Needs Assessment and Proposals for Action: Immigrant Mental Health in Washtenaw County

Ruth Kraut, M.A., M.P.H.
Washtenaw Health Plan
Washtenaw County Public Health

Evan Martin, B.S.
University of Michigan Medical School
Global Health Disparities Pathway of Excellence

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Executive Summary

In 2012, the Washtenaw Health Plan identified the mental health needs of a growing immigrant population in Washtenaw County as an access to care gap. With the assistance of a grant from the Ethel and James Flinn Foundation, the WHP was able to initiate some small steps to reducing that gap, by providing support to Catholic Social Services and Jewish Family Services to ensure ongoing capacity for mental health services in Spanish and Arabic. In addition, the Flinn Foundation funding allowed the WHP to complete a needs assessment in order to identify additional gaps in service, and to follow that with the development of a strategic plan to address those gaps.

The development of the needs assessment included interviews with key informants—primarily professionals who either work extensively with immigrants in a variety of organizations, or who work extensively in the mental health field; focus groups with Spanish-speaking men and women; individual interviews in English with Arabic speakers who spoke English well enough to discuss key issues; assessment of data from the *Encuesta Buenos Vecinos*, the Latino Health Survey conducted by Washtenaw County in 2014; census data; and some additional data sources.

The intent of this project is to provide a picture of immigrants in Washtenaw County, their mental health needs, and how they are—or are not—being met. Immigrants in Washtenaw County come from a diverse array of backgrounds, and for immigrants with mild, moderate, or severe mental health issues, there are many opportunities to improve resources.

While many immigrants arrive in this country with trauma, anxiety, and depression, these issues are exacerbated by issues with understanding the English language, economic stressors, and difficulty understanding cultural cues. This report suggests several strategies to address the mental health needs of individuals, and some of the most important ones indirectly address mental health needs by addressing language, cultural, and economic barriers. For example:

- Local nonprofit organizations should be encouraged to translate key documents, including documents publicizing services (for instance, how to access domestic violence services), into multiple languages—and should have a strategy for using language line or other interpretation when somebody calls or visits.

- Nonprofits and school districts offering adult English as a Second Language programs should coordinate publicity and publicize the offerings in other languages.

- Organizations that provide mental health services should work to identify staff (particularly therapists) who are bilingual/bicultural in any languages/cultures, and publicize that information.
Introduction—Two Immigrant Populations

According to the 2012 American Community Survey, there are 39,359 foreign born residents in Washtenaw County, representing about 13% of the population. Washtenaw County has the highest proportion of foreign born residents in the state of Michigan according to the 2012 American Community Survey. Among the immigrant population, the ACS identifies the most common countries of origin as China (4678), India (4390), and Korea (3633). By race, the ACS estimates the largest percent of the Washtenaw County immigrant population as Asian (49.7%), White (38.6%), and Black (6.3%) with 9.3% of the population identifying as Hispanic or Latino ethnic origin.

This, however, only begins to tell the tale of immigrants in Washtenaw County. Washtenaw County immigrants come from many countries and six continents, and in the Ann Arbor school district alone, students come from homes where over 60 languages are spoken. Because of the presence of the University of Michigan and Eastern Michigan University, there are many foreign-born county residents who are here either as students or faculty/professionals, with significant technical skills and higher incomes.

Yet there is another type of immigrant in Washtenaw County—low-income and under-resourced, with limited language or literacy skills in English, and sometimes in other languages as well. They may have come here with green cards (brought over as a family member or spouse; entering through the diversity lottery; or as refugees/asylees); they may be here with work permits or student status; they may be here as undocumented/unauthorized immigrants or with DACA (Deferred Action for Childhood Arrivals) status. They are more likely to come from South/Central America, the Middle East, or Africa—and very often they are fleeing conditions of conflict or deprivation. Their journeys may have been harrowing; they may have stopped for long periods of time in refugee camps or other locations; they may have experienced torture, sexual or physical assault, and loss of family ties. And their premigration or migration history will likely affect their mental health status for years to come.

For this second group of immigrants, the necessity to make a living and make a new life may initially trump other needs, including mental health needs. And yet, their mental health needs may affect their physical health, their ability to adapt to a new culture, and the lives of the rest of their family. In addition, economic and linguistic issues are additional, major stressors.

Thus, although the top countries for immigration to Washtenaw County include Korea and China, the low-income immigrant population looks different—with many immigrants from Central and South America, from the Middle East, from Africa, and from Vietnam and Pakistan. Thus the most frequent users of services to low-income county residents are more likely to speak Spanish, Arabic, French, or Vietnamese.
While immigrants come for different reasons, and as a result experience different stressors, many of the most common stressors are common to all immigrants: language stress, culture stress, economic stress. These everyday stressors can be exacerbated by trauma histories, domestic violence, and immigration problems. Some of the most common stressors are most easily addressed with interventions that are not related to physical or mental health—for example, English learning opportunities. When physical health or mental health interventions are needed, however, it is best if they can be given in a culturally-competent manner, and where possible in the patient’s native language. At the end of this needs assessment are recommendations for strategic planning and possible interventions to address the mental health needs of immigrants.

**Methods**

The goal of this needs assessment was to collect data and do a comprehensive overview and summary of mental health needs of immigrants in Washtenaw County. We worked to access data about immigrants and mental health issues at multiple levels. We conducted an extensive literature search and collected census and other data. We interviewed over 30 professionals who work with the county’s immigrant population in a variety of roles. The staff who were interviewed included several individuals who were themselves immigrants—some had come over as refugees; others as economic immigrants; and still others had initially come as students.

We completed two focus groups in Spanish, one for men, and one for women, with Spanish-speaking immigrants. We completed individual interviews with immigrants from Arabic-speaking countries. We also did an extensive review of the data from the Encuesta Buenos Vecinos (EBV), a local survey of the Latino population in Washtenaw County that was conducted in 2013 and 2014.¹

**Literature Review**

**Immigration Framework**

Current research describes premigration, migration and post-migration as important periods when immigrants are exposed to risks and stressors. In premigration, immigrants must endure disruptions in their social, educational, and economic status often in the wake of political or economic forces that range from inhospitable to traumatic. In the course of migration, immigrants may experience unfamiliar living conditions, poor nutrition and violence that may lead to further isolation and loss of hope for the future. Upon reaching the United States (postmigration), immigrants must

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¹ The Encuesta Buenos Vecinos (EBV) project was supported by the U.S. Housing and Urban Development - Sustainable Communities Project, Michigan Institute for Clinical & Health Research - Community University Research Partnership (Grant No. 2UL1TR000433-06), Michigan Department of Community Health - Health Equity Capacity Building Project, and Washtenaw County Public Health.
navigate an environment complicated by foreign cultural and linguistic norms that may inhibit their ability to find employment, education, and a community in a context of uncertainty about their new life and worry about those that they left behind.\textsuperscript{2}

Stressors during premigration, migration, and post-migration are associated with various risks for mental health disorders.

**Premigration**

Traumatic or harmful premigration experience has been widely associated with depression and post-traumatic stress disorder (PTSD) among refugees and the general immigrant population\textsuperscript{3,4}. Montgomery et al. found that 6.7\% of immigrants to the United States experience premigration harm. After controlling for gender, visa type and country of origin, the immigrants who fell victim to premigration harm were more than twice as likely as unaffected immigrants to experience major depression with dysphoria (OR: 2.239). Among this group, female immigrants experienced twice the risk of major depression with dysphoria than males (OR: 2.199). Also, immigrants with refugee or asylee visa status reported significantly higher rates of major depression with dysphoria (OR: 1.486). Country of origin did not significantly impact measured mental health.

**Migration**

A strenuous migration may be characterized by hazardous travel, separation from family, and witnessing violence leading to higher rates of depression, PTSD, and mental-health related disability. In the event of immigrant detention, immigrants experienced significant worry about the immigration application process (81\%) and worry about their family back home (87\%). Life in detention centers is described as being boring (83\%), isolating (79\%) and overcrowded (48\%) with poor quality food (45\%). This unsettling environment is further stressing as many immigrants experience interpersonal stress through being victim to racist intimidation from other detainees (82\%), witnessing physical assault (61\%) and self-harm (68\%). Immigrants report enduring this environment without access to medical care (48\%), despite having high prevalence of depression, PTSD and mental health-related disability that worsened with the length of detention (Fig.1).\textsuperscript{5}
Prevalence of Mental Disorders and Disability among Detained Immigrants

![Graph showing prevalence of mental disorders among detained immigrants.](image)

Figure 1

*Prevalence of depression, post-traumatic stress disorder and mental health-related disability among Iraqi and Iranian immigrants who experienced no detention (n=91), detention for 1-5 months (n=57), and detention for >6 months (n=93) in an immigrant detention center. □ Depression, □ PTSD, □ Mental health-related disability.*

**Postmigration**

Postmigration conditions such as having access to private and permanent housing as well as employment opportunities lead to better mental health. However, immigrants often struggle finding employment that is skill appropriate; consequently, immigrants with higher levels of education experience worse mental health. Perception of downward social mobility has been associated with higher rates of depression.

