COMMUNITY-DEFINED SOLUTIONS FOR MIXTECO MENTAL HEALTH CARE DISPARITIES

CALIFORNIA REDUCING DISPARITIES PROJECT
LATINO STRATEGIC PLANNING
WORKGROUP POPULATION REPORT

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Requests for information about this report should be directed to
UC Davis Center for Reducing Health Disparities
2921 Stockdale Blvd., Suite 1400, Sacramento, CA 95817
E-mail: CRHD@ucdmc.ucdavis.edu
http://ucdmc.ucdavis.edu/crhd

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Concilio Members: **Sergio Aguilar-Gaxiola**, UC Davis, Center for Reducing Health Disparities, **Denise Chavira**, University of California, San Diego, **Sonia Contreras**, Secretary of Health of Mexico, **Benjamin Flores**, Ampla Health, **Katherine Flores**, UC San Francisco, Fresno, **Juan Garcia**, California State University, Fresno, **Luis Garcia**, Pacific Clinics, **Piedad Garcia**, County of San Diego, Mental Health Service, **Ruben Imperial**, Stanislaus County Behavioral Health & Recovery Services MHSA, **Rachel Guerrero**, **Manuel Jimenez**, Merced County, **María Lemus**, Visión y Compromiso Promotoras program, **Gustavo Loera**, UC Davis, Center for Reducing Health Disparities, **Arcenio Lopez**, Mixteco/Indígena Community Organizing Program, **Lina Méndez**, UC Davis, Center for Reducing Health Disparities, **Lali Moheno**, Lali Moheno & Associates, **Perfecto Muñoz**, University of California, Berkeley, **Roger Palomino**, Migrant Representative, **Refugio "Cuco" Rodriguez**, County of Santa Barbara Department of Mental Health, **Juan-Carlos Rodrigo-Miranda**, UC Davis, Center for Reducing Health Disparities, **Ricardo Vásquez**, Promesa Behavioral Health, **William Vega**, Edward R. Roybal on Aging, University of Southern California, **Henry Villanueva**, Ventura County Behavioral Health Department, **Richard Zaldivar**, The Wall-Las Memorias Project.

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Others: Jahmal Miller and Marina Augusto, Office of Health Equity (OHE), California Department of Public Health (CDPH).

Executive Summary

California's mental health system continues to be under pressure to transform from the business-as-usual ways of doing things to an effectively functioning recovery-driven system that thrives in achieving health equity by improving accessibility, availability, appropriateness, affordability, and advocacy to mental health care for the historically underserved communities (Aguilar-Gaxiola et al., 2012). In our 2012 study, the *Community-Defined Solutions for Latino Mental Health Care Disparities* we concluded, "Distinguishing among Latino subgroups (e.g., Mixtecos) from different regions and examination of their demography, history, culture, and views on mental health are important for future research on disparities" (Aguilar-Gaxiola, et al., 2012). In collaboration with Mixteco/Indígena Community Organizing Project (MICOP), a network of Mixtecos Ventura County, is a community-based organization that combines community advocacy, community engagement, and community capacity building. Its main objective is to organize and empower the indigenous community. MICOP also aims to help reduce mental health disparities among the indigenous population through education and training.

According to Mines, Nichols, and Runsten (2010), California is home to the largest population of migrants from Mexico who speak more than 23 languages. Presently, no standard structure of oral and written communication has been established for the Mixteco language (Jiménez & Smith, 2008). Social and economic factors, such as limited to no education, poverty, and lack of basic living necessities, combined with exploitation and discrimination are among the major causes restricting access to quality mental health care for recently arrived Mixteco immigrants in California. They remain culturally and linguistically isolated, and in greater risk of prolonged mental health disorder. The language barrier limits their contact with people outside of their own indigenous community. This impedes their access to education about mental health services.

KEY FINDINGS

Key Findings – The accessibility of mental health care:

- The lack of information and understanding of the mental health system was considered a significant factor contributing to limited or no access to care.

- Many barriers to access, stigma and fear, discrimination within the group, and Mixteco culture and language were also viewed as common barriers to access to care.

Key Findings – The availability of mental health care:

- The lack of a mental health professional that is familiar with the Mixteco communities. For example, lack of interpreters that speak and comprehend the language of the community.
- Social and systemic barriers related to treatment and services, such as poor living conditions, inadequate transportation and work schedule, long waiting times and treatment hours of service are not aligned with work schedules.
- The lack of school-based mental health programs to serve Mixteco youth struggling with a mental health problem.

Key Findings – The appropriateness of mental health care:

- The lack of culturally and linguistically appropriate services for a diverse Mixteco population is critical to mental health treatment that is suitable to each indigenous community.
- The recognition and appreciation for Mixtecos' use of traditional (cultural) treatments and remedies are vital to their access to treatment and compliance.

Key Findings – The affordability and advocacy of mental health care:

- The scarcity of resources and poor living conditions were reported to negatively impact Mixtecos' access and utilization of mental health services.
- The absence in advocacy unity and a unified voice to increase Mixtecos integration and participation in community life.

STRATEGIC DIRECTIONS AND RECOMMENDATIONS

Strategic direction 1 – Empower the Mixteco community and increase their participation in the decision-making process:

Develop and implement mechanisms to engage the Mixteco community in implementing solutions that come from this report. This includes recognizing MICOP as a best practice and funding their efforts to serve the Mixteco population and other indigenous groups in California.

Strategic direction 2 – Increase culturally and linguistically appropriate treatment for Mixtecos:

The goal is to provide care and treatment that is appropriate to Mixteco communities. To achieve this, it is important to communicate with members from each indigenous community in a way that acknowledges their beliefs about mental health.

Strategic direction 3 – Prevention and early intervention and Mixteco youth:

Earlier, participants voiced their fears of youth feeling embarrassed about their indigenous culture and language. Also substance use (alcohol and drugs) is increasing among Mixteco youth. The strategy is to work with schools and train teachers about the culture and ways to detect early signs of mental health disorders.

Strategic direction 4 – Workforce development:

Develop and sustain a culturally and linguistically competent mental health workforce consistent with the culture and language of Mixteco communities. Also, establish a college and career pipeline model in schools to interest Mixteco youth in pursuing careers in the mental health field.

Strategic direction 5 – Establish a Mixteco Concilio that operates from MICOP:

Provide funding to MICOP, an already established organization reaching thousands of indigenous people using grassroots strategies. Working through MICOP, the following can be achieved: (1) strengthening their outreach program to engage Mixtecos and other indigenous groups that continue to be disengaged from community life; (2) building mental health leadership in the Mixteco community through training and education; (3) defining mental health in a way that is understood and in terms that matter to the Mixteco community without tweaking or ignoring their dialects; and (4) building local capacity aimed at reducing the treatment gap and improving mental health outcomes for the Mixteco and other indigenous communities.

As we highlighted in our 2012 *Community-Defined Solutions for Latino Mental Health Care Disparities* report, and continue to stress in this report, systemic solutions must go beyond the conventional "well-intentioned" solutions that lead to more of the same failures and disparities. Our call to action is for the system to focus its efforts on building capacity along side the Mixteco communities and growing leaders from within the culture. That is, new leaders that emerge from the underserved indigenous communities must replace the "well-

intentioned” systemic programs and leaders who fail to serve the Mixteco and other indigenous communities. If the 2004 MHSA and the 2009 CRDP are to transform the system from the business-as-usual ways and achieve their principal aim, to eradicate mental health disparities among underserved communities, the solutions and strategies must by defined by the underserved community.

