ETHNIC COMMUNITIES OF SANTA CLARA COUNTY

SEEKING TO HELP PERSONS STRUGGLING WITH MENTAL ILLNESS, THEIR FAMILIES AND COMMUNITIES, AND TO HELP FULFILL THE PROMISE OF MHSA – SYSTEM TRANSFORMATION

PROVIDE PERSPECTIVES AND OPINIONS ON MENTAL HEALTH

2006
Santa Clara Valley Health and Hospital System
Santa Clara County Mental Health Department
828 South Bascom Avenue, Suite 200
San Jose, California
DEDICATION

This document is dedicated to the many giants that walked among us who without limits gave of their lives so that persons in Santa Clara County with mental illness and their families would receive services that are accessible, supportive, respectful, culturally competent, and so that those who work delivering those services would also thrive in organizations that support them and their passion- to help individuals recover from mental illness always living with dignity, as is their right. In their memory we continue the struggle to fulfill the dream!

Leonard Goveia

Edward Z. Kawazoe

Dr. Ken Meinhardt

Helen Hansen

Josie Torralba Romero

Leonida Mesa

and all other elders and teachers not named here.

We dedicate this document foremost to Josie and Leonida. While Josie was very ill, she advocated and anticipated with excitement the passage and promise of Proposition 63. Though Leonida was experiencing her own serious health problems during the county’s MHSA inreach and outreach phase, she worked to include her clients in the development of this document in faithful effort to improve services for the Filipino Community.
Acknowledgement

Thank you to hundreds of individuals who gave their time and energy to the making of this document for the mental health system. We acknowledge how you, with your beliefs, faith and, sometimes, well-placed mistrust of the system, dialogued and discussed your personal feelings, ideas and thoughts. You brought culture and community, understanding about mental illness and the mental health system, and most important the solutions that heal your community.

Thank you to thousands of individuals who responded to the community survey, your ranking of concerns and solutions give beginnings for future discussions, your compelling words on coping with problems are contained in this document.

The many individuals and groups who created this document engaged the mental health system into the suffering in their community that today is gravely impacting mental health and wellbeing. They do bring their knowledge, wisdom and powerful traditions, culture and community – holding recovery from mental illness. They do offer significant recommendations and solutions. Their participation and contributions are deeply appreciated and acknowledged.

In Santa Clara County, high-risk ethnic individuals requiring mental health services would account for over 75 percent of the clients served, if there was equity in service access. Today, ethnic communities endure great disparities of under service in the mental health system and over-representation in punitive systems. Therefore, the mental health system knows, it cannot transform without the entire system enabled to maintain the full participation of ethnic communities at all levels and at every juncture.

All of us together, acknowledge the commitment and trust that is reflected in the narratives and survey results offered in this document. So, this document must be used to help improve the lives of many, many individuals who suffer with mental illness and their families. The community has spoken, to listen and act is to appreciate sincerely.

We acknowledge this living document of health and recovery leads to transformation.
Santa Clara County Mental Health Department
Ethnic Community Perspectives and Opinions

The content of this document was collected during community/mental health system engagement for the implementation of Proposition 63, the Mental Health Services Act (MHSA), which started in March 2005 and continues today.

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PROPOSITION 63, THE MENTAL HEALTH SERVICES ACT - A COMPELLING PROMISE FOR ETHNIC COMMUNITIES

“Why this document is important.”

PROMISE: A Commitment to Ethnic Communities
California voters passed Proposition 63, entitled the Mental Health Services Act (MHSA) on November 1, 2004 proposing a TRANSFORMATION of the public mental health system of California. Voters gave hope and many new opportunities to ethnic communities. The State Department of Mental Health (DMH) has provided California counties explicit requirements, for MHSA, thereby offering strong promises for California’s highest at-risk, most under and inadequately served populations.

From the State DMH Requirements to Counties for the MHSA Community Services and Supports:

- Community Collaboration
- Cultural Competence
- Client/Family Driven Mental Health System for Older Adults, Adults, Transitional Age Youth, and Family Driven Services for Children and Youth
- Wellness focus, which includes the concepts of Recovery and Resiliency
- Integrated Service Experience for Clients and their Families Throughout their Interaction with the Mental Health System
- Based in strong system partnerships

TRANSFORMATION: Cultural Competency in MHSA Implementation
Intrinsic to transformation is filling the system’s deep gaps with respect to services for ethnic communities and asserting that to achieve this, all parties implementing MHSA must first personally engage, as learners. This document records ideas, feelings, and wisdom from our ethnic communities. Participants gave of themselves so that their experience would help persons with mental illness receive more accessible and effective help, as called for in MHSA. Santa Clara County proposed to implement a transformative new program based on community input, through its MHSA funded Community Services and Support (CSS) plan, approved by the State DMH.

From the Santa Clara County CSS Plan, submitted to the State and approved for funding:

Key Objectives

- Reduction in subjective suffering from mental illness
- Increase in meaningful use of time and capabilities (school, work, activities)
- Reduction of homelessness and expansion of safe and permanent housing
- Increase in natural network of supportive relationships
- Reduction in multiple foster care placements
- Reduction in incarceration/juvenile justice involvement
- Reduction in disparities to service access
- Increase in self help and consumer/family involvement

Key Elements

- A lifespan approach
- Community engagement and support
- Cultural competency throughout
- A social ecology focus
- An emphasis on connectedness
- Recovery and resiliency-based models of care
- Consumer and family driven
FORESEEING SUCCESS: The Learners and the Doers

As someone with mental illness, you should expect policy makers and providers to have knowledge of your life experience, culture, problems, strengths, and community – in order to serve you. Alarming statistics and the promises in MHSA require this level of cultural competency in the mental health system.

We in Santa Clara County, while maintaining a strong focus on our MHSA goals, must learn and remember that our county’s ethnic communities face huge burdens while simultaneously being underserved or inappropriately served by the mental health system. One must always ask “WHY?” Facing and eliminating the following disparities, which are illustrated in the Santa Clara County’s CSS, plan must be seen by the doers as indicators of truly successful mental health system transformation and fulfillment of the promise of Proposition 63.

Disparities Faced by Elders

- Though American Indian elders are .4 percent of the county population over 60 years, American Indian elders are 2.04 percent of the elder clients in the county’s substance abuse treatment services.
- Though African elders are 1.7 percent of the county population over 60 years, African elders are 12.24 percent of the elder clients in the county’s substance abuse treatment services.
- Though Latino elders are 12.3 percent of the county population over 60 years, Latino elders are 40.82 percent of the elder clients in the county’s substance abuse treatment services.

Disparities Faced by Youth, including Transitional Age (16-25 years)

- While American Indian youth are .23 percent of the county’s population under 18, American Indian youth are .6 percent of the children in Foster Care.
- While African youth are 2 percent of the county population under 18 years, African youth are 12 percent Juvenile Probation Department (JPD) detention youth and 13.6 percent children in Foster Care.
- While Latinos youth are 29 percent of the county population under 18 years, Latino youth are 58 percent of the youth in JPD detention and 53 percent of the children in Foster Care.

Underserved and unserved children and youth in mental health services:

- White youth were more likely to receive services than children of color.
- Children of color are more likely to receive services in juvenile hall or after being arrested and detained.
- Latino children are the highest portion of underserved youth.
- Asian and Latino transitional age youth are more likely to be underserved relative to their representation in the county’s poverty population.
- No Native American children receive wrap around programming.
- Among the unserved, Latino and Asians are over represented compared to whites.
- Asians are 28 percent of poverty population, yet they are only 19 percent of those receiving outpatient services.
- Latinos are 36 percent of poverty population and, yet the are only 20 percent of those receiving outpatient services.

Disparities faced by Adults

- American Indian adults are .34 percent of the county adult county population yet American Indian adults are 4 percent of the adult homeless and 1.59 percent of the adult clients served by the county’s substance abuse treatment services.
- African adults are 2.7 percent of the county adult county population yet African adults are 21 percent of the adult homeless, 12.9 percent of the county daily jail population, and 8 percent of the adult clients served by the county’s substance abuse treatment services.
- Latino adults are 23.09 percent of the county adult county population yet Latino adults are 52.2 percent of the county daily jail population, and 40.03 percent of the adult clients served by the county’s substance abuse treatment services.
Fulfilling the transformative promise of MHSA requires active commitment. This document is a start and a tool to be used by participants of Santa Clara County’s implementation of all MHSA programs. Subsequently, deeper participation of ethnic communities and deeper study and transformation on the part of all policy makers, mental health service providers and managers is required. As all engage, the ethnic communities will expand what is presented here in this living document.

TRANSFORMATION

Transformation begins within the individual, in the heart, in the spirit, the soul and the mind.

Transformation is familial, is communal, it deepens connections, kindness, generosity, trust and love.

Transformation is the new and the renewed mental health system.

Transformation for ALL means never to return, always to progress.
PERSPECTIVES ON THE MENTAL HEALTH SERVICES ACT FROM THE AFRICAN COMMUNITY

Summary
People of African ancestry in Santa Clara County make up approximately 3% of the population yet are over represented in all areas of concern to the community by often triple our number. These areas include:

- Infant mortality
- Mental Health Services – 6%
- Juvenile Probation Network – 22% (In Santa Clara County - African youth are 3% of the youth population, 8% of those arrested and 11% of CYA commitments)
- Social Services – 15%

These areas of concern are indicators of service need and levels of racism and discrimination within the environment and systems. As a people, we are denied or provided substandard health care, police over patrol our neighborhoods and target African people for arrest. Social Services makes decisions about our children, resulting in lower rates of reunification and higher rates of removal and adoption.

Once we are involved in these systems, it is very difficult for us to get out. These experiences, historically and persistently, undermine/destroy our natural support networks, normalize institutional involvement in our lives, and de-value African people’s culture and resiliency.

In order to effect changes in our disproportionate representation in these community areas of concern, it is imperative to study our needs as well as institutional racism and systems policies and practices that impede our peoples’ ability to be healthy, thrive and succeed.

Strengths in the African Community
African families are child centered
Interdependence and connectedness are valued
Resilient
Importance of spiritually in all aspects of daily life
Respect and reverence towards ancestors/elders
Sharing resources is a cultural value

Critical Concerns in the African Community
Over diagnosis of Attention Deficit Disorder for school aged children
Under diagnosis and treatment of depression in adolescence and adults
Too much medication and not enough supportive services
Additional stressors of living in a Eurocentric ruled environment
Minors easily charged with felonies setting them up for three-strikes
Placement of our children out of our families
Invasion of the parent/child relationship by institutions
Lack of understanding by professionals of African cultural norms
No local psychiatric hospitalization for children
Numbers of Foster Care youth who age out of system with needs
Sexual abuse victims isolated and fearful of getting help
Ethnic professional’s recommendations are typically marginalized or ignored when not consistent with the systems’ Eurocentric plan/action. This voids out cultural competent/proficient interventions and recommendations.

African community has a history of providing feedback about our community and our concerns and the information provided is not considered or utilized in the development of policies or services. The process of talking with us is used as a way of checking off a task being done – without consideration…

Needs of gay, lesbian and bisexual Africans in a cultural context

**Barriers to Services for the African Community**

Mental Health system is cumbersome and restrictive and labels people
When asking for help, systems overwhelm the family and are punitive
First psychotic breaks or onset of Mental Health issues difficult to initiate services - no previous history, making person unfamiliar to the system
Lack of understanding African culture
Lack of acknowledgement of racism, discrimination, and oppression in society and systems today and its impact on access to services and type

**Potential Solutions for the African Community**

Counselors to treat PTSD (Post Traumatic Stress Disorder) in children
Increase community programs/services for children and youth to reduce involvement in the Juvenile Probation Department and Social Services Agency.
Training for Teachers to increase understanding of culture and child developmental stages
Develop culturally centered media campaigns that focus on mental health education/stigma/services available
Services that support and increase knowledge of Special Needs children-drug exposed children
Services supporting Grandparents with children who have been traumatized or taken from their parents

In-services for professionals and training for parents on behavior disorders and institutional racism within schools that labels and undermines academic success

Marriage/family strengthening classes/services – issues related to divorce and the impact on families

Advocates that work with the parent/family and child to help navigate the various systems

One time (short term) drop-in counseling (without bureaucratic process) to help individuals and families with issues or support natural support systems (i.e. pastors)

Wellness Principles – holistic approaches to health/life/healing that includes a variety of culturally centered approaches

More affordable housing linked with services
THE AFRICAN COMMUNITY Responds to the Mental Health Services ACT

During the last week of September and first week of October 2005 three open meetings were scheduled to obtain feedback, from the African community, on the MHSA Strategy Team’s draft.

The draft was organized into major bullet points by age groups and presented for discussion and feedback. The following responses are organized in these age groups. In the African tradition, and as described by Dr. Wade Nobles’ African family protocol, we will begin with the elders group (our composers). In the middle are the adults and those becoming adult and young adults (our conductors and musicians respectively) and ending with the children (our music).

Older Adults 60+ years

Day services that are culturally centered, that are church or community based with transportation support. Use facilities that are nearby and that provide other services that are useful for our elder (Eastridge, nearby fitness or community center, church recreation facility).

Outreach services to our elders that is culturally proficient

Peer Support was altered to Grandparent Support because of the common experience in the African community of elders raising children. To assist in this, it was suggested that family oriented senior housing be developed that does not restrict children.

Services for elders be provided more quickly

Need support people and/or treatment coordinators for elders

Education on elder abuse and a hotline to connect elders to help/services

Community partnering that is spiritually based and culturally proficient

Emergency clinic screening that specializes in treating elders in a culturally proficient way and linking them with providers that serve African people.

Respite for elder caregivers

Expand in-home support services to include mental health consumers

Adults 26-59 years

Peer support and mentoring:

Single mothers groups

Fathers groups

Marriage support groups

Expanding/redesigning treatment court services that embrace people and provide better assessment/diagnosis/treatment focus

Integrate substance abuse and mental health services that are culturally focused
Subsidized supported housing

More culturally focused community based case management support services

Advocacy and support for people released from jails and prisons with mental health issues. Concerns expressed about the large numbers of African people in the justice system with untreated mental health issues.

JOBS - Specialized employment opportunities with life skills/enrichment activities that are culturally centered. Employment services must specialize in helping solve the problem of criminal histories as barriers to employment.

Coordinate mental health services with primary care. Having a primary care physician on mental health sites

Community education on mental health is needed. Link health/life stress to mental health issues and focus on the health aspects of mental health- how to keep you mentally healthy in a culturally proficient manner (linking body, mind and spirit)

Peer support needs to be altered to be activity focused – action oriented – politically focused.

Benefits experts to help with income and health benefits

Support and education services for family members and caregivers

**Young Adults 16-25 years**

Mobile mental health services - all agreed were important for this age group.

A One-Stop shop for mental health services integrated with substance abuse prevention and intervention services

JOBS - Specialized employment opportunities with life skills/enrichment activities that are culturally centered

All groups, who attended the meetings, did not respond to treatment for sex offenders positively. Suggestions on affecting this issue focused on prevention by educating professionals, children and parents on normal sexual development and helping /guiding children to appropriate behavior and sexual responsibility. Prevention responses should be spiritually and culturally based

Healthy sexual behavior education

24-hour drop-in centers specializing in services for African teenagered males and young adults

Pro-active mobile team services that are culturally proficient

Subsidized housing with services developing independent living skills – culturally centered

Culturally relevant specialized education and vocational services that are year around utilizing professional case managers that partner with youth. Services should also include education on legal and civil rights

Develop links with City College and Middle College

Culturally focused recreational and life skills activities
**Children 0-15 years**

It is essential that the multi-disciplinary team approach be culturally focused and develops collaborative partnerships to best serve our children.

Mental Health professionals should be supported to advocate for children involved in various institutions.

Mental health prevention and early intervention should be provided and connected to schools and involve parents. Consistently, responses stating the value and effectiveness of including parents and treating them together with the children were repeated in all groups. Comments also included the need to teach professionals on children’s issues (developmental, cultural, societal, environmental, etc….)

Respite and support services for families with special needs children

Culturally proficient health classes in schools should include information on mental health to increase understanding, decrease stigma, and increase awareness of treatment and resources

Children of incarcerated parents were missing as a target group for services given that criminal justice systems target, over-charge, and disproportionately convict and imprison African people. Children and families suffer greatly when one or both parents are incarcerated.

All groups did not respond to treatment for sex offenders positively.

Suggestions on affecting this issue focused on prevention by educating professional, children and parents on normal sexual development and helping/guiding children to appropriate behavior and sexual responsibility. Prevention responses should be spiritually and culturally based.

Parent Partners as a concept did not seem to fit culturally. Support groups for parents focusing on mentoring and empowerment

Consistent thoughts were expressed that crisis lines were not used much by African people and that 24-hour crisis centers providing culturally proficient mental health/support services would be more effective. These centers would need to be flexible and available

Crisis residential services were important and must be culturally focused

Pro-active mobile team services that are culturally proficient

Integration of mental health and substance abuse treatment
COMMUNITY DIALOGUES ON MENTAL HEALTH IN THE AMERICAN INDIAN/ALASKAN NATIVE COMMUNITY OF SANTA CLARA COUNTY

Prologue

Imagine waking up one morning to sounds of gunfire: of men, women and children screaming in pain and agony from being shot. Imagine watching loved ones wounded or killed in front of you. Imagine being forced to then live on a desolate piece of land called a reservation, hundreds or thousands of miles from your traditional homeland, subsisting on rations provided by your captors. Imagine not being allowed to work or fend for yourself but being told to grow foreign crops to support yourself and family. Then imagine them saying you are a ward of their government and that they will provide you with an education that teaches you about their history, their laws, and their foods. They tell you to assimilate because that is now the present and the way of the future. Then they take your children, at age 5 or 6 to the age of 18, far away to boarding schools to teach them about their customs, culture and language; about another world that is foreign to you. Imagine your children being punished and beaten when they try to speak their language or practice traditional ways.

Then imagine your children and grandchildren growing up on this piece of land with no options for employment, dependent on rations and whatever else your vanquisher provides for you. When you look around this reservation, all you see is poverty, alcoholism, emotional and physical trauma, and you wonder how you can survive. Then imagine many generations later, your captors say that they are sponsoring a relocation program to move families to the cities to provide more opportunities for employment and assimilation. You go but all you find there is the same despair you saw on the reservation because many of the people that relocated had no job skills, did not speak the language, and did not know how to seek out resources on their new ‘reservation.’ Feeling hopeless, angry and disconnected, you reach out to other members of your group because no one else understands how you feel or seems to care.

Introduction

There are currently over 500 American Indian/Alaskan Native tribes in the United States that are federally recognized, with hundreds more petitioning for acknowledgement of their culture, customs and language. Since the 1600s American Indians have experienced various policies of conquest, treaty making, assimilation, and complete termination. Only in the 1970s did the policy of self-determination take hold in which tribes were able to start to determine their own laws and institutions without fear of being hunted or killed, to reclaim their cultural practices, and to relearn their languages.

Through perseverance, many urban and California Indians who experienced reservation life and/or relocation have become successful in life. Over 60% of American Indians now live in urban areas across the country. However, it is clear that the American Indian experience has put American Indian communities at high risk for mental health and substance abuse issues. Intergenerational
trauma is a term that is now being used to describe the impact that hundreds of years of destruction and annihilation has had on the American Indian community. In this narrative report, American Indian leaders, mental health staff, and American Indian youth who reside in the greater San Jose, California area discuss the critical concerns related to mental health, barriers to receiving treatment, and potential solutions for the American Indian community.

