

# Mental Health Care for Latino Immigrants in the U.S.A. and the Quest for Global Health Equities\*

## Servicios de Salud Mental para los Inmigrantes Latinos en los Estados Unidos y la Lucha por una Igualdad en Salud Global

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**Abstract.** Currently, approximately 190 million immigrants world-wide live in host societies located in countries that have higher economic resources and political power than the countries of origin of immigrants. In this paper I use ecological and system theories (eco-systems) to frame the relationship between Latino immigrants and the host society in the U.S.A. The eco-system perspective highlights that policies and initiatives to address the mental health care of Latino immigrants must weigh dilemmas such as: (a) containing the costs of care while providing high quality (efficacious) care, and (b) the power inequity between immigrants and their host society. I posit that Social Justice/Public Health frameworks are needed to address these dilemmas because they are mindful of the receiving community needs, inclusive of immigrants, as well as of other marginalized populations. The framework is consistent with the proposed focus on *Health Equity* in public health in the U.S. (Braveman et al., 2011) and is relevant for the global phenomenon of immigration.

**Keywords:** ecological, immigration, latinos, public health, social justice.

**Resumen.** En la actualidad, aproximadamente 190 millones de inmigrantes de todo el mundo viven en sociedades de acogida situadas en países con mayores recursos económicos y mayor poder político que los países de origen de los inmigrantes. En este artículo utilizo las teorías ecológicas y de sistemas (ecosistemas) para analizar la relación entre los inmigrantes latinos y la sociedad de acogida en los EEUU. El enfoque de ecosistemas pone de relieve que las políticas e iniciativas para abordar la asistencia sanitaria de los inmigrantes latinos deben sopesar dilemas como: (a) la contención de costes sanitarios al tiempo que se proporciona una atención de alta calidad (eficaz), y (b) la desigualdad de poder entre los inmigrantes y su sociedad de acogida. Postulo que el marco de la Justicia Social/Salud Pública es necesario para abordar estos dilemas, porque toma en consideración las necesidades de la comunidad receptora, así como de los inmigrantes y de otras poblaciones marginadas. Dicho marco concuerda con el enfoque propuesto basado en la *Igualdad Sanitaria* del sistema de salud de los EEUU (Braveman et al., 2011) y es relevante para el fenómeno global de la inmigración.

**Palabras clave:** ecológico, inmigración, justicia social, latinos, salud pública.

Clearly, immigration is a world-wide phenomenon with major public policy proportions given that is a major life stressor that likely impacts the well-being of immigrants and is likely to disrupt the life of those who live in the host country. In the last decade it was estimated that 190 million (3% of the world's population) were immigrants (Hossain, 2007). The vast majority of immigration is motivated by immigrants' drive to improve their living conditions. Accordingly, the major immigration flows are from Latin America to the U.S., and Africa to Europe (Hossain, 2007), that is,

from countries with some level of economic hardship to countries experiencing better economic conditions and/or sociopolitical stability. Given that political unrest and world-wide imbalances in economic power are not likely to disappear in the near future, immigrant populations are likely to grow rather than to decline. Thus, "host" nations that receive immigrants will likely continue to live with a significant presence of immigrants.

In this paper I discuss the key aspects of Latino immigrant population in U.S.A. using an eco-systemic framework. The goal of the analyses is to discuss avenues for mental health initiatives (e.g., interventions and research) that are likely to be fruitful and sustainable given the realities of the relationship between Latino immigrants and their host society. I conclude

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with implications for immigrant mental health care policy in global contexts.

### Latino immigrants in U.S.A. Communities

The total population of Latinos in the U.S.A. totals over 50 million, making the U.S.A. the second largest concentration of Latinos in the world, only outnumbered by México's population of 112 million (U.S. Census Bureau, 2011). Immigrant (foreign-born) Latinos are estimated to be nearly half of the total Latino population (47%). Latinos are to an ethnocultural group that is often defined as individuals who live or have close ties (family, history) with Latin language (primarily Spanish and some Portuguese) in the content of America. These countries extend from the bottom tip of South America (e.g., Argentina and Chile) to México, the border country with the U.S.A. and include Caribbean islands such as Cuba, Puerto Rico and the Dominican Republic. In addition to geographic location and language, Latino countries share the history of being conquered by European powers such as Spain, France and Great Britain. The populations of Latin American countries include native tribes who lived in these lands before the arrival of European powers and a large portion of Mestizos, that is, individuals born with both Native American and European blood. There is also a substantial representation of African descent groups in the Caribbean islands. Thus, Latinos include White, Black, and medium dark skin phenotypic expressions. A large portion of immigrants are native Spanish speakers; thus they might have poor fluency in English, the dominant language and/or speak English with a noticeable accent. In 2009 it was estimated that 76% of Latinos five years of age and older spoke Spanish at home (U.S. Census Bureau, 2011).

Many Latino immigrants acquire jobs that are physically demanding and low wage-earning. One-quarter (25.3%) of Latinos have incomes that qualifies them as living in "poverty" and nearly one-third (32.4%) lack health insurance (U.S. Census Bureau, 2011). A large portion of Latinos live in low-income settings and in many instances in "immigrant-ethnic enclaves", that is, neighborhoods with high concentrations of immigrants from a particular ethnicity.