Introduction

Community-defined practices require communities to engage in identifying prevention and early intervention approaches that are compatible to their unique blend of cultural values. The indigenous people's vocation to survival is strongly rooted in their culture and language. Although they are resilient people, their mental health status remains an issue of importance.

California's mental health system continues to be under pressure to transform from the business-as-usual ways of doing things to an effectively functioning recovery-driven system that thrives in achieving health equity by improving accessibility, availability, appropriateness, affordability, and advocacy to mental health care for the historically underserved communities (Aguilar-Gaxiola et al., 2012). Since the implementation of the 2004 Mental Health Services Act (MHSA), much of the discussion has been on closing the treatment gap in mental health care. In 2009 the California Department of Public Health launched the California Reducing Disparities Project (CRDP), a statewide prevention and early intervention framework focusing on five underserved populations: African Americans, Asian and Pacific Islanders, Latinos, LGBTQ (lesbian, gay, bisexual, transgender, queer and questioning), and Native Americans (see www.cdph.ca.gov/ for more information). The history and research on the treatment gap in mental health care proves that the mental health needs of historically underserved populations have often gone undetected and untreated. Researchers estimated that between 50 to 90% of people with serious mental health disorders do not receive *appropriate* mental health care in any given year (Kohn, Saxena, Levav, & Saraceno, 2004; Patel et al., 2010; Wang, Aguilar-Gaxiola, Alonso, et al., 2007). Another reason for the treatment gap is that, even when these underserved populations have access to mental health treatment, it doesn't always translate to them utilizing it.

The *Community-Defined Solutions for Latino Mental Health Care Disparities* report by Aguilar-Gaxiola and colleagues (2012) presents a comprehensive two-year study that detailed barriers to access and utilization of mental health services among Latinos in California. It also offers community-defined strategies and solutions for removing barriers and reducing mental health disparities. This study is the first of its kind to use a community-based, grassroots approach to identify barriers and seek solutions to mental health care needs in historically underserved Latino communities. While comprehensive, based on more than 550 Latino participants statewide, the authors recognized that Latino indigenous groups were not carefully represented in the sample. In our attempt to avoid treating Latinos as a homogenous community, we identified and acknowledged the indigenous population (e.g., Mixtecos) as

another severely underserved population that also struggles with mental health problems. In our recent study, we concluded, “Distinguishing among Latino subgroups (e.g., Mixtecos) from different regions and examination of their demography, history, culture, and views on mental health are important for future research on disparities” (Aguilar-Gaxiola, et al., 2012). This forms the rationale and purpose for the current report.

Since the 1970s, Mixtecos have played a vital role in California’s agricultural industry. Currently, Ventura County, California, is home to approximately 20,000 indigenous people from Oaxaca, Mexico. Mixteco/Indígena Community Organizing Project (MICOP) is a network of Mixtecos who share a common purpose to thrive in a labor-intensive agricultural environment and fully participate in community life. Fostering economic, human, and community development has been the central focus of MICOP. MICOP is a community-based organization that combines community advocacy, community engagement, and community capacity building. Its main objective is to organize and empower the indigenous community. MICOP also aims to help reduce mental health disparities among the indigenous population through education and training.

INDIGENOUS CULTURE AND LANGUAGE

The cultures of the indigenous people originating from Oaxaca, Mexico, can be characterized as authentic intellectual landscapes (Libbrecht, 2007) that evolved and survived from the complexities of their history and language. Indigenous groups from the Mexican state of Oaxaca have often been assumed to be homogenous. However, because of their individual towns and tribal groups living in isolation from each other, over time they became more diverse and variations in customs, traditions, and language emerged (Schmal, 2010). Throughout their history, the Mixteco people have migrated away from their birthplace villages to create new communities with new traditions and new dialects. According to estimates from the Mexican government, the country has more than 12 million indigenous people from diverse cultures that speak more than 60 different languages (Insituto Nacional de Estadistica Geographica e Informática, INEGI; 2007).

According to Mines, Nichols, and Runsten (2010), California is home to the largest population of migrants from Mexico who speak more than 23 languages. Presently, no standard structure of oral and written communication has been established for the Mixteco language (Jiménez & Smith, 2008). In fact, Mixteco language can differ from one indigenous community to another making communication difficult. The use of the Mixteco language is declining, especially among

the indigenous youth (Reyes, 2012). Therefore, to avoid confusion and disputes, most Mixtecos (youth in particular) will learn and prefer to speak Spanish with one another. Spanish and other dominant languages (i.e., English) will eventually replace indigenous languages. Unfortunately, replacing the Mixteco language with Spanish may also mean losing the Mixteco culture. The survival of a language represents the survival of a culture (Libbrecht, 2007). The migrant and first-generation Mixtecos in California tend to remain true to their indigenous ancestors' customs and traditions. However, they fear that newer generations are loosing these cultural values and indigenous language. That is, second-and third-generation Mixtecos are becoming more and more strongly rooted in the values of the new United States culture, and only connected to their indigenous culture through family and education.

MENTAL HEALTH STATUS OF MIXTECO POPULATION

As a society, we have adjusted to the stereotype that continues to reinforce the characterization of Mexican indigenous immigrants as a workforce performing low-paying and hard-labor jobs. Despite their significant presence and contributions to the United States' economy, Mexican indigenous people continue to be poorly integrated into our society. That is, indigenous people are often treated as outsiders and as inferiors, and excluded economically, socially, and politically (Cohen, 1999). According to Aguilar-Gaxiola et al. (2012), social exclusion is the process by which individuals and groups of people are wholly or partly barred from participation in social activities. In this process, some individuals, due to their background, life experiences, or circumstances, are denied access to society's resources, resulting in poor living conditions, physical and mental health problems, and other interrelated problems. Social exclusion is measured not only in an individual's or community's living conditions (i.e., poverty), but also in an individual's sense of not belonging to a community or, on a broader scale, a community not belonging to a larger society (Incayawar & Maldonado-Bouchard, 2009). Stress can occur when one's cultural identity and beliefs are invisible or suppressed because it is not accepted in the host culture (Paige & Goode, 2009).

The business-as-usual ways of doing things are fast losing their relevance (Kim, 2009), as the mental health system is now more than ever challenged to face the diversity and complexity of underserved Latino communities (Aguilar-Gaxiola et al., 2012), in particular the Latino indigenous population. The lack of adequate mental health services and the exclusion of the Latino indigenous people continue to be severe (Incayawar & Maldonado-Bouchard, 2009). Mental health care providers continue to search for community-defined strategies that will lead to innovative solutions to community mental health problems. If the mental health community

is to successfully reduce disparities for this population, we must recognize that Mixtecos bring with them and maintain a wide range of experiences that require careful examination through their cultural lens, and collective action from the mental health community to provide adequate and appropriate health and mental health care services. With so many indigenous dialects, overcoming linguistic barriers is critical. Moreover, it makes defining and describing mental health a daunting task. In fact, several Mixteco informants for this report argue that the terms "mental health" or "mental illness" can be more harmful when translated into their dialect because of the lack of proper translation. As a Mixteco woman in Ventura County put it, "To express mental health problems, Mixtecos have to use too many words . . . in Mixteco to describe what it is . . . and still you may not get it right. . . . To understand mental health, it has to be a slow process that requires patience." This linguistic barrier prevents Mixteco communities from interpreting and relating to mental health and treatment, because it is difficult for them to detect and recognize mental health symptoms.

Social and economic factors, such as limited to no education, poverty, and lack of basic living necessities, combined with exploitation and discrimination are among the major causes restricting access to quality mental health care for recently arrived Mixteco immigrants in California. They remain culturally and linguistically isolated, and in greater risk of prolonged mental health disorder. The language barrier limits their contact with people outside of their own indigenous community. This impedes their access to education about mental health services.