**Strengths of the American Indian Community**

An important and sustaining strength of the American Indian community is its strong social and community system. The American Indian community in Santa Clara county consists of three tribes that are indigenous to this area, the Muwekma Ohlone Tribe of the San Francisco Bay Area, the Amah Mutsun Tribal Band, and the Ohlone Costanoan Esselen Nation. In addition, Indians from reservations from across the country were relocated to San Jose as part of the US Government’s Relocation Program from the 1950s to the 1970s. This program gave tribal members living on reservations a one-way bus ticket to an urban area and a promise of job training and temporary housing. Because there is no dominant tribe in the area, community organizations have been created ranging from health care to media programs to address the community’s needs. Organizations include the American Indian Alliance, American Indian Education, the Indian Health Center, the San Jose Elder’s Group, the Center for Training and Careers, Indian Times, radio station KKUP 95.1FM, Native Voice, St. Phillips Church, the All Tribes Baptism Fellowship, and numerous state and community college American Indian student clubs. The local tribes and these organizations all contribute to community gatherings and the well being of the community.

Culture and tradition are healing for the American Indian community. Connection to other members of the community is what is sustaining in the American Indian community. Having strong families and focusing on the well being of the group is the foundation of all aspects of health which includes the mental, physical, emotional, and spiritual. Individuals are seen in the context of their family and history, and not separate from everything that has influenced them.

From 2003 to 2005, the Indian Health Center (IHC) was able to provide substance abuse prevention services using the GONA (Gathering of Native Americans) model. One of the primary philosophies of the GONA model is that connecting and empowering people help address underlying factors that contribute to substance abuse as well as other problems. The IHC held six community gatherings which more than 600 people attended, about 80% of which were American Indian community members. The main goal of these events is to reduce substance abuse by addressing feelings of isolation and historical prejudice that many members of the American Indian community experience. GONAs brought the American Indian community in Santa Clara County together to start to heal the pain that had developed over the years. They have been instrumental in building community trust and laying the foundation for future community collaborations. (IHC’s Future Generation Project, 2005)
Critical Concerns of the American Indian Community

- **Poverty** and **homelessness** are seen as issues not only for those living on reservations but those living in urban areas as well.
- When American Indians emigrated from reservations to urban areas, they had to contend with the high cost of living and **loss of family, cultural traditions, ceremonies, nature, and health care** that had sustained them and been a part of their lives on the sovereign reservation.
- **Substance abuse** is a widespread epidemic in the American Indian community
- When attempting recovery, people with substance abuse issues may self-medicate because of **emotional issues** that arise.
- Many American Indian youth are identifying with popular Western cultural values, thus **losing their traditional cultural identity** and values

There is a large percentage of American Indians living at or below the poverty level. Past policies of the U.S. government has resulted in disastrous consequences as many American Indians lost their allotted lands and had little left for survival. Many have fallen into poverty since then. Housing shortages and limited resources were already problems on some reservations. When they emigrated from reservations to urban areas, American Indians faced more difficulties in affording life necessities including housing. They were hit hard by the high cost of living in cities.

Homelessness was identified as a major concern. Homeless American Indians do not have access to resources or health insurance. Many eligible American Indians living in cities or on reservations do not enroll in health insurance programs such as MediCal. This may reflect their distrust in the system, or lack of knowledge and information about resources that are available. Many American Indians have a historical distrust of government agencies and are reluctant to obtain services they may need. In addition, they do not respond well to programs that do not address their unique cultural needs.

According to the 2000 Census, over 60% of American Indians are now living in urban areas. This migration process is a reflection of the government’s relocation program as well as a search for employment, education and housing opportunities. When they emigrated, American Indians lost access to health care and other benefits they were entitled to on reservations. The same policies and programs that failed to provide them with a sufficient lifestyle on the reservation once again failed to provide them with better lives in the cities. Furthermore, because they tended to disperse throughout the city, they tended to lose cultural, religious and historical ties. The lack of family support and social contact combined with the pressures of an urban environment has placed American Indians at high risk for mental health problems.

Alcohol and drug abuse issues is another destructive health problem that American Indian communities face. Even though alcohol and substance use is common in American Indian communities, the quantities and level of usage vary due to the diversity of the tribe and age of the user. Abuse among teenage users is increasing and this group is considered to be at high-risk. Substance abuse is also related to high rates of homicide and suicide in many American Indian communities. American Indians suffer five times the rate of alcoholism and have a suicide rate that is 50 percent higher than whites, but they are less likely to seek and receive services. Poverty, social
isolation and cultural conflict have also contributed to substance abuse. Some American Indians self-medicate to temporarily escape depression, emotional problems or personal obstacles. When attempting sobriety, some deal with severe feelings of guilt when they relapse.

American Indians have a deep concern for the younger generation, especially for those growing up in cities. The lack of cultural continuity and historical ties cause many youth to lose their cultural identity and norms. Also, because of forced assimilation, some feel they cannot be who they are – American Indians. Youth start adopting and identifying with the mainstream culture, which many times is defined by popular media or their peers. In their search for identity, some turn to gangs for social support and security. More and more youth are growing up not knowing the culture, traditions or values of the American Indian community.

**Barriers to Treatment for the American Indian Community**

- The Western mode of mental health treatment is not as effective for the American Indian community without traditional healing methods.
- Insensitive and rigid counselors cannot understand youth or cope with them.
- For some substance abuse programs such as Proposition 36, clients need a court referral to receive services, and people have to commit a crime to receive treatment.
- Short residential treatment for long-term drug users.
- Housing shortages lessen treatment’s effectiveness since there is no long-term solution or well-rounded system of care.
- Lack of staff to accommodate all mental health needs.
- Staff burnout due to large caseloads which affects delivery of care.
- Lack of funding to develop services.

The lack of cultural-based practices in the Western medical model is a barrier to treatment success for American Indians. Standardized healing practices such as herbal remedies and American Indian healers are an effective way of treatment. Mental health services, such as one hour counseling sessions for someone whose relatives have died, does not have the same impact as participating in a ceremony to let go of the grief. Part of the reason is because it is a transformative event and in ceremony the focus is on the family and community, not just the individual.

Different cultural norms between tribes may also build a barrier in creating a system of care within the American Indian community. There are over 125 different tribes represented in the county ranging from local California tribes to tribes from the plains and southwest, i.e., Choctaw, Kiowa, Apache, Navajo, Hopi, Sioux, Cherokee, and Blackfeet, to name a few. The loss of the American Indian Community Center in 1995 has created a void in the American Indian community which may also contribute to a sense of social isolation since there is no longer a central gathering place.

For youth, the main barrier to successful mental health services include counselors who lack patience when working with youth, who lock up youth because they are unable to deal with them, and who do not understand youth, which in turn irritates youth. In addition, some youth feel that some counselors are too old and do not remember what it was like to be young. Counselors should understand what youth are going through and be able to see issues from the youth’s perspectives.
However, counselors shared that there is a shortage of staff available to help these troubled youth and existing counselors become overwhelmed and experience burnout.

Another barrier that exists is limited access to mental health services in the county. The county mental health Call Center and CalWORKs program require a diagnosis and a referral from a primary physician in order to allow a client to receive mental health services. If a client with substance abuse issues who is in a Prop 63 treatment program needs mental health services, they need a court referral. Communication problems often result in services not being used. Individuals need to complete “the footwork” to get into mental health services but are then denied access, possibly because many services have limited eligibility. When clients are treated for drug and alcohol problems, their mental health issues are not addressed. Primary care health settings are one of the few places that address dual diagnosis (i.e., mental health and substance abuse combined).

Residential services for substance abuse treatment are brief. Forty-five days of treatment services is not enough for drug users who have a long history of substance abuse. If 30 days are used to detoxify this leaves even fewer days for treatment. Clients are discharged and expected to live a healthy, sober lifestyle with few support services in place. Moreover, substance abuse transitional housing units are closing down. While Proposition 36 programs are educating the addict and providing some tools for sober living, many programs cannot provide aftercare or other drug and alcohol services after the person is discharged.

An additional problem is that there are not enough American Indian staff or staff with experience working with this community to accommodate the emotional and mental health needs of American Indians. The Indian Health Center has only two to three mental health staff who are overwhelmed because of the complexity of providing culturally appropriate services with a demanding caseload.

County contract guidelines can sometimes create additional barriers to services since they regulate how agencies can provide services and impose strict guidelines on providers. For example, at the Indian Health Center, mental health services are limited to children and families. If an American Indian adult needs help but does not fall within the specific guidelines, they have to be referred to outside agencies for treatment. Thus, there are times when American Indians cannot have their emotional needs met. Another way of providing/granting funding may be to ask agencies how they want to provide services in a culturally competent way.

**Potential Solutions for the American Indian Community**

- **Community approach**: Create a treatment model that is culturally appropriate for American Indians that includes community.
- **Family approach**: Increase the participation of families in treatment plans.
- **Integrated mental health services**: There is a great need for integrated, coordinated and culturally appropriate mental health services for the American Indian community.
- **Housing**: Address the need for temporary shelters and provide permanent housing solutions.
- **School-based programs**: Develop school-based programs that focus on both prevention and intervention.
Potential solutions for American Indians regarding their emotional health should reflect their wishes for a united community and continuation of their traditional values and culture.

Retraditionalization, or learning about and practicing the ceremonies and traditions of one’s tribe, can be transformative and is a powerful healing intervention for American Indian community members. Because American Indians are spread out and do not live in a concentrated area of the city or county, setting up a more structured community would be beneficial. Each tribe has unique ceremonies and traditions and sharing these can bring different communities together. Cultural activities such as sweats, dancing, drumming, and traditional healing programs are the best ways for people to manage issues, to share in times of happiness or sadness, and to feel a sense of belonging and security. At the last GONA event in June 2005, participants agreed that in order to plan any services for the community, members must feel a sense of belonging, have a connection to the community, and develop knowledge of one another especially since they come from different areas of the country and tribes.

Connections to local tribes and a network of American Indian programs needs to be re-established. Tribal members and agencies can collaborate and meet regularly to find the most appropriate and effective strategies to help the community. Functions that provide a variety of activities for people to participate in will keep the community healthy. This network can identify mental health needs in the community by establishing outreach teams to go out to the community periodically and check on individuals living alone to see if they need help.

In addition to using a community approach, service plans should also focus on a family approach. People find strength in family relationships and values. Therefore, there is a need to nourish the family so they can help integrate the person into the community. The focus on and importance of community to American Indians means that if one person has a problem, the whole family and community faces problems as well.

In terms of strategies for services for youth, there should be counselors who understand the challenges of working with youth. Counselors should be able to empathize with youth, have the patience to explain processes, share similar experiences or understand the culture of youth, and have good listening skills. They should be mentors and role models vs. “counselors.” Moreover, knowledgeable case managers are needed who can connect the individual to community services and events to help provide a sense of connection and belonging.

For youth who are at risk of having emotional problems or who have already had problems, a school-based program is needed that provides peer support and counselors. Youth need someone they can talk to, in-person or by phone, who will listen to them. They need to receive advice from someone who understands their cultural norms and who can also empathize with being young. Some youth shared that they can help themselves by writing, meditating, walking, and thinking. In addition, some youth who currently receive services at IHC expressed a wish to have services provided in more relaxing environments such as at beaches, lodges and camps, where they can feel freer to express themselves.

There are approximately 75 American Indian teachers in Santa Clara County. This is an opportunity to connect the teachers with American Indian Education Title VII programs in school districts such as Santa Clara, Sunnyvale, San Jose Unified and Eastside Union districts. Many
children identify themselves as mixed blood; therefore, we need to reach out and provide social and mental health services that they can participate in. Also, we need to find children in Title VII programs at schools, including college groups such as San Jose State University, and De Anza College. There is a real need to detect early warning signs of symptoms of mental illness and provide services before services are court ordered. Prevention is a critical part of intervention.

For the increasing problem of alcohol abuse, more culturally appropriate interventions need to be developed. Strong models of success for the American Indian community have been developed over the years, including using the sweat lodge as a central part of substance abuse treatment. Culturally competent interventions mean not only incorporating tradition into treatment but also having staff that know the language and norms/culture, and are sensitive to clients’ needs. In terms of substance abuse residential treatment programs, there is a need for a clean and sober living environment housing programs and a local residential treatment facility for American Indians. Currently, American Indians who need residential substance abuse treatment are sent to the Friendship House in San Francisco. A local program, Shelter Plus Housing, has been beneficial for people who need subsidized housing to stabilize. Because people do not become addicts over night, they need long-term treatment to change their mindset and behavior.

“Housing, housing, and more housing” has been a consistent call to help solve mental health problems. One of the proposed solutions is temporary shelter provided for individuals or families who find themselves homeless. These temporary shelters can be a mobile home or a hotel that offers three to four week accommodations at discount rates. Another solution is the Shelter Plus Housing Program, where people can live for one year and receive subsidized rent.

Mental health services needs to break traditional boundaries. Service providers need to work in the community together with clients, go to meetings and powwows, and feel that same sense of belonging. Conversely, clients need to know that they are responsible to the community, that they have responsibilities, and that they can keep their commitments. This support will help people fulfill their responsibilities and not disappear.

An ideal way of funding agencies is to provide grant money and ask agencies how they want to administer their services in a culturally appropriate way. Agencies should be able to provide services to all members of the American Indian community. Additional programs that would benefit the community and agencies are outreach teams that can conduct assessments and link community members with employment and other community resources. These outreach workers must have a strong knowledge of community resources and be well connected with the American Indian community. Job skills development should also be open to all clients.
THE CHINESE COMMUNITY
THE CHINESE COMMUNITY’S PERSPECTIVE ON MENTAL HEALTH ISSUES IN SANTA CLARA COUNTY

Chinese people living in the U.S. come from a variety of historical, cultural and political contexts. There are many forms of Chinese dialects depending on which province they came from, which separates them linguistically even though the written language is the same. There are also great differences between class and social backgrounds. Some Chinese people are immigrants of middle-class families and some are refugees, primarily from Vietnam or mainland China, who arrived during the 1970’s and 1980’s.

Despite these differences, whether a Chinese person comes from Hong Kong, Taiwan, China, Vietnam, or other parts of the world, they all share a continuity of historical and cultural traditions from the early Chinese era and its teachings. Confucianist principles dictate many ways of living for the Chinese. From childhood, they are socialized to the hierarchical roles of family and the proper way to behave and treat others in life. Adherence to these principles is still found in Chinese culture today.

During the last few decades, Chinese Americans have become an important element in California’s Asian Pacific population, which is one of largest and fastest-growing minority groups. Chinese comprised more than 20 percent of the 11.9 million people who identified themselves as Asians in the Census 2000, according to a report by the Commerce Department’s Census Bureau. That translates into 2.7 million people reporting as Chinese—the largest Asian group in the United States.

California has the largest number of people reporting as Asian, with the highest concentrations in San Francisco and Santa Clara counties. Recently, in Santa Clara County not only are Chinese the largest group of Asian Pacific Islanders, but the dialects of Mandarin and Cantonese have also become threshold languages.

This report contains the identified critical concerns, barriers, strengths and potential solutions regarding mental health issues gathered from the Chinese community meetings that were held during June and July 2005. This limited compilation of input is taken specifically from a group of mental health professionals and other community providers who serve the Chinese community as well as from focus groups with mental health consumers and family members.

**Strengths of the Chinese Community**

- Collective altruism
- Strong family values and beliefs
- Cultural traditions and activities
- Resilience, love, hope and faith
- Humility, politeness, harmony and non-confrontation
- Values in higher education
- Loyalty and interdependency
• Respect of authority
• Filial piety and reciprocal family relationship between elderly parents and adult children

Consumers and family members agreed that the fear of being labeled is huge, but they also do not want to burden society with their problems. They hold a sense of responsibility for their family problems, care about their community and want to care for themselves. They want to get well, get a job, get off social security income (SSI) and be able to contribute to society. This collective altruism is one of the strengths of this community.

Similar to other ethnic communities, Chinese people find strength in their supportive family members and friends. They have a strong sense of community that cuts across multiple generations, provinces and dialects. Chinese are such a closely-knit community that language can instantly bond one person to another upon greeting and realizing that the other person can understand their dialect.

They embrace and celebrate their heritage. Chinese continuously uphold their beliefs and pass on traditions to their children. They set high expectations on children and grandchildren out of love and wanting only the best for future generations. Although they face many challenges, they continue to be resilient with hope. They do not give up on their loved ones and they pool their resources, especially financial, when they have to help with buying medications. Finally, but not least, they feel that there is hope because people in the U.S. are more open to talking about mental health issues than in China and their homeland.

**Critical Concerns of the Chinese Community**

• Cultural gap between youth, adults and generations
• Ethnic/cultural identity conflict
• Culturally relevant family conflicts between parents and children
• Marital and parenting problems leading to depression
• Single parenting issues and lack of support
• Avoidance of seeking help due to fear of being labeled
• Cultural isolation and loneliness
• Lack of support groups for single relationships
• Lack of social networks for elders
• Severe mental illness, including schizophrenia, depression, suicide and autism
• Lack of transitional services

When Chinese people come to the United States, many feel the pressures of having to learn English as well as assimilating to Westernized culture. Their stress comes from the need to find employment, housing, food and a sense of stability in their lives. Many Chinese refugees face challenges of securing their basic needs and do not have time to focus on their emotional needs.

Another group of Chinese people who come to the U.S. for educational purposes also find it difficult to adjust to living here. For different reasons, they also have difficulty maintaining emotional health. In their attempt to transition successfully in the U.S., they find themselves in conflict with
their cultural identities. There is a vast difference in values and beliefs between American society and traditional Chinese society that set immigrants into a constant cultural conflict about their identities.

In recent years, providers have observed an increase in Chinese clients coming to them for help regarding family conflicts related to acculturation issues, marital problems and child rearing issues, for symptoms of severe depression or informational resources.

Chinese families struggle in raising their children because they work long hours and do not have time to provide guidance. The children of first generation Chinese immigrants are raised in the home with strict traditional roles and rules of conduct. They are expected to be self-disciplined and honor their parents by doing well in school to bring pride to the family. When Chinese parents attempt to discipline children for misbehavior or for not performing well academically, it is challenged by their children who are more familiarized with western culture.

Many times, Chinese couples experience marital problems as well as financial problems. Their marital discord may result in divorce and children suffer most from this impact. There is also a rise in the number of single Chinese parents and the issues that go along with being a single parent such as working long hours to provide for their children, lacking time for discipline, and no support in general for newly single parents. Many children of single parents become latchkey kids and are not well disciplined. Because the parent is too busy working.

Meanwhile, their children are quickly learning English at school and adopting a whole different set of values from the traditional Chinese beliefs. Chinese parents believe that education and hard work can achieve any dream in the U.S., and they pass this optimism onto their children. Chinese parents emphasize the importance of academic scores to their children and set very high expectations on them.

These children respect their parents and many will perform well academically and behave obediently at school. Chinese youth and adolescents will witness marital conflicts, experience sibling rivalry and divorce without showing obvious symptoms of depression. In a sense, they carry these problems on their mind but have been socialized not to speak about family problems to people outside of family. Instead, they focus on school and thrive academically. Therefore, teachers rarely detect symptoms of mental illness among Chinese children because they do not misbehave in the classroom.