The rate of growth of Latinos in the U.S.A. has steadily grown. The Latino population has risen from 12.5% in 2000, to 15.5% in 2010, and is projected to be 17.8% in 2020 (Ennis, Ríos-Vargas, & Albert, 2011). In 25 of 52 states Latinos were the largest ethnic minority group. In 82 out of 3,143 counties, Latinos were the largest percentage of the population. In the last two decades there has been a spiked surge of Latino populations in communities and States. For example, the state of South Carolina experienced a 145% growth of Latinos between 2000 and 2010 (U.S. Census Bureau, 2011). Although the sheer number of

Latino immigrants in some communities is low compared to others (e.g., under 20,000), the notoriety of Latinos is large because of the sharp surges in terms of the portion of the local population (e.g., from less than 1% to 10% or more). Such sharp surges test the infrastructure of local public and human services given the lack of experience in living and working with Latinos.

### Latino Immigrants and Health Disparities

Even though there is relatively strong consensus among policy makers that Latinos and ethnic minority groups in the U.S.A. experience *health disparities*, care for Latino immigrants *per se* is bound to be controversial. Along with African Americans, Asian Americans, Latinos and Native Americans have poorer mental health outcomes and usage of mental health services especially when compared to middle to upper income European descent (White) Americans (i.e., *Health Disparities*, U.S. Department of Health and Human Services [USDHHS], 2001). Latino immigrants, by virtue of their ethnicity, can be a target of special care given the documented health disparities that they experience.

On the other hand, the policies and initiatives that intend to eliminate health disparities may not extend to Latino immigrants. It is crucial to bring to bear that *immigrant* status makes mental health care and any other public services for Latino immigrants contentious. Some segments of society in the U.S.A have anti-immigrant discourses and policies (National Immigration Law Center, 2012). Others states, especially those with histories with larger concentrations of Latino immigrants, are more likely to have welcoming policies (e.g., Pallares & Flores-Gonzales, 2010). Given dynamic nature of the demographics of Latinos (e.g., heterogeneity, growing numbers and dispersion) as well as the contentious pro and anti-immigrant public discourses and policies across communities, it is essential that mental health care initiatives be mindful of Latino immigrant and host society relationships contexts.

### Eco-Systemic Framework of Latino Immigrant and U.S.A as host society

I posit that it is fruitful to see the relationship between immigrant groups such as Latinos and the host society through *eco-systemic* lenses because: (a) the usefulness of the framework to improve relationships in groups with complex compositions and history, and (b) the utility of implications for the broader global context of immigrant group and host society relationships.

Latino mental health researchers have used ecologi-

cal theories and their variants to study and understand the mental health of Latino youth (e.g., Kral et al., 2011; Szapocznik & Coatsworth, 1999; Gonzales et al., 2011). The models stem from Bronfenbrenner (1979) ecological model of human development which draws attention to the embedded-ness of micro (e.g., family, peers), and macro (e.g., institutions, neighborhoods, polices) social contexts, and their inter-relation. Latino mental health researchers also place cultural norms front-and-center in ecological models. For example, Latinos have been found to be likely to place high value on familism (i.e., expectations to provide and receive from the family and to have hierarchical values in family relationships that uphold the respect and authority of parents (see Gonzales et al., 2011; Szapocznik & Kurtines, 1993; Vega, Ang, Rodriguez, & Finch, 2011). Latino mental health researchers are uncovering how cultural values and traditions of Latino immigrant families impact Latino family-youth relationships. Additionally the settings where Latino families live impacts both youth and their families in nuanced ways that are becoming more clear with the use of ecological models (e.g., Cruz-Santiago & Ramírez García, 2011; Gonzales et al., 2011; Manongdo & Ramírez García, 2007; Vega et al., 2011).

Because ecological frameworks in essence examine the relationship between individuals and their context, they are applicable in other life sciences. Biological ecologists also study local contexts (e.g., Jiggins, 2004 cited in Kelly, 2006) and use *eco-systems* to refer to a local habitat's characteristics such as climate, terrain, and existing species that live in it and that have adapted to its conditions. For example, in a forest eco-system, given the abundant rainfall, the conditions are ripe for specific species that thrive in these conditions and would be unlikely to do so in a desert environment. The presence of the particular *group* of species produces a unique local environment that consists of the relationship between the species that enables each of them to survive, provided environmental conditions are relatively constant. A disruption in the environment as in the case of the introduction of new species that reproduces at a high rate, and strips resources also at a high rate, is highly threatening to the local eco-system. On the other hand, a new species that thrives in the eco-system in ways that do not over-tax its resources is likely to have long-term positive prospects in the new eco-system.

The illustrations of the application of ecological frameworks to biological habitats and to host societies highlight the importance of the meaningful relationships between different sub-groups and subunits. Such relationship interactions are central to *System Theory* used to study human relationships including families (e.g., Cleek, Wotsy, Boyd, Mundy, & Howell, 2012; Boyd-Franklin, 2003; Szapocznik & Kurtines, 1989), organizations (e.g., Fuqua & Newman, 2005), and social settings broadly speaking (e.g., Tseng & Seidman, 2007).

Systems Theory defines a group by its: (a) repeated patterns of interaction, and (b) organization including types of groups and hierarchical structure. Interaction patterns include communication patterns, what the groups does to organize itself to achieve goals, and the degree of closeness between members such as how much time they spend together as well as the nature of their relationships (e.g., nurturing, distant). Subgroups emerge along common characteristics, interests, and/or the amount of time that people share together.

Another key aspects highlighted by biological ecology is the importance of local settings. Those interested in ecological aspects of human behavior have also drawn attention to the importance of *local ecologies*. Given the wide scope that environments and settings can cover, it is important to focus attention on the immediate local environment. For example, mental health and interventions with Latino origin populations have underscored the importance of local eco-systems (Díaz-Guerrero, 1989) or ecological niches (Roosa, Morgan-López, Cree, & Spater, 2002) and "what is at stake" in local communities (Lakes, López, & Garro, 2006). In sum, ecological perspectives are central to understand life processes of individuals who interact with environments with a cultural context that differs to some extent to theirs, as is the case of immigrants.