Studies have shown that historically, the estimated 200,000 Mexican indigenous people in California have faced many years of prejudice, discrimination, social exclusion, and violence (Minkoff-Zern, 2012; Portal, Suck, & Hinkle, 2010). These lived experiences are unique to the Mexican indigenous and often linked to a high prevalence of mental health disorders (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 1999; Donlan & Lee, 2010). To appreciate the Mexican indigenous experience, it is important to contextualize their disparities and lived experiences using a community-based participatory research (CBPR) approach. A detailed description of this framework is described elsewhere (e.g., Aguilar-Gaxiola, et al., 2012; Minkler & Wallerstein, 2008). While we recognize that other Mexican indigenous groups speaking different languages have settled in California, we limit this report to the indigenous people from Oaxaca, Mexico (Mixtecos), with a significant presence in Ventura County, California. Mixtecos are defined as indigenous Mesoamerican peoples inhabiting the Mexican region of Oaxaca, Guerrero, and Puebla. Traditionally, Mixtecos are known to practice agriculture and produce artisan crafts, such as weaving, wool and cotton woven textiles, pottery, baskets, and other palm products

(Kellogg, 2005).

The unique experiences of the Mixteco population and their cultural identity and adaptation of a new culture suggests that their mental health status, and the factors that are significantly associated with it, may be more severe when compared to non-indigenous Mexicans, and other Latino populations in the United States (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000a, 2000b). Studies have shown that indigenous people often experience racism, discrimination, and violence in Mexico (Portal, Suck, & Hinkle, 2010; Saraví, Abrantes, & Busquets, 2014), as well as during and after migrating to the United States, where those experiences often lead to stress and depression (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 1999). However, research on the Mixteco and indigenous communities' mental health status is still lacking and needs more attention.

In summary, extreme social and economic inequalities can be seen as significant factors that explain the mental health status of the Mixteco and other indigenous communities. Aguilar-Gaxiola and colleagues (2012) describe inequalities as barriers related to *accessibility* (e.g., lack of services opportunities, such as time, location, and hours of operation of the agency); availability or critical shortages of mental health facilities and providers (e.g., inadequate language-proficient workforce and services, services not available after work hours); *appropriateness* and the lack of culturally and linguistically relevant services specific to the culture and language of the Mixteco community (e.g., poor quality of Mixteco consumer-provider interactions early in treatment, lack of specialization in treating Mixteco mental health consumers); *affordability* and lack of health care coverage and economic resources (e.g., cost of treatment is perceived to be too high); and *advocacy* and health literacy (e.g., lack of information in the language of the Mixteco community, and lack of advocacy programs in support of Mixtecos).

Methods

We used qualitative methods in order to appropriately explore Mixteco participants' opinions and attitudes toward mental health. This section of the report includes descriptions of the participants and the group interview activities and protocol used to collect data.

Participants

The research team conducted group interviews with indigenous participants from Ventura County, California. The data used to create this report was collected from nine group interviews that occurred in November 2014 consisting of 36 participants from the Mixteco community. All interviews were conducted at the MICOP facility. Purposive sampling was used to identify indigenous participants, who lived in Ventura County. All participants were recruited from the MICOP because it is a well-established project in Ventura County, that has the capacity to reach a large number of indigenous individuals.

Procedure

The research team initially contacted the executive director from MICOP to explain the study and the method for collecting data, as well as answer any questions. Members of MICOP, who were familiar with the Mixteco community and spoke and understood Mixteco, facilitated all group interviews. The participants who preferred their group interview be done in Mixteco only were assigned to a group in which the facilitator conducted the entire interview in their native language. The rationale for doing this was to make participants feel more comfortable expressing their views and thoughts in their Mixteco dialect. Also, a fluent bilingual interpreter (Mixteco and Spanish) was assigned to this group and translated in Spanish for the audio. The rest of the group interviews were conducted in Spanish. Therefore, all group interviews were transcribed in Spanish first and translated into English by a research team member fluent in both languages. All identifying information for participants was removed from the transcripts, and in this report to ensure confidentiality. Depending on the amount of information shared by the participants, the group interviews lasted from 60 to 90 minutes. All discussions were audio recorded, transcribed, translated, and edited for accuracy (Lincoln & Guba, 1985).

To enhance the credibility of the translation, analytical process, and readability of the preliminary findings, in February 2015 the CRHD research team in collaboration with MICOP reconvened 21 participants from the November 2014 session and 16 new participants. The participants were given a presentation on the preliminary findings and then divided into four

groups of six to eight participants. MICOP staff facilitated all group interviews and translated Mixteco content to Spanish. The aim for this second session was to obtain reactions, additional information, and recommendations to the analyses and preliminary findings. In March 2015, we asked more than 20 Concilio members, who are community mental health experts and have extensive experience working with Latino indigenous and underserved communities with mental health issues, to react to the preliminary results and make recommendations to enhance the report.

Group Interview Tool

The semi-structured group interview protocol used for this report consisted of 11 key questions with 19 follow-up questions (see Appendix A). The overarching purpose of the questions was to understand the lived experiences and perspectives of Mixteco communities with regard to mental health disparities. The focus groups included both prepared open-ended questions and unplanned probes in order to elicit respondents' insights (Richards & Morse, 2007). The California Reducing Disparities Project and the Latino Concilio (see Aguilar-Gaxiola et al., 2012) developed the protocol that guided these focus groups. After its development, the protocol was reviewed and critiqued by 10 experts of the Mixteco community of Ventura County who are affiliated with MICOP. These experts are from the Mixteco community and provide trainings and other educational services to community members. All of their recommendations were incorporated in the revised work group protocol, which was then organized around seven major domains.

Domain 1: Background and History Questions

The protocol included items asking about their cultural identity (e.g., **"How is it to be, or how does it feel to be a member of your indigenous group?"**). The aim was to start with this question, because the assumption is that respondents will be more familiar and comfortable with talking about their ethnicity or culture, and it eases them into a discussion about mental health (e.g., **"As a Mixteco in California, what does mental health mean to you?"**). Probing for differences in what the respondent experiences in Oaxaca, Mexico, in contrast to their home or community environment in California may be particularly effective. This question also helped us address the differences in these contexts.

Domain 2: Barriers and Stigma

This area contained a range of questions that asked generally about barriers and increasing access to mental health care (e.g., **"What can we do to reduce the barriers in access to mental**

health care, both as individuals and as a community?"). With this question, we were trying to get respondents' perceptions of cultural awareness, discrimination, stigma, and other considerations related to their indigenous background (e.g., **"What ideas do we have to reduce mental health stigma?"**). This probing question is intended to isolate the community barriers that prevent access to care and that focus on solutions that reduce barriers, and to increase family and community support and engagement.

Domain 3: Access to Programs and Services

This area included several questions that related to improving existing mental health programs (e.g., **"What can we do to improve the access to the existing mental health programs and services?"**). This question is intended to elucidate how much respondents know about existing mental health programs and services in their community, and how accessible these programs are (e.g., **"What mental health programs can we suggest that have proven to be successful for Mixtecos?"**). We also wanted to know what ideas respondents had to improve Mixtecos' access to services that these programs offered (e.g., **"What ideas can we share to increase the participation of the Mixteco community in mental health treatment?")**.