Many Chinese families do not recognize the importance of mental health, only giving attention to physical health. When parents neglect their children’s emotional needs, it may lead to tragedy. There are warning signs, but the parents might have been too busy to recognize them.

Some Chinese children have been diagnosed with autism and their parents cannot afford treatment services because of financial barriers. Innovative brain enhancement treatment for autism has been shown to greatly improve a child’s life functioning skills, but these services are costly and rarely common knowledge to the Chinese community. It causes a lot of stress to the parents.

Many mental health issues are taboo to speak about within the Chinese family and community. Men and women experience emotional distress and frustration that is not talked about. Chinese men cope with their problems by using drugs or alcohol and their wives feel depressed from being isolated from everyone and being a housewife with limited English speaking skills.
There are also many depressed adults who call into the Suicide Hotline who have been diagnosed with severe schizophrenia or depression. These callers want to speak in Chinese and have only called because their illness is at a crisis level. Oftentimes, the callers are feeling very low and desperate in order to call for help.

Chinese elderly experience a high level of cultural isolation and loneliness as well. They usually are left alone at home and have no other social networks besides their children and immediate family. They are isolated because of their lack of English and depend on their children for everything. Elders do not know how to communicate and are often abused or neglected. They tend to deny their emotional problems and report physical symptoms of pain. Chinese elderly do not want to talk to a counselor about their problems and instead they prefer to have a case manager find them resources.

Chinese mental health consumers and family members report many critical concerns that were previously stated. Additionally, Chinese consumers and family members feel there is a lack of education about mental illness symptoms and treatment services in their community. They do not have the financial resources to utilize mental health services and do not understand health insurance coverage changes from MediCal to private insurance. They are also afraid to talk about their mental illnesses because of the stigmatization. When they do seek help, they discover that there is a lack of bilingual practitioners and culturally appropriate services.

Family members of mentally ill persons have specific concerns regarding mental health. There is a lack of transitional care for severely mentally ill individuals. Those who get better and obtain a steady, low-level income job lose their MediCal or county benefits as a result of low-paid employment. They can no longer afford expensive psychiatric medications or inpatient care that are not covered by their basic private insurance. Nevertheless, family members express a strong sense of value and social responsibility to encourage their adult children to keep jobs over the risk of losing MediCal or social security income (SSI) benefits. These individuals need help and information about how to deal with changes in coverage and/or transitional services to lower levels of care.

**Barriers and Disparities for the Chinese Community**

- Language barrier in communication
- Lack of culturally and linguistically appropriate services, such as phone conversations or primary doctors
- Limited knowledge about mental illness and resources available
- Social and cultural stigma of mental illness and treatment
- Lack of health insurance to obtain services
- Shortage of bilingual staff in the public sector
- Avoidance of talking about emotional health or problems due to fear and distrust of system, e.g., racism, disparity of resources
- Shame and guilt
- Family secrets and loss of face
- Family name supersedes personal needs
- Social isolation
Chinese people find it difficult to access mental health services because of the language barrier in communication between providers and consumers. There is a lack of culturally appropriate services in the mental health system, such as the shortage of bilingual practitioners. The limited outreach to the community is evident by the underutilization of services. Chinese people are not aware of services and resources that are available to them. If they do become aware of services, they may not be able to access them because of a lack of health insurance or the stigma that surrounds having a mental illness.

Chinese parents may observe and suspect that their children suffer from emotional distress, but they do not seek help because they do not understand the illness and severity of the issue. There is also a deep seeded fear of being labeled once they come out and talk about it. When they do seek help, they prefer to consult with someone over the phone anonymously or to speak with their primary care provider. This is because the primary care provider is someone they have chosen and entrusted with all of their medical problems.

Individuals in this community tend to be hesitant about seeking help for mental health issues. If primary care providers appropriately refer them to a mental health specialist, Chinese people will not talk to them. They fear the stigmatization of mental illness. This fear is intense because they do not want their neighbors to talk about them and be referred to as “crazy.” Oftentimes they wait until the illness becomes very severe or a crisis before they seek help and regret it afterwards. In addition, their denial and resistance to seek treatment is worsened due to their fear and distrust of the system. They prefer to receive treatment in their home or in natural environments.

The stigma of mental illness has huge effects on one’s life. One family member stated that her daughter disclosed her mental illness and had to change jobs due to stigmatization. Moreover, her daughter no longer wishes to discuss her mental illness with anyone and feels the painful burden of hiding her illness.

**Potential Solutions for the Chinese Community**

- Culturally and linguistically competent interventions
- Increased education about mental health and services
- More bilingual support groups for families and consumers
- Age appropriate services for elders and youth
- Increase social and problem solving skills in children
- Social networks for Chinese elders
- Provide educational workshops for parents
- Focus on prevention
- Mental health education and training
- More Chinese speaking therapists

Potential strategies for improving the mental health of the Chinese populations should consider culturally and linguistically appropriate interventions. This would include increased outreach to raise awareness about mental health and the services provided within the county. Outreach strategies
should work with people and at places that are more comfortable for Chinese to seek help, such as Chinese primary care providers’ offices, school personnel, law enforcement and an anonymous 24-hour Chinese Crisis Hotline. Services should be tailored to the needs and comfort level of the community. There is also a crucial shortage of Chinese speaking therapists and staff in the public and private sectors.

Many Chinese youth and adults, and their families, would benefit from having support groups for coping with mental illnesses. Youth need a safe place where they can learn social and problem solving skills. Adults need a group to assist them in understanding the frustrations and recognizing the importance of mental health and other life issues. The elderly need a place where they can connect with other elders, socialize and be a resource to one another.

Consumers and family members have reported high satisfaction and usefulness of bilingual support groups. One support group for family members has increased members’ awareness about symptoms, the spectrum of disorders and the services and resources available to them. Many people seek resources for basic needs first before they can even think about resolving their emotional distresses. For example, a Chinese residential drug treatment program helps Chinese men to reduce substance abuse before they become open to mental health services through biblical teaching.

Consumers report that educational workshops would be most helpful for parents. Parents would benefit from stress management and parenting skills workshops. Outreach strategies should be more culturally sensitive. Chinese people tend to have a lack of awareness of mental disease or psychiatric illness. They are more inclined to address problems through somatic symptoms.

Services should focus on prevention, providing activities that cut across generations, teaching family communication skills, understanding the importance of mental health, and how to speak out and get help. Education about mental health needs, including insurance coverage and early intervention, should be the essential focus of services to this community.

Providing mental health training for young professionals, teachers and the police would also prove beneficial. In recent years, the community has experienced increased incidences of police brutality. Training about the community and mental health should be provided to the police force. Chinese youth would benefit from school screenings to detect early symptoms of mental illness. Teachers and school personnel could be trained to detect some symptoms common to this community. Young professionals in the field could be trained to work with monolingual consumers and family members. This would greatly increase the access and quality of services within the county.

Chinese people, as an underserved population, need a lot of effective community outreach and mental health education. Besides specialty mental health services, prevention and early intervention will enable them to come out and seek treatments in a timely manner. Culturally and linguistically appropriate staffing and services are essential for engagement and the success of mental health intervention.
COMMUNITY CONVERSATION ON MENTAL HEALTH IN THE FILIPINO COMMUNITY OF SANTA CLARA COUNTY

Filipinos have been migrating to the U.S. from the Philippines since the 17th century. Circumstances, time period and the politics of the time have determined who could come, how many could come, and what they could do once they got here. Thus, the origin and growth of Filipino communities in the U.S. was largely determined by immigration policy. In 1898, after the Spanish American War, the U.S. replaced Spanish colonialism with its own dominant policies and the Philippines became a U.S protectorate.

U.S. immigration policy was highly influenced by the politics of the times and often shifted from a flexible to a highly restrictive policy. Such policies determined the size of the immigrant flow, as well as the gender composition, the ability to own land, whether Filipinos could work as licensed professionals, whether they could marry white women, and the intensity of racism experienced by Filipinos in general. Not until the period from 1946 – 1965 did Filipino communities experience significant growth and stability.

After the 1980’s, the closure of U.S. military bases in the Philippines led many Filipino Americans to relocate to the states. These closures also increased the number of correspondence brides and brokers. In addition, politics in the Philippines has affected immigration. “With the lifting of martial law in 1986, new immigrants are a much more diverse group of more educated, upper class young Filipinos and a mixed-age group of a less educated lower socioeconomic class.”

Today Filipino Americans are the second largest Asian group in the United States and Santa Clara County has the largest number of Filipinos in northern California. About 70 percent of Filipino Americans are immigrants and thirty percent are U.S. born. A large undocumented population also resides in Santa Clara County. The mental health needs of this community are strongly affected by this diversity. The Stanford Geriatric Education Center expects the cohorts of older Filipino Americans to be mostly immigrants well into the 21st century. Older immigrants and recent immigrants are less likely to speak English well and more likely to adhere to traditional Filipino values such as respect for elders, interdependence, and reciprocity (utang loob), i.e. giving back what one has received. Love and respect for parents as well as for grandparents is a key part of traditional values. In these multigenerational households, grandparents are an integral part of the family. Grandparents often provide childcare as well as cooking and cleaning. As the grandparents age, the family in turn, takes care of them. There is a strong emphasis on group harmony, loyalty and respect for elders and authority. These values are passed on from one generation to another.

A concern within the community is the loss of such values as well as the loss of the language as the members of the second and third generations assimilate and acculturate. Economic stressors may also contribute to the decline of the extended family as families follow their jobs to other areas. Such stressors as well as lack of information about resources can at times lead to elder abuse (McBride, M.p 4). Additionally, “geographic separation or alienation from family and financial

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2 Fujimoto, Nadien. Knowledge of Immigrant nationalities of Santa Clara County (KIN) - Philippines
difficulties are. . . common stressors among clinically depressed Filipinos.” (Tompar-Tiu & Susento-Seneriches, 1995) [cited in Melen McBride].

Several large scale studies have documented the underutilization of mental health services by Asian Americans. These studies indicate that when Asian Americans do use these services they are more severely ill than white Americans who use the same services. Another study found that 20 percent of Filipinos lack health insurance, thus posing yet another barrier as was cited in the Surgeon General’s Report. Although the need for mental health services exists, many Filipinos seek community-based healers and spiritual counselors. Traditional treatment may include the use of herbs, massage/manipulation of bones, nutritional supplements and prayer. (McBride, 2001)

A 2004 report by the White house Office of National Drug Control Policy released and cited in Asian American Recovery Services Community Needs Assessment found “a 52 percent increase among Asian American teens undergoing drug treatment in the last five years.” The report found that 2.2 percent of Filipinos were using illegal drugs. The decline in the quality of our schools (large class sizes, lack of textbooks, poor facilities, and few Filipino teachers and administrators) may be in part responsible for the lack of interest of Filipino students. In addition, the decline in the economy leading parents to work two jobs may also lead to less supervision and connection with Filipino youngsters.

Continuing immigration from the Philippines ensures continued diversity within this community. Community members mirror the white population (mainstream population) in their love and concern for their children and their desire to make a better life for themselves and their families. Yet, as a group they experience a system of mental health that is not always responsive to their needs.

**Strengths and Coping Mechanisms in the Filipino Community**

- Supportive family and friends; caring; generosity
- Matulungin (helpful, accommodating)
- Sense of integrity
- Determination
- Catholic faith, spirituality
- Politeness
- Patience
- Maalalahanin (thoughtful, always thinking about others)
- God fearing (practice religion out of sincerity and not out of fear)
- Fun loving—arts, music and dance
- Enjoy being part of a group, value being together and helping one another
- Strong work ethic

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3 Surgeon General’s Report, Chapter 5, p. 4
Filipino families value cooperation. They work together to help other family members who may be struggling. During difficult economic times, and especially among more recent immigrants, it is not uncommon to find several families sharing a roof. Reciprocity is highly valued. Filipino families are often multigenerational. Grandparents often provide child-care and as they themselves age, their adult children care for them. The extended family and friends come together often to celebrate birthdays, weddings, and simply to have fun. The group is valued over the individual, thus it is not uncommon in Filipino communities to find numerous groups organized along social and political lines. The reciprocity, cooperative, and social nature of the group lends itself to assist in supporting those with mental illness.

**Significant Problems and Critical Concerns in the Filipino Community**

Conversations with Filipino community members yielded the following critical concerns:

- Young people have no respect for elders
- Dislike for school leads to truancy
- Lack of parental support/supervision
- Mental health issues brought on by substance abuse
- Addiction to drug and alcohol
- The impact of stress on mental health
- Domestic violence
- Violence in general
- Discrimination
- Cultural isolation (mixed group focus group)
- Undocumented legal status
- Overseas Filipino workers

One Licensed Social Worker (LCSW) shared a case involving a father and his son. The father found he was unable to discipline his son in the traditional way (hitting), so he convinced the son to return with him to the Philippines. As soon as they arrived at the airport, the father reportedly beat the son.

Elder abuse such as the adult grandchildren or the children taking the elder’s social security is not uncommon.

Domestic violence is not unusual especially in situations where the woman is in the U.S. without her extended family. This is often the case with ‘correspondence’ marriages.

A long time nurse discussed the decline in the economy and its effect on middle class Filipino families whose main breadwinners lost their jobs and/or was working at a lower paying job; many have brought their parents to care for their children while they are at work. She has seen an increase in domestic violence and problems with violence, in general. In the Bay Area as well as in other Filipino communities throughout the country, several murder suicides have occurred, most recently in Milpitas. In these cases the father kills his wife, himself and his children. Economic stress appears to provide the context for these tragedies.
A Filipina MFT believes the zero to five focal populations is a critical group. As an example, she described a four-year-old client whose family were recent immigrants. A couple months later, the client’s mother passed away after battling with several health complications. The family was forced to live with a relative, but had no legal status to stay here in America. The father sold everything they had in the Philippines to pay for his wife’s medical bills, thus he felt it was necessary to stay and find work to give his children a future. He worked a graveyard shift in a hotel and would ask his older son who was 17, to watch his younger brother at night. The child’s teacher referred the child to counseling due to his behavioral problems which included not wanting to go to school, not getting along with peers, and grief over his mother’s passing and his father getting married soon after his mother passed. The child mentioned to his teacher that his brother had pinched his "private part" when they would take a shower. This led to an investigation from Child Protective Services (CPS) and subsequent removal of the child from his family. Although there were cultural factors that may have played into this, the child was put in a shelter.

The MFT worked with the father, due to language issues, and a non-Filipino therapist saw the child. The father expressed his grief over his first wife and talked about his how new marriage to helped him and his family become legal residents. The Filipina MFT soon left the agency and did not know what happened to this family. A year ago, the father’s cousin whom the family had been living with, walked into East Valley Mental Health Center due to PTSD (Post Traumatic Stress Disorder) and anxiety. She mentioned that she witnessed her cousin (the father) stab his second wife to death. The father is now in prison and the family faces daily threats from the second wife’s family. The now eight-year-old boy sits and waits at the Children’s Shelter lobby wondering why his father is not there to visit him and bring him his favorite food. His father's message was, "I did everything that I could to give you the best and so you can stay in America. Forget about me now."

The family suffered several traumatic life transitions, beginning with their migration to the U.S. Unfortunately, the most victimized in all of this is the four-year-old boy who has not yet developed a sophisticated way to express and deal with what is happening to him, not to mention the language and cultural gap that he has to make sense of. Had a more family oriented approach been utilized, perhaps an alternative solution could have been found so that that child would not be further traumatized – the loss of his mother, sexual abuse, then losing family as well.

Overseas Filipino workers share a number of concerns. Chief among these is the mental health problems related to adjusting to a new country. The adjustment process involved in migrating to a new country often triggers depression and anxiety.

Economic conditions in the Philippines have led some to accept lower status jobs in the U.S., despite their professional background. Many suffer emotional distress as they attempt to hide their level of education.

Others suffer high anxiety due to fear their contracts will not be renewed. This signifies shame in the Philippines because it is seen as a sign of failure. A substantial number of Filipinos are in the U.S. with various degrees of legal status. Many will not seek help for fear of deportation. Yet many are suffering from various mental illnesses – some stemming from their status.

Issues surrounding gender identity has also become a growing concern in the community. A therapist treated a Filipino who told her that he had always felt effeminate, even as a young boy.
growing up in the Philippines. His brother had to continually defend him from taunts as well as physical bullying. His family moved to the U.S. where he attended high school and experienced more homophobia. As an adult, he worked for many years but finally decided to openly identify as female. When this individual underwent surgery to become female, she experienced a great deal of discrimination at her workplace and ultimately lost her job when numerous employees were laid off. Since then she has had trouble holding down a job and the deep shame of her sexuality when around her family as well as her shame about not having an income led her to prostitution. She was beat up and robbed on one occasion. She was also arrested for prostitution.

This individual’s family has been very supportive as far as providing her with housing and basic income. However, this individual experiences deep shame and anxiety when around her family. This shame and anxiety also stems from sexual abuse from an uncle. Her therapist suggested she also visit the Billy de Frank Center; she did but did not feel comfortable going there.

**Disparities and Other Barriers for the Filipino Community**

- Shame associated with mental health
- Keeping it (mental illness) within the family
- Shyness

One person mentioned that some families were upper or middle class in the Philippines and now in America, they’re doing low status jobs, and feel great shame.

- Denial of mental health problems

People come in when they are very ill. As soon as they feel better they do not return until they have another crisis, then they return to emergency.

- Cultural beliefs/customs that make it not “okay” to access services
- Lack of support system to help access services
- Language
- Housing discrimination
- Rigid definitions of financial need which limit early intervention
- Challenges to services faced by older adults and World War II veterans
- Young people do not access services due to fear of being “taken advantage of” (more specifically for girls)
- Young men prone to putting themselves in risky situations which results in involvement with may lead to involvement with the criminal justice system
- Young people don’t like being told what to do
- Sometimes counselors get “too involved” in helping, which doesn’t help the situation

**System Barriers**

- Underutilization of services
- Medical/Medicare coverage (Dental)
- Better communication between doctor and patient
• Lack of sufficient bilingual mental health professionals
• Lack of knowledge about resources
• Lack of money/insurance to access mental health services
• Lack of transportation
• Lack of culturally competent providers

World War II veterans suffering from mental illness are often mistakenly directed to the Veteran’s Administration (VA). Oftentimes, these older adults have some mix of Medical and Medicare and may or may not qualify for services.

The experience of the counselors who serve in the Filipino population, indicates the critical need for outreach. Once members of the community know there are counselors who are culturally competent they will often seek them out.

Once clients find a culturally competent therapist they sometimes will not admit that they have private insurance so that they can continue seeing their therapist. Yet, the therapist must close the case, because, if these clients with insurance are seen they are subsequently billed for the services.

**Potential Solutions and Strategies for the Filipino Community**

• Create public outreach and education
• Early intervention
• More Filipino staff

Public outreach and education is very important to let Filipinos know what services exist and how to access them. Education is also important to eliminate the stigma and shame surrounding mental illness.

One recent study of the Child Welfare System in Santa Clara County found that among Asians in the system, the ones who got out of the system more quickly had received early intervention services. In other words, someone noticed symptoms of problems and someone worked with the family at an early stage. When the child is not removed from the home, the family is more apt to work with the system. Family maintenance through early intervention works.