### Host Society-Immigrant Group Dilemmas

The biological eco-systems example has implications for the analysis of the co-existence of different cultural groups including immigrants. Communities (local eco-systems) have meaningful groups of individuals such as ethnic groups who have lived in those environments and have developed a set of strategies and relationships to use their available resources. The particular living history of the groups, their relationships, as well as their environmental resources that drive the community's sustainability, varies from setting to setting and yields different local contexts.

When immigrants arrive, local community members may be challenged to cope with the new members because of its impact on their setting. The rate of influx of immigrants, their use of local resources, and the types and amount of their contributions will impact their short and long-term relationship with the new community. Accordingly, it is common for immigration policies to aim to: (a) contain the amount and type of immigration influx, and (b) maximize the benefits of immigration. In other words, to maximize the benefits and contain costs.

### Balancing costs/benefits of immigrants

At the federal level, the U.S. has implemented laws to contain the influx of all immigrants including Latinos. The laws make it illegal for non-U.S. citizen

Latinos to enter and stay in the country unless as specified by a legal route such as a temporary permit, or residence for long-term living and employment in the U.S. These laws contain the influx of immigrants while allowing some immigration under specific circumstances. Thus, the laws define two major types of Latino immigrants: (a) those who live in the country legally, and (b) those who have entered the country illegally. Neither of these two groups are homogenous. For example, there are those who have entered the country legally on a temporary basis such as the holders of temporary work and school visas, there are "border crossers" who can enter the U.S.A. but are not permitted to be in the country longer than 36 hours and travel to the interior far from the border. There are also those who have acquired permanent resident status and who can live and work in the U.S.A. A large portion of illegal immigrants are those who cross the border in search for jobs in the U.S.A. Although the jobs represent low wages and hard earned labor (e.g., picking produce in fields, washing dishes in restaurants, cleaning houses and hotels), such jobs represent a much better proposition than unemployment or under-employment in their country of origin, or other more undesirable circumstances.

Based on an ecosystems framework, one can predict that in times of scarcity of resources and/ or drops in such indicators, the perceived threat of immigrants will increase. Threat would also increase by factors such as the sheer number of immigrants and pace of growth relative to the numbers of the host society, as well as the relative contributions of immigrants. Immigrants who are perceived to be a high threat are likely to be rejected, while those who are seen as beneficial to the host society are less likely to be rejected. However, large migration patterns consist of immigrants in high need and who seek to join societies that are well-off or at least in a better position than that of their origin. Therefore, the host society sees immigrants and individuals with multiple needs, and is particularly sensitive to signs that they cause an imbalance in the available resources relative to immigrants' contributions to the host society.

Based on the perspective above, mental health policy and research are at a disadvantage from the start. That is, addressing the needs of immigrants represents a use of the local host society's resources; such loss in resources could be avoided by eliminating or containing the presence of immigrants. Moreover, a large portion of immigrants live in socially disadvantaged settings and thus they are vulnerable. That is, the high stress living conditions and the stressors of immigration per se, are likely to result in illness-prone conditions (Fuligni & Perreira, 2009). Accordingly risk for health/mental health conditions are high yet the need for containment of health costs is even more crucial than that of the population at-large, because the presence of immigrants is likely to be questioned.

### ***Power Inequity in Relationship between immigrants and host society***

Power in the relationships between group members is one of the key concepts in systems theory (e.g., Szapocznik & Kurtines, 1989). A group's actions are governed around a power structure. For example power can be held by one particular individual or subgroup (e.g., parents in a family with children). Alternatively it can be as equally distributed as possible among all group members or a large portion of its members. In addition to the question of who holds power, another important dimension of power is the style/or way in which power is exerted. Even though a subgroup may hold power, they might be authoritarian (let others know without the opportunity of input). In contrast, those who hold power can involve others in decision making in ways that do not undermine the authority of those in power but that treat others with dignity. An important implication for those who apply systems theory, is that effective and sustainable change is more likely by engaging those in power in the change processes.

The host society holds practically all of the power and leverage in their relationship with immigrants. In other words, immigrants are for the most part disempowered particularly those who have entered the country illegally, and/or those with low socio-economic status. Because of the combination of cultural and social differences with the mainstream society, immigrants are in a difficult position to participate fully in the major institutions of the new host society. Therefore, it is expected that the average immigrant will take time to climb the ladder of economic-political power; a process that make take generations. Thus, power inequity is a crucial part of the context of initiatives by the host society to address the needs of immigrants including health and mental health policies and interventions.

### **Implications for Policy, Intervention and Research: The case for Social Justice/Public Health Approaches**

Given the reality that providing mental health care to immigrants faces the dilemmas of balancing costs of care as well as power inequities, I posit that the use of Social Justice/Public Health perspectives in the mental health care of immigrants is essential. I present examples of initiatives to address these two key host society-immigrant group dilemmas with Social Justice/Public Health approaches (See Table 1). Neither the dilemmas nor examples are exhaustive. However, they do illustrate ways to address these key dilemmas.

