



Latino Adolescent
Migration, Health,
and Adaptation

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Latino Immigrant Parents: Accessing Mental Health Services for their Adolescents

Final Results

**Krista M. Perreira, PhD
Department of Public Policy**

**Catinca Bucsan
Department of Public Policy**

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Catinca Bucsan



UNC
CAROLINA
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CENTER

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ABOUT THE AUTHORS

Catinca Bucsan (BA in Public Policy, UNC-Chapel Hill) is a Research Assistant at the Carolina Population Center at UNC-Chapel Hill. She will be attending the UNC Gillings School of Global Public Health in 2011 to pursue a Master of Healthcare Administration.

Krista M. Perreira (Ph.D. in Health Economics, U.C. Berkeley, 1999) is an Associate Professor in the Department of Public Policy at UNC-Chapel Hill and the Principal Investigator for the Latino Adolescent, Migration, Health, and Adaptation Study. Her research focuses on the relationships among family, health, and social policy, with an emphasis on racial disparities in health and education. Please refer questions about this study to Dr. Perreira.

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SUMMARY

This final report focuses on immigrant Latino parents' usage of general health and mental health services for their adolescents. The adolescents of these Latino immigrant parents were between the ages of 12 and 19 and were enrolled in a high school or middle school in North Carolina between Fall 2005 and Spring 2006. We first provide an overview of individual characteristics for both Latino adolescents and their caregivers. We then describe immigrant parents' usage of health services for their adolescents and the factors which promote or hinder their use of these services.

- **Socio-economic Status.** As non-citizens with few years of residency in the US and low incomes, Latino immigrant families participating in this study were at high risk for mental health problems and the need for mental health services. Most adolescents were of Mexican origin (95%), had moved to the U.S. before the age of 13 (82%) and were not U.S. citizens (93%). Their parents had typically not finished high school and lived at or below the Federal Poverty Level (FPL) in 2006 (64%). Although they lived in poverty, only 9% of immigrant families received any support from public assistance programs such as the Supplemental Nutrition Assistance Program (SNAP) or the Temporary Assistance for Needy Families Program (TANF).
- **Physical and Mental Health.** Despite their poor socio-economic circumstances and the challenges of migration, most Latino adolescent immigrants (90%) and their parents (87%) reported good to excellent physical health. However, 31% of adolescents showed signs of sub-clinical or clinical anxiety and 18% showed signs of depression. These rates were higher than those reported among the full LAMHA sample and suggest that parents whose children had mental health concerns were more likely to participate in this study.
- **Health and Social Service Utilization.** The majority (62%) of adolescents had had a physical exam or had been to a health professional at least once in the past year. At the same time, few (4%) had received any mental health services or had been in contact with any social service providers in their communities (14%). Youth whose parents had lived in the US fewer than 5 years, had less than a high school education, and lived below the FPL received significantly fewer health or mental health services.
- **Structural Barriers to Health Service Utilization.** Nearly one out of every three parents and one out of every five adolescents did not have health insurance. Those without health insurance reported significantly lower health care utilization rates (59% vs. 75%). In order of their importance to participants, other barriers to health service use reported by parents included the ability to take time off work (70%) or school (87%), lack of information about health services (81%), cost of health services (73%), the limited availability of services in their community (43%), and a lack of transportation (19%). In many cases, these barriers were particularly acute for adolescents whose parents had

lived in the US fewer than five years, had less than a high school education, or lived below the Federal Poverty Level.

- **Linguistic and Cultural Barriers to Health Service Utilization.** Limited English skills and the lack of culturally competent providers in their communities also reduced the likelihood that parents would seek health care services. Eighty-five percent of parents reported that they or their children had difficulty communicating with health care providers. Moreover, when asked to rank the importance of having a provider that understood their language and culture, 61% indicate it was very important that providers speak their language and 47% indicated that it was very important that providers understand their culture.
- **Social-Psychological Barrier to Health Service Utilization.** One half of our parents expressed a reluctance to use mental health services because they were afraid of or uncomfortable interacting with medical providers, felt self-conscious about seeking support outside of their families, and worried about social stigmas associated with the use of mental health services. These concerns were more prevalent among less educated parents (89% vs. 67%) and among poorer parents (88% vs. 67%).

To improve health service use among Latino immigrant adolescents in North Carolina, structural barriers to health care utilization must be removed. Expansions in the availability of public health insurance and low-cost community health centers can reduce financial barriers to access. But, even in the absence of these expansions, these results suggest several strategies which can be utilized to improve access to care for immigrant populations. As discussed at the end of this report, community-based organizations and health care providers can work with Latino youth and their families to facilitate access and utilization of health services.

PROJECT DESCRIPTION

In North Carolina, the population grew 394% from 77,000 in 1990 to 379,000 in 2000 (U.S. Census Bureau 2001).¹ This growth created many new challenges for North Carolina's health and social service organizations. One area where resources and data were especially lacking was mental health. At a state level, Hispanics, advocates, and policy makers attending the March 2001 *El Foro Latino*, an annual discussion forum for Hispanics in North Carolina, identified mental health needs as a key concern for the Latino community. At the national level, the Surgeon General released a report identifying many of the barriers faced by Latinos and other minorities in finding, accessing, and utilizing mental health services (U.S. Department of Health and Human Services 2001). The report concluded with a call to action, saying that "...the National agenda can be informed by understanding how the strengths of different groups' cultural and historical experiences might be drawn upon to help prevent the emergence of mental health problems or reduce the effects of mental illness when it strikes."