One example that was given was when a parent called in and said, “I’m going to kill my kid!” The person on the phone was aware enough to know not to call Child Protective Services (CSP) and understood that the mom simply needed to be listened to.

• Include family members in outreach efforts
• Design support systems to get people into services
• Empower clients to communicate
• Have people of the same age and/or cultural background support each other
• Affordable housing
• Transportation tokens
• Socialization programs (mixed group focus group)
• Career development specific to Filipino culture
• More community meetings
• One stop shop: medical, dental, legal, individual and family counseling, recreational gym facilities for the young and old, immigration advise, education and training for family members and community regarding mental illness-- under one roof.

Discussion of various ways to “hook” community so they can come in for mental health services. A one-stop center would have to have a special entry door so that mental health clients will not be as visible.

• Financial help
• Information via newsletter to decrease isolation and keep the community informed
• Literature in doctor’s offices and clinics
• System support system made up of people who have been through similar experiences
• Medication and counseling

Develop informational campaign to decrease stigma against mental illness. Perhaps model this campaign on the HIV/AIDS awareness campaign. Advertise about depression like the pharmaceuticals companies do.
NARRATIVE FROM COMMUNITY CONVERSATIONS WITH THE LATINO COMMUNITY

Recognition of the vast diversity within Latino communities in Santa Clara County is essential to an understanding of this group’s engagement and evaluation of the mental health system. Members of this community differ on dimensions such as racial/ethnic identity, degree of acculturation, age, level of education, socio-economic background, and sexual orientation.

Latinos have been emigrating from 22 different countries for about 200 years, thus accounting for the diversity of tastes in food, music, language, religion, and views of mental health symptoms and treatment. While a small percentage of Mexicans resided in the U.S. before the U.S. Mexican War, the vast majority of Latinos are immigrants and/or descendants of immigrants.

Consequently, at any point in time we will find Latinos who recently arrived in the U.S. and speak very little English and identify strongly with their mother country. At the same time there will be others who are acculturated but continue to identify as Latinos and still others who no longer identify with their family’s country of origin, yet have not assimilated into the U.S. mainstream.

Among Latinos there is a diverse view of mental illness. Some do not recognize symptoms of depression, for example and may attribute symptoms to laziness. Others will refer to “nervios” as a female illness and view it as a broad category of ills including anxiety and depression. Many do not trust the mental health system and strongly adhere to the adage “la ropa sucia se lava en casa,” or keep the family problems within the family. Latinos are very conscious of the social stigma associated with mental illness and will prefer to keep the family member at home and perhaps seek folk remedies (Ilerbero, sobador, curandero). Lack of understanding of mental illness and lack of information about resources keeps this practice in place. Many families simply do not know what services exist or how to access these services.

Yet bilingual, bicultural therapists are intensely sought after by community members. A Latina therapist says, “Familias knocking on my door and following me to other agencies because there are not enough culturally competent therapists!” Once the community knows there is someone who speaks Spanish understands the culture (not enough to speak the language) they will come for services. Another consumer says she lived in Los Angeles and now in San Jose, says it is very difficult to find Spanish speaking compassionate therapists.

Strengths of the Latino Community

• Faith in God and spirituality
• Supportive families- cooperation, familism
• Perseverance in the face of adversity
• La Cultura Cura (The culture heals)
• Bilingual and bicultural

Although there is a great heterogeneity among Latino families, some generalities hold. Latino families will extend themselves to help their family members in need. There is a great love for children,
respect for elders, and cooperation among families. Family members see themselves as part of a collective and not simply as individuals. Cooperation among the group as well as loyalty to the group is valued. Families will often double up to make room for relatives struggling economically. In addition, it is not uncommon to find grandparents living with their adult children. Grandparents care for the grandchildren and as they age, their children reciprocate by taking care of them.

Family members identify strongly with their families—including the extended family. In addition, the system of compadrazgo brings in non-blood relatives as padrino (godfather) and madrina (godmother). It is essential that we utilize these built-in systems in order to support parents struggling with adolescents and mentally ill relatives. These systems can be best utilized with young families as part of a program of early intervention.

**Critical Concerns of the Latino Community**

Many families who have had their loved ones treated in the system have numerous complaints. In this situation several things are problematic. First, some families simply do not know who to complain to or may not have the English language skills to do so. Second, even when they do, they may feel intimidated or hopeless that their voice can be heard. One Latino middle class, highly articulate, family shared their experience “struggling” with the system. Over the course of 20 years advocating for their loved one (they brought a 2 inch thick file folder to the meeting as proof of their efforts), they are very dissatisfied.

Latinos experience a system of mental health not always responsive to their needs. Conversations with Latino community members yielded the following critical concerns:

- Stigma and shame around mental illness
- Removal of children by Social Services
- Parents are separated from their children when they are placed in Juvenile Hall
- Parents fear for their safety when adult children become agitated
- Isolation of family
- Police insensitivity
- Lack of knowledge/awareness about mental illness among public employees in schools, criminal justice, and other social service settings
- Insufficient knowledge about accessing the mental health system
- Insufficient knowledge among consumers and their families about how to go about improving the services they receive
- Insufficient housing for those released from a 72-hour hold
- Lack of culturally competent (bilingual, bicultural) therapists

**Children who are removed from their home by Social Services**

The rate at which Latino children are being removed from their families is alarming and signals the dramatic need to adopt a system of early intervention and education of providers as well as families. Providers need to be culturally aware of value judgments they carry. Such judgments may lead them to make hasty decisions involving removal. Families, especially immigrant families
may not be aware of corporal punishment laws in the U.S. Families barely able to provide for their children need financial assistance in order to better provide for their children.

A professional, with many years of work with Latino families whose children have been removed and placed in foster care, shared the story of cases where poverty, misconception regarding punishment and prejudice contributed to unjustified removal of children. He echoed the deep concern of Latino parents about the overrepresentation of Latino children in the foster care system. A typical case is the single mother living in a converted garage with inadequate facilities, depending on welfare, and her two children are removed from the home, even when the mother is working odd jobs, like cleaning houses to improve the living situation.

In another case, a collection was taken by friends who raised $800 to help the mother have the children returned home. Friends of the family also circulated a petition signed by community members to the effect that she was a good mother, yet the children were not returned and finally placed for adoption.

In another case, a grandmother without any past legal record was not considered fit to adopt the grandchild because she was also deemed incapable of offering an appropriate home to the child, like not having an extra bedroom for him to have his privacy. The process of removing the child, finding foster placements and later putting the child up for adoption cost thousands of dollars, yet some poor parents will receive no housing assistance.

In another case, the parents had five children and all five of whom were removed from the home. The children deemed to be “at risk” because the father “hurt the one who was always causing trouble” – perhaps in an attempt to restrain him. The parents lost all five children. A month later, a psychiatric evaluation confirmed that the “child in trouble” was diagnosed with a mental illness, a severely emotionally distributed kid. Only after almost a year that the identified child received treatment in a residential facility, were the other four children returned to the parents. To add insult to injury, the parents, now have been asked to pay for the services provided by the foster families for their children. This is yet another case in which the family probably needed better assessment, more services and support, not punishment.

**Parents’ separated from their children when placed in Juvenile Hall**

There is a concern that when adolescents (12 – 18 year olds) are placed in Juvenile Hall, the connection between the parent and the child is broken. The parent no longer feels he/she has any authority over the child and slowly the two become distant and disconnected. One therapist working with youth at Juvenile Hall noted that she has several youth that have returned to Juvenile Hall as many as 16 times. A few of these youth have committed atrocious acts such as murdering others as part of a gang action.

The parents tend to ‘give up’ – they throw up their hands in utter powerlessness. They decide there is nothing they can do for their child. The youth in turn feels alienated and abandoned by his family and may turn to drugs or gangs with increased fervor. This is a cycle that needs to be broken.

Youth that enter Juvenile Hall as a result of parental neglect or other minor transgressions are kept in-doors for up to 23 hours a day, seven days a week. The institution is a multi-story building.
Youth need to be outdoors for a greater part of the day. This type of experience reinforces the idea that society cares little for its youth. This treatment of Latino youth is simply unacceptable.

**Police Insensitivity**

The encounters between Latinos and the police frequently lead Latinos to complain that the police discriminate against Latinos, and are not sensitive to the problems of mentally ill Latinos. Family members complain that the police beat the mentally ill. They want more Spanish speaking officers so as to avoid misunderstandings. Such misunderstandings result in severe consequences. In one case the parents physically restrained their mentally ill daughter (who became violent) from running away from home. The police arrested the father who served four months in jail. At the same time, he was prevented from seeing the daughter for four years despite the daughter wanting to see him. Had the police responded to the parent’s request for a Spanish speaking person, this trauma to the entire family could have been avoided.

Parents complain that when children are removed from the home the parents aren’t informed as to where they can find them. Imagine a parent’s distress at not knowing where they can find their loved one.

**Isolation of family**

**Parents fear for their safety when adult children become agitated**

Latino parents with mentally ill adult children often opt to care for them themselves. They do so because,

- i. They do not know of other options
- ii. They do not understand and/or
- iii. They do not trust the mental health system.

This group of parents needs to be better supported. Taking care of a mentally ill loved one takes an enormous amount of energy and time. When there are two family members caring for the loved one, they may have to take turns going to work and then coming home to more work. Single-family caretakers are at risk of exhaustion or worse, of abusing their loved one. Moreover, the emotional toll and despair a parent feels to watch their loved ones is substantial.

Isolation sets in, as members of their extended families grow distant because of their misconceptions around mental illness. Isolation also results from the lack of help with caretaking. This means parents are not able to stay in close touch with their families. Thus, parents end up isolated just when they need support.

Caretakers of adult mentally ill family members are also at risk. One mother talked about fearing for her safety and literally sleeping by the door in order to have a quick escape during periods of time when her adult mentally ill son became violent. These families want the broader community as well as their own extended families to better understand mental illness. They would like to have help with their children so they can rest from the daily exhaustion of being caretakers. This is especially true for single parents.

Staff in educational settings lack knowledge and sensitivity about mental illness. One parent said her son was dropped from school because he missed two days. Teachers and other school
personnel need training so they can better respond to students with symptoms of possible mental illness. Teachers can help eliminate stigma around mental illness which will in turn, make it easier for families to stop being embarrassed to admit they have children with mental illness.

One parent shared that her son began to exhibit signs of mental illness as early as the fifth grade. The teacher, the nurse, and the principal insisted that the child simply “wanted to be the boss.” The child eventually was diagnosed with Cardio Facial Syndrome and he was placed on several different medications including Zoloft, Zypreza, Depracote, and Respirol. The side effects from these medications made him very sleepy. He missed a great deal of school. He resisted returning to school because he had no friends. Sensitive school personnel can make a huge difference. A librarian was able to think well about him and got him a friend. The child returned to school and was doing well. Unfortunately, his friend moved away and the child again became estranged from school.

**Insufficient housing for those released from 72-hour hold**

Oftentimes, consumers are released from a 72-hour hold. These consumers are not stable yet they are put on the street. The shelters have long waiting lists.

**Barriers for the Latino Community**

- Lack of cultural sensitivity in mental health system
- Culturally competent (bilingual, bicultural) therapists are carrying excessive case loads
- Lack of good nutrition and overall care at residential facilities
- Lack of standards at locked facilities regarding privacy
- Lack information about how to access the mental health system
- Apprehension about getting deported
- Financial eligibility

There is a strong need for more Spanish speaking employees in all systems: educational, medical, criminal justice, and mental health. Culturally competent therapists are carrying excessive caseloads. This is a concern because it could lead to exhaustion and therapists leaving the field. In addition, an overwhelmed therapist/case manager is less effective.

Lack of cultural sensitivity is reflected in one example where a child who spoke little English was assigned to a Vietnamese doctor, who did not speak Spanish. Police need to be sensitive to adolescents and consumers in the mental health system, especially to Latino consumers *not in the system.*

The family’s embarrassment about having a child with mental illness is a key barrier. This coupled with the family’s lack of information about the system and not ‘knowing’ anyone (a provider they can trust) in the system creates a barrier.

Some consumers expressed concern over the lack of privacy at a locked facility. Family members find it inappropriate for their son to be bathed by a female.

Of great concern are the substandard levels of nutrition, care and supervision at residential facilities. Consumers complain of being served the same menus daily, of poor tasting food, and of not
being served such basic foods such as milk. Poor supervision regarding the coming and going of consumers is also a concern.

Fear of apprehension by the authorities is a barrier to accessing mental health services. A substantial number of Latinos are in the U.S. with various degrees of legal status. Many will not seek help for fear of deportation. Yet many are suffering from various mental illnesses – some stemming from their status. The adjustment process involved in migrating to a new country often triggers depression and anxiety. Immigrants are far from their loved ones and are adapting to a new language, a new culture as well as to the accompanying discrimination.

Some immigrants are highly educated, but are unable to work in their profession. Those without proper legal status often suffer from post traumatic stress disorder (PTSD) resulting from the migration process itself, and this causes them to be in a state of hyper-vigilance.

One therapist conducted a depression group for Spanish speaking clients. She found that most of the group members were depressed because they missed their family (including their children) and friends. Interestingly, many were living with family members whom they may not have grown up with and were no longer close to them.

The formula used to determine eligibility for mental health services is a barrier against people with mild mental illness. Only those with Major Depression, Schizophrenia, and other major mental illness are accepted into the system. Yet, early intervention is important to preventing chronic severe mental illness.

**Potential Solutions for the Latino Community**

- Services in addition to medication
- *Family* treatment plan vs. individual treatment plan
- Provide sexual education for sexually active consumers
- Familia a Familia classes for family members
- Increase family member’s knowledge of how to complain about services and facilities
- Consumer ability to have more say in their treatment plan
- Assistance for consumers in locating employment
- Increased availability of case managers to deal with consumer crisis
- Adjust system so that when consumers work they retain their medical benefits
- Adjust system so that early intervention is a priority
- Support for smoking cessation
- Large scale public campaign aimed at eliminating stigma
- Increased advocacy from inside and outside the system
- Culturally competent Latin@ auditor for quality assurance audits
- Increase the number of shelters
- Increase the number of residential facilities such as La Casa del Puente
• Support/partner with organizations such as Latino Soccer Leagues which offer alternative activities for young boys and girls
• Resume convening Latino Family Mental Health conference
• Increase the flexibility of hiring more culturally competent staff by not requiring all staff to be licensed
• Partner with the faith community
• Compassion and real caring

Consumers and their families would like to have therapy and other services in addition to medication. The idea that they may need to take medications indefinitely is quite disconcerting. It would make them feel more hopeful if they could receive additional treatment.

Familia a Familia, a self-help organization operated by Latino consumers’ families provides classes to teach other parents with sons and daughters with mental illness how to live with them. They are offered support and strategies for dealing with the upset parents often experience when they see their children in an institution. Sometimes the parents may find their son or daughter was drugged and may have their tongue hanging out or be unable to lift their head. This is torture for the parents.

Classes such as those provided by Familia a Familia help to increase family members’ knowledge of “dónde encontrar recursos,” or where to locate available services; this is especially needed for consumers new to the system. More of the Familia a Familia type of education and support is needed. Here family members can find information and support provided in a culturally competent manner.

Families expressed a need to learn productive ways to channel their frustration with poor service and conditions. One example was accessing services for a person suffering from schizophrenia since age 20, when he received a referral to Alliance. He did not receive services because he was not in the system—he is now 24. Another example shared by a family was poor conditions in some inpatient facilities. They want to learn the best way to document and change such conditions. Finally, families want to know how to go about changing case managers and having more say in their treatment plans.

Latino consumers expressed difficulty obtaining a job due to the social stigma associated with mental illness. They believe they would have more credibility if they had support from a program or from individuals lobbying for them. This support is critical in keeping the consumer’s job if a consumer has a mental health crisis.

Further, consumers want to see the system adjusted in such a way that they do not lose their medical benefits when they work.

Latino family members and consumers expressed a need for case managers to be more available to deal with a crisis as well as for case managers to provide transportation to medical appointments. In the past, case managers were more available for emergency crisis; one consumer said the case manager was unwilling to provide transportation to a medical appointment.
A large-scale campaign to raise awareness about mental illness will go a long way in educating families and reducing the stigma associated with mental illness. This campaign needs to be in the Spanish language media, on the radio, television, print media, in pamphlets in libraries, churches, doctor’s offices, beauty shops, and other places Latinos frequent.

Some Latino consumers emphasized the importance of simple caring. Many shared that they received more help from caring neighbors, maintenance people, and thoughtful strangers than from many of the mental health staff.
THE VIETNAMESE COMMUNITY
THE VIETNAMESE COMMUNITY’S PERSPECTIVE
ON MENTAL HEALTH ISSUES IN SANTA CLARA COUNTY

Imagine a place where you feel a sense of belonging and your extended family is either living with you or living nearby. You are happy, selling goods in front of your home, making a living and chatting with your neighbors and whoever stops by. Imagine a community where your neighbor can watch your child or your business for you when you need to run an errand. Imagine a place where you do not need to quit your job in order to care for your elderly parents or become a mother. Just imagine always being among people who not only understand your native tongue, but also understand all your gestures, beliefs, and way of living.

Now imagine having to leave your home and country to go on a long journey away from your family, friends, and everything you are familiar with. When you get to your destination, you are disoriented by events and losses along the way, and you do not understand what anyone is saying. Also, you find yourself without money, valuable goods, and/or the support of friends and family. You don’t even have the language skills to ask for help.

What you have just imagined is a brief description of the life and journey of many Vietnamese individuals who reside in Santa Clara County today. Since 1975, an increasing number of Vietnamese have arrived in the United States, first as refugees, then as immigrants. Many Vietnamese have transitioned well, attained higher education, and achieved success in the American society. However, some continue to struggle with poverty and lack of resources. As a community, the Vietnamese are challenged with many issues associated with immigration and acculturation.

This document is a summary of an ongoing dialogue between the Vietnamese community and the Santa Clara County Department of Mental Health. The Vietnamese Community Group consisted of mental health professionals, community leaders, and mental health consumers and family members. This group met at least monthly from April to July 2005 to discuss current issues and needs in the Vietnamese community. This document was written and revised based on community members’ feedback. It outlines the Vietnamese community’s strengths, critical concerns, barriers and disparities, and potential solutions.

Strengths of the Vietnamese Community

- Strong familial ties and support
- Respect for elders
- Strong sense of pride in their culture
- Care about the welfare of the community
- Spiritual beliefs and values
- Positive attitude of survival in life
- Successful in their transition and adaptation to a Western society

Although the Vietnamese have endured many struggles and obstacles in their new country, they also retain many cultural values that facilitate individual resiliency and promote community welfare.
Cultural factors that help Vietnamese individuals cope with hardships and achieve success in the United States are strong familial ties, concern for the community, and spiritual beliefs and values.

The traditional Vietnamese household is likely to be multi-generational, consisting of great-grandparents, grandparents, parents, aunts, uncles, cousins, unmarried adults, and children. If not living in the same house, extended family members tend to live close by. The level of authority in the family is hierarchical according to generation, gender, and birth order. Elders are the most respected and they are sought after for advice. They draw on their own life experience to provide guidance and help the family make decisions. Fathers typically work outside the home, while mothers work at home and succeed by being an effective homemaker through cooking, cleaning, and caring for others. Some women help supplement the family income through having their own small businesses (e.g., selling food in front of their house) or helping with the family business.

