more comprehensive picture of the structures, perceptions, and processes of access and use of behavioral health.

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Mental Health and Culture: A Qualitative Inquiry

4. Qualitative Phase: Focus Groups and Key Informant Interviews

Project Access was implemented in four strategic phases including: (1) focus groups, (2) surveys, (3) secondary data analysis of DBH client dataset, and (4) key informant interviews. Focus groups were conducted by the research team through the month of April, 2009 targeting three main cohorts: the Latino population, the Vietnamese population-representing Asian Pacific Islanders, and the African American population within the County of San Bernardino. Furthermore, the study was designed to ensure adequate representation of Latinos, given the demographic distribution of the county and the documented low use of mental health services among Latinos.

Each of the three cohorts was chosen according to the needs and focus of the study. Because approximately 47.5% of San Bernardino County's population consists of individuals identifying with the Hispanic community, this cohort was oversampled throughout the focus group phase (U.S. Census Bureau, 2008). The Asian Pacific-Islander (API) cohort was defined more precisely by selecting one of the three largest API communities in San Bernardino County, which include in order of size: the Chinese community, the Filipino community, and the Vietnamese community. Considering that Vietnamese is approaching one of the threshold languages of San Bernardino County, and because this community is one of the more marginalized API populations, the Vietnamese cohort was selected to represent the API community for the focus group phase. The Vietnamese community reportedly had high rates of PTSD and is perceived to be more homogenous than the Chinese population and less acculturated than the Filipino and Chinese communities. Lastly, the African American cohort was selected because it represents an important ethnic/racial minority population in San Bernardino County and because of its overrepresentation in acute mental health service.

The three racial/ethnic cohorts were subdivided into two groups: (1) consumers of mental health services, and (2) non-consumers identified as community members with no personal experience seeking mental health services. Both consumers and non-consumers were asked about their understanding of mental health and mental health services. Participants shared their views on barriers to mental health services. Barriers were divided into two categories structural and attitudinal. Structural barriers included financial, lack of insurance, lack of transportation, lack of language services, and lack of awareness regarding mental health services. Attitudinal barriers included fear, stigma, and cultural beliefs that may delay mental health services access. However, cultural beliefs and practices are also presented as areas that need to be understood and can be used as opportunities to improve the quality of mental health services and overall understanding of mental health. This becomes even more important when looking at the responses of both consumers and non-consumers regarding their understanding of mental health, where both groups tended to focus more on a deficit view, in other words mental illness, rather than a positive mental health perspective. Finally, based on their experiences, participants were given the opportunity to voice their suggestions and recommendations on how to improve mental health services in their community. Over 200 hours of focus discussion provides invaluable insights into cultural factors and perception of mental health and quality of service among participants. While multiple statements and quotes

support the selected theme, due to space limitation, only a few quotes that are representative of the theme are included in this report. The following tables provide a quantitative summary of all Project Access focus groups:

Latino Cohort

LOCATION OF FOCUS GROUPS	NO. OF PARTICIPANTS
CONSUMERS	
Pacific Clinic	5
TAY Center	7
Teamhouse	35
Subtotal	47
NON-CONSUMERS	
Spanish SDA Church	15
SACHS Clinic	15
El Sol Neighborhood Education Center	12
Subtotal	42
TOTAL	89

African-American Cohort

LOCATION OF FOCUS GROUPS	NO. OF PARTICIPANTS
CONSUMERS	
Teamhouse	8
Teamhouse	13
Subtotal	21
NON-CONSUMERS	
Community members	7
Temple Community Outreach Center	10
Subtotal	17
TOTAL	38

Asian Pacific Islander Cohort

LOCATION OF FOCUS GROUPS	NO. OF PARTICIPANTS
TOTAL	41
Upland Community Counseling Clinic	8
Upland Community Counseling Clinic	6
Subtotal	14
NON-CONSUMERS	
Asian American Resource Center	13
Vietnamese SDA Church	7
Asian American Resource Center	7
Subtotal	27

4.1. Latinos and Use of Mental Health Services

The Latino population in San Bernardino County is estimated to be 1.05 million, accounting for approximately 50 percent of the total population (California Department of Finance, 2008). According to the 2008 report from the San Bernardino County Department of Behavioral Health (DBH), Latino consumers accounted for 28 percent of all DBH clients (San Bernardino County Department of Behavioral Health [DBH], 2008). The Latino cohort of Project Access (phase I) is comprised of 89 community members. To better understand factors that influence access to mental health services, three consumer focus groups and three non-consumer focus groups were conducted for a total of six focus groups.

Given the fact that Latinos represent close to 50% of the population of San Bernardino County (U.S. Census Bureau, 2008), this community was oversampled in the focus groups conducted as part of Project Access. Latino participants shared their views on barriers to mental health services, and barriers were divided into two categories: structural and attitudinal. Structural barriers included financial, lack of insurance, lack of transportation, lack of awareness and quality of mental health services. Attitudinal barriers included fear, stigma, and cultural beliefs that may delay mental health services access. However, cultural beliefs and practices are also presented as areas that need to be understood could be used as opportunities to improve the quality of mental health services and overall understanding of mental health. This becomes even more important when looking at the responses of both consumers and non-consumers regarding their understanding of mental health, where both groups tended to focus more on a deficit view, in other words mental illness, rather than a positive mental health perspective. Finally, based on their experiences, participants were given the opportunity to voice their suggestions and recommendations on how to improve mental health services in their community. Over 100 hours of focus discussion provides invaluable insights into cultural factors and perception of mental health and quality of service among participants. While multiple statements and quotes support the selected theme, due to space limitation, only a few quotes that are representative of the theme are included in this report.

MENTAL HEALTH DEFINITION

Both consumers and non consumer participants were more likely to define mental health as mental illness, relying on a deficit model vs. a positive health model. Two community co-investigators and mental health promoters explain a common community response in defining mental health:

Les pregunta: ¿qué es salud mental? y se enfocan luego luego en enfermedad mental.

[You ask them what mental health is, then they immediately focus on mental health disease.]

Mencionan ¿qué es salud mental?, y te mencionan todo lo opuesto. Te mencionan todas las enfermedades, los síntomas que tienen, y no tienen bien definido lo que es, ni como mantener una buena salud mental.

[They say: What is mental health to you?, and they immediately say the opposite. They start listing all of the mental health diseases and symptoms, and they do not understand well what mental health is and how to maintain it.]

In general, consumers were more narrowly focused on a particular diagnosis (i.e. Schizophrenia) when describing mental health; non-consumers had a more difficult time defining mental health or would describe it as “being crazy” or would refer to depression, again focusing on mental illness. Considering that many of our Latino participants were immigrants or had family members who were immigrants, depression is a recurring theme in the immigrant experience (Gonzales, Haan, & Hinton, 2001).

Participants who did not focus on mental illness, when asked about mental health, tended to link mental health with a sense of *balance* or *equilibrium*, with an understanding of the importance of the mind-body connection. However, what stood out significantly from Latino respondents was the importance of relationships on mental health.

Para mi es muy significativa la salud mental porque teniendo una buena salud mental tiene una buena comunicación con su familia, con amigos, y se puede uno desenvolver en un ambiente mucho más efectivo.

[For me, mental health is very important because if one has a good mental health, one has good communication with our families, with friends, and we can live in a healthier environment.]

Some participants described mental health as a determinant of good relationships, while others recognized positive relationships as a sign of mental health. Both views show the importance of social and family relationships and their role in creating and maintaining mental health.

Pues para mi, salud mental es también sentirte bien contigo misma, aceptar a los demás y tener una buena relación con los demás, y disfrutar de la vida; de cada cosa que tu haces.

[For me, mental health is to feel good about yourself, to accept others, and have a good relationship with others, and to enjoy life; in everything that you do.]

The importance of *Familismo*, defined as a strong identification and loyalty to family (Strolin-Goltzman, Matto, & Mogro-Wilson, 2007) was a dominant theme when participants described mental health. There was also wide spread concern of how mental health problems can negatively impact family relations. Again, the understanding of balance as a key element of mental health was explicit in focus group discussions. Participants would often define mental health as related to a person's ability to function within the family structure or society. The following participant reflects this tendency with her focus on problem solving:

También la capacidad para poder solucionar, o arreglar cosas que nos molestan y que no estamos conformes con ellas, y tener la capacidad de resolverlos de una manera positiva y hacer el cambio.

[Also, to be able to solve problems that bother us or that make us feel uneasy, and to be able to solve them in a positive way and to make change.]

The previous quote emphasizes the ability to problem solve as a sign of a healthy state of mind, and also alludes to the need for each individual to be able to address his or her problems, which may indicate an emphasis on self reliance that could translate to resistance in help-seeking behaviors.

Despite the various definitions that were given by consumers and non-consumers, many non-consumers found it difficult to define mental health.

Hay veces que, pues que se dice de la salud mental, pero simplemente pensamos en lo que tenemos que estar bien de la mente pero específicamente ¿qué es la salud mental? No sabemos. La verdad, yo pienso que casi no la entendemos.

[There are times that, mental health is talked about, but we simply think that we have to have a healthy mind, but specifically, what is mental health? We do not know. The truth is that we do not understand what mental health is, I think.]

The lack of awareness of mental health was related to the lack of non-consumer's awareness regarding mental health services. Consumers obviously knew where to seek services since they were currently accessing them, but non-consumers expressed a general lack of knowledge regarding where and how to access mental health services. Both consumers and non-consumers agreed that in general the community is unaware of the mental health resources that exist.

...que la comunidad Latina necesita educación para reconocer primeramente que necesita atención médica para su salud mental. Porque esto es lo que más cuesta de reconocer.

[... the Latino community needs education to primarily recognize that medical attention is needed to have good mental health. Because that is what is the hardest to accept.]

The role of the mental health provider is also not understood. Some had a vague idea, others did not view the mental health provider as a recognized resource to address mental health problems.

La verdad es que no se le da importancia, pero por ejemplo, tu no sabes por lo regular qué es un psicólogo. ¿Qué es lo que hace un psicólogo?

[The truth is that people play down the importance of mental health; but for example, we do not know what a psychologist does. What does a psychologist do?]

The lack of understanding of mental health professions is also problematic to efforts that seek to increase the workforce diversity of mental health. Mental health professions cannot be considered as future career opportunity if people are unaware of what mental health professionals do. Adding to this lack of awareness is the apparent gap in the referral system between primary health care providers and mental health providers.

Entonces lo que entiendo es que no se dan una referencia para la salud mental, los proveedores no dan una referencia para ir a esos servicios de salud mental y además no saben ustedes dónde se puede ir, ¿verdad? No, no se sabe en qué clínicas, o en dónde se ofrecen esos servicios de salud mental, ¿verdad?"

[Then what I am understanding is that a referral for mental health is not given; the health care providers do not give out referrals for mental health services and you do not know where you can go to request services anyway, right? No, you do not know in which clinics, or where those mental health services are offered, right?]

This break in the referral system was mentioned repeatedly by various participants:

El médico nunca nos manda. También nos hubieran de hacer como un chequeo de cada seis meses. Yo siento que también es necesario., ¿verdad?

[The physician never sends us. They should also examine us every six months. I feel it is also necessary, right?]

Participants, mainly consumers, discussed in detail what some of the main barriers to accessing mental health care were. These barriers were divided into **structural** barriers and **attitudinal** barriers.

STRUCTURAL BARRIERS

The two main structural barriers mentioned by participants were lack of insurance and mental health staff. According to the Surgeon General's report, lack of insurance coverage for specific mental disorders makes it more difficult for individuals to access mental health services (USDHHS, 1999). While views on mental health providers could be considered an attitudinal barrier, it was categorized as a structural barrier since it addresses how staff members, representing the mental health system, respond to clients. Perceptions on the effectiveness of mental health professionals will be addressed in the attitudinal barriers section.

Views on mental health providers and staff

Participants expressed their views on mental health providers and staff freely. The feedback given ranged from satisfaction to discontent. Most of the consumers that expressed satisfaction were those who attended the TAY (Transitional Age Youth) centers and the T.E.A.M. (Trust, Encouragement, And Motivation) club houses who saw them as a valuable resource to address their mental health issues.

Finding the right places... your own problems... Finding a place that you're comfortable with. If you're comfortable there then you'll stay there... Like I'm comfortable being here, you know (At TAY center). I have no problem, this is a nice place. People, you guys are cool. You know what I mean? Nobody is A-wall, like nobody is off the wall, like tripping and shit.

Oh, I'm proud that the community actually has rehabs and rehabilitations for people like me, whatever; they are trying to change the lives around. I'm proud of that.

Some of the outpatient consumers were more critical of their interaction with mental health staff.

Getting scared when you go ask for help, because you're tired of asking for help. You're tired of getting the run around.

Complaints about the staff mainly focused on experiences when staff have not been helpful or have been perceived as being rude.

In most cases is that they do not even give the proper doctor or therapist to go to because they do not even know; they do not have the knowledge.

They do not say hi, good morning, how are you doing? Nothing.

Lack of insurance

Lack of health insurance covering mental health treatment was repeatedly mentioned as a barrier to mental health services.

A veces si lo recomiendan [ir al psicólogo], pero ¿qué pasa?, que la persona no tiene aseguranza, pues a veces es una terapia, de tres meses o no sé cuánto. Y si califica en el programa tal vez si la toma pero si no lo hace ¿qué pasa?, pues se queda sin ir al psicólogo, ¿verdad?...

[Sometimes it is recommended (to see a psychologist) but what happens? the person does not have health insurance; sometimes it's a therapy, of three months long or I do not know for how long. And if you qualify to be in the program, maybe you go; but if not, what happens? You end up not seeing the psychologist, right?...]

They told us to fill out the forms, and everything, talked to the worker, and everything, we stayed there for hours, having a mental breakdown, but they could not help us because they could not get the insurance company to pay.

ATTITUDINAL BARRIERS

Mental health stigma has been well identified as a serious barrier for people seeking help for mental health issues. Although this stigma exists across cultural boundaries it is also informed by culture. In the Latino culture the influence of family is important on how the mental illness is perceived, and what actions should follow to address it. As in any other culture, Latinos fear being labeled “crazy” if they seek mental health services. But as part of a collective culture, what others believe and say about you (*el que dirán* [what others may think/say) carries more weight than for someone ascribing to individualistic cultural norms (Perea & Slater, 1999).

La mayoría de las personas asocian la salud mental con estar loco. Sí, la mayoría. Porque a veces ellos piensan que si necesitan ver al

psicólogo pero por "el qué dirán", porque si saben que yo estoy yendo a un psicólogo van a decir que estoy loca.

[The majority of people associate mental health with being crazy. Yes, the majority. Because sometimes they think they need to see the psychologist but because of what other people will say; because if they know I am seeing a psychologist they will say that I am crazy.]

The hierarchy of needs and where physical health and mental health fit in that scheme is important when discussing values and priorities. Participants were honest about the higher value placed on physical health and how mental health is often left out.

Lo que pasa es que a veces, porque apenas tenemos tiempo para ir supongamos al doctor, para no sé, para la salud si estamos enfermas o algo, como que la salud mental la dejamos para un lado.

[What happens is that sometimes because we just have time to go to the doctor, I don't know what for, for health reasons if we are sick or something, it's like we put aside mental health.]

The previous statement supports literature that states that Latinos tend to view physical health as more important than mental health, and are more likely to seek help for physical illness, often ignoring mental issues (Kouyoumdjian, Zamboanga, & Hansen, 2003)

Views on medication

Latino participants were more skeptical regarding mental health medications (a contrast with the Asian and Pacific Islander (API) populations who were more likely to trust medications). Even those who were on medication voiced some concerns with side effects. These concerns help reinforce the existing fear of medications.

I take the pill, Risperdal, and it makes me go to sleep. Every time I got a medication, they always give me that, like I got the worse problem or something... I almost OD on that shit! I took that shit and my tongue would stick out.... It's like for a ... way to calm your nerves, so you won't be like laughing at people and shit.

Perceptions on the effectiveness of mental health professionals

Many participants, mainly non-consumers voiced doubtfulness as to the effectiveness of mental health professionals. The same respondents that shared their reservations about mental health professionals also had more information about traditional mental health beliefs and culture-bound illnesses.

La gente no cree, por ejemplo si alguien trae un problema o tiene un problema y a veces le dicen a uno tienes que ir con un psicólogo, "hay no, el no me va a curar, ósea el no me va curar lo que yo tengo"...

[People do not believe, for example, if somebody has a problem and sometimes they tell us: you have to go to see a psychologist: "Oh, no, he will not cure me; that is, he will not be able to treat what I have...]

No se les confía a los psicólogos.

[There is lack of trust in psychologists]

Ella tuvo una separación con su esposo, ok, y dice que iba y le platicaba y todo sus problemas y dice que no, no sintió que le ayudaran.

[She separated from her husband, aha, and she said she used to go to the psychologist and talked about her problems, but she felt it did not help her].

And those who did trust the skills of mental health workers often cited financial barriers in accessing their services.

Y cobran caro (los psicólogos), por lo mismo. Porque ayudan mucho. Ayudan mucho. Cobran mucho ellos de esta forma.

[And they charge a lot (psychologists). Because they help a lot. They help a lot. They charge a lot in that way.]

Stigma

Besides the usual stigma against mental health, some participants pointed out that some of the mental health campaigns have contributed to the stigma by portraying people affected by mental illness in a negative light.

Yo creo que algunas de las razones por las cuales también en la comunidad no se habla mucho, es porque en las campañas que se habían hecho acerca de salud mental, por ejemplo alguna persona

con depresión y se ponía a la persona despelucada que no era capaz de nada. Es el estereotipo.

[I think one of the reasons because mental health is not talked about in the community is because of the previous campaigns about mental health; for example, a depressed person was portrayed as a person with messed up hair incapable of doing anything. That is the stereotype.]

Osea la palabra loco es lo que se le llama a salud mental. Yo no voy porque yo no estoy loca. Entonces, eso es lo que desgraciadamente se está equivocadamente diciendo, pues, que yo no voy por ejemplo al psiquiatra, porque, o al psicólogo porque piensan que yo estoy loca.

[So, the word “crazy” is what we call mental health. I do not go because I am not crazy. Therefore, that is what we unfortunately and erroneously are saying because I, for example, do not go to see a psychiatrist, because, or a psychologist because they think I am crazy.]

It is hard to socialize and people treat us differently. We are humiliated.

Culture

Cultural beliefs and practices are an important part of understanding help seeking attitudes among various ethnic groups. Some researchers attribute the underutilization of mental health services and the high treatment incompleteness rates among Latinos to cultural beliefs and values (Kouyoumdjian, Zamboanga, & Hansen, 2003).

Within culture we explored various themes that surfaced during the focus groups with both consumer and non consumer Latinos. Some of the cultural elements that were mentioned through the experiences described by the participants included explanatory models for mental illness and disease; impact of collective cultural norms on mental health perceptions and behaviors; blaming ignorance on culture; and culture specific gender roles and coping strategies in dealing with mental illness.

Pues es nuestra cultura la que trae la ignorancia, y de ahí mismo de esas raíces, como que no hemos podido salir y necesitamos esa información.

[Ignorance is within our culture, and from these roots, is like we have not been able to move on and we need that information].

Explanatory Models of Illness

Kleinman (1986) defines illness as how the patient interprets their loss of health, including what caused the illness and often what should be done about it. Disease on the other hand is defined as an objective, diagnosed condition that is objectively identified by the health care provider. The explanatory model of disease is how the person makes sense of what has happened and why they are sick. Culture influences the explanatory models of disease or illness often dividing them into natural causation, personalistic causation, and supernatural causation. Natural causation is when someone breaks a natural law that leads to an imbalance. A good example of natural causation is an imbalance of hot and cold. If you go to sleep with wet hair you will probably catch a cold. Personalistic causation is when someone intentionally causes you to get sick. Evil eye is often understood as an unintentional effect of someone's gaze on another person's health. These culture-bound illnesses include evil eye (*mal de ojo*), *nervios* or *ataque de nervios*, and hexes.

Si mal de ojo. Ay pues dicen que cuando se le hay un niño muy bonito, supongamos, y alguien dice: "¡Ay que bonito!" y no lo agarran, que dicen que ya se enferman. Que dicen que ya la misma vista de uno lo daña. Lo daña.

[Yes, mal de ojo. Oh, people say that when a little boy is handsome, and then somebody tells him: "Oh what a beautiful child!", but they do not touch/carry him; the child gets sick. That is what people say. People say that one's sight is what makes them get sick. Yes, they get sick.]

However, evil eye can be intentional as well, hence the name.

Mal de ojo es porque son personas que son así, que son malas

[Evil eye happens because there are people who are like that; they are bad people]

Children are most susceptible to evil eye, which is a mental force that manifests itself through physical illness.

El mal de ojo daña a los niños físicamente, o sea, los enferma, los enferma, los enferma, los enferma. No pueden dormir, o les pega calentura- o los ojos rojos.

[Mal de ojo harms children physically; that is; el mal de ojo makes them sick, sick, sick, sick. Children cannot sleep; or they get fever; or their eyes get red.]

This topic is usually told not only as someone else's beliefs or practices, but in a joking manner as if the person telling it does not really believe in it. But most Latinos, especially immigrants, are quite familiar with these beliefs.

“¡Ay le clavaron el mono, jajajaja! Ay, pues es lo que le dicen, ¿verdad?”

[Oh, he/she was hexed with a voodoo totem, hahaha! That is what they say, right?]

Envy can cause illness as well, mainly on the person who is being envied. This is considered a personalistic causation. Finally, supernatural causation is when a non-human or spiritual force is involved in causing the disease or illness. There may be some overlap between personalistic and supernatural. The use of voodoo dolls, for example, is both personalistic and supernatural. By using a voodoo doll one person can cause harm to another. This is an area that needs more research, especially in its connection to mental health. Study participants who felt more at ease in discussing this subject expressed how these explanatory models are a real part of the Latino community. This is such a sensitive subject that most participants who brought it up did so in the third person. What is clear to most people in the Latino community is that the modern health care and mental health care provider does not understand or is aware of these beliefs.

Witchcraft, “mal de ojo” (evil eye), “nervios” or “ataque de nervios”. Things that doctors don’t understand that are in our culture.

Los doctores no creen en mal de ojo; Son nuestras creencias.

[Physicians do not believe in mal de ojo.; Those are Latino culture’s beliefs]

Participants understood that there is a gap between their health world views and that of their health care providers. While this mainly focuses on physical health care, it can also be applied to mental health care providers that need to understand these cultural explanatory models of mental health illnesses. The participants were vocal on this issue and in their descriptions of shared experiences around mental health demonstrated a clear sense of collectivism.

La salud mental es tener un equilibrio en tus pensamientos, en tus acciones, en tus sentimientos y esa salud te lleva a tener buenas relaciones sociales y familiares, y una autoestima alta.

[Mental health is to have equilibrium in your thoughts, in your actions, and in your feelings and this health helps you to have good social and family relationships and a high self esteem.]

Collectivism vs. Individualism

There appears to be a clash between traditional immigrant values which tend to be more collectivistic, and more individualistic host culture values (Perea & Slater, 1999). In describing the effects or impact of mental illness on people's lives, Latino participants were concerned with the effect on relationships.

Para mí la salud mental es la tranquilidad de mi conciencia...Porque cuando uno tiene algún problema con alguna persona la conciencia no está tranquila, la salud no está tranquila.

[For me, mental health is the tranquility of my conscience. Because when one has a problem with another person, one's conscience is not in peace, one's health is not good.]

This sense of collectivism brings added pressure to not let others in your family or social circle down. There is pressure to prove that you can overcome a challenge, which ironically must be done through individual effort.

Anteriormente como dice el compañero era: "Te fregaste, estas enferma, no tienes lucha, y ya esclavizado a vivir marginado."

[Before, as our partner is saying, it was: You are screwed, you are sick, you have no fight left in you, you are destined to be marginalized]

...porque la gente piensa que cuando ya se enferma ya no tiene lucha.

[...because people think that when they get sick they have no fight left in them]

Primeramente siento que es, es por miedo a ser discriminados por la sociedad, o nuestra familia.

[First of all it's because of fear to be discriminated by society or by our family]

[I primarily believe is because of fear to be discriminated against by society, or our family]

Gender

Latina women were portrayed by participants as being more dependant, timid, and submissive; character traits that reportedly do not fit in well with the dominant American culture.

Yo creo también que, la forma especialmente, en las familias latinas que a las mujeres las crían con, una actitud muy tímidas, que no deben de hacer esto, que no pueden hacer esto, que eso no es cosa de mujeres, y muy tímidas. Y luego cuando uno viene a este país, que todo es muy agresivo, y usted ve allí las mujeres luchando como cualquier hombre, la mujer Latina se siente muy incómoda.

I think it is also in the way, that especially, Latino families raise women. They raise them to be very shy; they should not do this; that they cannot do this; that is not for women; and very shy. And then when they come to this country, where everything is very aggressive, and you see women working like any other man; the Latino woman feels uncomfortable.

Cultural expectations of how men should act and how they should express themselves were discussed portraying the Latino male as one who does not show emotions and keeps his feelings inside. Participants recognized that this is not healthy behavior and that it leads to behavioral problems including alcohol abuse.

...el hombre fue creado de una manera ruda, ósea el no puede, ósea los hombres no lloran, ¿verdad? Los hombres pues no se pueden deprimir. Creo que hay personas que piensan, no osea los hombres no se pueden dar ese lujo de deprimirse y eso es lo que también recurran al alcoholismo muchos ¿no?

[...the man was created to be tough; that is, they cannot, men cannot cry, right? Men cannot be depressed. I think there are people who think that men cannot have that privilege of admitting that they are depressed, and that is what makes them to start drinking, right?]

Immigration

A common experience among many of the Latino respondents, mainly those who were Spanish speaking was immigration. Immigration was the common thread that runs through the Latino community. Isolation was the most common theme that emerged from the larger topic of

immigration. Isolation from family, friends, and from what is familiar. For a collectivistic culture and community, isolation is perhaps the greatest determinant of mental illness mainly in the form of depression (Schmaling & Hernandez, 2008; Shatell, 2008).

Yo me encontrado con personas, que no son de aquí, de este país, y sienten muy solas. Y le dicen a uno, “¡que bueno que veniste porque aquí no conocemos a nadie!” y luego, este, se sienten solas, deprimidas, porque no conocen aquí a nadie. Entonces este, yo pienso que, esas personas si necesitan ayuda.

[I have come across people, who are not from here, and they feel alone. And they say: “Oh, how nice that you came by because we do not know anybody here”, and then they feel alone, depressed, because they do not know anybody. Thus, I think that those people do need help.]

Fear was a common theme within the topic of immigration. For the undocumented population fear is a constant reality, one that can impact a person’s mental health. In discussing undocumented immigrant experiences a participant recognized this risk stating:

No hay peor enemigo para la salud mental que el miedo.

[There is no worst enemy to mental health than fear]

Fear of deportation is a reality for undocumented immigrants who need mental health services but are afraid to access them out of fear of deportation.

Pues yo creo también que por la misma timidez, que no tengo papeles, que no estoy, aquí soy ilegal, ¿a dónde voy?, si voy me van a sacar del país.

[I also believe that is because of shyness. I do not have a legal status here. I am an illegal immigrant; where do I go? If I go to request services, they will deport me to my country.]

Another participant expressed concern over the high number of undocumented immigrants in San Bernardino County who lack access to mental health services.

Mas del 50 por ciento de los Hispanos, de la población aquí en el Condado, son Latinos. Pero de este 50 por ciento, yo creo que más del 60 son ilegales, no tienen papeles. Y la mayoría de esos son de las personas que no tienen documentos, y no los van a atender en una clínica para tratar, sino simplemente la emergencia y ya, ¿y eso qué?, es una de las barreras también por las cuales el condado

debe de mirar cómo mejorar ese esquema de servicios, algo si nada más.