#### **Balancing Costs/Contributions of immigrants**

##### ***Use Public Health System and Principles to Plan and Deliver Mental Health Care***

The inclusiveness of immigrants as a vulnerable

Table 1. Host Society-Immigrant groups relationship dilemmas, Public Health Principles and Illustrative examples

Host Society-Immigrant Dilemmas	Social Justice/Public Health Approach Principles	Illustrative Examples
<b>Balancing costs and benefits of hosting immigrants while providing public services</b>	Use <i>epidemiological surveillance, needs assessments, and empirically supported treatments</i> as a means to maximize benefits per costs and integrate care into a public mental health agenda for the society at-large.	<ul style="list-style-type: none"> <li>• Promote research based-initiatives (WHO, 2011).               <ul style="list-style-type: none"> <li>– Epidemiological research (e.g., Alegría, et al., 2008; Vega et al., 1999).</li> <li>– Intervention/mental health services research with immigrants (e.g., Szapocznik et al., 1997).</li> <li>– Development of local needs assessments and reports that focus on special populations including immigrants (e.g., Cardemil et al., 2007).</li> </ul> </li> </ul>
	Use <i>inter-sectorial initiatives</i> to promote prevention, early detection and integrated treatment to minimize costs and maximize efficiency and quality of care (WHO, 2001).	<ul style="list-style-type: none"> <li>• Integrate mental health services with primary health care.</li> <li>• Garner support for mental health initiatives and integration of mental health services with other community sectors such as education, law-justice system, non-for profit organizations.</li> </ul>
<b>Managing the power inequity of the relationship between the host society and immigrants</b>	Use <i>fairness to others (social justice) and human rights axioms</i> to justify health and mental health care policies for immigrants (e.g., Vasquez, 2012; World Health Organization [WHO], 2001).	<ul style="list-style-type: none"> <li>• Mental health policies for the population at-large need to provide special attention to vulnerable populations inclusive of immigrants.               <ul style="list-style-type: none"> <li>– World Health Organization's report on mental health [WHO] (2001).</li> <li>– Supplement report on Mental Health: Culture, Race and Ethnicity by the U.S.</li> </ul> </li> </ul>
	Provide <i>protection and voice to immigrants</i> to manage power inequity with host society.	<ul style="list-style-type: none"> <li>• Represent the voice of immigrants in policy making bodies such as state partnerships and local mental health councils.</li> <li>• Bridge gap between health information and immigrants.</li> <li>• Used mixed-methods programs of research that include Community-Based Participatory Research (e.g., Balcazar et al., 2009).</li> </ul>
	Conduct initiatives to <i>enhance capacity of individuals and showcase their contributions to society</i> alongside those that focus on alleviation of problems and symptoms.	<ul style="list-style-type: none"> <li>• Integrate mental health initiatives and research with the goals of promoting social functioning, educational achievement, and the availability of apprenticeships (e.g., Gonzales et al., 2007).</li> <li>• Strengthen social support systems such as the family and its ties to a larger web of support in the community (e.g., Szapocznik et al. 1997).</li> </ul>

group deserving attention by society's *Public Health* sector has at least two advantages. First, ideally Public Health policy makers are not only invested in providing high quality care, but they have to be mindful of resources given that they are accountable to the society at-large. Thus, immigrant mental health care costs would not only be expected to be capitated or contained, but also to be in a good position to yield high returns because of the experience and infrastructure of Public Health systems. In other words, national, regional and local resources to provide care for the public at-large should be available for immigrants when immigrants are explicitly included in Public Health agendas. Second, inclusion of immigrants in Public Health agendas legitimizes the provision of care to immigrants because it becomes an explicit part for the society's public policy agenda. Such legitimization is not trivial especially in cases when political will to provide care for immigrants is low, and when it is low to moderate, inclusion of mental health care for immigrants in public health agendas should serve as a vivid reminder to continue to work on this challenge.

In the U.S.A, mental health care for Latino immigrants has been implicitly been made part of the Public Health agenda in recent policy minded reports from credible and powerful authorities. One of the most notable reports came from the U.S. Surgeon general, the Commander-in-Chief of the nation's Health Policy. The U.S. Surgeon General's Report on Mental Health: Culture, Race and Ethnicity documented higher prevalence of mental health problems, higher exposure to risk factors, and lower access to high quality of mental health care among the Latino population including immigrant Latinos compared to national norms (USDHHS, 2001). In the U.S.A. the Surgeon General spearheads action directed to health policy issues that are deemed as most crucial given contemporary problems and scientific findings. Federal public health resources should therefore be allocated to provide mental health care for Latinos including grants to conduct research and disseminate services. Arguably, the U.S. Surgeon General's Report has been instrumental to support initiatives to address mental health disparities experienced by Latinos and Latino immigrants. I personally have participated in national conferences, funded by

National Institutes of Health, that convene the nation's leading Latino mental health researchers to discuss the latest findings and mentor new investigators. Research papers have been published in journal special sections and some of these provide directions for future policy and research (e.g., López 2002; Vega et al., 2007; Zayas, 2010).

### ***Epidemiological Surveillance, Needs Assessments & Empirically Supported Treatments***

Public Health models are likely to maximize the quality of care provided and contain costs through scientific-based strategies including: Surveillance of illnesses/diseases, and use of Empirically Supported Interventions and Practices to combat mental health problems. For example, large-scale epidemiological studies have revealed that immigrant Latinos in the U.S.A. have a lower prevalence of mental health problems than Latinos born in the U.S.A., that is, second and later generation Latinos (Alegría et al., 2008; López, Barrio, Kopelowicz, & Vega 2012; Vega et al., 1998). In other words, the rates of mental health problems of immigrants are lower than average than those of the general population. One interpretation of these robust epidemiological findings is that there is resilience to mental health problems among Latino immigrants when compared to the general U.S.A. population and also to non-immigrant Latinos.