In response to a lack of state and national data on the prevalence or etiology of mental health problem, researchers at UNC-Chapel Hill designed the Latino Adolescent Migration, Health, and Adaptation (LAMHA) study. The study aimed to: (1) provide prevalence data on mental health symptoms among first-generation Latino youth, (2) describe the characteristics of the community, school, and family contexts that affect the mental health of new immigrant youth, (3) describe the migration and acculturation experiences of immigrant Latino youth, and (4) explore parent and adolescent understandings of mental health and illness. After its initiation, the project was expanded with the aim of understanding barriers to accessing mental health services.

Results from the first stage of the project are summarized in the report, "Migration and Mental Health: Latino Youth and Parents Adapting to Life in the American South. (Perreira, et al. 2008). This report summarizes data from the second stage of the project on barriers to accessing mental health services. Overall, this project provides a foundation for the development of culturally-tailored interventions and the improvement of mental health services to Latino populations.

¹ Throughout this report, we will use the word "Latino" or "Hispanic" interchangeably to describe the population of interest. We recognize that this term spans a variety of cultural groups with different migration histories, cultural traditions, and needs.

METHODS

The LAMHA study collected data on a stratified random sample of 283 first-generation Latino immigrant youth ages 12-19 and 283 of their primary caregivers (mostly mothers) living in both rural and urban areas of North Carolina. First-generation immigrant youth were defined as youth born outside of the U.S. to foreign-born parents.² All youth participating in this study were enrolled in one of 18 middle or high schools randomly selected from 6 rural and 4 urban school districts with large and growing Latino populations.

In the main study, teens and parents were asked to complete an interview-administered survey which included questions regarding participants' demographic and socioeconomic backgrounds, parent's mental health, and youth mental health (Table 1). All questionnaire items utilized had been validated extensively with Spanish-speaking populations.

In a secondary study, parents were asked to participate in a survey of mental health service use patterns adapted from the Adolescent and Adolescent Service Assessment (CASA) (Ascher et al. 1996).³ A subsample of 166 parents participating in the main study agreed to complete the additional survey on mental health service usage.

Finally, qualitative interviews about migration and acculturation experiences were completed with 20 Latino youth and qualitative interviews about mental health beliefs were completed with 14 primary caregivers.⁴ In a preliminary pilot study for the LAMHA project, qualitative interviews with 20 Latino parents were also conducted. All data were collected between 2005 and 2006 and has been made available by the Carolina Population Center through a contract use agreement (see <http://www.cpc.unc.edu/projects/lamha>).

To review more details regarding the contents of the survey and the sampling design, please see an earlier report by Perreira et al. (2008).

² Youth born abroad to at least one U.S. born parent are U.S. citizens and are not included as first-generation immigrants.

³ Students and parents participating in the LAMHA study on access to care are a subset of those participating in the LAMHA study. Because data collection for this aspect of the study did not begin until 2005, the sample is not a fully random sample. Service use data were collected in 9 of the 10 participating school districts and 16 of the 18 participating schools.

⁴ The majority of qualitative interviews were conducted in Spanish. Interviewers translated and transcribed interviews. Dr. Perreira directed the adolescent interviews. She is fluent in Spanish and met weekly with interviewers on the adolescent interview team to review all transcriptions and translations. Though Dr. Chapman directed the health beliefs component of the study, Dr. Perreira also provided oversight of the transcription and translation of the health belief interviews with parents. These efforts help to ensure the integrity of the translations from Spanish to English.

Table 1. Contents of Caregiver and Youth Surveys

Factual Areas	
(1)	Age at entry
(2)	Length of time in the U.S.
(3)	Family structure and Family functioning (Familism and FACES)
(4)	Parent & child employment and education histories
(5)	Views of School
(8)	Migration Experience and Acculturation
Mental Health Measures – Youth	
(1)	Child Behavior Checklist (parent completed)
(2)	Youth Self-Report
(3)	Trauma Symptom Checklist for Children
(4)	Children’s Depression Inventory
(5)	Multidimensional Anxiety Scale for Children
(6)	Youth Reported Delinquency
Mental Health Measures – Caregiver	
(1)	Modified PTSD Symptom Scale
(2)	Center for Epidemiologic Studies- Depression Scale
(3)	PRIME-MD Clinical Depression Scale
(4)	K3 Psychological Distress Scale
Health Service Use Patterns for their Children – Caregiver	
(1)	Receptivity to Services
(2)	Perceptions of Barriers to Services
(3)	General Service Use

OVERVIEW OF STUDY PARTICIPANTS

Caregivers

Caregivers participating the LAMHA service use study were mostly mothers (79%) who had immigrated to the US five or more years ago (85%; Table 2). Consequently, most were not US citizens (98%) and only spoke Spanish (66%). Most also had less than a high school education (72%). These characteristics potentially limited their access to health services, their abilities to advocate for the needs of their children, and their abilities to communicate with health and social service providers.

Though their educations, citizenship status, and language skills potentially limited their access to health services, caregivers benefited from strong social support systems. The majority (75%) were married and nearly half attended religious services weekly. Most (60%) had also not experienced any separation from their children. Protracted separations can disrupt parent-child bonds in immigrant families and lead to family conflict when parents and children are reunited (Suárez-Orozco and Suárez-Orozco 2001).