[More than 50 percent of Hispanics, of the County's population are Latino. But out of that 50 percent, I think that more than 60 percent of them are illegal in this country. They do not have legal documents. And the majority of those who do not have legal documents will not be seen in a clinic to be followed up but treated in the emergency room only. That is one of the barriers which the county should look upon for improving access to services. At least that if nothing else.]

Religion & Faith

The role of faith in maintaining mental health and in coping with mental illness was a dominant theme in our discussions with Latino focus group participants. Faith is seen as a way to maintain a balanced life which leads to optimal mental health.

Entonces, si uno ama a Dios. Si tiene un principio de fe, no importa de qué religión sea, la salud mental será más muchísimo más equilibrada.

[Therefore if one loves God, if one has faith, it does not matter what religion it is, mental health will be more in equilibrium.]

What makes this point of view problematic is if the person has been affected by a mental illness then it may be interpreted as a failure on their part or due to a weak faith in God.

Pero, ¿qué de un Cristiano que está deprimido? Vivimos aquí en un ambiente, eh, de Cristianos, ¿no? Y hay gente de otras religiones, eh, que vienen aquí. Y, ¿Cómo sería que nosotros sepamos que unos de los líderes está deprimido ¿Cuál sería nuestra reacción? No tiene una relación con Dios, no tiene fe, no tiene esperanza, está mal, no puede ser un líder en esas condiciones.

[But, what will it be of a Christian person who is depressed?. We live here in a Christian environment, right?. And there is people of other religions who come here, and, "How will it be if we knew that one of the leaders is depressed? What would be our reaction? He does not have a close relationship with God, he does not have faith, he does not have hope; it is wrong to be a leader in that situation.]

Role of Faith-Based Organizations (FBOs) in Addressing Mental Health Needs

La iglesia es uno de los mejores hospitales para la salud mental.

[The church is one of the best mental health hospitals.]

One respondent compared talking with a psychologist to confessing with a priest.

Un psicólogo te va a ayudar. Como cuando ustedes van a un sacerdote, ustedes van y se confiesan con un sacerdote. El sacerdote no va a decir lo que ustedes le confesaron.

[A psychologist will help you. Is like when you go see a priest, you go to confess with a priest. The priest will not divulge anything that you have told him.]

Churches often fill a social void for isolated immigrants (Derose, et al., 2000). This was recognized by a respondent that saw the church as an important solution to address isolation and depression.

Yo estoy de acuerdo en que las reuniones sociales, reuniones espirituales, que se tengan, eh, como iglesia, como comunidad; todo eso ayuda a una persona que está deprimida a salir de su soledad.

[I agree with the fact that social reunions, spiritual reunions, meetings that are held, uh, at the church, in the community; all that helps a depressed person to overcome their loneliness.]

The need for training faith leaders and people within the faith community on mental health education and referral to mental health services was seen as key intervention that needs to be addressed. The following participant expressed his limitations in attempting to help someone who needed mental health services besides prayer.

A veces vamos haciendo visitación a gente que no es de la iglesia pero que necesitan rezar el evangelio, y te encuentras con unos panoramas que no sabes a dónde dirigirlos, y acabas diciendo lo que todos decimos: "Yo no te puedo ayudar pero yo te puedo llevar al que te puede ayudar que es Jesús", pero hay veces que la enfermedad es una enfermedad que no solamente con eso ya necesita. Ha llegado a un punto que ya necesita una ayuda médica y hay que saber a dónde llevarlos.

[Sometimes we visit people that are not church members but need to read the Bible, and you come cross people with complex

problems, but we don't know where to refer them, and we end up saying what we all say: "I personally cannot help you but I can take you to the one who can, Jesus." But there are situations where they need something else. The disease has progressed to a point where medical attention is needed; that is why we need to know where to take them.]

Again, the lack of awareness of where to find mental health services is apparent. By training faith leaders on where to refer and how to identify mental health issues, they could become strong allies of the mental health service system, like a type of mental health promoters, with the ability to reach individuals for who church is their only contact with the outside world.

RECOMMENDATIONS

When asked about suggestions on how to improve the quality and access to mental health services, participants shared the following recommendations:

- § Educating young people to be more aware of mental health and reduce stigma from an early age through a preventive strategy.

I think it will be along the lines of prevention. I think educating the young people it is very important, so they can recognize what is going on with them. Just like sex education, when they learn what is going on with their hormones, we need to let them know that there are mental issues out there.

- § Educating law enforcement

I think educating the police officers on how to deal with clients who have mental health problems.

- § Addressing housing needs of people with mental health needs considering many end up homeless.

...improving housing services for people with mental health problems will be beneficial.

- § The need of more Latinos in the mental health profession

People like Hispanic young people who are interested in hearing our problems. Who are devoted to help people with mental health problems.

- § Frequent mental health screenings similar to annual physicals are needed

Nos deberían de recomendar cada año, ¿verdad? El doctor... Nos hubieran de referir cada año. [They should refer us every year, right? The doctor... They should refer us every year.]

§ Use of mental health *Promotores*

§ When asked if mental health services can be improved one participant responded:

¡Sí, claro! Si las promotoras de salud nos harían el favor! Dile al grupo que piense así más y que no nada más, que se den esas clases [de salud mental), ¿verdad? Más clases.

[Yes, of course. If the health promoters could do us the favor. Tell the group to think that way more, and not only that... we would like them to teach those classes (classes on mental health), right? More classes.]

§ The need to provide mental Health education at faith based organizations

§ When asked about mental Health awareness one respondent stated:

Como iglesia y como comunidad nosotros necesitamos educación, la información.

[As a church and as a community we need education, information.]

§ Need for more peer advocates

I found out when I started coming here and volunteering, they offered me this position, which I took over. I found out that I have the same problems that these people. They have the same problems I do, and I feel for them since I have the same problems as they do. We care for each other, how we get along, and how we understand... and we care about whatever they are doing, and they help me out. By the same time, we work together.

Another stressor that immigrants suffer from is the change in identity, where in their home countries they are respected professionals, yet when they come to the United States they become service workers.

Tú puedes tener un título en tu país pero cuando llegas aquí no puedes ejercerlo. Eh, no vale. Tienes que empezar de cero, arañando a donde sea. Entonces esto desequilibra la mente, y ahí es donde viene el problema de la salud mental.

[You can have a degree from your country of origin but when you come here you cannot practice. Uh, it is not worth anything. You have to start from zero, clawing your way up. That is what affects the mind's balance, and is where mental health problems come from.]

The balance that was described as so important to optimal mental health is seen as affected by the immigrant experience, caused by undocumented status, unfamiliarity, changes in identity and social status, and culture shock.

Hay un desequilibrio digamos, mencionamos que el idioma, la cultura, algo nuevo, es un país nuevo, personas que no conocemos.

[We said that when a person recently arrives to this country there is a loss of balance; we mentioned language, culture, something new; it is a new country; people we do not know.]

[Let's say there is an imbalance, we mentioned language, culture, something new, it is a new country, people we do not know.]

SUMMARY OF KEY FINDINGS

- Latino non-consumers lack information and overall awareness about mental health in general, and availability of specific mental health services. A poor understanding of what mental health professionals do contributes to poor access to health professional services and aspirations of Latino youth to become mental health professionals.
- Mental health is commonly defined by consumers and non-consumers as mental illness, using an illness model.
- When mental health was defined, balance and equilibrium was seen as a key determinant.
- *Familismo*, the strong dependence on family relationships, was a strong theme as participant's described determinants of mental health as well as help seeking behaviors of mental health services. Strong family support may protect against maintain illness, but may also delay or hinder treatment-seeking.
- Social pressure and public image play important roles in Latinos reluctance to discuss mental health with others in their community.
- Participants expressed concern over the lack of referrals between their primary health providers and mental health services.
- Key structural barriers identified included a) lack of insurance and cost of mental health services; and b) negative interactions with mental health staff
- Key attitudinal barriers identified included a) lack of trust in medications and mental health professionals; b) fear of deportation due to undocumented status; c) fear of being labeled "crazy" or abnormal.
- Need for mental health providers to understand Latino culture-bound illnesses such as *nervios*, evil eye, and supernatural beliefs and practices that affect mental health.
- Immigration was identified as a prominent theme in discussing mental health stressors such as fear, isolation, depression, and undocumented status-related stress.
- Religion and faith play an important role in mental health maintenance and coping with mental illness.
- The faith-based organizations can play an important role in identifying mental health issues and referring people to mental health services.

The fact that language was not emphasized as a barrier to mental health services during the focus group discussion was surprising considering the large monolingual Spanish speaking community in the County of San Bernardino. Although it was not an intentional element of the study design, it should be noted that focus group with consumers of mental health services were conducted mainly in English, while non-consumer focus groups included mainly Spanish-speaking individuals. Therefore, it may be the case that individuals who would consider language to be a barrier to services are not yet accessing the services and would not know whether language does in fact constitute a barrier.

4.2. African Americans and Use of Mental Health Services

The African American population in San Bernardino County is estimated to be 215,734, accounting for approximately 10 percent of the total population (California Department of Finance, 2008). According to the 2008 report from the San Bernardino County Department of Behavior Health (DBH), African American consumers accounted for 17 percent of all DBH clients (San Bernardino County Department of Behavioral Health [DBH], 2008). Thus, it appears that the African American population is over-represented among consumers. The African American cohort of Project Access (phase I) is comprised of 38 community members. To better understand factors that influence access to mental health services, two consumer focus groups and two non-consumer focus groups were conducted for a total of four focus groups. Key themes that emerged from the focus group data included: a mental health worldview that sees the individual having control over his or her state of mental normalcy; historical and current racial discrimination and its impact on mental health; substance abuse as a cause of mental illness, and the stress that comes from living in neighborhoods where drugs and drug-related violence are common, and how this chronic stress affects the mind.

MENTAL HEALTH DEFINITION

Normalcy

Participants of focus group discussion viewed mental health as the dynamic relationship between being “normal” and being “abnormal”. Normalcy being a social construct defined by the surrounding society as well as and individual’s family and friends. Normalcy, despite its abstract character, was a constant in all the definitions offered by the participants, however, no precise definition was provided by the participants despite being prompted. The participants considered any deviance from what is considered normal as negative, especially in regards to mental health. A participant offered the following statement:

I think it's like basically thinking outside of the box, like outside of the society. You don't think like normal, and you have to be monitored. They give you medication to think normal, otherwise they get lost without it. It's like people that don't think like normal people or have to be medicated to think normally or certain issues down out of the head.

(Mental health involves) ...people that don't think like normal people or have to be medicated to think normally or certain issues down out of the head, voices, or anything like that...

Any aberration from the ordinary thought process and functionality of the brain is considered a mental health issue, especially if the condition requires medication.

Mental health is not only a state of internal normalcy evident in thought processes and brain functions, but it is also the conditions by which an individual interacts with the surrounding society. According to consumer participants, mental health means:

...being treated equally as everybody else... as a normal person, and somebody that could be able to live in the community without knowing you have your disabilities and being able to live a normal life.

This definition diminishes mental health's reliance on internal processes and instead equates mental health with one's ability to function in a "normal" world made possible by the individual's ability to hide internal flaws indicative of abnormalities. One consumer described her struggle to function in her environment as a sign of mental health problems:

It also means to that one could be sent to an environment, and the environment to me is not normal; it's not in normal status. My environment of bipolar is not normal. So the things that are around me may not be true, but they are true to me and that is where the difference comes in how people look at me. Sometimes people look at you and they think you're normal because you dress right, you look right, and have your makeup right. And sometimes your interactions around you make the dysfunction not normal.

Sense of Control

Part of maintaining a state of normalcy requires control. Participants mentioned control as a sign or indicator of positive mental health. This control can come from two different sources: (1) the individual, and (2) medication. Lack of control evokes the sense of negative health issues, especially when considering treatment and the need for professional intervention. If a person can control a fault, weakness, or disability, he/she is considered to harbor a state of positive mental health that is void of any significant "problem" or "issue". This seems to be the case for most consumers; they desire to control their mental illnesses without the help of medication.

...but, you know what you have to do for the behavior and to control the way you are with others. How to interact with others...you know how to control it. It's you, it's not the disability, it's you yourself, you can do, it's not the disability.

Conversations included stories of struggles and desire to gain control without the use of medication and without the scrutiny of others. Thus, according to focus group participants, a state of positive mental health is contingent upon one's ability to control weakness of character and/or clinically diagnosed disabilities.

Universality of Mental Health

A mental disease is not designated solely to a specific race or other categorical factor, but rather it is blind of all visual or internal differences that exist among populations. One consumer described mental health by stating,

Mental health does not see color...being bipolar does not see color. Yes, being bipolar does not see color.

Participants discussed the definition of mental health and described it to be inclusive of all people and communities. Thus, mental health became a universal character binding all people together and claiming no boundaries or stipulations as to how or why it manifests differently for each individual. Because of its unbiased and objective character, mental health was discussed as an important factor of not only individuals but also communities. It was also noted, as exemplified in the proceeding quote, that a mental illness does not limit an individual to never accomplishing any goals:

Mental health includes knowing that you may have your disability, but we are all the same and if you want to accomplish something you should be able to accomplish it.

Focus group participants provided an additional aspect of mental health that includes the dynamic that exists between a healthy society and a healthy individual. One consumer stated that having “a healthy society and a healthy community is what mental health is about” which relies on the act of “looking out for each other”. A non-consumer mentioned the same relationship between society and the individual:

Well, to me it means having a healthy community. I just think having a healthy society and community is what mental health is about. You know, looking out for each other. If somebody is talking to themselves on the street, try to call the right people to help them.

The previous quote is reflective of the characteristics of social capital. Social capital has become a multi-disciplinary term used to describe the dynamics of populations and groups. Its characteristics have included trust, information exchange, and an expectation of reciprocity (Castle, 2002). The dialogue that flowed from a non-consumer focus group evoked themes of social capital with emphasis on healthy societies and their contribution to healthy individuals. Healthy societies and healthy communities were discussed as the ideal fundament of mental health and included the idea of neighbors helping neighbors.

A healthy society can cultivate and typically harbors healthy individuals. Participants suggested that if this relationship is disrupted or dysfunctional, mental health diseases are likely to occur.

CAUSES OF MENTAL ILLNESS

Study participants were asked about causes of mental illness in their community and what they believed the main issues were. African American focus group discussions focused on alcohol and drug abuse as key determinants of mental illnesses in the African American population. There was also mention of homelessness, escapism, and social practices (i.e. parties) and their relationship to mental health. When mentioned, participants wanted to make it clear that “escapism” was not an action carried-out intentionally by the African American population but rather a coping strategy to deal with their environmental stress, media campaigns by alcoholic beverage companies, and poverty. One non-consumer described the aura of the African American community as follows:

This is the difference...when you go to lower economic areas, you see a lot of liquor stores, and it's a booming business. I don't want to say it's like an escapism, but I think a lot of Black people probably turn to drugs or alcohol as a way to just ...ease their problems and deal with them. But that's the way we are portrayed. You see it in videos...portrayed as okay to have alcohol and to spray it on your friends.

Poverty, alcohol and drug use, and homelessness were discussed as the standard for the African American community. Alcohol and drug use is associated with approximately 23.5% of the reported homeless cases in the county of San Bernardino (SBC, 2007). It is also evident from the above quote that some members of the African American community feel that America's marketing strategy and the media's portrayal of the African American community are restricting and strong influences. It could be possible that America's media contributes to the African American image caught in a somewhat stagnant cycle. A consumer summarized this recurring cycle with the following statement:

The majority of our culture goes through family problems with drugs, broken homes and siblings.

Alcohol and drug use has a strong presence in the neighborhoods of many African American communities. This realism for neighborhoods was associated with the presence of mental health issues in the following account:

You don't feel if the drug man is living on your street, you don't feel paranoid seeing 800 people on your street coming through here? Drugs and alcohol in your neighborhood will make you paranoid, schizophrenic because you don't know who is coming through your neighborhood, you understand? You locking your doors, you wanna feel safe, but how can you feel safe when you got all these people posting there, selling drugs... You got cars coming through your neighborhood all night long, blowing on

music, blasting. That's going to make you feel safe at three or four o'clock in the morning, and you got children? Paranoid, you understand.

It is evident that these issues are on the minds of many in the African American community. Descriptions and stories flowed about similar struggles in broken homes, struggles with abusive family members, struggles with crime and the constant presence of alcohol and drugs in the home. The following quote made by a consumer expresses the silent hope that many feel when caught in these mind-numbing situations:

I would wake up next to her in bed naked, drugged up on cocaine. I would wake up smelling the stuff. She (my mom) traumatized me because when you wake up to a mother on cocaine, you could smell it, and step dad hitting her and stuff like that....you can't shake it. It threw me out of focus. I could have been more brilliant if I did not have all this stuff slowing me down on my mind...

THE EFFECT OF HISTORY

Participants indicated that history cannot be denied, and that the African American race has much to tell and remember considering that much of this population's significant transition in status and freedom occurred within the last century. An old, rich, and diverse history and a contrasting young period of freedom, progress, and professional opportunities describe the forces balanced on the fulcrum of today's reality and the population's current state of mind.

The country's increasing diversity has spawned an increase in research concerning the topics of racial and ethnic identity over the past 25 years (Smith et al., 2009). Ethnic identity has in the past been defined as "one's sense of belonging to an ethnic group and the part of one's thinking, perceptions, feelings, and behavior that is due to group membership" (Rotheram & Phinney, 1987, p. 13). If a race's most current negative and traumatic experiences have occurred within the past century, what repercussions are to be expected in mental health when considering individual soundness of mind and its link to racial identity?

Discussion within focus groups included the topic of history. One statement included the acknowledgement of differences within populations to be attributable partly to cultural roots.

I think every culture has its own roots. The Asians, Japanese, special roots protect each person. And I think we all have different moods and different command in our roots that help us.

After much discussion on history's impact on individual lives, the conversation moved on to include the relationship between a complete race's history and an individual's health.

I was just thinking, cuz I think a lot about history, I go maybe like depression because I am half Black and half White. Like for Black...(history) the most common to slavery, and that may bring depression.

The previous statement is an example of the dialogue constructed around the theme of the African American history in the United States. The dialogue provided evidence of indirect consequences and the repercussions of a stigmatized race. In addition to the previously discussed theme of inter-racial and intra-racial division, does history's account of injustice lead to loss of identity? One consumer stated a realization about the African American community:

There is no little Africa. Well, he had a good point, like you got little Italy, little China, little this and little that...you don't have nowhere where there is some Black people. There is (only) the ghetto where they put all those Black people...

Perhaps the strive to determine differences and unique qualities among the African American population does not foster healthy discovery amongst a race that has endured many hardships and has only recently been released from much of society's control, stigma, and prejudice. It is evident that this community is still healing from the injustices it endured.

Something I think that they don't understand is that even though slavery is over and we got the equal rights amendment and all that we still face a lot of discrimination, which is really stupid. Cause our blood is all red, you know, and everybody is mixed up now.

IDENTITY AND PREJUDICE WITHIN THE COMMUNITY

Focus group participants expressed that they are aware their community is distinctly different from surrounding racial communities. However, it was also expressed that a similar divide exists within the community's very own people.

The whole overarching issue with the Black community ... we hate on each other.

Participants also discussed the cause of this apparent division within the African American community. Some have expressed that one cause of the division within the community is heredity, culture differences, or which country, state, city, territory, etc. from which you come. If someone categorically belongs to the Black community according to the standardized racial groups created by the U.S. census, which are typically based on perceived physical and physiological similarities, it is then assumed that this individual has the same background as the majority of the African American community. One consumer noted the different gradations, tints, and shades that are often used to assist in dividing the African American community:

I think this. The Black people, they got all the bad stuff. It's the people, say, 'of color'. Because we are colored people, we are not Black. There is a difference. There is Black, brown, red, Afro-American. There is "colored-people", and there is color. The Black stuff? ...I don't know anything about.

There is a second motivational difference that drives these divisions within the African American community. Discussion about the chasm dividing the community led to the expression of difficulties communicating with family members who have continued their education and acquired jobs in the professional realm. Thus, much of the divide can be associated with differences between lower and upper classes. An example of such dialogue is as follows:

Cuz once you get to a different level...I can't do it. I don't care if you have a lot of money or whatever, but you still gonna be from the hood. If I'm with my dad's side of the family, which, I mean, these people are lawyers, doctors, and what have you. It's nice to hang out with them and stuff, but I still can't deal with it. But, if I go to my mom's side of the family, they are more humble and down to earth. They're not putting up a front. Some people front and let their money do the talking instead of bringing personality and themselves to talk.

I think what causes me depression is the way my race divides... and my race divides from other different races.

ATTITUDINAL BARRIERS

Two main attitudinal barriers were discussed by the African American focus groups. These attitudinal barriers include: (1) the trend of the community's current percept of treatment and (2) stigma within the community.

Current Perceptions of Treatment

Two main categories of treatment, according to consumers: counseling and chemical treatment (medication). The traditional view is for consumers to be dependent on medication.

You know that is what the medication is supposed to be for, so that you may not feel, you may be normal. So you do, so I do meet myself, I need my medication.

However, there is also the rising idea of reliance on self and more natural forms of coping rather than on medication. This does not mean that the majority of participants view medication negatively, but medication can be viewed as a vice, a sign of weakness, a crutch or a controller of the human.

You don't always need the medication to control yourself. But, you know what you have to do for the behavior and to control the way you are with others, how to interact with others, you know how to control it. It's you, it's not the disability, it's you yourself, you can do, it's not the disability.

It is innate human character to protest restriction, which may explain the common desire of consumers to seek treatment aside from medication. It is for this reason that persons may choose to not seek help from mental health services.

Stigma

There is a common sense of misunderstanding that accompanies any form of stigma. Consumers acknowledge the negative responses from society as well as the variances from typical interactions seen in reciprocated and healthy relationships and, in turn, rightfully respond with a jaded or hopeless attitude. They vocalize their internal struggle to accept the quick judgments and the generalizations about their abilities, their potential, and their humanness.

I think we all need to be able to not be put down because we have a mental illness. We are not illiterate; we are not illiterate. All of us may have a problem where we cannot learn. Okay, but it's not because we don't want to. It's not because we can't. It's because we have an illness that is prevent us from keeping it, okay? I work on the computer, and I love it. I draw, and I love that...but my focus needs help.

Stigma has a way of influencing our beliefs and actions. Its external pressure can cause rifts and separation to occur amongst friends and within families. Non-consumers mentioned the common human reaction to mental illnesses seen in families: embarrassment.

Nobody really likes to address those problems, especially within the African-American community. They use the excuses there... 'They have learning disabilities. They aren't able...they aren't able to learn...their IQ's are low'. They still have those mentalities.

Often the community fails to acknowledge mental health issues simply because they are viewed as family issues. To avoid external embarrassment, the issues are dealt with internally, within the family unit.

A lot of people don't talk about it openly because if it's a family issue, becomes a symbol of embarrassment, you know. Not that you should be embarrassed if you have a family member with mental illnesses. Sometimes their behavior patterns, you know, will cause you to be embarrassed.

Despite the perception of unavoidable stigma, participants also discussed denial and its effects on mental health. Denial is a safety mechanism that we as humans use to protect ourselves from seeing the disappointing realities of our character and our environment. Participants noted their community's silent acknowledgement of mental health issues. Despite attempts to maintain a sense of naiveté and privacy with the topic of mental health, issues do not go unnoticed. Non-consumers feel that the probability of the community acknowledging the issue relies on the individual's honesty, the society's definition of normalcy, and the community's acceptance of any deviation from the norm. When will the silent cycle end? Participants expressed a hope for relief found within the very same buffer that stifled community discussion on the topic of mental health.

I feel like I was ashamed I wanted to keep it in; I don't want anybody knowing my business, but the more I keep it in, the more it was making me sick. So I begin to start sharing some stuff with my grandkids and stuff, u know, so make them aware of things in the street and stuff. So you have to bring this stuff out for your inner health; you can't hold on to them.

Families are currently the beginning and the end of the cycle. Consumers engaged in discussion that reflected implications of the practice of familism. While not feeling comfortable discussing mental health topics with friends and other members of society, consumers found it to be beneficial to talk about such topics with family, especially grandchildren. In-home discussions such as this can serve as a way of addressing societal ignorance while considering and respecting the current perception that mental health is a family matter. Thus, discussion on the topic of mental health can begin within the family but rarely will it find its way to the dinner tables of the community.

STRUCTURAL BARRIERS

Within this category, three main themes appeared when talking with focus group participants. These three themes include the following: perception of poor service based on experience, lack of cultural competency (including language barriers), and lack of adequate insurance coverage.

Language and Cultural Differences

In the field of mental health, it is immensely crucial for patients to have the ability to relate to health professionals. Each patient relates to the communication that is necessary in building a trusting relationship between client and therapist. According to the Surgeon General's report,

many members of different ethnic groups prefer to be treated by mental health professionals from similar backgrounds (USDHHS, 1999).

While it may seem ironic that clients who speak English struggle with language barriers when accessing care, consumers voiced their struggle with understanding physicians who speak English as a second language.

A lot of it is just like the language barrier...there are a lot of Asians in there and Indians and Iraqis. I don't know what they are, but they're not Black, and they don't understand a lot of the things that you're saying and you don't understand half of what they're saying. So they just keep you there for three days and then say that they're gonna change your medicine, but you're usually back on the same thing.

Similarly, participants discussed difficulties in relating to mental health professionals. Attempts to relate to physicians fall through with consumers noting the “culture stop” that exists.

There's a lot of culture shock going around. People that don't understand other groups, and people might not interact with each other and with other groups. This could possibly be one of the main problems in this field. I believe it is culture shock.

The African American community places priority on commonness in racial background to be a very important characteristic of mental health providers. Discussion about the difference between outward appearance and inward racial identity reflected a similar struggle that exists within the African American community, that being the difficulty with racial identity and division.

Perception of Poor Service

Perception of poor service can be discussed within the context of the contingent relationship existing between quality and quantity. Consumers abide by appropriate protocol but struggle with difficulties in scheduling appointments, inconsistencies among multiple different mental health professionals, lack of quality time with professionals, long wait times, a sense of insincerity from professionals, cultural divisions/differences, and limited options in coverage to assist in accessing services.

They don't listen to you. They kind of put you on what everyone is getting at the time instead of dealing. They'll see you and stuff, but they're not listening you know, or saying 'let's change something; let's work with the individual'. That's what I'm seeing as the problem.

In all forms of service, sincerity is a major component of satisfaction for consumers. The African American community expressed frustration with lack of feedback and disregard for their concerns. One such experience is presented in the following quote:

Most psychiatrists don't give you feedback for an answer on the solution to your problem. They just ask you if you think you should do this and so what and so forth, you know? But, they do more listening than actually having a mental antidote for it. Like the answer to the situation, telling them I have an anger problem. So how can I control this? They don't give you solutions. They document everything you say, that's it. Someone who can actually think about the situation and who can give you advice on what you may do.

These participants conversed about their inability to address their mental health issues on their own, yet mental healthcare providers do not provide the necessary tools to be knowledgeable about their condition or to treat their condition.

In addition to the lack of communication between the consumer and the medical professional, consumers discussed the issue of limited time with mental healthcare providers to be a barrier that influences their decision to seek care or not. Treatment is currently seen as a revolving door, which does not allow for feedback or true interaction between the health-care professional and patient. Appointment times no longer represent quality time with a provider but instead portray a ten-minute session in which medication dosage is determined.

Most doctors, if you have insurance, will at least give you half an hour. Without insurance and with Medicare, they only give you 15 minutes... It's a revolving door...it's just like a revolving door.

