CLINICAS DE SALUD DEL PUEBLO, INC.

Project Salud Libre

AN ASSESSMENT OF THE MENTAL HEALTH NEEDS IN IMPERIAL COUNTY'S COMMUNITIES

May 2006

Funded by:

The California Endowment

Professional Consultation by:

PROFESSIONAL & PERSONAL EXCELLENCE INTERNATIONAL

PROYECTO SALUD LIBRE: AN ASSESSMENT OF THE MENTAL HEALTH NEEDS IN IMPERIAL COUNTY'S COMMUNITIES

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Proyecto Salud Libre; A report presented by:

Clinicas de Salud del Pueblo, Inc.
Professional & Personal Excellence International

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TABLE OF CONTENTS

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EXECUTIVE SUMMARY

This report presents the findings of Project *Salud Libre*, a mental health needs assessment conducted among Imperial County, California's communities in 2005 and 2006. The assessment was performed by Clinicas de Salud del Pueblo, Inc. with major consultation from Professional & Personal Excellence International.

Best national data show that people living in US rural settings face significant healthcare access barriers. They often have lower family incomes and are less likely to be covered by health insurance than their urban counterparts. In addition, fewer skilled providers are available in rural than urban settings. Culturally and linguistically distinct groups, such as Latinos, also tend to experience disparities in healthcare. Latinos in rural settings thus face the potential double jeopardy of regional and ethnic-specific service deficits.

These circumstances are true for mental as well as physical healthcare. Nationally, limited mental health services for rural and culturally distinct populations have been cited as causing several problems. Fewer people obtain any care at all. Those who do get help receive it later in the course of their illness. Consequences include more severe, persistent, and disabling symptoms that are expensive to treat.

Imperial County is one area potentially impacted by the factors described above. Located in the Southeastern-most corner of California, the region is largely rural and agricultural. A majority of its residents are of Mexican birth or descent. Over the last several years Clinicas de Salud del Pueblo, Inc. (Clinicas), the region's major community clinic system, has noted unmet mental health needs in the patients it serves. Such clinical observations, plus anecdotal information from other community members, prompted this more systematic needs assessment.

Salud Libre's assessment consisted of data gathered through 424 written surveys (including 413 adults & 11 adolescents), 10 structured focus groups (with 82 adults), and 20 key stakeholder interviews. Activities were conducted in Spanish and English across many Imperial County locations. The survey compiled demographic, acculturation, mental health symptom, service access / utilization, care preference and related information. Focus group and key stakeholder protocols assessed similar facts. Standard qualitative and quantitative techniques were used to analyze our data. Results were integrated by identifying consistencies across data types. Project *Salud Libre's* key findings and recommendations are listed below.

Key Findings

1. Imperial Valley residents tend to experience significant stressors. Most commonly these are tied to limited and unstable economics, extreme summer heat, isolation, and physical illness.

2. There is a clear unmet mental health service need in Imperial County. Best estimates show that roughly 30% of resident are in clinically noteworthy distress. Yet fewer than 30% of such persons have ever received any formal treatment.

3. Most commonly cited mental health symptoms are related to anxiety, depression, and frustration. In addition, people often describe physical difficulties that they tend to connect with emotional problems.

4. Links between physical illnesses and emotional distress are well-recognized by local residents. Respiratory illnesses, type 2 diabetes, and cancer are prevalent physical concerns.

5. Substance abuse and dependence are also noteworthy problems in Imperial County. Alcohol, methamphetamines, marijuana, Rohypnol, heroin, and crack cocaine were the most frequently cited substances of choice.

6. Women, adolescents, the elderly, and those who are less acculturated (e.g., persons who speak little or no English) appear most at risk for emotional distress.

7. Stressors and mental health symptoms cause or exacerbate impairments in activities of daily living (e.g., school, work, family). Family discord is particularly common and sometimes leads to abuse, divorce, and abandonment.

8. Like adults, children and adolescents experience noteworthy stressors. Consequent difficulties are known to include truancy and decreased school performance, aggression (e.g., fights), and substance abuse.

9. Some people make constructive attempts to cope with emotional distress. But many lack knowledge about how to deal with mental health issues. Informal sources of information such as friends, family, and “the street” are common.

10. Service barriers are most often economic. The number of uninsured is, for example, high compared to nationally reported figures. But too few culturally / linguistically competent providers, cultural taboos against services, and lack of knowledge about mental health treatment options are also major barriers. Limited English speakers encounter some of the greatest barriers.

11. Mexico is the most common source of mental and physical health care. This option provides some needed access. But limited controls on treatment and medications in Mexico pose difficulties.

12. Community members asked that family therapy, support groups, treatment for children and adolescents, individual therapy, drug / alcohol recovery services, and psychiatric medications be made more available in the Imperial Valley.

13. Outreach through the media, churches, schools, and community events (e.g., health fairs) was described as effective. In addition, the use of Community Health Workers (*promotoras*) was cited as important.

Recommendations

1. Imperial Valley healthcare agencies and providers should make all possible efforts to expand mental health services in the region. Increased outpatient treatment would be most advantageous.

2. Expanded treatment should focus on family inclusion, affordability, and cultural / linguistic competence. In addition support groups and treatment for adolescents / children are particularly desired by the community. Respect for consumers is essential in any service provision.

3. On-going coordination with primary care is important. But primary care doctors should not be formally relied upon to close mental health service gaps.

4. Coordination and collaboration between local institutions is most likely to bring needed resources and services to the region.

5. Educational institutions should be encouraged to offer local programs that increase the number of available and culturally competent providers.

6. Insurance systems, including government sponsored programs, should eliminate policies that artificially bar some licensed providers from third-party reimbursements in remote and underserved locations.

We ultimately hope this assessment will prompt a range of organizations, particularly in cooperative and collaborative efforts, to bring needed resources to the Imperial Valley.

Imperial County

Situated at the southeastern-most corner of California, Imperial County covers almost 4,500 square miles. It is bordered by San Diego County to the west, Riverside County to the north, the State of Arizona to the east, and the Mexican State of Baja California to the south. 2000 Census data noted the area's population density as 34/mi^2. Geographically located in the Imperial Valley, the County's larges city, El Centro, has a population of over 37,000. There are several locales (e.g., Ocotillo) with less than 300 residents. Communities are spread over much of the total area, and the region's economic base is largely agricultural. Most (72%) County residents are of Latino (primarily Mexican) birth or descent. Other local ethnic groups include non-Latino Whites (22%), African Americans (3%), Asian / Pacific Islander (2%), and Native Americans (1%).[1]

The Imperial Valley's population, currently estimated at over 150,000, is expected to double over the next 30 years. Given this growth, the region's health care needs will likely increase. At the same time major challenges in the provision of adequate mental health services to rural locations and culturally / linguistically distinct ethnic groups have been nationally recognized. Such circumstances thus require specific attention. Primary issues are as follows:

Mental Health Care in Rural Areas

Mental illness in both adults and children tends to occur in similar proportions among rural and urban US populations.[2] But on average, people living in rural areas face more difficulties accessing care than their urban counterparts. Those in rural settings often have lower family incomes and are less likely to be covered by general or mental health insurance. Even those with private insurance tend to have higher deductibles than their urban peers.[3,4]

Service access is further hindered by the comparatively few skilled mental health providers (e.g., psychiatrists, psychologists, and clinical social workers) who are available in rural locations.[5,6] Consequently, the President's 2002-2003 New Freedom Commission on Mental Health noted that primary care is often used to deal with mental health issues.[7] But the

Commission also warned about the limitation of this approach, stating that "*many primary care providers in rural areas are unprepared to diagnose and treat mental illness*."

These circumstances have both personal and societal impact. Relative to their urban counterparts, fewer persons in rural areas who have metal illnesses receive any care at all. Those who enter treatment tend to do so later in the course of their illness. Consequently their symptoms are more severe, persistent, and disabling, and they require more intensive treatment.[8] As a result, individuals experience more and longer-term personal distress. Broader society faces greater treatment costs and loss of productivity (e.g., when mental illness reduces people's ability to work or become more educated).

Cultural and Linguistic Issues

The high proportion of Mexican Americans in Imperial County warrants additional considerations. That culturally and linguistically distinct US populations, including Latinos, encounter disparities in mental health care is well documented. On average, such groups receive a lesser quality of care than their White counterparts, even when health insurance coverage is equivalent.[9,10] The Surgeon General's 1999 Report on Mental Health, for example, notes that many Latinos are not seen by providers who speak Spanish and / or understand their culture. Consequently, presented symptoms may be misinterpreted. This includes a potential failure to recognize difficulties as falling into, or meeting the threshold of a formal mental disorder.[10] As a result people may be incorrectly denied services.

The scientific literature further notes that provider reactions based on conscious and unconscious stereotypes can hamper their interactions with Latinos.[11,12] Additionally, incongruent expectations between patient and provider can foster misunderstandings, mistrust, and lack of treatment follow-through.[9] In short, limited cultural competence hampers treatment efforts.[13,14] In this context "cultural competence" means that providers (a) recognize culture as important to health care, (b) acknowledge their own potential to stereotype patients, (c) know about basic cultural norms, (d) know if, when, and how to apply such knowledge with individual patients. The negative consequences of cultural incompetence can include diagnostic errors and treatment failure.[15]

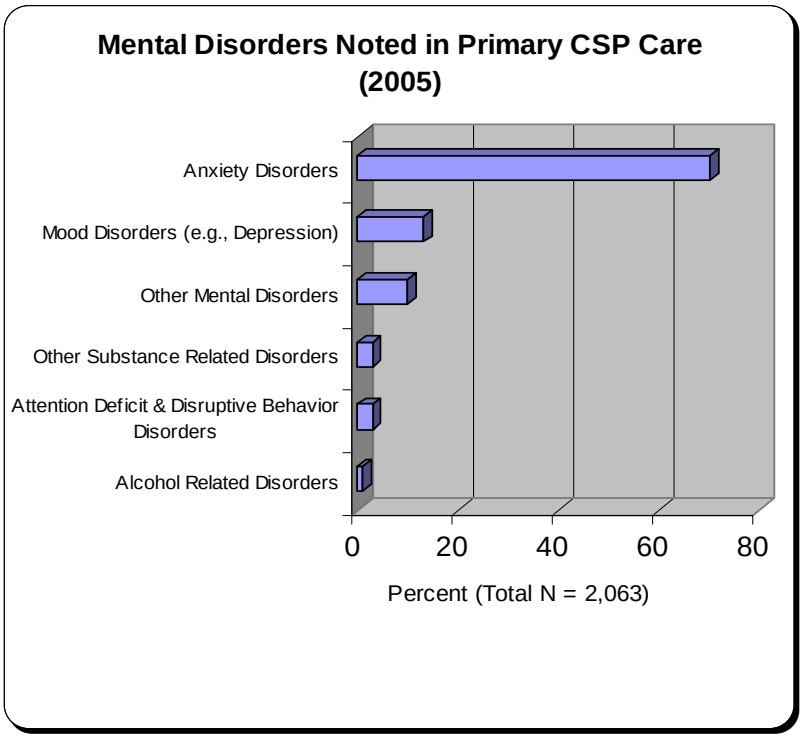
Latinos in rural settings such as the Imperial Valley thus face the potential "double jeopardy" of regional and ethnic-specific service deficits.[16] At the same time, they have substantial mental health needs. One study, for example, noted that 51% of Latino farmworkers in North Carolina described themselves as experiencing high levels of stress. They ascribed this stress to work problems (e.g., job instability), language issues, immigration status, and drug / alcohol abuse.[17] Hypertension and psychosocial issues have also been noted as common problems among Mexican immigrants in rural settings.[18] Finally, levels of anxiety and depression among Latino (particularly Mexican American) adolescents have sometimes exceeded those of their non-Latino White counterparts.[19,20]

These realities have prompted regulatory, policy, and ethics initiatives. The standards of various

professional groups (e.g., the American Psychological Association) now recognize culture as an important factor in prevention and treatment.[21] The California Board of Psychology has developed outlines specifying cultural factors in mental health service provision.[22] On the federal level, the U.S. Department of Health & Human Services, Office of Civil Rights, has provided guidance on how to assure that healthcare practices comply with prohibition against national origin discrimination, as it affects persons with limited English proficiency under the Civil Rights Act of 1964.[23] In addition, the US Office of Minority Health (OMH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have each developed national standards for culturally and linguistically appropriate care.[24,25] Despite such initiatives, progress toward culturally competent mental health care has been modest. Mental healthcare systems have, for example, been described as slow to address culture-specific needs of various populations.[26,27]

Consequently, the US Department of Health and Human Services' national *Healthy People 2010* agenda continues to list "eliminate health disparities" as one of its primary goals.[28] In this context, Focus Area 18 (Mental Health and Mental Disorders) is an important topic. Perhaps most specific to this discussion, the President's New Freedom Commission on Mental Health's essential goals included: 1) improving access to quality care that is culturally competent (Recommendation 3.1), and 2) improving access to quality care in rural and geographically remote areas (Recommendation 3.2).[7]

Impetus for this Needs Assessment



There is reason to assume that the above-referenced national findings are also reflected in Imperial County. Clinicas de Salud del Pueblo, Inc. (Clinicas), a major source of primary and dental care in the area, has, for example, noted the substantial need for mental health services through its own clinical records. In 2005 Clinicas identified 2,063 patients (in 3,445 encounters) that required various levels of mental health care by way of its Universal Data Systems. Noted difficulties included stress, anxiety, depression, attention deficit and disruptive behavior disorders, and alcohol / drug dependence / abuse. The 2005 figures cited above are similar to those found through Clinicas' records in recent previous years.

While these numbers are significant, they likely under-represent Imperial County's true needs for several reasons: First, the data are limited to clinic patients. Thus the numbers consist only of people who have some contact with community health services. Secondly, they reflect coding done by practitioners who saw the patients as part of their general medical case management. Consequently, the main focus was on physical illnesses, and mental health needs were noted on an adjunctive basis. In short, the system was not set up for mental health issues, and coding was not done by mental health specialists. While limited, these numbers, plus anecdotal information, do however show that a service need exists. As such they helped prompt our current broader and more systematic needs assessment.

At the same time, a basic review of mental healthcare systems and providers in the Imperial Valley shows that present services are limited (see resource list in Appendix B). There are comparatively few mental health providers (psychiatrists, psychologists, licensed clinical social workers, or marriage & family therapists) in private practice valley-wide. Even fewer are located outside El Centro and / or are economically accessible to those with limited financial means.

The mandated local government-based institution is Imperial County's Behavioral Health Services. According to its literature and an interview with one of its administrators, service eligibility is based on criteria under California Welfare and Institutions Code Section 5600.3. This section describes criteria for "seriously emotionally disturbed" children and adolescents as well as adults with a "serious mental disorder." In other words, it focuses on those in crisis (e.g., who are suicidal) and those who have major and persistent impairments. The County's literature further describes people who meet "medical necessity" as eligible for services.[29] From the assessment standpoint "medical necessity" means that (a) an individual's symptoms meet the Diagnostics and Statistical Manual of Mental Disorders' (4^{th} Ed – Text Revision)[30] criteria for a substantial mental disorder and (b) that symptoms notably impair a person's activities of daily living (e.g., working, going to school, taking care of children).

Taking these eligibility criteria together, it is our best conclusion that the County's present system serves people requiring emergency services and those with severe disorders. In short, it assists persons needing the highest level of care. We further understand that primary care is presumed to handle less severe cases.

It is understandable that mental health systems use their limited resources to triage care toward the most in need. But it is also true that this approach severely limits early intervention. The overall Imperial Valley service realities described above appear to match those found common but problematic in rural environments by the President's New Freedom Commission. This raised questions about what happens to people with "legitimate" but moderately severe difficulties. Do they receive appropriate services that reduce their time in distress? Or do they end up having to wait for services until their condition has become more severe (and will thus require more intensive and costly intervention)? Do people get services at all? Are services culturally and

linguistically appropriate? Is there a need for increased outpatient care in the area? Such questions prompted this needs assessment.

Over the past 34 years, Clinicas de Salud del Pueblo, Inc. (Clinicas) has become the leading outpatient health service agency for Imperial and Southeast Riverside Counties. A Federally Qualified Health Center (FQHC), Clinicas operates eight comprehensive community health clinics, two dental clinics, and three Women, Infant and Children (WIC) programs. Its health centers are located in designated Medically Underserved Areas (MUA) and High Migrant Impact (HMI) areas. In 2003, Clinicas' service network provided a total of annual 134,379 visits to over 40,000 patients.