**Mental Health Risk Factors**

The rates of mental health disorders depend on a variety of immigrant characteristics including age, gender, socio-economic status, degree of family stress, English speaking proficiency, reasons for immigration, and number of years in the host country. These factors may determine the degree to which immigrants are able to cope with acculturative stressors in the United States. For instance, bicultural individuals fluent in both the culture of their home and host county report better mental health, as they embrace both lineages of their ancestry and are advantageously able to adapt to social norms according to their cultural environment.

**Mental Health Effect of Origin, Age, and Generation of Immigration**

Looking more closely at US nativity and age of immigration, the majority of research shows that immigrants have lower lifetime prevalence of many types of mental health disorders (mood/anxiety disorders and personality disorders) than US born as seen in Figure 2.
Age and Generation of Immigration

A further protective association seems to exist among those who immigrate as adolescents or adults, as mental health disorders tend to rise among later generations of immigrants. First generation immigrants may have better mental health because they maintain social support, cultural practices, extended family support networks, and lower rates of substance abuse. However, rates of mental health disorders rise among 2nd and 3rd generation immigrants toward becoming equal with the US born population.
Figure 3

_Lifetime prevalence of mental health disorders of first- and second-generation adult immigrants from Asia, Africa, Europe and Latin America and native-born adults in the United States._11

**Origin of Immigrants**

Research varies widely in their comparisons of groups of immigrants by demographic identities of origin, and, consequently, obscures conclusions in the overall discussion of predictors of mental health disorders among immigrants. While some research focuses on larger groups, such as Asian, African, European and Latin American immigrants, other research attempts to reveal differences within the continental origin by looking at region, country, and/or race of origin. For example, Breslau et al found lower rates of mood and anxiety disorders among Hispanics from Mexico, non-Hispanic Whites from Eastern Europe, and non-Hispanic Blacks from Africa or the Caribbean who arrived in their adolescent or adult years when compared to the US born population. However, Hispanic-Cubans, South or Central Americans, and Puerto Ricans reported equal rates of mood and anxiety disorders to the US born population.

**Race and Religion**

Race and religion are also identities that seem to impact mental health. Immigrants finding a supportive community and practicing their religion report better mental health outcomes. Immigrants who perceive racial or religious discrimination report worse mental health.12
Access to Mental Health Care

While immigrants experience significant stressors resulting in poorer mental health, immigrants also face barriers to access of mental health services in the United States\textsuperscript{16,17,18}. One study found that US born Blacks were significantly more likely to receive specialty mental health services than Black immigrants born in the Caribbean, 13\% and 2\% respectively \textsuperscript{16}. This significant difference was also seen in a similar study with 6\% of US-born Asians and 2\% of foreign-born Asian immigrants receiving specialty mental health services \textsuperscript{17}.

In explaining these differences in mental health care use, researchers have hypothesized that immigrants may have had inadequate mental health systems in their home countries. Thus, immigrants may be unfamiliar with mental health care, have undiagnosed mental disorders, and be unaware of the effect of mental health on their well-being. Also, research has widely documented linguistic and cultural barriers in the US health system. While it is clear that low English proficiency would severely limit mental health care, immigrants may lack vocabulary for mental health disorders in English or in their mother tongue. This linguistic barrier may be worsened by cultural identities that frown upon sharing personal problems outside of the family, as it would admit to a stigmatized condition within their community.

Census Data—Who Lives Here?

2012 ACS 5-year demographics of the general population of Washtenaw County and State of Michigan.

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Washtenaw</th>
<th>Michigan</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 Population</td>
<td>351,146</td>
<td>9,882,519</td>
</tr>
<tr>
<td>White</td>
<td>75.2%</td>
<td>80.1%</td>
</tr>
<tr>
<td>(264,062)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>12.9%</td>
<td>14.3%</td>
</tr>
<tr>
<td>(45,298)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>8.2%</td>
<td>2.6%</td>
</tr>
<tr>
<td>(28,794)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+ Races</td>
<td>3.2%</td>
<td>2.2%</td>
</tr>
<tr>
<td>(11,237)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>4.3%</td>
<td>4.6%</td>
</tr>
<tr>
<td>(15,099)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign-born persons (5-yr.)</td>
<td>11.4%</td>
<td>6.0%</td>
</tr>
<tr>
<td>(40,031)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speak language other than English at home, age 5+ (5-yr)</td>
<td>14.3%</td>
<td>9.0%</td>
</tr>
<tr>
<td>(47,062)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent below poverty level (5-year)</td>
<td>14.6%</td>
<td>16.3%</td>
</tr>
<tr>
<td>(51,267)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2012 ACS 5-year demographics of the general population of Washtenaw County and the cities of Ann Arbor and Ypsilanti, MI.

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Washtenaw</th>
<th>Ann Arbor</th>
<th>Ypsilanti</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 Population</td>
<td>351,146</td>
<td>116,121</td>
<td>19,809</td>
</tr>
<tr>
<td>White</td>
<td>75.2% (264,062)</td>
<td>73.0</td>
<td>61.5%</td>
</tr>
<tr>
<td>Black</td>
<td>12.9% (45,298)</td>
<td>7.7%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>8.2% (28,794)</td>
<td>14.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td>2+ Races</td>
<td>3.2% (11,237)</td>
<td>3.6%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>4.3% (15,099)</td>
<td>4.1%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Foreign-born persons (5-yr.)</td>
<td>11.4% (40,031)</td>
<td>18.2%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Speak language other than English at home, age 5+ (5-yr)</td>
<td>14.3% (47,062)</td>
<td>21.5%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Percent below poverty level (5-year)</td>
<td>14.6% (51,267)</td>
<td>21.9%</td>
<td>28.8%</td>
</tr>
</tbody>
</table>

2012 ACS 5-year demographics of immigrant origin and time of immigration in Washtenaw and Michigan.

Table 3

<table>
<thead>
<tr>
<th></th>
<th>Washtenaw</th>
<th>Michigan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Born</td>
<td>11.4%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Entered 2010 or Later</td>
<td>1.9% (+/- 1.2%)</td>
<td>2.2%</td>
</tr>
<tr>
<td>Entered Before 2010</td>
<td>98.1%</td>
<td>97.8%</td>
</tr>
<tr>
<td>Naturalized</td>
<td>41.5%</td>
<td>49.6%</td>
</tr>
<tr>
<td>Not Naturalized</td>
<td>58.5%</td>
<td>50.4%</td>
</tr>
<tr>
<td>From Europe</td>
<td>18.7%</td>
<td>24.1%</td>
</tr>
<tr>
<td>From Asia</td>
<td>57.3%</td>
<td>45.7%</td>
</tr>
<tr>
<td>From Africa</td>
<td>6.5%</td>
<td>4.0%</td>
</tr>
<tr>
<td>From Latin America</td>
<td>11.8%</td>
<td>19.2%</td>
</tr>
<tr>
<td>From N. America</td>
<td>5.2%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>
Compared to the rest of Michigan, Washtenaw County is home to many more immigrants, with the majority of immigrants in the county coming from Asia. According to the American Community Survey, 32% of people who speak Spanish at home do not speak English very well; 21% of people who speak other Indo-European languages at home do not speak English very well; and 37% of people who speak Asian languages at home do not speak English very well. Senior citizens are least likely to say they speak English very well.

Washtenaw County is home to a diverse array of immigrants, and they are concentrated in the urban core. Many immigrant communities are concentrated in particular census tracts, and even particular apartment complexes. Spanish, Arabic and French speakers are concentrated in the eastern and south/central parts of Washtenaw County (Ypsilanti, Ypsilanti Township, Superior Township, Pittsfield Township, and the east side of Ann Arbor), while speakers of Asian languages (Chinese, Korean, and Japanese) are concentrated in the northeastern quadrant of Ann Arbor and in Ann Arbor Township.

Jewish Family Services of Washtenaw County is the refugee resettlement agency for Washtenaw County. In the past 5 years they have resettled over 250 refugees, primarily from Iraq, Syria, Iran, and Afghanistan. Many of the refugees have spent time in transit/refugee camps, and have experienced war conditions, torture, or other traumatic events. Often, the refugees join other family members—who may or may not be admitted under a refugee visa (they may have been sponsored by a relative), but who may have experienced similar issues before they arrived.