Lack of Adequate Insurance Coverage

The above quote is also an example of the discussion that continued regarding lack of adequate insurance coverage to obtain quality mental healthcare. Consumers feel that if they do not have adequate insurance, no mental health service providers would want to help treat their disabilities. They also feel that insurance is necessary to acquire sufficient and effective time with physicians. They equate the quality of service with their stature of health insurance.

RECOMMENDATIONS

Some of the recommendations made by both consumers and non-consumers included the following:

- § Offer **programs** that facilitate the management of discussion groups to generate a support system for consumers and non-consumers

Places like this (the focus group)...programs like this to go and actually learn something about your disabilities so you can better understand it.

§ Provide **information** and **feedback** to consumers and non-consumers about their mental health through substantial **person-to-person** interaction with a healthcare professional

You know its not just cuz we're Black because of the program we're in... and I believe its like you said because of the medical insurance that we have its just that's what we got you know, and its uh just like a revolving door.

Someone who can actually think about the situation and who can give you advice on what you may do.

§ Improve **marketing** and **advertising** strategies for mental health services

I have a case manager and a psychiatrist and I found out about this by accident, they didn't even tell me, you know, so they need to advertise what they have available.

I think that they could advertise better because there are a lot of benefits and programs that they have.

§ Utilize peer-and-family advocates to connect consumers with mental health services

It's a new integration to the system. My counselors with their peers, people who have had mental health problems with issues, some people or family members, whatever, and they put them through counseling positions. To provide assistance. They need more. They could work for private contract.

§ Utilize the **youth** of the community to help address mental health at an early age and for creating awareness in the community

In the African community, the youth can make a movement...

SUMMARY OF KEY FINDINGS

- Many African American participants defined mental health with descriptions such as its relationship to a state of what is “normal”, and was contingent on a sense of control, and inclusion of the individual and the community.
- Non-consumers conversed about the individual's role in mental health as well as the importance of a healthy community for positive mental health.
- Common causes of mental illness mentioned by participants include stress, heredity, a chemical imbalance, alcohol and drugs, environment/trauma, age, and the economy.
- Repercussions from African American history of oppression and discrimination contribute to loss of racial identity, low self-esteem, and internalization of racism. However, this history also contributes to a sense of resilience and belief that they are able to overcome adversity.
- Major barriers in addressing and seeking help for mental health illnesses include current perception of treatment, stigma, language and cultural barriers, perception of poor service, and lack of adequate health insurance.

Findings which emerged from focus groups are indicative of major internal and external factors that contribute to an unhealthy and misconstrued conception of mental health services within the African American population. These factors are correlated to lower access and utilization rates of mental health services among the African American population living in San Bernardino County.

4.3. Asian and Pacific Islanders and Use of Mental Health Services

The Asian Pacific Islander population in San Bernardino County is estimated to be 136,725, accounting for approximately 7% of the total population (California Department of Finance, 2008). According to the 2008 report from the San Bernardino County Department of Behavioral Health (DBH), Asian Pacific Islanders accounted for only 2 percent of all DBH clients (San Bernardino County Department of Behavioral Health [DBH], 2008). The Asian Pacific Islander cohort of Project Access (phase I) is comprised of 41 community members. To better understand factors that influence access to mental health services, two consumer focus groups and three non-consumer focus groups were conducted for a total of five focus groups.

MENTAL HEALTH DEFINITION

In many Asian/Pacific Islander subgroups, including the Vietnamese community, status of psychological and physical wellbeing are critically interconnected to a point where mental issues may manifest through physical problems and physical distress may lead to mental health problems (Sue & Sue, 2003). In reference to this, the perception of mental health among Vietnamese consumers and non-consumers of mental health services is focused on the physical and mental balance within an individual. For example, a participant offered the following definition:

Mental health has to do with our physical and mental wellbeing. So, if our mental health is not well, then it affects physical health as well. And the two goes hand in hand.

Another prominent theme related to perception of mental health among Vietnamese individuals is the differentiation of neurological disorders from mental disorders. Based on focus groups, it is evident that both consumer and non-consumer participants accentuate the difference between experiencing neurological problems and mental problems. In some instances, participants admitted not having shared their own psychological problems because of their inability to explain that [they] have neurological problems and not mental problems. Whether neurological or mental, both issues are viewed negatively by the Vietnamese community and therefore never shared in a community setting as expressed by focus group participants.

In the Vietnamese community, to word “mental” means “crazy” and physiological problems but also include neurological problems. That is why we don’t talk about it because it is embarrassing. In my own experience, I feel embarrassed talking about it, but I can’t just stand there and explain that I have neurological problems and not mental problems. Most of the Vietnamese community people view us as crazy.

According to what I believe, diseases involving neurological illnesses, in general people will consider mental illness. I have epilepsy. There is a lot of time personally I feel like it has to do with being sad and worry.

When focus group participants were asked for a definition of mental health, most described mental health by emphasizing the presence or absence of mental illness. However, definitions of mental health differed between consumer and non-consumer participants. Consumers of mental health services described mental health as the existence or lack of mental stability.

Mental illness is being sick. Some days you are happy, some days you are not feeling well, some days you are feeling lonely and you do not want to do anything.

Non-consumers of mental health services had a more difficult time defining mental health and were more likely to link mental health to a person's attitude and a balance between physical, social, and spiritual health. In summary, it was more difficult for non-consumers to define mental health than it was for consumers.

What do you mean mental health? Mental health is.....umm. I don't really know. I don't encounter that term a lot.

In addition, mental health was also linked to having a strong mind, as well as affected by the presence or absence of financial, social or family stress. Individual mental fortitude is attributed to mental health, implying that mental illness is a sign of mental weakness.

According to what I know, and this is only my opinion... in the family life, there are a lot of issues. Sometimes economics and other issues that affect the family life. It affects the way that we raise our children and the lifestyle over here. It causes a lot of tension. And if we don't have a strong mind, then it can happen to anyone. However, if we were able to overcome those issues, then mental health would not be strongly affected. For those who are scared or depressed, then we can more likely get the mental health disease.

Loss of memory, especially in the case of the elderly, was defined as a sign or precursor to mental illness. The concept of memory as a marker for mental health contradicts comments mentioned earlier differentiating neurological from mental illness, where memory loss, a symptom of Alzheimer's disease is not considered a mental disorder but a neurological disorder (Disease Control Priorities Project, 2006).

Vietnamese refugees may have been more affected in mental health. Sometimes for example, they will be driving home and later don't remember how to get home.

Moreover, participants insisted that a strong memory is a preventive measure against mental illnesses. In addition, many participants agreed that stress leads to mental illnesses. Tension or stress related to family problems, financial worries, and strong sustained emotions like anger, will eventually cause mental illnesses.

Sometimes being lonely or alone and don't have a lot of friends to talk to and everyone is busy, it seems like everyone keeps it to themselves. They get stressed out. Like in Vietnam, they don't go see a psychologist.

So all the issues regarding family and work don't get talk about, and they hold it all inside to the point they become stressed out.

Language

Language barriers or limited English proficiency can be a contributing factor to mental health disparities among language isolated communities such as the Vietnamese community. Since limited English proficiency is associated with lower use of mental health services, the Vietnamese and other API communities are susceptible to continued mental health disparities. Many Vietnamese focus group participants expressed their experience with language barriers.

There is a language barrier. Our English may not be very good. And sometimes we go to hospital and we need a translator.

...there are some people that live behind my apartment near my store. Those people are very scared when they receive a letter in the mail whether it's good or bad. If they have anything to do with language, they get really scared.

A common language between the patient and the provider guides the patient-provider relationship and allows patients to express their needs clearly and understand the recommendations of the mental health specialists directly. Like many focus group participants stated, most individuals with mental health illnesses “don't know how to explain their illnesses.” While not being able to clearly communicate one's own mental health issues can be due to differences in explanatory models of illness, language barriers are a more obvious hurdle in allowing effective patient-provider communication.

When there's no translator, we need to find Vietnamese doctors, so they can explain more thoroughly in a way we can understand. Possible in Orange County, there are more Vietnamese people as

compared to here. And so therefore, it's possible the services are more spread out and utilized more in Orange County.

Language barriers are common between Vietnamese individuals seeking mental health services and most mental health providers and staff. According to several focus group participants, Vietnamese language resources were rare in the mental health system. While some mental health service consumers affirmed having received mental health care services in Vietnamese, many non-consumers perceived that there was a lack of services for Vietnamese people with mental health illnesses.

Right now there are American services, but Vietnamese people don't know how to go there and get service. If they know about it, then they will go. Otherwise, they don't and they stay home.

In the American community there are services, but how would you know to access them? The Vietnamese community does not currently have to such services.

Lack of mental health services, mental health materials in Vietnamese, and low levels of health literacy represent significant barriers in accessing mental health services. For example, individuals may be able to access application forms for mental health services, but they “don't know how to answer the questions of the applications,” impeding the actual delivery of services to such individuals as well as aggravating any existing mental problems.

For example, when I go somewhere and there are papers I have to apply, and I can't communicate very well, I get frustrated. That is when the symptoms arise. And in those times, I just stay home all day. And some other times when the neighbors will call the ambulance to come. Otherwise, I will stay at home and nobody knows.

Interpreter services were regarded as inefficient as interpreters were not always available when most needed. Most non-consumers of mental health services complained of not using mental health services due to the provider's inability to communicate in Vietnamese and also due to the long waiting time for interpreters. The frustration of waiting for interpreters was manifested in a comment made by one non-consumer focus group participant who shared the following experience:

Those who get sick will go to the doctor to get treated. That is the normal way. But the problem is that going to the American doctor, there is a language barrier. And the doctor knows that he can't communicate in Vietnamese and tell me to wait, and I wait and I wait until the translator comes. However, the translator doesn't

show up, so they tell me to come in another day. That is where the real problem is. Getting treated for an illness is possible, but it becomes a problem when language is a problem.

Evidence shows that many patients communicating through interpreters with their providers often have more questions about their own mental health that are never asked (Green, et al, 2005). Such findings indicate that use of interpreters versus language-concordance with the provider can compromise the communication between patients and providers.

I think that if the services can be spread out, and also have services in Vietnamese, and doctors who can speak Vietnamese, that would be very good.

Lack of Vietnamese Staff

While language and cultural barriers continue to create problems for Vietnamese individuals seeking to access and use mental health services, both barriers can be tackled by recruiting and hiring more Vietnamese individuals as mental health providers, counselors, case managers, and other staff. Even though focus group participants acknowledged a rare presence of Vietnamese counselors, the respect and preference for psychiatrists and medications was made clear.

I think drugs are very important in helping mental health; however, I believe that there should be other helps especially for old age groups. There are usually counselors or coaches, but they are not really experts.

The Elderly

Since the elderly Vietnamese population is at higher risk of mental health issues, it is important for the mental health care system to adapt to the specific cultural and linguistic needs of this specific population. Lack of effective communication between elderly mentally ill Vietnamese individuals is associated with language, cultural, and generational barriers between the patients and their providers. Continuing to improve culturally and linguistically appropriate services will strengthen the relationship between Vietnamese patients and Vietnamese providers. Patient-provider communication depends on more than language affinity; it also relies on cultural fit and mutual understanding of the patient and provider's mental health worldview. This point was further verified by a focus group participant who echoed the opinion of many others in the following statement:

Actually, in my opinion, going to an American doctor would not do anything. You cannot know for sure. For example, say even if you speak English really well, but between the American and Vietnamese culture, there is a lot of differences. Between a Vietnamese doctor and a Vietnamese patient, a lot of times there is a common sympathy and understanding. A Vietnamese person will feel more at home when talking to a Vietnamese doctor who

shares the same culture. They can express all their thoughts and ideas, but on the other hand with American doctors, there are two different cultures. Even if you say everything and even if you know a lot of English, it may not fully express everything you want to say. There are certain things that are hard to express to someone not in the same culture. On the other hand, if the American doctors know about the culture, then that is beside the point. But for the most part, it is best to go to a Vietnamese doctor.

Cultural Stigma and Openness

Mental health stigma exists in most cultures, but in some cultures it appears to be more severe. In the Asian/Pacific Islander culture, where honor is regarded as one of the highest social values and shame to be avoided at all cost, mental health stigma becomes a more complex and severe issue. API participants expressed how internalizing their stress and feelings was a common trait in their community and in a culture that valued privacy, especially regarding personal or family problems.

In the Asian community, they are always hesitant. Don't want to talk about our personal problem out loud. If anything, we may say with our closest family and friends and explain it. In Asian community, such topics are kept very private.

I see that sometimes, not just Vietnamese people, but Asian community, things that are private they don't share it. Because sharing with one person, that person will share with other people. Things that are shared become part of society and affect all aspects of their family and relationships. And the idea of having such openness could also be stressing. Often Asian people are like that, not just Vietnamese people. But not Americans, they are a lot more open and they share everything. Asian people, it is our customs and habits to be more private and not share. And so keeping it in, in regards to the elderly, might not understand that the younger generations are different now. Everyone has his or her own life.

Focus group participants indicated that most people are afraid to address mental health issues out of fear of being judged. Emotional problems are generally considered shameful and distressing, preventing individuals from engaging in help-seeking behaviors (Sue & Sue, 1999). Also, participants expressed a reluctance of people to address their own mental health issues out of fear of being labeled "crazy." While discussing mental health issues with people in the community was seen as unsafe and risky, "doctors" were regarded as trusted confidants.

No, it is not talked openly in the community because people will think you are crazy. The only time we hear about mental health is when the doctor talks about that topic. If there is no doctor present, we don't really hear about mental health.

The reason why that it is not talked about is that we are worried that we might be judged. We are scared that when people mention about mental help that it is associated with being "crazy" and senile. In the Vietnamese culture, we don't talk about it because it is not good for the society. Me personally, I hesitate talking about it but the doctor helps to get rid of some of the idea about it. For example, going to temple and talking about it, there is no reason to be embarrassed about it.

Some focus group participants stated that difficulty with being accepted as a mentally unwell person prevents them from sharing mental health issues with family members and providers as it affects their self esteems.

In my opinion, when we encounter these challenges, and when we go out, it not always easy. But the good thing about it is here we have a lot of good services. But one thing that is hard to realize is that when we have this disease, they think we are crazy. It is not good for our self-esteems.

In addition, having a mental illness is not considered a good character trait. Based on an analysis of Vietnamese culture, the value of self-control is highly emphasized and sharing emotional or mental health problems is viewed as an indication of a "weak person" who cannot exercise self-control (Kramer, Kwong, Lee, & Chung, 2002). Consequently, individuals show even greater fear to seek services to avoid being labeled as having a weak character.

People do not talk about it because they don't want other people to hear about it. It is their own personal thing. People can't talk about mental issues with each other. They don't want to be embarrassed, and they want their privacy.

In correlation with fear of losing one's self-esteem, many participants also described discussions over mental health issues as negative influences on the Vietnamese society. As stated by one focus group participant, "in the Vietnamese culture, they don't talk about it [mental health] because it is not good for the society." In addition, as reflected in the literature, most Asian/Pacific Islanders are less likely to share mental health issues to prevent such problems from negatively influencing their social networks (Kim, Sherman, Ko, & Taylor 2006). Therefore, not only is there fear of being affected, ostracized and judged due to a mental illness, there is also concern with affecting others with one's problems.

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In summary, increasing openness about mental health issues can be stigmatizing and stressful for reasons mentioned above by participants. Research indicates that Asian/Pacific Islanders are less likely to share mental health concerns with family or friends, mental health professionals, or primary care physicians compared to other ethnic groups (Zhang, Snowden, & Sue, 1998). Participant feedback supported the lack of sharing mental health issues with friends and family members, but most participants agreed that mental health professionals were to be trusted if there was the ability to communicate.

Role of Primary Care Providers

Another barrier to accessing mental health services mentioned by focus group participants was the disconnection between primary care physicians and mental health specialists. It was reported that there was a lack of referrals by primary care physicians. Focus group participants expressed a concern that most often their “general family doctor” failed to recommend seeing a mental health physician for mental health issues expressed by the patients themselves. Interestingly, while most Asian/Pacific Islanders are more likely to request mental health services from their primary care providers, they are less likely to be referred to those services from primary care physicians (Fancher, Ton, Le Meyer, Ho, & Paterniti, 2009). Consumer focus group participants also indicated that there is a need for primary care physicians to discuss mental health needs and issues with patients. According to Surgeon General’s report, primary care physicians have a responsibility to become aware of mental health services and connect individuals to such services (USDHHS, 1999). Having primary care physicians serve as a gateway to specialty services such as mental health care is instrumental in order to reduce some of the initial stigma felt by the Vietnamese community in discussing or addressing mental health issues.

Reliance and Faith in the Biomedical System

Contrary to the other two ethnic cohorts, Vietnamese focus group participants indicated that being in the presence of a physician encouraged individuals to have dialogue over mental health. In addition, Vietnamese consumers and non-consumers of mental health services depicted the physicians and counselors as sources of information and knowledge, and a treatment guide when addressing mental health issues.

The most important thing is that the doctors are important. I went to two different mental health doctors, and it is nothing different but normal. But when I came here [mental health clinic], I found that the nurses and doctors help us a lot...not only the doctors but also the nurses. Not only did they give us medicines, they took care

of us like family. Whatever we needed, they would help us, and that was normal for them.

Both consumers and non-consumers expressed that open discussions about mental health with non providers are very infrequent because of a general fear that “people will think you are crazy”. However, physicians are able to guide these discussions and help mentally ill individuals to “improve [their own] lifestyle.” Despite cultural differences between Vietnamese patients and their non-Vietnamese providers, there seems to be a general openness to use professional therapy and biomedical treatment to address mental health issues. Research also shows that while there is a generally different way to address mental health issues within the Vietnamese culture, Vietnamese individuals seem open to using services provided by mental health professionals (McKelvey, Baldassar, Sang, & Roberts, 1999). However, lack of awareness of mental health services offered leads to underutilization of mental health services by the Vietnamese community.

It is very important for the doctors to understand their patients and then explain how to take the medications, for example to take a pill one pill a day, or take it in the morning or afternoon and explain it. This will help the patients to understand and feel more comfortable. This will help mental health patients. For example, someone would say, “Oh I feel so crazy today. I don’t know what I think, it’s a raining day.” But the doctor will hear that and having a lot of experience will ask the patient, “How do you know its raining or not, but why do you go outside when it raining?” If you meet the right person to communicate your problems, it will help. But the problem is that they will only let you go one or two times because it is really expensive. Another problem is that not a lot of people access the psychological services because they might not know such services.

In addition to trust in biomedical treatment, Vietnamese consumers expressed openness to use of medication and other drugs to tackle mental health issues. While non-consumers were more skeptical over use of medication to alleviate mental health illnesses, consumers were very comfortable with the effects of medication on their own mental health.

They [physicians] do give medications to mental health patients. In my opinion, in the American community, a lot of money is spent for mental health services, and the issue is that, mental health leads to several other problems, including shooting people. It’s understandable because you are crazy, and you say a lot of inappropriate things. I also think that being diagnosis is important because the sooner you know the sooner you can get treatment.

Non-consumers expressed doubt in taking medication to address mental health issues due to concerns over side-effects and risk of overdose. However, it was evident that non-consumers based their comments on media's depiction of medication used to treat mental illnesses as a harmful narcotic.

Medications have a lot of side effects and medication makes you want to commit suicide.

Financial Barriers

During focus groups, one of the major barriers to seeking and accessing mental health services was related to financial stressors such as perceived high costs of services and lack of financial stability in light of the current recession. It was understood that while seeing a primary care physician can be expensive, going to see a mental health specialist can be even more costly.

To be honest there are private medical doctors, but it cost money, you have to make appointments to talk to them. Or if you're able to pay for it, you can get access. But I believe that treating mental health is very expensive, and it asks a lot of the doctors to be able to competently explain illness to the patients. Not everyone can do that or else it would be cheaper.

Even though private insurance may cover costs for specialist such as mental health providers, other types of insurance such as MediCal, might not do so. In presence of many existing barriers such as language and cultural barriers, financial hardships make it more difficult for individuals to prioritize their own health and seek mental health services. In turn, the lack of financial stability during the current economic recession seems to be contributing to mental stress as mentioned by some focus group participants.

A problem, however regarding mental health disease, it is not free. Medicare doesn't pay for mental health services. You have to pay in cash if the Medicare does not cover it. If you go to a general family doctor, never will they tell you that you have mental health doctor. No, no... you have to go to a specialist doctor for mental health so therefore Medicare will not pay.

Contrary to the opinions of the focus group participants, studies conducted among Vietnamese immigrants in countries providing universal health care and mental health services at almost no cost show that use of mental health services remains generally low among Vietnamese immigrants even when high costs of services is not an issue (Lai & Chau 2007). It is important to note that while cost can be a barrier to seeking mental health services, cultural and linguistic barriers are perhaps a priority in addressing the Vietnamese community's access to mental health care services.

A reason has to do with culture. Vietnamese people in America come here when they get sick, but they don't have resources like in Vietnam. In Vietnam, when you get sick, you have access to a taxi to take you straight to the hospital. But here, you call 911, and culture and language are both barriers. Because you can't speak English and there are other difficulties. Like people calling polices that we are being disruptive but we can't explain why because we can't help it since we can't speak the language. That makes it very frustrating, just like your hands; you have long fingers and short fingers. Some of the everyday struggles that we have.

Faith

Based on qualitative findings, addressing the relationship between faith and mental health is essential in understanding how individuals deal with mental health illnesses. According to many consumer and non-consumer participants, attending a place of worship is a very helpful and effective way of coping with mental health issues. Going to church or a place of worship was seen as not only a way to cope with mental health issues but also a way to learn more about “health as well as psychological processes.” In addition, focus group participants suggested that faith-based institutions and places of worship provide solutions to “certain problems that you can't solve.” In emphasizing the importance of religion in their methods to address mental health and mental health issues, many participants generally agreed that:

Having faith in God is important to have a good mental health.

It is evident that many immigrant and minority communities identify faith as a coping mechanism when confronting mental health issues. In addition, the tendency to rely on faith as a coping mechanism is deeply embedded in the cultural and personal beliefs of many minority individuals (Lee & Chan, 2009). Correspondingly, data collected through Project Access also reveals that the notion of faith as an approach to address mental health issues is frequently mentioned by both consumer and non-consumer Vietnamese participants.

Sometimes you are so sad, especially in America without a happy family, and the person that brings in happiness into your life. There are certain problems that you can't solve, so you go to church and pray so you feel better.

As indicated by focus group participants, attending church services and praying are two very helpful activities for combating mental health issues. Research shows that Vietnamese individuals who reported higher attendance at religious meetings experienced lower levels of distress overall (Jarvis, Kirmayer, Weinfeld, & Lasry, 2005). In relation to mental distress, some focus group participants reported visits to church or place of worship and praying as outlets to “release tension” that may cause mental health issues. The Vietnamese community confirms the relationship between church/prayer and amelioration of symptoms associated with mental illnesses.

Someone makes me go to Church, and I have a prayer chapel next to it. I believe that in the prayer I will release tension.

Churches, temples, or places of worship coincide well with reduction of mental stress and improvement of mental health status because in addition to their religious or spiritual value, they also serve as spaces for social interactions. Both consumer and non-consumer focus group participants emphasized churches, temples, or places of worship as places that are “compatible to talk” with friends. In this way, places of worship provide an optimal opportunity for individuals to interact with other individuals and discuss mental health and other important issues. These faith based settings can provide a spiritual, social, and mental benefit to those not inclined to seek support elsewhere.

Here, we don't live near other Vietnamese people. So, we have to search out places that are compatible just to talk, for example temple. No, they don't talk at the temple, but the values that they have and the way they live their lives is something that we can apply our lives to. Otherwise, whom can we rely on beside ourselves? With our ages, how can we take care of others, we can only take care of ourselves in order to have peace of mind. We go to temple to talk to friends. Friends don't really have to understand about what mental health is, what they say is general anyways, but it does help. And the friendship can help us lessen the problems. If not, we just go there to eat anyways.

Therefore, in order to bridge the gap between low penetration of the mental health care system and an increased need for mental health services in the Vietnamese community, providers must recognize the key role of faith in treatment of mental health issues. As stated by a focus group participant using mental health services as well as relying on faith to treat mental illness.

I go to Church and God will help cure me. So I go to Church and pray so God will cure me. And I feel better know.

This statement identifies the importance of faith and church in any treatment regimen accommodated to a mentally unwell Vietnamese individual.

Suicide

Participants indicated that the increase in suicides among Vietnamese individuals deserves attention by researchers and health providers. Based on data collected from focus groups, the tendency of committing suicide is induced by many factors including helplessness, isolation, and even medication/drugs. The sense of helplessness mentioned in focus groups is a result of many factors such as language barriers, cultural barriers, and older age.

Based on input from participants, language barriers limit the freedom of accessing mental health services because there is an obvious lack of Vietnamese-speaking staff and written material for only Vietnamese-speaking patients. Also, cultural barriers induce helplessness due to lack of openness about mental health issues and services within the Vietnamese culture. As one participant indicated that most mental health issues are kept inside and

It is not good because they keep thinking that I want to die. I want to kill myself.

Aging is also a process that continues to isolate individuals from resources and further intensifies their sense of dependence and helplessness. Research shows that among Asian Americans, suicide risks increase with age (Range, Leach, McIntyre, Posey-Deters, Marion, Kovac, & et al., 1999). In addition, for women aged 75 and older, the suicide rate for Asian/Pacific Islanders was 7.95 per 100,000 individuals compared to only 4.18 for White and 1.18 for Black counterparts (Centers for Disease Control and Prevention, 2007). Also, focus group participants expressed that elderly individuals with mental health issues isolate themselves socially to avoid becoming a burden on others, as stated below:

We don't have anyone talk to or we don't want to talk to anyone. Our children are busy because they have to work so we don't want to be a burden to them. Sometimes we call our friends or coworker, but sometime we feel bad because we don't want to interfere with their lifestyle.

Many participants also indicated that being in a state of bad mental health drives individuals to commit suicide. Also, as mentioned by participants, the introverted and closed-up tendencies of individuals with mental illnesses are factors that often lead to suicide, evident in a statement expressed by a focus group participant.

Mental illness gets so confusing that you do not know what to do.

Trauma

Trauma and Post Traumatic Stress Disorder (PTSD) continue to affect Vietnamese refugees settled in the United States and other countries even decades after the actual traumatic events. Despite some level of successful acculturation into the American life, many Vietnamese suffer from increased mental health needs due to past wartime experiences, loss of loved ones, and financial hardship (Gold, 1992).

Focus group participants cited conflicts and wartime, such as the Vietnam War, as very pertinent factors in causing mental illnesses. Prior traumatic experiences during conflicts or wars have left a lasting impression on the minds of Vietnamese refugees causing development of mental disorders. The impact of trauma on mental health and its contribution to development of mental illness is portrayed in the following quote from Vietnamese mental health consumers:

In the Vietnam War, I saw dead people in the battlefield. I see gunshot and blood flying everywhere. So when we sleep, I was restless and kept thinking about it day in and day out. Flashbacks keep staying in the mind, and so when think about it and gets scared. So therefore, our minds are always on it and thinking about it. This can cause mental illness.

I have terrible memories because of the Vietnamese communists. The experience in Vietnam is that we need to take a lot of medications, and it seems to help. During the time the doctor speaks with me about craziness and mental health problems, and the experience is really good. But few days later, the symptoms would arise again.

Mental health doctors don't understand completely. In the war in Vietnam brought a lot of mental problems. I don't know the specific mental problems. The Americans, some people can overcome it and some people can't. Some Vietnamese people don't get sick at all. Some Vietnamese people do get sick. So to say that they do not get sick is incorrect. In 1985, lots of things happen, people went to jail. There is no way where you can't develop problems. All the issues are in your mind. You develop mental problems.