Given caregivers limited economic means these social support systems helped to sustain immigrant parents and their families. The majority of the caregivers (73%) worked full- or part-time and over half also had a working partner (58%). However, their average monthly household income was only \$1,811 or approximately \$21,732 in a year. For a family of five (the average family size of participants in this study), the 2006 Federal Poverty Level (FPL) was \$23,400 (U.S. Dept. of HHS 2006). Thus, most participating families lived below poverty. In addition to supporting their household, caregivers also sent an average of \$112 a month (6% of their monthly incomes) in remittances to their families in Latin America.

Only a small percentage (9%) of the caregivers reported receiving any public assistance (e.g. TANF, SSI or food stamps). This low participation in public assistance is likely due, in part, to the 1996 welfare reforms that preclude immigrant groups from receiving assistance during their first five years of residence (Massey et al. 2002). Nevertheless, even in the face of significant economic constraints, about a fifth (22%) of the caregivers reported owning their home, typically a trailer.

Table 2. Selected LAMHA Caregiver Characteristics	%/Mean	N
Mothers answered the survey	79%	164
Caregiver's avg. age	40	162
Immigration and Acculturation		
Non U.S. citizen	98%	162
Speaks only Spanish in the home	66%	164
Total time in the United States		
Less than 5 years	15%	161
Five or more years	85%	161
Family Separation		
Never separated	60%	162
One month or more	10%	162
One year or more	30%	162
Social Support		
Caregiver is married	75%	163
Attended religious services weekly	49%	148
Educational Background		
Eighth grade or less	44%	164
Beyond 8th grade, no high school	28%	164
High school	15%	164
Vocational, trade, or business school	7%	164
Bachelor's degree	5%	164
Socio-Economic Background		
Caregiver works full- or part-time	73%	164
Both caregivers work full- or part-time	58%	147
Avg. Monthly Income	\$1,811	132
Avg. Monthly Remittances	\$112	156
Avg. Household Size	5	159
Receives Public Assistance	9%	164
Owens a Home	22%	163

NOTE: Ns are the total of students responding to a question. Missing values are present when students refuse to answer or don't know the answer to a question.

Adolescents

Reflecting national trends, adolescents who participated in the health service usage survey were from a variety of Latin American countries (Table 3). According to the 2000 U.S. Census (Guzman 2001), Latino immigrants were primarily from Mexico (59%) with smaller percentages from Central America or the Caribbean (24%) and South America (4%). In our sample, 85% of the students were from Mexico, 3% from South America, and 12% from Central America/Caribbean.⁵ The average age of participants was 14 years old.

Fifty-six percent of the Latino immigrant adolescents surveyed had lived in the U.S. for five or more years. Additionally, the vast majority of participants were not U.S. citizens (93%). Given residency requirements for citizenship, the short length of residency for this population may partially explain their low citizenship rates. Many of the adolescents had also entered the US without authorization, which would make securing citizenship unlikely.

Despite their citizenship status, the adolescents surveyed had begun to acculturate to life in the U.S. According to the Short Acculturation Scale for Hispanics⁶ (SASH) (Marin et al. 1987), 85% of students had high English language proficiency. This widespread proficiency with English reflected the fact that most (82%) moved to the US before their 13th birthday. Even though many had moved to the US at a young age, they maintained their Spanish language skills. Forty-one percent spoke only Spanish in their homes.

Like their parents, adolescents also had high levels of social support from living in two-parent families and participation in religious organizations. The majority, 70%, lived with both biological parents and 46% attended religious activities at least weekly. Relatively few (28%) had held jobs in the past year.

⁵ The data for the country from which the family immigrated was collected from the caregivers not the adolescents.

⁶ The Short Acculturation Scale for Hispanics includes 12 items related to three factors including language use, media, and ethnic social relations. We utilized the four language use items to measure low and high English language acculturation.

Table 3. Selected Youth Participant Characteristics	%/Mean	N
Boys interviewed	51%	162
Girls interviewed	49%	162
Average age of youth	14	154
Immigration Experience		
Immigrated from Mexico	85%	164
Immigrated from South America	3%	164
Immigrated from Central America/Caribbean	12%	164
Acculturation		
Non-U.S. citizen	93%	152
English language ability (SASH)		
High (score=8+)	85%	162
Low (score<8)	15%	162
Speaks only Spanish in the home	41%	162
Total time in the United States		
Less than 5 years	44%	162
Five or more years	56%	162
Age at arrival		
Before Age 6	31%	158
Six years old to twelve years old	51%	158
Thirteen years or older	18%	158
Social Support		
Youth lived with two biological parents	70%	161
Attends religious services weekly	46%	152
Socio-Economic Background		
Youth worked in past 12 months	28%	159