Domain: 4 New Programs and Modifications

The questions in this area focused on inquiring ideas about new programs that could increase the participation of the Mixteco population in treatment (e.g., **"What new programs and/or changes do we recommend to improve mental health services and increase the participation of the Mixteco community?"**). This question seeks respondents' perceived ideas about specific components that new programs should have in order to increase Mixtecos' participation in treatment. We also wanted to know their ideas on enhancing existing programs to better meet the needs of Mixtecos (e.g., **"What ideas do we have on new mental health programs that should be offered to improve the participation of the Mixteco community?"**). We were interested in their thoughts about which ingredients were necessary in order for a community-based program to succeed in serving Mixtecos (e.g., **"What are our thoughts about modifying existing programs to improve Mixtecos' participation?"**).

Domain 5: New programs and Changes to Increase Retention

The set of questions in this category asked participants to think about recommendations for new programs to enhance the treatment retention of Mixtecos (e.g., **"What recommendations do we have for new programs and/or changes on the delivery of services to enhance Mixtecos' retention in mental health treatment?"**). This question solicits respondents'

perceptions of "serious and compelling reasons" that may lead Mixteco individuals and their family to drop out of services (e.g., **"What can we do to improve the retention of Mixtecos in mental health treatment?"**). We also wanted to know their ideas on changes in delivery of services and ways to enhance mental health service programs in order to encourage Mixtecos to continue participation and to help reduce dropout rates (e.g., **"How can we change the mental health programs that exist to improve treatment retention for Mixtecos?"**).

Domain 6: Recommendations (results on success of treatment)

This section included questions that related to specific recommendations to improve Mixteco treatment outcomes (e.g., **"What recommendations do we have for new programs and/or changes in services that exist to improve the outcomes of Mixtecos' mental health treatment?"**). Now that respondents have had the time to think about improving mental health services in their community, we wanted to know how they want to change, expand, or add to programs to improve treatment outcomes other than just retention (e.g., **"What are our recommendations on new programs that could improve the outcomes of mental health treatment for Mixtecos?"**). This set of questions also provides respondents with a sense of closure. If they have any other thoughts they wanted to express, this question gave them the opportunity to do so (e.g., **"Is there anything more about the Mixteco community and mental health treatment and services that we did not mention that you want to share?"**).

Domain 7: Evaluation and Recommendations

This final set of open-ended questions asked about evaluation methods that were appropriate to the Mixtecos and criteria that would represent successful program outcomes (e.g., **"What can we recommend as effective evaluation approaches to assess the recommendations implemented in Mixteco communities?"**). We are interested in community-defined evaluation approaches that engage the community and that demonstrate stakeholder accountability.

Key Findings and Discussion

For this portion of the report, we discuss key findings and overarching themes that emerged from the group interviews. These themes represent the topics that the Mixteco participants prioritized as areas of most importance.

Quantitative

Descriptive statistics were used to describe the demographic characteristics of the Mixteco participants. In particular, we focused on six key features of the population, their gender, their education level, their birthplace, their region of Mexico, their indigenous identification, and their preferred language. Our data revealed that these six features shed light on the mental health problems of the Mixteco population.

DEMOGRAPHIC CHARACTERISTICS OF MIXTECO PARTICIPANTS

- Elementary and middle school (42.4%) was the highest educational level, followed by high school (27.3%), and no school (24.2%).
- The participants were born in Mexico (91.8%) with Oaxaca as their birthplace (86.4%), and 73.9% self-identified as Mixtecos.
- Indigenous participants reported multiple languages comprising Mixteco (47.5%), Spanish (40.4%), English (9.1%), and Zapoteco (3.0%).

The youngest participant was 13 years of age and the oldest 72; the average age was 33.85. The majority of the participants self-identified as a member of one of these six groups: (1) family member, 24.4%; (2) person with interest in learning more about mental health, 24.4%; (3) youth and young adult, 21.8%; (4) promotor/a and educator, 9.8%; (5) consumer and person with a mental health condition, 9.8%; and (6) student, 9.8%. Exhibit 1 shows the gender and education level of the Mixteco participants. Overall, these demographics were similar in both sessions.

More females participated compared to males. The over-representation of females is consistent with findings from our previous study on the general Latino population (Aguilar-Gaxiola, 2012). This gender difference agrees with one key finding on gender roles indicating that females are more likely to attend these types of meetings than do their male counterparts. That is, mothers/females tend to be more concerned with community and school activities

(e.g., meetings, workshops, volunteering). On the other hand, fathers/males are more concerned with work-related activities and providing for the family. The female participants identified gender roles as a contributor to the lack of awareness and education about mental health issues.

Exhibit 1. Gender and Education Level of Mixteco Participants

	November, 2014 (n = 36)		February, 2015 (n = 30)		All Participants (n = 66)	
	n	%	n	%	n	%
Gender						
Female	20	55.6%	21	70.0%	41	62.1%
Male	16	44.4%	9	30.0%	25	37.9%
Total	36	100.0%	30	100.0%	66	100.0%
Education Level						
Elementary/middle school	15	41.7%	13	43.3%	28	42.4%
High school/high school graduate	10	27.8%	8	26.7%	18	27.3%
No school/less than elementary school	9	25.0%	7	23.3%	16	24.2%
Post-secondary school	2	5.5%	2	6.7%	4	6.1%
Total	36	100.0%	30	100.0%	66	100.0%

The highest level of education completed by the majority of the participants was elementary and middle school (grades K-7). It is also very likely that many of these participants completed their secondary schooling in Mexico. It is common for Mixteco immigrants to come to the United States with a low education level. Although education is a valued commodity, when it comes to the livelihood of the family and household, education is not the priority. This is also the case with the children of Mixteco immigrants, who are often expected to miss days of school to work in the field to help support the family. After missing too many days of school, many youth indicated that motivation to finish school was difficult to achieve, which for some led to stress and depression (Aguilar-Gaxiola et al., 2012).

There was agreement among the participants that a lack of education can also contribute to their limited job opportunities, inadequate resources and lack of knowledge about mental health treatment. One shared the observation that the Mixteco community is "…close-minded within our culture because many of us do not know . . . we live in isolation . . ." Another participant suggested that more be done to increase the educational pathways for Mixteco youth so that they can benefit from an education and career to change their parents' mindset.

The participants were mostly born in Mexico with the majority being from the state of Oaxaca (see Exhibit 2). The results from this table support our earlier claim of focusing on Mixtecos from Oaxaca who are current residents of Ventura County, California. Although the current study represents a significant contribution to the literature about the mental health status of Mixtecos, it also has limitations in our ability to generalize these findings to other indigenous groups from Mexico and from Central America.

Exhibit 2. Birthplace and Region of Mixteco Participants

	November, 2014 (n = 36)		February, 2015 (n = 30)		All Participants (n = 66)	
	n	%	n	%	n	%
Birthplace						
Mexico	34	94.4%	22	88.0%	56	91.8%
USA	2	5.6%	3	12.0%	5	8.2%
Total	36	100.0%	25	100.0%	61	100.0%
Mexico Region						
Oaxaca	30	83.3%	27	90.0%	57	86.4%
Sinaloa	3	8.3%	0	0.0%	3	4.5%
Guerrero	1	2.8%	1	3.3%	2	3.0%
Other	2	5.6%	2	6.7%	4	6.1%
Total	36	100.0%	30	100.0%	66	100.0%

The indigenous identification and language of the participants are shown in Exhibit 3. Over 70% of the participants identified as Mixteco. Moreover, the majority of the participants also spoke a Mixteco dialect, often differentiated as “Mixteco bajo,” or “Mixteco alto.” Spanish was the second language spoken by the participants. Fewer than 5% of the participants indicated English as their spoken language. Given the evidence from this report and our previous study, the lack of interpreters combined with language barriers contribute to the treatment gap described earlier. One Mixteco-speaking participant noted the communication difficulties when seeking services in general “because we are limited in Spanish, we talk more Mixteco than we do Spanish and . . . services only exist in English.” Another reported that communicating with the health providers can be difficult and stressful because of the language barrier. The Mixteco community is less likely to seek services if in their first interaction with a mental health clinic they encounter difficulties communicating with staff and completing paperwork that is not in their language. A critical implication here is the value of a Mixteco-speaking workforce. In other

words, speaking the language of the Mixteco individual is a key aspect of mental health treatment.