When individuals continually experience flashbacks of conflicts or war, they are driven to a state of mental illness or even suicidal thoughts. As stated by one non-consumer individual.

I think a lot about the topic. In the family, the effects of the war and everyday living, there are certain conflicts. And in those conflicts, it brings some issues that force us to think. If we think about it for a long time, you start to feel lost and will become crazy to the point that you feel that you cannot live anymore. You want to kill yourself. So therefore, the health of your own mental health is of the most important. The medicine can only help so much. The doctor is the one that helps and guides you to an improve lifestyle.

SUMMARY OF KEY FINDINGS

- The perception of mental health among Vietnamese consumers and non-consumers of mental health services is focused on the physical and mental balance within an individual.
- Based on focus groups, it is evident that both consumer and non-consumer participants accentuate the difference between experiencing neurological problems and mental problems.
- According to focus group participants, some reasons for mental illnesses include depression, isolation due to growing old, intake of legal or illegal drugs, and traumatic experiences such as wartime conflicts.
- Some barriers to addressing mental health issues included age, stigma, and high fees of professional services.
- Language interpreters as well as translated materials and information are essential for proper mental health care.
- There is a lack of awareness about mental health issues and availability of mental health services.
- Lack of openness in the community around mental health topics exists.
- Having primary care physicians as a gateway to specialty services, such as mental health care, is instrumental to reduce the initial stigma associated with discussing or addressing mental health issues. Focus group participants indicated that being in the presence of a physician encouraged individuals to have dialogue over mental health.
- Focus group participants stressed the importance of faith and church in any treatment regimen accommodated to a mentally unwell Vietnamese individual.
- As discussed by focus group participants, feeling of helplessness, isolation, and aging, are indicators for the tendency of individuals with mentally illness to commit suicide,

Recommendations

§ Improve on culturally competent and linguistically appropriate services. Mental health specialists and/or staff from the Vietnamese culture can serve as cultural brokers and offer a better understanding towards Vietnamese patients.

§ Provider monitoring. While assessing mental health issues among Vietnamese patients, providers should pay close attention to both the physical and psychological (psychosomatic) symptoms manifested by the patient.

A Vietnamese person will feel more at home when talking to a Vietnamese doctor who shares the same culture. They can express all their thoughts and ideas, but on the other hand with American doctors, there are two different cultures

§ Build existing support systems. Provide professional support along with support from the family and the community. In addition, provide support to families by educating them and giving them tools to address mental health issues and the associated stigma in order to encourage access to mental health services.

We need support group to make mental health issues easier to talk about, and also the community knows more the issues and be more aware.

We should continually treat the patients and give them opportunities to share and discuss so they do not feel alone and depressed.

I ask my friends that I know and they said that it is helpful when family members know what to do and help out.

§ Faith-based partnerships. Utilize Faith-based organizations as a platform of discussion, education, and referrals to mental health services.

There are certain problems that you can't solve, so you go to church and pray so you feel better.

§ Public education. Create opportunities for open dialogue about mental health topics through community forums, publications, and social and cultural assemblies.

... you got to have a program to help them so people can come out and socialize.

We need support group to make mental health issues easier to talk about, and also the community knows more the issues and be more aware.

In our community, there should be more articles in the Vietnamese newspapers so that people will know more about these services.

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PROJECT ACCESS

Identifying Factors that Influence Access and Use of Mental Health Services for African Americans, Latinos, and Asian-Pacific Islanders in San Bernardino County

System Strengths and Weaknesses: Key Informant Perceptions

5. System Strengths and Weaknesses

The study included an assessment of organizational strengths and limitations following Appreciative Inquiry methodology. During this process, 21 key informant interviews were conducted with participants who were selected because of their responsibilities with the San Bernardino County Department of Public Health (DBH) or because they are providers of behavioral health services subcontracted by DBH. The report is organized by the various geographic regions. The statements included in this section are representative of themes and trends that emerged from the more than 80 hours of interviews with key informants.

5.1. West Valley Region

Strengths

Based on interviews with Department of Behavioral Health staff, there is great emphasis on improving the quality of life of clients and helping them to improve and recover from their illness. The following statement is representative of some

That is right. I guess what I focus on equally is to improve their functioning and quality of life. Both of those outcomes are extremely important. Functioning and quality of life, because without functioning, quality of life is dependent on it, anyways, so it is a good focus for us.

In addition, as staff continues to make efforts for recovery of clients, they accommodate individuals from different cultures and background by uniting them under the collective goal of recovery. For example, Clubhouses and TAY center staff reported attending to individuals from different ethnicities and races and guide interaction between these groups under the larger umbrella of recovery. According to the staff, keeping recovery in mind, racial difference and cultural difference that might inhibit recovery usually dissolve away due to the strategic efforts.

It just has not happened, and I do not think I have had an African American people come to me and say: "But where do Latinos go". It just has not been an issue here, as far as the negative side of race.

While Clubhouses might be a strong point in all regions, they were mentioned by interviewees as a true asset to the mental health consumers. Clubhouses provide a platform for individuals coping with mental illnesses to share their medical as well as social difficulties. Since mentally ill individuals become isolated and lack social support, clubhouses are very instrumental in allowing these individuals to step into daily tasks without difficulty.

We have 10 clubhouses, and they have people who come in, they socialize, they go to groups, play cards or whatever, and they are accepted if they have not services, anywhere.

Lack of adequate transportation to mental health services was a barrier reported by most focus group participants in preventing them from accessing the services that were needed. Likewise, transportation was also reported as a barrier by DBH staff. However, in the West region, staff provides support to individuals seeking transportation to services by linking them to resources such as bus passes, carpool, and other ways of reaching the services.

We work with people, getting them bus passes, and getting a car, taking them all in the bus to get familiar with busses routes....and so we are very aware of transportation problems and needs here.

In addition to professional therapy, there are also examples of collaboration with spiritual and religious centers as a way of approaching mental illnesses from different perspectives. Since spirituality and religion were reported to be a large part of healing mental illnesses among focus group participants, Interviewees mentioned incorporating spiritual input into treatment gives clinicians a tool to effectively deal with mental illnesses.

We have the Salvation Army representatives, we have the Baptist church representatives, uh, we have a number of clinicians who are very interested in spirituality, we have clients interested in spirituality, and it is one of the most exciting things I have done in a while.

One of the key strengths reported by interviewees from the West region is the reorganization of the treatment plan every year in order to address emerging needs of the clients. In other words, the treatment protocol is not a piece of guidelines that was drafted once and then left unchanged. On the other hand, the treatment protocol allows for new cases to be incorporated into the system and renews the system of services to address arising issues among clients.

Because we know we get new clients with unmet needs, so every year we reorganize. Just seeing the same people every year for year in and year out. Here, we do not. We try to keep things fresh, new, and exciting for the clients, and I think that is one reason why our attendance usually runs from 35 to 40 people a day

Barriers

Lack of funding for current programs and not many options for future funding for much needed programs is a major barrier in all regions of the San Bernardino County. While clinicians aim to maximize the number of clients that can be served within the given capacity, issues associated with unpaid bills and lack of medical coverage characteristic of most of the client base is a hindrance. As a result, more clients are being turned away even after they seek services for mental health issues.

Oh, oh, for right now, uh, with the budget problems, they are turning away more people that they usually do, and again that is happening in all regions, and people who do not have Medical are lost about what to do right now, and we are focusing quite a bit on Medical, getting billing, getting money to balance our budget off Medical, and so other areas suffer because of that.

Limitations

Similar to popular belief expressed during focus groups, interviewees also expressed stigma as one of the major limitations in providing services to mentally ill individuals. While providers are aware of stigma as a major obstruction in getting individuals to seek services for their mental health issues, they are not able to fully address access issues that arise due to stigma. As a result, individuals who really need services often fall into a cycle of delay in seeking services because they either feel too stigmatized to seek services or they are less often directed to appropriate services by family or friends.

Well, I think the number one, as far as I can understand it is stigma. I think it is, if I know a little bit about numbers that half of the people with mental health illnesses will never seek services and that is largely because of stigma, and that is why I think I did not seek services when I was in real trouble many years ago because I was afraid that I was going to lose my job or whatever, and I did it for almost four years. So I think stigma is a big one. It is still a problem.

5.2. Central Valley Region

Strengths

As mentioned by interviewees from the Central Valley region, one of the key strengths in providing comprehensive services to mental health consumers is the Full Service Partnership Program. Through the Full Service Partnership Program, clients are able to access services such as 24/7 crisis hotlines. Use of crisis hotlines not only minimizes hospital visits for some clients but it also offers an easier method of addressing mental health issues as compared to scheduling appointments with the mental health care provider. In addition, the Full Service Partnership Program targets clients who are in high-risk categories such as former prisoners, homeless, or on verge of becoming homeless.

I think because we have that Full service Partnership, so, that is an added service for the clients that qualify for this type of particular program, and we even have the 24 7, uh, phone, uh, the phone, you know, the crisis hotline that is open for the SSP clients. And I

think that is very helpful. We have had a lot of success in keeping the clients out of the hospital.

It is a particular program that, uh, it is not new, but it is new to the department, uh. It is more like you have... the client has to meet the criteria to be in the full service partnership. They either have to be homeless or becoming homeless, or they have to be involved with the criminal justice system, so like coming in and out jail or prison, or, uh, have been in and out of the hospital many times.

Related to program strengths, the central region interviewees reported that the 24-hour crisis hotline and the Quick Clinics are true assets in the region. Existing 24/7 services for mental health consumers serves as a convenient point of service where clients can access services at the time of need avoiding delay.

We also have the crisis response team, which is also a 24-hour service. And we also have the Quick clinics, but there is an issue right now with the county that I believe they have not gotten 24 services yet, but they are working on that, so that you can come to the clinic. But there is access to the department for behavioral sciences' staff 24 hours a day.

Barriers

Lack of information translated into the primary language of the mental health consumers is a barrier in providing services. While it is a county protocol to translate all pertinent patient information into languages that portray threshold levels of use, most of the information is not available in the client's primary language. Even though interpreters are available to facilitate dialogue between patients and providers, the actual paperwork such as application, prescriptions, medication information, etc. cannot be translated word-by-word by the interpreter. So, more information should be handed out in the respective language of the client to ease the communication barrier felt by providers when trying to explain medication and therapy to the mental health consumers.

I would love to see all of the paperwork translated into different languages. I understand that it has to be a threshold language before we say that, you know, we can actually do that. But, I mean, it is required by law that we need to serve the client in the client's native language. And there is sometimes paperwork that is related to medications, and if the client, and if the client does not understand what he is reading or she is reading, it is a risk for the department. You know they did not know the side effects of the medication; they do not know the direction how to take the medications. I understand there is a budget problem, but I am

thinking, we have we have in English and in Spanish, but we should have it in other languages as well.

Another regional barrier mentioned regarding translation of information for patients is the amount of time lost by staff in translating materials word by word for the client. To address this barrier, more standardized handouts in different languages allow the staff more time to focus on providing services rather than the lack of understanding between patients and providers.

I should have to sit with them and actually complete the paperwork with them because all of the paperwork are in English, and I mean, they sign this paperwork trusting me that, ok, I briefly explained to them that this is what it is saying, but they sign something, they finally document based on what I told them. And they put that trust on me, and I think it will be better if we have it in the clients' language, so that they sign and they know what they are signing, and that way it is better for them. They know what they are getting themselves in.

There were several operational barriers mentioned in relation to the limited access of the mental health consumers to mental health services. Limited hours of operation were mentioned as barriers that reduce access of the community residing in the Central Valley region to mental health services. As mentioned by the staff, the availability of physicians and case managers can vary.

Hours of operation. That is an issue because I am only there once a week, and the doctor is there only once a week.

In addition, hours of operation are not accommodating to the clients because they do not allow for any evening hours when clients can utilize mental health services. With rotation of hours and alternation between some evening slots, more clients will be able to receive mental health services.

Yes, I have noticed that we do have less evening hours. That is a barrier. Big barrier. I do not know why we do not shift that. The operating hours have gone back to kind of like an 8 to 5 pm approach although we have emergency services, so if we can change that to even two nights a week, that will really change. Yeah.

In addition, understaffed clinics pose a barrier in that mental health consumers are not able to receive the maximum amount of services that they might need. Also, since budget cuts have influenced the personnel capacity of clinics all over the county, hiring new staff is unlikely to happen in the near future to address current issues related to understaffing.

I will say, another one is to hire more staff, hahaha, because we are so under staffed. Yeah. Yeah. That is the thing. When people leave they cannot replace anyone because of the budget problem.

Lack of appropriate communication with the community in dissemination of information is a barrier in utilization of mental health services. In other words, individuals are not fully aware of the services offered by Department of Behavioral Health due to lack of appropriate communication with the community. Mediums of communication such as flyers, print media, radio, etc. need to be evaluated in assessing their impact in increasing awareness of mental health services among the community. In general, low awareness of mental health services results in less utilization of services because the gap between needs and resources is not being addressed.

I think one of my concerns is how information is given out. Who is giving out? How is it giving out? How do people know where to go to seek services? These are the questions that we should be asking. People are like "I did not know, I did not hear about it", so I do not know how much there is, the ability to use radio, the print media, do people give flyers out? Do people hand out material from house to house? How do they do it? I do not believe they are getting the information given out.

Limitations

Lack of available housing options for clients who are need of housing is a major limitation felt by clinicians serving the Central Valley region of the County. While most clients are unable to secure housing due to lack of steady flow of income, being mentally ill or having a history of mental illness predisposes individuals to rejection from housing facilities. So, the task of securing housing for clients is made more difficult for case managers. However, there is a general lack of housing options for clients that are being served in the mental health care system. Lack of housing options linked to other issues such as budgeting and lack of funding limit the capability of the system to serve most mentally ill clients.

Yes, housing. When a client comes and they say "I need housing", which a lot of them.. Every time that I see a client come in and ask for housing, I am like: "I am sorry, there is nothing out there". Because the funding issue, we use it for so many programs and we no longer have them because of the budget problem.

Recommendations

One of the recommendations made is the development of a resource management system to maximize the use of existing resources, especially by clients who need services but are unable to acquire them due to operational, financial, or other types of barriers. A resource management system can include a listing of all community resources, community organizations,

clinics, and programs available to individuals in different languages and in different geographic areas. In addition, this resource management system is strengthened by partnerships with community-based organizations in informing those in need of mental health services and directing them to the resources.

We have bilingual, monolingual staff that can assist in crisis, so we are building that, and we are trying to present that to the community more so that they can have access to services. So I call it a resource management system because I want to make sure when you walk away, because we are trying to satisfy the clients, people know what we can provide. So our relations with our partners are increasing access from that stand point.

A key recommendation also made was to encourage more students from different ethnic backgrounds to join career pathways leading to social work, psychology, and behavioral sciences. In recruiting more multi-cultural representation into the future workforce within the mental healthcare system is a method to address lack of cultural competency in some providers working with a multiethnic patient pool. In addition, a workforce from different cultural backgrounds also brings a variety of linguistic capacities to the mental health care system and resolves part of the language barriers that prevent clients from seeking and using mental health care services.

So what we are doing is to encourage students to consider Social work or Psychology or Behavioral Sciences as a possible career path. We need them, we are looking for them, and so we are establishing ways to communicate with them that this is a good profession. That we need their linguistic services, that we need them because they understand the communities, so I think that is also, we need that is what we need in our mental health sector, so I think that is what we are heading. We know they can be such a powerful tool to go back to their communities and say: we provide services; we are part of the community. So we are seriously trying to increase the number of students in these fields.

Another recommendation was made towards increase in cultural competency training with the staff and providers within the mental health care system. Training in becoming more culturally competent directly translates into better provision of mental health services.

I think that some of the barriers lie within us. I think our staff; we have to have a better trained staff in cultural competence. I think there are still individuals which still need to work through some of their issues about their culture. I think we need to, and I am not just even talking about if the Latinos. I am talking about

professionals having to open their minds regarding cultural differences and what it needs to be done.

5.3. East Valley Region

Strength

Overall access in this region was described as one of its strengths. The variety in access, ranging from clubhouses to clinics, offers the community a choice as to which mental health service is best suited for individual needs and preferences. Because homelessness and low-income status define this population, shelters and homeless programs are also seen as vital in providing the tertiary needs of the community. It was also felt that the community is aware of mental health services' presence in the community.

The community has pretty good access. We have clubhouses; we have shelters and homeless programs where people can walk in, and they are fairly well-advertised throughout the local community and within the homeless population.

We have a big clinic up on Gilbert Street where people can go for psychiatry assessment and medications. We also have a big clinic in Rialto BHRC where people can go for crisis intervention services, medication, and therapy and case-management.

The API population does not contribute highly to the demographic of the population in the East Valley, but recurring and consistent referrals are made to direct API consumers to mental health services. It was also expressed that there is a higher concentration of APIs in the West region, and special programs do exist to reach this population.

We don't have a special program for outreaching to the API community. We do have regular API consumers who come in through the regular referral process whether it be from church or school or other agencies or other community providers. But their access is equal to any others...but not that I'm aware of as far as any special outreach or access for them in this area. They tend to be a smaller part of the population in this area. We have a higher concentration of that population on the Westside, and they do some special outreach over there.

Similar to the Latino population, the African American population is viewed as having more than adequate access to mental health services. Because the African American population has a strong presence in the community, their high rates of attendance in DBH programs are noted.

East Valley providers are, again, reaching out to local churches and local homeless service providers in order to build referral services and reach the African American population.

I think it's excellent. We have a large AA population in our clinics and our clubhouses. And they are pretty well represented in terms of all the referral sources. There is a large AA community. Again, we outreach to the local churches and the local homeless service providers. And, you know, for whatever reason, the AA population is over-represented in the lower-income population or the mental health population sowe have good access for them and they participate fairly frequently in our programs.

There are clinics who have specialized groups just for the Latino groups...Increase in bilingual staff, a lot of training , interpreter training...so the interpreters can become more skilled in assisting the non-bilingual staff to provide services. A lot more training to be culturally competent for the API and Latino populations. A lot of community events that we have around API and Latino holidays and culture that draws people in....

An additional strength mentioned was the Mental Health Services Act. Many good outcomes have resulted from the MHSA including the development of the workforce education and training department and the coordination of training programs emerging from the department.

Again, through MHSA, we have a whole outreach team that targets all aspects of the community including FBOs in the community. I believe this team has contacted many of the churches that serve either specific populations like AA or Latinos or FBOs in general...we have a mental health commissioner who is very involved in a coalition of FBOs and she also assists in identifying and linking with these FBOs.

Through that entity we developed a workforce education and training component in our department that provides very good training in terms of providing services to all the populations. So that enables us to provide more effective services and access research and evidence-based practices and provide state-of-the-art services coordinated through our workforce education and training department which is pretty effective and really was highly developed with a lot of staff and resources.

Barriers

Despite the mention of housing programs being a necessary and often-used resource, the East Valley region recognizes sufficient housing as the biggest challenge residents and clients in the

region must face. The East Valley region serves “a lot more homeless and low-income people because of the concentration of that demographic in the San Bernardino area”. Knowing this, the acknowledgement of housing issues well defines the struggles of the population to find stability in a stressful and an unstable environment.

Well, housing is the biggest challenge because it is such a low-income area and housing is so expensive it's very hard to assist the consumers to get decent housing. And most of the housing that is inexpensive is usually located in the very bad parts of town where there is a lot of gang violence, or drugs, or prostitution and a lot of the buildings are old and dilapidated. A lot of people in the community rent out sub-standard housing to the mentally-ill population. So, I would say housing is one of the biggest challenges because it's hard to stabilize somebody if you don't have them in a stable housing situation.

Recommendations

The main concern expressed by the East Valley is the need for improved access to housing. It was suggested that additional housing programs be considered and implemented in the East Valley in order to facilitate the growth and development of the lives of those seeking mental health services.

Again, developing more housing. Even though we have developed new housing resources, it's only a drop-in-the-bucket compared to the need.

An additional recommendation for the East Valley concerns the development of additional employment-based services or avenues through which employment-based services can reach the clients expressing needs. Conversation revealed anecdotal descriptions of clients' struggles to establish a sound foundation upon which to build their lives and develop potential careers.

I think there could be improvement in terms of developing more employment-based services or linkages to employment-based services for the clients who express a need in this area. But, we have some programs, but we could use a lot more. Because of cut-backs and budget cuts recently in the basic services, we have trouble providing individual therapy and medication supports for a lot of the consumers particularly those who don't have any insurance like medical or any types of funding.

5.3. Desert-Mountain Region

Strengths

The Full Service Partnership Program was recognized as a positive point in the mental health care system for the High Desert Region. The program is unique in the way that it allows service providers to reach the community outside the clinic, perform home visits, and provide transportation.

That will be the Full Service Partnership Program. With that program, we are able to go out, to do home visits, and provide transportation for those patients who need it. That has helped a lot. But of course, we only have the ability to help 60 to 80 clients in that program, but those who are able to be in that program, we have done intense case management, transportation, we do provide a lot of services.

In order to communicate unmet needs of the community, staff in the High Desert Region hosts focus groups with the community under the requirements of the Mental Health Services Act. Through focus groups and interaction with community members, the staff is able to gather information in regards to which gaps continue to exist between resources and individuals.

Well, we do focus groups, especially when the mental Health Services Act came about, you know, that was a requirement to provide focus groups to the community to hear what their needs were. And that is what DBH does. They even have the (word not understood) meeting. I do not know what it stands for, but they do have that meeting every month here in the club house to hear what they community needs are: And they are open to the community and not only to patients here in the clinic.

Initiation of satellite programs in the High Desert Region has been a significant point of improvement within the mental health care system serving this area. In addition, to accommodate for the lack of geographical movement, the staff working in the High Desert Region have been offered trainings on the web to allow dissemination of up-to-date information to the staff.

Ok, well, to increase access in the last couple of years we have established programs, you know, satellite programs. I think the other mental health agency in the area has done the same thing in the last couple of years. Now, to increase the quality, I think we have had webinars, so web trainings have helped with keeping staff up-to-date to acquire new skills, and there has been more emphasis in the company about cultural diversity celebration to embrace cultural differences, and uh, that is it.

Since the High desert region is very vast with the population spread into different pockets of the region, it was cited by interviewees that the smaller population living in a larger area contributes to a greater distance between individuals who need services and the location of the services. For example, it may take more than 45 minutes to see a client in their home.

Uh, we serve maybe a smaller population within a larger geographic area, so from this office, one way to a client's home is, because these are primarily filed based services, could easily be 45 minutes, one way. That is the main difference I see, uh.

In addition, due to the larger area, it is more difficult to distribute resources to some very isolated population pockets in the High Desert Region. Since most individuals are looking to be isolated, they are not easily accessible to offer services to and disseminate information about available mental health services.

Well, going back to the challenges, uh, I just think lifestyle up here is harder because it is harder to get around, and a lot of people come out here to be away from people, but you can have a place here in the mountains, but then they have kids, and the kids have special needs, and then they (the parents) can get them to places that offer services for kids with special needs, and with any other resource. So I think it is harder to give resources to the families.

Presence of a larger Caucasian population in the High Desert Region has contributed to some issues such as gang violence by Active White Supremacy groups. In addition, the youth moving into the High Desert Region are initiating small community gangs to avoid isolation from their own community. Emergence of more gangs is a problem that the area continues to tackle.

We have Active White Supremacy groups out here. So I think that is kind of cool, but also it has lead to some other problems such as gang issues. The gang issues is that, uh, there is a lot of parents that are in prison, and they come out here whereas grandparents are retired, and then they (the gang members) do not want to be isolated, so they start building their own little community gangs, but it is becoming a serious issue here in the area.

Barriers

One of the main operational barriers was limited hours of operation. Having alternating evening and morning hours will allow more clients to access services.

We used to be open until late; two days a week , but then that service stopped, so I think that some people expressed that it will

easy for them to access services in we have some evening hours as well.

Due to the geographic location of the High Desert, there is a notion among the staff that it is always a region that is given the least attention. The needs of the clients in other regions are addressed more often than the needs of the clients in the High Desert Region. In other words, access to mental health services is not the same across all regions and especially difficult in the High Desert Region.

No, well, I just think that when it comes to accessing services within the county, within our department is just seem that the dessert region is the last one to be paid attention to. So I think that the needs of clients are looked up upon more down the hill in the county. Access to mental health services is not fair across the board. You know, I just think that the staff and everything will be the same in all four regions.

In addition, since the staff in the High Desert Region understands the isolation that the clients experience living in less populated regions, they are aware of individuals living within the county who don't really fall under any of the four regions. Since individuals in such isolated regions rarely access mental health services, they are often far along the stages of their own mental health illness. In other words, the illnesses become more serious and less manageable.

And in terms of needs, I think we have more than the other four regions, you know, I have had doctors and psychiatrists who have told me that the people that live farther out move out there because they cannot function in mainstream areas, so they move up to the high desert so that they can function better, it is more sparse, it is more isolated so that they can hide under the radar, and you know, I have worked for seven years and those have been my experiences as well. You know, people have harsher symptoms and more needs than we just think we do not get a lot of resources.

5.4. General Findings

There were some patterns that emerged among all regions of the county. Such patterns include similar barriers, limitations, and strengths that include all four regions of the county.

Strengths and Limitations

Also, collaboration between the Department of Behavioral Health and community based initiatives such as Beinestar and El Sol Neighborhood Educational Center create environment of

exchange of issues expressed by the community and concerns of the providers. Dialogue between DBH and the community directly influences efforts to increase or improve services to address access issues.

Yeah, as we noticed in the Latino Coalition, some of those organizations are Bienestar, El Sol Neighborhood Educational Center. Those are the two examples that I can think of right now, but the Latino Coalition was one that we believed could be an organization that can help us in that collaborative process. Our goal is to open up access to services for more clients, so we are going to be seeking new partners to join us.

The Peer and Family Advocates are considered as a plus point in the entire county because they serve as a link between the mental health care system and the communities and families that they work with. With numerous Peer and Family Advocates dispersed across the county, their work is multifaceted ranging from clinical work, interaction with families, community crisis team, and various other services. In addition, Peer and Family Advocates serve as a very diverse body of individuals who are able to reach out to individuals from different backgrounds and cultures.

One thing that we have invested in the last two years is what we called PFAs, Peer and Family Advocates. These are family members. I am one of them, and the Peers are our consumers that are trained, we have a career ladder where they can come in, at the entry level, and advance up through the career ladder, and they are assigned to the clinics and various other services. They are on the CCRT, very active, and in the community crisis response team, and they are trained to go out to interact with people that are in crisis.

When asked about strengths, one common theme was prevention and early intervention (PEI). All comments about PEI were positive and anticipatory of what the program will bring in the future.

We were able to successfully accomplish 95 percent of our contracts. DBH, PH, First5, and so on...but, were we really successful with the families? I would say...no because our therapists are only trained to work inside of a box instead of working within a family.

Our success is what happens when we provide an ounce of prevention for them. Giving them clothing for school is that ounce of prevention, and not medicating children and labeling them in

their school is that ounce of prevention. So our success is looking at the prevention versus the treatment.

The different regions of the county can be described relative to their respective “culture”, and this culture is what defines the varying yet equally important perspectives of the mental health professionals in each region.

*The West end feels like they are the **step-child** because they are so small and so far away that they only receive about 10 percent of the total funding for services. The Mountains feel that they are the **forgotten child**. They are so high up there that no body really wants to go up there unless they are going to the lake or going to go skiing. The Yucca Valley and the High Desert, which includes Barstow, Needles, and Trona, they just feel that they are the **lost child**. They probably get...maybe 3-4 percent of the total funding. Now where does the rest of the funding go? Well, very obvious...where are all of the big buildings? San Bernardino, Rialto, Fontana, Redlands...they receive maybe 70-80 percent of the total funding because four out of the five supervisors are encapsulated in this small region.*

Barriers

Transportation is a barrier to accessing mental health services across all regions of the County. Lack of transportation and rising costs of transportation were main issues that the DBH staff reported based on experiences with clients who were unable to access and reach services due to issues with transportation.