In the Vietnamese family, relative power goes hand in hand with responsibility. Elders, males, and older siblings often make personal sacrifices for the good of the whole family. Younger family members are expected to be respectful and obedient to their elders. The relationships among family members are characterized by respect, obligation, and cooperation. In the United States, the family continues to be the primary source of support and resources for Vietnamese individuals.

Cultural values influence how family members express affection and cope with conflict. For example, parents and children will show care and love for each other through nonverbal gestures, such as parents cooking food for their children, and children earning good grades for their parents. This example shows the underlining values that are instilled in children even though they grow up in an individualistic society. In dealing with conflicts, there is a tendency to avoid confrontation out of respect for elders and others of higher status. Therefore, many Vietnamese individuals would hold back or “bite their tongues,” not stating their own opinions or newly adapted values. This is one of many behaviors that may not seem functional to Westerners but are actually acts of strength and positive regard for the family and community.

Another important cultural value is one of collectivism and cooperation. The Vietnamese are proud of their culture and have a strong sense community. Many Vietnamese continue to see themselves less as individuals and more as part of the family and the larger community. Individual actions are evaluated in terms of positive or negative impact on the family and community. Community members are respectfully addressed as “uncle,” “brother,” “aunt” or “sister.” Many Vietnamese individuals devote their time and resources to promote the welfare of the community. Many professionals even go back to Vietnam and use their skills to help those who are poor and less fortunate.

Additionally, some spiritual beliefs and values help Vietnamese individuals cope with hardships and achieve success in the United States. Buddhism, Confucianism, and Taoism are the oldest religions in Vietnam and have the most influence on culture and tradition. For example, the saying “Change yourself before you can change others” can be interpreted based on Confucius’ teaching of self-cultivation and pursuit of education. Confucius taught that self-cultivation is an important first step. A cultivated and educated person then has the responsibility of making positive changes for the family and community. Another common proverb is “If you don’t succeed, try again.” This proverb teaches diligence and hard work in order to succeed. It is a positive outlook in life and an optimistic
belief that one will survive in the new country and eventually achieve success. In sum, these spiritual beliefs and values have motivated many Vietnamese individuals and families to accept hard work and pursue higher education in order to achieve success.

Strong familial ties, concern for the community, and spiritual beliefs are cultural factors that help Vietnamese individuals cope with hardships in their transition and adaptation to the new country. Many have transitioned well, attained higher education, and achieve success in the American society. However, many continue to struggle with poverty and lack of resources. The next sections discuss critical concerns, barriers, and potential solutions.

**Critical Concerns of the Vietnamese Community**

- Mental illness resulted from or exacerbated by the migration and acculturation process
- Elders’ social and cultural isolation
- Dichotomy of values, cultural gap, and cultural identity conflict
- Family conflicts between parents and children
- Male youth involved with delinquency
- Smoking and drinking problems related to family issues
- Conflicts between husband and wife, which can lead to domestic violence.
- Stress from daily activities, or concerning family issues
- Low self-esteem from multiple losses

Critical concerns in the Vietnamese community include mental health issues related to war experiences and the process of migration and adjustment to a new country, effects of differential acculturation on family relationships, negative coping strategies for stress, and lack of communication and education on mental health and illness.

For many Vietnamese, especially the older generations, the experiences of war and persecution, as well as the traumatic experiences many endured during the migration process, can put individuals at risk for social and psychological problems. When the Vietnamese finally arrived in their new country, they did not have much in terms of material possessions, and many lacked training and education, including English skills to help them get good jobs. Moreover, for many adults, their age limits their ability to learn a new language quickly and to begin their lives in a new county. These factors further increase risks for social and psychological problems. The most common problems are isolation, depression and post-traumatic stress disorder (PTSD).

The process of acculturation to the American society also changes the family structure and roles, as well as the values of individuals. Each member of the family experiences different acculturational challenges. The generational gap is widened with individualized acculturation processes and differences in acculturation rates among generations, causing intergenerational family conflicts and stress.

For the elders in the family, having to leave their homeland to immigrate to the United States resulted in personal, financial, and severe emotional loss. Elders have many difficulties adapting to a new life. Older adults in the Vietnamese community identify with the Vietnamese media, which explicitly
reminds them that their homeland is Vietnam. Elders also feel a lack of purpose when they are not sought after for advice by younger family members. They feel ignored and disrespected by the new ways the younger generations think and behave. Elders in the family no longer have power, money, and/or land. Many become financially dependent on their children. The main concern for Vietnamese elders is that they no longer feel useful. They can become very socially and culturally isolated. They feel that their lives have become meaningless and empty. At the same time, many continue to experience post-traumatic stress.

Unlike the elders, younger family members adapt new ways of living much more quickly, assimilate more successfully, and have better English language skills. Consequently, the younger generations no longer look up to their elders for advice. However, in situations where disagreements arise, some younger family members might defer to elders out of respect, but this often results in further frustration and misunderstanding. Vietnamese youth also experience cultural conflicts. They are given very mixed messages about values by their parents and grandparents. These messages are often in conflict with values promoted by their teachers and peers. Youth are constantly reminded of their heritage by family members, but they may identify more with American cultural norms.

Many youth cope with stress by drinking, smoking, engaging in risky sexual behaviors, and participating in delinquent behaviors. Young males tend to be involved with delinquent behaviors that lead them to juvenile hall detention or tragic death. Many youth exhibit these behaviors as early as middle school. Youth who are estranged from their families tend to feel more secured among their delinquent peers and seek protection from them without an understanding of detrimental consequences to themselves and their families.

In addition to intergenerational conflicts, the process of acculturation to the American society also causes much gender and marital conflicts in the family. In the United States, gender roles are more egalitarian. This is in direct conflict with the hierarchy of authority in traditional Vietnamese families, causing problems related to role expectations. Also, in many families, men are no longer the main breadwinners, causing them to feel a loss of control and authority in the family. They also feel pressured and stressed that they cannot fulfill their traditional roles and responsibilities to the family.

On the other hand, Vietnamese women feel they lead a double life. They feel pressured to maintain their traditional roles as homemakers, as well as to be successful in the working world in order to support the family financially. Women find it difficult to fulfill these conflicting expectations. For example, very successful and independent women do not feel they can express themselves freely at home and in the Vietnamese community. Often, they will defer to men and elders out of respect. Also, women feel they cannot talk to their family about things that bother them, or talk about certain topics such as sexuality and mental health issues.

Both Vietnamese men and women experience multiple losses, stress from too many demands and obligations, and lack of resources. Many deal with stress by self medicating through smoking, drinking, using drugs, gambling, and taking out their stress, depression, and anger on their loved ones. Gambling is very problematic in most Asian communities, but especially among the Vietnamese. Domestic violence is another major issue in the Vietnamese community.

Finally, another major concern in the Vietnamese community is the lack of communication and education about severe mental illnesses, such as schizophrenia, bipolar disorder, major depression,
autism, and suicide. There is a lot of stigma associated with mental illness, and talking about it is perceived as bringing shame to the family. Thus, individuals with severe mental illness and their families often do not receive the support they need from their extended family, friends, and the community. Because of shame and stigma associated with mental illness, individuals do not come in for help until there is a crisis. Therefore, mental health professionals tend to have in their caseloads Vietnamese consumers who are on the severe end of the mental health/illness spectrum.

In summary, this section discussed critical concerns in the Vietnamese community. These are mental health issues related to war experiences and the process of migration and adjustment to a new county, family conflicts due to differential acculturation of family members, harmful behaviors in attempts to cope with stress, and stigma of mental illness. The next section discusses barriers and disparities in seeking and receiving mental health services.

**Barriers and Disparities for the Vietnamese Community**

- Stigma of mental illness
- Cultural isolation leads to lack of information about help and available resources
- Cultural belief in mental illness as the result of karma, past misdeeds, and evil spirits.
- Cultural aspect of suffering (one can be proud if one can swallow the bitterness without complaining)
- Cross-cultural misunderstanding between patients and health care providers
- Language barriers in communication
- Westernized medical practices vs. traditional herbal remedies

Many of the critical concerns addressed above are connected to the barriers and disparities experienced by the Vietnamese community. These are cultural beliefs that hinders seeking help for mental illness, financial and systemic factors that impede access to mental health services, limited availability of cultural competent mental health professionals, and discrepancy between Western and Eastern medical practices.

Cultural beliefs serve as barriers to seeking help for mental illness. Some cultural beliefs deny the concept of mental illness as a biological disorder that can be treated. For example, there is a belief that “the son inherits the sins of the father.” This belief in mental illness as bad karma accumulated from misdeeds of past lives, or being possessed by an evil spirit, creates shame for the family. This hinders their ability to understand and seek mental health services. Another cultural belief is the high value placed on enduring one’s own suffering stoically and heroically. That is, the ability to endure suffering without seeking help is a way of demonstrating one’s strong character and/or acceptance of fate. Consequently, there is a fear that families and individuals who seek help for emotional issues would be considered “weak” or “morally deficient.”

Because of these cultural beliefs, it is a shame on the whole family to have a member with mental illness. Therefore, mental illness is often feared or denied. Those who are ill are hidden away by their families until family members can no longer care for them. Unfortunately, the social stigma of mental illness in this community increases the prevalence of undetected and untreated cases of severe illnesses.
Because of social stigma on mental illness in the Vietnamese community, and the taboo of the topic, many individuals and families seek guidance from religious leaders who will keep their “secret.” They also turn to spiritual leaders for help with their emotional distress. Unfortunately, sometimes they are given skewed advice. For example, a woman disclosed about family violence to a religious leader and was told that suffering and forgiveness are good values. She was not informed that domestic violence could be a crime.

When family members finally decide that they need to seek mental health services for an individual with a mental illness, they are challenged with financial, systemic, and language and cultural barriers in accessing and utilizing mental health services. For many Vietnamese, lack of health insurance and limited finances are barriers to accessing mental health services. Individuals and families who are not eligible for Medi-Cal or those who earn a little above the poverty level cannot access public mental health services.

Besides financial factors, there are systemic barriers to accessing public mental health services. In the Vietnamese community, family members are usually the ones who try to find help for the individual with mental illness. Many feel that access to public mental health services is very difficult, even when there is a serious mental illness that meets medical necessity. The process of getting mental health services is very complicated for individuals and family members. It is complicated even for Vietnamese social service professionals, who often feel frustrated with not being able to help those in need.

Many times, Vietnamese families feel that access to public mental health services is very difficult. They do not know how to get help, even with a serious mental illness. Family members have asked for mental health treatment at social services agencies like the Asian Pacific Family Resource Center. Family members are given the Call Center number as a resource. When they call this number, they usually do not get to talk to a person in their first attempts, and they are not comfortable with leaving messages on the voice-mail. Even when they actually reach a Call Center staff on the phone, many Vietnamese individuals and family members hang up and do not speak to anyone. Many feel too much shame and stigma to fully disclose their concerns to someone over the phone. Because of this, many Vietnamese are deemed ineligible for services.

In addition to the issues related to accessing mental health services, Vietnamese families are concerned about finding culturally and linguistically competent mental health providers. This is an issue even for individuals and families who have private insurance. In the public sector, there are currently not enough service providers who speak Vietnamese and understand the Vietnamese culture. Often, Vietnamese individuals with mental illness and their families cannot utilize the services that they critically need. Furthermore, the Vietnamese tend not to disclose family problems to an outsider. It is not unusual for some to show mistrust for non-Vietnamese providers. They are afraid that these providers will give them advice and treatment that is not consistent with their values and worldview. These concerns about non-Vietnamese providers, coupled with cross-cultural misunderstanding between patients and health care providers, could lead to non-adherence to treatment.

Western medical practices also act as a barrier that prevents many Vietnamese from seeking treatments for their medical problems. Many Vietnamese are hesitant to take Western medications
for long periods of time because they feel it is not natural and may have negative side effects. Consequently, they turn to herbal remedies and Eastern medical practices that they are more familiar with. Their doctors may not be aware that they are not complying with medications or that there are potentially dangerous drug interactions.

In sum, this section discussed the Vietnamese’ cultural beliefs about mental illness, shame and stigma, and the reluctance to seek help for mental health problems. Financial and systemic factors serve as barriers in accessing mental health services. Barriers and disparities in receiving mental health services include availability of culturally and linguistically competent mental health providers and mistrust and unfamiliarity with Western medical practices. The next section discusses potential solutions for the Vietnamese community.

**Potential Solutions for the Vietnamese Community**

- Vietnamese professionals sharing expertise and knowledge with each other and the community
- Engaging community leaders and building opportunities for coalitions
- Building mutually beneficial relations with religious leaders
- Have more bilingual mental health workers
- Have more Vietnamese speaking psychiatrists
- Work within the cultural framework of clients
- More services for older adults
- Support services to older adults in care homes
- Male counselors for young males involved with delinquency
- Academic assistance to youth failing in school
- Parent education and training
- Focus on funding for prevention work in community-based organizations

Potential solutions for the Vietnamese community include collaboration among Vietnamese professionals, involvement of religious leaders, suggestions for changes in the Mental Health system, and age-specific services and interventions.

The Vietnamese community already has many professionals who are highly educated and have experience or expertise in working with and helping others in the community. Vietnamese professionals need to organize, form coalitions, and become a united front so that they can become the authority on current issues in the community. Vietnamese professional could also inform and educate others within the community as well as those outside of the community, on current needs and appropriate resources and services to meet these needs.

Since the Vietnamese are highly spiritual and rely on religious institutions like Buddhist temples and Christian churches, it is important to invite participation from religious leaders in providing mental health services. It would be ideal to involve religious leaders who are progressive and already have a good understanding of mental health issues and laws regarding abuse, neglect, and domestic
violence. Mental health service providers need to reach out to religious leaders on an individual basis and establish mutually trusting relationships.

Within the Santa Clara County Mental Health system, the Vietnamese Community Group recommends the following potential solutions to address barriers to access and service utilization. First, it is very important to have more mental health providers who are culturally and linguistically competent. Specifically, there is a great need for more bilingual Vietnamese therapists and psychiatrists. There is also a need for mental health education specialists and community workers. Having culturally and linguistically competent service providers would address the current concerns of mistrust of non-Vietnamese providers, language and communication barriers, and non-compliance to treatment due to unfamiliarity with Western medical practices. These providers would be able to work within the cultural framework of Vietnamese consumers, appropriately involve family members and/or religious leaders in the treatment process, utilize available resources in the Vietnamese community, and address cultural and spiritual beliefs that help or hinder treatment outcomes.

Second, because of severe social stigma in the Vietnamese community surrounding mental illness, and the resulting reluctance to seek help, there is a great need in this community for outreach, education, prevention and early intervention services. Community outreach and education can take place at churches and temples, educational settings, senior centers, daycare centers, community centers, board and care homes, and community events and gatherings. It is important for mental health service providers to build working relationships with family physicians, teachers, and religious leaders. These professionals are likely to be the first ones to be aware of mental health issues and can make referrals for services.

Community education should be provided by culturally and linguistically competent professionals. These professionals can address shame and stigma, causes and treatment for mental illness, prevention strategies, the importance of early intervention, and available resources for consumers and families. One proven effective tool for community education is through Vietnamese radio programs, where community members are given information on physical and mental health issues, and they can call in to ask specific questions. Community education also includes books and newspaper and magazines articles written in Vietnamese. There is also a need for high quality translations of materials provided by the State and County, such as the Guide To MediCal Mental Health Services and other similar guidelines and resource directories.

Third, there is a need to improve the Vietnamese community’s access to mental health services. One area for improvement is the Call Center, currently the first point of contact for mental health services. When an individual or family member calls, they will first hear a recorded greeting in English, followed by Spanish, Vietnamese etc. They have to listen to a couple menus and make the right selections. This process is complicated, confusing and frustrating, even for English speakers who are familiar with the Mental Health system. One potential solution is to minimize misunderstanding of instructions and frustrations by having separate numbers for all threshold languages. Monolingual Vietnamese individuals and family members could call and speak directly to a Vietnamese bilingual staff about their mental health needs and concerns. Another recommendation is to give individuals and family members the option of walking into a clinic or contract agency to speak directly to a Vietnamese mental health staff about their needs and concerns.
The Vietnamese Community Group has the following potential solutions regarding services for each age group in the Vietnamese community. Vietnamese older adults, as compared to other age groups, are more prone to social isolation, depression, and post-traumatic stress disorder. They are also more likely to be monolingual and homebound, which contributes to their social isolation. There is a serious need for case management services to help seniors with severe health and mental health problems access needed resources, such as housing, in-home supportive services, senior daycare, home health care programs, transportation services, meals-on-wheel, and English and citizenship classes. A potential solution would be to develop or expand services that address specific needs of Vietnamese elders and their caretakers. These services include senior centers, board and care homes, low cost transportation services, senior companion programs, and respite programs to support caregivers.

Critical issues for Vietnamese youth are cultural conflicts, cultural identity, alienation from family, substance use, and gang involvement. Vietnamese youth and their families critically need outreach, education, and treatment to address acculturation issues, undiagnosed learning disabilities, drug and alcohol use, gang involvement, and family discord and violence. There is a need for service providers who understand the structure, roles, and expectations in a Vietnamese family in order to help family members work through conflicts. One potential solution is to address the high youth involvement in delinquent behaviors by having male counselors as role models who provide academic assistance to youth failing in school. Another potential solution is to provide positive social and recreational activities for youth. For parents, there could be education and training on topics such as effective child discipline techniques, communication and conflict resolution strategies, how acculturational and generational issues affect family relationships, community resources, and how to network and build natural social support systems.

Critical issues for Vietnamese men and women are gender roles and marital conflicts. Men feel a loss of control and authority in the family, and women feel torn between maintaining the traditional homemaker role and working outside the home. Many attempt to deal with these stressors by smoking, drinking, gambling, and committing acts of domestic violence. Mental health services should include helping men and women understand the potential role changes, how these changes might impact family relationships, and how to ease and/or cope with issues arising from the process of acculturation. Mental health services must also address drug use, gambling, and domestic violence. Some strategies for addressing these issues are community education through Vietnamese media, collaboration with community leaders and organizations (including faith-based), and providing workshops on these topics.

In summary, this section discussed potential solutions for critical concerns, barriers and disparities discussed in previous sections. Potential solutions for the Vietnamese community include collaboration among Vietnamese professionals to identify needs and resources for the community, and involvement of religious leaders in helping individuals with mental health concerns and their families. Suggestions for changes to the Mental Health system to address access and utilization issues include having more culturally and linguistically competent providers, focusing on community outreach and education, and making changes to the Call Center. Finally, there are also suggestions for age-specific services and interventions.
FOCUS GROUP HELD BY THE REFUGEE AND IMMIGRANT FORUM ON MENTAL HEALTH ISSUES FOR REFUGEES AND IMMIGRANTS IN SANTA CLARA COUNTY

Three focus groups were held on April 20, 2005 at the Social Service Agency located at 333 West Julian Street in San Jose. The focus group participants included immigrant and refugee community leaders and service providers. The following summary provides a documentation of discussions held during all three focus groups.

The focus group was composed of representatives of community based organizations, mutual assistance agencies and refugee and immigrant service providers, most of whom are consumers/refugees themselves. Thus, there was refugee and immigrant representation from Southeast Asia, Africa, and Eastern Europe in attendance.