Its broad infrastructure placed Clinicas in a good position to complete this assessment. In part, results will serve to inform Clinicas' internal scope of services (e.g., if and how outpatient mental health care should be initiated). But we also hope that the assessment will prompt additional organizations, particularly in cooperative efforts, to bring needed attention and resources to the Imperial Valley.

This section provides a basic description of the methods and procedures used in our needs assessment. Because the report is designed for community members and professionals who do not necessarily have an interest or a background in statistical analyses and other technical research issues, we limit such details.

Overall, we used and integrated three basic methods to collect information: 1) paper-and pencil surveys 2) focus groups with community members, and 3) individual interviews with "key stakeholders" who, by virtue of their professional experience and/or position in the community, had a broader overview of the issues relevant to this assessment.

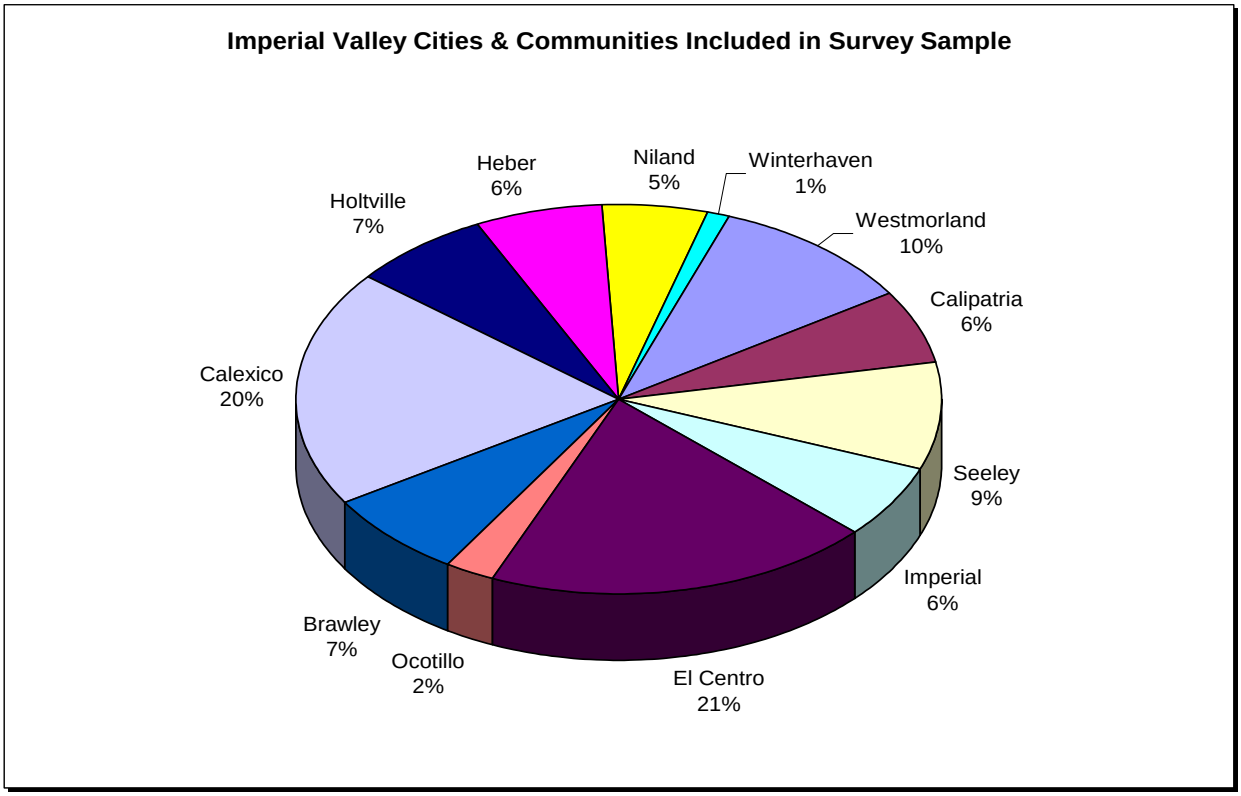
Because they involved more informal discussions, the latter two methods allowed us to learn unexpected information. We had basic protocols for these conversations (see Appendix A). But the process also enabled us to pursue important topics we simply had not considered at the outset. This approach is often best when relatively little is known about a particular set of circumstances. Surveys, on the other hand, provided information that could undergo statistical analyses. We could consequently use such data to identify significant mathematical relationships between people's background and experiences. Survey information was analyzed using the SPSS 11.5 statistical software package. Focus group and key stakeholder transcripts were reviewed using standard qualitative methods.[31,32] and the QSR NVivo software. We believe that combining and integrating these methods (e.g., by identifying results that are consistent across data types) allowed us to get a fairly broad impression of community needs. Each is discussed in more detail below.

The Survey

In total, 413 adult volunteers completed our survey between November 28, 2005 and March 1, 2006. As shown in the chart on the next page, they were collected in the Imperial Valley cities and communities of El Centro (21%), Calexico (20%), Westmorland (10%), Seeley (9%), Holtville (7%), Brawley (7%), Heber (6%), Imperial (6%), Calipatria (6%), Niland (5%), Ocotillo (2%), and Winterhaven (1%). Survey results further included a small group of 11 adolescents ages 13 to 17. All were from Seeley

The survey instrument included questions about respondents' demographics (age, gender, education, marital and employment status, income, country of origin, people in household, ethnic / national origin or descent, generational status). We also asked several questions about general and mental health insurance coverage, mental health service preferences, and experience with mental and general health care providers. Finally, we assessed acculturation and any personal difficulties respondents were having. Acculturation is the degree to which people have learned the skills and customs that comprise mainstream US culture. English speaking ability is a large, but not the only part of this process. Acculturation was measured using the Bidimensional Acculturation Scale for Hispanics (BAS).[33] It is noteworthy that

"acculturation" is not the same as "assimilation". The latter presumes that people will automatically loose the customs and values they have brought from their country of origin as they become "more American". Acculturation, on the other hand, presumes that people can choose to be bicultural. In other words, they can learn skills necessary for life in the US without giving up customs and practices from their country of origin they believe valuable. We measured acculturation in a way that accounts for biculturalism.



Finally, personal difficulties were assessed through the Brief Symptom Inventory (BSI).[34] The BSI measures a broad range of psychopathology while, with 53 items, it remains short compared to many similar measures. The BSI can be administered to persons 13 years or older. Its items are written at the 6th grade reading level. Several studies have supported the BSI's use in English and Spanish, and with Latinos.[35,36]

The BSI provides three indices of global functioning. Global Severity Index (GSI) measures a person's overall psychological distress level. The Positive Symptom Distress Index (PSDI) assesses symptom intensity, and the Positive Symptom Total (PST) provide the overall number of self-reported symptoms. Finally the BSI includes nine subscales which help to pinpoint the type of distress or disorder a person is experiencing. These are:

- Somatization (SOM) (distress associated with perceived physical problems)
- Obsessive-Compulsive (O-C) (unwanted but persistent thoughts and impulses)
- Interpersonal Sensitivity (I-S) (feelings of personal inferiority and discomfort around others)

- Depression (DEP) (sad mood and affect, a lack of motivation, and lost of interest in life)
- Anxiety (ANX) (nervousness and tension, feeling apprehensive and panicky)
- Hostility (HOS) (feelings of anger and wanting to lash out at people or objects)
- Phobic Anxiety (PHOB) (fearfulness of some specific person, place, object, animal, or situation)
- Paranoid Ideation (PAR) (persistent and unwarranted suspiciousness / fearfulness of others)
- Psychoticism (PSY) (odd and unusual thoughts often associated with psychotic disorders)

The BSI's inclusion on the survey also allowed us to see how the number and type of difficulties reported by our participants match those in the broader US population.

Surveys were provided in English and Spanish. Validated Spanish versions of the BAS and BSI are widely available. Demographic and other survey questions were translated into Spanish using standard backtranslation methods.[37] Project *Salud Libre* staff members were available to individually helped respondents (e.g., those with low literacy levels) fill out the questionnaires.

Focus Groups

Project *Salud Libre* conducted 10 focus group meetings (with a total of 82 people) at various Imperial Valley cities and communities over the course of the project. Specific sites included Casa Para Mujeres in Brawley, Club de Nutrición "Vida Sana," the House of Hope, and Clinicas de Salud del Pueblo in El Centro, Guadalupe Shelter in Calexico, and other locations in Heber, Holtville, Imperial, and Westmorland. Eight groups were conducted in Spanish. The remaining two included bilingual (English / Spanish) comments.

Protocols asked community members about the types of stressful events and emotional problems people in the Imperial Valley tend to experience, why such problems exist, who is most susceptible to them, related physical illnesses, how problems impact people's daily life, and how individuals have tried to cope with these difficulties. It further asked if people in distress are receiving the professional help they need, where they tend to go for help, what the facilitators of and barriers to care exist, what types of services should be offered in the future, and what ways work best to reach people in need. The complete protocol is provided in Appendix A.

Key Stakeholder Interviews

Finally the *Salud Libre* team conducted 20 individual interviews with persons who had the vantage point of a community leader, professional, or other respected individual. We focused on talking to persons from a broad range of backgrounds to understand the needs of diverse groups, women, and adolescents. Key stakeholders included those from local school systems, higher education, general health care, mental health care, housing, government, law enforcement, social service, and community-based organizations. Interview locations included

Holtville, Calexico, El Centro, Brawley, and Seeley. Questions were similar to those asked in our focus groups.

Project Salud Libre Risk Management

All information collection methods and procedures were designed to protect the confidentiality, rights, and welfare of persons who chose to participate in the research. Adult participants were presented with written and oral informed consent procedures which informed them that their participation was confidential and voluntary, that they could withdraw at any point, and that their decisions regarding participation would not impact their future relationship with Clinicas or other involved parties. They were also informed of any potential risks and given project contact information in case they wished to ask any later questions or express any concerns. Parental consent and participant assent was obtained in the case of adolescent participants.

Analyses

Analysis of focus group and key stakeholder transcripts centered on identification of common themes. Statistical analyses of surveys included 1) the assessment of basic demographic information and 2) inferential techniques (e.g., multiple regression) that explored the relationships between people's demographic profiles, acculturation factors, and emotional difficulties. Because this report is written for a broad audience, we have not included statistical nomenclature in the body of the text. But all described relationships between various factors from survey data (differences between genders and other groups, links between background and psychological symptoms, etc.) were "statistically significant" ($p<.05$). In other words, there is at least a 95% certainty that these findings reflect "real-world" situations rather than errors and/or random fluctuations in our data.

Methods used to collect our information allow us to draw some conclusions with more, and some with less certainty. Since we included people who were available to us (e.g., who volunteered), we cannot assume that our sample is completely representative of all communities in the Imperial Valley. Consequently, we cannot say with certainty that they experience the exact same proportion of symptoms as noted in our survey sample. The relatively large and broad-based survey sample, coupled with our interviews, does increase the likelihood that our evaluation of existing needs is reasonably accurate. In addition, we can be reasonably certain about links between the type of problems people with such experiences have, what demographic factors they are linked to, and how people try to cope with them. Given our desire to facilitate effective mental health services, this was the information of prime importance to us.

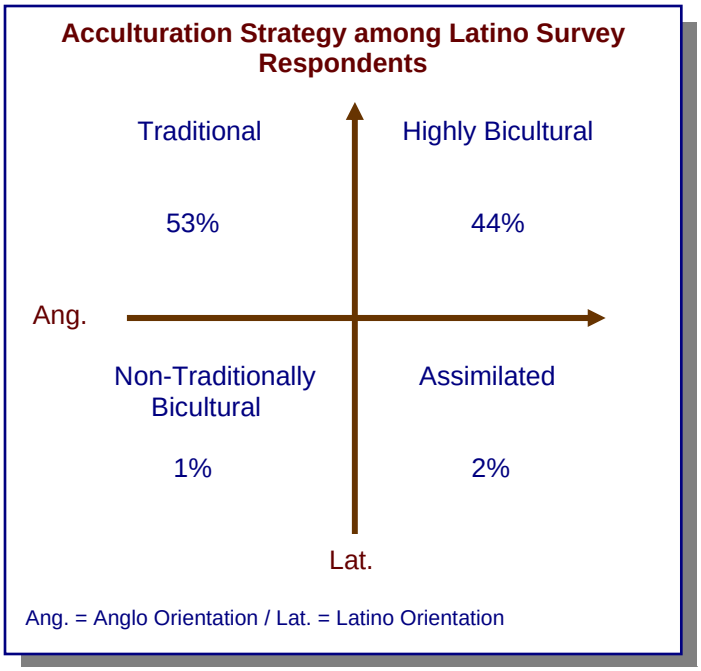
Participants

This section provides a demographic overview of participants who shared their experiences and circumstances with the *Salud Libre* team.

Basic Survey Demographics: Origins, Language, & Acculturation: Of the 413 adults who completed our survey, most (85%) chose to do so in Spanish. The remaining measures were completed in English. The sample included a slightly larger number of women (54%) than men (46%). Ages ranged from 18 to 83 (average = 40).

Eighty percent of respondents self-identified as Mexican American. Of the remainder 18% described themselves as Latino, two people (less the 1%) were non-Latino Whites, and 5 (1.2%) were American Indians. Even among those using the terms "Latino" or "Hispanic," 78% reported they were born in Mexico. In short, the sample was overwhelmingly of Mexican origin or descent. In addition, most (80%) were first-generation immigrants. Other non-US countries of origin cited by Latinos were El Salvador, Guatemala, and Nicaragua.

Among Latinos, less than half (45%) described themselves speaking English "well" or "very well." On the other hand, 98% indicated speaking Spanish "well" or "very well." In addition, 95% reported being literate in Spanish, and 45% said they were literate in English. Only two people completing the survey reported speaking languages other than English or Spanish. These additional languages were French, Italian, and Portuguese.

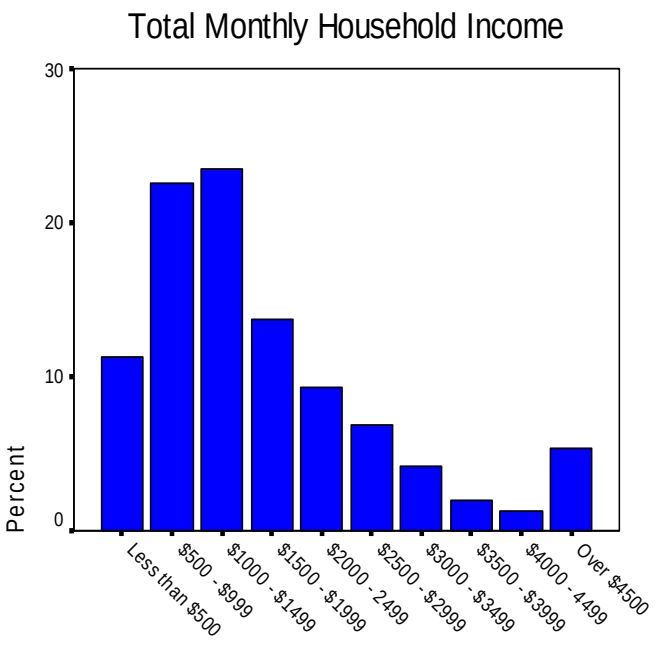


Our assessment also considered overall acculturation styles and choices among Latinos. The concept of "acculturation" includes but goes well beyond language use. It also considers ethnic self-identification, who people generally associate with, the media sources they attend to, and related factors. The most common theoretical model differentiates between four acculturation styles: (a) people who have not acculturated very much (traditional), (b) those who have maintained their country of origin traditions and also adopted the language and some norms of their new country (highly bicultural), (c) people who have dropped traditional skills and norms in favor of those of their new country

(assimilated), and finally (d) those whose acculturation process includes unique new elements not readily identifiable as coming from their original of new country (non-traditionally bicultural or "marginal"). Most Latinos completing our survey were either "traditional" (53%) or "highly bicultural" (44%) in their approach to acculturation.

Lifestyle and Family: A majority of survey respondents (55%) were married, 20% were single, 8% were living with a partner, 7% were divorced, 6% were separated, and 4% were widowed. Roughly 12% lived by themselves, and 76% had children 17 years of age or younger living with them. The average number of persons per household was 3 (and ranged from 0-10) and the average number of children among those who had them was 2 (ranging from1 to 7).