![Incoming Washtenaw County Refugees, 2009-2016](chart)

*Over the past several years, cases have primarily come from Iraq, Ethiopia, Somalia, Syria, Iran, and Afghanistan.*
In addition to refugees, there are other immigrants who have experienced the same experiences as refugees (fleeing war or famine), but who have been sponsored by relatives and come into the country under a different legal status. Because they are not an easily-identified group, they may “fly under the radar,” having the same needs but different access to resources.

**Mental Health among Latino Immigrants of Washtenaw County: Prevalence and Risk Factors in the Encuesta Buenos Vecinos**

In 2013 the Washtenaw Health Department led a study, called the *Encuesta Buenos Vecinos* (EBV), to enumerate the mental health and stressors of Latino immigrants in Washtenaw County\(^\text{19}\). The EBV surveyed 400 Latino immigrants about a variety of demographic and self-reported health information. A secondary study of this county data set was conducted to:

1) Identify the prevalence of mental distress among Latino immigrants
2) Identify and compare the relationship of immigration-related risk factors to the prevalence of mental distress among Latino immigrants.

**Methods**

**Self-Reported Quality of Life Measures**

Self-reported health information was analyzed from 400 Latino immigrants living in Washtenaw County in 2013. Respondents were asked “during the past 30 days, for about how many days have you felt”: 1) your physical health was not good, 2) your mental health was not good, 3) poor physical or mental health kept you from your activities, 4) sad, blue or depressed, 5) worried, tense, anxious. Responses to each question were from 0-30 days.

These five bilingual and culturally appropriate questions were modeled on the Healthy Days measures of the Health Related Quality of Life survey module included in the U.S. Behavioral Risk Factor Surveillance System (BRFSS) of the Centers for Disease Control and Prevention\(^\text{21}\). The Health Related Quality of Life survey has been widely used to assess self-perceived health. Healthy Days measures have strongly associated with clinically validated measures of depression and anxiety disorders, such as the PHQ-8\(^\text{23}\). Also, retest reliability is excellent, as Anderson et. al showed that re-interviewing respondents 2 weeks after the initial Healthy Days interview yielded responses that were over 75% reliable to their first responses\(^\text{24}\).

We analyzed the characteristics of the Healthy Days measures of our county sample, as well as compared our county sample with the national and statewide BRFSS sample. Between group differences were evaluated using chi-square test.
Frequent Mental Distress (FMD)

Within the Healthy Days measures, our primary outcome variable was Frequent Mental Distress (FMD), which the CDC is defined as 14 or more days in the last month when mental health is not good. A threshold of 14 days is similar to clinically useful markers of depression and anxiety disorders, and poor mental health lasting beyond 14 days is associated with less ability to work and worse quality of life. FMD is a validated global measure of mental health and widely used in population health surveys. Bivariate analysis conducted with chi square and independent samples t-test for categorical and continuous variables, respectively. Significant difference was identified with a p value of less than .05.

Results

Geographic Distribution of Frequent Mental Distress (FMD)

In Washtenaw County, the prevalence of FMD was found to be 11.5% (N= 46) of surveyed Latino immigrants, as compared to 10.4% and 10.6% of all US and Michigan respondents, respectively. Latino immigrants in Washtenaw County experienced an average of 4.3 days in which their mental health was not good. The prevalence of FMD was reported by zip code in Washtenaw County (Figure 5). Of highest prevalence, 14.5% of those surveyed in zip code 48197 (Ypsilanti, MI) met the criteria for FMD. The lowest prevalence of FMD was seen at 7.9%, reported by immigrants living in zip code 48103 (Ann Arbor).

Prevalence of FMD by Zip Code in Washtenaw County

Prevalence of FMD (%) among Latino immigrants differed by zip code (N= FMD/total surveyed): 14.3% in 48197 (N= 13/91), 12.9% in 48104 (N= 4/31), 12.5% in 48198 (N= 7/56), 11.4% in 48108 (N= 4/35), 10.3% in 48105 (N= 4/39), and 7.9% in 48103 (N= 6/76)
One interpretation of this distribution of mental health may correlate with the socioeconomic status of the respective zip codes. For instance, the US census reports that the general population of 48103 when compared to 48197 has a higher median income ($61,809 v $44,171), higher rate of home ownership (66.5% v 48%) and earned college degrees (62.4% v 38.9%), and that zip codes of 48105, 48108, and 48198 fall in between. While extensive literature supports a link between health disparity and socioeconomic disparity, this interpretation relies on US census data from the general population and is not directly relatable to our study population.

Among immigrants surveyed in the EBV dataset, we did not find significant association between measures of socioeconomic status, such as household income, and FMD.

It is also worth noting that 48104 and 48197 includes the University of Michigan and Eastern Michigan University. We had a total of 50 survey respondents who identified as current students. While we would suspect that this group encounters different factors of mental distress, such as academic responsibility, than other immigrants, we did not find significant associations between current student status and FMD.

Failing to find a significant association may be due to a limitation of the study's power. Surveying a larger number of Latino immigrants in future research may illuminate significant disparities.

Demographics of Immigrants with and without Frequent Mental Distress (FMD)

Survey respondents had a mean (range) age of 38.1 (18-88) years. Table 4 shows a comparison between immigrants with FMD and without FMD. This comparison revealed no significant associations between FMD and age, sex, race, education, occupation, poverty level, marital status or region of birth. However, immigrants with larger families tended to have significantly less FMD. This finding is aligned with the widely documented protective effect of social support on mental health of immigrants.
Demographic comparison between those with and without Frequent Mental Distress (FMD). Percent (Number). * p ≤ .05; ** p ≤ .01

Table 4

<table>
<thead>
<tr>
<th></th>
<th>Immigrants without FMD</th>
<th>Immigrants with FMD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 354</td>
<td>N = 46</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>30.9% (109)</td>
<td>26% (12)</td>
</tr>
<tr>
<td>30-44</td>
<td>43.4% (153)</td>
<td>36.9% (17)</td>
</tr>
<tr>
<td>45+</td>
<td>25.5% (90)</td>
<td>36.9% (17)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>57% (202)</td>
<td>65.2% (30)</td>
</tr>
<tr>
<td>Male</td>
<td>43% (152)</td>
<td>34.8% (16)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiracial</td>
<td>8.5% (30)</td>
<td>19.6% (9)</td>
</tr>
<tr>
<td><strong>Education (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤11</td>
<td>35.9% (125)</td>
<td>27.2% (12)</td>
</tr>
<tr>
<td>12</td>
<td>34.3% (120)</td>
<td>43.1% (19)</td>
</tr>
<tr>
<td>13-15</td>
<td>7.1% (25)</td>
<td>11.3% (5)</td>
</tr>
<tr>
<td>≥16</td>
<td>22% (78)</td>
<td>18% (8)</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
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</tr>
<tr>
<td>Employed</td>
<td>63.9% (228)</td>
<td>63.1% (29)</td>
</tr>
<tr>
<td>Student</td>
<td>11.8% (42)</td>
<td>17.4% (8)</td>
</tr>
<tr>
<td><strong>Poverty Level (%)</strong></td>
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</tr>
<tr>
<td>≤100%</td>
<td>83.7% (201)</td>
<td>46.8% (30)</td>
</tr>
<tr>
<td>&gt;100%</td>
<td>16.3% (39)</td>
<td>53.2% (34)</td>
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<tr>
<td><strong>Marital Status</strong></td>
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<tr>
<td>Single or Dating</td>
<td>26.1% (92)</td>
<td>36.9% (17)</td>
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<tr>
<td>Committed relationship</td>
<td>21.8% (77)</td>
<td>15.2% (7)</td>
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<tr>
<td>Married</td>
<td>46% (162)</td>
<td>32.6% (15)</td>
</tr>
<tr>
<td>Divorced/widowed</td>
<td>6% (21)</td>
<td>15.2% (7)</td>
</tr>
<tr>
<td><strong>Region of Birth</strong></td>
<td></td>
<td></td>
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<tr>
<td>Mexico</td>
<td>44.9% (159)</td>
<td>43.4% (20)</td>
</tr>
<tr>
<td>Central America/PR</td>
<td>26.5% (94)</td>
<td>30.4% (14)</td>
</tr>
<tr>
<td>South America</td>
<td>24.8% (88)</td>
<td>21.7% (10)</td>
</tr>
<tr>
<td>Caribbean</td>
<td>3.6% (13)</td>
<td>4.3% (2)</td>
</tr>
<tr>
<td><strong>Family Size</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>27.1% (88)</td>
<td>26.8% (11)</td>
</tr>
<tr>
<td>2</td>
<td>10.8% (35)</td>
<td>27.2% (12)</td>
</tr>
<tr>
<td>3 or more</td>
<td>62% (201)</td>
<td>47.7% (21)</td>
</tr>
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</table>
Characteristics of Immigrants with and without Frequent Mental Distress (FMD)

The second aim of this data analysis was to identify and compare the relationship of immigration-related risk factors to the prevalence of mental distress among Latino immigrants.