**Strengths and Coping Mechanisms of Refugees and Immigrants**

**Individuals**

- Motivated
- Hopeful
- Eager to learn English and computer skills
- Seek employment
- Start to trust
- Try to use English language
- Adapt to changes
- Let go of past expectations
- Form friendships
- Learn
- Express themselves
- Show pride in accomplishments
- Family reunification resulting in individual stabilization
- Form long term realistic expectations, like going to college
- Gain knowledge and understanding of the systems
- Learn the importance of compliance with mental health treatment and/or medication

**Community Resources**

- Leaders within the ethnic communities
- Mutual Assistance Agencies (MAAs)
- Community Based Organizations (CBOs)
- Voluntary agencies
• Public Health Department
• Education and employment resources
• Legal assistance
• Existing health promotion groups in Vietnamese, Eritrean and Latino communities

Culture
• Emerging leadership within ethnic communities
• Places of worship—mosques and churches
• Celebrations
• Cultural events
• Culture affirmation and heritage preservation

**Significant Problems and Critical Concerns for Refugees and Immigrants**

Symptoms and Emotional Problems
• Anxiety, frustration, fear, depression, post-traumatic stress disorder (PTSD), trauma, angry and uncooperative

At the beginning, if individual is on public cash assistance, tight, controlled, not trusting, confusion, fear 30 percent are stuck and disoriented. Isolated, lack of confidence, hesitant, still unrealistic about strengths and don’t know how to apply strengths
• After several months still scared, but looking for employment, more open to opportunity, still need social support and encouragement

Financial/Resources
Financial-employment issues, no job, not enough money to support family, financial insecurity, lack of insurance, lack of jobs, housing, cost of housing and public transportation, childcare problems, cultural shock, American legal, health, financial and other systems are hard to negotiate

Expectations
Unrealistic expectations, misinformed prior to coming to the U.S., misinformation about the American way of life, expectations of parents, role reversal of child and parent, economics of the valley, increased rent, navigation of the system

Lack of Socialization and Social Problems
Lack of social adjustment activities offered during arrival and at each phase of their life. Role reversal of child and parent, homebound, isolation, own community is ineffective to provide social support, peer pressure, anti-immigrant sentiment, stigma, labeling, isolation, violence, discrimination

Acculturation and Cultural Problems
Language barrier, cultural differences and adjustment, not understanding rules and/or expectations, fear of police or being shot. Lack of social adjustment activities offered during arrival and at each phase of their life. Switching roles in the family, such as kids taking over parent’s role.
Intergenerational conflict, conflicting value issues, language barrier for the newcomers as well as long-term residents, differences in U.S. social systems and structure starting at the neighborhood level

**Family and Primary Support Group Problems**
Intergenerational conflict, role reversal of child and parent, switching roles in the family, such as kids taking over parent’s role, loss or separation from family, reunification problems, own community is ineffective to provide social support, victims of domestic violence, over disciplining children

**Identity and Professional Losses/Professional, Religious and Group Affiliation**
- Loss of professional status and credentials
- Cultural continuity problems

**Education**
Frustration about educational goals, illiteracy in own country or own language, school and education system problems

**Legal System**
Legal misunderstanding, legal problems, American systems are hard to negotiate, immigration status, not understanding courts and legal system, fear of police or being shot

**Loss**
Loss or separation from family, reunification problems, loss of identity

**Developmental Problems**
Aging

**Health**

**Disparities or Other Barriers for Refugees and Immigrants**

**Education and Services**
Frustrations about educational goals, illiteracy in own country or own language

**Financial and Employment**
Financial and employment issues, no job, not enough money to support family, financial insecurity, lack of insurance, lack of jobs, housing, cost of housing and public transportation, childcare problems, American legal and health systems are hard to negotiate

**Health**
Lack of prior health education, linguistic problems, language access, appropriate health service and complexity of the health care system

**Socialization/Culture Preservation/Celebration**
Lack of social adjustment activities offered during arrival and at each phase of their life. Role reversal of child and parent, homebound, isolation, own community is ineffective to provide social support, peer pressure, anti-immigrant sentiment, stigma, labeling, isolation, violence, discrimination
Methods, Practice, Information and Referrals/Informal and Formal Counseling
Deficiencies and limitations of existing services, childcare, education, not enough jobs, no recognition for prior professional status, hard to navigate system, lack of health insurance

Cultural Orientation and ESL classes, Tutoring, Mentoring, and Advocacy
Inadequacy in policies, complexity and lack of responsiveness

Potential Solution and Strategies for Refugees and Immigrants
By Community Based Organizations and Mutual Assistance Agencies: Addressing Stressors

Provision of Education Services for Clients and the Community on Refugees’ Issues
- Welcoming programs, cultural orientation and ESL classes
- Citizenship classes
- Tutoring and mentoring
- Education for services available
- Parent education
- Computer classes
- Nutrition education
- Education on laws and legal system

Provision of Financial and Employment Services
- Financial literacy and job training
- Job readiness and employment services
- Financial workshops
- Services for financial stability through educational and savings programs, e.g. independent development accounts/matching savings program
- Tax credit preparation and return assistance

Provision of Health Related Services
- Health education, counseling and screenings
- Referrals for health services.
- Ethnic specific nursing care, e.g. Ethiopian Community Services promoting Ethiopian nursing resource
- Workshops by doctors who speak the language of the participants, e.g. Russian speaking doctors providing workshops at Jewish Family Services
- Nursing services

Opportunities for Socialization, Culture Preservation and Celebration
- Senior socialization services
- Recreational programs
- Social cultural activities
• Movies and holiday celebrations: family, youth and senior oriented and at after-school program
• Provide safety net
• Social adjustment activities

Support Services, Methods and Practice: Information and Referral, Case Management and Informal and Formal Counseling
• Legal counseling services related to group’s needs
• Short-term, transitional housing and assistance with housing
• Transportation assistance
• Translation and interpretation services
• Intensive case management services, including information and referral services, e.g. referral to shelters
• Cultural specific counseling, e.g. Ethiopian Community Services uses elders to provide counseling
• Referrals to psychiatric and/or mental health agencies and other social services
• Short-term or transitional housing
• After school programs
• Immigration and legal services
• Good communication techniques: “Be a good listener, allow clients to talk... sometimes there are no solutions.”
• Energy assistance programs
• Visiting program to the elderly

Acculturation/Orientation
• Field trips
• Provide safety net
• Introduction to local community
• Workshops on or direct assistance in “navigating the system”

Advocacy
• Recommendations for policy change
• Letter writing campaigns for issues by agency and clients
• Individual advocacy, pushing for services for clients

Overall and Underlying Methodology and Program Direction Goals
• Address the general wellbeing of the refugee
• Cry with refugee clients, listen and empathize
• Building self sufficiency
• Relationship building—become a friend to the refugee
• Resettlement planning
• Introduction of resources
• Encourage mainstreaming and integration
• Provide health education
• Promote higher and continuing education
• Job training and placement
• Guide through transition
• Asset development
• Cultural Affirmation and heritage preservation
• Provide social events
• Dissemination of information through radio, newsletter, etc.
• Help clients become self motivated
• Provide counseling that helps client become independent, self-sufficient and less dependant on relatives
• Use volunteers for outreach and in-home services
• Enable social orientation, e.g. parenting skills for this society
• Domestic violence prevention
• Promote financial stability
• Promote education, learning and benefits of education
• Be an advocate
• Document stressors
• Develop programs to meet needs
• Provide resources, information and referrals
• Find more money to help clients
• Be willing to transport clients

**Best Practices and Most Effective Strategies**

• Match grant program, including ESL, job training, placement and case management for four to six months.
• Intensive vocational training for a minimum of three months
• Scholarship program
• Education—workshops, ESL and media
• Job placement and replacement
• Peer communication and mentoring
• Parties, celebrations and cultural events
• Individual focus, encouragement and empowerment
• Building confidence and creating higher expectation for the individual
• Share experiences to create confidence that they can do it
• Have confidence to share information that clients are unable to share with others
• One-to-one meetings to build trust, which creates open communication and helps individuals share confidential information, for example information about HIV, marital problem, personal problems, drug and alcohol problems, etc.
• Integrated case management, meeting needs in different areas or wraparound services for the whole family, e.g. case managers make referrals and conduct necessary follow-up
• Integrated services must be timely, ongoing and integrated by providing one case manager for the whole family to address all their needs.
• Community empowerment, building community networks at political, social and cultural levels so individuals can help each other as they receive mutual benefits
• Listening — validate complex issues and refer to appropriate agency
• Experience of workers
• Be understanding and non-judgmental
• Language and culture sensitivity
• Affirm culture
• Focus on everyday trauma
• Connecting with other people and groups
• Enable domestic violence victims and empower them with information
• Set goals
• Individual and group counseling
• Workshops and prevention counseling
• School counseling
• “Train the trainers” mental health training for community professionals
• Bring together health promoters to address mental health and talk about problems. Invite additional groups to join trainings, such as lawmakers, judges and police
• Churches/mosques can connect place of worship with community (training leaders)
• Public health and community education for nurses and education leaders
• Work with ethnic media to educate community
• Train social workers, eligibility workers and probation officers
• Sensitivity training for workers/resource people
• Cut down red tape
Ways Mental Health Staff Could Work with Mutual Assistance Agencies and Community Based Organizations

- Provide grants and resources to CBOs and MAAs to develop transitional and social adjustment programs
- Help with educational sources to embed mental health concepts into curriculum
- Provide list of pro-bono referrals for post-traumatic stress disorder (PTSD) and depression
- Provide workshops on various mental health subjects
- Come to office once a week and speak directly to the consumers as a group. As trust builds, provide individual counseling and support.
- Orientation and training for staff to recognize mental health symptoms in the clients (example: effects of trauma)
- Help client self identify needs and have services available to them
- Balancing between group and individual intervention, as group intervention can help individuals who may not be willing to seek individual services.
- Refer client to mental health services
- Orientation to mental health system
- Culturally linguistically proficient mental health staff
- Regular training in community about mental health to address stigma and provide community mental health education
- Know emergency response consequences
- Dangers of calling 911
- Law enforcement training
- Police training on mental health issues
- Programs specific to refugee and immigrant mental health issues and intervention
- 24-hour hotline assistance
- Intervention in the community (assist with processing)
- Education, referral, community forum (use understandable and meaningful language)
- Address stigma through education
- Family night model to prevent domestic violence
- Learn from community mobilization, positive responses organized
- Individual and group consultations for mental health issues on part-time basis
- Consultations and training for staff
- Money for affordable housing is priority number one
- Written information—booklets, flyers, and telephone numbers of who and where to call
- Educate the mental health team, or worker, about culture and traditions of the clients and ask clients to explain how mental health is provided in their culture.
• Mental health team and staff can use the client’s culture when providing mental health services.
• Sit with the case manager and new clients during the first intake meeting
• Mental health and case manager co-develop questionnaire for every client to identify mental health needs. Translate the questionnaire into the client’s language.
• Mental health staff that can speak with refugee and immigrant and general population
• Mental health system accountability
• Resourceful and knowledgeable about housing, employment etc.
• Multicultural/multi-service skills
• Connection with mental health department to link client to system
• Assist with scheduling appointments
• System only services crisis situations. Need to expand criteria for treatment.
• System too complicated to make accessible
• Make it easier to make appointments
• Need to be multilingual
• Good listener
• One respondent: Not good use of resources. Workshops are more effective.
ETHNIC COMMUNITY ADVISORY COMMITTEES
ETHNIC COMMUNITY ADVISORY COMMITTEES

Ethnic Community Advisory Committees are established on this premise:

- Everyone desires the same outcomes for persons with emotional problems or mental illness – children thriving, youth succeeding in school, adults having good relationships and meaningful work, and elders secure at home connected to loved ones.

- Essential healing, recovery and resiliency are enhanced by the natural systems found in community. As result, social interaction and deep connections within our community, be it family, neighborhood or other social environments, must be central to all service delivery systems.

- Many individuals, as members of their ethnic community, demonstrate understanding of the challenges brought on by mental illness, particularly as it relates to themselves, their family and their ethnic community. Likewise, they offer their own solutions.

- Simultaneously, these individuals extend care, commit and desire to help persons with mental illness receive the help they need in the forms that are most helpful to the individual and their family.

Therefore, the mental health system looks to ethnic communities and their natural systems as sources of information and direction, and as the starting point for community capacity building for serving persons of all ages and their families.

In the same fashion, ethnic communities need to step forward. The community needs to not leave people alone and isolated. The Mental Health System is asking ethnic communities: “How do we help you?” “What resources do you need to create, strengthen and develop those natural networks?”

In partnership, we will create new systems and resolve lasting problems starting with the acknowledgement that within ethnic communities, it is important to address: stigma & isolation. Furthermore, racism and discrimination in society, most often manifested in institutions, must be addressed in order to help persons with mental illness recover.
The Ethnic Community Advisory Committees (ECAC) are being developed in support of the transformation of the mental health system required by the Mental Health Services Act (MHSA). The first component of MHSA expands the service system and addresses three areas: outreach and engagement, full service partnerships and system development.

**The Goals of the Ethnic Community Advisory Committees**

The Ethnic Community Advisory Committees are established to empower consumers and their families to have a permanent role in the public mental health system. The membership includes consumers and family members, other community members and service providers.

Ethnic Community Advisory Committees:

- Envision ways the mental health system’s community engagement process can be more inclusive of ethnic consumers, family members and community
- Help consumers and their families engage in the system
- Identify and support the natural systems in the community
- Actively participate in service strategy development and implementation
- Answer: “What does the community want to do with early intervention?” “How will self help look?”
- Identify what will keep ECAC members engaged as active participants in the mental health system’s community process.

As described above, the Ethnic Community Advisory Committees play a permanent role in the mental health system. Their role in MHSA implementation and system transformation is evolving.

**The Ethnic Community Advisory Committees’ Role in the Community Services and Supports Planning Process for the MHSA**

The Community Support Service (CSS) planning process developed new service strategies for specific focal populations. Nine Strategy Teams were appointed to research, design, and recommend: service expansion, client/family engagement and transformation strategies for age-based focal populations, per the requirements outlined in the California Department of Mental Health (DMH) CSS requirements.

The Community Services and Supports planning process included active participation from the ECAC as key stakeholders to help create more self-help and education, and support the development of the natural systems in the community. ECAC members were actively engaged in the Strategy Team process and as stakeholders in the planning process. Each ECAC conducted numerous meetings where discussions coincided with the questions addressed in the CSS planning outreach and in-reach process. Thus, each ECAC identified Strengths, Critical Concerns, Barriers to Treatment, and Potential Solutions.
ECAC Community Narrative Reports

During the planning process, each ECAC community held group meetings. The groups included consumers, family members, community members and mental health professionals. These discussion groups were held to create understanding among the ethnic community on topics critical to addressing the mental health needs of the specific ethnic community. At the same time, the reports generated assisted the mental health system and participating community members plan the new Community Services and Supports.

The ECAC Community Reports document the discussions of the participants of ECAC meetings and focus groups. In some cases, they also contain pertinent literary citations. These documents are not intended to be complete summaries or comprehensive descriptions of the specific communities. They are written as participants spoke, clearly and direct. They are only the beginning of the conversation and study of these communities in Santa Clara County. At the same time, these documents present very enlightening and helpful information. The ECAC will continue their discussions and expand these reports and their participation in the mental health system.
COMMUNITY SURVEY RESPONSES
Dear Consumer, Family Member and Community Member:

Thank you for completing this survey. In November 2004 California voters passed a law to provide funding to expand mental health services in the community. These funds are to be used to address the biggest concerns in our community related to people suffering from untreated mental health problems. We are asking community members what they see as the most important mental health needs for youth, adults and seniors in Santa Clara County, and what services they think are most needed to address those needs.

1. Are you
   CJ Current Client   CJ Family of a Client   CJ Mental Health Provider
   CJ Other (specify)

2. Your Country of Birth: ___________________________ Ethnicity: ___________________________

3. Preferred language ___________________________

4. Age: ___________   CJ Male   CJ Female

5. Kids 0-18 years old- Which of these are the most important problems for children and teens in your community? Have you or someone in your family experienced those problems?
   a. Sadness and depression
   b. Isolation & loneliness
   c. Not going to school
   d. Failing in school
   e. Disobey parents/teachers
   f. In trouble with the law or police
   g. Being in a psychiatric hospital
   h. Abuse by parents/others
   i. Removed from home
   j. Homelessness/runaway
   k. Drug or alcohol abuse
   l. Memories of trauma
   m. Other:

6. What help do you think children and teens need most for these problems?
   a. More mental health services in my culture and language
   b. More mental health services in schools
   c. More mental health services in doctor/pediatrician offices
   d. More services in mental health clinics
   e. More information about mental health and kids in my community
   f. More education about improving family relationships
   g. More after school programs
   h. Counseling in places of worship (church, synagogue, temple, mosque)
   i. Other: ___________________________

7. What qualities in yourself, your culture or community help children and youth cope with these problems?

***** CONTINUED ON NEXT PAGE *****
8. **Adults** • Which of these problems are the biggest results of emotional or psychological problems for adults in your community? Have you or someone in your family experienced those problems?

a. Sadness, depression, suicide  Inmycommunity In myself or my family
b. Isolation and loneliness  Inmycommunity In myself or my family
c. Anxiety and fear  Inmycommunity In myself or my family
d. Violence in the home  Inmycommunity In myself or my family
e. Violence in the community  Inmycommunity In myself or my family
f. Unable to care for family  Inmycommunity In myself or my family
g. Unable to work  Inmycommunity In myself or my family
h. In trouble with the law or police  Inmycommunity In myself or my family
i. Going to a psychiatric hospital  Inmycommunity In myself or my family
j. Drug or alcohol abuse  Inmycommunity In myself or my family
k. Memories of trauma  Inmycommunity In myself or my family
l. Other:  Inmycommunity In myself or my family

9. **What help do you think adults need most for these problems?**

a. 0 More mental health services in my culture and language
b. 0 More mental health services in primary care doctors offices
c. 0 More information about mental health and mental illnesses
d. 0 More information about improving family relationships
e. 0 More help with housing and finances
f. 0 More social activity and recreation with friends
g. 0 Counseling in places of worship (church, synagogue, temple, mosque)
h. 0 Other: -----------

10. **What qualities in yourself, your culture or community help adults cope with these problems?**

11. **Seniors** • Which of these problems are the biggest results of emotional or psychological problems for older adults in your community? Have you or someone in your family experienced these problems?

a. Sadness, depression, suicide  Inmycommunity In myself or my family
b. Shut in at home and isolation  Inmycommunity In myself or my family
c. Anxiety and fear  Inmycommunity In myself or my family
d. Grief and loss of loved one  Inmycommunity In myself or my family
e. Medical problems  Inmycommunity In myself or my family
f. Going to a psychiatric hospital  Inmycommunity In myself or my family
g. In trouble with the police/law  Inmycommunity In myself or my family
h. Violence in the family  Inmycommunity In myself or my family
i. Homelessness  Inmycommunity In myself or my family
j. Drug or alcohol abuse  Inmycommunity In myself or my family
k. Memories of trauma  Inmycommunity In myself or my family
l. Other:  Inmycommunity In myself or my family

12. **What help do you think seniors need most for these problems?**

a. 0 More mental health services in my culture and language
b. 0 More mental health services in primary care doctors offices
c. 0 More services in mental health clinics
d. 0 More information about mental health and mental illnesses
e. 0 More help with housing and finances
f. 0 More social and recreational activities
g. 0 Counseling in places of worship (church, synagogue, temple, mosque)
h. 0 Other: -----------

13. **What qualities in yourself, your culture or community help older adults cope with these problems?**

MHSA Survey Santa Clara Co. 03/05

THANK YOU!