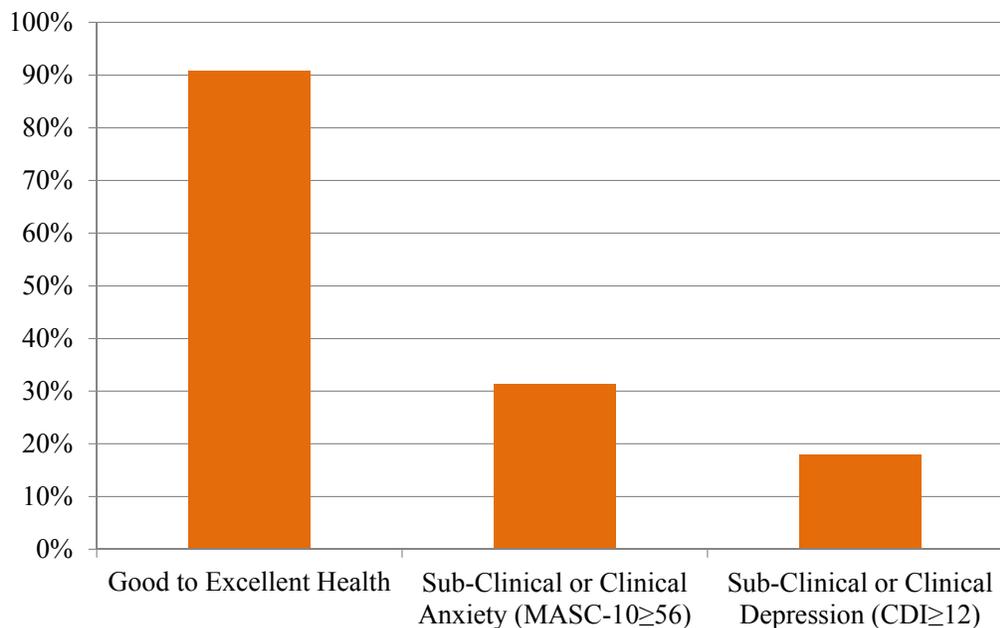
NOTE: Ns are the total of students responding to a question. Missing values are present when students refuse to answer or don't know the answer to a question.

ADOLESCENT AND PARENT HEALTH

To gauge their need for mental health services, we first examined the physical and mental health of adolescents and their caregivers. By and large, both adolescents and parents reported good to excellent health. However, mental health concerns were prevalent among the Latino youth who participated in this study.

Adolescent Health

Figure 1. Adolescent Physical and Mental Health



When asked, “In general, how is your health,” the vast majority of adolescents answered that they had good to excellent health (90%; Figure 1). Despite reporting good to excellent general health, many screened positive for symptoms of sub-clinical or clinical anxiety (30%) as well as depression (18%). These reports were based on two commonly utilized measurement instruments in adolescent populations --, the Multidimensional Anxiety Scale for Adolescents (MASC-10; March et al. 1997) and the Children’s Depression Inventory (CDI; Kovacs 1992). Reports of anxiety (29%) were similar in the full LAMHA sample but reports of depression (7%) were substantially lower (Potochnick and Perreira 2010). Thus, parents with depressed children were somewhat more likely to take part in the service use portion of the LAMHA study.

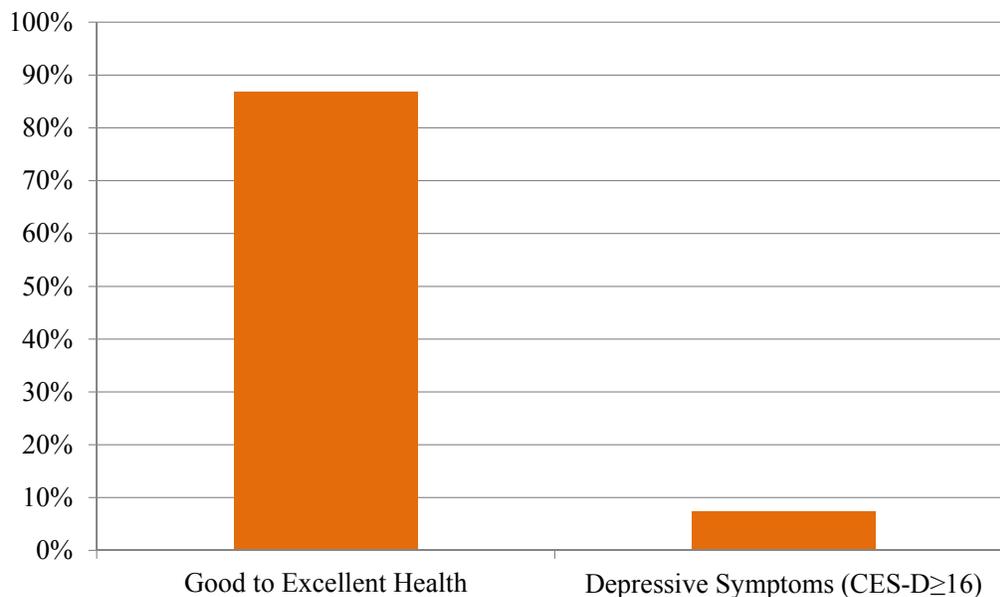
The health of children can be influenced by a variety of socioeconomic factors such as poverty status and parents’ education as well as access to physical and mental health services. However, we found no association between these factors and self-reported physical health, anxiety symptoms, or depressive symptoms among children. In research reported elsewhere (Potochnick and Perreira, 2010), we found that migration stressors (i.e. traumatic events, choice

of migration, discrimination, and documentation status) and migration supports (i.e. family and teacher support, acculturation, and personal-motivation) were most strongly associated with depressive symptoms and anxiety.

Parent Health

Like their children, caregivers reported high rates of good to excellent health (87%; Figure 2). In contrast to their children, they reported lower levels of significant depressive symptoms. Based on the Center for Epidemiological Studies Depression Scale (CES-D; Radloff 1977), only 7% reported a score of greater than 16, a core indicating clinically significant symptoms of depression. In the full LAMHA sample (Perreira et al., 2008), nearly 15% of immigrant Latina parents in the reported depressive symptoms. Thus, it appears that parents with depression were less likely to participate in the service use component of the LAMHA study.