Socioeconomic Status (SES): All indicators we measured showed that a majority of adults completing our survey fell at the lower end of the socioeconomic spectrum. Almost half (49%) had not completed a high school diploma or its equivalent and only 7% had a college degree. The full educational breakdown was as follows: Three percent reported no education beyond Kindergarten, 18% had no further schooling than the 6th grade, 17% had only completed 9th grade, 12% had stopped schooling at the 10th or 11th grade, 25% had a high school diploma or its equivalent, 18% had some college, 4% had obtained a four-year university degree, and another 3% had a post-graduate degree (Masters or Doctorate). Among all respondents 64% completed their formal education in the Mexico and 35% had done so in the US. Other schooling in El Salvador, Nicaragua, and Guatemala was also described. It is noteworthy that a quarter of respondents said they were in the process of furthering their education in one way or another.



At the time of the survey 33% were employed for wages, 12% were self-employed, 25% were students, and 13% listed themselves as homemakers. Eight percent reported being unemployed and looking for work. The remaining people said they were retired, disabled, or otherwise unable to work. Most commonly listed occupations included fieldworker (14%) and sales (3%).

On average, survey respondents' monthly income was also limited. More than 33% made below $1,000 per month and 71% of the sample's reported monthly income fell below $2,000. Only 6% said they made over $4,000 per month.

Adolescent Survey Respondents: The 11 adolescent survey respondents ranged in age from 13 to 17 years (average = 15). Six (55%) were girls and 5 (45%) were boys. All self-identified as

Mexican American or Latino, completed the questionnaire in English, were attending school in the US, and were highly bilingual. Two (18%) had been born in Mexico and the remaining 9 (82%) were born in the US.

Focus Groups The 82 individuals who participated in *Salud Libre* focus group meetings were from a variety of communities including Brawley, El Centro, Calexico, Heber, Holtville, Imperial, and Westmorland. Participants' age ranged from 20 to 87 years (average = 44). Most (77%) were women. Eighty-one percent had been born in Mexico, and listed Spanish as their primary or only language. Average time of residence in the Imperial Valley was about 19 years (and ranged from 3 months to 73 years).

Key Stakeholder Interviews: Our 20 key stakeholders included persons from a broad range of backgrounds to understand the needs of diverse groups, women, and adolescents. Key stakeholders included those from local school systems (e.g., counselors), higher education (e.g., professors), general health care (e.g., primary care physicians), and mental health care. They further included people from housing, government, law enforcement, social service, and community-based organizations.

Community Stressors and Circumstances

Asked how commonly people in the Imperial Valley experience stressors and emotional difficulties, all key stakeholders agreed that such problems are substantial and require solutions. Sixteen of 20 stakeholders described major stressors as "very common" or being present "all the time." They further estimated that 35% to 50% of the general population is experiencing notable difficulties. Those working for service agencies tended to report higher proportions (e.g., up to 80%), presumably because their profession fosters direct contact with most-in-need sub-groups.

Frequently Cited Stressors

- Unemployment and limited income (e.g., transient / seasonal nature of farm work)
- Separation of families due to economics (e.g., one spouse seeking work elsewhere)
- Isolation ("nothing to do," separation of family, distance between population centers, language problems)
- High cost of housing and utilities (e.g., during summer heat)
- Limited positive activities for children / adolescents
- Heat during summer months
- Physical illnesses including asthma, allergies, diabetes, heart disease, and cancers

Focus members also agreed that there are pervasive local stressors. When asked what kinds of difficulties people in the Imperial Valley tend to experience, they most commonly discussed a number of economic issues. Community members, for example, cited unemployment and seasonal (e.g., agricultural) work as one major problem. They said that, because of poorly paid and unstable jobs, individual family members (e.g., husbands) often leave home to seek work elsewhere. This results in a disruption of family life and support. Women are, for example, left at home with their children. Consequently

people feel more isolated and adolescents act out. Sometimes adolescents are left at home alone because both parents have to work.

Other economically tied problems were high utility bills (particularly over the hot summer months), little affordable housing, having to purchase medicines because many are not covered by other assistance, and ever-rising gasoline prices. Almost all in the focus groups expressed some insecurity about the region's economy and their personal abilities to "make ends meet." Additional problems included the extreme summer heat and a lack of "things to do." This reportedly contributes to further isolation and family conflict. Some noted that there are local activities, but that they can not participate because they lacked the money and / or English language skills to do so.

Key stakeholders concurred that low socioeconomic circumstances contribute to the stresses many people in the Imperial Valley experience. They further noted that problems are exacerbated by poor physical health, a large number of children per household, family breakdown and abandonment, single parenthood, a general lack of education, and limited parenting skills. They cited the latter as contributing to child abuse and poor childhood development. Regarding this topic one stakeholder commented "*I believe that* (they) *all want to be good parents, but they just don't know how*."

Another stakeholder also said that many young military service members are likely to, or have already gone to fight in Iraq. That generates obvious stress for the deployed individuals and their families. The stakeholder further commented that, other than law enforcement, skills people learn in the armed forces do not fit well with the requirements of the Imperial Valley economy. Consequently ex-service members often wind up moving or being unemployed.

Focus group members generally expressed the opinion that stressors were exacerbated by a lack of social / government support, their own limited communication skills (including among family members, particularly with their children), alcohol and drug abuse / dependence, and lack of opportunities to improve life. One participant summed up the general sentiment by saying "*there is a lack of information and support and education. Even if some opportunity exists we don't have the resources at hand to use them. Also life in a small town tends to be more stressful because there is nothing to do*."

Types of Emotional Distress

Stakeholders and focus group participants mentioned depression as the most common reaction to stress. They described impacted persons as often lonely and abandoned. General frustration and anxiety was second among commonly noted problems. Some described adolescents as particularly nervous and said they tend to respond to stress with anger. Other cited mental health problems included Posttraumatic Stress Disorder (PTSD), antisocial behaviors, and psychotic disorders (e.g., Schizophrenia) among adults. Attention Deficit / Hyperactivity Disorder (ADHD) was described as a problem among adolescents and children. Mental health difficulties

were also noted among adult survey respondents. Only 17% reported no symptoms whatsoever. The fifteen most common and severe individual difficulties among those who described having some on the Brief Symptom Inventory (BSI) were as follows (in rank order):

1) feeling easily annoyed or irritated
2) trouble remembering things
3) feeling "blue"
4) feelings being hurt easily
5) feeling that most people cannot be trusted
6) having to check and re-check what you do
7) trouble falling asleep
8) nervousness and shakiness inside
9) trouble concentrating
10) feeling tense or keyed up
11) numbness or tingling in parts of your body
12) difficulties making decisions
13) feeling that other people will take advantage of you if you let them
14) feeling lonely
15) temper outbursts that you could not control

As first described in this report's methods section, the BSI also allows for the analysis of reported symptoms in a number of different ways. First, it merges individual responses into clusters that are common to specific disorders (e.g., anxiety, depression). Secondly, it allows comparisons of these symptom clusters, as well as the three more global indicators of overall distress, to people in the broader population. For this assessment we reviewed how our survey sample compared to other men and women from the general population not receiving mental health services. In addition, we compared our results to other people who were receiving outpatient mental health services when they completed the BSI. In this process we were able to determine the percentage of our Imperial Valley sample that (a) was not experiencing substantial distress, (b) was experiencing some noteworthy distress, and (c) was experiencing distress at a level equivalent or greater than most people who have sought outpatient mental health treatment.

Taken together, results show that about 40% of women and 45% of men reported difficulties that are average for people who are not in any substantial psychological distress. About 28% of men and women described a level of overall distress that is clinically significant. Formal diagnoses are never made on the basis of one measure or test. But people with "clinically significant" symptoms would benefit from a more comprehensive individual evaluation.

Finally, about 10% of women and 9% of men reported difficulties that are equal to or greater than those of people who are in outpatient mental health settings. It is noteworthy that the BSI also allows for comparisons to those receiving services in inpatient (e.g., hospital) settings.

Contrary to what one might think, acute distress in such settings tends to be a bit lower than for people receiving outpatient treatment. Perhaps because inpatients are in a closed-off and highly structured place, they are (at least temporarily) not dealing with the daily "real-world" stressors on the same level as outpatients. In short, the level of distress noted for "outpatients" on the BSI is some of the most severe.

A review of the nine symptom groups showed that many people see their distress as associated with physical problems (somatization). While general anxiety did not stand out as more prevalent than other types of distress, fearfulness of specific situation (e.g., nervousness when left alone) was one of the most common problems for both men and women. In general, people also reported some suspiciousness of, and discomfort around, others. The overall prevalence of depression did not stand out as large when compared to other problems. But several difficulties often associated with depression (trouble concentrating and remembering things, insomnia, feeling lonely) were some of the most frequently mentioned. While they did not describe any intent or plan to act on their feelings, 4% of respondents acknowledge having had some, at least moderate, thoughts about suicide and death.

Finally, about 9% of women and 8% of men had symptoms often associated with psychotic disorders (e.g., ideas that someone controls your thoughts) at levels equivalent to people receiving outpatient treatment. While these results are noteworthy, we also caution that psychological instruments sometimes yield overly inflated scores on "psychotic" dimensions because of the way symptoms are culturally presented. A table showing overall BSI results follows.

Women			
Clinical Dimensions	% at or below average for those not in treatment	% with clinically notable symptoms	% at or above average clinical outpatients
Somatization (SOM)	43.1%	31.7%	31.7%
Obsessive-Compulsive (O-C)	45.9%	29.4%	10.1%
Interpersonal Sensitivity (I-S)	50.0%	28.0%	10.1%
Depression (DEP)	50.5%	31.2%	6.4%
Anxiety (ANX)	48.2%	24.3%	7.3%
Hostility (HOS)	52.8%	28.0%	13.8%
Phobic Anxiety (PHOB)	56.4%	27.1%	20.6%
Paranoid Ideation (PAR)	30.3%	33.5%	23.9%
Psychoticism (PSY)	49.5%	33.5%	9.6%
Global Scales			
Global Severity Index (GSI)	40.8%	31.7%	9.2%
Positive Symptom Total (PST)	39.4%	30.7%	15.6%
Positive Symptom Distress Index (PSDI)	38.6%	22.8%	6.6%

Men			
Clinical Dimensions	% at or below average for those not in treatment	% with clinically notable symptoms	% at or above average for clinical outpatients
Somatization (SOM)	55.1%	26.5%	26.5%
Obsessive-Compulsive (O-C)	44.9%	24.3%	8.1%
Interpersonal Sensitivity (I-S)	50.8%	33.0%	5.4%
Depression (DEP)	45.9%	29.7%	4.9%
Anxiety (ANX)	60.0%	18.8%	3.8%
Hostility (HOS)	43.2%	22.7%	22.7%
Phobic Anxiety (PHOB)	63.8%	20.5%	15.7%
Paranoid Ideation (PAR)	43.8%	21.6%	21.6%
Psychoticism (PSY)	50.3%	27.6%	8.1%
Global Scales			
Global Severity Index (GSI)	45.4%	27.6%	4.9%
Positive Symptom Total (PST)	49.7%	28.1%	9.2%
Positive Symptom Distress Index (PSDI)	42.5%	24.8%	13.1%

Adolescents: Most of the adolescents in our sample (81%) did not show signs of clinically significant problems. But some difficulties were noted. The most common of these were suspiciousness of and hostility toward others, somatization, and depression. Because our sample of adolescents was so small, results have limited generalizability to other adolescents in Imperial County and must be treated with caution.

Gender Differences: Overall, BSI results showed that women were more likely to cite difficulties than men. Similar results have been found across many other locations and cultures. We note that such results do not automatically mean that women have more distress, but that they are more willing to acknowledge it. Men were more likely to acknowledge physical responses to anger (e.g., having the urge to break or smash things) than women.

Asked to elaborate on gender-specific issues, focus groups also noted fairly stereotypical differences. They described men as trying to deny problems while they saw women as more emotional and willing to seek help. At the same time, respondents said men act out, sometimes with violence, by leaving the family, and / or by getting drunk while women are left "*in isolation*" and "*children suffer it all.*" They also expressed concern that "*the Government at times takes your children*" (presumably in response to child abuse or neglect). Adding to the discussion on family dynamics, participants complained that poor economic conditions, lack of community support, and lack of mental health services as perpetuating distress. But they also acknowledge that "*we don't know how to communicate well, or look for help to improve ourselves*." One man noted: "*Many of us have a home but we live in the street. Our families don't believe that we want to change.*"

One key stakeholder expressed hope, saying that men are now more likely to be open and seek services than in the past: "*I think men are now seeking therapy more. I'm finding that 15 years ago they were showing up because their wife was bringing them in. Now they are showing up because "my wife is not happy…I give her everything, but she is not happy." They are now showing up on their own. For women it is a little different because they are no longer looking at their partner to fix their problem. They are now saying something is wrong instead of if only he would change."*

Susceptibility to Emotional Distress: Within four of the focus groups, children and adolescents were identified as at particular risk for emotional problems. Respondents described a lack of productive activities youths could participate in and expressed worries about a number of consequences including teen pregnancies ("*children having children*"). They also noted suicidal ideation as a problem. One participant said that "*… today there are many of the young people who want to commit suicide*". Focus groups expressed further concern that some problems are generational. For example, they described drug / alcohol use and dysfunctional ways of interacting with others as passed on from parents to their children. In addition, focus group members said those with little education were at particular risk of risk of emotional difficulties.

Most Susceptible to Emotional Distress

- Children / adolescents
- People with limited income
- The elderly
- Women
- Those who are less acculturated (e.g., limited English speakers)

Stakeholders most frequently cited those from low income household, children, and the elderly as being at particular risk. One person summed up a common economic problems by saying *"Unfortunately, most of our population is low income. They tend to work in very physical / manual labor such as in the fields. They have a high risk of depression because once they suffer a work related injury, and are displaced from their work they don't have any skill to go anywhere else. They fall into a depression or anxiety because they can't do anything …* (even though) *they want to."*

Statistical analyses on BSI results also showed that Latinos who were more acculturated (e.g., spoke more English) described fewer total symptoms than those who were more traditional. In addition, acculturation was linked to less somatization, fewer obsessive-compulsive thoughts, less interpersonal sensitivity, and less anxiety. Highly acculturated women tended to report the least anxiety.

Physical - Mental Health Relationships

As noted in the BSI results, survey respondents often cited physical problems. Key stakeholders and focus group members also mentioned the negative impact of stressors on general health. One focus group respondent, for example, said *"Without working and with so much heat if you become stressed out, you wind up straight to the hospital*."

Asked to elaborate on the connections between physical and emotional problems, two focus groups specifically described the negative impact of a physical problem on emotional well-being, both for the disabled and their caretakers. Another highlighted the relationships between stress and weakened resistance to disease. Finally, one noted that people tend to experience emotional distress (e.g., anxiety) as physical symptoms, saying: "*I know a lady. They took her to the hospital for heart problems and because she could not breathe. Once there they told her that she doesn't have anything* (physically) *wrong with her*."

Nineteen of twenty key stakeholders mentioned relationships between physical disorders and mental health issues. Many specifically highlighted asthma, allergies, and other respiratory problems as common because of the Imperial Valley's agricultural environment, and said this is a source of emotional distress. In addition, respondents described type 2 diabetes (fostered by obesity and lack of physical activity), cancer, and heart disease as common illnesses. One stakeholder commented "*Pretty much every person you talk to here has been touched by a death due to cancer. Pretty much every person you talk around here knows someone who has some type of upper respiratory problems*." Another added "*If you have heart disease, diabetes, or chronic pain…it will eventually cause depression as well as the medication that is being administered could cause symptoms of depression or anxiety*."

Speaking about physical disabilities, one respondent said: "*For example, if the person is wheel chair bound it is difficult for the person to get used to depending on others, especially Hispanic men. The whole 'machismo' just adds to it.* "

Drugs and Alcohol

In detailed conversations, both focus group members and key stakeholders described alcohol and drug abuse / dependence as a major concern in the Imperial Valley. Some stakeholders cited the problem as "rampant." Others estimated that up to 90% of the people they served had alcohol or drug problems. One commented:

> "*This morning I stopped to get gas, and everybody was walking out with a 12 pack so early in the morning. I don't know if it was for later in the day or to start the day. Alcohol use in the Imperial Valley is high*."