In the past month, those with FMD reported significantly more days of poor physical health (14.2 days), poor mental health (24.2 days), limitation from activity (12.7 days), feeling sad, blue or depressed (16.7 days) and feeling worried, tense, or anxious (18.2 days) as compared to immigrants without FMD (Figure 5). Latino immigrants with FMD experience significantly worse physical and mental health, and limitation from activity due to health compared to those without FMD ($p \leq .001$). This supports previous research that validated FMD as a global measure of mental health status.

Interestingly, respondents with FMD not only reported increased number of days where their mental health was not good but also reported increased number of days where their physical health was not good. While we cannot show causality, there is a strong association between mental and physical health. One interpretation could be that mental health affects perception or state of one’s physical health. It may also show that those with poor physical health are more likely to have poor mental health.

Potential Predictors of Frequent Mental Distress (FMD)

The bivariate analysis identified a number of risk factors associated with high FMD. We organized the risk factors into two categories: Healthcare Related (Figure 6) and Family and Community Risk Factors (Figure 7).
Healthcare Related Predictors for Frequent Mental Distress (FMD)

Many healthcare related risk factors associated strongly with high levels of FMD (Figure 6). Immigrants with FMD were more likely to have received specialized mental health care (p= .001) and received a mental health diagnosis (p=.000) than those without FMD. 29.5% of Latino immigrants with FMD reported having seen a psychologist or counselor in the past year and 43.2% reported having ever been diagnosed with depression. Notably, 31% of Latino immigrants with FMD were unable to fill their drug prescription due to cost, which was significantly more than those without FMD (p=.031).

Healthcare related risk factors for FMD among Latino immigrants include visited a doctor in the past year (88.8%; p= .146); saw psychologist or counselor in the past year (29.5%; p=.001); ever diagnosed with depression (43.2%, p=.000); no insurance (34.7%; p=.057); and could not fill a prescription due to cost (31.5%; p=.031).

The study population reported relatively high rates of seeking medical attention. 89% of immigrants with FMD and 80% of immigrants without FMD visited the doctor in the past year. The difference was not statistically significant (p=.146).

Also, we documented higher than expected uninsured rates among Latino immigrants. In this study, 34.7% of immigrants with FMD and 21.5% of immigrants without FMD reported not having health insurance. This survey was completed prior to recent Healthy Michigan plan enrollment made possible by the Affordable Care Act. However, the high rate of uninsured among immigrants with FMD merits concern, as Figure 5 shows that poor mental health will likely limit one’s activity, such as mobility or initiative. Thus, mental health disorders may obstruct one from enrolling in a health plan.
Family and Community Related Predictors for Frequent Mental Distress (FMD)

Many Latino immigrants report not receiving the social and emotional support that they need. 68.9% of immigrants with FMD experience low social and emotional support, which is significantly higher than those without FMD (p=.003). Looking more closely, we see that immigrants with FMD report low family contact with 41.3% talking on the phone or in person with their family less than a few times a month. This estrangement from family extends to low trust in their community, as 53.5% of immigrants with FMD either strongly disagreed or disagreed when asked whether people in their community can be trusted and would help each other out.

Without social and emotional support from family, friends, or neighbors, immigrants may be more susceptible to or unable to cope with significant mental health stressors in their environment, such as high levels of discrimination.

51% of Latino immigrants with FMD reported experiencing one or more of the following forms of discrimination at least a few times a week: 1) treated with less respect than other people, 2) people act as if you are not as good as they are, 3) called names or insulted, 4) threatened or harassed. Those with FMD are more likely to experience discrimination (p=.012). Furthermore, it is important to see that more than 30% of all Latino immigrants surveyed experience a form of discrimination at least a few times every week.

![Figure 7](https://via.placeholder.com/150)

Prevalence of low family contact, low trust in community, high discrimination, and low social and emotional support among Latino immigrants with and without FMD. * p ≤ .05; ** p ≤ .01; *** p ≤ .001
Language and Frequent Mental Distress (FMD)

Our analysis looked at rates of FMD in immigrants based on language proficiency (table 5). 94.75% of surveyed Latino immigrants speak well, very well or excellently in Spanish while about 46% speak English well, very well or excellently. Nearly half are bilingual, about 44% report speaking both English and Spanish well, very well, or excellently. We found that immigrants with and without FMD had similar rates of proficiency as English speakers, Spanish speakers, and bilingual speakers. Specifically, poor English speaking proficiency was not associated with FMD.

Time in US and Frequent Mental Distress (FMD)

In addition, we looked at the time that immigrants lived in the United States and whether that affected FMD. Most Latino immigrants surveyed have lived in the US for more than 15 years (57.25%). 26.5% of immigrants have lived in the US between 5 and 15 years, and 16.25% of immigrants have lived in the US for less than 5 years. We did not find a significant association between lengths of time living in the United States and rates of FMD.

Post-Immigration Stressors and Frequent Mental Distress (FMD)

As previously discussed, immigrants continue to face many stressors after they immigrate. We found that Latino immigrants reported experiencing fear of deportation, belief that they would be reported to immigration by a social or governmental agency, or legal status has limited contact with friends or family. 60.5% of all Latino immigrants surveyed experience at least one post-migration stressor. We did not find a significant association between post-migration stressors and FMD.

Language speaking proficiency, length of time living in US and post-migration stress among Latino immigrants with and without FMD. Language speaking proficiency, time living in US, and post-migration stressors were not associated with FMD.

Table 5

<table>
<thead>
<tr>
<th>English Proficiency</th>
<th>Without FMD N = 354</th>
<th>With FMD N = 46</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaks Not at all/ Poor/ Fair</td>
<td>53.2% (188)</td>
<td>56.8% (25)</td>
</tr>
<tr>
<td>Speaks Well/ Very Well/ Excellent</td>
<td>46.7% (165)</td>
<td>43.1% (19)</td>
</tr>
<tr>
<td>Spanish Proficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speaks Not at all/ Poor/ Fair</td>
<td>5.0% (18)</td>
<td>4.4% (2)</td>
</tr>
<tr>
<td>Speaks Well/ Very Well/ Excellent</td>
<td>95% (336)</td>
<td>95.6% (43)</td>
</tr>
<tr>
<td>Bilingual Proficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speaks English and Spanish</td>
<td>43.8% (155)</td>
<td>39.2% (18)</td>
</tr>
<tr>
<td>Well/ Very Well/ Excellent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of time in US (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 5</td>
<td>16.5% (58)</td>
<td>10.9% (5)</td>
</tr>
<tr>
<td>5 - 15</td>
<td>26.5% (93)</td>
<td>26.1% (12)</td>
</tr>
<tr>
<td>≥15</td>
<td>57.0% (200)</td>
<td>63.0% (29)</td>
</tr>
<tr>
<td>Immigration Stress (any)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>39.9% (141)</td>
<td>36.9% (17)</td>
</tr>
<tr>
<td>High</td>
<td>60.1% (213)</td>
<td>63.1% (29)</td>
</tr>
</tbody>
</table>
Conclusions from the Encuesta Buenos Vecinos Analysis

Immigration creates challenging social and cultural circumstances that may limit the ability of immigrants to transition to a healthy and productive life in the United States. By analyzing the primary outcome variable of Frequent Mental Distress (FMD), which the Centers for Disease Control’s Healthy Days Measure defines as 14 or more days in the last month when mental health was not good, we were able to:

1) Identify the prevalence of FMD among Latino immigrants
2) Identify and compare the relationship of immigration-related risk factors to the prevalence of FMD among Latino immigrants.

In Washtenaw County, 11.5% of Latino immigrants have frequent mental distress, which compares to 10.6% and 10.4% of the general populations in Michigan and the US, respectively. Furthermore, in our sample, Latino immigrants with FMD, on average, experience poor mental health for more than 24 days in the past month. This is significant considering the demonstrated strong association linking poor mental health with poor physical health and limitations in daily activity.

Interestingly, we found several predictor factors that strongly associate with FMD. Thus, these family, community, and health factors may help identify Latino immigrants with FMD in population screening.

Latino immigrants with FMD generally have poor family and community context. 68.9% of immigrants with FMD experience low social and emotional support. Reporting low contact with family and low trust in their neighbors, immigrants with FMD may be more susceptible to or unable to cope with significant mental health stressors in their environment. For instance, it is important to be aware that more than half of immigrants with FMD describe experiencing a high level of discrimination in their communities.