Exhibit 3. Indigenous Identification and Language

	November, 2014 (n = 36)		February, 2015 (n = 30)		All Participants (n = 66)	
	n	%	n	%	n	%
Indigenous Group						
Mixteco	28	77.8%	21	70.0%	49	74.3%
Indigena	6	16.7%	7	23.3%	13	19.7%
Zapoteco	2	5.5%	0	0.0%	2	3.0%
Latino/a	0	0.0%	2	6.7%	2	3.0%
Total	36	100.0%	30	100.0%	66	100.0%
Languages*						
Mixteco	25	44.6%	22	51.2%	47	47.5%
Spanish	23	41.1%	17	39.5%	40	40.4%
English	5	8.9%	4	9.3%	9	9.1%
Zapoteco	3	5.4%	0	0.0%	3	3.0%
Total	56	100.0%	43	100.0%	99	100.0%

Note: *Participants were allowed to select multiple languages.

Qualitative

A qualitative approach was used to obtain the emergent themes and subthemes that follow. The emergent themes and subthemes captured the essence of participants' views, attitudes, and experiences related to mental health care. The data analysis revealed 10 overall themes that were common among the participants:

This section highlights these 10 overarching themes and connects them with a few selected quotes from the participants' group interviews. The 10 themes are represented within one of the five inequity issues (i.e., accessibility, availability, appropriateness, affordability, and advocacy).

THE ACCESSIBILITY TO MENTAL HEALTH CARE

- The lack of information and understanding of the mental health system was considered a significant factor contributing to limited or no access to care.
- Many barriers to access, stigma and fear, discrimination within the group, and Mixteco culture and language were also viewed as common barriers to access to care.

Theme 1: Lack of information and awareness. The majority of the participants emphasized the lack of information about issues and services related to mental health. Responses, such as, "We will not go because we don't know of these illnesses . . . if I have problems that I am sad . . . I don't see it as an illness," were commonly expressed when Mixteco participants reported on the reasons for not accessing mental health services. Another person emphasized that the clinics have to do more to educate the community about mental health problems, ". . .they have to teach us what are those problems that they are talking about . . . If they are mental health problems, then what are the services available for us, so that we know and we can go [for help]?" Another person noted, ". . .there is plenty of help here [California], it's just a question of knowing where . . . when you get here and you don't know where, then you remain the same. It is very important to know where to find the help."

Theme 2: Stigma and fear. Stigma manifests itself in the form of fear of violence and shame, ". . . many of us do not speak up because we are afraid . . . or because we are threatened by our partner . . . or because of shame," stated one participant. Mixteco women in particular may be unwilling to talk about mental health or seek help because their husbands threaten them and are shamed by others in the culture for talking about mental health. One Mixteco mother described her fear and frustration of not being able to seek help for her child because of the threats from her husband:

> *Many of us do not know or we do know, but we are afraid to speak . . . as women we live with someone who says 'if you say something or do something, I will kill you,' and there are the threats . . . We women are afraid to talk or seek help to get ahead . . . Within our culture in Oaxaca, we grew up the same way with our fathers . . . if we didn't do something, we got a beating . . . And this is why the fathers start getting violent against the mothers or . . . with the child and this is how the child is learning the same thing that we learned in Oaxaca . . . Many of us will not dare to talk or speak up of what we live through or our living conditions, really, because we are ashamed and afraid to do so.*

This traumatic experience of fear among Mixteco women for talking about mental health or seeking access to services for their children reinforces the stigma and fear associated with mental health problems that is passed down from generation to generation. One female participant noted that cultural beliefs are often used to explain the violence, trauma, and mental health problems. Discrimination within the group associated with being indigenous and immigrant was also cited as a barrier that prevented Mixteco individuals from accessing and utilizing mental health services. Being called derogatory names, such as "indio" and "Oaxaquita," or harassed about getting deported by their U.S.-born Mexican counterparts was upsetting and led to feeling insecure and withdrawn from society. One youths' comment exemplified this experience that prevented him from seeking services:

> *They [U.S.-born Mexicans] are not kind, they have no patience . . . since we don't speak English or . . . I don't know how it is in other places, a lot has to do with how they look at you. I have noticed that the Americans . . . treat us better than our own people . . . Latinos treat us worse [are more prejudice] than the Americans.*

Our data also revealed *machismo and exposure to violence* as a subtheme of stigma and fear. The majority of the female participants reported a lack of participation from the fathers in activities related to mental health treatment or education. One participant reported that when her son was having issues at school because of the violent treatment from the father, she suggested therapy, and the father refused, threatening her with more violence. "For the father of my child . . . getting therapy is to be crazy. He says no, 'I am not going to allow my child to go to therapy. My child is not crazy . . .'" added the female participant. However, it is important to note and caution that this negative male characteristic of a segment of the Mixteco community does not reflect all Mixteco males and fathers. There are male role models in leadership positions that are working toward bettering the lives of indigenous communities and advancing their social and economic stability.

Theme 3: Mixteco culture and language. The Mixteco culture was also seen as a barrier that influences the ways in which individuals interpret seeking mental health services. For example, one participant expressed her frustrations with Mixteco individuals refusing to attend meetings, workshops, or trainings on mental health care, saying, "I see people, or our [Mixteco] people, as if they don't want to go, or they make light of it and don't want to participate, and this is what sometimes frustrates me because to me, if they are inviting you, it must be for your own good. I

think so . . . but there are many of our people that don't think like I do." Participants suggested that as a culture, Mixtecos do not have a lot of knowledge about mental health, "so then what can we do so that they can come out of this . . . unlock that [cultural] space that is impeding them so that they may take a step forward and say, 'I want to be involved in the community' or 'I also want to help with this [effort]'." One participant attributed her lack of participation in community events that inform people about mental health services to a lack of culture that promotes community integration. As a Mixteco culture and community she says, "we have to become more integrated . . . sometimes we don't have the information that we need . . . there are a lot of indigenous people that don't know how to speak Spanish or how to find help."

The participants also expressed language as a major barrier associated with accessing mental health services. Because many Mixteco individuals do not speak Spanish, and the term mental health does not easily translate into their indigenous language, it becomes difficult to detect and put into words what they are feeling in a mental health context. Overall, our data revealed that the Mixteco community does not have specific words that define or describe "mental health" or "mental illness." For example, one participant said, "We do not have a word or a specific response that says this is mental health, and we still have not defined it, so then we are learning that it is a . . . person that is completely crazy . . . in Mixteco there is no one direct word that defines mental health."

THE AVAILABILITY OF MENTAL HEALTH CARE

- The lack of a mental health professional that is familiar with the Mixteco communities. For example, lack of interpreters that speak and comprehend the language of the community.
- Social and systemic barriers related to treatment and services, such as poor living conditions, inadequate transportation and work schedule, long waiting times and treatment hours of service are not aligned with work schedules.
- The lack of school-based mental health programs to serve Mixteco youth struggling with a mental health problem.