Alcohol was most frequently described as a problem by almost every focus group and key stakeholder. Drugs mentioned by key stakeholders in order of frequency were methamphetamines, marijuana, heroin, and crack cocaine. Respondents also discussed inhalant use, but at lower rates than they mentioned other drugs. When referring to adolescent drug abuse, nothing was ruled out. One stakeholder said they use "*anything that's inexpensive. Anything this is available – if it's around, kids around here are doing it*." Others added that adolescents, more than adults, go directly to drugs (rather than starting with alcohol) and that

the problem is growing. They tended to describe those who use alcohol as “generational users.” In other words, their parents also drink heavily.

Finally, stakeholders cited Mexicali, Mexico as the place where people go to obtain drugs including “Roche” (trade name Rohypnol / generic name flunitrazepam). It is noteworthy that Rohypnol is a powerful benzodiazepine not legally used in the US. Benzodiazepines are a family of anti-anxiety medications known to be habit forming with long-term use. Rohypnol has further been noted as a “date rape drug” because it has been used to incapacitate and then sexually assault individuals.

Frequently Abused Substances

- Alcohol
- Methamphetamines / crystal
- Marijuana
- Heroin
- Crack cocaine
- Rohypnol

Like key stakeholders, focus group members cited alcohol most frequently but also mentioned, marijuana, “crystal meth,” cocaine, heroin, and “pills.” They also agreed that alcohol abuse / dependence is more of a problem with adults while adolescents are more likely to use various drugs. Both key stakeholders and focus group participants said drugs and alcohol are used to relieve boredom, to self-medicate, and because addiction then perpetuates the problem.

We did not ask our survey respondents if they had any history of alcohol and/or drug use. Thus we cannot make conclusive links between such use and their reported psychological distress. But concerns about physical problems (somatization), suspiciousness of others (paranoid ideation), anger (hostility), and unusual thoughts (psychoticism) can be caused by certain drug and/or alcohol. Thus at least a portion of reported problems may have had their roots in substance abuse / dependence.

Impact on Activities of Daily Living

Focus group members linked mental health problems with multiple impairments in activities of daily living. General family dysfunction, problems working, alcohol / drug use, and gambling were commonly described. Poor school performance and acting out (e.g., truancy, gang involvement, and drug/alcohol use) was specifically mentioned in the case of adolescents and children.

Respondents said they had heard of incidents involving domestic violence, child abuse / neglect, and divorce. Describing adolescents, one key stakeholder said: “*There is a lot of trauma - anger issues because of problems at home. The kids try to take it out on other kids and staff from the school*.”

Other consequences mentioned by focus group members included legal problems (e.g., DWI arrests), loss of respect from others (seeing you as "bad" or "crazy'), and lack of concentration that causes people to be confused and forgetful.

As previously noted, survey respondents also described similar functional restrictions brought on by mental health difficulties. They most frequently cited reduced concentration and short-term memory, difficulty making decision, insomnia, temper outbursts, and "blocked at getting things done."

Mental Illness: Cultural Understanding and Personal Attempts to Cope

Focus groups and key stakeholders noted that few people have any clear understanding about mental health problems. They mentioned depression, stress, inability to sleep, "*nervios*," and "being crazy" as common ways community members describe such difficulties. Some also commented that afflicted individuals are seen as "bad" and problematic. Consequently there are taboos against receiving professional services. In addition, acculturation issues (e.g., more acculturated children in conflict with more traditional parents) were described. Some representative quotes from stakeholders are:

> *"They say 'I have family problems.' They won't say I feel depressed or I have mental health problems. They'll say 'I don't feel good.'"*
>
> *"If they do think that something is wrong…when you say behavioral health they are okay with it, but when you translate it to salud mental …it's like my son or daughter is not crazy. I think that there is a very strong stigma with behavioral health."*
>
> *"Religious beliefs …sometimes people think that we will ask them to negate their religious beliefs. There is also a belief that family member is possessed by an evil spirit."*
>
> *"… misconceptions – that they may receive electric shock treatment. People are not socialized to receive mental therapy. They don't know what to expect."*

At least one stakeholder expressed the belief that people are becoming more educated about mental health issues. The respondent noted that some negative assumptions about mental health problems (that people who have them are bad or weak) are less pronounced than in the past.

We further asked what specific message adolescents and children receive about mental health. Focus group said that they receive little or no information about this topic at home because such things are not talked about or because "*most of us adults don't know anything*, (therefore*) our children know less*." They also commented that some receive "*the wrong information in the street*." But respondents further acknowledged that some families are proactive and encourage their children to seek assistance when needed, and/or do so themselves. One key stakeholder summed this up by saying: *"It depends …if the parents have a sense of values and they are educated about how to deal with emotions … like everybody cries, everybody gets angry…then they will get a positive message. Often though they are told to be quite, to suck it up, to not even think about it etc. Then they start having difficulties at school.*" A few focus group respondents noted that school systems place too-strong emphasis on diagnosing children as hyperactive.

Overall the importance of parenting was highlighted by almost everyone (e.g., "*They tend to learn from home… that old saying 'don't do as a do, do as I say' doesn't work. Children learn from their parents if they are mean and constantly yelling and screaming then that's what the child will learn*.")

Personal Coping Efforts: Focus group members said that some people try to cope with emotional problems in positive ways. They described going for walks, visiting friends and family, reading the Bible and other inspirational books, looking for help through the church, "*thinking positive*," and proactively seeking health care information and assistance. For example a few mentioned the Immigrant Program as providing good advice for families.

They further reported that some people try to ignore problems by being "*occupied with other things. Women clean and sew; men watch TV or escape from their house*." In addition they described attempts at self-medication through drugs, alcohol, and smoking as a major problem. They acknowledge that these methods do not work and that the end result is often acting out (e.g., family violence, children fighting, and people "*looking for all types of problems in the street"*). They said the consequences are family dysfunction (domestic violence, divorce), "*total isolation*," and an increase in symptoms. One respondent described acquaintances who had become more and more anxious and were constantly chewing their fingernails.

Key stakeholders agreed that community members often try to cope through support from family, church and friends, through denial, and by self-medicating with alcohol and drugs. They also cited use of resources in Mexicali, Mexico.

In describing dysfunctional coping attempts, one noted "*Many times they can't handle it and they just give up. They want someone to just come and pick them up…. to come and pick up the children, or whoever is having problems. A lot of families are looking for a place that they can drop them off and have them fix them for them*."

Other stakeholders were more hopeful. One described the situation as "*better than it used to be. People are seeking help, talking more… that everyone has challenges.* (There is now) *a*

healthier sense of coping now than ever before." Another added: "*They're working more with the schools, staff, attending parenting classes and community trainings*."

Traditional Remedies: Focus group respondents cited a number of herbal and home remedies used for emotional problems. Herbs included wild toronjil (*melittis melissophyllum*), balms, teas [e.g., mint, *siete azares* (seven blossom), chamomile, passiflorina (passion flower), *tila* (lime flower), valerian (green), lion tooth], and cholla cactus root. In addition, use of liquid oxygen was mentioned. Some of the listed herbs are known to have sedative properties. Focus group participants also said that some people visit traditional / spiritualistic healers in Mexico to receive *limpias* (to remove curses).

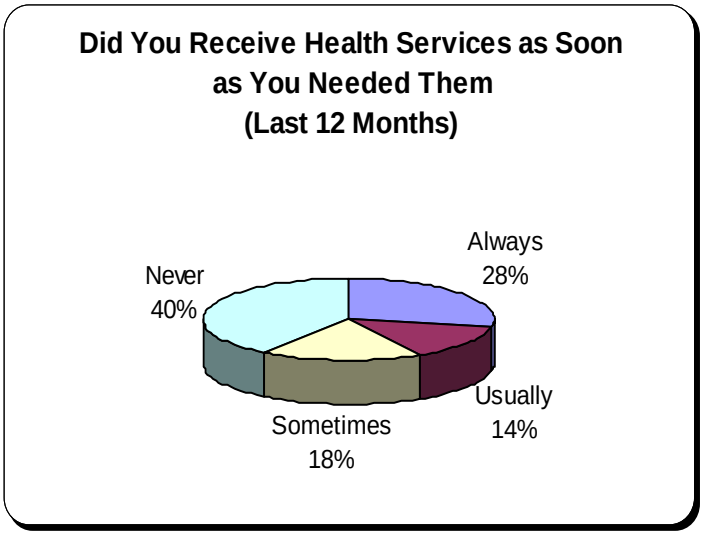
Key stakeholders also described use of herbal remedies such as teas and valerian root. In addition, they said that some people try to use over-the-counter sedatives and cold medications (e.g., Tylenol PM, Nyquil, Sudafed) as remedies for emotional problems. Finally, they acknowledge that a few people try acupuncture and massages and / or go to traditional healers (*curanderos*) for help.

Needs

All the types of information we gathered collectively pointed to major limitations in mental and general health service access. Focus group estimates as to how many persons with mental health needs actually receive professional help ranged from 10% to 60%. On average, respondents put their estimates at around 25%. Several acknowledged that an accurate figure is difficult to obtain because "*who knows; there is not a lot of information in this respect. This is still a taboo and many opt to go to Mexicali where nobody knows you*." Others commented that few people know what potential help exist in the area. Finally one said "*There is little help, until they* (people) *are in very serious problems. If it is emotional the doctor loses* (his or her) *temper but gives you medicines so that you are quiet and don't return*."

In response to the same question, key stakeholders estimates were comparable. They said that somewhere between 20% and 60% of persons in need receive adequate (or in most cases any kind of) mental health care. The most commonly cited estimates were around 30%. Finally, among survey respondents whose symptoms on the BMI matched those generally found among outpatients, 39% reported ever receiving professional mental health treatment, and only 18% had received such care in the previous 12 months.

Survey results also noted general health care deficits. Thirty-three percent of participants reported that they and / or their family members had needed urgent or emergency care within the last year. With 37%, women tended to report such need in greater numbers than men (28%). No substantial difference in urgent or emergency care needs among ethnic or generational status groups was noted.



While a need thus existed, survey results showed that many people requiring care did not receive it in a timely manner. Only 28% said they were "always" able to obtain services as quickly as they felt necessary. Another 14% said they "usually," and 18% reported they "sometimes" received them. Forty percent reported that they "never" received care when most needed, or experienced substantial problems obtaining timely help. We observed no significant differences in this pattern for men and women and across ethnic-origin groups. Limited English skills did, however, impede access to care. Forty-three percent of those who completed the survey in Spanish reported never

receiving timely services. In contrast, a smaller proportion (25%) of those who completed it in English described such problems.

Access & Utilization

Asked why so few people received any or adequate care, focus group members most often described economic issues (lack of money, no or limited insurance coverage including prescription coverage). In addition participants noted a lack of knowledge about health resources, concern about the social stigma associated with mental health issues (being labeled as "crazy"), and limited English proficiency as common barriers. One mentioned that people who are not US citizens worry that seeking services will hurt their immigration status. Finally at least on person said that too many people "*lack interest in their own health*."

Like their focus group counterparts, stakeholders noted people's concern about embarrassment and about the potential impact of government services on immigration status as barriers to care. A majority further cited the lack of available services as a primary barrier. For example, one said *"… lets say* (people are) *dual diagnosed and they need to be in observation, there is only one place on Clark Road that would take them and they only have 6 beds and a waiting list. The only other option is San Diego."* Another cited that existing services are difficult to reach from some locations such as Niland. Overall, a typical comment summing up access issues was:

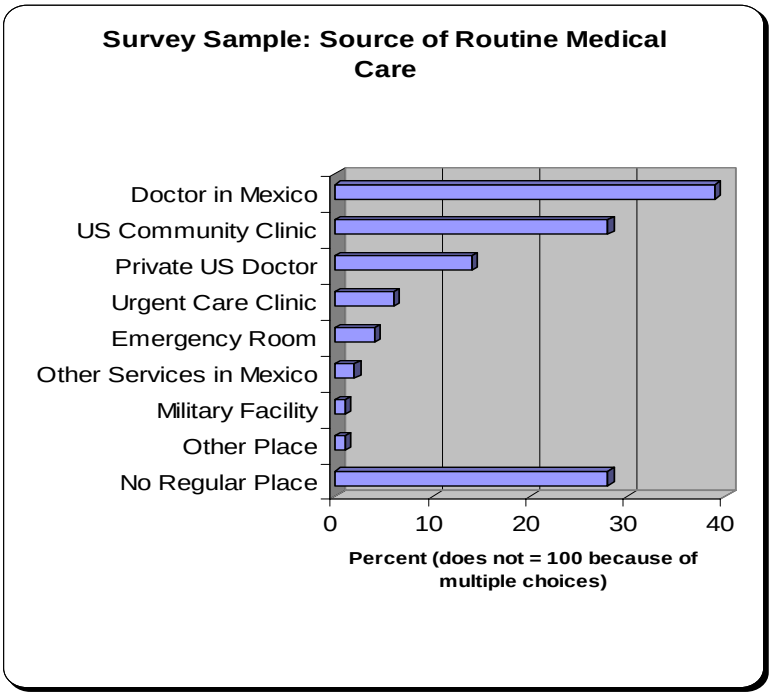
> "*Many look for services, but they are just not available. Language is a barrier for them. If we had more providers here in the Valley that would really help. There really aren't very many service providers other than Behavioral Health and a few private ones. We get many calls saying that they can't find anybody…and if they do, they say that they have an appointment 5 months from now. That's very discouraging.*"

Such comments prompted further questions about current general and mental health care utilization patterns. Everyone participating in *Salud Libre's* various assessment activities was asked about experiences with, and opinions about such care. In this process we asked where people get services, where they get health information, why they choose certain kinds of providers, and what makes care attractive to them. We also posed more detailed questions about any barriers they had encountered. Finally we asked participants to recommend steps that can 1) improve the Imperial Valley's mental health services and 2) inform specific Project *Salud Libre* follow-up activities.

Sources of Health Care & Information

Sources of Routine Care: Asked where community members get basic medical care, 39% of survey respondents said they go to a doctor in Mexico. Another 28% indicated frequenting the

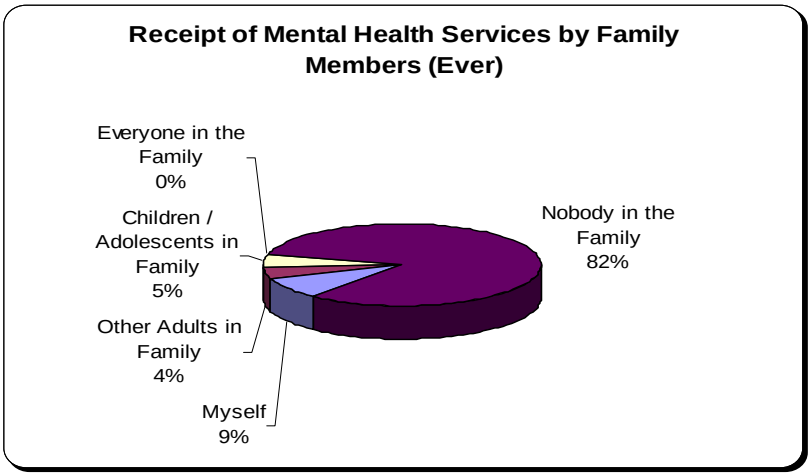
community clinic system and 14% reported going to a private physician in the US. Additional sources included urgent care facilities (6%), emergency rooms (4%), a range of non-physician services in Mexico, and military facilities (1%). Twenty-eight percent reported having no regular doctor or other health care.



Many focus group members also noted that people in the Imperial Valley tend to go to pharmacies in Mexico (Mexicali) because such businesses "*will sell you anything*" without a prescription and are more affordable than US sources. Some said that even adolescents can get easy access to medications there. They further reported that pharmacists often recommend teas (e.g., mint), herbs, and other homeopathic remedies to help people "*sleep or get up*."

Focus groups expressed concern that easy and uncontrolled access to medications results in some people taking many different ones at the same time. Addressing the same problem, one stakeholder who is a primary care doctor noted:

> "*Most … patients come here with medications from Mexicali or I don't know where they get them, and sometimes it's a problem. They have good access to any medication they want across the border and sometimes when they come here they've already been on multiple medications. Most are prescribed by the doctors there, but it's not doing them much good at all*."