While we see that a majority of immigrants with FMD (89%) have seen a physician in the past year, only 43.2% have ever had a diagnosis of depression, and less than 30% have seen a psychologist or counselor in the past year. The widely documented socioeconomic barriers to healthcare access are also supported by our sample, as less than 35% of patients have insurance, and, even if they have received a drug prescription, 31.5% of patients are unable to fill their prescription due to cost.

As family and community factors seem prominent among Latino immigrants with FMD further evaluation of this domain is necessary to target support interventions. Screening for current psychiatric symptoms or barriers to receiving care should be encouraged, especially, when medical professionals see patients who are immigrants.
Physical Health and Mental Health: Intersections of Culture, Language, History

Cultural Issues

The role that cultural issues play is elucidated in this excerpt from an interview with case managers in Washtenaw County:

Case Manager: *I think language and culture are a barrier, even beyond the getting [health] coverage. I think that that's a huge--a huge barrier, especially when it comes to receiving med--mental health treatment as opposed to medical. So I think the language then becomes kind of part of your treatment more in mental health than it is in medical.*

Interviewer: *Yeah, one of the Jewish Family Services staff told me when they started for this grant, when they started to try and translate their documents, they realized there were a lot of words that really did not translate. And the words just didn’t exist in the same way.*

Case Manager: *Even like cultural, like I have a refugee that's from Iraq and the way she's got--she sees a pain doctor here who says her case of PTSD is the worst he's ever seen. And she's a refugee so she's documented and has Medicaid so she goes to CSTS. But the CSTS recommendation--so the recommendations for treating severe PTSD right now with soldiers coming back is to use therapy dogs and I guess it's really effective to wake them up when they're having nightmares and kind of console them and comfort them. But in the Arabic [world] and Islam, dogs are seen as impure so that recommendation was given to her but that's not at all appropriate for her religion.*

This same case worker went on to describe another way that cultural issues come to play:

[I work with] a 73 year old Japanese man that's severely mentally ill and when--and he speaks English. But when we've brought in people from his own culture, he's--it's almost like some of his symptoms have gone away in a way. So it's kind of hard to tell really in our cultural context, what we might consider as mental illness might be appropriate behavior in another culture and we really have no way of knowing that. Yeah, so kind of even the issue of diagnosis kind of comes into play too.

Another case worker simply said, “Stuff that goes on in the home country ends up affecting them.”

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2 Now known as CMH, Community Mental Health.
Stigma

Although the term “stigma” was not introduced by the interviewers in any discussion, it was brought up by a majority of the professionals who were interviewed.

The powerful effect of stigma is implicated in the statements of several of the professionals who were interviewed. One, who works in a health clinic, described how she often sees immigrants who have both diabetes and depression. They may be isolated and feel a certain amount of fatalism about their diabetes. Repeatedly, she said, she saw clients who had started on anti-depressants. But because of the stigma attached to mental health conditions, they didn’t get support from their family members and so they would stop taking their medications.

In other cases, concern about stigma keeps people from seeking any help whatsoever. Because they may live in a close-knit community, they may not want anyone to know their concerns.

Language Challenges

Repeatedly, language barriers were mentioned by interviewees and by professionals. As one interviewee, who came over as a refugee at age 1, described it:

*Interviewer:* Thinking about the people that you know, what things caused the most stress and anxiety?
*Respondent:* Probably the language barrier and now knowing anyone.
*I* The language barrier and not knowing anybody?
*R* Mm-hmm. Cause when we came here it was just us. We lived in Jacksonville. My parents didn’t know anyone. We had a social worker that kind of helped us--helped my parents get work and stuff, but it was still difficult because they still couldn’t speak the language and they had to put the kids through school. And it was just hard money wise as well.
*I* Right. Do they talk about that now, how hard that was?
*R* No.
*I* No.
*R* They don’t bring it up.
*I* So how do you know it was hard?
*R* Because I’ve seen it on their faces. They don’t mention it, but you see it on their face that it was hard for them.

Employment and Economic Issues

Providing for basic needs is the first order of business for most new immigrants. Thus it is not surprising that in some cases, employment itself can be a stressor.

For economic immigrants, the amount of time they spend working can take a toll. One case worker described seeing Latino men who are working two and three
jobs and suffering from major depression. In her opinion, the shift work and sleep deprivation contributed to the depression.

Another immigrant described how his brother’s expectations may have been unrealistic, but it was still stressful:

R Yeah, so finding job, it’s hard. So we, we, we try everything. We, you know, gas station. You go to [inaudible] and you wait and wait. So for them, I find out one month it’s long. Waiting one month, they say you have to wait four weeks, five weeks sometimes. It’s too long. It’s very stressful, this time.

I The waiting?

R The waiting. Even though if you ask him before you came because you came from war zone, how long you are out of work he will say one year.

I Right.

R Yeah, but for, for some reason, when he came here, maybe he has different image he will find maybe job, just when he exit the airport. But reality is different. So this is very stressful for them to understand, finding job, it takes time.

 Asked what causes the most stress and anxiety, one focus group interviewee said:

I would say three things: the broken relationships, having to leave behind your relations and coming to a place where is not easy to establish new ones, it not at all easy. The duration of life, time is slower; here it has to be faster, with respect to money, car. Relationships, time and overrating of money, where money comes to be the number one priority. In our countries not everything depends on money, but here everything depends on money. And if you don’t play that game, you are done. You think about money, the relationships and money, and then you are not at all well.

Physical Health Diagnosis vs. Mental Health Diagnosis: “I’m Tired”

One case worker indicated that she thought that clinicians who are not tuned in to the immigrant’s history are at risk of misdiagnosing problems. She said,

I think ways that there were misdiagnoses--well, we would call it misdiagnoses, specifically were--the ways a lot of our clients present issues is, “I’m tired.” And then they start talking about other things in their lives that are making them tired, and then it always gets diagnosed as adjustment disorder [adjustment to the U.S.]. But saying, “I’m tired” is actually more serious than just, “I’m tired.” And they may be going to what’s outside because that’s what they see is actually causing their distress and they want the doctor to kind of help with what’s outside, but that’s not--and then that’s missing the trauma or the posttraumatic stress disorder that’s happening. That’s what I see.

And another staff person added:
Or we'll see problems remembering or problems focusing, and we're like, is this a cognitive issue or is it an emotional issue? And we can't get from them what’s kind of normal to know whether this is abnormal or not.

One staff person, who had herself been a refugee, commented that the trauma happens to the entire community, and that clinicians have trouble understanding that.

And with the people that I grew up with you had women that were having babies in refugee camps and tents being blown away 'cause it's a very--was a very windy area. So to grow up in a communal country where you have your parents and your friends and everybody around you, and that’s what you consider healthy, and then all of a sudden you have war and you have to leave. There's no, I don’t think--there’s no medication. There’s no experience in life that can essentially reward that experience or solve that problem because it’s their upbringing. So it’s very difficult in a sense because, again, they had to leave everything. And everything that you had is now gone. And I think even with having a lot of psychiatry patients over at the U, it’s very difficult I think for the Western clinician to understand that.

Substance Use Disorders

One of the limitations of this needs assessment is that there were no specific questions about substance use. However, several case workers did bring it up as an issue. A staff person who works with migrant farm workers noted a recent increase in single male migrants, and identified alcohol/substance use as a problem. Another social worker who works with many immigrant seniors, for instance, noted that in part due to isolation, some of the seniors he works with drink a lot—and that he believes the drinking is sometimes self-medication.

A focus group interviewee highlights how culturally-specific services can be helpful:

*I went to AA, my uncle was an alcoholic, a very hard working man but he drank during the job and after the job he kept drinking. And exactly where we lived there is a place of Alcoholics Anonymous; it was the first place for Latinos. We go there for the chats, he left the alcohol from one day to the next, it’s been 6 years that he doesn’t drink and nobody can believe it because it’s so hard to stop drinking.*

He continued,

*R*  
*I think that for things such as alcoholism, drug addiction, educational problems, all is very well instituted but I believe there are not places.*

*I*  
*There are not? Or we don’t know where they are?*
There are places, but they are in English, so you go and they speak 50% in English, once talked, you understand just 25%, and you don’t have a person to explain it to you.

Severe Mental Health Issues

Community Mental Health is the community mental health organization for Washtenaw County. Its mission is to treat those in the county who have severe and persistent mental illness, as well as those with significant developmental delays.