A public health perspective dictates that Empirically Supported Treatments (ESTs) are imperative to address the health/mental health problems so that resources are invested in approaches that are most likely to work. However, in the U.S.A. immigrants and vulnerable populations are less likely to use Empirically Supported Treatments (ESTs), that is, problem (or illness) focused programs that have been shown empirically to reduce the levels of symptoms and psychological distress (USDHHS, 2001). The lower usage of mental health services and ESTs applies to immigrant Latinos (Alegría et al., 2008; López et al., 2012; Vega et al., 1999).

Proposed efforts to bridge the gap between ESTs and ethnic minority (and immigrant) populations have included the: (a) development of treatments that stem from ethnic minority's culture, (b) modification of ESTs during their implementation so that they are more compatible and more likely to work with ethnic minorities, and (c) training of therapists to be more culturally competent so that they become more effective when they apply an EST with ethnic minorities (Hall, 2001; Cardemil & Sarmiento, 2009). There are data showing that when ESTs are modified during their implementation with ethnic minorities, including Spanish speaking Latinos, they are more effective than when those ESTs implemented without modifications (Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Smith, Domenech-Rodriguez, & Bernal, 2011). Certainly,

there is much more work to be done by Latino mental health researchers in order to understand better how to improve the efficacy and reach of interventions for Latino immigrants (López et al., 2012).

### ***Localize immigrant mental health care initiatives***

In large part because care is ultimately delivered at the local community level, developing strategic and comprehensive mental health care plans for immigrants and vulnerable populations at the local level is essential. Therefore, translating national policies and research findings to local communities' initiatives is essential as well. In this vein, Aguilar-Axiola et al. (2002) presented a case study of the collaboration of research scientists with local authorities to address the mental health care of Mexican Americans including immigrants in a community in Fresno County, California. They classified their work into three major phases: (a) community education and mobilization, (b) translating data for multiple stakeholders, and (c) effecting policy. The authors described their work as transactional rather than linear, as highly demanding in working across stakeholder's and disciplinary "languages, and as more time-demanding than expected". Cardemil et al. (2007) also described community a Needs Assessment to ascertain the prevalence of mental health problems and of usage of mental health services by Latinos living in Worcester, Massachusetts. The authors also report the arduous task of developing the survey and sampling in the local community as well as the value of the results for local community stakeholders and their planning efforts to provide care for the Latino population in their service sector.

In my professional experiences in the state of Illinois, I also observed and participated in community efforts to develop locally-anchored plans and initiatives to increase the amount and quality of their services to Latino populations. One community with Latino population of more than one-third planned a Needs Assessment in order to inform the stakeholders' and its strategic service plan. The project was challenged in balancing the depth and bread of the Needs Assessment with the limited resources available to conduct it. A second community with a lower concentration of Latinos of approximately 12% obtained a federal grant to improve its system of care and was able to deploy an Empirically Supported Treatment that focused on strengthening families and their relationship with the multiple service providers in the local system of care. Even with the available federal funds, the community was challenged in deploying more ESTs to address the multiple needs of the Latino population as well of other non-Latino vulnerable populations. A third community with even a lower concentration of Latinos of less than 5% commissioned a Needs Assessment. The report documented the disparities in access to services by ethno-racial minorities who typi-

cally lived in in socially disadvantaged settings, and of Latino and Asian immigrant communities. Based on the report, the local mental health authority implemented the policy to require that local mental health agencies include action plans to increase the reach of their services by underserved populations.

Taken together, policy development and implementation, and strategic planning at the local community level are essential to implement the policies and results of epidemiological and intervention research studies for vulnerable populations. The examples cited above are likely to represent instances in which local mental health authorities and stakeholders are highly invested in providing the best care for Latino immigrants and vulnerable populations. Even in these cases there are multiple challenges, including low levels of resources including tight and decreasing budgets for public mental health care as well as the time needed to execute needs assessment and strategic planning agendas in collaborative ventures with multiple stakeholders. In sum, applying scientific findings in local public mental health agendas demands a serious investment of resources by all stakeholders (Barrera, Castro, & Steiker, 2011; Baumann, Domenech-Rodríguez, & Parra-Cardona, 2011; Trickett & Schensul, 2009).

### *Use of Inter-Sectorial Initiatives*

Another implication that follows the use of a public health model is the recommendation by the World Health Organization (WHO, 2001) is to integrate mental health care with primary health care. For example, the presence of mental health professionals in primary health care clinics can improve the detection of mental health problems in the population at-large, including detection at early stages allowing for interventions before problems escalate and become more costly. This recommendation is consistent with the finding that a large portion of Latinos in the general population have reported that they first sought help from a primary care physician for a mental health problem (e.g., Vega et al., 1999). Accordingly, the integration of mental health care with primary health care has been identified as one of the priorities in Latino mental health in the U.S.A (López et al., 2012).

An illustrative example of integration of mental health services with primary care services is a Spanish speaking mental health practicum that colleagues and I developed at a community in the state of Illinois (Buki et al., 2008). University faculty who trained graduate students in mental health professions collaborated with a primary mental health clinic that largely focused on providing physical health care services to the indigent population. The team of bilingual graduate trainees augmented the capacity of the clinic to serve the Spanish speaking clientele who represented approximately one-third of the case load even though Latinos

altogether made less than 5% of the total local population. Thus, the partnership with the primary clinic allowed for services to reach a segment of the Latino population who would otherwise not be reached at that time or who would have received mental health services following a crises ensuing the escalation of their co-occurring physical and mental health problems. The project required much work to logistically set up the services and to integrate the expertise of the different mental health and physical care disciplines and was supported by local mental health policy makers.