Mental Health Care: In the survey sample, a great majority (81.6%) had never received any form of personal or family mental health services. Ninety-three percent had not received any mental health care in the last 12 months. Most who had received services during their lifetime reported obtaining

them from counselors (35%), psychologists (19%) and psychiatrists (13%). Other mentioned sources were marriage counselors, drug / alcohol rehabilitation programs, primary care, neurologists, and "motivational talks." Among those who had care in the last 12 months, psychologists (29%), psychiatrists (29%) and counselors (14%) were the most frequently mentioned providers. Emergency room services were also described by 9%.

We find it particularly noteworthy that of adult survey respondents with the most severe mental health symptoms, only 39% had ever received professional treatment, and only 18% had received such care in the previous 12 months. None of the eleven adolescent respondents reported prior contact with mental healthcare.

On a more positive note, people who had contact with professional mental health care in the US often found it beneficial. Overall, 73% described such services as helpful. People were more likely to report positive outcomes if they had obtained treatment for themselves (79%) or their children (84%), than if care had been received by other adult family members (44%).

As with general health care, Mexico was often mentioned as a source of treatment. Focus groups almost universally acknowledged that many people in the Imperial Valley go to Mexicali for mental health services. Referring to monetary barriers, they noted that some go to healers who "*are not professional but are cheap*." But they added that professional services in Mexico, while overall more accessible than in the US, are also beyond the means of some who need them. Most frequently cited sources of care in the Imperial Valley were County Behavioral Health and urgent care facilities.

Key stakeholders, in order of frequency, mentioned the following US sources of professional care: County Behavioral Health, primary care, emergency / urgent care facilities, and mental health providers in private practice. One added that the correctional system provides care when people are arrested / incarcerated. In addition, stakeholders acknowledged churches and (like focus groups) services in Mexico as noteworthy sources of help.

Asked if they are aware of any local organized efforts (e.g., community programs) that attempt to improve emotional wellbeing in culturally effective ways, twelve of 20 key stakeholders responded with a simple "no." Efforts that were mentioned by the remainder included the Campesinos Project, County Behavioral Health, and Clinicas de Salud del Pueblo (through primary care). In addition, one respondent mentioned the Child Abuse Prevention Council and the Center for Family Solutions as having provided assistance (e.g., parenting classes and groups) in the past. But the stakeholder was not certain if these services are still in place.

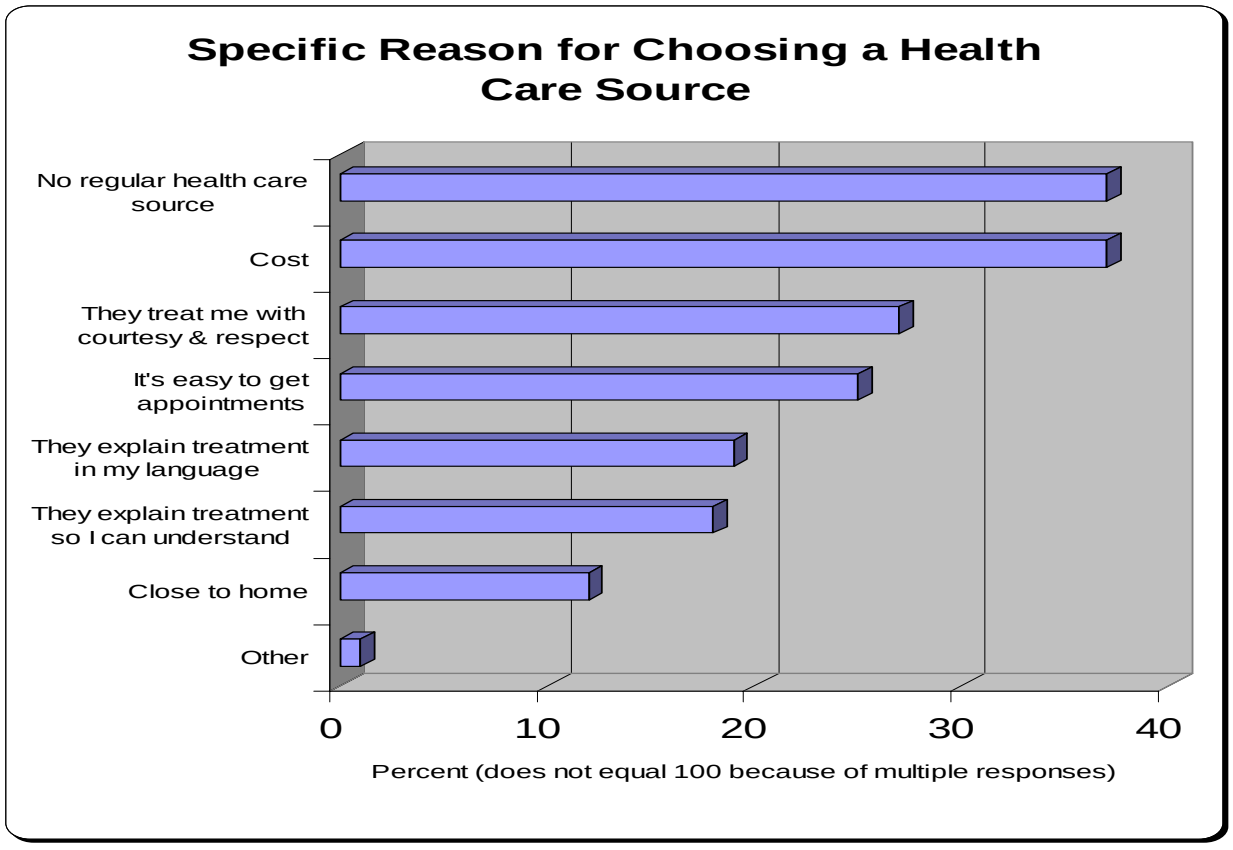
<u>Sources of Mental Health Information</u>: Focus group respondents most often said that community members receive advice about emotional problems from informal sources such as friends, family members, and neighbors. They also described church contacts (e.g., priests and ministers) as often providing advice. Others said that people receive most of their guidance "*in the streets*" and "*in the tavern*." More formal sources mentioned were clinics and providers in

the Imperial Valley, Mexico, and San Diego, County Behavioral Health, schools, resource centers, Alcoholics Anonymous and Narcotics Anonymous groups, and an immigrant program.

Key stakeholders agreed that friends, family, and churches are the most common sources of information. Several also highlighted the positive role of teachers. In addition, they said family physicians and resource centers provide assistance. Overall, formal mental health treatment was infrequently cited. One mental health provider noted:

> "*I usually get them as a last result. Which is after they've had years of trauma. When they can't sleep, have flash backs, panic attacks, depression, are suicidal…it's unfortunate because it shouldn't have to get there*."

Why People Chose Specific Health Care Sources: Survey participants were also asked why they choose one type of health care facility over another. The top six cited reasons in rank order were: cost (37%), they treat me with courtesy and respect (27%) it's easy to get appointments (25%), they explain treatment in my language (19%), they explain treatment so I can understand (18%), it's close to home (12%). An additional 37% said they could not answer the question because they have no regular source of health care. (The overall percentages do not total 100 because respondents were asked to mark more than one option.)



Not surprisingly, limited English speakers cited provider language skills as particularly important. But cost was the most common determining factor for everyone. We find it noteworthy that among those with limited English skills, 39% said they had no regular place to get care. In contrast, 25% of English speakers reported no regular care facility.

Major Barriers to Care

To obtain more details on the barriers to care, we asked survey respondents to tell us about, and rank problems. Specifically, we asked them to describe as many difficulties as they had encountered. Overall, 54% said they had encountered some sort of difficulty. Limited English speaking persons again described more access problems than others. Specifically, 58% percent reported encountering obstacles to health care. In contrast, 49% of English speakers described substantial access barriers. Those reporting difficulties portrayed the following personal and institutional problems:

Specific Access Problems Reported by Survey Respondents (Adult Survey Sample)

Description of Circumstance	English Speakers	Limited English Speakers	All Respondents
High cost of health care	32%	32%	32%
Lack of money*	25%	34%	30%
Lack of health Insurance*	17%	21%	19%
Language difficulties*	6%	24%	18%
Difficulties making appointment*	9%	12%	11%
Finding a doctor	7%	7%	7%
Poor treatment by medical staff	5%	2%	3%
Poor treatment by receptionist	3%	1%	2%
Legal residency status	1%	2%	1%
Other	3%	2%	2%

* indicates significant differences between those with limited English and English speakers

Economic problems (e.g., cost, lack of money, no insurance) were again cited across the board as top access barriers. But limited English speakers reported significantly more barriers due to lack of money, language problems and lack of health insurance, than their English speaking counterparts. They also reported greater difficulties making medical appointments.

Overall, 20% of survey respondents said they had stopped treatment because of poor care on at least one occasion. Contrary to what one might initially expect, more English speakers (33%) than monolingual Spanish speakers (17%) had done so. This difference may be present because English speakers tend to have more service options and can thus "afford" to discontinue poor treatment more readily than Spanish speakers.

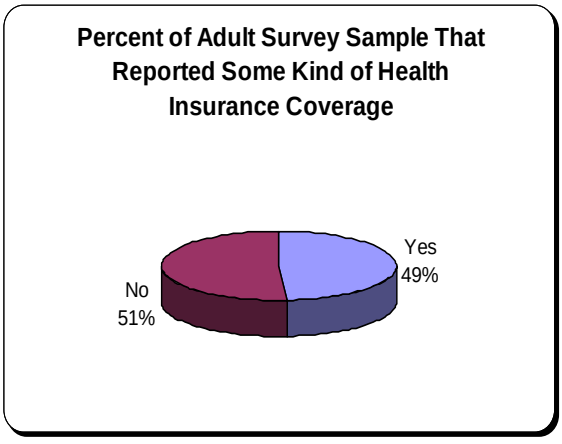
In addressing care barriers, many focus group participants noted that they had received consistently good services. Those with complaints most frequently cited long waiting times (even when they had established appointments) as a problem. They perceived not being seen on time as denoting a lack of respect. Other (though less common) complaints were a lack of confidentiality, impoliteness by staff, no Spanish skills (e.g., "*they treat you rudely and in some cases the receptionist or even doctors don't speak Spanish*"), and not being listened to (e.g., "*they tell you that you don't have anything wrong, then they give you more pills and they see you as a number*").

Addressing mental health care, stakeholders cited a host of problems including long waiting times (for appointments and then at the facility), lack of consistent and coordinated care (e.g., seeing different providers; people having to tell their story over and over again), too little compassion, respect, and follow-through by staff and professionals, few bilingual therapists, services limited to medications (particularly with children and adolescents), treatment ending before adequate progress has been made, and lack of clarity about treatment goals. One primary care doctor for example noted:

> "*I've gotten a lot of feedback from my patients and they feel that they are not getting adequate time and communication with the mental health providers. And they don't even understand why they are taking the medication and for what reason. So they don't know what to do about it…for how long and what's the goal.*"

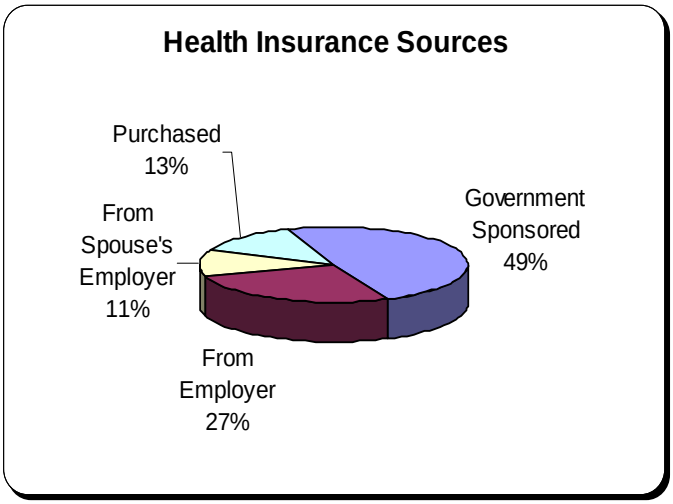
Health Insurance Coverage

Given the previously cited importance of economic issues, we asked participants about health insurance coverage. Forty-nine percent of adults completing our survey reported that they had some form of health insurance. Women (60%) were more likely to be covered than men (40%). In addition, persons born in the US (68%) were more likely to be insured than those born in Mexico (45%). Among people with insurance, 59% said they make no payments, 25% reported making per-service co-payments, and 16% indicated they pay a monthly premium.



The assessment's overall figures showed much higher uninsured rates in our Imperial Valley sample (51%) than those reported nationally (15%). The proportion of uninsured first-generation immigrants (55%) was also substantially higher than national statistics for those who are foreign born (33%) and/or in poverty (30%).[38]

Of those who had health insurance, the greatest proportion (49%) received it from governmental sources such as Medicare, Medicaid (Medi-Cal), or Healthy Families. Another 27% obtained it through their employers, 13% bought it themselves, and 11% were insured through their spouse's employer-based plans.



Government sponsored plans were the most common insurance source for both men (47%) and women (50%). Men were, however, more likely to be covered through employment than women. Women, in turn were more likely to be insured through a spouse's plan. Finally, a majority of monolingual Spanish speakers were receiving government sponsored insurance (58%).

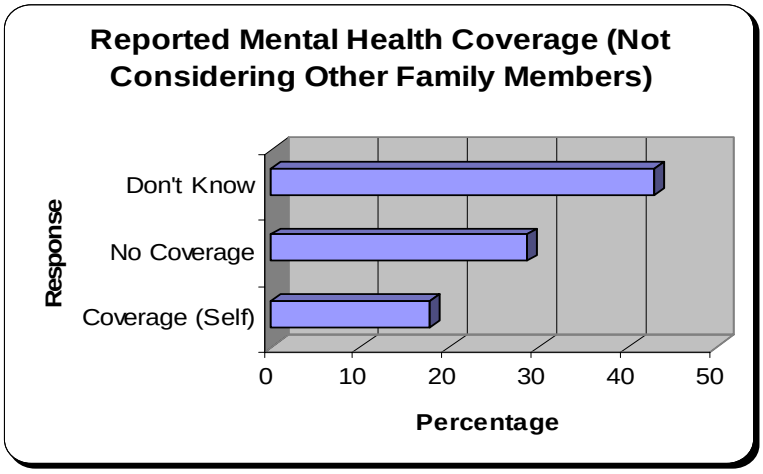
It is noteworthy that 31% of adult survey respondents said they believed applying to government-sponsored health insurance such as Medicare, Medicaid, and Healthy Families can negatively affect people's immigration status. This belief was most notable among monolingual Spanish speakers (50%), persons identifying themselves as American Indian (40%), Mexican American (31%), and other Latino (28%). In contrast, the few Non-Latino White or African American respondents in our survey sample did not voice this opinion.

Assumptions that using government supported health care negatively affects immigration procedures are generally incorrect. San Diego's Consumer Center for Health Education and Advocacy, for example, reports that lawful use of such care by documented immigrants does not hurt their chances of getting and keeping a green card, or of obtaining US citizenship. Using such services is, however, tied to income. Consequently, it may bring up questions whether people who are trying to sponsor relatives for US entry have the economic resources to do so.

Focus group members and key stakeholders tended to report information that concurred with our survey results. They generally agreed that people in the Imperial Valley are often underinsured. Government supported programs (e.g., Medi-Cal, Medicare, and Healthy Families) were mentioned as the most common type of coverage. Referring to comparatively more accessible service in Mexico, on commented "*thanks to God we live on the Border*." Respondents further commented that some of the "most hard working" persons (e.g., field workers) are often "forgotten" when it comes to health insurance.

Coverage for Children and Adolescents: Overall, 47% of survey respondents who had children (age 17 or younger) in their home reported having some type of health insurance that covered their children. Forty-one percent indicated all, and an additional 6% said that some of their

children were covered. The consequent overall percentage of uninsured children in our surveys (53%) was almost four times that reported nationally (12%).[38]



Mental Health Coverage: Asked if their insurance covered mental health services, the greatest proportion of adult respondents (43%) said they simply did not know. Another 29% reported that they did not think they had such coverage. Some acknowledged that they were unsure about how they could find out if their plans, in fact, covered mental health services.

Mental Health Service Preferences

A core part of this assessment was to learn what circumstances would allow people to seek and have confidence in mental health services. According to focus group members, general factors that make mental health care appealing included bilingual services, cultural understanding, cordiality and listening skills (e.g., "*treat me as a person"*), confidentiality, affordability, the provision of relevant information, and that the facility has a "good reputation." Key stakeholders often mentioned logistic such as easy-to-reach locations and flexible hours-of-operation as important. Like focus groups, they emphasized affordability and bilingual (English/Spanish) capability by staff.