Community Mental Health is legally mandated to provide all necessary interpretive services. They either have a low number of immigrants calling in for services, or immigrants are using relatives for translators. For their “Access Line” intake, in the first five months of 2014, they accessed Language Line for the following languages (# of times in parentheses): Arabic (3); Vietnamese (8); Japanese (1); Spanish (4); Behdini (1); Kurdish (3); Urdu (1); Mongolian (1). For part of this time they did have a Spanish speaker on staff. While this use of Language Line illustrates the diversity of the immigrant community in Washtenaw County, it is likely that people who need interpretation are calling in and not getting offered interpretation services.

CMH is also limited because at the current time, their funding is so limited that—with the exception of crisis services—they are only serving the population that gets full Medicaid. Since many recent immigrants are not eligible for full Medicaid, they often cannot be served by CMH even if they have severe mental health issues.

Other Barriers to Getting Help

In some cases, noted one case worker, the immigrant does not see mental health issues as a disease that can be treated. In other cases, because they are in a “small community,” they do not want friends or relatives to translate for them. Thus, a lack of English—or a lack of services in their native language—becomes a barrier. As one case worker noted, “They ask for help with money, but not mental health.”

When interviewees were asked about speaking about the past, about their experiences, some said they tried to avoid it.

So a lot of people who come here as immigrants like your parents were leaving behind war and violence. And some people like your family lived in refugee camps, had that experience which is also difficult. Do you think the people that you know want to talk about these things? Do they want to talk about what happened in Iraq, what happened in the refugee camps in Saudi Arabia or Jordan or--

My parents don’t, just because it upsets them. And I don’t like bringing it up with them unless I have a question about it, otherwise I don’t talk to them about it.

So you don’t bring it up because it upsets them. And they don’t--do they talk to each other a lot about it or is it like--
R They don’t—they just don’t talk about it.
I Because it upsets them too much.
R Yeah.
I Is do you think that’s with their friends and relatives is that kind of the reaction like let’s not talk about--
R The majority of them, yeah.
I And if people—if there are—if they do have relatives who want to talk about it?
R Then they will talk about it.
I And are they okay with that? If they had a friend or a cousin who kept bringing up bombs in Iraq or not having enough food or whatever, they would be okay with--
R They’d be able to talk about it, but I just don’t—personally I don’t like bringing it up with them. I just don’t.
I ‘Cause you just find that they get upset.
R They get upset and very uncomfortable talking about it.
I Do you think that’s most ‘cause they want to protect you or because they don’t want to remember?
R They don’t want to remember.

She continues,

R Not a lot of people in my community—I guess we don’t really identify with mental health as Americans do. If I’m all stressed out I’ll just get over it. There’s like—no one in my family is depressed. If we feel depressed and we know we’re depressed we don’t really need to take pills or do whatever for it. We just cope with it and deal with it on our own way and then—I don’t know. You know what I mean?
I So when you say cope with it…I think part of the reason that we’re focused on this is that a lot of people don’t treat physical and mental health like they’re the same thing. They say, well, you have a physical health issue—if you broke your arm you wouldn’t just say deal with that. So a lot of people think differently about mental health, and I want to try and understand better why do people think differently about—you’re depressed or you’re worried all the time, why do they think differently about it in your culture?
R I think it’s ‘cause overseas mental health isn’t really a big thing, and over here it is. I think that's the main—we don’t really go into it deep overseas.
I It’s like just get over it and—unless you’re very, very seriously ill.
R Right. ‘Cause here it’s okay I guess if you have a sort of mental issue you can just go get help and you know it will get better. Over there it’s just like you get over it, deal with it, move on.

Another interviewee noted that the community itself can provide support:

I Okay. So when people you know get depressed or anxious, people here in the U.S., people you know here who are immigrants, is there somewhere they can go for help?
R Yeah.
I Do you know where?
R First of all the close relationships. They got family. They got relatives or friends here.

Distrust of Medications

Many immigrants express reluctance to take medications for depression, anxiety, or other mental health conditions. One focus group interviewee describes the school’s effort to provide medication for his son:

In my son’s case, there was a teacher and a social worker who said that because of the type of autism that he has, and then he has hyperactivity symptoms, we are going to refer him to get medication. I told them that only over my dead body, let’s going to work, there are other ways to work, let’s work and I will take responsibility for doing my part. Sometimes it is required to medicate, but the problem here in the United States the pharmaceutical companies make gifts to the doctors, and the doctors, in order to keep receiving these gifts, prescribe the medication, so is a vicious circle, where anything that is being given and that is not benefiting us.

And another parent said,

I went through that with my son, in the school they want to give him pills for that [anxiety], and my friend told me, no... you cannot accept that they give medicines to your son, because that medicine is a drug, and when will be growing he won’t be able to live without that drug, so I didn’t accept that they medicate him because it’s a drug.

When asked directly about taking medications for depression, one woman said,

[I think] that they are addictive, I think that I cannot stop taking them. I don’t like to take pills, if I have a headache I don’t take medicine, only in case that is unbearable, that is turning me out. But you hear them say this is going to help you, but it has side effects... There is much ignorance in all the community about that, problems with anxiety, with stress... you don’t see it as an illness but as something passing.

Population-Specific Discussion

Refugees

The staff at Jewish Family Services described some of the stressors of being a refugee: leaving without time to prepare, and leaving family and things behind; worrying about family that is left behind. Identifying problems can take some time.

Noted one staff person:
And mind you, they've been through three [State Department] interviews at this point, three extensive interviews where they're asked about their entire lives and why they feel they deserve to be refugees. And these are stressful interviews. They're very long interviews. And they're by individuals who kind of determine their fate. So they don't--when they come here and then I've also got 14 pages of questions I need to ask them... It's kind of like reliving that process for them, and I have to make sure I do that in a way that's not stressful for them or retraumatizing to them.

A recent refugee case elucidates some clear issues.

An Iranian refugee, who had experienced severe torture and has severe PTSD, and who had come over via refugee camps with his teenage child, has no local ties (no relatives) and speaks no English, only Farsi and some Turkish. A search for a Farsi-speaking therapist uncovered one in Battle Creek and one in Macomb County, both too far away to be of use.

Some of the immigrants have survivor's guilt. Noted one JFS staff person:

My thought was that they'll get here and be so happy because they're away from whatever disastrous situations they were involved in. And the piece that I had not considered was the fact that they had to leave without any time to prepare. Once you get that note that you have to leave, you have to leave. And so they leave to take care of themselves, but they leave behind so much of their family, so much of their things, which is devastating for a lot of them. And a lot of times they're so worried about their basic needs that that part is kind of put on the back burner as far as their mental health needs and that kind of thing. I know a lot of the families that come here, their needs are getting met but they're worried about their family that's still there. That's a huge, I think, stressor. Sometimes in some cases our families have come here and not their whole immediate family comes here. They have to leave a child or their parents are there or brothers and sisters, and it weighs heavily on them. They even have survivor's guilt of getting out of the country and they're here. And in some cases I've also heard that their family is being threatened because they are here. There's a lot of that as well.

Others find issues surface after a delay of months or even years, only after basic needs are met:

What's really important to always try and remember, too, is when they come here they're so worried about getting into housing, getting their benefits, that they're—six months later everything is coming flooding back to them. That's when they really start thinking about everything they've left behind or families or friends. It's when they've settled down that that kind of stuff pops up.

A staff person described the community that moves as being “frozen in time.”
I think trauma, we look at it on an individual level, that it kind of freezes a person in time. But I think that that happens also in a community, that community kind of gets frozen from where they kind of got disrupted, and then--even then they don’t grow. My family was from a small village and when they came here the whole idea was that we’re gonna create this small village again, and they did do that. But then they didn’t evolve over time. They kind of just stuck in the 70's. That’s kind of their mindset. But back in Syria people probably changed, but they didn’t really change.

Undocumented Immigrants

Undocumented immigrants often live with constant fear of being found out by immigration services. In some cases they may be living their lives entirely “under the table,” without any services in their name. In other cases, they may have obtained a social security number or tax ID number, and be able to live nearly indistinguishably from their neighbors. As one case worker described it, though, “If they go back [after a length of time in the U.S.] they have disconnected from the home country.”

In many cases, their trips to get here were traumatic. As one focus group participant explained,

*I was locked-up in the baggage compartment, three persons, and I felt that I was choking, just 3 minutes, but your breath was cut, and it was hot in the road. That was 10 years ago, I was like 27.*

A priest at a local parish that works with many Latino immigrants noted that in many cases, the husband or boyfriend may be the only one deported, leaving a mixed-status family behind. The children may be citizens, and the mom may or may not also be undocumented, but now may need to raise her children as a single mom, losing much of her economic support. So for those who are undocumented, fear of being deported and economic challenges may combine to be potent stressors.