Figure 2. Parent Physical and Mental Health

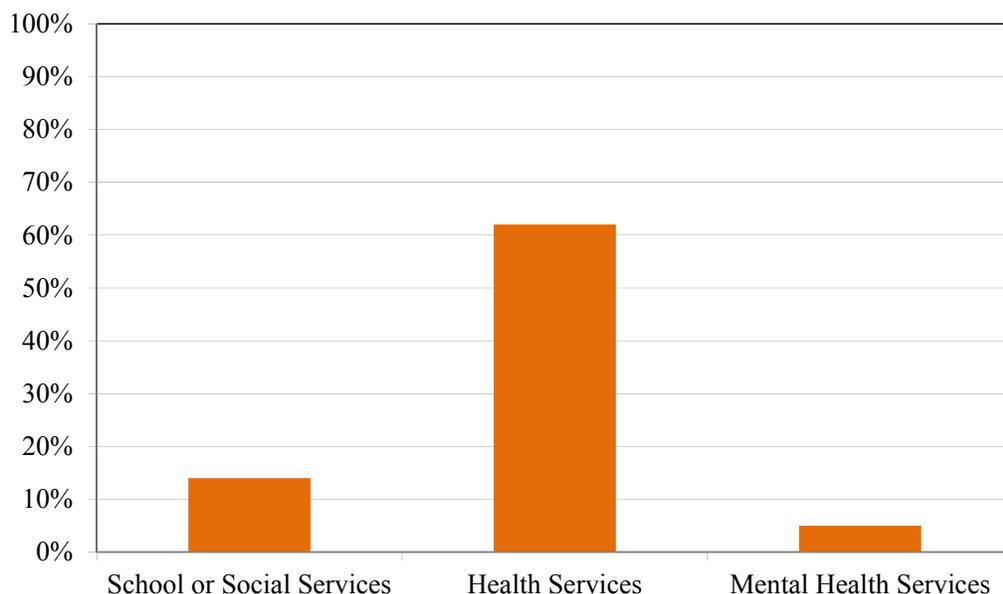


As with the health of children, the health of parents can be influenced by socio-economic circumstances access to insurance, and utilization of health care. Among these first-generation immigrant parents, we found no significant differences in self-report physical health or depressive symptoms by socioeconomic conditions such as poverty and education. However, parents who had health insurance were more likely to report good-excellent health (94% vs. 84%) and less likely to report significant depressive symptoms (8% vs. 18%). As with children, the health of immigrant parents was most strongly associated with the stresses of migration and adaptation to life in the US (Ornelas and Perreira 2011).

GENERAL SERVICE USE

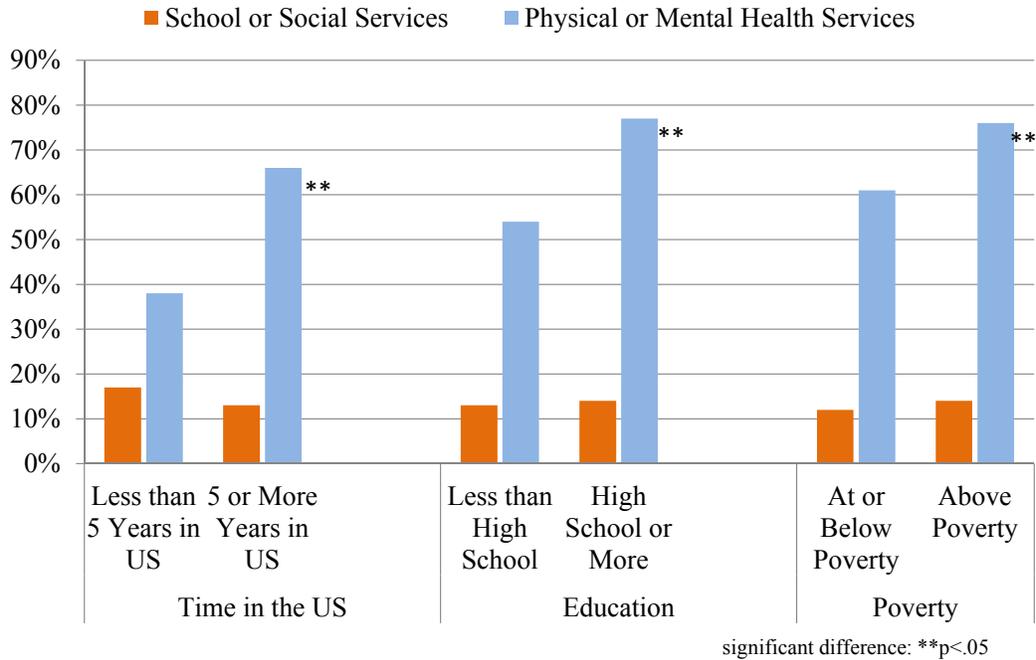
Adolescents surveyed used a variety of school, social, and health services. Such services included school-provided guidance counseling, services provided by the Department of Social Services, Juvenile Justice Services, health services such as doctor visits, and mental health services. The majority of adolescents had had a physical exam or had been to a health professional at least once in the past year (62%; Figure 3). But, very few had received any psychological or emotional counseling (4%) or had been in contact with any other social service providers at school or in their communities (14%).

Figure 3. Adolescent General Service Use in Past Year



Adolescents' use of school services and other social services did not differ significantly by their primary caregiver's time in the US, level of education, or poverty level (Figure 4). However, the use of mental and physical health services did vary significantly by each of these factors. Youth whose parents had lived in the US fewer than 5 years, had less than a high school education, and were living in poverty tended to utilize fewer health services. This is consistent with previous research (Lara et al. 2005; Peifer et al. 200; Vega 2001). With greater time in the US parents gain familiarity with the types of services available in their communities. In addition, parents with higher education levels may find it easier to navigate the US health care system. Finally, parents with higher income levels can better afford the cost of health care.