Theme 4: Shortage of workforce. The lack of an indigenous workforce available to serve Mixtecos was an issue that the participants discussed. Many participants voiced their reluctance to seek mental health services to the lack of Mixteco-speaking mental health providers. One participant emphasized, "We need more people that speak . . . like us indigenous persons. We need to be spoken to in our own language." Another participant

expressed her frustration with having to wait a long time to get an appointment because the clinic did not have someone who could speak Mixteco:

> *I called and they told me they would be able to help him [my son], but then they told me they would call me back in 30 days to notify me if they were going to help my son get therapy. . . I then started calling several places, and I have been told that they have a long waiting list, so they don't know until when they will take him in.*

Many participants also described their unsatisfactory experiences with the lack of well-trained interpreters who were not able to relate to their Mixteco culture and their life experiences. One participant who experienced this frustration said, "[For] Mixteco people who do not know how to read, it would be better if they receive information in their language so they can understand." For example, a participant described his views about the need for interpreters:

> *We have to find people that have an adequate understanding of our community and have more interpreters. Educate the people who do work with our community to teach them to have more patience and professionalism, to know how to communicate with our indigenous people, and be well trained to work with our community. . . Increase the participation of our Mixteco community . . . Improve the quality of interpreters for people who speak Mixteco [dialects] . . .*

The lack of available Mixteco workforce also means long waiting times and conventional treatments. "Now that I am sick, and I don't want to go to the doctor because they don't do anything for me . . . Seriously, it's a waste of my time – two or three hours in the waiting room, then the doctor tends to you and he says that everything is normal and they turn you back," said one participant who was frustrated with a lack of Mixteco providers that could do more than just a routine examination.

Theme 5: Social and systemic barriers. The majority of the participants described the salience of time and resources in their decisions to seek and utilize mental health services. One participant illustrated her own experience stating, "You just lose time . . . waiting two to three hours in the waiting room, they see you and tell you that everything is normal and they send you back. . . They need to tend to us much quicker and do it with kindness . . . if people are to return for treatment, they need to treat us well and not make us wait too long." Low-income Mixtecos with little resources work long hours and cannot afford to take time off from work to seek care.

This finding is consistent with our 2012 study (see Aguilar-Gaxiola et al., 2012) that indicated mental health providers must make services available based on Mixtecos' work schedules and not make them wait hours, days, weeks, or months for their appointment. Along similar lines of making mental health services readily available, one participant described inadequate transportation from the agencies as another formidable barrier to treatment, and "have a schedule that is more appropriate for people who work [long hours] in the fields."

Theme 6: Lack of school-based programs for Mixteco youth. The youth participants verbalized the anxiety most evident in immigrant indigenous children who are at greater risk of stress and discrimination that, when undetected, leads to mental health problems. Overall, our data on youth are consistent with our previous study (Aguilar-Gaxiola, 2012) in that such risk factors associated with mental health problems can be tied to the lack of school-based programs. One Mixteco youth said, "I think that . . . schools should allow children that are new arrivals . . . this country . . . to speak Mixteco . . . so that they can be well socialized . . . and they can say, 'well here I do feel understood. I am well here.'" Another youth participant shared a friend's experience in schools that do not support both culturally and linguistically:

> *I had a friend when I was in middle school and he was indigenous . . . he spoke Mixteco, and he would come to school and I began to noticed his seriousness . . . He didn't know any Spanish or English . . . the teacher made an effort to help him learn Spanish and English . . . He seemed frustrated that he could not understand Spanish or English . . . He felt stressed and scared because there was no support in school, or someone he could talk to in his language . . . it is then when he needed another young man with knowledge of his culture . . . a peer that could guide him . . . schools need to have more persons that can speak one's indigenous language. I last saw my friend in the summer working as a farmworker in Salinas . . . that's the last time I saw him.*

Thus, findings are consistent with our 2012 study in which Latino youth participants indicated that failing to make programs available to address the risk factors that youth experience in their schools and communities will eventually lead to more severe outcomes, including substance abuse and/or suicide. One parent indicated that she had always wanted to return back to Oaxaca and not have to worry about time and money, "back home," she says, "if you did not have money to buy [food], you always knew that the farm would provide you with food," but then as their lives developed and their children became older, life in the United States became more routine and stressful:

> *We worked long hours in the fields that I hardly got to see and spend time with my little children . . . I only saw them in the wee hours of the morning when I would wake them up and get them ready to be dropped off with a relative . . . I would always worry about their well-being while I was working out in the fields . . . then when I picked them up in night, most of the time they were already asleep, so there went another day without spending time with them . . . so that became my daily stressful routine.*

Another parent shared this sentiment:

> *Our children here do not have the attention they need. . . On the other hand, back in our village [in Oaxaca], our children help out with farming and caring for the animals. We are all active and together, but here families get divided. . . That is a big problem here in that the family is divided and we find ourselves inside a machine that goes too fast.*

These two statements expressed the concern that often becomes the priority in the lives of the Mixteco community. This also speaks to the treatment gap in that mental health services can be made available to help these parents deal with these various stressors before they become more severe, but they may still not utilize them. To ensure that individuals will access services that are available to them, we must also give serious attention to helping them better manage these life stressors.

THE APPROPRIATENESS OF MENTAL HEALTH CARE

- The lack of culturally and linguistically appropriate services for a diverse Mixteco population is critical to mental health treatment that is suitable to each indigenous community.
- The recognition and appreciation for Mixtecos' use of traditional (cultural) treatments and remedies are vital to their access to treatment and compliance.

Theme 7: Culturally and linguistically appropriate services. The lack of culturally and linguistically appropriate mental health services (e.g., language and culturally proficient) can discourage many Mixtecos with mental health problems from seeking treatment. This theme is highlighted in the following statement:

> *Whoever works with the Mixteco [community] has to be trained in the Mixteco culture to make their [provider's] work relevant and useful. If not, then [the provider] will assume that the [Mixteco] people are no good . . . for them [providers] to know. . . to prescribe good treatment, they have to know the culture.*

The participants believe that hospitals and clinics are not equipped with the appropriate workforce and resources to help the Mixteco communities. Participants stressed the importance of having a person or persons that can speak the Mixteco dialects in a way that the information is understood and free of misunderstandings. "More interpreters . . . many times the text on the paperwork says a lot, but if the staff that is giving you this paperwork does not know that this [Mixteco] person can't read, and the staff just hands it to the Mixteco, that is also an obstacle . . . it's important that they [staff] can clarify a bit more."

Many participants described their unsatisfactory experiences with the interpretation procedures, including interpreters who were not able to related to their life experiences. One participant noted, "I recently discovered that agencies . . . have interpreters, who realistically aren't interpreters, or they know a few words in Mixteco and they consider them interpreters. . . They are not going to give a good interpretation for us who speak Mixteco." This statement expressed personal expectation of appropriate cultural and linguistic services that are aligned with the Mixteco consumer's historical background. As illustrated by the quote below, a participant recalls a situation when he witnessed a medical doctor having a hard time understanding a Mixteco-speaking woman describe her symptoms and the confusion that both were experiencing during the interaction:

> *I got to see a [Mixteco] woman in the clinic and she needed help to describe her symptoms . . . and there were no interpreters there to interpret what the [Mixteco] woman was saying . . . [she] didn't know how to tell the doctor what was hurting . . . the doctor was trying to guess . . . what the Mixteco-speaking woman was saying . . . and like that, so how was [the doctor] going to prescribe what the indigenous woman really needed?*

Another participant reacted to the above statement emphasizing the need to have more interpreters that are familiar with the Mixteco culture and able to comprehend the various Mixteco dialects. "We need more cultural interpreters that can understand us and help us . . .

as we just heard, the doctor was simply guessing and will most likely give her [Mixteco woman] an inaccurate diagnosis and prescribe the wrong medication."