A female focus group interviewee describes her experience:

*The second one [deportation] was harder because it was the deportation of my boyfriend. [Respondent tears up and excuses herself.] It always affects me... the process was long, they were assigned to a court and they have to wait for the court day, he has to wait two weeks for the audience, and now the laws have changed, but how they have to wait so much time? Afterwards they give them a four months permit and later he has to leave the country. I was ok but I could not sleep, I had panic because I didn’t sleep well. I felt tired, I need to sleep because I have to work, I couldn't sleep and they were advertising a medication for depression.*
I took several medications and talking with some friends they ask me why I didn’t go to a psychologist, and I said because the insurance [Washtenaw Health Plan] doesn’t cover it, then I speak with a doctor and she explained me that I can go to Catholic Social Services, because there they speak Spanish. I was taking medication and I didn’t like that; I was taking many medicines and that didn’t work, there were many secondary effects, and I began with the psychologist because I didn’t know what was happening to me, I felt sad, and I told the doctor that yes I did feel sad but I want to live, I want to have a family, I don’t want to die, and she pass me the contact information of a very good person and she told me: you have anxiety, your family is in Costa Rica and you are here, you have to make a decision and to leave those medications that are killing you. Talking with her helped me a lot, I had weekly appointments and afterwards a monthly appointment, however, that helped me a lot.

After one year all the stress and frustration and my boyfriend’s deportation, it’s been one year of all these and I am very well, thank God, I found a pill that makes me feel good but I feel tired, I take one pill and divide it in eight. And God has helped me a lot, and I take that little pill at bedtime, but it is more of a tradition, because of fear that I couldn’t sleep; but it is something that has been hard because in front of deportation you feel impotent.

**Domestic Violence and Sexual Abuse**

Of particular concern are issues of domestic violence. In the focus groups and individual interviews, people were asked directly whether they felt that domestic violence was worse or better in the U.S. Generally, people cited the legal ramifications in the U.S. as a reason that domestic violence is less here.

Noted one female focus group participant:

*It’s better here, in our countries the boyfriends beat the women, and there is no law. In our countries there is no law. There you say: he’s beating me and they say you: what did you do to him? They almost say: keep beating her.*

Nonetheless, domestic violence is an issue for many immigrants, particularly women. Washtenaw Health Plan staff has identified several cases in the last several months. Women who are here without documentation, or who may be entirely dependent on the income of a spouse or partner are faced with the dilemma of going to the authorities and risking deportation, or putting up with abuse. In some cases, the threat of deportation is held over their heads by the abuser.

As one focus group interviewee describes,

*I came here and after one month I went out with a boyfriend. But this little man was so jealous, and he pushed me and I knew that here you cannot beat women, and he told me: here is the phone, but if you call the police they will take you to Immigration, and remember that you came here to help out your son who is in*
Guatemala. So I was in that situation about six months, and afterward I told him that I didn’t care if they took me to the police, because afterwards it wasn’t just a push, he beat me, and I left, then a girl asked me: what happened?... She took me to her apartment and told me: Don’t be silly, call the police; and I said, “No,” because I don’t want them taking me to Immigration. And I said no, I didn’t come here to suffer so much. Then I told my boyfriend that I don’t want to live with him anymore, and I left, and now living here I know that things are very much different here.

My sister also had problems with domestic violence and I call the police for her, and they arrested him and didn’t do anything to her. I was helping her and she could get out of there. But when you arrive to this country you are afraid of everything.

In other cases, control may be exerted by a male relative who is not a parent or spouse. Being a new immigrant, unfamiliar with US laws, makes the individual even more vulnerable.

As one female focus group participant explains,

I came with my cousin but he was married, when I arrived he wanted to control my salary, my life, he told me: you cannot do this because the police would be coming, if somebody knocked at the door I didn’t open, I cannot even watch the TV because he doesn’t want that anybody knows that I was here, and it is different in Mexico. When I began to work, he told me that I have to give him part of the check, and the problem was that it was a check, not cash, so he told me: give me the check and I will keep the money for you; and I told him: no, give me my check because I need money to send to Mexico… He got me traumatized; I cannot even leave the apartment, and then his wife’s sister arrived. She asked me to go with her, let’s go walking, and I told her: how can we go walking, what about the police? And she said, what police? And she got me out of that entire trauma and she told me how things were... To this date we don’t speak to each other [my cousin and I], we just say hello and that’s it. Because he didn’t allow me even to stick my head out of the window.

In some cases, women are assaulted during their journey to the United States. Although that is often characterized as a women’s issue, one of the men’s focus group interviewees felt it has an impact on the men as well:

There were pregnant women that came walking and those at the border take whatever you have. Your wife or daughter is raped, those are very hard things.

Parents and Youth

One area identified in several interviews as a stressor is the relationship between parents and children in their teens and twenties, who may be acculturated to United States culture and may see their parents’ ways as old-fashioned. Difficulties between parents and children may be a stressor for both groups.
As one focus group interviewee explained succinctly, "Families like ours, they are of two worlds."

In many cases, the access to education, particularly English as a Second Language, gives youth a “leg up” in negotiating with the outside world. In other cases, needing to act as a translator for parents can be a significant stressor for children.

One interviewee described her older sister and her parents,

I What about language? Was it difficulty with the language, like you guys speaking English and--
R It was helpful for my parents that we were speaking English. My older sister actu--she was, I think, maybe 10. We were living in Dearborn, and she was the one that was making sure we were paying what we had--the bills were getting paid and stuff because my parents couldn’t call companies and be like, “What’s this bill for? What is this? Blah, blah, blah.” She would actually have to call them at 10 years old and be like, “What does this--” she would ask the people on the phone, “What does this word mean? How does this get paid?” And then my parents will work, make sure the money is there to pay the bills.

Cultural clashes can also be challenging. She continued,

I Do you think--looking around at your friends and your community, what are the biggest conflicts between parents and kids?
R Independence.
I Independence. Explain to me. Tell me more about what you mean by that?
R For example, I’m 21 years old and they still won’t let me sleep over at someone’s house.
I Oh.
R Yeah. It sounds ridiculous, but it can turn into a big argument. I’ve never slept over at any of my friends’ house before.

Cultural issues can be exacerbated by the economic pressures of parents who are working many hours.

R When you see a family struggle working, he work in gas stations 14 hours. You know, I ask one guy, he told him, “How old is your kids?” He will say four years, six years, ten years,” because he sees them only when they are in bed sleeping.

In other cases, parents and children have been separated for several years. One mom described a difficult reunion with her son:

I brought my son, he crossed the border, was detained in Houston for 3 months, he is 13 years old, he was detained in a children’s center, they sent him here to me, I paid his ticket. I haven’t seen him since he was two years old, we just saw each
other thru Skype, when he came here, after the first four months I didn’t want to arrive home, I want to arrive late and just go to my bedroom to sleep, because it was only fighting when I got home...

He was in trouble at school, and in trouble at home. She continues,

Afterwards somebody told me – because we go to church - and the Pastor told me: you have to see more God and put everything on God’s hands, because I wanted to get a psychologist and everything, but no, thanks God I’ve seeking refuge in Him and that has helped my son a lot, but at that moment I said who can help me out with this problem? Afterwards I went to the school and the Director told me that he was going to speak with the psychologist or social worker, to chat and to know he has some hatred against me, and that helped enough and the chats helped him, but at that moment I didn’t know where to go and until today, I still don’t know where to go if something happens... He also suffered the trauma of coming here, that was what the school worker told me. You have to be patient because you know what is to cross the border and later get caught, even more because he’s just a child.

Seniors

Immigrant senior citizens in Washtenaw County live in a variety of housing situations. Some of them have been brought over by their children, and they then either live with their children or in independent living situations.

As one case worker noted:

With regards to the different cultures, like the expectations of, of where you get care from I think is different in different cultures too. Here we kind of are--our go to is looking to the government for different funding and different ways to help people. But I think what I’ve found in other cultures is the family and the community expectations are different, especially with the elderly population. And so I think that that too could be a stressor for someone trying to figure out in their culture, they might have the expectation that they will be cared for in their--by their community whereas here, it’s much more individualized.

Isolation

Social workers who work with the aged identified several issues. Some that are not specific to the elderly include having limited financial resources and not knowing where to go for help. In some cases, their children have moved away; in other cases, they stay in their children’s homes and have a limited support network. Either way, isolation and depression can result.

As one informant explained,

I Now with immigrants, especially when older age, it’s a big trouble, the language. Then beside the language, the culture because let me tell you about, for example,
my parents. When they came here, they thought they would find social life like middle East people has very social life. The term of life is not fast as here so they think when they--when they sit home, you know, everybody gathering and they find out it's not. So the--

I They feel isolated?
R Right. Yeah. The neighbor, no communication with the neighbor. I mean, when they walk, they think--but no English, so no communication.