Figure 4. Service Use by Caregiver's Time in the US, Education, and Poverty



In addition to time in the US, education, and poverty-level, access to health insurance can strongly influence the utilization of health services. In our sample, 31% of caregivers and 20% of children reported having health insurance. Those youth with health insurance reported significantly higher health services utilization (75% vs. 59%) and used other social services more frequently than youth without health insurance (22% vs. 12%). Moreover, those youth with health insurance tended to have parents with at least a high school education (32% vs. 13%) who had lived in the US longer than five years (20% vs. 17%) and who were living above the federal poverty level (30% vs. 15%). Thus, the parents of insured children had more ability to navigate complex US health and social service systems.

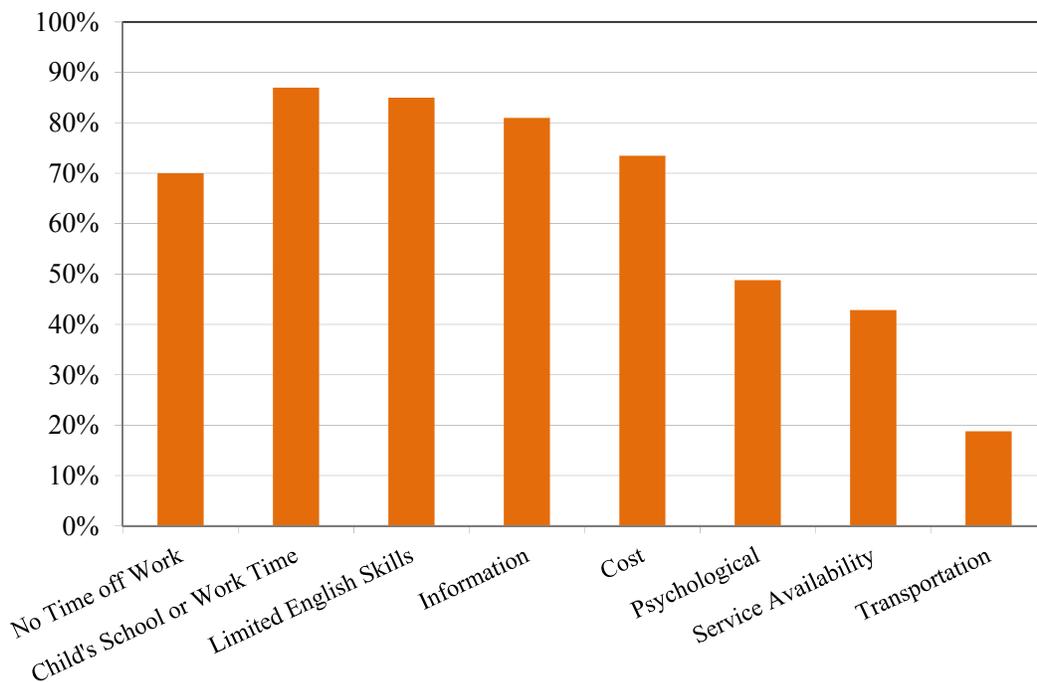
As of 1996, access to public health insurance benefits for immigrant parents and their children has been limited throughout the United States. Immigrant parents with fewer than 5 years of residency in the US are barred from obtaining insurance through the Medicaid program, a public health insurance program for poor families. Under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), states can choose to cover children up to age 21 who have not yet met the US residency requirements (Kaiser Commission on Medicaid and the Uninsured 2009). However, North Carolina did not take up this option until 2010. Nevertheless, regardless of the length of their residency unauthorized immigrants cannot receive federally-funded public insurance coverage in North Carolina except in emergency cases.

BARRIERS TO MENTAL HEALTH SERVICE USE

Parents interviewed for this study were extremely receptive to seeking mental health services – all agreed with the statement that “When people have serious emotional or behavioral health problems, it’s a good idea for them to try and get help or treatment.” The vast majority also believed that counselors or doctors could help with emotional or behavioral problems (97%) or that their child would want to get help for a serious problem (98%).