I think that access to services in our community is difficult because the costs of transportation are increasing. Many of them are not afford a vehicle or have access to one or have access to a secure vehicle, or maybe it is always breaking down, an unreliable vehicle, and I know that there have been some families that I have worked in the past who have told me that one of the reason why they are not able to come to the clinic is because it is and all day adventure.

Key-informants mentioned several times the lack of understanding of the needs in San Bernardino, and these needs are not only mental health needs but also the basic needs of the people. Mental health uniquely encompasses the internal aspects of an individual’s health, but external factors are many times contributors to the outputs of mental health and can be seen in manifestations exhibited by the individual.

Additionally, key informants spoke about “tertiary needs” in reference to needs that are “in addition” to mental health needs. The participants indicated that there is a discrepancy as to

how much a mental health provider should assist the patient but some providers acknowledge that they must assist in connecting consumers to the appropriate resource when their role has been fulfilled or needs supplementary action or services.

The needs are all the same as far as mental health. But if we look at their tertiary needs, which are job training, childcare, transportation, TAD, etc., there is a big disparity there. But, mental health has not learned to work together with the public services or the additional services that are out there.

Key-informants discussed the limitations associated with mental health providers and lack of creativity or unconventional practices. It was also mentioned that the practice of mental health is often placed in a box, and DBH mental health providers have done such in the past and present. Participants shared what happens when providers become too entrenched in this system. Often times providers can easily forget to see clients as individual humans with needs reflective of personal experiences as well as influenced by environment.

We were able to successfully accomplish 95 percent of our contracts. DBH, PH, First5, and so on...but, were we really successful with the families? I would say...no because our therapists are only trained to work inside of a box instead of working within a family.

PROJECT ACCESS

Identifying Factors that Influence Access and Use of Mental Health Services for African Americans, Latinos, and Asian-Pacific Islanders in San Bernardino County

Analysis of Community-based Surveys and Intake Dataset from San Bernardino County Department of Behavioral Health

6. Quantitative Phase: Surveys and Analysis of Data Set

6.1. Introduction

There is an urgent need to better understand the mental health needs of minorities and the barriers they encounter in accessing appropriate care. Ethnic minority status has been found to be significantly associated with lower rates of mental health service use (Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). Studies suggest that minority racial/ethnic groups are more likely than whites to use emergency services for mental health care (Chow, Jaffee, & Snowden, 2003). In fact, it was found that Asian Americans and Mexican Americans underutilized services, whereas African Americans over-utilized mental health services (Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

This disparity in the use of mental health services is also found in the county of San Bernardino, California, located in the “Third California,” a term used to describe the disparities in social and economic indicators between sub-regions in California (Kotkin, 2007). San Bernardino is estimated to have a population of 2,083,640; 50 percent identified as Latinos (1,048, 708), 10 percent African Americans (215,734), and 7 percent identified as Asian-Americans (136,725: U.S. Census, 2007). An analysis of county data shows that during fiscal year 2007-2008, there were 36,980 unduplicated clients served in the mental health program. Of these, Asians accounted for only 2 percent, 17 percent were Black, 28 percent were Latino/Hispanic, 1 percent was Native American, 43 percent were white, and 8 percent did not disclose race/ethnicity. However, it is worth noting that 87 percent of consumers preferred to communicate in English, while only 5 percent had a preference for Spanish, 1 percent for Vietnamese, and other languages accounted for 8 percent (San Bernardino County Department of Behavioral Health [DBH], 2008).

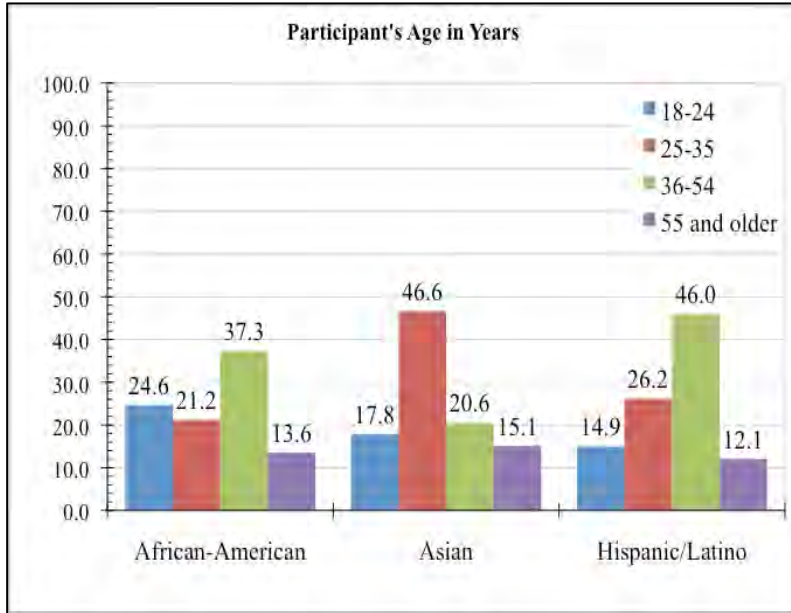
6.2. Community survey

To better understand factors that may influence use of mental health services in San Bernardino, a cross-sectional, descriptive, non-experimental study with a convenience sample ($n=539$) of consumers of mental health services and non-consumers was designed to include representation of African Americans ($n=118$), Asian and Pacific Islander ($n=73$), and Latinos/Hispanics ($n=348$). Participants were recruited in two ways: Consumers of mental health services were recruited at DBH-contracted mental health service providers, community clinics with behavioral health services, and community-based behavioral health organizations. Non-consumers (i.e. individuals who have not used mental health services) were also recruited through convenience sampling and recruited in churches and social service agencies. Survey respondents received a \$10 gift card as an incentive. African-American participants used the English survey as did the majority of Asians (68%), although 30.1% of Asian Pacific Islanders took the survey in Vietnamese. The overwhelming majority (88.5%) of Latinos/Hispanics took the survey in Spanish, while only 11.5% completed the survey in English.

PARTICIPANT CHARACTERISTICS

Studies have found that use of mental health services correlates to demographic characteristics, including ethnicity, age, gender, geographic location, insurance status, income, wealth, and education (Alegria et al., 2002)

Age



As shown in Exhibit 1, the cohort with greater representation among African American (37.3%) and Latino/Hispanic (46.0%) were participants between ages of 36 and 54. On the other hand, the largest age cohort among Asian and Pacific Islanders (46.6%) were individuals between the ages of 25 through 35

Gender

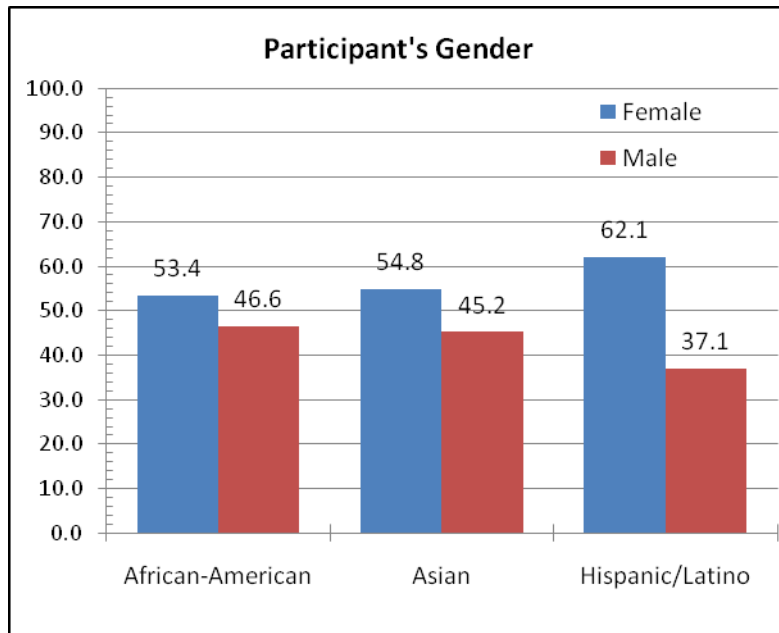
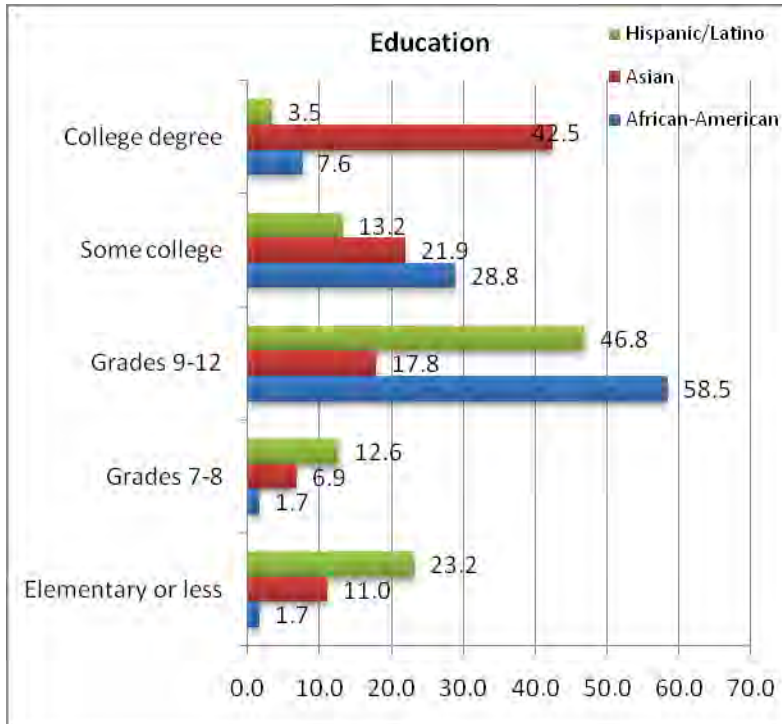


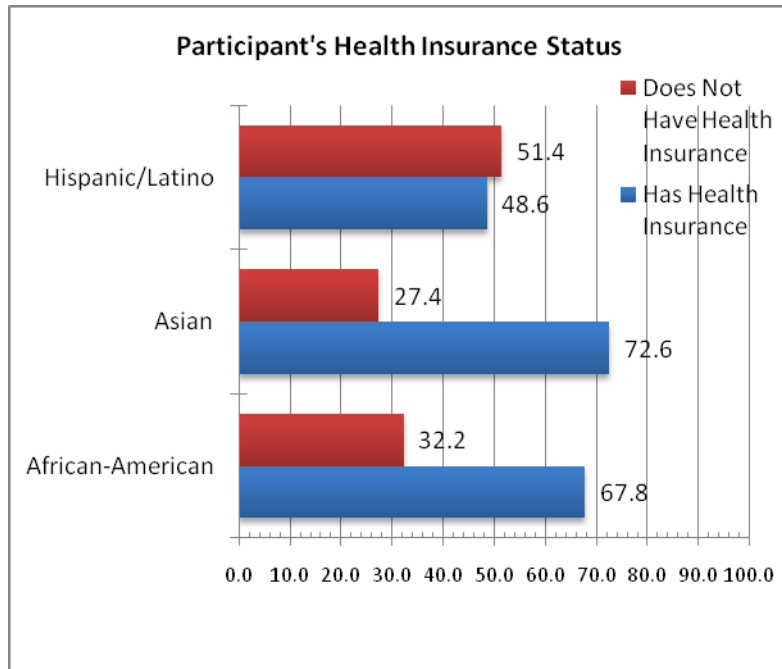
Exhibit 2 shows that in the sample, gender was fairly equally represented, with 53.4% females and 46.6% males among African Americans, 54.8% female and 45.2% male among Asian Pacific Islanders. However, among Latinos, females constituted 62.1% of the sample.

Education



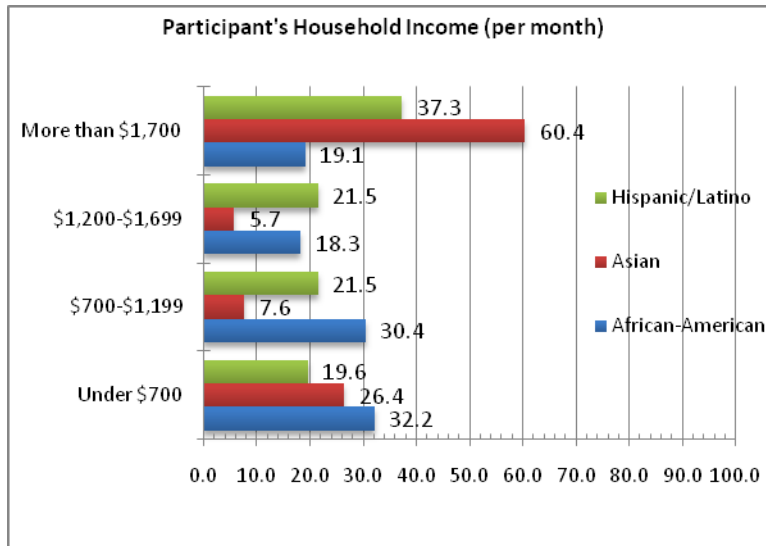
Previous studies seem to support the idea that education levels correlate to use of mental health services. Exhibit 3 shows that in the study's sample, a majority (58.5%) of African Americans had completed grades 9-12, while among Latinos it was 46.8%. Educational attainment was higher among Asian Pacific Islanders, with 42.5% reporting having a college degree.

Health Insurance



As shown in Exhibit 4, both African Americans and Asian Pacific Islanders had a greater proportion of individuals with health insurance. However, a majority (51.4%) of Latino/Hispanic participants indicated that they did not have health insurance.

Income

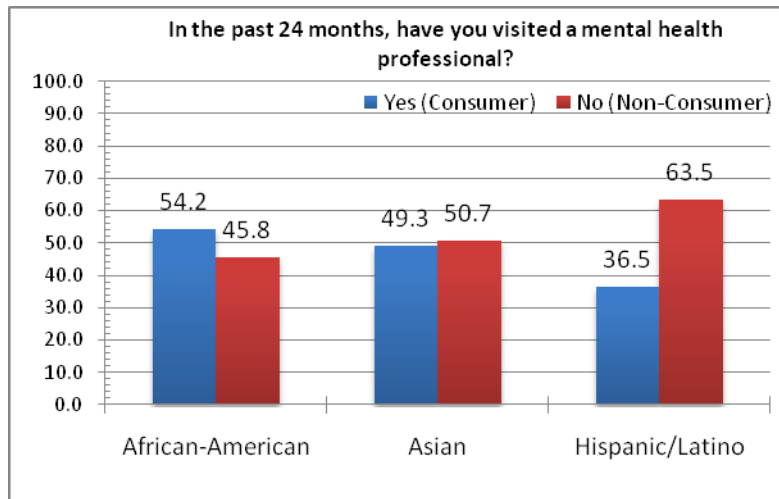


Studies suggest that income and the lack of adequate insurance coverage for mental health, or costs of treatment may pose barrier to use of mental health services and that individuals with lower incomes carry a greater risk of having unmet mental health needs. Exhibit 5 shows the monthly household income among respondents. Specifically, among Asian and Pacific Islanders, 60.4% of the participants reported an income greater than \$1700 per month, compared to 37.3% among

Hispanics and 19.1% among African Americans.

USE OF MENTAL HEALTH SERVICES

Previous use of Mental Health Services

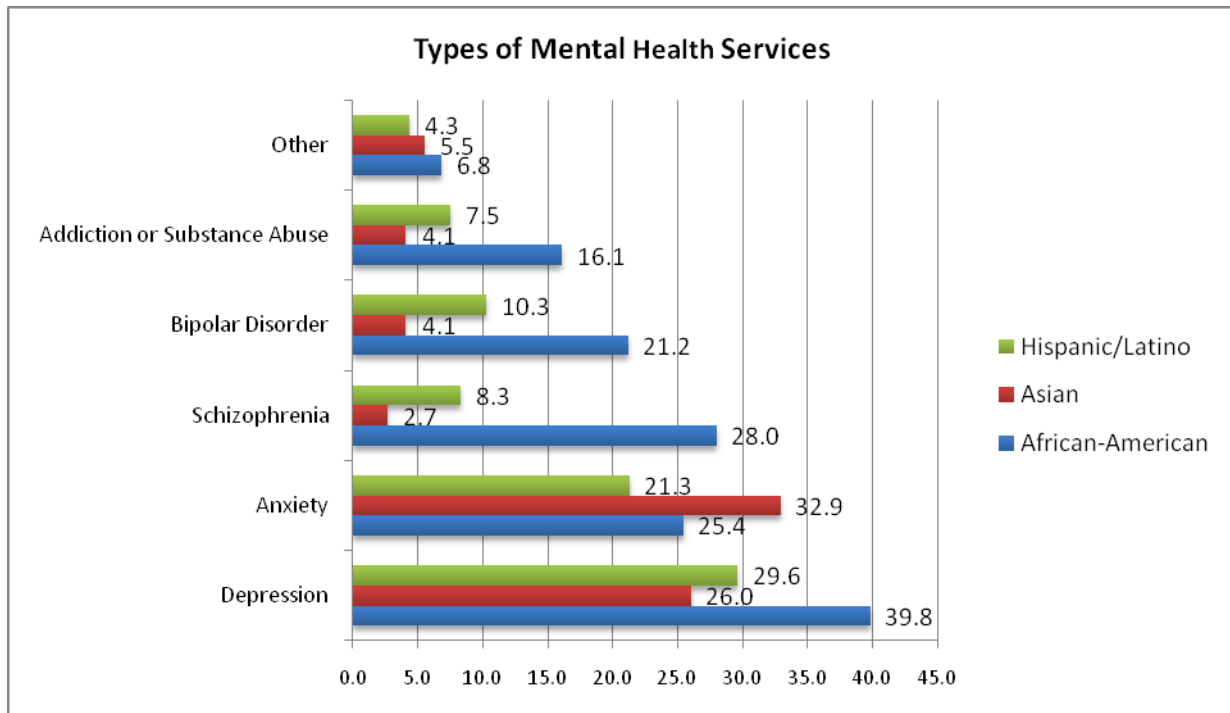


Participants were asked whether they had visited a mental health provider in the past. Exhibit 6 presents the response distribution of African-American, Asian and Latino/Hispanic race/ethnic groups to the question "In the past 24 months, have you visited a behavioral/mental health professional due to a personal difficulty or mental health concern." Those who answered "Yes" were classified as "consumer" while those who

answered "No" were classified as "non-consumer." Among African-Americans, there were more respondents who were classified as Consumers (54.2%). Among Asian Pacific Islanders, there was almost equal representation of consumers (49.3%) versus non-consumers (50.7%). However, among Latinos/Hispanics, there were more respondents classified as Non-Consumers, 63.5% compared to 36.5% consumers.

Type of Mental Health Service

Consumers of mental health services were asked to identify the type of service received. Response options were (1) depression, (2) anxiety, (3) schizophrenia, (4) bipolar disorder, (5) addictions or substance abuse; and (6) other. Participants were able to specifically identify “other” services.



As Exhibit 7 illustrates, Among African-Americans, 39.8% utilized mental health services for depression, while 28.0% went in for schizophrenia. On the other hand, 32.9% of Asians sought services or anxiety while 26.0% for depression. Those of Hispanic/Latino origins were similar to Asian and Pacific Islanders in requiring depression (29.6%), followed by anxiety (21.3%). Note that the term “type” was used in the survey instead of “diagnosis” because during the qualitative phase of the study, focus group participants indicated that using the term “diagnosis” carried greater stigma.

Care and social support

The survey also identified whether the respondent had any of the following: discussion of emotional issues with other health providers (e.g. physicians and nurses); discussion of mental health with family and friends, use of assistance hotlines or self-help groups; discussion of mental health with religious leaders (e.g. priest, minister, pastor, reverend, bishop, etc.); discussion of mental health with folk / traditional healers (e.g. *curandero*, *sobador*, *yerbero*); use of traditional remedies for mental health issues (e.g. hot water baths, unguent/pomade, herbs, meditation); use prescription medicine; and use of alcohol or illegal drugs to self-medicate.

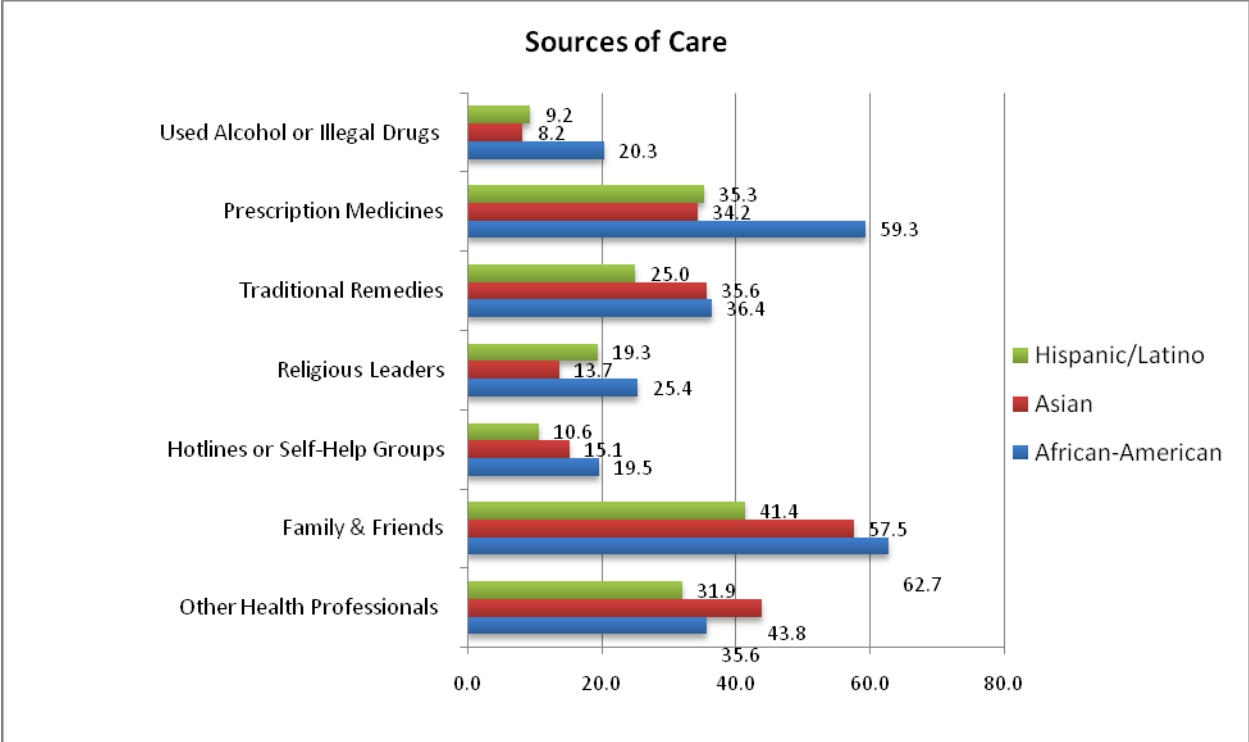
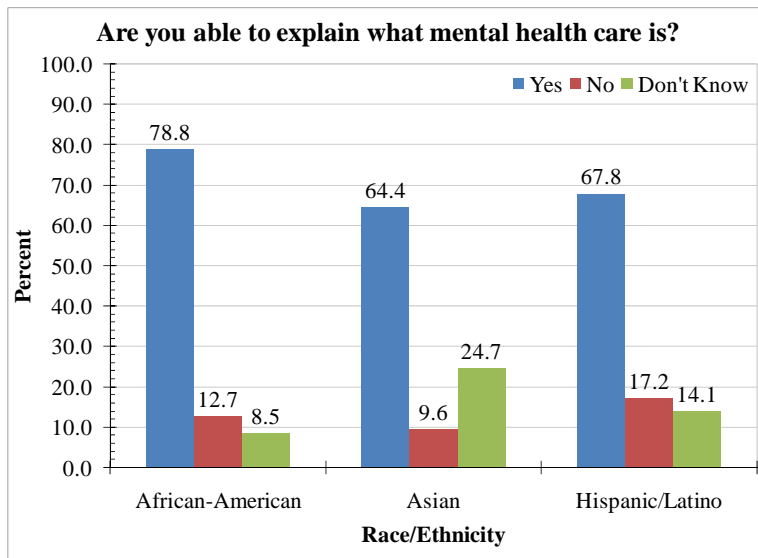


Exhibit 8 presents the sources of mental health care used by race/ethnicity in San Bernardino County. Among African-Americans, 62.7% used family and friends, 59.3% used Prescription Medicines and 35.6% used Other Health Professionals (e.g. Physicians, Nurses, etc). Among Asians, the same trends were observed, although more Asians (43.8%) preferred Other Health Professionals over Prescription Medicines (34.2%). Among Hispanic/Latinos, 41.4% went to Family and Friends, followed by 35.3% and 31.9% who used Prescription Medicines and Other Health Professionals, respectively. The percentage of those who endorsed complementary and alternative medicine (CAM) appears to be low compared with previously reported use of CAM among Latinos.

KNOWLEDGE AND LOCATION OF MENTAL HEALTH SERVICES

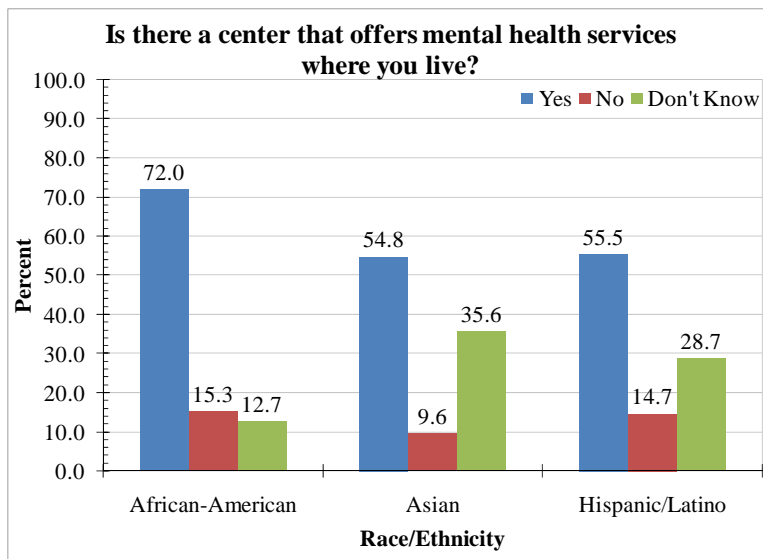
Explaining Mental Health

Understanding what mental health is may also contribute to increased use of mental health services. Studies have also demonstrated that lack of knowledge about health problems and symptoms and the availability and location of services pose significant barriers to mental health services (Aguilar-Gaxiola, et al., 2002). Participants were asked “Are you able to explain what mental health is, including describing mental health problems?”



As shown in figure 9, the majority of respondents indicated that they were able to explain what mental health care is. Among African-Americans and Latinos/Hispanics, more respondents answered “no” compared to those who answered “don’t know.” However, it should be noted that 24.7 % of Asian Pacific Islanders indicated that they were not sure that they could explain what mental health is compared to those who answered “no.”

Location of Mental Health Services



Studies have shown that location and the proximity of mental health services may also influence use of mental health services. Exhibit 10 presents the response frequency distribution of African-American, Asian and Latino/Hispanic race/ethnic groups to the question “Is there a center/clinic that offers mental health services in the community where you live?” The majority response in each race/ethnic group was “yes.” However, among African-Americans, more respondents

answered “no” than “don’t know” while in Asians and Latinos/Hispanics, more respondents answered “don’t know” compared to answering “no.”