Ethnic Communities of Santa Clara County Provide Perspectives and Opinions on Mental Health Survey on Community Mental Health Needs Page 86
AFRICAN COMMUNITY SURVEY RESULTS

A total of 255 African respondents completed the survey. Twenty three of the respondents were between the ages of 0 to 15, 79 respondents were between the ages of 16 to 25, 131 respondents were between the ages of 26 to 59, and 12 respondents were age 60 and over. Ten respondents did not indicate their age.

**CHILDREN AND YOUTH, 0 TO 18 YEARS OLD**

Which of these are the most important problems for children and teens in your community?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse by parents/others</td>
<td>38%</td>
</tr>
<tr>
<td>Disobey parents/teachers</td>
<td>66%</td>
</tr>
<tr>
<td>Drug or alcohol abuse</td>
<td>60%</td>
</tr>
<tr>
<td>Falling in school</td>
<td>58%</td>
</tr>
<tr>
<td>Being in a psychiatric hospital</td>
<td>37%</td>
</tr>
<tr>
<td>Homelessness/runaway</td>
<td>49%</td>
</tr>
<tr>
<td>Isolation and loneliness</td>
<td>55%</td>
</tr>
<tr>
<td>Memories of trauma</td>
<td>50%</td>
</tr>
<tr>
<td>Not going to school</td>
<td>46%</td>
</tr>
<tr>
<td>Removed from home</td>
<td>45%</td>
</tr>
<tr>
<td>Sadness and depression</td>
<td>82%</td>
</tr>
<tr>
<td>In trouble with the law or police</td>
<td>65%</td>
</tr>
</tbody>
</table>

Have you or someone in your family experienced those problems?

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<td>33%</td>
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<tr>
<td>Falling in school</td>
<td>36%</td>
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<tr>
<td>Being in a psychiatric hospital</td>
<td>21%</td>
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<tr>
<td>In trouble with the law or police</td>
<td>29%</td>
</tr>
</tbody>
</table>

What help do you think children and teens need the most for these problems?

- Counseling in places of worship: 20%
- More after school programs: 40%
- More education on improving family relationships: 42%
- More information about mental health and kids: 28%
- More services in mental health clinics: 26%
- More mental health services in my culture and language: 23%
- More mental health services in doctors offices: 18%
- More mental health services in schools: 32%
What qualities in yourself, your culture or your community help children and youth cope with these problems?

*Youth Quotes*
- Just talk to each other
- To cope with my problems, I do kickboxing or sport to keep my mind of my problems

*Transitional Aged Youth Quotes*
- Family
- Gatherings
- Good listeners, good sense of humor
- Having someone to talk to who is a really good friend

*Adult Quotes*
- A strong sense of family and community. A willingness to advocate and make a change.
- Ability to understand their state of mind, setting good example for them by whom they respect, providing an environment which minimizes the exposure to mental conditions.
- Caring and dedicated helping professionals.
- Close family ties and extended family members.
- Community and family.
- Company of the family.
- Downtown Mental Health Services.
- Easy access to treatment without involving law enforcement.
- Encouragement and support.
- Experience through my life.
- Going through recovery process of mental illness helps understand children with this problem.
- Help from other people. Counseling.
- I really don't know.
- Mentors, positive outlets/art classes, music classes, after school programs.
- More programs for Blacks.
- None
- None. Still improving on myself while homeless.
- Patience, love, understanding, empathy, listening ears.
- Positive attitudes about all the negative things that are out there, which may influence children in the wrong direction.
- The ability to counsel and provide individuals with resources to MH services.

*Older Adult Quotes*
- Having someone to talk to
- In helping kids that I do know need help and trying to do what I can do to help them. By me being ill, I'm not around kids that often, but when I am I'll have us do something together if I have money to do so. But by me being on a set income I can't do that much for myself, but I would love to be able to help those kids, this is one thing I do pray for maybe one day God will and I'll be able to help the kids that do need love and so I pray for this that one day I'll be able to give back some of what God has blessed me with. I hope you can understand what I'm trying to say, I can't spell that well but I'm trying
- Music, dance
- Role models, mentors of like culture
- Sharing time and activities in immediate family
- Church activities among peer group and in the community
- Participating in after school programs

*Ethnic Communities of Santa Clara County Provide Perspectives and Opinions on Mental Health*

*African Community Survey Results*
ADULTS, 19 TO 59 YEARS OLD

Which of these problems are the biggest results of emotional or psychological problems for adults in your community?

<table>
<thead>
<tr>
<th>Problem</th>
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<tbody>
<tr>
<td>Violence in the home</td>
<td>12</td>
</tr>
<tr>
<td>Violence in the community</td>
<td>9</td>
</tr>
<tr>
<td>Unable to work</td>
<td>15</td>
</tr>
<tr>
<td>Unable to care for family</td>
<td>14</td>
</tr>
<tr>
<td>Sadness, depression, suicide</td>
<td>26</td>
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<tr>
<td>Memories of trauma</td>
<td>23</td>
</tr>
<tr>
<td>Isolation and loneliness</td>
<td>20</td>
</tr>
<tr>
<td>In trouble with the law or police</td>
<td>7</td>
</tr>
<tr>
<td>Homelessness</td>
<td>14</td>
</tr>
<tr>
<td>Going to a psychiatric hospital</td>
<td>12</td>
</tr>
<tr>
<td>Drug or alcohol abuse</td>
<td>15</td>
</tr>
<tr>
<td>Anxiety and fear</td>
<td>22</td>
</tr>
</tbody>
</table>

Have you or someone in your family experienced those problems?

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<th>Problem</th>
<th>Percentage</th>
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<tr>
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</tr>
<tr>
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<td>27</td>
</tr>
<tr>
<td>Violence in the home</td>
<td>30</td>
</tr>
</tbody>
</table>

What help do you think adults need most for these problems?

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Counseling in places of worship</td>
<td>36</td>
</tr>
<tr>
<td>More mental health services in doctors offices</td>
<td>35</td>
</tr>
<tr>
<td>More services in my culture and language</td>
<td>35</td>
</tr>
<tr>
<td>More mental health services in mental health clinics</td>
<td>34</td>
</tr>
<tr>
<td>More social activity and recreation with friends</td>
<td>25</td>
</tr>
<tr>
<td>More information about mental illnesses</td>
<td>25</td>
</tr>
<tr>
<td>More information about improving family relations</td>
<td>24</td>
</tr>
<tr>
<td>More help with housing and finances</td>
<td>21</td>
</tr>
</tbody>
</table>
What qualities in yourself, your culture or community help adults cope with these problems?

**Youth Quotes**
- Just talk to each other and work
- Some don’t cope with their problems and others try to do before. By helping
- Strong family values

**Transitional Aged Youth Quotes**
- Bill Wilson Center
- Easier jobs
- Family support.
- Helping more instead of judging
- Someone to talk to

**Adult Quotes**
- Encouragement and support
- Friends and family
- A dedication and commitment to build communities
- Ability to listen and be compassionate
- Accept that I have a Mental Health illness and ask for help
- Counseling services available, medication
- Being strong willed, also _____ with good friends, planning ahead and thinking positive even in times of greatest disappointment
- Drugs
- Extended community ties
- Help from my church and mental health agency
- More education and services offered instead of authorities & facilities all the time
- None. Still improving on myself while homeless and with a mental problems
- Not sure
- Qualified caring and dedicated mental health professionals
- Talking about our problems and learning how to help others
- Talking to people classes
- Talking to someone who will listen helps a great deal
- Their belief that services are available for them and there will be no discrimination against them

**Older Adult Quotes**
- Culturally sensitive services and treatments
- Social activities
- Strong religious background as well as close family community
- Good social service assistance when needed
- Talk to someone about it
OLDER ADULTS, 60 PLUS YEARS OF AGE

Which of these problems are the biggest results of emotional or psychological problems for older adults in your community?

- Violence in the family
- Shut in at home and isolation
- Sadness, depression, suicide
- Memories of trauma
- Medical problems
- In trouble with the law or police
- Homelessness
- Grief and loss of loved one
- Going to a psychiatric hospital
- Drug or alcohol abuse
- Anxiety and fear

Have you or someone in your family experienced these problems?

- Violence in the family
- Shut in at home and isolation
- Sadness, depression, suicide
- Memories of trauma
- Medical problems
- In trouble with the law or police
- Homelessness
- Grief and loss of loved one
- Going to a psychiatric hospital
- Drug or alcohol abuse
- Anxiety and fear

What help do you think seniors need most for these problems?

- Counseling in places of worship
- More help with housing and finances
- More mental information about mental health and mental illnesses
- More mental health services in my culture and language
- More mental health services in doctors offices
- More mental health clinics
- More social and recreational activities
What qualities in yourself, your culture or community help older adults cope with these problems?

Youth Quotes
- Just talk to each other and work it out

Transitional Aged Youth Quotes
- Better housing.
- Family.
- Someone to talk to and listen to you.
- Volunteer groups.

Adult Quotes
- A commitment to community
- Ability to listen and be compassionate
- Being Godly. Having hope in the mercy of a supreme being in times of hopelessness and prayer life helps state of mind
- Encouragement & family support. More free services
- Extended community members
- Going to Classes about the problem
- Local place for adults with mental health problems to socialize like Grace Community Center
- None.
- Ability to listen
- None. Have mental problems and homeless. I can not live on social security - if it is … that I have to be on a social security list without getting money, that is fine
- Not sure
- Their faith in a higher power

Older Adult Quotes
- Have someone to talk about it.
- Home visitation programs. Free transportation to social, recreational activities and places of worship.
- I have approached county agency for assistance but didn't work out and I have succeeded with church community. Good for strong relationships.
- I try to help them in anyway I can. By me being ill and not having a car I really can't do it too much. The people that I do talk with, they do not stay where I can walk to see them, so I call them every day. I don't get money for bus [passes], so I do what I can over the phone.
- Religion
AMERICAN INDIAN/ALASKAN NATIVE COMMUNITY SURVEY RESULTS

A total of 63 American Indian/Alaskan Native respondents completed the survey. Four of the respondents were between the ages of 0 to 15, 13 respondents were between the ages of 16 to 25, 40 respondents were between the ages of 26 to 59, and 4 respondents were age 60 and over. Four respondents did not indicate their age.

CHILDREN AND YOUTH, 0 TO 18 YEARS OLD

Which of these are the most important problems for children and teens in your community?

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<th>Problem</th>
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<td>Abuse by parents/others</td>
<td>8</td>
</tr>
<tr>
<td>Disobey parents/teachers</td>
<td>12</td>
</tr>
<tr>
<td>Drug or alcohol abuse</td>
<td>14</td>
</tr>
<tr>
<td>Failing in school</td>
<td>15</td>
</tr>
<tr>
<td>Being in a psychiatric hospital</td>
<td>6</td>
</tr>
<tr>
<td>Homelessness/runaway</td>
<td>7</td>
</tr>
<tr>
<td>Isolation and loneliness</td>
<td>19</td>
</tr>
<tr>
<td>Memories of trauma</td>
<td>10</td>
</tr>
<tr>
<td>Not going to school</td>
<td>12</td>
</tr>
<tr>
<td>Removed from home</td>
<td>5</td>
</tr>
<tr>
<td>Sadness and depression</td>
<td>23</td>
</tr>
<tr>
<td>In trouble with the law or police</td>
<td>11</td>
</tr>
</tbody>
</table>

Have you or someone in your family experienced those problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
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<td>33</td>
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<td>Failing in school</td>
<td>36</td>
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<tr>
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<td>21</td>
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<td>Homelessness/runaway</td>
<td>33</td>
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</tr>
<tr>
<td>Memories of trauma</td>
<td>25</td>
</tr>
<tr>
<td>Not going to school</td>
<td>37</td>
</tr>
<tr>
<td>Removed from home</td>
<td>26</td>
</tr>
<tr>
<td>Sadness and depression</td>
<td>27</td>
</tr>
<tr>
<td>In trouble with the law or police</td>
<td>26</td>
</tr>
</tbody>
</table>

What help do you think children and teens need most for these problems?

<table>
<thead>
<tr>
<th>Help</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling in places of worship</td>
<td>20</td>
</tr>
<tr>
<td>More after school programs</td>
<td>40</td>
</tr>
<tr>
<td>More education on improving family relationships</td>
<td>42</td>
</tr>
<tr>
<td>More information about mental health and kids</td>
<td>28</td>
</tr>
<tr>
<td>More services in mental health clinics</td>
<td>26</td>
</tr>
<tr>
<td>More mental health services in my culture and language</td>
<td>23</td>
</tr>
<tr>
<td>More mental health services in doctors offices</td>
<td>18</td>
</tr>
<tr>
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<td>32</td>
</tr>
</tbody>
</table>
What qualities in yourself, your culture or community help children and youth cope with these problems?

**Youth Quotes**
- Indian Health Center

**Transitional Aged Youth Quotes**
- Children’s counseling
- Having family gather and being with the one we love and communicating

**Adult Quotes**
- Drive, motivation to assist community. Willingness to learn and share culture. Ability to listen
- Empathy for the oppressed
- Having a therapist to talk to
- I'm a good listener.
- I think Lakota children could cope better when learning about our culture.
- Money to provide better life for children
- Nothing
- Open-mindedness – adaptability
- People are aware of youth problems … feel helpless to do anything about it
- Prayer and friendship, connecting
- Specific help for Native American youth
- Talking and getting it out
- To understand and to talk with other individuals; provide support and guidance; be inclusive
- Wisdom that goes with age; patience for the life process, job rehab programs, community understanding
- Traditional values, American Indian Ceremonies

**Older Adult Quotes**
- After school programs
- Pre-school programs for children and parents to keep some problems from ever becoming a reality. We're working on re-establishing our tribal unity at the Indian Center
ADULTS, 19 TO 59 YEARS OLD

Which of these problems are the biggest results of emotional or psychological problems for adults in your community?

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<td>Sadness, depression, suicide</td>
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<tr>
<td>Memories of trauma</td>
<td>23</td>
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<tr>
<td>Isolation and loneliness</td>
<td>20</td>
</tr>
<tr>
<td>In trouble with the law or police</td>
<td>7</td>
</tr>
<tr>
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<tr>
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Have you or someone in your family experienced those problems?

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<td>27</td>
</tr>
<tr>
<td>Violence in the home</td>
<td>30</td>
</tr>
</tbody>
</table>

What help do you think adults need most for these problems?

- Counseling in places of worship: 36
- More mental health services in doctors offices: 35
- More mental health services in my culture and language: 35
- More mental health services in mental health clinics: 34
- More social activity and recreation with friends: 25
- More information about mental health and mental illnesses: 25
- More information about improving family relationships: 24
- More help with housing and finances: 21
What qualities in yourself, your culture or community help adults cope with these problems?

*Adult Quotes*

- Alliance for Community Care
- American Indian ceremonies and tradition
- Aware of some services available to community as a referral, wish I knew more
- Culture
- Drive motivation to assist community. Willingness to learn and share culture. Ability to listen
- Ethnic background helps me relate. Family history and dynamics. Personal experience in the system
- Having a professionally trained therapist to talk to
- Letting it out in the open
- More sincerity and understanding
- Nothing
- People generally care but we’re leaving it up to the next guy
- Social activities help
- Specific help for Native American youth
- Straight talk, openness
- Talking circles are available
- Talking circles
- There are much fewer resources to help adults cope

*Older Adult Quotes*

- Few
### Older Adults, 60 Plus Years of Age

Which of these problems are the biggest results of emotional or psychological problems for older adults in your community?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence in the family</td>
<td>7</td>
</tr>
<tr>
<td>Shut in at home and isolation</td>
<td>7</td>
</tr>
<tr>
<td>Sadness, depression, suicide</td>
<td>9</td>
</tr>
<tr>
<td>Memories of trauma</td>
<td>9</td>
</tr>
<tr>
<td>Medical problems</td>
<td>14</td>
</tr>
<tr>
<td>In trouble with the law or police</td>
<td>3</td>
</tr>
<tr>
<td>Homelessness</td>
<td>8</td>
</tr>
<tr>
<td>Grief and loss of loved one</td>
<td>14</td>
</tr>
<tr>
<td>Going to a psychiatric hospital</td>
<td>6</td>
</tr>
<tr>
<td>Drug or alcohol abuse</td>
<td>9</td>
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<td>Anxiety and fear</td>
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Have you or someone in your family experienced these problems?

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<td>Memories of trauma</td>
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<tr>
<td>Medical problems</td>
<td>25</td>
</tr>
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<td>In trouble with the law or police</td>
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<td>21</td>
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</tbody>
</table>

What help do you think seniors need most for these problems?

<table>
<thead>
<tr>
<th>Type of Help</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling in places of worship</td>
<td>15</td>
</tr>
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<tr>
<td>More mental health services in doctors offices</td>
<td>22</td>
</tr>
<tr>
<td>More mental health clinics</td>
<td>21</td>
</tr>
<tr>
<td>More services in mental health clinics</td>
<td>33</td>
</tr>
<tr>
<td>More social and recreational activities</td>
<td>46</td>
</tr>
</tbody>
</table>
What qualities in yourself, your culture or community help older adults cope with these problems?

Youth Quotes

- Indian Health Center

Transitional Aged Youth Quotes

- Church counseling
- Having a clinic that provides mental health care

Adult Quotes

- Culture
- Drive motivation to assist community. Willingness to learn & share culture. Ability to listen
- Family culture, the family cares for elders
- Having a professionally trained therapist to talk to
- I don’t know
- Me. Understanding, patience. Community senior
- More sincerity and understanding
- My love for people
- Nothing
- Socializing helps
- Talking circles are available and senior activities
- Transportation to services
- Volunteer and get more involved with seniors

Older Adult Quotes

- Few
FILIPINO COMMUNITY SURVEY RESULTS

There were a total of 133 Filipino respondents who completed the survey. Eighteen of the respondents were between the ages of 0 to 15, 33 respondents were between the ages of 16 to 25, 68 respondents were between the ages of 26 to 59, and 13 respondents were age 60 and over. One respondent did not indicate their age.

CHILDREN AND YOUTH, 0 TO 18 YEARS OLD

Which of these are the most important problems for children and teens in your community?

Have you or someone in your family experienced those problems?

What help do you think children and teens need the most for these problems?
What qualities in yourself, your culture or community help children and youth cope with these problems?

Youth Quotes
- Having good parents, good friends, and I like school.
- I have good parents, family and friends.
- Positive influences and interaction with family, friends and teachers.

Adult Quotes
- Give the student in any dept. the lessons they wanted.
- Caring, patience.
- Give them an extra activities and extra time and love.
- Patience
- Problem, * don't talk about mental illness - " family issue".
- Quality time.
- Respect of children to parents.
- The government must create more programs or jobs for children appropriate with age to attend or work to so that they can avoid loneliness by keeping them busy or isolated.
- Bonding between parents and children.
- Patience.
- Social support groups for parents and adults. Church, clubs, neighborhood groups.
- We need to proclaim our duties and to day with_____and____

Older Adult Quotes
- Improvement in the community in all aspects, especially in school in the public places on the mental health of every individual.
- Quality time.
- Traditional respect to elderly. Closeness of family relations among activities.
- Guidance and counseling among members of the family and attending worship service for spiritual development.
ADULTS, 19 TO 59 YEARS OLD

Which of these problems are the biggest results of emotional or psychological problems for adults in your community?