He continued:

R So what, what they will do, they will go to the park, just walk. They feel early retire. They are retired early. Yeah, this is very stressful, I think, yeah, for older people.
I Do they find a--do they find a community, maybe not in the neighborhood but did they--
R No, no, no.
I No?
R No.
I They still feel isolated?
R Oh, yeah, yeah. They go--some--they go to the mosque which is--this is very helpful. This is the best in Ann Arbor if you have Islamic Center, I think this is the best things.

He went on to suggest a possible resource:

R You know what I found that help him a lot--help them a lot? The Internet.
I The Internet helps them.
R Internet.
I Okay.
R Because they stay in contact through Skype or all of this with--
I With relatives--
R --back home, back home.
I --in other places.

A man from Costa Rica described it this way in the focus group interview:

In Costa Rica my grandparents died with the family, acquaintances, with the grandchildren, here they make you dysfunctional, you are 70 years old and you are gathering shopping carts in Walmart because the money is not enough, then in our countries when you age that’s a person who get respect, and they love them, here if you don’t function, you are of no use.

Additional Physical and Mental Health Challenges

For some clients, physical health challenges like being hard-of-hearing can complicate treatment.
Senior citizens may also have issues with dementia. As a St. Joseph Mercy Health System social worker described, an elderly woman was found—confused—on a public bus. The bus driver called the police, who brought her to the hospital. She could not tell them her name, or even the language that she spoke—and it wasn’t until the family filed a missing persons report that she was identified.

The social workers we spoke with identified hoarding as an issue, in some cases as a result of earlier deprivation in their home countries, and in other cases related to dementia or other mental health issues. They also noted that substance abuse—particularly of alcohol—may be used as self-medication and may become a problem in and of itself. Frail physical health may complicate the situation.

As one social worker who works in a low-income complex, which houses many Chinese and Russian seniors, noted, “They ask for help with money and other things, but not mental health.”

**Immigrant Supports**

**Anchor Individuals**

In many cases, both formally and informally, an individual in a community—often an immigrant who has been in the U.S. longer—acts as an anchor for other people. Noted a JFS staff person, discussing the Somali population:

*We have one woman who pretty much has been the anchor for everybody who has arrived, and she’s really good about reaching out in the community and just finding whatever the family needs and getting it done.*

A staff person at JFS noted that many immigrants end up living near each other, and are able to support each other, even if they come from different countries and backgrounds.

*That kind of brings up a good point, though, at how resilient the families we work with are. They still form relationships with people. And they still form their own types of community—you walk into an ESL class here and everybody is talking with everybody, everybody knows about each other’s children and what difficulties their having. They all come from such different backgrounds but they’re able to relate on such common issues like raising children or what’s the best phone provider to get. They’re able to form these bonds that are just really amazing.*

**Anchor Organizations**

Many organizations incidentally are in touch with some immigrants, but others see immigrants on a daily basis. Some of these organizations are well-known for the work they do with immigrants—Jewish Family Services, Catholic Social Services, the Washtenaw Health Plan, the WIC program at Washtenaw County Public
Health—while others, such as the schools, particular senior housing complexes, and immigration attorneys, are not classically thought of as part of the social support network.

When immigrants were asked about support for newer immigrants, congregations that work with communities that are largely immigrant came up repeatedly. The Islamic Center (for Middle Easterners, Somalis, Pakistanis, Bangladeshis...), the First United Methodist Church in Ypsilanti and a couple of Catholic parishes for Spanish speakers, several Chinese and Korean churches for Chinese and Korean speakers.

One professional who is herself a Chinese immigrant explained that there are a diverse array of organizations supporting the Chinese community—with different language, religion, and country of origin groupings.

In the case of the Muslim community and the Latino community, different individuals have attempted to create social service agencies and referral hubs. Start-up groups, such as the Muslim Social Services organization and Casa Latina, have been challenged by a lack of resources that has limited their resources and reach.

**Acción Buenos Vecinos**

Following the *Encuesta Buenos Vecinos*, the Latino Health Survey, the EBV’s Community Leadership Team worked to identify a “Top Ten” list of areas that Depression, and Access to English Language Learning--have the potential to fit into any strategic plan that addresses immigrants and mental health needs. To address these issues, they have formed a group, the *Acción Buenos Vecinos*, or Good Neighbor Action Team.

**Other County’s Resources**

In some cases, other counties have resources in place, and some immigrants do go to the other counties to access them. For instance, in Wayne County, ACCESS provides a wide array of services to the Arabic-speaking community, and in Southwest Detroit there are several organizations providing services to the Spanish-speaking community.

**Conclusion**

**Services**

Over the past few years, some aspects of services to immigrants have improved greatly:

1. Easier access to medical services in various languages (especially through UMHS), but Packard and some of the IHA practices have Spanish practitioners and some other languages as well.
2. Through the Flinn grant, additional language support at CSS in Spanish for therapy, and at JFS in Arabic for therapy, including translated documents such as intakes.
3. Women’s Center now has a Spanish speaking therapist.

**Ongoing Issues**

- Language/literacy classes can be difficult to access (both due to services being unknown and due to conflicting work schedules).
- Public benefits can be difficult to access, especially with a language barrier.
- Fear of ICE (immigration services)
- CMH reduction in service, and limitations in any case on services to immigrants not eligible for full Medicaid.
- Reduction in services at Casa Latina.
- More immigrants coming from a wide variety of locations...especially new refugees.
- Many languages are not addressed with our services, except for language line.
- Subset with significant trauma histories.

As noted in the Executive Summary, some high priority items could be addressed immediately.

1. Local nonprofit organizations should be encouraged to translate key documents, including documents publicizing services (for instance, how to access domestic violence services), into multiple languages—and should have a strategy for using language line or other interpretation when somebody calls or visits.

2. Nonprofits and school districts offering adult English as a Second Language programs should coordinate publicity and publicize the offerings in other languages.

3. Organizations that provide mental health services should work to identify staff (particularly therapists) who are bilingual/bicultural in any languages/cultures, and publicize that information.

Last, but not least, a strategic planning process that fully develops a plan to address immigrant mental health would be extremely useful.
Recommendations for Strategic Planning and Possible Solutions for Immigrants and Mental Health in Washtenaw County

What follows is a list of potential action items to address issues around immigrants and mental health in Washtenaw County. Most of them need additional research and development to become a reality. Some could be addressed immediately.

Language Supports

- Provide resources and information in different languages.
- Identify a way to have the organizations that teach English Language Learners share information about their programs in many languages, and in a coordinated way, so that individuals can choose the best programs for themselves.

Mental Health Organizational Work

- Find alternative ways to deliver therapies, for instance computerized behavioral programs are in different languages and are worth investigating; some studies show good results.
- Telepsychiatry is potentially billable and may allow for mental health support from a distance.
- For CMH and other organizations, encourage the advertising/promotion of access to different languages/language capacity.
- Set up or identify a list where therapists, psychiatrists can list second language competencies (this may be an existing database).
- Encourage advertising of second language competencies for hiring of new staff--In organizations across the county, look for/recruit more individuals with second language fluency for jobs (may need to pay extra for this).
- Encourage organizations to consider running some support groups in other languages (Spanish, Arabic).

Schools Supports

- Cultural competency with schools staff on issues with immigrant parents and their children who are growing up in the U.S.
- For schools with large numbers of immigrant parents, offer translation/interpretation at parent-teacher conferences and other events where parent involvement is desired.
Enhancing the Resources of the Immigrant Communities Themselves

- Have more psychological education in the immigrant communities—ok to ask for help—speak out against stigma.

- Support and educate clergy so they can appropriately/comfortably “facilitate” mental health referrals.

- Support the Acción Buenos Vecinos, the action committee following up on the Latino Health Survey’s priorities.

- Use peer support models--support the skill sets of anchor individuals and develop individuals who can provide peer support.

- Use the knowledge of immigrants who have been here longer to develop programs. Recent immigrants “don’t know what they don’t know”—ask longer term immigrants “What things did you not know but now you do know.”

Cultural Competency

- Education of professionals in mental health/social service organizations about the cultures and challenges of immigrant communities.

- Cultural competency work for organizations that work in the mental health field, particularly around cultural expectations around mental health issues.

Other county’s resources

- Refer individuals to resources in other counties (such as ACCESS in Dearborn or the Trauma Recovery Center at Wayne State University) when that is appropriate.

- Examine programs being used in other counties and replicate them if that makes sense (ACCESS programs in Dearborn, Latino organizations in southwest Detroit).
Bibliography