Stakeholders further augmented focus group comments by highlighting the importance of confidentiality, presenting a "*relaxed as opposed to rigid environment*," friendliness and respect, minimal waiting times, "*not overwhelming people with paper work*," cultural understanding, professionalism, and follow-through.

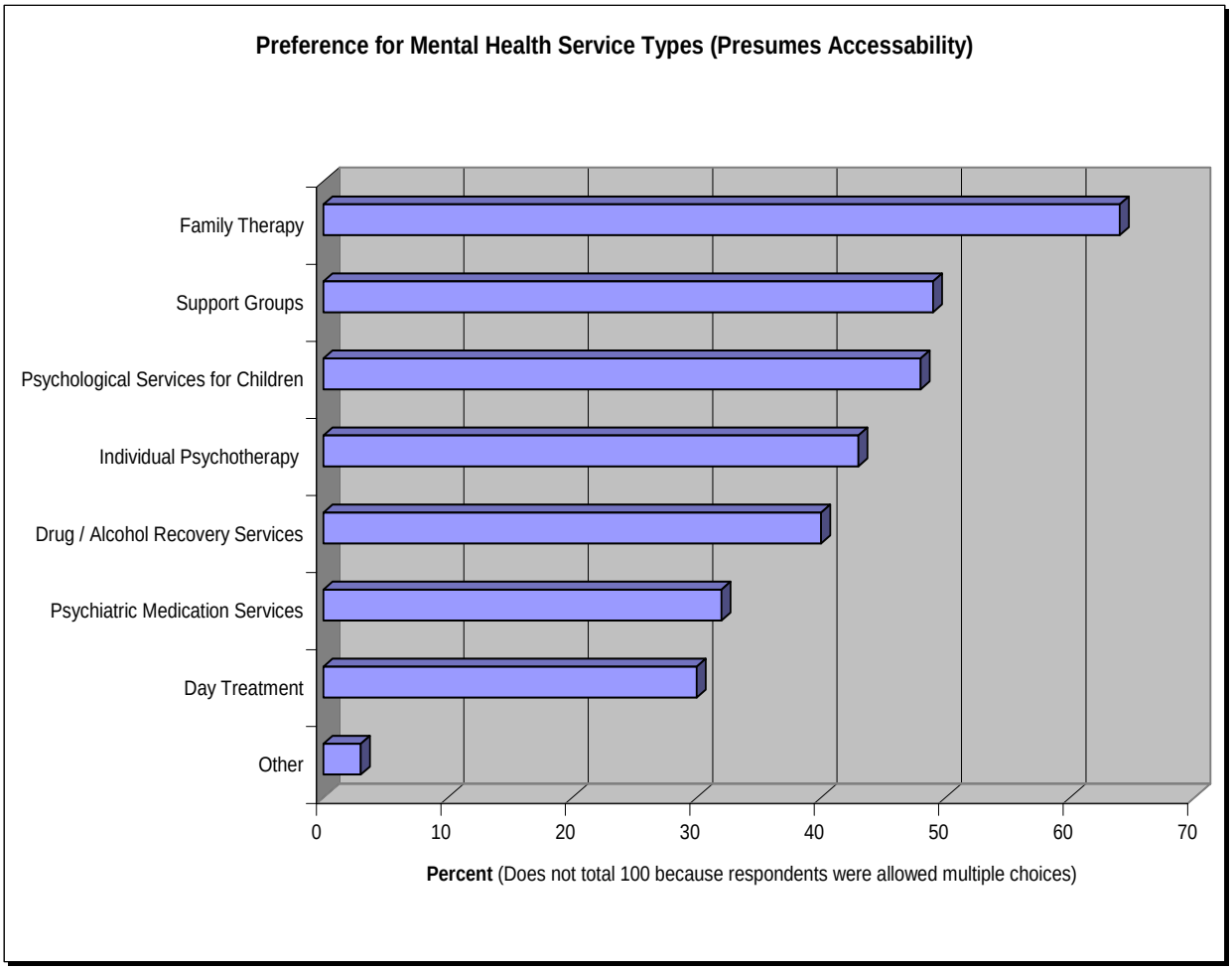
In identifying more specific care needs and preferences, focus groups and survey respondents most often described services that entailed multiple family members. This included support for parents. In addition, adult respondents said that professional help from psychologists, psychiatrists, counselors, and therapists was needed. They cited both individual and group processes as essential. Several noted that the provider's attitude rather than his or her title counts most (e.g., *"… a person who is listening; who puts attention to your problem. The title she or he has doesn't matter*").

Focus groups also mentioned the importance of stress reduction for children, having accessible services at multiple locations (e.g., "at all the clinics"), not treating clients as "crazy," providing

bilingual and culturally competent care, and using proven treatment methods (e.g., *"not try new treatments and experiment on us just because we are of low income*").

Key stakeholders, like focus groups, emphasized the needs for bilingual services that address the family system. In addition to individual psychiatric and therapy services for all age groups, they advocated for parenting and anger management classes, groups for victims of violence and abuse, and strong overall mental health education efforts. In addition, they recommended coordinated referral services for those requiring a higher level of care than appropriate for an outpatient setting.

Asked to choose all of the mental health services they would prefer if they were affordable and accessible to them, adult survey participants responded as follows: In descending order they cited family therapy [64%], support groups (e.g., domestic violence, single parents) [49%], psychological services for children [48%], individual psychotherapy [43%], drug / alcohol recovery services [40%], psychiatric medication services [32%], day treatment [30%] and other services [3%]. Other services mentioned on the questionnaires included parenting classes, stress management, and psychological services for the disabled.



Our adolescent survey participants most often listed support groups, and the combination of medications and psychotherapy as desirable. They also expressed some interest in family therapy and drug / alcohol recovery services.

When asked what else should be considered in expanding mental health care for the Imperial Valley one focus group highlighted the effectiveness of *promotoras* (Community Health Workers) "*because until now they are the only ones who offer better understanding of the people and have very good information regarding programs and new projects that exist in our community*."

Outreach Strategies

When asked how best to reach out to persons in need of mental health services, focus groups mentioned the media (radio, TV, newspapers). They also said that outreach needs to occur at AA and NA meetings and community events (e.g., 4th of July celebration). Several people highlighted the importance of spreading information through personal contact and word-of-mouth. They also said it is important to advertise that "free information" will be given.

Other mentioned ways to reach persons was through churches and schools, at restaurants and parks, at places where people wait for public transportation (e.g., bus stops), and at casinos.

Frequently Recommended Outreach Strategies

- Through radio, TV, and newspapers
- At places of worship
- Through primary care
- At existing social service agencies
- At existing self-help meetings
- Through educational institutions
- At community events (e.g., health fairs)
- Through use of *promotoras*

Key stakeholders emphasized identifying people with mental health needs through primary care. Other methods they recommended were outreach through schools, service agencies, and shelters, using Community Health Workers (*promotoras*), talking at community events, and exhibiting at health fairs. One noted that "*at every health fair we meet 10-15 people that didn't even know we exist and could benefit from our services*."

One key stakeholder further expressed the need for accountability through additional data saying "*we need to get statistics of all patients that are being referred for any mental health issues and see how many of those patients are actually getting the service that they deserve, and if we can know the outcome of those service.*"

Our assessment results lead us to a number of conclusions. Many people in the Imperial Valley handle life-stressors well and do not cite mental health problems. Thus we do not intend to label a whole population as overly "pathological." But we also found an obvious unmet mental healthcare need. In consensus, our data revealed that at least 30% of the population experience emotional difficulties that are clinically noteworthy. Roughly 10% reported severe symptoms. Yet very few people had ever received any professional treatment. On average, focus groups and stakeholders estimated that only 25-30% of those who need it receive any formal care. Among survey respondents with the most severe needs, only 18% had obtained any services in the last year.

Most commonly described problems included anxiety (e.g., fearfulness, irritability, nervousness, and anger), suspiciousness, and depression (e.g., loneliness, sadness). A lesser number of people also reported odd and unusual thoughts / behaviors. These symptoms often interfered with people's activities of daily living. Difficulties concentrating, remembering recent events, and making decisions were most frequently cited. Such impairments were described as hindering routine chores, schooling, and work performance. Alcohol and drug abuse / dependence were also described as very prevalent in Imperial County and may be responsible for some of the noted symptom patterns.

While it is increasingly recognized that many psychiatric disorders have a biological basis, life stresses can also cause, or at least exacerbate difficulties. Participants reported facing several local stressors. Job instabilities and economic burdens were most often cited. They reportedly lead to family discord and fragmentation. Additional stressors were the high summer heat and physical illnesses (e.g., respiratory problems, diabetes, and cancer).

Women, adolescents, the elderly, and those who are less acculturated (e.g., are more traditional than bicultural; speak little or no English) tended to be most at risk for psychological distress. We were somewhat surprised by this last result. Research has most often shown the opposite - that acculturated and US-born Mexican Americans tend to have a higher lifetime rate of mental disorders than those who are more traditional and / or born in Mexico.[39,40] Investigators have presumed that adherence to cultural and family traditions creates a safe and structured environment which helps limit emotional distress. Conversely, adaptation to new and sometimes unhealthy habits tends to erode such comfort zones. Our differing results may have been found for two primary reasons. First, participants described economic and other stressors as often fracturing their families. The traditional safety net was consequently less intact. Secondly, people who were more acculturated (e.g., spoke and read English), described much greater access to community resources. This likely provides them the tools to decrease isolation and effectively prevent or deal with stressors.

We further noted several overlaps between our results and information recently collected through focus groups by Imperial County's Behavioral Health under the Mental Health Services

Act (MHSA).[41] Both highlight the importance of enhancing the local service infrastructure, particularly in areas of mental health education and access. Like the County's, our participants reported that people often worry about the social stigmas associated with mental health services. But our participants rated such barriers as secondary to economic issues. In addition, participants across all of our activities strongly requested a range of mental health services.

Such responses support a basic "if we build it they will come" stance. Certainly, education about emotional illness *per se*, types of care, treatment effectiveness, confidentiality, and related issues is required. Such efforts, done in a culturally and linguistically effective way, have the potential to overcome erroneous assumptions and fears. It is heartening that even modest cultural accommodation can improve treatment acceptability.[42] In short, we cannot assume that cultural taboos are insurmountable.

The most commonly cited barriers to care in rank order were treatment costs, lack of insurance, language barriers (among those with Limited English proficiency), difficulties making appointments and finding a provider, and poor treatment by medical and support staff. We further noted that uninsured rates in the Imperial Valley are well above national figures.

In our view, attention to relationships between physical and mental health is also essential to service provision. Focus group members often described the negative impact of physical illnesses on emotional well-being. Brief Symptom Inventory (BSI) results further highlighted distress associated with (or interpreted as) physical problems. Such observations emphasize the need to understand mental and physical health as integrated rather than separate. The importance of this awareness in increasingly understood. Psychological factors are, for example, key to the prevention and control of metabolic irregularities such as diabetes and metabolic syndrome.[43,44] Recognizing these links, Chemicon International has noted that "*Of all factors influencing metabolic syndrome, chronic psychosocial stress is likely the most pervasive and controllable*."[45] Difficulties such as depression, anxiety, and poor self-image, are often associated with overeating,[46] weight gain, and lack of physical activity, especially if they are exacerbated by environmental stressors.[29] Black[47] describes such stressors as activating chronic inflammatory processes. These factors are, in turn, linked with the development of insulin resistance. Metabolic problems then bring risks for a host of other illnesses including heart disease and depression. In summary, psychological and physical illnesses are inexorably connected. Psychological distress can increase physiological risks and impede positive lifestyle changes. Physical illness, in turn heightens risks for further mental disorders. The overall process is an interactive spiral that creates multi-spectrum health problems. If that were not enough, some psychotropic medications (e.g. the antipsychotics olanzapine and clozapine) are known to cause metabolic problems.[48]

Such observations highlight the importance of coordination physical and mental health care. At the same time, we echo the Presidents New Freedom Commission's recommendation that mental health systems cannot formally rely on primary care to close service gaps.[7] Primary care doctors often serve as an important first line of defense in mental health. But ultimately, they

should not be expected to have full expertise in mental disorders. Such expertise is increasingly important. Psychiatric and psychological treatment methods are becoming more varied and complex. Not surprisingly, research has shown that specialty training and experience thus result in better outcomes. In one study, for example, treatment consistency and accuracy was greater among patients receiving antidepressants through psychiatrists than among those seeing general practitioners.[49] General and family practitioners, should, however use diagnostic tools such as the PRIME-MD[50] that take little time and can spot patients who need mental health specialty care.

In addition, we note that services should not be limited to medication management. Often a combination of psychotropic medications and psychotherapy (using evidence-based techniques) is most effective and most satisfactory to the consumer.[51]

Given the needs and shortages our participant described, we conclude that additional mental health services should be made available in Imperial County. To the degree possible (e.g., given confidentiality requirements) these services should use a family-based systemic approach. They should focus on anxiety, depressive, and related disorders that are appropriate for outpatient treatment. We strongly believe there is an underutilized service niche in which people meet "medical necessity" requirements but are not so severely impaired that outpatient care is ineffective. Expansion of outpatient services is likely to 1) limit suffering, 2) intervene before people require more intensive and expensive care, 3) reduce region-wide treatment costs, 4) enhance overall social wellness as people retain or recover their school and work performance.

In this context we believe that enhanced services are best achieved through creative collaboration and coordination between government, health care systems, grass-roots organizations, and individuals. We hope that this report will serve as one vehicle to foster such collaboration and, with it, increase mental health resources available in the Imperial Valley.

Efforts to enhance mental health services will bring some challenges. The President's New Freedom Commission cited a shortage of mental health service providers in rural communities across the US.[7] We found this to be true in the Imperial Valley. Educational institutions should thus be encouraged to train such professionals in and for rural locations. Additionally, some current health care policies hinder provider availability. We, for example, understand that Federally Qualified Health Centers (FQHCs) such as Clinicas de Salud del Pueblo, Inc. cannot bill for the services of California – licensed Marriage and Family Therapists (MFTs). At the same time they can do so for other practitioners holding a Masters-level license (Clinical Social Workers). Policies that include some, but exclude other professionals with essentially the same education level artificially shrink the pool of available services in rural and underserved locations.

Stakeholders and focus groups cited the media (e.g., newspapers), churches, schools, and events such as health fairs as ways to provide mental health information. We also found it

important that some participants highlighted the effectiveness of *promotoras* in mental health outreach. *Promotoras*, often called "community health advisors" (CHAs) or "lay health advisors" (LHAs) are members of social networks who have compassion for, and leadership roles in, their neighborhood. As such, they have the potential to make a number of important contributions. Because they have attention and respect, CHA's serve as positive role models and foster personal empowerment. In this process they can create awareness, disseminate health information, and support behavior change. On the most basic level, CHAs can overcome language barriers. In addition, they are in a good position to overcome cultural stigmas about health problems and services.

The formal use of CHAs is growing and has been shown as effective in improving access to health care among Latinos in a number of settings including rural environments.[52,53] The Institute of Medicine thus directly supports the use of community health workers (Recommendation 5-10).[9] This assessment utilized *promotoras* for a substantial of its data collection, and found them very effective. We believe they have equal potential to make important contributions to service outreach efforts.

This report has three primary limitations. Our survey participants were not selected at random. Thus we cannot say with certainty that the percentage of individuals we found to have emotional distress exactly matches that of the whole Imperial County population. Secondly, our sample of adolescent participants was quite small. Thus much of what we leaned about youth needs came from adults talking about adolescents, not adolescents talking about themselves. In addition, the great majority of our survey sample was lower-income Mexican Americans. Thus results do not necessarily reflect the needs and circumstances of other ethnic groups or of those who are more affluent. But all the diverse types of information we collected showed large similar needs for mental health services in the area. This strengthens the veracity of our primary findings and recommendations. Findings and recommendations, presented in summary form, are as follows:

Key Findings

1. Imperial Valley residents tend to experience significant stressors. Most commonly these are tied to limited and unstable economics, extreme summer heat, isolation, and physical illness.

2. There is a clear unmet mental health service need in Imperial County. Best estimates show that roughly 30% of resident are in clinically noteworthy distress. Yet fewer than 30% of such persons have ever received any formal treatment.

3. Most commonly cited mental health symptoms are related to anxiety, depression, and frustration. In addition, people often describe physical difficulties that they tend to connect with emotional problems.