Theme 8: Recognition and appreciation for traditional treatments. As was reported in our previous study (Aguilar-Gaxiola et al., 2012), like Latinos, Mixtecos consider *curanderos* [folk healers] and *sobadores* [masseurs] culturally appropriate and effective treatments. "Cultures that have existed for many years practice *curanderismo* . . . its something well known in the Mixteco community . . . the Mixtecos, instead of going to a doctor, prefer to go to a *curandero* to get cured." Another participant stated:

> *The most important thing is to know exactly what problems exist within each [Mixteco] community, because the truth [is] from where we come from. . . [we] have different customs, different histories. . . Interactions with our Mixteco communities [is important] to know what is affecting each community. . . What affects each community is not the same. There is diversity in our indigenous communities . . . each of our communities have different needs.*

The above statements reinforce the notion that Mixtecos are not a homogenous population but rather a heterogeneous population that speaks different dialects in Mixteco and have lived experiences that are unique to their town or *pueblo* in Oaxaca.

THE AFFORDABILITY AND ADVOCACY TO MENTAL HEALTH CARE

- The scarcity of resources and poor living conditions were reported to negatively impact Mixtecos' access and utilization of mental health services.
- The absence in advocacy unity and a unified voice to increase Mixtecos integration and participation in community life.

Theme 9: Scarcity of resources and living conditions. Participants cited difficulties related to poverty, cost of living, and food for their families, simultaneously, as contributors and burdens to mental health. In particular, many participants reported that they experience a significant degree of anxiety related to providing food and housing for themselves and their families. Because Mixtecos had to focus on working to provide the basic necessities of life, they frequently did not have the time or resources to obtain mental health care. One participant indicated the problem of not having health care insurance, "It's a problem that we have to go to the doctor – again we are going to spend money and no insurance – the cost is expensive."

Illustrated by one participant's economic status:

> *Everything comes down to the system. . . and it has to do with mental health. . . So, in part it is a systemic problem . . . they raise your pay and the cost also goes up, so it is pointless . . . we have to make changes in the entire system because it is very difficult. . . We need voices, it's important that we unite together to form a voice, to form a force to make changes.*

Theme 10: Absence in advocacy and unity. Overall, participants described the need to unite the Mixteco voice and the need for a platform to give value to the contributions and assets of the Mixteco communities. One participant defined her own value in her artesian work, stating, "The things that we do for people have no value, they don't value our labor . . . and the truth is that it is sad that they do not value what we do because it doesn't have a label. That is why offering workshops so that we can see what we are capable of doing and help each other with what we can do, come together as a community. . . be united. More workshops to learn how to make things that are important to our community." The lack of community integration and participation is attributed to a lack of a platform to come together and unite as a force to create change. One participant emphasized that MICOP "is an organization where we can all unite; it is a platform to be able to continue educating ourselves and our communities. MICOP. . . has done a lot not just for Mixtecos, but for Zapotecos and other indigenous populations, and [MICOP] is an organization that we should all be participating in, given that they provide many informational workshops that can be helpful to our indigenous communities."

Strategic Directions and Recommendations for Reducing Mental Health Disparities for Mixteco Communities

These five strategic directions and recommendations serve as guiding principles to promote and enhance the ability to identify community-defined promising practices, increase access and utilization of quality services, and improve treatment outcomes and quality of life for Mixtecos.

Strategic direction 1: Empower the Mixteco community and increase their participation in the decision-making process

Develop and implement mechanisms to engage the Mixteco community in implementing solutions that come from this report. This includes recognizing MICOP as a best practice and funding their efforts to serve the Mixteco population and other indigenous groups in California.

Recommended actions at the local and state levels

1.1 Increase the participation of Mixteco males and fathers. One Mixteco female indicated that even though her husband does not physically attends events, he gets informed through other forms of community media (e.g., *fotonovels* or media booklets about community issues), and he has become more open and understanding of her involvement and participation in meetings. However, this is not the case for all Mixteco women.

1.2 Provide workshops and community conversations (i.e., *pláticas*) in the community for Mixteco men that are conducted by other Mixteco men who are deeply invested and active participants in the indigenous communities. These educational workshops conducted in a safe setting will help to address stigma associated with mental health and other issues related to domestic violence and trauma.

1.3 Increase community-based activities and commitment to community. Sponsor community activities that give people a purpose and enjoy the activity at the same time. Participants recommended activities, such as pottery and arts and crafts, music and dance, and community garden. These activities were also important to one's mental health in that people feel connected and a sense of belonging.

1.4 Enhance community engagement activities that can easily help to build stronger linkages and trust between the Mixteco community and the mental health institutions. Participants

cited mistrust as a reason for not accessing and utilizing mental health services, even though they are in proximity.

Strategic direction 2: Increase culturally and linguistically appropriate treatment for Mixtecos

The goal is to provide care and treatment that is appropriate to Mixteco communities. To achieve this, it is important to communicate with members from each indigenous community in a way that acknowledges their beliefs about mental health.

Recommended actions at the local and state levels

2.1 Employ *promotoras/es* from within the Mixteco community. Ensure that in every clinical or hospital setting there is a person who not only speaks Mixteco, but also has a deep understanding of the Mixteco community and mental health issues so that this person serves as a role model to the Mixteco community. Implement a "train-the-trainer" approach in that by training established promotoras/es, they can now help to train other promotoras/es and community leaders.

2.2 Increase the number of interpreters that are proficient in various Mixteco dialects and Spanish and English. It is important to work with hospitals and clinics to recognize authentic Mixteco translation. A person that only knows a few words in Mixteco is not an authentic or appropriate interpreter for this population. What is needed, are translators and interpreters that understand the Mixteco language from an oral to a written form within a cultural context.

2.3 Provide training and education to non-Mixteco health providers and staff in hospitals and clinics who come in contact with Mixtecos. It is important that staff recognizes and respects the Mixteco cultural remedies and practices used to treat illnesses. Encourage providers to become familiar with these remedies and practices and, when prescribing a treatment, to combine these indigenous practices with traditional medication. This has the potential to build provider-consumer trust.

2.4 Define mental health using the indigenous dialect most appropriate for that group. It is important that the correct words are used to avoid offending members of the Mixteco community and exacerbating stigma associated with a mental health disorder. To start, Mixteco participants recommend the words "bienestar emocional" or "emotional wellbeing."

Strategic direction 3: Prevention and early intervention and Mixteco youth

Earlier, participants voiced their fears of youth feeling embarrassed about their indigenous culture and language. Also substance use (alcohol and drugs) is increasing among Mixteco youth. The strategy is to work with schools and train teachers about the culture and ways to detect early signs of mental health disorders.

Recommended actions at the local and state levels

3.1 Increase advocacy efforts and programs in schools to ensure accurate and early detection of mental disorders among Mixteco youth as a strategy to change the course of a potential mental health disorder, as well as to avoid possible misdiagnoses that may result in mistreatment and high dropout rates.

3.2 Work with school administrators and leaders to develop a plan to create and integrate mental health and substance use educational standards and topics into the schools' curriculum.

3.3 Develop and offer parenting classes or seminars to educate Mixteco parents about the educational system, and to increase their awareness of available free or inexpensive educational and mental health services.

3.4 Increase school-based mental health programs in schools with a Mixtecos population, and provide interventions aimed to decrease the risk of drug and alcohol use, and mental illness.

Strategic direction 4: Workforce development

Develop and sustain a culturally and linguistically competent mental health workforce consistent with the culture and language of Mixteco communities. Also, establish a college and career pipeline model in schools to interest Mixteco youth in pursuing careers in the mental health field.