- Anxiety and fear: 36%
- Drug or alcohol abuse: 11%
- Going to a psychiatric hospital: 6%
- Homelessness: 5%
- In trouble with the law or police: 10%
- Isolation and loneliness: 25%
- Memories of trauma: 10%
- Sadness, depression, suicide: 33%
- Unable to care for family: 9%
- Unable to work: 17%
- Violence in the community: 10%
- Violence in the home: 14%

Have you or someone in your family experienced those problems?

- Anxiety and fear: 49%
- Drug or alcohol abuse: 58%
- Going to a psychiatric hospital: 38%
- Homelessness: 55%
- In trouble with the law or police: 45%
- Isolation and loneliness: 53%
- Memories of trauma: 39%
- Sadness, depression, suicide: 59%
- Unable to care for family: 49%
- Unable to work: 57%
- Violence in the community: 50%
- Violence in the home: 48%

What help do you think seniors need the most for these problems?

- More social activity and recreation with friends: 55%
- More mental health services in doctors offices: 50%
- More mental health services in mental health clinics: 47%
- More mental health services in my culture and language: 50%
- More information about mental illnesses: 55%
- More information about improving family relationships: 62%
- More help with housing and finances: 61%
- Counseling in places of worship: 40%
What qualities in yourself, your culture or community help adults cope with these problems?

Youth Quotes
- My parents brought me up as a person who can deal with almost everything.
- Nice and don’t cause problems.
- Programs will enable them to interact with positive people.

Adult Quotes
- Writing to the senators Hillary Rodham Clinton and to the President of the United States of America.
- Caring, patience
- Caring.
- Family closeness/religion
- Friendly - help each other.
- Need more advice.
- One on one basis case to care relationship with a caseworker who can put more time for them.
- I have to struggle myself not doing bad to my co-worker and community of culture and development.
- Licensed practitioner in mental health. ______ cultural mental health practitioner, compassion, care for people and special needs, recognize people have differences.
- Patience.
- Strong support network among families and their organizations.
- Talking with our friends, community support

Older Adult Quotes
- A mental health professional for many years
- Guidance and counseling on how to become productive and responsible citizen
OLDER ADULTS, 60 PLUS YEARS OF AGE

Which of the problems are the biggest results of emotional or psychological problems for older adults in your community?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety and fear</td>
<td>8</td>
</tr>
<tr>
<td>Drug or alcohol abuse</td>
<td>6</td>
</tr>
<tr>
<td>Going to a psychiatric hospital</td>
<td>7</td>
</tr>
<tr>
<td>Grief and loss of loved one</td>
<td>17</td>
</tr>
<tr>
<td>Homelessness</td>
<td>6</td>
</tr>
<tr>
<td>In trouble with the law or police</td>
<td>7</td>
</tr>
<tr>
<td>Medical problems</td>
<td>15</td>
</tr>
<tr>
<td>Memories of trauma</td>
<td>7</td>
</tr>
<tr>
<td>Sadness, depression, suicide</td>
<td>12</td>
</tr>
<tr>
<td>Shut in at home and isolation</td>
<td>9</td>
</tr>
<tr>
<td>Violence in the family</td>
<td>5</td>
</tr>
</tbody>
</table>

Have you or someone in your family experienced these problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety and fear</td>
<td>46</td>
</tr>
<tr>
<td>Drug or alcohol abuse</td>
<td>33</td>
</tr>
<tr>
<td>Going to a psychiatric hospital</td>
<td>30</td>
</tr>
<tr>
<td>Grief or loss of loved one</td>
<td>48</td>
</tr>
<tr>
<td>Homelessness</td>
<td>49</td>
</tr>
<tr>
<td>In trouble with the law or police</td>
<td>28</td>
</tr>
<tr>
<td>Medical problems</td>
<td>44</td>
</tr>
<tr>
<td>Memories of trauma</td>
<td>37</td>
</tr>
<tr>
<td>Sadness, depression, suicide</td>
<td>46</td>
</tr>
<tr>
<td>Shut in at home and isolation</td>
<td>52</td>
</tr>
<tr>
<td>Violence in the family</td>
<td>33</td>
</tr>
</tbody>
</table>

What help do you think seniors need most for these problems?

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling in places of worship</td>
<td>37</td>
</tr>
<tr>
<td>More help with housing and finances</td>
<td>47</td>
</tr>
<tr>
<td>More information about mental health and mental illnesses</td>
<td>42</td>
</tr>
<tr>
<td>More mental health services in my culture and language</td>
<td>41</td>
</tr>
<tr>
<td>More mental health services in doctors offices</td>
<td>46</td>
</tr>
<tr>
<td>More mental health clinics</td>
<td>38</td>
</tr>
<tr>
<td>More services in recreational activities</td>
<td>50</td>
</tr>
</tbody>
</table>
What qualities in yourself, your culture or community help older adults cope with these problems?

**Youth Quotes**
- Having good grandparents who care for everyone.
- Positive family interaction and recreational programs.
- Don’t cause trouble.

**Adult Quotes**
- Adults should be united with their family members
- Be helpful to the older people.
- Caring, patience.
- Caring.
- Entertainment. And additional funds you got extras.
- Family oneness/religion - faith to the almighty or anything beyond. Government help
- I think it is the best way to understand most … to … like my sickness & tradition.
- One on one basis/cases with caseworker. Just make time for them. Explain well to family … caretaker.
- I think it is the best way to understand most … to … like my sickness & tradition
- Integration of seniors to social programs
- Patience
- Support among family members

**Older Adult Quotes**
- By participating in the culture of community activities, for the mental health of every person.
- Quality time.
- Regular Attendance of the social and group seminar on gatherings in senior and community centers.
- Volunteerism, social services network, church ministries.
- Participation with guidance and counseling process to achieve its mission objectives.
LATINO COMMUNITY SURVEY RESULTS

A total of 1,841 Latino respondents completed the survey. Two hundred and twelve of the respondents were between the ages of 0 to 15, 495 respondents were between the ages of 16 to 25, 992 respondents were between the ages of 26 to 59, and 77 respondents were age 60 and over. Sixty-five respondents did not indicate their age.

CHILDREN AND YOUTH, 0 TO 18 YEARS OLD

Which of these are the most important problems for children and teens in your community?

Have you or someone in your family experienced those problems?

What help do you think children and teens need most for these problems?
What qualities in yourself, your culture or community help children and youth cope with these problems?

**Youth Quotes**

- By being a good listener and understanding about a lot of people.
- Community centers, counseling, after school programs, family counseling.
- Community Centers.
- Counseling them on what is good and what is not
- Counselors
- Drawing, talking to others.
- Expressing my feelings.
- Family and friends.
- Family, church.
- Good uncles to talk to and some friends that are experiencing some of these problems.
- Having friends that give good advise and that give information.
- Having friends.
- I have a loving family and we are Christians so we attend church and that helps me cope with these problems.
- I have never used any drugs or been beaten. I haven't been great. I've always had great friendships, and I love to go to school.
- I tell my friends about my problems.
- I think in myself it is doing a hobby. In my community doing sports. It is one way of getting your mind off things.
- I think what helps is people to talk to and people to understand problems.
- I try to help by speaking to them and try to understand them.
- Information about their problems they have.
- Keep problems to yourself
- Friends and family.
- Hitting things.
- I had a good family, friends and adult friends.
ADULTS, 19 TO 59 YEARS OLD
Which of these problems are the biggest results of emotional or psychological problems for adults in your community?

![Bar chart showing the number of people experiencing various problems.]

Have you or someone in your family experienced those problems?

![Bar chart showing the number of people experiencing various problems.]

What help do you think adults need most for these problems?

![Bar chart showing the number of people preferring different types of help.]

Ethnic Communities of Santa Clara County Provide Perspectives and Opinions on Mental Health
Latino Community Survey Results
OLDER ADULTS, 60 PLUS YEARS OF AGE
Which of these problems are the biggest results of emotional or psychological problems for older adults in your community?

Have you or someone in your family experienced these problems?

What help do you think seniors need the most for these problems?
VIETNAMESE COMMUNITY SURVEY RESULTS

There were a total of 416 Vietnamese respondents who completed surveys. Thirty seven of the respondents were between the ages of 0 to 15, 86 respondents were between the ages of 16 to 25, 225 respondents were between the ages of 26 to 59, and 50 respondents were age 60 and over. Eighteen respondents did not indicate their age.

CHILDREN AND YOUTH, 0 TO 18 YEARS OLD

Which of these are the most important problems for children and teens in your community?

Have you or someone in your family experienced those problems?

What help do you think children and teens need most for these problems?
What qualities in yourself, your culture and community help children and youth cope with these problems?

Youth Quotes

• I don't know.
• I go to church regularly and pray every night.
• I had a good group. I have a good and loving family
• I like my teachers.
• My friends would help me cope with problems.
• Support and encourage.
• The community is caring.
• The counselor.

Transitional Aged Youth Quotes

• Gives us a sense of origin.
• After school program, school services.
• Being confident, having activities, jobs.
• Community, religions and youth activities
• Counselors at school are really helpful, patient
• Gathering together.
• Having a sense of community and having lasting values and the nature of their illness, helps to age.
• Having good friends
• Nothing
• Parents' appropriate concerns. Parents should know ways to communicate with their children.
• People handle their problem with care and decency
• Religion, sometimes elders or friends

Adult Quotes

• Activities during festival (Vietnamese Lunar New Year)
• Advice, encouragement, financial support in order to help youth go to school regularly and parents' concern
• Better outreach service for kid, especially after school program.
• Boy scout, Eucharist youth.
• Celebration at Vietnamese New Year.
• Closeness, give advice from parents, elderly toward children in Vietnamese family.
• Community activities.
• Community center, vocational school.
• Don't have any problems.
• Don't have problem.
• Family closeness, support system, great church.
• Family involvement & activities.
• Family.
• Having additional humanity organizations. More youth involvement.
• In educational system, we should have the Vietnamese moral classes. In social activities we should have more opportunities to meet to exchange information in order to assist youth to have better understanding new society and promote healthy life style, and also avoid negative social activities
• Increase additional good school for youth. Spend more time with children.
• Increase more youth activities. Expand Vietnamese clinics.
• Listening to their parents.
• Living together in big family (grandparents)
• Meet and seek advice from counselors
• Meeting, celebration, studying, listening from each other.
• More community activities regularly in order to … youth negative activities such as gambling.
• More education.
• Need to have more contacts with good friends. Should always encourage our children to volunteer or involve in humanitarian works.
• None.
• Not be able to awake one's rights & justice system in America. Involvement in community and religious activities. Vietnamese student Association in schools and colleges.
• Open additional, more group activities or community centers for youth.
• Organize children, youth positive activities in weekend so they hang out in appropriate places.
• Organize educational activities regularly.
• Provide life style's activities for each ethnic background at school in order to awake children's awareness.
• Should have educational class or non-profit agency to assist youth when needed.
• Study at schools with peers.
• Traditional festival: Moon festival, Vietnamese New Year. Concern from elders toward youth.
• Trouble maintaining Vietnamese language and family tradition. Provide healthy activities in Western lifestyle. Improve services, private nonprofit agencies.
• Unconditional love from family.
• Very good.
• Willing to be patient and concerns toward children's education. Sacrificing everything for their children. Assist children (students) to be able to catch and improve their English.
• Willing to love, learn new things.

Older Adult Quotes
• Children obey their parents. Willing to learn from older people's experience. English language problem, limited in … justice legal system. New lifestyle, low acculturation.
• Don't have other problem
• Expand Vietnamese claims.
• Introduce language to appropriate providers.
• Language, education, knowledge, compassionate, patient, understand two cultural Vietnamese & America.
• Mental health services.
• Provide assistance for students, provide transportation, school tuition.
• Providing good mental health services that are appropriate with culture, linguistic to provide excellent educational support in order to improve family relationships.
• Son's ill-treatment. Son's (abandonment)
• We must be straight forward with children and youth and willing to help them in dealing with above problems.
ADULTS, 19 TO 59 YEARS OLD

Have you or someone in your family experienced those problems?

What help do you think adults need most for these problems?

Ethnic Communities of Santa Clara County Provide Perspectives and Opinions on Mental Health
Vietnamese Community Survey Results
What qualities in yourself, your culture or community help adults cope with these problems?

**Youth Quotes**
- Caring
- Counseling.
- Family support and good friends.
- Help with finances.
- I don’t know.
- Their significant other.
- They are able to express their anger and not repress it.

**Transitional Aged Youth Quotes**
- Adults have problems, that will solve it themselves, with full responsibility.
- Family Therapy.
- Friends.
- Gathering together.
- Hospital, community services.
- If there were more Vietnamese that went through the experience ahead,
- Nothing.
- Patience, people with listening skills

**Adult Quotes**
- Cultural perspective that looks at elderly like a part of community not an obsolete machine
- Educational centers, vocational school.
- Involved in community activities
- Make them go to program.
- Advice, willing to learn relating to parenting.
- Assist disabled population who are unable to support themselves.
- Be able to learn justice (legal) system in media to increase awareness
- Community activities, and family activities every week. Going to temple & church. Family & community activities.
- Community activities.
- Do not allow using substance abuse.
- Drug treatment centers.
- Educational centers, vocational school.
- Family & community’s activities.
- Family structure.
- Find happiness in present, recent, living situation.
- Free vocational training or low fee.
- Hard worker, willing to work hard, be able to listen good advice. Should increase additional social classes such as ViVo. Job placement.
- Health care, social security.
- Help low-income families when needed.
- Increase free health care clinics in different locations.
- Increase media publicity relating assistance to help community.
- Interactions with peers, society.
- Is not allowed to have substance abuse.
• Living together with several generations.
• More resources on community services & resources to English-limited adults.
• Not applicable
• Not using heroin much.
• Not using substance abuse.
• Open additional counseling centers in community, especially for elderly and support.
• Organize and expand healthy life style.
• Pray, community involvement & activities, social, such as club associations.
• Provide assistance to illiterate population.
• Really need.
• Sadness, anxiety.
• Should come to humanity organizations to study ESL and vocational trainings, also volunteer at church, temple.
• Should explain and help them when needed.
• Should have vocational training, which in short term and simple ways to support & assist in job placement, especially for new comers.
• Showing respect to elderly.
• Support system, religion, unconditional & support from family.

Older Adult Quotes
• Be patient in dealing with adult mental disorders.
• Community activities.
• Do not allow using substance abuse.
• Don’t have other problem
• Lack of ability to American life.
• Media publicity.
• Patient, willing to learn new thing, coping strategies #8 Free translation services, explain personal documentation in understandable format.
• Should have additional free vocational training.
OLDER ADULTS, 60 PLUS YEARS OF AGE

Which of these problems are the biggest results of emotional or psychological problems for older adults in your community?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug or alcohol abuse</td>
<td>26%</td>
</tr>
<tr>
<td>Going to a psychiatric hospital</td>
<td>31%</td>
</tr>
<tr>
<td>Grief and loss of loved one</td>
<td>57%</td>
</tr>
<tr>
<td>Homelessness</td>
<td>18%</td>
</tr>
<tr>
<td>In trouble with the law or police</td>
<td>28%</td>
</tr>
<tr>
<td>Medical problems</td>
<td>96%</td>
</tr>
<tr>
<td>Memories of trauma</td>
<td>38%</td>
</tr>
<tr>
<td>Sadness, depression, suicide</td>
<td>51%</td>
</tr>
<tr>
<td>Shut in at home and isolation</td>
<td>70%</td>
</tr>
<tr>
<td>Violence in the family</td>
<td>27%</td>
</tr>
</tbody>
</table>

Have you or someone in your family experienced these problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety and fear</td>
<td>117%</td>
</tr>
<tr>
<td>Drug or alcohol abuse</td>
<td>11%</td>
</tr>
<tr>
<td>Going to a psychiatric hospital</td>
<td>73%</td>
</tr>
<tr>
<td>Grief, loss of loved one</td>
<td>98%</td>
</tr>
<tr>
<td>Homelessness</td>
<td>74%</td>
</tr>
<tr>
<td>In trouble with the law or police</td>
<td>72%</td>
</tr>
<tr>
<td>Medical problems</td>
<td>125%</td>
</tr>
<tr>
<td>Memories of trauma</td>
<td>77%</td>
</tr>
<tr>
<td>Sadness, depression, suicide</td>
<td>115%</td>
</tr>
<tr>
<td>Shut in at home and isolation</td>
<td>131%</td>
</tr>
<tr>
<td>Violence in the family</td>
<td>70%</td>
</tr>
</tbody>
</table>

What help do you think seniors need most for these problems?

<table>
<thead>
<tr>
<th>Service</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling in places of worship</td>
<td>138</td>
</tr>
<tr>
<td>More help with housing and finances</td>
<td>175</td>
</tr>
<tr>
<td>More information about mental health and mental illnesses</td>
<td>143</td>
</tr>
<tr>
<td>More mental services in my culture and language</td>
<td>212</td>
</tr>
<tr>
<td>More mental health services in doctors offices</td>
<td>153</td>
</tr>
<tr>
<td>More services in mental health clinics</td>
<td>138</td>
</tr>
<tr>
<td>More social and recreational activities</td>
<td>173</td>
</tr>
</tbody>
</table>
What qualities in yourself, your culture or community help older adults cope with these problems?

**Youth Quotes**
- Caring
- Counseling
- Family
- I don't have grandparents
- I don't know
- Love and caring
- Patience
- They have good family members who care for them and visit them at their nursing homes or live with them

**Transitional Aged Youth Quotes**
- Children and grandchildren take care of older adults in the family
- Having a sense of community and routine activity, knowing there is help, really helps
- Having somebody to talk to
- More programs for them to be together
- Nothing
- Older adult talk with young kids and teens with their problems
- Someone to talk to

**Adult Quotes**
- Always have community activities to assist disabled population to overcome loneliness
- Children’s attitude toward elderly in their family
- Children, grandchildren, grandparents live in the same house. Help elderly less lonely. Healthcare. Need for more Vietnamese doctors who speak same language
- Community activities, family and church
- Community action, open more events & invite older people
- Community activities
- Don’t have any ideas
- Don’t have anything else
- Financial support, being of from community
- I am going to Vietnam to visit motherland and relatives
- Increase senior’s activities
- Increase social and recreational activities
- Always have community activities to assist disabled population to overcome loneliness
- Live, concentrate in community
- Living in the same community together
- Living in the same community
- Living together with children
- More Vietnamese schools
- Need to get together within community
- Providing assistance to community
- Racism; discrimination. Bilingual/educated, vocational training
- Recreational centers for elderly
- Respect for elderly, extended family support
• Should increase additional organizations or senior clubs to meet and participate or exchange opinions, ideas in the weekend
• Sleep and wake up early
• Respect for elderly, extended family support

*Older Adult Quotes*

• It is important to show compassion towards elderly
• Activities at temple
• Don't have other problem
• Expand Vietnamese claims
• Live in Community
• Need help on transportation
• Need help with transportation to go to church
• None