Vulnerable populations are often over-represented in correctional programs as well (WHO, 2001). In the case of “illegal” immigrants, serious offenses that break the law are likely to result in deportation. However, even when the law is broken by immigrants, in the U.S.A., there are often cases in which the mental health evaluations, therapy and/or other human services are needed to make informed legal decisions about the welfare of the immigrants and their families. Thus, the need for mental health services that are tightly linked with criminal justice and who have the capacity to cope with the challenges that stem from the linguistic, cultural, and social realities of the immigrant populations is critical given the serious long-term consequences of these legal decisions. Accordingly, integration of mental health care with the criminal justice system per se has also been identified as a priority for Latino mental health (López et al., 2012).

Other key examples of inter-sectorial collaboration with immigrants include schools and community centers. In the U.S.A public schools are also settings where behavioral problems may come to surface. It is common for schools to provide human service providers such as school workers who triage and assess behavioral problems. However, linkages to other mental health services in the community might be non-existent or fragile. There are full-scale programs sponsored by community mental health agencies that may actually provide services inside the school’s campuses in collaboration with schools but with agencies’ own staff. There is certainly more than one way to link community mental health services with schools.

Immigrant enclaves in the U.S.A. often give rise to ad-hoc Community Centers that offer a variety of information and linkages for immigrants to meet basic needs. For example, in one mid-size city with a growing Latino immigrant population, an apartment complex owner who became aware of the rising number of Latino immigrants in his/her apartments, donated one apartment unit to be used as a community center for the immigrant population. The community center provided information and resources for immigrants including how to get a driver’s license, school and health related information. The local community mental health authority not only provided information in this center about their services at their own clinics, but also developed an initiative to provide peer-based services in the commu-

nity. The peer-based services were offered by a local community member and included one-on-one coaching on how to accrue resources and support to cope with problems currently faced by the immigrant families.

### **Managing/Addressing Power Inequities between Immigrants and Host Society**

Immigrants as a group, particularly those who have entered the country illegally have limited, if any, power in the new society while the host society has political, economic, and legal power in their relationship with the immigrants. Accordingly, health/mental health initiatives exist in a context of power inequities between the host society and immigrant populations. Even in an optimal scenario in which immigrant health care is largely unquestioned by the host society, the provision of health care and related services can be viewed as a verification of the power relationship. That is, decisions of when, how, and how much care to give are a manifestation of power by the host society and can be perceived as so by the immigrants receiving the care. In worse case scenarios, the host society institutions can deny care to immigrant on the basis of their illegal entry and status in the country and proceed to deport them as soon as possible. As such it is essential to explicitly address power inequities in the mental health care for immigrants.

### **Develop Policies based on Social Justice/ Human Rights Justifications**

In contexts when there is low political will to provide any public services to immigrants, it is critical to invoke fairness to others as well as the human rights clauses tenets of *Social Justice* (Vasquez, 2012; WHO, 2001). These principals justify the provision of care for individuals in need even when their presence is questioned and their contributions to society are minimal. Social justice prescribes: (a) the provision of basic human needs to all individuals regardless of their background, including the provision of health care, and (b) ensuring that vulnerable populations such as immigrants are treated with fairness (Vasquez, 2012). That is, treating humans fairly “may involve treating equals equally and unequals unequally but in proportion to their relevant differences” (Vasquez, 2012). In other words, immigrants may receive health services even though their direct contributions to the host society, including tax revenues that pay for public services, is low compared to long-standing members of the host society. This is justifiable because of immigrants’ life circumstances including their current limitations to contribute to the host society. That is, individuals in a society may receive more than they have contributed at a given point in time given their stage of life, devel-

opmental trajectory, and life circumstances. The fairness argument is also consistent with the “golden rule”, that is, treatment of others as you would like to be treated if life circumstances were reversed (Vasquez, 2012).

Notably, Social Justice and Human Rights principles applied to community public mental health systems imply that the best health care be given with available resources to *all* vulnerable groups rather than immigrants only. The needs of the local community’s vulnerable populations should not be neglected at the expense of the other. It is important to underscore this aspect of *Fairness* in Social Justice and Human Rights to garner support from and collaborate with multiple stakeholders, and advocates of different vulnerable populations.

### **Provide protection and voice to immigrants**

Another implication of the power inequity between the host society and immigrant populations is the need to provide opportunities for immigrants to be fully informed and understand health and health initiatives (e.g., interventions, research). Information dissemination needs to be coupled with opportunities to make decisions. The latter can range from advocacy approaches in cases in which immigrants are not in a position to readily activate their own voice, to coaching immigrants to voice their opinion. In the realm of policy, providing voice to immigrants can include advocacy for them in venues such as local councils, health and mental health boards and similar policy making bodies. In local communities, immigrant voices should be represented in public health and community health bodies. Inter-city/cross-county partnerships should also have representation of immigrants given that such partnerships can be instrumental to garner support and resources that is otherwise out of reach for individual mid- to low size communities. With respect to research, Community Based Participatory Research (CBPR) methods are particularly conducive to represent the voices of disempowered groups such as immigrants. By their nature CBPR entails that the local communities co-construct research and initiatives with researchers and other stakeholders (e.g., Balcazar, García-Iriarte, & Suarez-Balcazar, 2009; Kneipp et al., 2011). Notably, such co-construction and cooperative approaches are also likely to challenge professionals including researchers and services providers in their views of their own roles and of the help and care-giving transactions. The expert role and authority stances need to be balanced with a predisposition to find solutions that work and that may integrate community members’ own wisdom and experiences about the problems that they face.