Recommended actions at the local and state levels

4.1 Employ promotoras/es from within the Mixteco community and provide the necessary training about mental health and strategies to increase access and utilization for those that suffer from a mental health disorder.

4.2 Connect schoolwork and work experience with social and economic aspirations to encourage Mixteco youths' interest in the mental health workforce. This can ensure an effective pipeline of culturally and linguistically trained individuals entering the mental health workforce and not the pipeline to prison.

4.3 Increase school workforce pipeline programs that include career pathway academies, associate degree and certificate programs at community colleges, as well as other educational and career-related curricula for Mixteco youth.

4.4 Increase opportunities for Mixteco elders who are willing to volunteer (or work for pay) help translate in Mixteco. What makes this recommendation unique is the lived experiences and language proficiency of these elder Mixtecos. Age should not be an issue. This also gives the elder Mixteco community a sense of purpose and minimizes their risk of depression and, in some cases, suicide.

Strategic direction 5: Establish a Mixteco Concilio that operates from MICOP

Provide funding to MICOP, an already established organization reaching thousands of indigenous people using grassroots strategies. Working through MICOP, the following can be achieved: (1) strengthening their outreach program to engage Mixtecos and other indigenous groups that continue to be disengaged from community life; (2) building mental health leadership in the Mixteco community through training and education; (3) defining mental health in a way that is understood and in terms that matter to the Mixteco community without tweaking or ignoring their dialects; and (4) building local capacity aimed at reducing the treatment gap and improving mental health outcomes for the Mixteco and other indigenous communities.

Recommended actions at the local and state levels

5.1 Establish a partnership with MICOP to identify Mixteco leaders who are committed to play an active role in advocating and implementing solutions found in this report. Also, in preserving the cultural traditions, language dialects, and community structures from which it was formed. For example, valuing the agricultural work performed by the Mixteco community, and value for their artistry (e.g., weaving, wool and cotton woven textiles, pottery, baskets, etc.)

5.2 Provide support to MICOP to work with adults, young adults, and children who suffer from trauma after making the long trip from Oaxaca to the United States. Trauma from border crossings can increase post-traumatic stress and fear in Mixtecos immigrating to the United States.

5.3 Work with MICOP to evaluate the influence of these five recommendations for the Mixteco population. Design data collection procedures that are in line with the Mixteco communities, and implement an evaluation design in a way that analysis of the data leads to meaningful outcomes for the Mixteco population.

5.4 Recognize MICOP as a best practice that: (1) engages in capacity building and consciousness rising; (2) raises public awareness about mental health issues in the indigenous communities; (3) engages in community outreach to increase knowledge about health and mental health; (4) increases access to resources pertinent to Mixteco's social and economic mobility and eventually well being; (5) creates opportunities for the Mixteco community to explore new and better ways to engage those that have been excluded or not accepted because of their views or group identity (e.g., sexual orientation); (6) has proven to be an evidenced –based practice for Mixteco and other indigenous populations; and (7) possesses a reputation that the Mixteco community can relate to and trust.

Conclusion

The conclusion summarizing the socioeconomic exclusion that the Mixteco population that continues to endure when it comes their fully participation in community life in accessing and utilizing mental health services are is provided in this section.

The current mental health system treats the Mixteco population as a homogenous Latino group and not as it own unique heterogeneous indigenous culture. Henry Villanueva, the quality assurance manager for Ventura County Behavioral Health Department argues that, "the behavioral health system…has failed to address the behavioral health needs of the Mixteco population because they [system] have a norm that all Latinos [including Mixtecos] are a homogenous group." The issue he continues "is not recognizing the Mixteco and other indigenous populations as its own community (personal communication, March 11, 2015)." Failure to treat the Mixteco and other indigenous groups as their own unique culture with culture-specific priorities will continue to alienate them from decision-making opportunities that can lead to changes to their living conditions and mental health.

As we highlighted in our 2012 *Community-Defined Solutions for Latino Mental Health Care Disparities* report, and continue to stress in this report, systemic solutions must go beyond the conventional "well-intentioned" solutions that lead to more of the same failures and disparities. Our call to action is for the system to focus its efforts on building capacity along side the Mixteco communities and growing leaders from within the culture. That is, new leaders that emerge from the underserved indigenous communities must replace the "well-intentioned" systemic programs and leaders who fail to serve the Mixteco and other indigenous communities. Borrowing from Paulo Freire (2000), "People are fulfilled only the extent that they create their own world and create it with their transforming labor (p. 145)." If the 2004 MHSA and the 2009 CRDP are to transform the system from the business-as-usual ways and achieve their principal aim, to eradicate mental health disparities among underserved communities, the solutions and strategies must by defined by the underserved community.

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APPENDIX A

Focus Groups Tool – Mixteco Communities

Introduction	Thank you for taking the time to share with us your views and stories of your community. This is an opportunity to share your views on mental health and disparities that exist in your community. Your comments are greatly appreciated, and all responses will be anonymous.
Background/ History	**1. How is it to be (or how does it feel) to be a member of your indigenous group?** **2. Why did you choose to Join MICOP?** **3. As Mixtecos in California, what does mental health mean to you?**
Barriers/ Stigma	**4. What can we do to reduce the barriers in access to mental health both as individuals and as a community?** a. What ideas do we have to reduce mental health stigma? b. How can we make sure that the workforce is appropriate for Mixtecos? c. How can we increase support from families and communities for Mixtecos? d. What suggestions do we have about mental health programs for Mixtecos?
Access to Programs and Services	**5. What can we do to improve the access to the mental health programs and services?** a. What ideas can we share on ways to improve access to existing mental health programs? b. What mental health programs can we suggest that have proven to be successful for Mixtecos? c. What ideas can we share on increasing the participation of the indigenous community in mental health treatment? d. What suggestions do we have on developing a workforce that is appropriate (education and training) to improve access to mental health programs for Mixtecos?
New Programs/ Modifications to Existing Programs	**6. What new programs and/or changes do we recommend to improve mental health services and increase the participation of the Mixteco community?** a. What ideas do we have on new mental health programs that should be offered to improve the participation of the Mixteco community? b. What are our thoughts on modifying existing programs to improve Mixtecos' participation? c. What mental health programs have proven successful in meeting the needs of Mixtecos?
New Programs/ Modifications to Increase Treatment Retention	**7. What recommendations do we have for new programs and/or changes on the delivery of services to enhance Mixtecos' retention in mental health treatment?** a. What can we do to improve the retention of Mixtecos in mental health treatment? b. How can we change the mental health programs that exist to improve treatment retention for Mixtecos? c. What new programs should be offered to improve Mixteco's retention in mental health treatment?
Recommendations (***Successful results from treatment***)	**8. What recommendations do we have for new programs and/or changes in services that exist to improve the outcomes of Mixteco's mental health treatment?** a. What are our recommendations on how we can modify existing programs to improve the outcomes of mental health treatment for Mixtecos? b. What are our recommendations on new programs to improve the outcomes of mental health treatment for Mixtecos?
Evaluation and Recommendations (***Quality of programs***)	**9. What can we recommend as effective evaluation approaches to assess the recommendations implemented in Mixteco communities?** a. What are our recommendations on how to assess the quality of mental health for Mixtecos? b. What are our recommendations on how to evaluate the interventions for Mixtecos? c. What are our recommendations on how to evaluate programs that cater to the Mixtecos?
Other Questions	**10. Is there anything more about the Mixteco community and mental health services that we did not mention that you want to share?** **11. Is there a program or type of mental health services that you can recommend to us?**

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