Accessibility of Mental Health Care Services

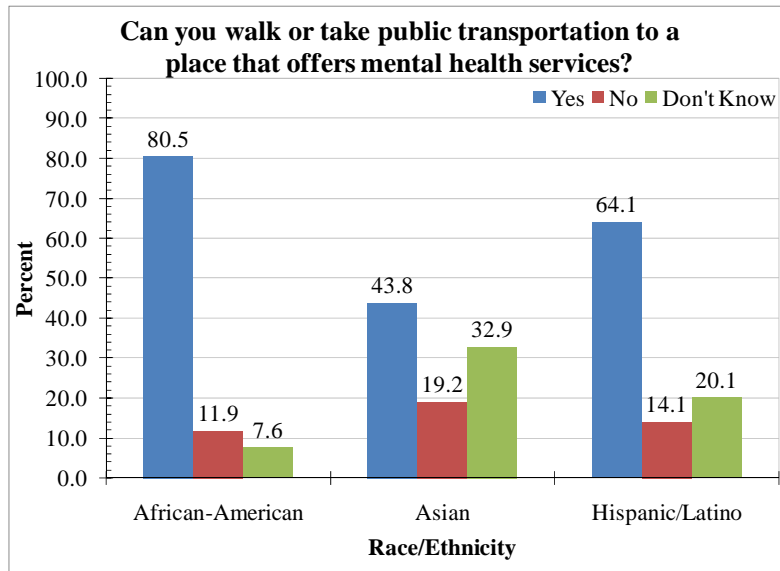


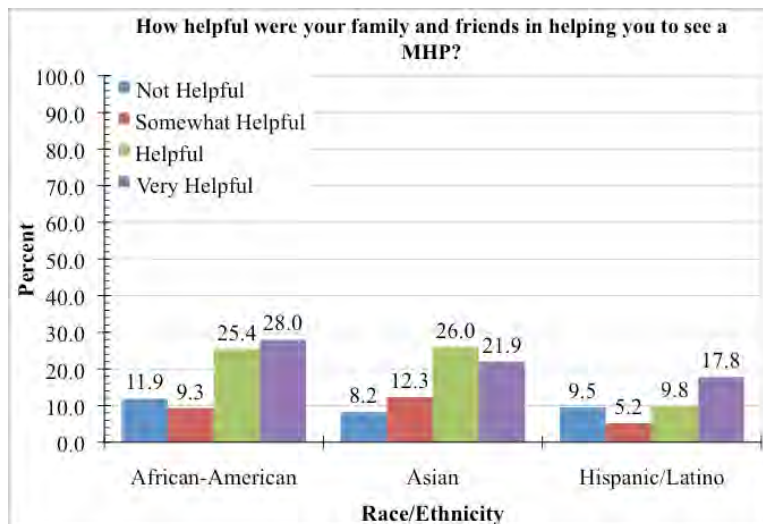
Exhibit 11 presents the response frequency distribution of African-American, Asian and Latino/Hispanic race/ethnic groups to the question “Is it possible for you to walk to or take public transportation to get to a place that offers mental health services?” Among all race/ethnic groups, the majority response was “yes.” Among African-Americans, more respondents answered “no” than “don’t know” and among Asians and Latinos/Hispanics, more respondents answered

“don’t know” than “no.” The response may suggest that transportation to a provider of mental health services is not a barrier.

SUPPORT IN ACCESS TO SERVICES

Use of mental health services can also be affected by the social support systems. Survey participants were asked to rate the contribution of each of the following in helping them to get access or to use a mental health professional: (a) Family and friends, (b) health professionals (i.e. physician or nurse), (c) clergy or religious / spiritual leader, and (d) community health worker.

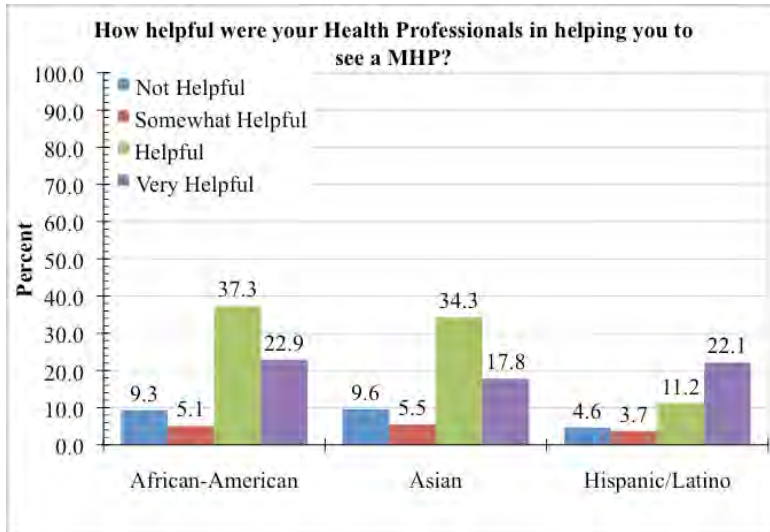
Family and Friends



Participants were asked “How helpful were your family and friends (not including clergy/religious leader, or health professional) in recommending or helping you to see (visit) a mental health professional.” Exhibit 12 shows that Among African-Americans, family and friends were mostly “Very Helpful” or “Helpful” whereas most of the Asian respondents found family and friends to be “Helpful.” Among Latinos, the response with

the most frequency was “Very Helpful”.

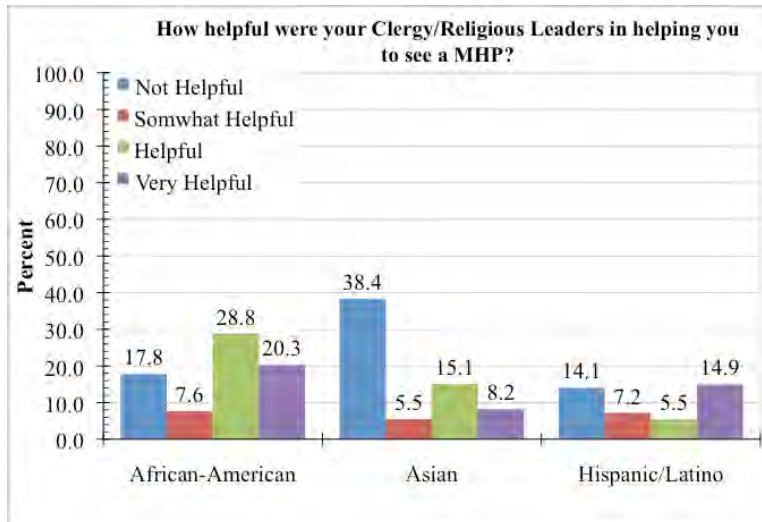
Health Professionals



Additionally, the study inquired into the role of health professionals in the process of seeking mental. Exhibit 13 presents the response distribution for African-American, Asian and Latino/Hispanic participants to the question “How helpful were your Health Professionals (i.e. physician or nurse) in recommending or helping you to see (visit) a mental health professional.” Among African-Americans and Asians, health

professionals were mostly “Helpful.” The major response from Latinos/Hispanics was “Very Helpful.”

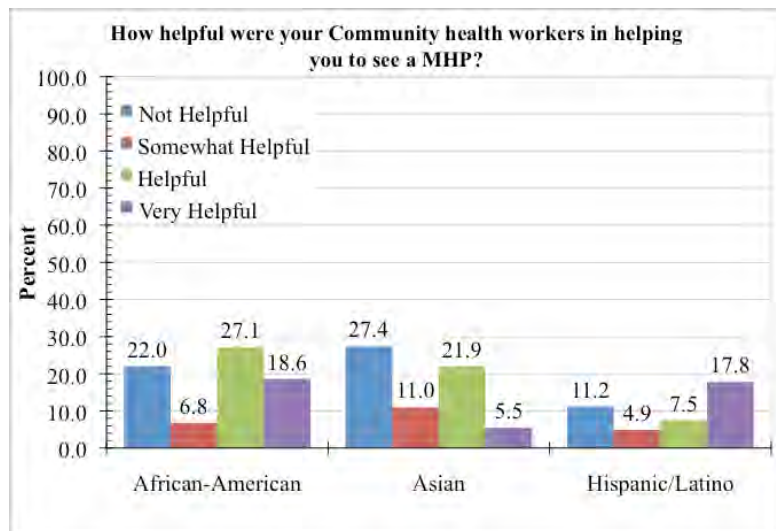
Clergy and Religious Leaders



The role of clergy and religious has been found to be important in use of mental health services. Exhibit 14 presents the response distribution of African-American, Asian and Latino/Hispanic participants to the question “How helpful was your Clergy or Religious/Spiritual Leader in recommending or helping you to see (visit) a mental health professional.” Among African-Americans, Clergy or Religious/Spiritual Leaders were

mostly “Helpful” although the response to “Very Helpful” and “Not Helpful” were almost identical. Asians mostly found Clergy or Religious/Spiritual Leaders to be “Not Helpful” while Latinos/Hispanics were divided between “Very Helpful” and “Not Helpful.”

Community Health Workers



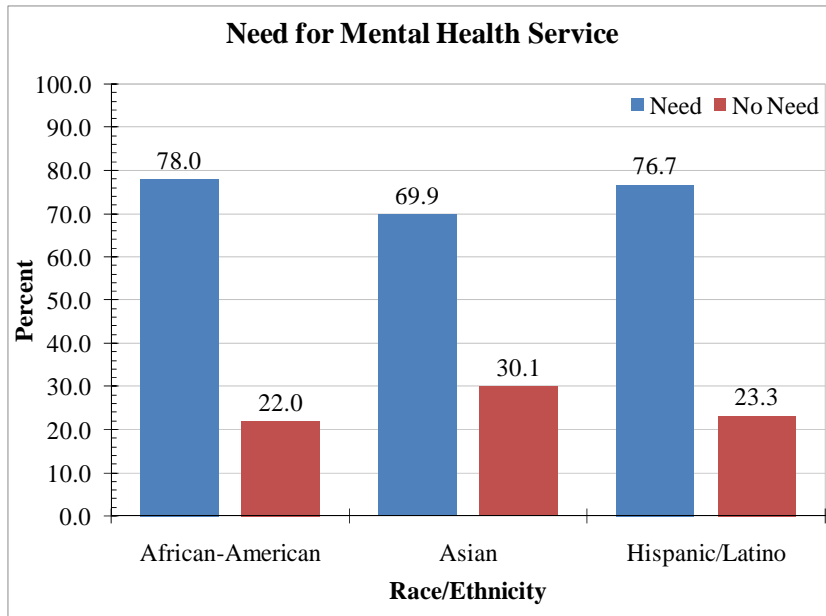
Participants were asked “How helpful were your Community health workers (i.e. health promoter) in recommending or helping you to see (visit) a mental health professional.” Exhibit 15 shows that among African-Americans, health professionals were mostly “Helpful” although the response frequency to “Very Helpful” and “Not Helpful” was similar. Asians mostly found community health workers to be “Not Helpful” while

Latinos/Hispanics were divided between “Very Helpful” and “Not Helpful” although the majority answered “Very Helpful.”

NEED FOR MENTAL HEALTH SERVICES

Need

Studies suggest that the use of mental health services is influenced by the need for services. In this study, need for mental health a service was assessed by determining symptomatology. Questions related to symptoms were taken from the *DSM-IV* (American Psychiatric Association, 1994). Respondents were asked (no/yes) the following questions: 1) for a period of at least 2 weeks, you had several of the following symptoms: (a) Feeling down, depressed or hopeless, (b) little interest or pleasure in doing things that you ordinarily would enjoy, (c) trouble sleeping, (d) feeling tired or having little energy, (e) feeling bad about yourself; 2) thinking about ending your life or harming yourself; 3) for a period of at least 1 week, you felt too “hyper,” wound up, or had racing thoughts; 4) other people told you that your behavior was unusual, abnormal, or bizarre; 5) having various unusual experiences, like feeling as if you have special powers, seeing things or hearing things that are not there, or feeling like you are being followed or that others are out to get you; 6) feeling anxious or nervous, unable to control your worry or distress; 7) had panic attacks when suddenly, and for no clear reason, you felt frightened or developed a lot of physical symptoms; 8) feeling afraid to leave the house or be around others; 9) feeling the need to repeat behaviors such as hand-washing or checking on/off switches; 10) having nightmares, flashbacks or re-experiencing a past trauma; 11) drinking too much alcohol, or having others say you are drinking too much; and 12) using illegal drugs like marijuana, cocaine, etc.



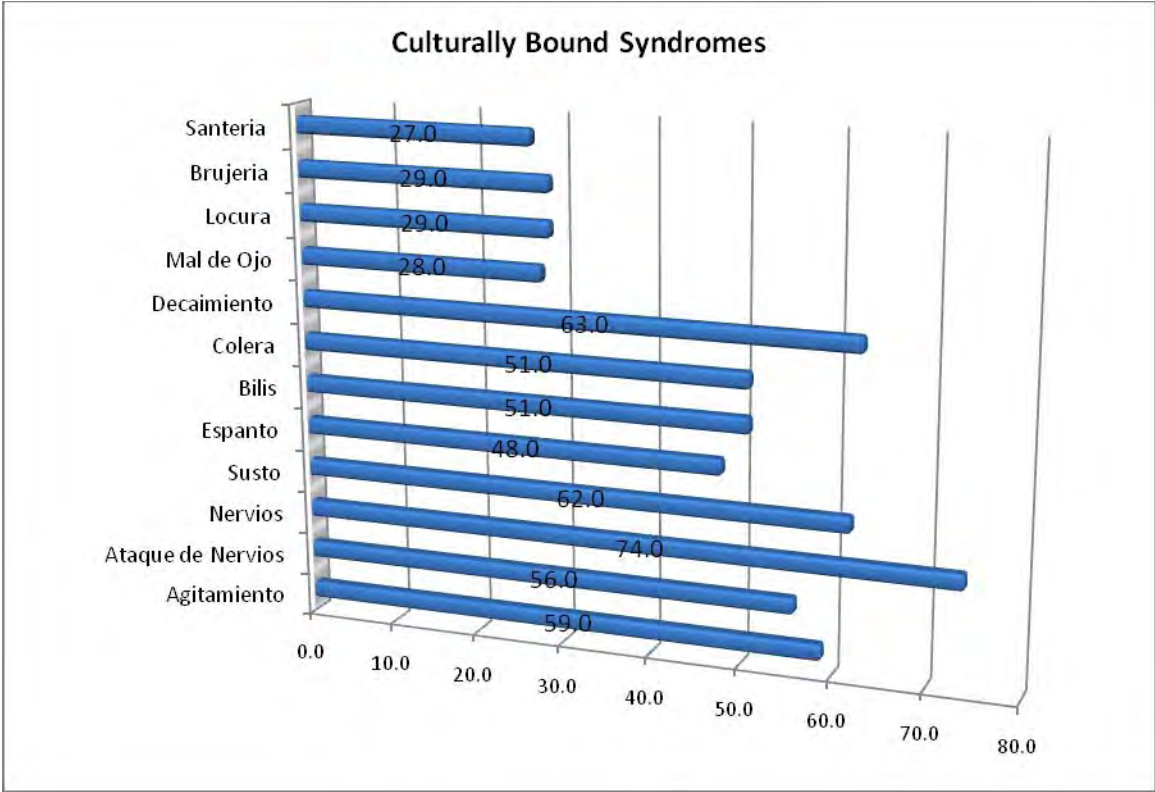
A positive response to any of the above questions resulted in the participant classified as having a “need.” Exhibit 16 shows the frequency of participants classified as having a mental health “Need.” Among all race/ethnic groups, there were more respondents who were classified as having a need. For example, 78% of American Americans, 69.9% of Asian Pacific Islanders, and 76.7% of Latinos/Hispanic identified at least one

symptom that would require need for mental health services.

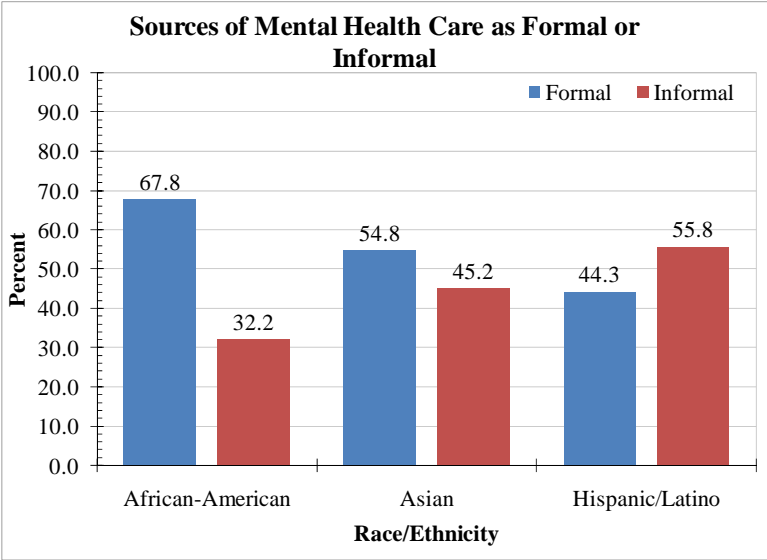
Culturally Bound Syndromes

Researchers have used the term “culture-bound syndromes” in reference to recurrent, locality-specific patterns of aberrant behavior and troubling experiences that may or may not be linked to a particular diagnostic category in the *Diagnostic and Statistical Manual-IV* (DSM-IV: American Psychiatric Association, 1994). These patterns are indigenously considered to be illnesses and are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations (Guarnaccia & Rogler, 1999, Murguía, Peterson, & Zea, 2003). Some of the culture-bound syndromes prevalent among Latinos include *empacho* (stomach ailment), *susto* (fright), *caida de mollera* (fallen fontanelle), *mal de ojo* (evil eye), *bilongo/hechizo* (hex), and *envidia* (envy) (Murguía, Peterson, & Zea, 2003; Paniagua, 2000).

Specific to Latino/Hispanic participants, the survey identified whether they had personally experienced or were familiar with the following culturally-bound syndromes. As depicted in Exhibit 17, the syndrome most frequently selected was *Nervios* (74%), followed by *Decaimiento* (63%), *Susto* (62%), *Agitamiento* (59%), *Ataque de Nervios* (56%). Interestingly, *Bilis and Colera* (both referring to similar psychosomatic experiences of anger) were identified by 51% of Latino/Hispanic participants.



Sources of Care



Participants were asked if they had any of the following: discussion of emotional issues with other health providers (e.g. physicians and nurses); discussion of mental health with family and friends, use of assistance hotlines or self-help groups; discussion of mental health with religious leaders (e.g. priest, minister, pastor, reverend, bishop, etc.); discussion of mental health with folk / traditional healers (e.g. *curandero*, *sobador*, *yerbero*); use of traditional remedies for mental health issues

(e.g. hot water baths, unguent/pomade, herbs, meditation); use prescription medicine; and use of alcohol or illegal drugs to self-medicate. Exhibit 18 presents the frequency distribution of African-American, Asian and Latino/Hispanic race/ethnic groups to their use of formal or informal sources of care. Among African-Americans and Asians, more respondents were classified as having used formal sources of care than informal sources of care. It is very

important to note that Latinos/Hispanics were more likely to be classified as having informal sources of care.

Barriers to Use of Mental Health Services

Survey respondents were asked (yes, no) to rank barriers to health services and to indicate if any of the following 11 situations prevented them from seeking mental health services: 1) lack of transportation, 2) lack of health insurance, 3) inability to pay for services, 4) being afraid to seek services due to immigration status, 5) long waiting times at clinics, 6) reputation of service providers, 7) not being able to take time off work, 8) language problems, 9) not knowing where to seek services, 10) belief that treatment would not be effective, 11) embarrassed or family did not approve, 12) inconvenience of operating hours, and 13) did not seek services due to racial discrimination at the clinic.

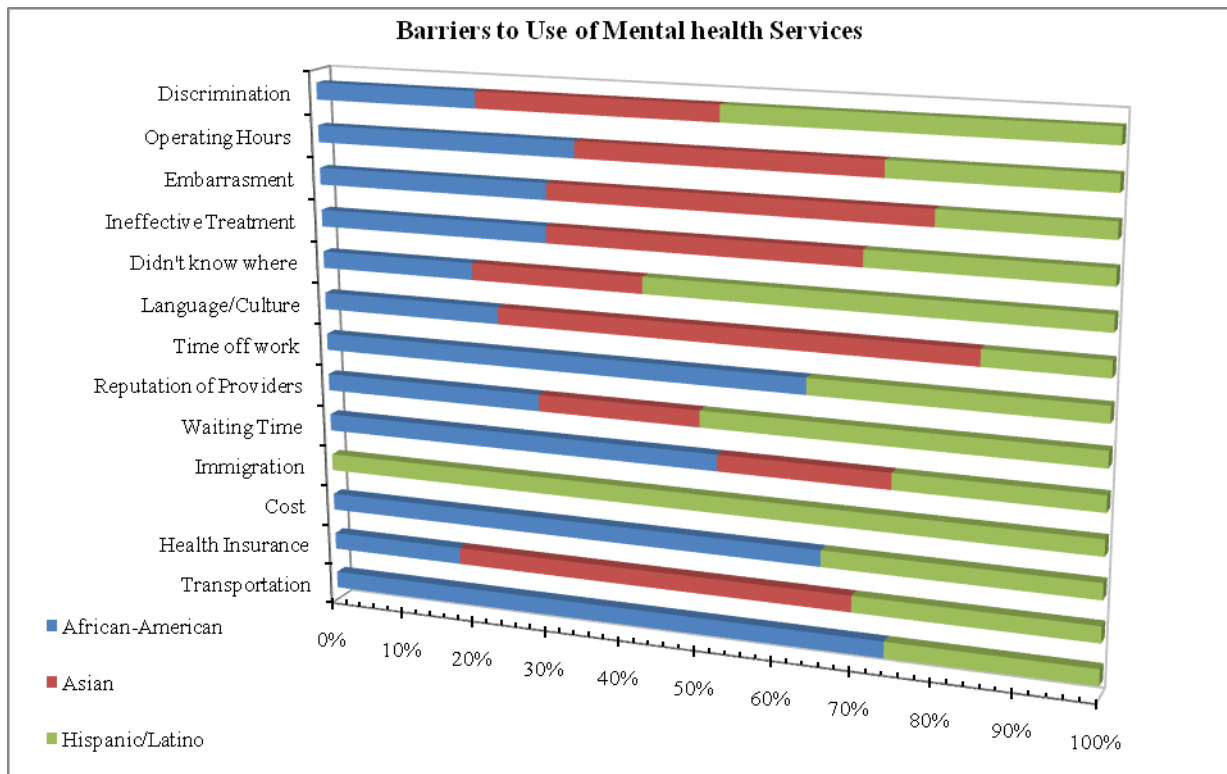
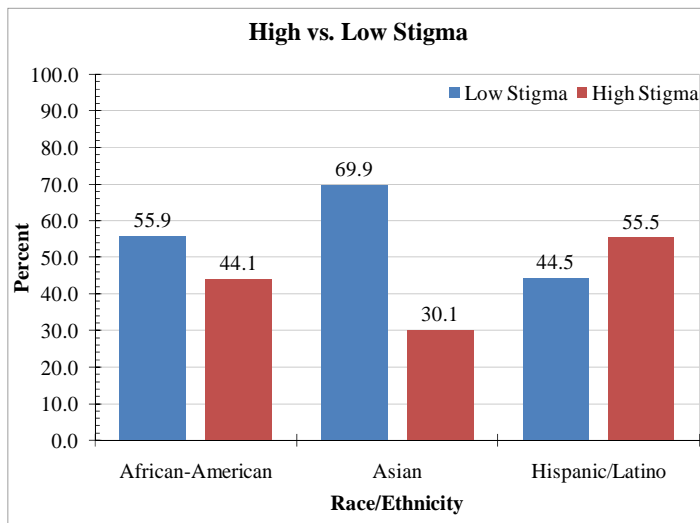


Exhibit 19 presents the frequency distribution of participants' barriers to use of mental health services. Among African-Americans, the top five barriers listed included cost, ineffective treatment, inconvenient office hours, and the embarrassment of family disapproval represented the highest response categories. Among Asian and Pacific Islanders, embarrassment was by far the greatest barrier. This was followed by operating hours, discrimination, ineffective treatment, and language/cultural barriers. The greatest barrier to use of mental health services among Latinos/Hispanics was immigration, followed by discrimination, and a lack of knowledge of mental health service facilities and a disbelief in the efficacy of mental health care. Latinos also identified the reputation of providers as a barrier to use of mental health services.

Economic status should not determine whether a person who needs mental health services seeks or obtains the required help. Furthermore, it should be noted that inconvenience of service hours was repeatedly identified as a barrier to use of mental health services. Providing services only during traditional office hours (i.e., 8 am-5 pm) also has implications for gender representation and may also account for the underrepresentation of Latino men among consumers of mental health services. Such impediment should be relatively easy to address.

Stigma

Stigma refers to a collection of negative attitudes, thoughts, beliefs, and behaviors that influence the individual or the general public, to fear, reject, avoid, show prejudice, and discriminate against people with mental disorders (Gary, 2005). Stigma and shame have been identified as barriers to help-seeking behaviors among minorities (Ojeda & Bergstresser, 2008). Guarnacia and Rodriguez (1996) argue that the shame and stigma associated with a mental illness, along with reliance on family tending to be stronger among Hispanics, sometimes presenting barriers to mental health treatment services. Similarly, stigma may explain the lower rate of mental health treatment, even when experiencing a severe mental disorder and may be the primary reason why individuals who would benefit from mental health services choose not to pursue them, or fail to fully participate once they begin (Corrigan, 2004; Chow, Jaffee, & Snowden, 2003).

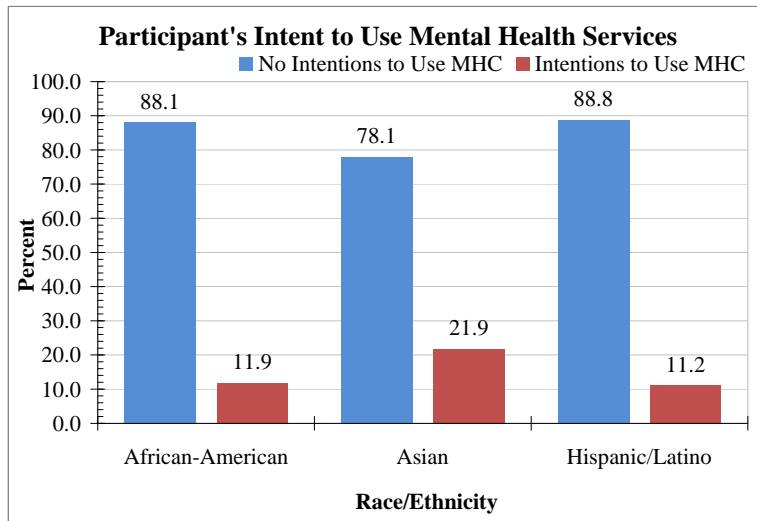


Stigma was measured using the Perceived Stigma Scale (Wrigley, Jackson, Judd, and Komiti, 2005). Exhibit 20 presents the frequency distribution of African-American, Asian and Latino/Hispanic race/ethnic groups to their perceived stigma. Among African-Americans and Asians, more respondents were classified as having a low stigma against mental health care services. On the other hand, among Latinos/Hispanics, more respondents were classified as having a high stigma against mental health care services. As

shown in Exhibit 20, a majority of African Americans (55.9%) and Asian Pacific Islanders (69.9%) were classified as having “low stigma”. However, among Latinos/Hispanics, a majority (55.5%) were classified as having “high stigma”.