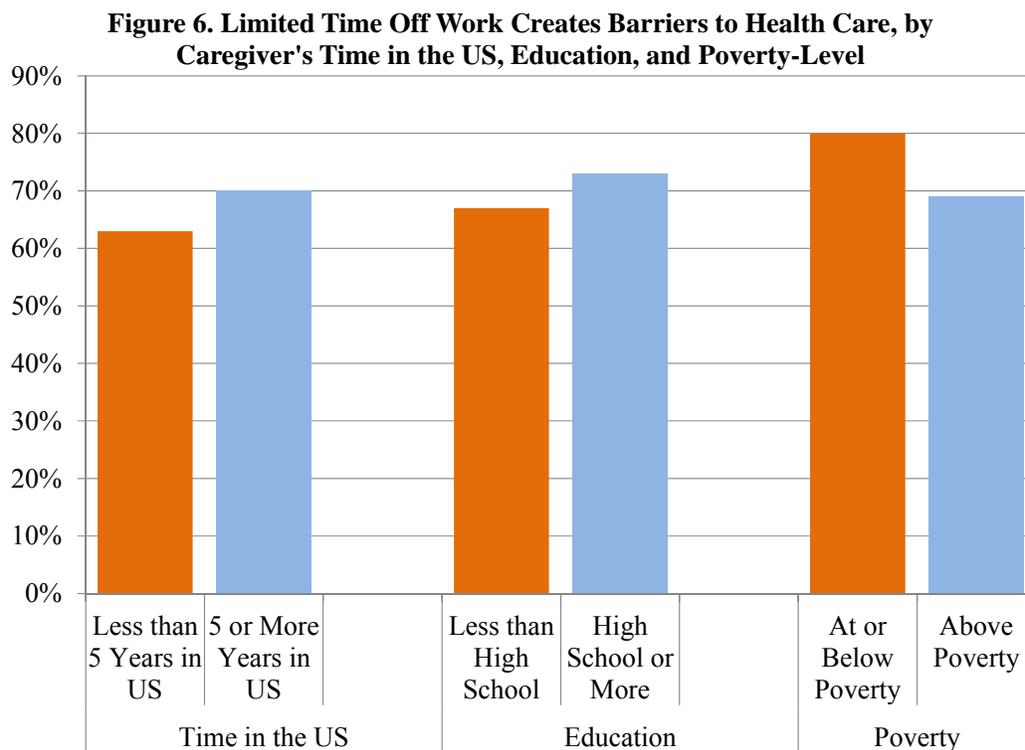
Though parents and adolescents were generally receptive to seeking mental health services, they faced psychological and structural barriers to actually accessing these services. Psychological barriers included self-consciousness, social stigma, and fear or discomfort with health providers. Structural barriers included time constraints due to work; difficulties communicating with providers, ability to pay for care, lack of information about available services, a lack of service available in their communities, and a lack of reliable transportation. In Figure 5, these constraints are ranked in mostly descending order of how strongly they affected caregivers’ access to health and mental health services for their adolescents.

Figure 5. Barriers to Health Service Use



Parent and Child Work or School Commitments

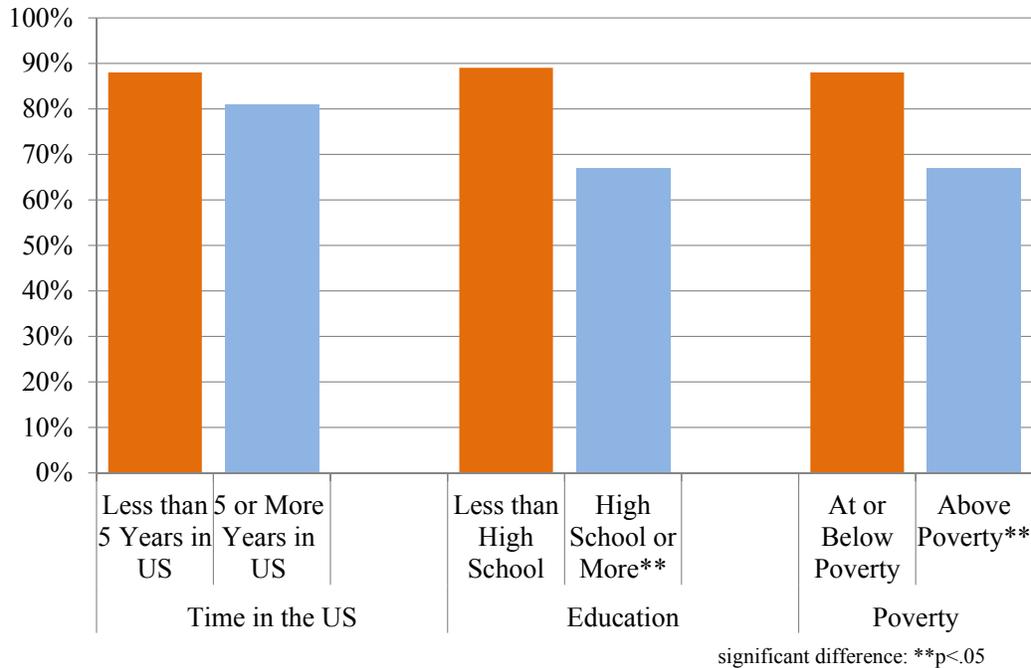
Parents did not utilize mental health services primarily because they could not take time off work and did not want their children to miss school or work commitments. Latino parents and the poor more often work in hourly jobs without access to sick leave and may not be able to forgo income in order to seek medical care (ICPSR 2011; Williams et al. 2011). Thus, all the immigrants we interviewed, regardless of their time in the US, education, or poverty-level, faced work obligations which prevented them from accessing care (Figure 6).



Language, Culture, and Information

Parents with limited English skills or whose children had limited English skills also reported that these limitations made it difficult to access care (Figure 7). In most cases, communication difficulties stemmed from parents' rather than children's difficulties communicating in English. Only 15% of parents indicated that their child would have difficulty communicating in English. Language barriers were significantly more common among those with less than a high school degree (89% vs. 67%) and among those living at or below poverty (88% vs. 67%). Moreover, when asked to rank the importance of having a provider that understood their language and culture, 61% indicated it was very important that providers speak their language and 47% indicated it was very important that providers understand their culture. Thus, the lack of linguistic and cultural competence among providers in North Carolina can substantially impair access to care for Latino immigrant families and their children.