Providing voice and informing immigrants about their health and health related choices should be inclusive of all standard health care practices including rou-

tine uses of public health systems such as the management of viral infections, immunizations, and other high-frequency contacts with health service providers. Likewise, health research that provides a voice to immigrants need not be confined to CBPR and qualitative approaches. It should be part of survey-based and epidemiological research, for example. Regardless of research methods, researchers should provide vulnerable populations and immigrants opportunity to voice their concerns and opinions directly through open-ended questions and also indirectly through advocates and community figures who are trusted by immigrants.

### ***Enhance Capacities of Immigrants while providing Mental Health Care***

Host society's views regarding the contributions of immigrants would benefit highly from balanced perspectives that contest views of immigrants as solely users of local resources. Unfortunately, the nature of the underground economy in which illegal immigrants function, often obscures their contribution to the public eye. For example, farmworkers who are in the fields, are likely to work in rural areas and thus away from large concentrations of individuals. Those who live and work in urban centers, are likely to do so in the shadows, as in the case of cooks and dishwashers in restaurants, house-keeping staff in hotels, and housekeepers / house cleaners in private middle class households. In this context, opportunities to appreciate the contributions of immigrants by the host society at large are rare. Exceptions in the U.S.A. include a documentary by national cable producer that portrayed sketches of highly successful Latino personalities many who were immigrant (Home Box Office, 2012). In addition to the exemplary industriousness shown by the set of featured Latinos in the latter documentary, common themes in their lives that stood out as crucial to build their success included: (a) education/apprenticeships, and (b) support systems.

With respect to education, Latinos in the U.S. have the highest high school drop-out rates of any ethnic group. Thus, even though 84% or more individuals who were 25 years or older in the U.S.A. have attained a high school education, only 59% Latino males and 62% Latina females did (U.S. Census Bureau, 2006). Accordingly, it is critical to integrate the mental health needs of immigrant youth with their school functioning. Some researchers are integrating the study of social support and family relationships, on educational outcomes among Latino youth (e.g., DeGarmo & Martinez, 2006; Esparza & Sanchez, 2008). Gonzales and colleagues (2007) have developed a community-based program that aims to transition successfully immigrant adolescents from middle school to high school (e.g., Gonzales, Dumka, Mauricio, & Germán, 2007).

In a community in the state of Illinois, I observed

that a community mental health authority joined forces with a local advocacy group with the mission to help Latinos succeed in their education pursuits. The mental health authority provided support for scholarships that the advocacy group used as an incentive for Latino students to enroll in human service careers. In turn, students who obtained degrees in human service professions committed to serve the local community for a portion of their careers.

Another strategy to enhance the capacity of individuals is to enhance social support systems. Social support not only buffers immigrants (and others) from stressors, but also boosts self-efficacy and self-esteem which in turn can promote healthy functioning (with or without the presence of stressors; see Barrera, 2000). Thus, mental health care initiatives that target the enhancement of social support system not only can help mitigate distress in the short-term but also enhance individuals' capacities in the long-term

A special/noteworthy support system is the family. It is a major socialization unit for children and youth, and a source of meaning and fulfillment for adults. An exceptional program of research that has focused on strengthening functioning of Latino families targeted youth substance use among Latino youth in the U.S.A. (Szapocznik et al., 1997). One of its foundations was research that examined that Latino families in the U.S.A. tended to have hierarchical styles that emphasized parental authority while American U.S.A. families were more likely to hold egalitarian relationships between parents and children/youth. Latino immigrant youth tended to espouse U.S.A. values and customs more quickly and readily than parents, thus resulting in risk for a cultural divide between youth-American culture and parent-Latino culture within Latino immigrant families (Szapocznik & Kurtines, 1993). Accordingly, family psychoeducation programs were developed to promote bicultural skills that bridge cultural differences in Latino families (Szapocznik, Rio, Perez-Vidal, & Kurtines, 1986).

Family intervention programs such as the ones cited above are based on systems theory (systemic views); as such they do not necessarily limit their focus on strengthening support systems to the nuclear family. For example, the focus of the program of intervention research cited above broadened and is now inclusive of linkages between the individual with problem behaviors and support figures outside of the family, the family members and other support figures, as well as family members and human service providers. In other words, the goal is to strengthen as much of the web of support systems rather than focusing on nuclear family relationships exclusively. As such, family support interventions are synergistic with interventions and initiatives that target the development of connections/ties between immigrants and other support systems in the local community. Strengthening immigrant families' of sources of support is likely to improve their overall

functioning rather than only address problematic behaviors and psychological distress at specific time periods.

### **Implications for Immigration as a Global Phenomenon: Toward Health Equity**

In this paper on immigrant health care, I have focused on the population of Latino immigrants in the U.S.A. Some notable aspects of this particular immigrant group include its large size of 50 plus million Latinos (half are estimated to be immigrant), diverse countries of origin, and the variety of settings where Latinos live in the U.S.A. Historical events weigh in the relationship between the U.S.A. and Latin American countries (USDHHS, 2001; Fuligni, & Perreira, 2009). In addition to their diverse countries of origin, Latinos in the U.S.A are one of four major and sizable ethnic minority groups including African Americans, Asian Americans, and Native Americans.