Intent to use Mental Health Services

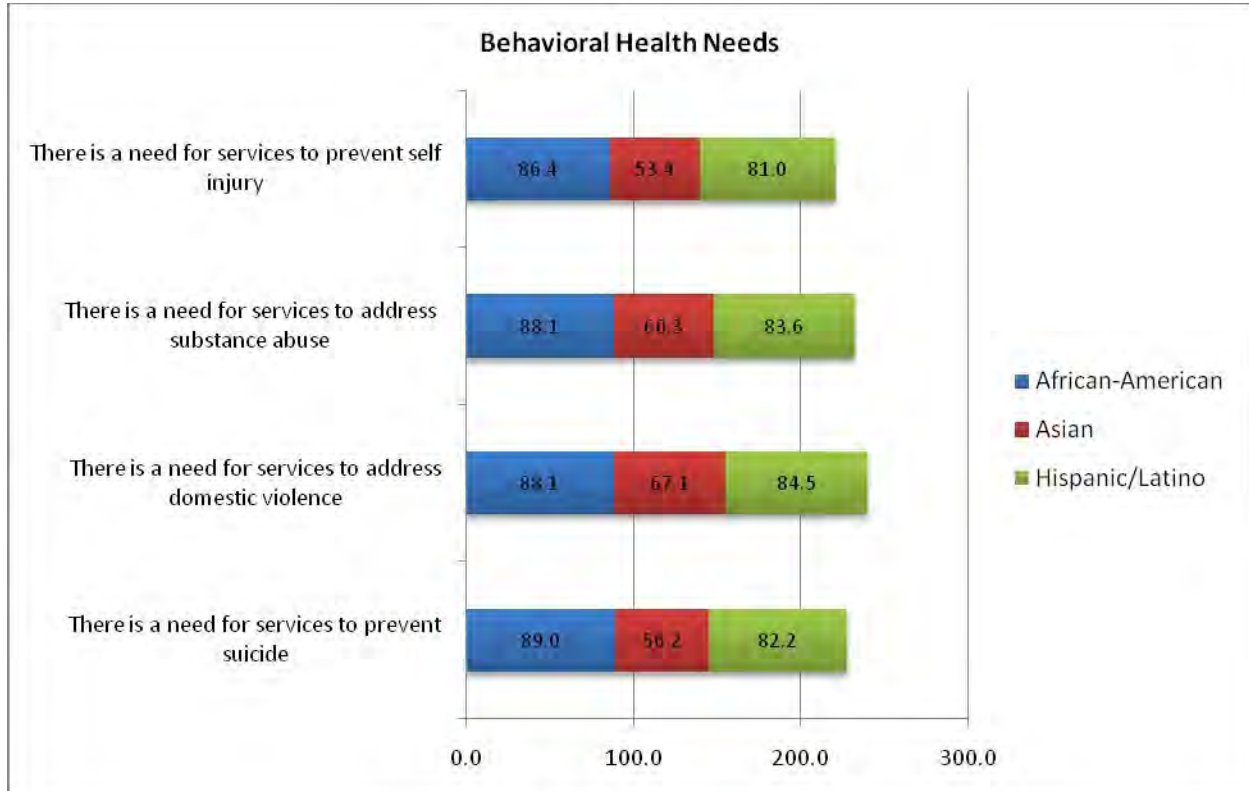
Intention to use service was measured by the question: “If you were to experience a significant emotional or mental health problem, how likely is it that you would *visit a mental health provider/professional (psychiatrist, psychologists, counselors, and social workers)*. Responses were measured on a 5-point Likert scale, 1=Very unlikely to 5=Very likely, with a middle neutral possibility. While the distribution on each of these questions was explored to see what participants felt about the issue, for analytic purposes this was recoded into a dichotomous variable (likely intention of use or not) with the neutral category moved toward “not likely to use.”



As shown in Exhibit 21, when asked about their intent to use mental health services (visit a mental health professional) in the future in case of experiencing a significant emotional or mental health problem, 88.1% of African Americans, 78.1% of Asian Pacific Islanders, and 88.8% of Latinos/Hispanics indicated that it was Very Unlikely or Unlikely (recoded as no intentions) that they would use mental health services.

Behavioral Health Priorities

Exhibit 22 shows that when asked about behavioral needs in their communities, 89% of African American participants, 56% of Asian Pacific Islanders, and 82% of Latinos, identified suicide prevention as a concern. Latinos also identified services to address domestic violence (84.5%), as did a majority of Asian and Pacific Islander participants (67.1%). Similarly 86.4% of African American participants, 53.4% Asian Pacific Islander, and 81.0% of Latinos identified the need for services to prevent self injury.



Recommendations based on findings of community surveys

1. **Demographics.** Factors such as race, ethnicity, gender, age, income, and health insurance must be addressed when developing strategies to increase use of mental health services. As shown, having health insurance alone was not an indicator of use of mental health services.
2. **Mental health beliefs.** Embarrassment (stigma) and perception of ineffectiveness of treatment were identified as barriers to use of mental health services. Policymakers interested in increasing the use of services may consider designing language specific social marketing and media campaigns, community forums, and other strategies to address mental health beliefs. This would aid in consumer empowerment and modifying the perceptions regarding mental health, and could be used to promote the availability of culturally appropriate services.
3. **Culture.** Particularly among Asian Pacific Islander participants, language and cultural barriers were the most significant barriers. Similarly, a majority of Latino/Hispanic participants indicated that they had personally experienced or were familiar with culture-bound syndromes. It is important to develop systems of care that understand and can relate to these syndromes. Diversification of the mental health care workforce and continuous education for mental health providers is an important strategy to address the need for cultural competent care.
4. **Intent to use mental health services.** Despite being a survey on use of mental health services, there was no apparent response bias when asked whether the participant would consider being seen by a mental health professional in the future. This was true for both consumers and non-consumers, which suggest that even among consumers there may be dissatisfaction with the services or high levels of stigma. Treatment plans should emphasize compliance and continuity of care.
5. **Sources of care.** The relevant research suggests that a client or potential client's social support system plays an important role in decisions to access and use mental health services. Involving families or significant others in care can serve to increase treatment adherence, retention and therefore improve outcomes for clients.
6. **Health professionals.** The findings emphasize the need for policymakers to develop strategies to increase referral coordination with health care providers. It is important to recognize that health professionals have an important role in referring or suggesting a consultation with a mental health service. For example, a brief mental health-screening instrument may be used during routine medical visits to identify individuals who may be experiencing a mental health challenge but due to stigma or other barriers have not discussed their concerns with a mental health professional.

7. **Clergy and religious leaders.** Although clergy and religious leaders were identified as being helpful or very helpful for both Asian-Pacific Islander and Latino/Hispanic participants in helping them to see a mental health professional, the role was even greater among African American. Therefore, to increase use of mental health services, policymakers should provide training to religious leaders so that they are able to identify and recognize mental health challenges. Furthermore, it is important to develop mechanisms to receive referrals from religious leaders to the mental health system.
8. **Community Health Workers.** The strategy of using *promotores de salud* (also known as community peer educators or community health workers), in addition to information dissemination, may serve to facilitate collective efficacy and increase social capital among community stakeholders which has been shown to be protective factor in mental health. Information dissemination must occur in the natural habitat of community residents. Particularly among Latinos, not knowing where to go or knowledge of availability of services constituted a significant barrier to use of mental health services. Behavioral health providers can no longer expect the community to go to a mental health service provider seeking assistance or information.
9. **Structural or organizational barriers.** Although location did not seem to represent a major barrier to use of mental health services, it is interesting to note that inconvenience of service hours and not being able to take time off from work were repeatedly identified as a barrier to use of mental health services. Likewise, transportation was identified as a barrier by a majority of African American participants. Providing services only during traditional office hours (i.e., 8 am-5 pm) also has implications for gender representation and may also account for the underrepresentation of men among consumers of mental health services. Such impediment should be relatively easy to address by expanding service hours.
10. **Behavioral health needs.** A vast majority of participants indicated having at least one symptom commonly associated with the need for mental health services. Although a diagnostic instrument was not used, the level of self-identified need among non-consumers should be reason for special attention. Additionally, participants identified the need for services to prevent self-injury, services to address substance abuse, prevent domestic violence and to prevent suicide. If not yet available, the behavioral health system should consider strategies to implement these services. If available, increased efforts at better promotion of available services should be implemented.

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6.3. Intake Data from San Bernardino County Department of Behavioral Health

Introduction

The data used in this report was secured from the San Bernardino Department of Behavioral health database and represents data on clients who received mental health services during the 2008-2009 fiscal year. Both client and staff data was used to generate this report. The client dataset consists of 61,291 cases and include client demographic information such as, gender, ethnicity and age. Clinical information such as client episode duration, diagnosis and reason for discharge, client employment status, insurance type, referral region, and region of residence is also included in this dataset. The entire data set was utilized for data analysis.

On the other hand, the staff dataset used for analysis consists of 841 cases and includes staff demographic information such as gender and ethnicity and staff characteristics such as discipline, and languages other than English spoken by staff. In some instances missing data in both data sets posed some limitations on facts presented for the relevant variables.

This report contributes to an understanding of the characteristics of mental health service users and providers in San Bernardino California. Additionally, this report will present information on client mental health outcomes following care and will also underscore critical information concerning the ethnic breakdown of clients and staff. The descriptive nature of the report confines the scope of reporting to the presentation of facts only. A discussion of the facts presented and recommendations for change will be discussed.

Description of Clients-Consumers of Mental Health Services

Table 1- Gender Composition of Clients

Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Female	30909	50.4	50.4	50.4
Male	30239	49.3	49.3	99.8
Unknown	143	.2	.2	100.0
Total	61291	100.0	100.0	

NO MISSING VALUES

The San Bernardino Department of Behavioral Health provides mental health care to a near equal number of males (49%) and females (50%).

Consumer Race and Ethnicity

Table 2. Race and Ethnicity of Clients

Ethnicity				
	Frequency	Percent	Valid Percent	Cumulative Percent
African American	10364	16.9	16.9	16.9
Asian Pacific Islander	1212	2.0	2.0	18.9
Caucasian	24110	39.3	39.3	58.2
Latino	20578	33.6	33.6	91.8
Native American	432	.7	.7	92.5
Other/Unknown	4595	7.5	7.5	100.0
Total	61291	100.0	100.0	

NO MISSING VALUES

Table 2 shows that Caucasians represent almost 40% of the clients served by the DBH with service to Latinos trailing closely behind at 34%. While African Americans were the third highest served (17%) they represented less than half of Caucasians and half of their Latino Counterparts.

Duration of Treatment

Table 3-Mental Health Treatment Duration

		Ethnicity and Episode Duration					
		Episode Duration					Total
		0-5	5-10	10-15	15-20	Over 20	
African American	Count	8691	1519	80	7	67	10364
	% within ETHNIC GRP	83.9%	14.7%	.8%	.1%	.6%	100.0%
	% within Episode Duration	17.1%	16.3%	14.5%	9.2%	18.5%	16.9%
Asian Pacific Islander	Count	944	213	46	6	3	1212
	% within ETHNIC GROUP	77.9%	17.6%	3.8%	.5%	.2%	100.0%
	% within Episode Duration	1.9%	2.3%	8.4%	7.9%	.8%	2.0%
Caucasian	Count	19544	4147	252	30	137	24110
	% within ETHNIC GROUP	81.1%	17.2%	1.0%	.1%	.6%	100.0%
	% within Episode Duration	38.4%	44.4%	45.8%	39.5%	37.7%	39.3%
Latino	Count	17515	2772	146	29	116	20578
	% within ETHNIC GROUP	85.1%	13.5%	.7%	.1%	.6%	100.0%
	% within Episode Duration	34.4%	29.7%	26.5%	38.2%	32.0%	33.6%
Native American	Count	364	58	7	0	3	432
	% within ETHNIC GROUP	84.3%	13.4%	1.6%	.0%	.7%	100.0%
	% within Episode Duration	.7%	.6%	1.3%	.0%	.8%	.7%
Other/Unknown	Count	3903	632	19	4	37	4595
	% within ETHNIC GROUP	84.9%	13.8%	.4%	.1%	.8%	100.0%
	% within Episode Duration	7.7%	6.8%	3.5%	5.3%	10.2%	7.5%
Total	Count	50961	9341	550	76	363	61291
	% within ETHNIC GROUP	83.1%	15.2%	.9%	.1%	.6%	100.0%
	% within Episode Duration	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

NO MISSING VALUES

As shown in Table 3, more than 80% of clients received mental health treatment through the DBH for a period lasting between 0-5 years and 15% for a period lasting between 5-10 years.

Additionally, of clients receiving mental health services for 0-5 years Caucasian (38%) and Latino (34%) clients represented twice as many African American (17%) and more than eighteen times as many Asian Pacific Islanders (1.9%). Only .9% of all clients served across all ethnic groups remained in treatment for a period of 10-15 years, .1% remained in treatment for 15-20 years and .6% remained in treatment for 20 years or more.

Treatment Outcomes

Table 4-Client Discharge Status

		Ethnicity and Reason for Discharge				Total
		Discharge Label				
		Missing or Other	Treatment Not Successful	Treatment Partially Successful	Treatment Successful	
African American	Count	7166	876	1283	1039	10364
	% within ETHNIC GROUP	69.1%	8.5%	12.4%	10.0%	100.0%
	% within Reason for Discharge	16.5%	17.0%	17.7%	19.0%	16.9%
Asian Pacific Islander	Count	914	86	115	97	1212
	% within ETHNIC GROUP	75.4%	7.1%	9.5%	8.0%	100.0%
	% within Reason for Discharge	2.1%	1.7%	1.6%	1.8%	2.0%
Caucasian	Count	17197	1965	2868	2080	24110
	% within ETHNIC GROUP	71.3%	8.2%	11.9%	8.6%	100.0%
	% within Reason for Discharge	39.6%	38.1%	39.6%	37.9%	39.3%
Latino	Count	14160	1919	2609	1890	20578
	% within ETHNIC GROUP	68.8%	9.3%	12.7%	9.2%	100.0%
	% within Reason for Discharge	32.6%	37.2%	36.0%	34.5%	33.6%
Native Ame	Count	293	38	58	43	432
	% within ETHNIC GROUP	67.8%	8.8%	13.4%	10.0%	100.0%
	% within Reason for Discharge	.7%	.7%	.8%	.8%	.7%
Other/Unk	Count	3679	273	310	333	4595
	% within ETHNIC GROUP	80.1%	5.9%	6.7%	7.2%	100.0%
	% within Reason for Discharge	8.5%	5.3%	4.3%	6.1%	7.5%
Total	Count	43409	5157	7243	5482	61291
	% within ETHNIC GROUP	70.8%	8.4%	11.8%	8.9%	100.0%
	% within Reason for Discharge	100.0%	100.0%	100.0%	100.0%	100.0%

NO MISSING VALUES

Of clients in treatment, 71% failed to complete treatment. Table 4 shows that rates of treatment non-completion were high among all groups with the highest rate of non-completion among Asian Pacific Islanders (75%). Treatment was successful for only 9% of clients, of which

38% were Caucasian and 35% was Latino compared to only 19% of African Americans and less than one percent (.8%) of Native Americans.

Region of Reporting Unit

Table 6- Client Reporting Unit Region

		Reporting Unit Region					Total
		missing	Central Valley	Desert Mountain	East Valley	West Valley	
African American	Count	483	1386	1629	5487	1379	10364
	% within ETHNIC GROUP	4.7%	13.4%	15.7%	52.9%	13.3%	100.0%
Asian Pl	Count	38	139	94	687	254	1212
	% within ETHNIC GROUP	3.1%	11.5%	7.8%	56.7%	21.0%	100.0%
Caucasian	Count	1247	2365	5647	12027	2824	24110
	% within ETHNIC GROUP	5.2%	9.8%	23.4%	49.9%	11.7%	100.0%
Latino	Count	1002	3256	2710	10113	3497	20578
	% within ETHNIC GROUP	4.9%	15.8%	13.2%	49.1%	17.0%	100.0%
Native Ame	Count	22	39	96	225	50	432
	% within ETHNIC GROUP	5.1%	9.0%	22.2%	52.1%	11.6%	100.0%
Other/Unk	Count	316	460	307	3001	511	4595
	% within ETHNIC GROUP	6.9%	10.0%	6.7%	65.3%	11.1%	100.0%
Total	Count	3108	7645	10483	31540	8515	61291
	% within ETHNIC GROUP	5.1%	12.5%	17.1%	51.5%	13.9%	100.0%

MISSING VALUES- 3108 (5.1%)

Reporting units in the East Valley account for more than half (52%) of all clients in treatment. 57% of Asian Pacific Islanders were referred by a reporting unit in the East valley Region, 53% of African Americans, 52% of Native Americans, 50% of Caucasians and 49% of Latinos.

Client Medi-Cal Status

Table 7- Client Medi-Cal Status

		Medical		Total
		No	Yes	
African American	Count	3547	6817	10364
	% within ETHNIC GROUP	34.2%	65.8%	100.0%
Asian Pacific Islanders	Count	353	859	1212
	% within ETHNIC GROUP	29.1%	70.9%	100.0%
Caucasian	Count	9463	14647	24110
	% within ETHNIC GROUP	39.2%	60.8%	100.0%
Latino	Count	7253	13325	20578
	% within ETHNIC GROUP	35.2%	64.8%	100.0%
Native American	Count	164	268	432
	% within ETHNIC GROUP	38.0%	62.0%	100.0%
Other/Unknown	Count	1849	2746	4595
	% within ETHNIC GROUP	40.2%	59.8%	100.0%
Total	Count	22629	38662	61291
	% within ETHNIC GROUP	36.9%	63.1%	100.0%

NO MISSING VALUES

As shown in Table 7, 63% of all clients who received treatment through the Department of Behavioral Health were MEDICAL clients. Asian Pacific Islanders (71%) comprised the largest group of MEDICAL clients followed closely by African American (66%), Latino (65%) and Native American (62%) clients.

Client Residence

Table 8- Client Residence Region

Ethnicity and Client Region

		CLIENT REGION					Total
		Central Valley	Desert Mountain	East Valley	West Valley		
African American	Count	1298	1761	2309	4158	838	10364
	% within ETHNIC GROUP	12.5%	17.0%	22.3%	40.1%	8.1%	100.0%
	% within CLIENT_REGION	16.0%	18.9%	14.4%	20.9%	10.5%	16.9%
Asian Pacific Islander	Count	163	132	144	506	267	1212
	% within ETHNIC GROUP	13.4%	10.9%	11.9%	41.7%	22.0%	100.0%
	% within CLIENT_REGION	2.0%	1.4%	.9%	2.5%	3.4%	2.0%
Caucasian	Count	2894	2353	8767	7350	2746	24110
	% within ETHNIC GROUP	12.0%	9.8%	36.4%	30.5%	11.4%	100.0%
	% within CLIENT_REGION	35.7%	25.3%	54.7%	37.0%	34.5%	39.3%
Latino	Count	2532	4413	3920	6257	3456	20578
	% within ETHNIC GROUP	12.3%	21.4%	19.0%	30.4%	16.8%	100.0%
	% within CLIENT_REGION	31.2%	47.5%	24.4%	31.5%	43.4%	33.6%
Native American	Count	44	44	158	151	35	432
	% within ETHNIC GROUP	10.2%	10.2%	36.6%	35.0%	8.1%	100.0%
	% within CLIENT_REGION	.5%	.5%	1.0%	.8%	.4%	.7%
Other/Unknown	Count	1185	591	737	1462	620	4595
	% within ETHNIC GROUP	25.8%	12.9%	16.0%	31.8%	13.5%	100.0%
	% within CLIENT_REGION	14.6%	6.4%	4.6%	7.4%	7.8%	7.5%
Total	Count	8116	9294	16035	19884	7962	61291
	% within ETHNIC GROUP	13.2%	15.2%	26.2%	32.4%	13.0%	100.0%
	% within CLIENT_REGION	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

MISSING VALUES- 8116 (13%)

Table 8 shows that most clients receiving treatment through the Department of Behavioral Health are from the East Valley Region (32%). The DM region accounts for 26% of all DBH clients and the CV and WV account for 15% and 13% respectively. Among African American clients 22% are from the DM region and 40% are from the EV region. 42% of Asian Pacific Islanders are from the EV region and 36% of Caucasians are from the DM region. An almost even amount of Native American clients are from the DM and EV regions at 37% and 35% respectively.

Education

Table 9- Client Educational Achievement

		Ethnicity and Education									
		none	Some Elementary	Elementary	Junior High	Some High school	High school	Some College	College	Graduate	Total
African American	Count	1326	1377	334	848	2423	2645	916	158	103	10130
	% within ETHNIC GROUP	13.1%	13.6%	3.3%	8.4%	23.9%	26.1%	9.0%	1.6%	1.0%	100.0%
	% within Education	15.8%	17.1%	16.7%	17.4%	17.0%	17.2%	16.7%	17.0%	17.9%	16.9%
Asian Pacific Islander	Count	163	174	32	88	305	271	118	19	8	1178
	% within ETHNIC GROUP	13.8%	14.8%	2.7%	7.5%	25.9%	23.0%	10.0%	1.6%	.7%	100.0%
	% within Education	1.9%	2.2%	1.6%	1.8%	2.1%	1.8%	2.1%	2.0%	1.4%	2.0%
Caucasian	Count	3217	3014	775	1945	5708	6154	2183	379	231	23606
	% within ETHNIC GROUP	13.6%	12.8%	3.3%	8.2%	24.2%	26.1%	9.2%	1.6%	1.0%	100.0%
	% within Education	38.4%	37.5%	38.7%	40.0%	39.9%	40.1%	39.7%	40.7%	40.1%	39.4%
Latino	Count	2924	2770	704	1599	4764	5055	1816	288	196	20116
	% within ETHNIC GROUP	14.5%	13.8%	3.5%	7.9%	23.7%	25.1%	9.0%	1.4%	1.0%	100.0%
	% within Education	34.9%	34.5%	35.2%	32.9%	33.3%	32.9%	33.0%	30.9%	34.0%	33.6%
Native American	Count	49	58	12	37	115	104	38	3	7	423
	% within ETHNIC GROUP	11.6%	13.7%	2.8%	8.7%	27.2%	24.6%	9.0%	.7%	1.7%	100.0%
	% within Education	.6%	.7%	.6%	.8%	.8%	.7%	.7%	.3%	1.2%	.7%
Other/Unknown	Count	701	637	145	349	978	1122	429	85	31	4477
	% within ETHNIC GROUP	15.7%	14.2%	3.2%	7.8%	21.8%	25.1%	9.6%	1.9%	.7%	100.0%
	% within Education	8.4%	7.9%	7.2%	7.2%	6.8%	7.3%	7.8%	9.1%	5.4%	7.5%
Total	Count	8380	8030	2002	4866	14293	15351	5500	932	576	59930
	% within ETHNIC GROUP	14.0%	13.4%	3.3%	8.1%	23.8%	25.6%	9.2%	1.6%	1.0%	100.0%
	% within Education	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

MISSING VALUES – 1361 (2.2%)

Approximately half (49%) of all clients across ethnicities had some high school and high school education. Just over one fourth (27%) of clients had no education and some elementary education. Of uneducated clients Caucasians and Latinos had the highest rates at 38% and 35% respectively. African Americans (16%) ranked third of all ethnic group among the uneducated. Furthermore, approximately one fourth of all clients in each ethnic group completed their high school education.

Age

Table 10- Client Age Category

		Ethnicity and Age				Total
		Age Group				
		0-15 yrs	16-25 yrs	26-59 yrs	60+ yrs	
African American	Count	2343	3005	4696	320	10364
	% within ETHNIC GROUP	22.6%	29.0%	45.3%	3.1%	100.0%
	% within Age group	17.0%	18.4%	16.5%	11.5%	16.9%
Asian Pacific Islander	Count	159	184	651	218	1212
	% within ETHNIC GROUP	13.1%	15.2%	53.7%	18.0%	100.0%
	% within Age group	1.2%	1.1%	2.3%	7.9%	2.0%
Caucasian	Count	4534	5484	12774	1318	24110
	% within ETHNIC GROUP	18.8%	22.7%	53.0%	5.5%	100.0%
	% within Age group	33.0%	33.6%	44.9%	47.5%	39.3%
Latino	Count	5637	6184	8081	676	20578
	% within ETHNIC GROUP	27.4%	30.1%	39.3%	3.3%	100.0%
	% within Age group	41.0%	37.9%	28.4%	24.4%	33.6%
Native American	Count	73	129	206	24	432
	% within ETHNIC GROUP	16.9%	29.9%	47.7%	5.6%	100.0%
	% within Age group	.5%	.8%	.7%	.9%	.7%
Other/Unknown	Count	1003	1328	2045	219	4595
	% within ETHNIC GROUP	21.8%	28.9%	44.5%	4.8%	100.0%
	% within Age group	7.3%	8.1%	7.2%	7.9%	7.5%
Total	Count	13749	16314	28453	2775	61291
	% within ETHNIC GROUP	22.4%	26.6%	46.4%	4.5%	100.0%
	% within Age group	100.0%	100.0%	100.0%	100.0%	100.0%

NO MISSING VALUES

Table 10 shows that children and adolescents represent 22% and transition age youth make up 27% of all clients served by the DBH. Almost half (46%) of the clients served are adults age 26-59. Among 26-59 year old clients, Caucasians and Latinos represent the highest number of clients at 45% and 28% respectively. Caucasians and Latinos account for the highest percentages of transition age you at 34% and 38% respectively and also represent the largest number of children and adolescents receiving mental health services at 33% and 41% respectively.

STAFF

Gender of Staff

Table 11- Staff Gender Composition

		Sex			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	.1	.1	.1
	Female	615	73.1	73.1	73.2
	Male	224	26.6	26.6	99.9
	Unknown	1	.1	.1	100.0
	Total	841	100.0	100.0	

NO MISSING VALUES

Females represent nearly three fourths (73%) of DBH staff.

Staff Race and Ethnicity

Table 12- Staff Race/Ethnic Composition

		Ethnicity			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	African American	119	14.1	14.1	14.1
	Asian Pacific Islander	57	6.8	6.8	20.9
	Caucasian	358	42.6	42.6	63.5
	Latino	222	26.4	26.4	89.9
	Native American	9	1.1	1.1	91.0
	Other/Unknown	76	9.0	9.0	100.0
	Total	841	100.0	100.0	

NO MISSING VALUES

Three times as many Caucasians (43%) and almost twice as many Latinos (26%) as African Americans make up DBH staff

Languages Spoken by Staff

Table 13- Language Other than English Spoken by Staff

		Language Other Than English										Total
		Arabic	Chinese	Farsi	Germany	Ilocano	Sign ASL	Spanish	Tagalog	Vietnamese		
African American	Count	115	0	1	0	0	0	0	3	0	0	119
	% within ethnic group	96.6%	.0%	.8%	.0%	.0%	.0%	.0%	2.5%	.0%	.0%	100.0%
Asian Pacific Islander	Count	30	1	4	0	0	1	0	2	14	5	57
	% within ethnic group	52.6%	1.8%	7.0%	.0%	.0%	1.8%	.0%	3.5%	24.6%	8.8%	100.0%
Caucasian	Count	345	0	0	1	1	2	4	5	0	0	358
	% within ethnic group	96.4%	.0%	.0%	.3%	.3%	.6%	1.1%	1.4%	.0%	.0%	100.0%
Latino	Count	148	0	0	0	0	1	1	72	0	0	222
	% within ethnic group	66.7%	.0%	.0%	.0%	.0%	.5%	.5%	32.4%	.0%	.0%	100.0%
Native American	Count	7	0	0	0	0	0	0	2	0	0	9
	% within ethnic group	77.8%	.0%	.0%	.0%	.0%	.0%	.0%	22.2%	.0%	.0%	100.0%
Other/Unknown	Count	73	0	0	0	0	1	0	2	0	0	76
	% within ethnic group	96.1%	.0%	.0%	.0%	.0%	1.3%	.0%	2.6%	.0%	.0%	100.0%
TOTAL	Count	718	1	5	1	1	5	5	86	14	5	841
	% within ethnic group	85.4%	.1%	.6%	.1%	.1%	.6%	.6%	10.2%	1.7%	.6%	100.0%

MISSING VALUES-718 (85%)

As shown in Table 13, one in ten DBH staff (10%) speaks Spanish. Latino account for 32% and Native Americans make up 22% of DBH staff who speak Spanish.