4. Links between physical illnesses and emotional distress are well-recognized by local residents. Respiratory illnesses, type 2 diabetes, and cancer are prevalent physical concerns.

5. Substance abuse and dependence are also noteworthy problems in Imperial County. Alcohol, methamphetamines, marijuana, Rohypnol, heroin, and crack cocaine were the most frequently cited substances of choice.

6. Women, adolescents, the elderly, and those who are less acculturated (e.g., persons who speak little or no English) appear most at risk for emotional distress.

7. Stressors and mental health symptoms cause or exacerbate impairments in activities of daily living (e.g., school, work, family). Family discord is particularly common and sometimes leads to abuse, divorce, and abandonment.

8. Like adults, children and adolescents experience noteworthy stressors. Consequent difficulties are known to include truancy and decreased school performance, aggression (e.g., fights), and substance abuse.

9. Some people make constructive attempts to cope with emotional distress. But many lack knowledge about how to deal with mental health issues. Informal sources of information such as friends, family, and “the street” are common.

10. Service barriers are most often economic. The number of uninsured is, for example, high compared to nationally reported figures. But too few culturally / linguistically competent providers, cultural taboos against services, and lack of knowledge about mental health treatment options are also major barriers. Limited English speakers encounter some of the greatest barriers.

11. Mexico is the most common source of mental and physical health care. This option provides some needed access. But limited controls on treatment and medications in Mexico pose difficulties.

12. Community members asked that family therapy, support groups, treatment for children and adolescents, individual therapy, drug / alcohol recovery services, and psychiatric medications be made more available in the Imperial Valley.

13. Outreach through the media, churches, schools, and community events (e.g., health fairs) was described as effective. In addition, the use of Community Health Workers (*promotoras*) was cited as important.

Recommendations

1. Imperial Valley healthcare agencies and providers should make all possible efforts to expand mental health services in the region. Increased outpatient treatment would be most advantageous.

2. Expanded treatment should focus on family inclusion, affordability, and cultural / linguistic competence. In addition support groups and treatment for adolescents / children are particularly desired by the community. Respect for consumers is essential in any service provision.

3. On-going coordination with primary care is important. But primary care doctors should not be formally relied upon to close mental health service gaps.

4. Coordination and collaboration between local institutions is most likely to bring needed resources and services to the region.

5. Educational institutions should be encouraged to offer local programs that increase the number of available and culturally competent providers.

6. Insurance systems, including government sponsored programs, should eliminate policies that artificially bar some licensed providers from third-party reimbursements in remote and underserved locations.

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APPENDIX A: QUALITATIVE DATA QUESTIONS

Sample Questions from Key Stakeholder Interviews

1. How common is it that people in the Imperial Valley experience major life stresses and emotional difficulties?
2. What are the most frequent types of emotional distress experienced by people you serve/work with?
3. What are the main reasons for any such distress (e.g., economics, transient nature of work, difficulties with family / support system)?
4. Who tends to be most at risk for such problems? (If necessary, elaborate in terms of national origins, age / gender groups, where they live, etc.)
5. Do some people suffer emotional problems because of physical illnesses and vice versa? Yes _ No_
6. If yes, what relationships between physical end emotional problems are common?
7. What are the consequences, if any, of this distress (e.g., on peoples' activities of daily living including work and/or school)?
8. What are some cultural circumstances that effect how emotional / psychological problems tend to be understood and described in the IV community?
9. Where do people usually get advice about emotional problems (i.e. family member, church, physician, school, books, community leaders, other)?
10. What, if any family circumstances facilitate or hinder emotional health care in the case of: women? men?
11. What, if any work situations help or hinder emotional health care in the case of: women? men?
12. What, if any other circumstances facilitate or hinder emotional health care in the case of: women? men?
13. What kinds of messages do children tend to get about emotional distress and how to handle /cope with it?
14. In your opinion, how have people in the community members been trying to cope?
15. How much alcohol / drug us is there in the IV community?
16. Which substances tend to be used most often?
17. Do people self-medicate with prescription or over-the-counter drugs to ease problems? (If so do they tend to get them in the US, in Mexico?)
18. What are some examples of traditional care or remedies persons use to try to manage stress and distress?
19. What are the main factors that keep any problems from being resolved?
20. What seems to work for people?
21. Are people in IV getting the professional care for emotional problems they need? (ask for the percentage respondent believes is getting adequate care)
22. If not (or low percentage), what do you think makes it difficult for them to get care?
23. Where are people in the IV most likely to get emotional health care? (e.g., from a primary care physician, in emergency rooms and urgent care facilities, in Mexico, from traditional healers, etc.)
24. What makes a source of emotional health care appealing to them? (e.g., type of provider, clinic staff, atmosphere, location, confidentiality. Bilingual services, etc.)
25. What do people tend to be most dissatisfied with?
26. Are you aware of any current organized efforts (for example, community programs) that attempt to treat emotional distress among the community in a culturally effective way?
27. Do they work? If so, what works?
28. If not, what are the problems?
29. What kinds of emotional health care services should CSP offer?
30. What kinds of behavioral healthcare insurance coverage do people you work with tend to have? (ask for rough percentages) None ____Medi-Cal____ Medicare___ Other HMO ____ PPO ____
31. What would allow people to feel comfortable about coming to CSP for emotional health care?
32. What would be the best ways to identify people who might benefit from such CSP services?
33. Is there anything else you think we should know so that we can develop effective services for the IV community?

Sample Questions from Focus Group Sessions

1. What kinds of stressful situations and emotional problems do people in the IV tend to experience?
2. Why do you believe such problems tend to exist?
3. Are some people more susceptible to emotional problems than others? (If so, who and why do you think that is?)
4. Are some emotional problems due to physical illnesses (or do some emotional problems make people physically ill)? Yes ___ No ___ If yes, describe some circumstances you have heard of.
5. How do emotional problems affect people's-day-to-day life (e.g., ability to work, parent; social isolation)?
6. In your opinion, how are emotional / mental health problems understood and described in your community?
7. What are some difference between men and women in:
   7a. what emotional problems they experience?
   7b. why they tend to experience these problems?
   7c. how they try to deal with emotional problems?
8. Where do people usually get advice about emotional problems (i.e. family member, church, physician, school, books, community leaders, other)?
9. What kinds of messages do children in your community get about emotional distress and how to handle /cope with it?
10. How do people typically try to cope with emotional problems?
11. How wide-spread is alcohol and drug use in this community? (What do people tend to use most often?)
12. Do people use prescription or over the counter drugs to ease emotional problems? If so, where do they tend to get them? (e.g. pharmacies in Mexico, from friends, etc.)
13. Do some people use traditional remedies or healers for emotional problems? If those, what types of remedies are used?
14. Are people in IV getting the professional care for emotional problems they need? (Ask for the percentage respondent believes is getting adequate care.)
15. If not (or low percentage), what do you think makes it difficult for them to get care?
16. Where are people in the IV most likely to get emotional health care? (e.g., from a primary care physician, in emergency rooms and urgent care facilities, in Mexico, traditional healers, etc.)
17. What would make a clinic appealing to you if you needed help for an emotional problem? (e.g., type of provider, clinic staff, atmosphere, location, confidentiality. Bilingual services, etc.)
18. What do people tend to be most dissatisfied with when they seek care?
19. Do people tend to have health care insurance? If so, what kind is most common?
20. What kinds of emotional health care services should CSP offer?
21. What would be the best ways to identify people who might benefit from CSP emotional health care services?
22. Where is this community most likely to meet in groups?
23. What might be some other ways to reach them?
24. Is there anything else you think we should know so that we can develop effective services for the IV community?

Local Community Resources – Imperial Valley

AGENCY	ADDRESS	PHONE
Sure Helpline	397 Broadway Suite 2 El Centro, CA 92243	(760) 352 7878
Center for Family Solutions	395 Broadway Suite 5 El Centro, CA 92243	(760) 352 6922
Behavioral Health Services	202 N. Eight St. El Centro, CA 92243	(760) 482 4029
Family Resource Center El Centro	1014 Brighton Av. El Centro, CA 92243	(760) 336 4536
Volunteers of America	1331 Clark Road El Centro, CA 92243	(760) 353 8482
Family Resource Center Brawley	480 North Street. Brawley, CA 92227	(760) 312 6095
Neighborhood House	504 4th Street Calexico, CA 92227 (760) 357 6750	(760) 357 6875
F-A-C-T Center Family and Community Together	1027 N. Street 8th El Centro, CA 92243	(760) 337 5097
March of Dimes	395 Broadway Suite 3 El Centro, CA 92243	(760) 312 5750
Alzheimer Association	584 B W Main Street El Centro, CA 92243	(760) 335 3725
CASA Court Appointed Special Advocacy	690 Broadway Street El Centro, CA 92243	(760) 353 7456

Local Community Resources - Description of Services

Sure Helpline

- Counseling, education & prevention, crisis intervention, housing referral advocacy, individual systems, legal
- Asesoramiento, educación y prevención, intervención de crisis, referimiento de vivienda y asesoramiento (individual, sistema legal)

Center for Family Solutions

- Adult counseling, anger management classes, crisis intervention, emergency assistance for battered women, housing for women & children, food/clothing, referral, job training skills, advocacy (individual, systems, legal).
- Asesoramiento de adultos en manejo de la ira, educación, prevención violencia domestica, vivienda a mujeres y niños, alimento y vestido, talleres de habilidades y de área legal

Volunteers of America

- Alcohol & drug abuse treatment, anger management classes, counseling education & prevention, crisis intervention, long and short term care for addiction in a social-model setting as well as support programs for their families and significant others.
- Tratamiento para residentes con abuso de alcohol y drogas, clases de prevención, intervención de crisis, asesoramiento psicológico, terapia de grupo, proveer cuidados de corto y largo tiempo, para el adicto y asistir a sus familiares.

Behavioral Health Services

- Adult counseling, crisis intervention, drug & alcohol, psychological counseling, treatment, workshops.
- Asesoramiento de adultos en intervención de crisis, alcohol y drogas, vivienda para enfermos mentales, talleres.

Centro F.A.C.T: "familias y comunidades unidas"

- Multi-agency program designed to provide families with support, referral services, and advocacy. Encouraging communication between families and schools to help children become healthy members of the community.
- Agencia con multiservicios designado a proveer apoyo de referencia y abogacía, comunicación entre familias y escuelas para ayudar en ser miembros saludables de la comunidad.

Alzheimer's Association

- Caregiver respite services, helpline, support groups (bilingual), safe return enrollment, educational programs. Services are free of charge.
- Servicios de cuidado respite, grupo de apoyo (bilingüe), programas educacionales. servicios son gratuitos.

March of Dimes

- Resources regarding pregnancy birth defects, genetics, drugs use, environmental hazards and other related topics.
- Recursos sobre como tener un embarazo saludable y un bebé sano.

CASA

- Court Appointed Special Advocates of Imperial County (CASA) provide advocacy for abused and neglected children in the Juvenile Dependency system.
- Apoyo para niños abusados y descuidados en el sistema Juvenil de Dependencia.

Counseling Services

Edward Cherlin, M. D. *230 8th Street, El Centro* *(760) 352 0448*

- *Private practice, counseling regarding sexual assault, incest, sexual abuse, spousal abuse, divorce and custody issues.*
- **Practica privada, consejería por abuso sexual, incesto, violencia familiar, custodia** y divorcio.

Peter Dimanno, L.C. S. W. *110 S. 3rd Street, El Centro* *(760) 352 4773*

- Private practice providing counseling services for victims of sexual assault, divorce, custody, trauma and death, issues, as well as child abuse and homicide.
- Practica privada, ofrece servicios para victimas por asalto sexual, divorcios custodia y trauma por muerte.

Nancy Moreno-Derks, M.F.T *1681 W. Main St. #406, El Centro* *(760) 352 1502*

- Private practice counseling service. Services are available in English and Spanish.
- Practica privada con servicios de consejeria los cuales estan en Ingles y Español.

Bernardo Ng, M. D. *300 S. Imperial #9, El Centro* *(760) 352 1502*

- Private practice, services include depression, substance abuse, sexual disorders, and attention deficit disorder. Services are available in Spanish.
- Practica privada. Los servicios que se ofrecen incluye; depresión, abuso de sustancias desordenes sexuales y deficiencia en atención.

James Shinn, L.C.S. W. *1310 S. Imperial, El Centro* *(760) 352 5059*

- Private practice. Depression, anxiety, stress reduction, substance abuse and sexual abuse.
- Practica privada. Depresión, ansiedad, reducción del estrés, abuso de sustancia / sexo.

Joan Tyler, M.F.T. *300 S. Imperial, El Centro* *(760) 352 6302*

- Private practice that provides counseling for sexual assault, incest, child sexual abuse, divorce/custody, trauma/death survivors. Also provides child abuse seminars. Counseling services are available for all ages.
- Practica privada. Ofrece consejería en; asalto sexual, incesto, abuso a niños, divorcios, custodia, Trauma a sobrevivientes de muerte. Se ofrecen seminarios sobre abuso a menores. Consejería se ofrece a todas las edades.

Cornelio Cuza, Ph. D. *107 S.5th Street #5th, El Centro* *(760) 353 3340*

- Private practice that provides counseling services for victims of sexual assault, spousal abuse, and trauma/death issues. Services include evaluation and treatment.
- Practica privada, provee servicios de consejería en asalto sexual, violencia domestica, y trauma de muerte. Evaluaciones y tratamiento.

Luis Blumberg Ph. D. *300 South Imperial, El Centro* *(760) 436 1767*

- Private practice counseling. Business accepts Medi-Cal. Services are offered in Spanish and English, for adults and children.
- Practica Privada en Consejería, se acepta Medi-Cal, se atiende a niños y adultos, servicios en Español.

Primary Care Providers

Clinicas de Salud del Pueblo Inc.	900 Main Street, Brawley, CA 92227	(760) 344 6475
IV Family Medical Care Group	1600 S Imperial Ave., El Centro, CA 92243	(760) 352 6661
Valley Family Care Center	1745 S Imperial Ave., El Centro, CA 92243	(760) 370 3700
Valley Physicians Outpatient	135 Main Street, Brawley, CA 92227	(760) 344 4141
Pioneers Memorial Hospital	207 West Legion Rd, Brawley, CA 92227	(760) 344 9492

Substance Abuse Programs & Support Groups

Alcoholics Anonymous	484 Broadway E., El Centro, CA 92243	(760) 352 0807
Al-Anon Support Group	*153 E Brighton Av.,* *El Centro, CA 92243*	*(760) 353 9996*
VOA Alcohol & Drug Services	1331-B Clark Rd., El Centro, CA 92243	(760) 353 8482
Turning Point Residential Center	1960 Underwood Rd., Holtville, CA 92250	(760) 356 4307
El Redentor-Redeemer	305 N 9th St., Brawley, CA 92227	(760) 344 0290

Victory Outreach	515 Main St., Brawley, CA 92227	(760) 351 1999
New Creations Residential Center	8 W. Worthington Rd., Imperial, CA 92251	(760) 355 4296

Support Groups and Organizations

American Lung Association	1275 State Street, El Centro	(760) 353 5864
Cancer Support Group	400 S 8th Street, El Centro	(760) 352 6656
I. C. Victim-Witness Assistance	210 10th Street, El Centro	(760) 336 3930
Southern Caregivers Resource Center	119 S 5th Street, Calexico	(760) 357 6875
ICBHS Recovery Center Clubhouse	343 S 8th Street, El Centro	(760) 377 7777
Rape Crisis Center	395 #2 Broadway, El Centro	(760) 352 7273
Association for Retarded Citizens	298 East Ross Street, El Centro	(760) 352 0180

Protection & Advocacy for Beneficiaries of Social Security

1111 Sixth Ave. Suite 200 *(619) 239 7861*
San Diego CA 92101 fax: (619) 239 7606

Agency Type: Private non-profit E. mail aleyda.toruno@pai-ca.org

CRLA 449 Broadway Av. Lupe Quintero (760) 353 0220
El Centro Calif. 92243 Community Worker

Shelters & Support Services

Emergency Shelter Providers

Agency Name	Address	City	Phone
Center for Family Solutions	727 W. Main Street	El Centro	353-6922
Guadalupe Men's Shelter	545 Encinas Street	Calexico	357-0894
House of Hope	1948 Orange Avenue	El Centro	352-1182
Neighborhood Houses Casa Villanueva	506 4th Street	Calexico	357-6875