A major caveat to Latino immigrant mental health care in the U.S.A. is the fact that the U.S.A. does not have a nation-wide, single-payer public health care system. The recent Health Care Reform Act extends existing coverage to individuals from private health insurance companies and from two federal programs (Medicaid, Medicare). Thus local public mental health systems rely on a mixed array of funding streams including Medicare and Medicaid, State and Local funds, and other temporary sources such as service grants and donations. Accordingly, local communities' resources can vary substantially and impact their ability to provide care for all vulnerable populations including immigrants.

The caveats presented above regarding the factors that impact immigrant policy and health care highlight the relevance of the eco-systemic perspective presented in this paper. Notwithstanding the uniqueness of national and local community settings, we expect that the disruption in the lives of a local community (local eco-system) brought about by the actual (or attributed) surge of immigrant populations is not peculiar to U.S.A. communities. It follows that the dilemma of spending resources in immigrant mental health care while capping costs will be of concern to host societies. Power inequities are also expected to be common given that the majority of destinations of immigrants are countries whose economies are stronger than immigrants' countries of origin.

Another thread that links immigrant mental health care in the U.S.A. to global settings is the framework of *Health Disparities* which brings attention to *several* ethno-racial groups that have worse health outcomes and access to health care than others. The concept of *Health Equity*, which is commonly used in European settings (see International Project Group Standards for Equity in Health Care for Migrants,

2011), is related to Health Disparities but it offers some advantages. A focus on *Health Equity*, is defined as Social Justice in health, that is, the elimination of health disparities that "adversely affect socially disadvantaged groups" and that "arise from intentional or unintentional discrimination or marginalization and ... are likely to reinforce social disadvantage and vulnerability" (Braveman et al., 2011, p. S150). Accordingly the goal of achieving Health Equity can be helpful in shifting the focus from existing differences in health outcomes to finding solutions to reduce the disparities. López et al. (2012) noted that 10 years after the U.S. Surgeon General's Report on Mental Health focusing on health disparities including those experienced by Latinos, little progress was made on developing solutions to reduce the disparities (promote equity). Furthermore, given that *Health Equity* is defined as Social Justice in health, it places Human Rights and Social Justice front and center whereas *Health Disparities* may not.

Health Equity promotes population health which in turn benefits the entire society (Braveman et al., 2011). First, healthier immigrants are more productive than unhealthy ones. Second, investments in providing mental health care to immigrants is likely to benefit the population at-large through improvements in host society's infrastructure to provide services. For example, research on the application of Empirically Supported Treatments (EST) with immigrants, can lead to insights that improve the EST and in turn benefit its application to the population at-large. This is because models of treatment dissemination dictate that program application results be linked back to the program and used for further improvements (for example, see Bernal, 2006; National Institute of Mental Health, 1999). On the other hand, efforts to understand immigrant and ethnic minority populations first and then derive programs that work for immigrants, should not be dismissed as having little relevance to the population at-large. For example, a program of research that started by primarily focusing on Cuban origin Latino youth with substance use problems, evolved to family interventions that are applicable to the population at-large, rather than only to Cuban-origin immigrants (Szapocznik et al., 1997). It has been shown that these interventions are effective as well with African American populations (Feaster et al., 2010).

Third, *health equity* emphasizes well-being and highest attainable levels of health such that individuals should not only be "symptom-free" but have reasonable opportunities to access education and society's means to live a functional and fulfilling life (Braveman et al., 2011). This is consistent with the emphasis on *Recovery* of persons that experience mental health problems, that is, the fuller integration of individuals into their community (Saavadera Macías, 2011; Shepherd, Boardman, & Slade, 2008). Similarly, it has been well argued that the relation between immigrants

and their health should emphasize immigrant's capacities to develop their agency and capacity to function in the new host society (e.g., García-Ramírez, de la Mata, Paloma, & Hernández-Plaza, 2011).

### Final Caveats and Conclusions

Even though, in this paper I make the case for the applicability of eco-systemic dilemmas across different settings, the unique histories and infrastructure of public health systems should not be overlooked. For example, political ideologies and the make-up of immigrant and cultural diverse populations are expected to bear on mental health systems (see Kirmayer & Minas, 2000). Relatedly, there are socio-political contexts in which Health Equity's emphasis on Social Justice and Human Rights do not bear weight even though they should. These settings may be war-torn, under significant economic distress, or even economic and politically stable communities in which current political discourses do not hold public health care, public services, and or social justice as a priority.

The paper's emphasis on improving the mental health of immigrants through public health and mental health services emphasizes the Social Justice aspect of extending the best available quality care to vulnerable populations. However, it is not meant to dismiss that there are instances, in which mental health improvements may be obtained through initiatives outside the realm of formal services in public health initiatives. These may include options provided by community grass-root organizations, or churches for example. They may also arise from individuals' personal strengths, support networks, and critical reflection about their conditions (e.g., Balcazar et al., 2012; García-Ramírez et al., 2011; Reyes-Cruz & Sonn, 2011).

Notwithstanding, in communities with some minimal level of political will and investment in improving the health of its citizens, scholars and research scientist who specialize in mental health care broadly and/or in immigrant populations are obliged to contribute to the well-being of immigrant populations (Baumann et al., 2011). There are many roads to improve the mental health of immigrants in the local population which depend on local histories, economic and socio-cultural and political realities. A steady pace based in the direction toward Health Equity in the population at-large, including vulnerable populations such as immigrants, is very likely to lead to fruitful avenues.

### Acknowledgements

I am thankful to Ed Lichtenstein for his input on a prior version of the manuscript.

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Manuscript received: 04/09/2012

Review received: 06/11/2012

Accepted: 06/11/2012