Staff Position by Ethnicity

Table-14 Staff Position

		Staff Ethnicity and Discipline										
			ADS Counseling	Case Management	MFT	Non-Clinical	Nursing	Occupational Therapy	Psychiatry	Psychology	Social Work	Total
African American	Count	0	2	20	17	57	1	2	1	3	16	119
	% within Ethnicity	.0%	1.7%	16.8%	14.3%	47.9%	.8%	1.7%	.8%	2.5%	13.4%	100.0%
	% within Discipline	.0%	8.0%	20.4%	14.9%	15.2%	6.7%	28.6%	1.8%	8.6%	13.8%	14.1%
Asian Pacific Islander	Count	0	1	1	5	10	2	0	28	2	8	57
	% within Ethnicity	.0%	1.8%	1.8%	8.8%	17.5%	3.5%	.0%	49.1%	3.5%	14.0%	100.0%
	% within Discipline	.0%	4.0%	1.0%	4.4%	2.7%	13.3%	.0%	50.9%	5.7%	6.9%	6.8%
Caucasian	Count	0	14	47	63	135	10	4	10	16	59	358
	% within Ethnicity	.0%	3.9%	13.1%	17.6%	37.7%	2.8%	1.1%	2.8%	4.5%	16.5%	100.0%
	% within Discipline	.0%	56.0%	48.0%	55.3%	36.1%	66.7%	57.1%	18.2%	45.7%	50.9%	42.6%
Latino	Count	1	7	27	13	139	2	1	3	5	24	222
	% within Ethnicity	.5%	3.2%	12.2%	5.9%	62.6%	.9%	.5%	1.4%	2.3%	10.8%	100.0%
	% within Discipline	50.0%	28.0%	27.6%	11.4%	37.2%	13.3%	14.3%	5.5%	14.3%	20.7%	26.4%
Native American	Count	0	0	1	0	5	0	0	0	0	3	9
	% within Ethnicity	.0%	.0%	11.1%	.0%	55.6%	.0%	.0%	.0%	.0%	33.3%	100.0%
	% within Discipline	.0%	.0%	1.0%	.0%	1.3%	.0%	.0%	.0%	.0%	2.6%	1.1%
Other/Unknown	Count	1	1	2	16	28	0	0	13	9	6	76
	% within Ethnicity	1.3%	1.3%	2.6%	21.1%	36.8%	.0%	.0%	17.1%	11.8%	7.9%	100.0%
	% within Discipline	50.0%	4.0%	2.0%	14.0%	7.5%	.0%	.0%	23.6%	25.7%	5.2%	9.0%
Total	Count	2	25	98	114	374	15	7	55	35	116	841
	% within Ethnicity	.2%	3.0%	11.7%	13.6%	44.5%	1.8%	.8%	6.5%	4.2%	13.8%	100.0%
	% within Discipline	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

MISSING VALUES-2 (.2%)

Table 14 shows that non-clinical staff account for 45% of all DBH staff with more than twice as many Latinos (37%) and Caucasians (36%) as African Americans (15%) serving in this capacity. Social Workers and Marriage and Family Therapists (MFT) together make up 28% of DBH staff. Caucasians (51%) account for more than twice as many Latino (21%) and nearly four times as many African American (14%) Social Workers. Caucasians also represent almost four times as many African American (15%) and nearly five times as many Latino MFTs. Asian Pacific Islanders account for 9% of DBH staff but represent nearly three times (51%) as many Caucasian (18%), nine times as many Latino (6%) and twenty-eight times as many African American (1.8%) psychiatrists.

Discussion of findings

The San Bernardino Department of Behavioral Health (DBH) and its affiliated agencies provide mental health services to an almost equal number of male and female clients. While males and females are served equally in this county, larger differences exist among ethnicities. This is evidenced by findings indicating that Caucasian clients continue to account for a significantly larger percentage of clients served when compared with African Americans, Asian Pacific Islanders and Native Americans. These findings underscore the disparities associated with mental health service utilization and highlight the need for prompt action to address mental health disparities and social inequities. It is encouraging to note that the percentage of Latinos served is quite similar to their Caucasian counterparts.

An examination of the age of persons utilizing mental health services revealed that almost half of clients served are adults age 26-59 with Caucasians and Latinos representing the highest number of clients within that group. Latinos represent the largest percentage of children and adolescents and transitions age youth receiving mental health treatment. These findings suggest that strategies to encourage mental health service utilization across ethnic groups may be tailored to reach the under represented age groups. Likewise retention strategies may be tailored to the represented age groups across ethnicities.

It is interesting to note that an examination of client discharge status revealed that among those receiving mental health services the majority of clients did not complete treatment. These findings raise questions concerning factors that influence client retention in treatment and client success. An examination of patient clinical and non-clinical characteristics, staff characteristics and organizational factors may offer an explanation for client non-completion of treatment. Knowledge of sources of influence on client retention will provide a means of intervention and improvement of outcomes for clients.

Treatment was indicated as successful for less than one in ten clients with Caucasians and Latinos having the highest success rates. Low success rates call into question the efficacy and fit of treatment interventions, organizational policies and procedures guiding treatment and outcome evaluation processes. An examination of client characteristics affecting outcomes may provide opportunities for intervention to improve client mental health outcomes.

Though household income data was not available for clients, Medi-Cal status and educational achievement act as indicators of the socio-economic status of the clients served. Findings show that most persons receiving care through the San Bernardino Department of Behavioral Health are Medi-Cal clients with Asian Pacific Islanders accounting for the largest of this group. Educational achievement appears to be low for clients, with almost half having some high school and high school education. Educational achievement across all four categories is shown to be nearly evenly distributed across ethnicities. This data suggests that most of the clients served may belong to a low socio-economic group which in turn may have some impact on mental health service utilization and treatment outcomes.

In addition to socio-economic status, access to treatment and outcomes may also be impacted by staff characteristics such as ethnicity. A review of DBH staff characteristics revealed that Caucasians not only represent the largest percentage of clients served but also account for the largest percentage of DBH workers. Though the percentage of Latino clients is quite similar to their Caucasian counterparts, Caucasian staff represents almost twice the percentage of Latinos. Latinos account for about one third of mental health clients, however, only one in ten DBH staff is indicated as Spanish speaking of which Latinos and Native Americans represent more than half. Almost half of the DBH staff functions in a non-clinical capacity with Latinos and Caucasians making up nearly three fourths of this group. Interestingly Asian Pacific Islanders represent less than one tenth of all DBH workers but represent more than half of all psychiatrists.

The above findings suggest that DBH staff may not be representative of mental health clients accessing service and may very well impact client retention and outcomes. Given that only a small number of persons in need of mental health services actually access such services, a representative staff is an important consideration in the provision of care.

Recommendations based on analysis of data set

Health disparities and social inequities has been of concern to many including service providers and consumers, interest groups, politicians, policy makers and researchers for years. Many have tried over time, to gain knowledge about health care access, utilization, and outcomes. Given the current economic crisis and the resulting elevated need for access to mental health care as well as governmental interest in health care reform, an examination and discussion of access to and use of mental health care is especially relevant.

The systemic nature of mental health care utilization, quality and outcomes is an especially important aspect of this discussion. Though the unit of analysis is the individual client and staff, an acknowledgement that their decisions and actions are influenced by several internal and external processes is warranted. Clients choose to seek and remain in care based on their financial position, level of education, culture, mental status, social support systems and service organizations. Likewise the nature and quality of care provided by mental health workers is influenced by workers' education and training, scope of practice and competence, organizational policies and procedures, federal and state guidelines and culture. Even organizations are influenced by federal and state regulations, physical location, resources, funding, management and organizational culture. The interaction of these facts come together to create what we examine and discuss as access to and use of mental health services. The ensuing recommendations will focus on organizational strategies that cumulatively will improve mental health service utilization and outcomes.

Client Factors

Attending to client challenges will serve to increase access to care, retention rates, and improve mental health outcomes. The result will be a reduction in health disparities.

1. **Survey Client Challenges**-A standardized approach to gathering information about client challenges that may disrupt treatment can be implemented throughout the county. Such information can be used to identify a client who may end treatment prematurely. One option is to collect secondary contact information that can be used to make follow-up contact with a client who is missing. The data collected through this process may also be used to conduct detailed examinations of the reasons for treatment non-completion and to develop strategies for best attending to such challenges. Knowledge of such factors will allow organizations to tailor operating policies and procedures to ameliorate identified challenges.
2. **Client Social Support**- The relevant research suggests that a client or potential client's social support system plays an important role in decisions to access and use mental health services. Such evidence can be integrated into practice to improve outcomes for clients. Involving families or significant others in care can serve to increase treatment adherence, retention and therefore improve outcomes for clients. Use of this strategy will benefit not only children and adolescents but will be

an important aspect of care for cultures that place high value on family and community. Such a practice must be supported by policies and procedures and should be part of standard practice.

Staff Factors

3. **Staff Representativeness**-The lack of representative of key members of staff such as psychiatrists, therapists and social workers is of particular concern. An endeavor to increase staff diversity requires long-term planning and implementation. Pipeline programs that introduce and encourage minority students into specific areas of specialization in one way to manage such a challenge in the long run. In the short-term, cultural competency trainings including learning to speak a second language could offer a more immediate solution to the problems. Providing incentives to workers who learn a second language or who engage in approved cultural competency training is one option for bridging the culture gap.
4. **Staff Beliefs**-The beliefs and attitudes of staff translate into behavior. Positive beliefs and attitudes will result in positive behavior toward clients and negative beliefs and attitudes will result in the opposite. Staff beliefs about the cause of mental illness and what constitutes appropriate care has an impact on who will access mental health care and the outcomes for those who do. While staff beliefs and attitudes are influenced heavily by their training and theoretical orientation, personal experiences, culture and other intrinsic factors also play a part. Studies have demonstrated differences in outcomes for clients associated with differences in clinician beliefs about mental illness and care and attitudes toward treatment. Changes in organizational expectations and guidelines can be used to attend to such challenges.

Organizational Factors

Increases in health equity will not occur unless there is organizational change. Organizations create the context within which mental health services are accessed, utilized and provided. Extensive research has demonstrated that organizations play a critical role in mental health outcomes. An organization creates the expectations of workers and provides guidelines, policies and operating procedures for providing services. An organizations' image can serve to encourage or discourage service access, use and retention.

5. **Organizational Culture**-An organization must decide and communicate clearly and often its expectation of workers. Workers should not be in doubt concerning the expectations they must fulfill. Workers should be clearly guided by procedures and policies that reflect the purpose of the organization. Once organizational policies

and guidelines are examined and attended to appropriately, workers will respond to such change and begin to work toward set goals.

The San Bernardino Department of Behavioral Health (DBH) and its affiliated agencies provide mental health services to an almost equal number of male and female clients. While males and females are served equally in this county, larger differences exist among ethnicities. This is evidenced by findings indicating that Caucasian clients continue to account for a significantly larger percentage of clients served when compared with African Americans, Asian Pacific Islanders and Native Americans. These findings underscore the disparities associated with mental health service utilization and highlight the need for prompt action to address mental health disparities and social inequities. Other key findings:

1. **Age and Ethnic Disparities.** An examination of the age of persons utilizing mental health services revealed that almost half of clients served are adults age 26-59 with Caucasians and Latinos representing the highest number of clients within that group. Latinos represent the largest percentage of children and adolescents and transitions age youth receiving mental health treatment. These findings suggest that strategies to encourage mental health service utilization across ethnic groups may be tailored to reach the under represented age groups. Likewise retention strategies may be tailored to the represented age groups across ethnicities.
2. **Treatment adherence.** It should be noted that an examination of client discharge status revealed that among those receiving mental health services the majority of clients did not complete treatment. These findings raise questions concerning factors that influence client retention in treatment and client success. An examination of patient clinical and non-clinical characteristics, staff characteristics and organizational factors may offer an explanation for client non-completion of treatment. Knowledge of sources of influence on client retention will provide a means of intervention and improvement of outcomes for clients.
3. **Successful treatment.** One important reason for concern is that treatment was indicated as successful for less than one in ten clients with Caucasians and Latinos having the highest success rates. Low success rates call into question the efficacy and fit of treatment interventions, organizational policies and procedures guiding treatment and outcome evaluation processes. An examination of client characteristics affecting outcomes may provide opportunities for intervention to improve client mental health outcomes.
4. **Socio-economic status.** Though household income data was not available for clients, Medi-Cal status and educational achievement act as indicators of the socio-economic status of the clients served. Findings show that most persons receiving care through the DBH are Medi-Cal clients with Asian Pacific Islanders accounting for the largest of this group. Educational achievement appears to be low for clients, with almost half having some high school and high school education. Educational achievement across all four

categories is shown to be nearly evenly distributed across ethnicities. This data suggests that most of the clients served may belong to a low socio-economic group which in turn may have some impact on mental health service utilization and treatment outcomes.

5. **Staff characteristics.** Access to treatment and outcomes may also be impacted by staff characteristics such as ethnicity. A review of DBH staff characteristics revealed that Caucasians not only represent the largest percentage of clients served but also account for the largest percentage of DBH workers. Though the percentage of Latino clients is quite similar to their Caucasian counterparts, Caucasian staff represents almost twice the percentage of Latinos. Latinos account for about one third of mental health clients, however, only one in ten DBH staff is indicated as Spanish speaking of which Latinos and Native Americans represent more than half. Almost half of the DBH staff functions in a non-clinical capacity with Latinos and Caucasians making up nearly three fourths of this group. Interestingly Asian Pacific Islanders represent less than one tenth of all DBH workers but represent more than half of all psychiatrists.

The above findings suggest that DBH staff may not be representative of mental health clients accessing service and may very well impact client retention and outcomes. Given that only a small number of persons in need of mental health services actually access such services, a representative staff is an important consideration in the provision of care.

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Study Recommendations

Implications for Policy and System Change

7. Recommendations: Implications for Policy and System Change

7.1. Socio Ecological Model: Individual-level

Identify Client Challenges. A standardized approach to gathering information about client challenges that may disrupt treatment can be implemented throughout the county. Such information can be used to identify a client who may end treatment prematurely. One option is to collect secondary contact information that can be used to make follow-up contact with a client who is missing. The data collected through this process may also be used to conduct detailed examinations of the reasons for treatment non-completion and to develop strategies for best attending to such challenges. Knowledge of such factors will allow organizations to tailor operating policies and procedures to ameliorate identified challenges.

Client Social Support. The relevant research suggests that a client or potential client's social support system plays an important role in decisions to access and use mental health services. Such evidence can be integrated into practice to improve outcomes for clients. Involving families or significant others in care can serve to increase treatment adherence, retention and therefore improve outcomes for clients. Use of this strategy will benefit not only children and adolescents but will be an important aspect of care for cultures that place high value on family and community. Such a practice must be supported by policies and procedures and should be part of standard practice.

Acculturation. Acculturation was found to be an important predictor of service use. Decision-makers need to ensure that mental health service providers are delivering services in a culturally-appropriate and competent way. It is important to understand the experiences of ethnic and racial minorities, to develop a mental health system that is responsive to their social and cultural context (Hines-Martin, Brown-Piper, Kim, & Malone, 2003). Additionally, strategies to impact service use in the long term may include expanding efforts such as educational pipeline initiatives to increase the diversity of mental health professionals.

Stigma. Decision-makers interested in increasing the use of services may consider designing culturally appropriate social marketing and media campaigns, community forums, and other strategies. This would aid in consumer empowerment and modifying the perceptions regarding mental health, and could be used to promote the availability of culturally appropriate services.

Explanatory Models of Illness. Policymakers should consider supporting educational interventions focusing on Latino mental health consumers and the general community to address beliefs regarding mental health and mental illness. Cultural competence is more than language services, but requires a provider who is able to empathize and value (or even share) the client's explanatory models of health and illness.

7.2. Socio Ecological Model: Community-level

Information dissemination must occur in the natural habitat of community residents. Service providers can no longer expect the community to go to a mental health service provider seeking assistance or information. For example, institutionalizing the support for *promotores de salud mental* (community health workers with a focus on mental health) may prove effective in increasing awareness regarding mental health, available resources, and reducing the stigma associated with mental illness

Social Capital - This study examined individual-level social capital which was found to be significantly correlated to self-rated mental health. Although causality cannot be determined, this finding is important. The focus on strengthening and increasing social capital among Latinos, in addition to the benefits already highlighted in the literature related to economic development or physical health, may also impact the mental health of Latinos. The strategy of using *promotores de salud*, in addition to information dissemination, may serve to facilitate collective efficacy and increase social capital among community stakeholders. This study supported the conclusion that social capital has a significant positive correlation with self-rated mental health status. Consequently, increasing social capital may have beneficial effects in the mental health status of community residents.

7.3. Socio Ecological Model: Organizational-level

Increases in health equity will not occur unless there is organizational change. Organizations create the context within which mental health services are accessed, utilized and provided. The extensive work of Charles Glisson has demonstrated that organizations play a critical role in mental health outcomes. An organization creates the expectations of workers and provides guidelines, policies and operating procedures for providing services. An organizations' image can serve to encourage or discourage service access, use and retention.

Staff representativeness-The lack of representative of key members of staff such as psychiatrists, therapists and social workers is of particular concern. An endeavor to increase staff diversity requires long-term planning and implementation. Pipeline programs that introduce and encourage minority students into specific areas of specialization in one way to manage such a challenge in the long run. In the short-term, cultural competency trainings including learning to speak a second language could offer a more immediate solution to the problems. Providing incentives to workers who learn a second language or who engage in approved cultural competency training is one option for bridging the culture gap.

Staff beliefs-The beliefs and attitudes of staff translate into behavior. Positive beliefs and attitudes will result in positive behavior toward clients and negative beliefs and attitudes will result in the opposite. Staff beliefs about the cause of mental illness and what constitutes appropriate care has an impact on who will access mental health care and the outcomes for those who do. While staff beliefs and attitudes are influenced heavily by their training and

theoretical orientation, personal experiences, culture and other intrinsic factors also play a part. Studies have demonstrated differences in outcomes for clients associated with differences in clinician beliefs about mental illness and care and attitudes toward treatment. Changes in organizational expectations and guidelines can be used to attend to such challenges.

Organizational culture-An organization must decide and communicate clearly and often its expectation of workers. Workers should not be in doubt concerning the expectations they must fulfill. Workers should be clearly guided by procedures and policies that reflect the purpose of the organization. Once organizational policies and guidelines are examined and attended to appropriately, workers will respond to such change and begin to work toward set goals.

Health providers. The findings emphasize the need for policymakers to address structural and organizational barriers to the use of mental health services. Developing strategies to increase referral coordination is paramount. Recognizing that health professionals have an important role in referring or suggesting a consultation with a mental health service provider, decision makers in the behavioral health system should evaluate strategies to establishing strategic relationships with health professionals (e.g. family physicians and nurse practitioners) to help facilitate referrals and other important information. For example, a brief mental health screening instrument may be used during routine medical visits to identify individuals who may be experiencing a mental health challenge but due to stigma or other barriers have not discussed their concerns with a mental health professional.

Family income. The study also showed that individuals with lower incomes carry a greater risk of having unmet mental health needs. Economic status should not determine whether a person who needs mental health services seeks or obtains the required help. Furthermore, it was surprising to note that inconvenience of service hours was repeatedly identified as a barrier to use of mental health services. Providing services only during traditional office hours (i.e., 8 am-5 pm) has implications for gender representation and may also account for the underrepresentation of Latino men among consumers of mental health services. Such impediment should be relatively easy to address. Although efforts to expand insurance availability to those who do not have it should be encouraged, health insurance alone would not necessarily translate to increased use of services as shown by the data. Issues of stigma and perception of effectiveness and quality of care must all be addressed.

Health disparities and social inequities has been of concern to many including service providers and consumers, interest groups, politicians, policy makers and researchers for years. Many have tried over time, to gain knowledge about health care access, utilization, and outcomes. Given the current economic crisis and the resulting elevated need for access to mental health care as well as governmental interest in health care reform, an examination and discussion of access to and use of mental health care is especially relevant.

The systemic nature of mental health care utilization, quality and outcomes is an especially important aspect of this discussion. Though the unit of analysis is the individual client and staff, an acknowledgement that their decisions and actions are influenced by several internal and external processes is warranted. Clients choose to seek and remain in care based on their

financial position, level of education, culture, mental status, social support systems and service organizations. Likewise the nature and quality of care provided by mental health workers is influenced by workers' education and training, scope of practice and competence, organizational policies and procedures, federal and state guidelines and culture. Even organizations are influenced by federal and state regulations, physical location, resources, funding, management and organizational culture. The interaction of these facts come together to create what we examine and discuss as access to and use of mental health services. The ensuing recommendations will focus on organizational strategies that cumulatively will improve mental health service utilization and outcomes.

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Study Strengths and Limitations

8. Study Strengths and Limitations

As is the case with any study, several potential limitations should be recognized. The study of mental health, its definition, diagnosis or treatment, or even the prevalence of mental disorders, was beyond the scope of this inquiry. Rather, this study aimed at examining factors that influence the use of mental health services. Additionally, the findings from this research may not be generalizable beyond the context and geographic settings in which the study was conducted.

8.1. Study Limitations

- **Time frame.** Despite the very tight timeline (only nine months), the project was successfully implemented without sacrificing the research design and level of community participation. This was due primarily to existing network and trust within the community. However, to ensure community ownership, future efforts should account for the inherent challenges in recruiting participants to discuss mental health related issues and to empower communities to address topics of interest and concern.
- **Self-reports.** To avoid the potential negative consequences associated with self-selection, the study was designed to survey consumers of mental health services as they “walked in” to the mental health facility seeking services. Additionally, IRB-approved protocols and Health Insurance Portability and Accountability Act (HIPAA) regulations precluded examination of medical records or directly contacting the consumers who met the inclusion criteria. Consequently, the study’s design called for voluntary and ideally, first-time users of mental health services by approaching potential participants as they went in for services at the mental health service provider.
- **Recruitment challenges.** The study was predicated on the reality of access problems and that Latinos and Asian Pacific Islanders were under-represented among consumers of behavioral health services in the county of San Bernardino, however, the magnitude of the challenges of access and use were underestimated. For example, a research team of 20 trained research assistants, working an average of 6 hours per day, were encountering an average of two Latino consumers per day who met the inclusion criteria. Additionally, although attempts were made to ensure the comfort level of respondents and assure them of the privacy and anonymity of their responses, social desirability may pose a threat to internal validity. For example, there may have been some under-reporting of “complementary and alternative medicine” which has been found to be more widespread among Latinos than was reported in this study. Mental health is a sensitive topic and not openly discussed within the Latino culture, so participants may have been hesitant to disclose the need or previous use of mental health services.
- **Symptomatology or need.** The study relied on questions adapted from the *DSM-IV* (American Psychiatric Association, 1994) to determine symptomatology or the level of

need for mental health services. However, it should be noted that this study did not include a validated clinical interview to screen or diagnose for mental health disorders. This may account for the apparently higher rates of symptomatology, particularly in rates of depression, than may be found in the general Latino population in San Bernardino. Consequently, the findings are preliminary rather than definitive and should be replicated in studies that use a more complete screening or diagnosis mechanism to determine the specific mental health needs among individuals not currently using mental health services.

- **Inclusion criteria.** To ensure that the study participants would be able to offer coherent and consistent responses, the study exclusion criteria limited the participation of respondents who had a “manageable” mental health problem, which may account for a higher rate of depression-related symptoms among respondents, in contrast to other mental health disorders such as bipolar disorder or schizophrenia. Consequently, it may be possible that varying diagnoses may have different associations to use of mental health services.

8.2. Strengths

Despite the limitations, this study has significant strengths that should be noted and the findings are important from both a theoretical and practical perspective.

- **Empirically-based.** The major strength of this study is the empirically-based nature of the research design, which addresses voids in the existing literature. For example, the study offers a novel design, such as the use of community-based participatory research and includes consumers of mental health services as well as non-consumers.
- **Community-driven.** Previous community-based studies have relied on respondents who volunteered to participate in the study and were recruited through widespread advertisements using fliers, electronic media or other strategies, which may introduce bias through self-selection. To counter this potential bias, this study interviewed consumers of mental health services at the mental health provider offices (walk-ins). Study participants were interviewed in a variety of settings, including health related sites and neutral non-health sites, such as social service organizations, schools, churches, the Mexican Consulate, fairs, etc
- **Comprehensive.** This study represents one of the most comprehensive community-based analyses of cultural factors and community norms associated with the use of mental health services among Latinos or Hispanic, African Americans, and Asian or Pacific Islanders. The use of four distinct data collection strategies (e.g. focus groups, key informant interviews, surveys, and secondary data analysis) also provides opportunity to triangulate the results which have significant implications for practice and policy and can be used to explore potential avenues for policy and organizational interventions to improve access and use of mental health services among specific racial or ethnic minority populations.

9. Conclusions

This report demonstrates that there are significant individual-level, community-level, and organizational-level barriers to access and use of mental health services. It is important to note that the study proposed an intentional differentiation between *use* of mental health services and *access* to mental health services. As shown, access is determined by the availability, acceptability, and cultural appropriateness of services, as well as location, hours of operation, transportation needs, and cost (USDHHS, 2009). Conversely, this study confirms that service utilization can be affected by factors not commonly associated with the above definition of accessibility of services. For example, individuals may have health insurance, may live near to a care facility, and yet not use the available services. So clearly, service use is about more than having insurance coverage or the ability to pay for services.

This study contributes to a better understanding of factors that influence or predict the use of mental health services. Understanding the experience of ethnic or cultural minorities is important in the process of designing services that are responsive to their cultural and social context (Hines-Martin, Brown-Piper, Kim, & Malone, 2003). Once these factors are known, practitioners and policymakers would be better equipped to design treatment or propose policy interventions to increase service use including the development of effective messages to promote prevention and treatment for mental health. This study, even with its limitations, may be used as a reference point for policymakers. Those charged with ensuring adequate care within the county are encouraged to incorporate the study findings to design and implement policies and programs that result in improved access and use of mental health services among Latinos in San Bernardino.

In November of 2004, the voters of California approved Proposition 63, which became a state law entitled the Mental Health Services Act (MHSA), providing additional funding for mental health services at the county-level and the expansion of community mental health programs. Following a debate on the State's budget crisis, on May 19, 2009 the voters of California again expressed their will to ensure sufficient funding for mental health services by defeating Proposition 1E, which would have transferred funds over a 2-year period from MHSA-funded programs to pay for mental health services for children and young adults funded through other sources (i.e., Early and Periodic Screening, Diagnosis, and Treatment Program).

However, as time has shown since the passing of Proposition 63, it is not enough to have increased funding or an additional program if a growing group that is in need does not use the services. It is likely that the use of mental health services is affected by many factors. Access is determined by the availability, acceptability, and cultural appropriateness of services, as well as location, hours of operation, transportation needs, and cost. Conversely, service utilization can be affected by factors not commonly associated with the above definition of accessibility of services. Individuals may have health insurance, may live near to a care facility, and yet not use the available services. So clearly, service use is determined by factors other than having insurance coverage or the ability to pay for services. These factors must be taken into account if equity in use of mental health services is to be achieved.

10. Maps