Transitional Housing

Center for Family Solutions Transitional Home	727 W. Min Street	El Centro	353-6922
New Creations` Transitional Home	312 E. 5th Street	Imperial	355- 4296
Turning Point	307 E. 8th Street	Holtville	356-4307
Volunteers of America	1331- B Clark Road	El Centro	353- 8482

Support Services

Imperial County Family Resource Center	Brawley, Calexico, El Centro, Imperial Niland, San Pasqual		312-6498
Calexico Housing Authority	1006 E. 5th Street	Calexico	357- 3013
Campesinos Unidos	1005 C Street	Brawley	351- 5100
Catholic Charities	250 W. Orange	El Centro	353-6822
Clinicas De Salud Del Pueblo, Inc	900 Main Street	Brawley	344-6471
Center For Family Solutions	727 W. Main Street	El Centro	353- 6922
Imperial County Health Department	935 Broadway	El Centro	339- 4438
Imperial County Social Services	29995 S. 4th Street	El Centro	337-6800
Imperial Valley Housing Authority	1401 D Street	Brawley	351-7000
Imperial Valley Behavioral Health	202 N. 8th Street	El Centro	339-4501
I. V. Independent Living Center	1450 Broadway,	El Centro	353-2802
Neighborhood House	506 E. 4th Street	Calexico	357-6875
Salvation Army	375 N. 5th Street	El Centro	352-4528
Sure Helpline	395 Broadway	El Centro	352-7873
Imperial Valley Food Bank	P.O. Box 4406	El Centro	370-0966
Veteran Services	1099 Airport Road	Imperial	337-7790
			1-800-827-1000

LOCAL LAW ENFORCEMENT / HOSPITALS / 24 HR. SERVICES

Law Enforcement

Brawley Police Department	344-2111
Calexcico Police Department	768-2140
Calipatria Police Department	348-2211
El Centro Police Department	352-2111
Holtville Police Department	356-2991
Imperial Police Department	355-4327
Westmorland Police Department	344-3457
I.C. Sheriff's Department	339-6311

Hospitals

El Centro Regional Medical Center	339-7100
Pioneers Memorial Hospital	351-3333

24-Hour Assistance

Imperial County Behavioral Health Services Hotline	(760) 482-4000
Imperial County Behavioral Health Services Toll-free	(800) 817-5292
Imperial County Child Protective Services Hotline	(760) 337-7750
Imperial County Adult Protective Services Hotline	(760) 337-7878
SURE Helpline Center Crisis Hotline	(760) 352-7873
SURE Helpline Center Tool-free	(760) 780-7776

FOR ALL LIFE THREATENING SITUATIONS CALL 911

ORGANIZATIONS AND AGENCIES IN MEXICALI MEXICO

PSYCHOLOGICAL / COUNSELING SERVICES – MEXICALI

CEAM(women's shelter) TEL. 563-4197

Av. Olivo # 500 Col. El Ciprés

- Escuela de padres / parenting classes
- Talleres / workshops
- Superación personal / self-esteem

MUJERES UNIDAS POR UN MUNDO MEJOR TEL. 555-4395

Av. Marmoleros Sur # 1808 Colonia Libertad TEL. 554-4292

- Atención y prevención de la violencia familiar / Domestic violence counseling and prevention

CAPCI Centro de Atención para la Comunidad Integral TEL. 553-6762

Av. Larroque # 1432 Colonia Industrial

- Asesoría psicológica, individual y de grupos / Psychological evaluations, individual & groups

INSTITUTO DE SALUD MENTAL TEL. 561-0920

Calle 11 y Rió Papaloapan Fraccionamiento Villa Verde

- Consulta externa psiquiátrica y psicológica / on-site psychological services
- Atención integral a las adicciones, rehabilitación / sustance abuse and rehabilitation
- Reinserción social del adicto y enfermo mental / psychosocial skill building
- Salud mental comunitaria / community mental health
- Clínica de atención integral del niño y del adolescente / children's clinic
- Servicio de hospitalización / hospitalization services
- Urgencias 24 horas / 24 hour emergency services

CAHOVA TEL. 561-8800

Av. Televisora # 1350 Colonia Xochimilco Fax. 561-8717

- Casa hogar para niños / children's shelter
- Menores de 7 a 13 Años / children ages 7 to 13
- Escuela y vivienda / school & home
- Consejería en general / general counseling service

LINEA JOVEN TEL. 554-8023

- Anónimo para cualquier emergencia psicológica. 24 horas /Anonymous, emergency, psychological services. 24 hours

CLEMENTINA DE SANCHEZ/PSICOLOGOS ASOCIADOS

Pasaje Uruapan # 574 Centro Cívico TEL. 557- 2816

**Services are available in English.*

Psicología aplicada a:

Familia: / Family

- Educación de hijos / child education
- Educación sexual / sex education; counseling

Jóvenes: / Teens

- Adolescentes, orientación vocacional / vocational training
- Prevención de uso de drogas y alcohol / alcohol & drug prevention

Niños: / children

- Problemas de aprendizaje, problemas de conducta / learning disabilities, behavioral issues

Adultos: / Adults

- Ansiedad, depresión **/** anxiety & depression
- Tratamiento integral de adicciones / substance abuse treatment

PSC. IGNACIO B. REYES TEL. 554- 3029

Av. Zaragoza y Calle F # 1398- Altos

- Atención a problemas de los nervios / anxiety disorders
- Niños y adultos / adults & children
- Terapia familiar / family therapy

PSC. DAVID MOLINA V. TEL. 553-4202

Calle a # 237-D
Zona Centro

- Dependencia psicológica / psychological and chemical dependence
- Desintoxificación física, médica / detoxification center

PSC. MARIA CONSUELO PEREZ TEL. 555-6229

Central Medica del Noroeste Av. Madero # 1173-B
Zona Centro

- Psiquiatría y psicoterapia / psychiatry & psychotherapy
- Problemas emocionales / emotional problems
- Problemas de conducta / conduct issues

PSC. JUAN SANCHEZ CORDOVA TEL. 557-2816

Pasaje Uruapan # 574 Centro Cívico (previa cita)
**Services are available in English.*

- Consejería y terapia / counseling & therapy
- Ansiedad y depresión **/** anxiety & depression

PSC. ANTONIO MAGAÑA CEJA TEL. 552-2722

Av. Obregón # 117 Local 2 Altos Zona Centro

- Trastornos mentales / mental health problems
- Aplicada a toda la familia / family therapy
- Trastornos emocionales / emotional problems

PSC. GLORIA AGUILERA TEL. 568-2384

Col. Cuauhtemoc calzada de las Americas # 220

- Neurosis / neurosis
- Psicosis / psychosis
- Trastornos de conducta y personalidad **/** conduct and emotional problems

PSC. OFELIA VELAZQUEZ VEGA TEL. 552-2722

Av. Obregón No. 117 Local 2 col. Nueva

- Psiquiatría psicoterapeuta / psychotherapy
- Hipnosis / hypnosis
- Trastornos mentales / mental health issues
- Trastornos emocionales / emocional issues
- Trastornos de conducta y aprendizaje / conduct and learning disabilities
- Psicoterapia individual / individual psychotherapy
- Psicoterapia de pareja / marital counseling
- Psicoterapia familiar / family therapy

CENTRO DE EDUCACION DE LA CONDUCTA

ASOCIACION PARA MODIFICACION DE LA CONDUCTA

Av. Navolato # 1250 Frac. Guajardo TEL. 555-1020

- Problemas emocionales leves / emotional problems
- Rasgos neuróticos transitorios / neurotic problems
- Hiperactividad / hiperactivity

INSTITUTO DOWN DE MEXICALI TEL. 555-3407

Av. Navolato # 1250
Frac. Guajardo

- Educar y capacitar a menores con síndrome de Down / Down syndrome

CENTRO DE CONVIVENCIA LA CASITA TEL. 555-8089

Av. Sierra Encantada # 2629
Frac. Solidaridad Virreyes

- Psicología infantil / child psychological services

COMITE PRO-REHABILITACION NIÑO DEFICIENTE MENTAL

Av. Jacarandas # 1398 Frac. Los Pinos TEL. 568-3477

- Obtener recursos / resource center

ESCUELA DE EDUCACION ESPECIAL (ISEP)

Av. Cuauhtemoc # 384 Frac. Las Fuentes TEL. 567-5389

- Educacion / education
- Educacion niños con diferentes capacidades / children services

CENTRO DE REHABILITACION ADULTOS CON DISCAPACIDAD

Av. Cuauhtemoc # 384 Frac. Las Fuentes TEL. 567-5390

- Educar/ education
- Capacitar / training
- Adultos con diferentes capacidades / adult services

CENTRO DE ESTIMULACION Y DESARROLLO ESPECIAL

Blvd. Benito Juárez # 1990 TEL. 566-8566

- Terapias físicas / physical therapy
- Conserjería necesaria para adultos / adult counseling

INSTITUTO CALAFIA TEL. 557-3232

Av. Atenco 2047 Frac. Calafia

- Desarrollo humano / human development
- Integración familiar / family integration

CENTROS DE REHABILITACION

**All services available only Spanish.*

EREDAL # 1 TEL. 563-6507

Av. Naranjo # 200 Col. Santa Cecilia TEL. 563-7293

- Rehabilitar enfermos de drogas y alcohol / alcohol - drug rehabilitation services
- Menores de 18 años / children under the age of 18

EREDAL # 2

Ejido Heriberto Jara Km. 1.5 Col. Progreso Cell. 04465948693

- Rehabilitar enfermos de drogas y alcohol / alcohol - drug rehabilitation services
- Hombres adultos / adult men

EREDAL # 3 TEL 563-6507

Av. Naranjo # 200 Col. Santa Cecilia TEL. 563-7293

- Rehabilitar enfermos de drogas y alcohol / alcohol - drug rehabilitation services
- Mujeres adultas / adult women

DALE LA MANO AL HERMANO TEL. 552-6326

Calle San Carlos # 9 Col Bella Vista

- Rehabilitación de fármaco dependiente/ chemical dependency
- Adultos y menores / adult and adolescent
- Grupos mixtos / groups
- Consejería familiar / family counseling

LA CIUDAD DEL REFUGIO TEL.566-1969

Av. Iztapa # 48 Col. San José

- Rehabilitación / rehabilitation services
- Adultos adictos a drogas / adult chemical dependency services

CRISTO ES LA RESPUESTA TEL. 01-686-5872752

Av. José Maria y Pavon # 41 Ejido Oaxaca

- Recuperación
- Fisico mental
- Hombres dañados por alcohol y drogas / men chemical dependency services
- Ayuda a reintengración a la sociedad y sus familiares / family reintegration services

DESAFIO JUVENIL TEL. 556-5741

Pasaje Acapulco # 648 Centro Cívico

- Rehabilitación de drogas y alcohol / drug and alcohol rehabilitation services
- Ayuda en problemas con delincuencia / adolescent behavioral issues
- Menores de 18 años / services for minors

DROGADICTOS ANÓNIMOS TEL. 593-2750

- Toda clase de ayuda/ various services for drug addictions

ALCOHOLICOS ANONIMOS /ALANON/ALATEEN

PAZ MENTAL

Calle del Espacio # 326 Sesiones 5 a 7 p.m.
Colonia Estrella Lunes, Miércoles y Viernes

*Sessions: 5-7 p.m. Mondays, Wednesdays and Fridays

MARTHA V.

Av. Michoacán # 1410 Sesiones 12 a 2 p.m.
Col. Pueblo Nuevo Sábado

*Sessions: 12-2 p.m. Saturdays

SENDERO DE VIDA

Altamirano # 110 Altos
Interior 208 Zona Centro

Sesiones 6:30 a 8:30 p.m.
Lunes, Miércoles y Viernes

*Sessions: 6:30 to 8:30 p.m. Mondays, Wednesdays and Friday

CAMBIANDO MI VIDA

Altamirano # 110 altos Interior 208 Zona Centro

Sesiones 6:30 a 8:30 p.m.
Todos los Sábados

*Sessions: 6:30 to 8:30 p.m. every Saturday

FORTALEZA Y ESPERANZA

Calle del Sol # 100

Col. Santa Isabel

Sesiones 9:30 a 11:30 a.m.

Martes y Jueves

*Sessions 9:30 to 11:30 a.m. Tuesdays and Thursdays

UNA LUZ EN MI CAMINO

Av. San Sebastián y Oaxaca

Col. Baja California

Sesiones 9:00 a.m. 10:30 a.m.

Martes y Jueves

*Sessions 9:00 to 10:30 a.m. Tuesdays and Thursdays

AMOR Y FE

Paseo San Marcos # 104
Frac. San Marcos

Sesiones 6:00 a 8:00 p.m.
Martes y Jueves

*Sessions: 6 to 8 p.m. Tuesdays and Thursdays

CASAS HOGAR / SHELTERS

ALBERGUE JUVENIL DEL DESIERTO TEL.554-6045

Av. Carpinteros # 1515
Col. Industrial

554-5364

- Exclusivo a hombres adultos deportados / mens' services only
- Estancia y comida (no más de 15 días) / food & shelter for no more than 15 days

ALBERGUE DE CATEDRAL TEL. 552-6725

Catedral de Nta. Señora de Guadalupe
Av. Reforma Zona Centro

- Estancia temporal adultos deportados / temporary shelter

CASA BETANIA TEL. 556-0271

Lago Hudson 3 2408
Colonia Xochimilco

- Estancia temporal a toda la familia deportada / family shelter

CENTRO PASTORAL MANA DE MEXICALI TEL. 556-0271

Callle Jesús Garcia 3 1799
Col. Nacozari

- Estancia temporal familiar (casos de emergencia) / emergency family shelter

EJERCITO DE SALVACION TEL. 553-1194

Av. Aguascalientes 3 2300
Col. Santa Clara

- Solamente en caso de emergencia (3 días solamente) / emergency 3 day shelter

ALBERGUE SAN GABRIEL TEL. 565-3249

- Estancia temporal a hombres deportados / men's shelter

ASISTENCIA MÚLTIPLE

CENTRO DE AYUDA PARA LA MUJER TEL. 567-2630

Av. Cristóbal Colon 3 788
Fracc. Las Palmas

- Embarazada, desamparada/ emergency assistance for women
- Ayuda a mujer económica, moral y legal / legal & financial assistance.

INSTITUTO FEMENINO TEL. 557-0194

Calle B 3 126
Zona Centro

- Apoyar la formación de la mujer en todos los aspectos / women services & support groups

DESARROLLO INTEGRAL COMUNITARIO TEL. 552-2835

Calle Jabonera # 5 TEL. 552-6543
Zona Centro

- Diferentes programas comunitarios / various community services

DISPENSARIO DE NTA. SEÑORA DE LA SALUD TEL. 553-0845

Av. Tierra Blanca # 2487 Col Estrella

- Atención médica general / general medicine
- Se reparten despensas / food assistance

MINISTERIO MARIPOSA

Av. Japón # 2378
Conjunto Urbano Orizaba

- Consejería a niños y jóvenes / child and adolescent counseling
- Entrenamiento / training
- Terapia ocupacional / occupational therapy

PROYECCIÓN JUVENIL CACHANILLA TEL. 562-4678

Av. Río Verde # 3290

Frac. Villa Verde

- Promover el desarrollo integral de los jóvenes/ child development services

MARIA DEL PILAR ROMAN DE PEREZ

Av. Blvd.. Circuito Siglo XX1 # 1900-B
Parque Industrial

- Estancia infantil a menores / day care services
- Exclusivo a trabajadores de empresas del parque industrial / exclusive for industrial park workers

ESTANCIA INFANTIL

Av. Plutón # 506
Col. Santo Niño de Atocha

- Atención a niños de (3 a 6) / childcare for ages 3-6
- Uso exclusivo cuando la madre trabaja / services for working mothers

HOSPITALES / HOSPITALS

ISSTECALI	TEL. 557-4200
ISESALUD	TEL. 557-2820
CRUZ ROJA	TEL. 552-9275
CENTRO DE SALUD HIDALGO	TEL. 561-8577
POLICLÍNICA	TEL. 557-5356
HOSPITAL GENERAL	TEL. 556-1124

(IMSS) INSTITUTO MEXICANO DEL SEGURO SOCIAL

IMSS 16	TEL. 555-5075
IMSS 30	TEL. 555-5150
IMSS 28	TEL. 555-5085
OFICINA ADMINISTRATIVA IMSS	TEL- 555-5085






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