Figure 7. Limited English Skills Create Barrier to Health Care, by Caregiver's Time in US, Education, and Poverty-Level

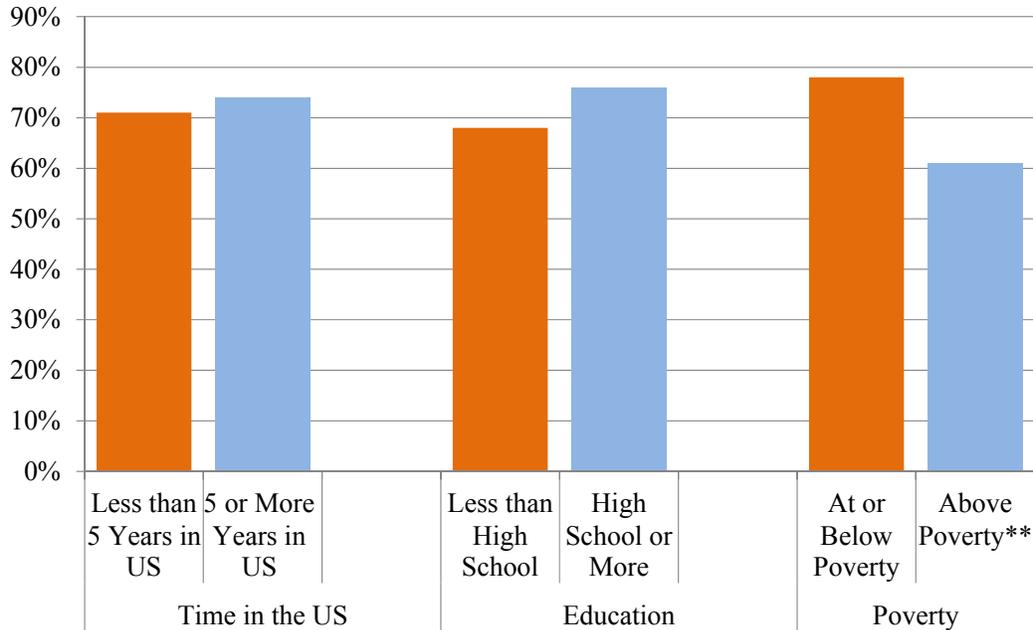


Ranked nearly as high as limited English skills as a barrier to care, access to information about the availability of services did not vary by time in the US, education, or poverty-level. All Latino immigrants regardless of socio-economic status indicated that they needed more information about the types of medical providers in the US that could help them and their children with mental health problems.

Costs

Difficulties with costs or paying for care stemmed from a lack of insurance or adequate insurance (Figure 8). Eighty-five percent of caregivers who could not afford the cost of care did not have insurance for their child and an additional 10% could not afford to pay costs not covered by their children's insurance. These financial barriers to care did not vary by caregiver's time in the US or education level, but did vary significantly by poverty level. Among those living at or below poverty, nearly 80% would not seek health care for their children due to its cost.

**Figure 8. Costs Create Barrier to Health Care,
by Caregivers Time in US, Education, and Poverty-Level**

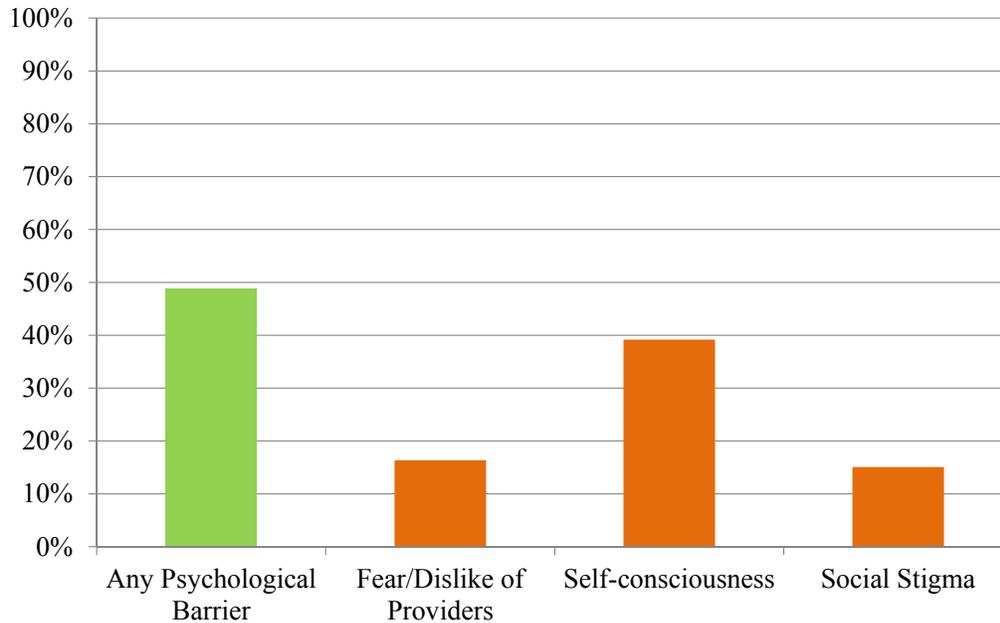


significant difference: **p<.05

Psychological Barriers

Psychological barriers to the use of mental health services included fear or discomfort with health providers, self-consciousness, and perceived social stigmas associated with service use (Figure 9). Overall, 49% of immigrant Latino parents reported at least one psychological barrier to seeking mental health services. Self-consciousness about asking non-family members for assistance kept many caregivers (39%) from seeking help for their adolescent child. High levels of fear and distrust reduced the likelihood that 16% of caregivers would seek help for themselves or their adolescent children. Finally, 15% of the immigrant parents interviewed worried about what their family, friends, or others would think if their child were to seek mental health services.

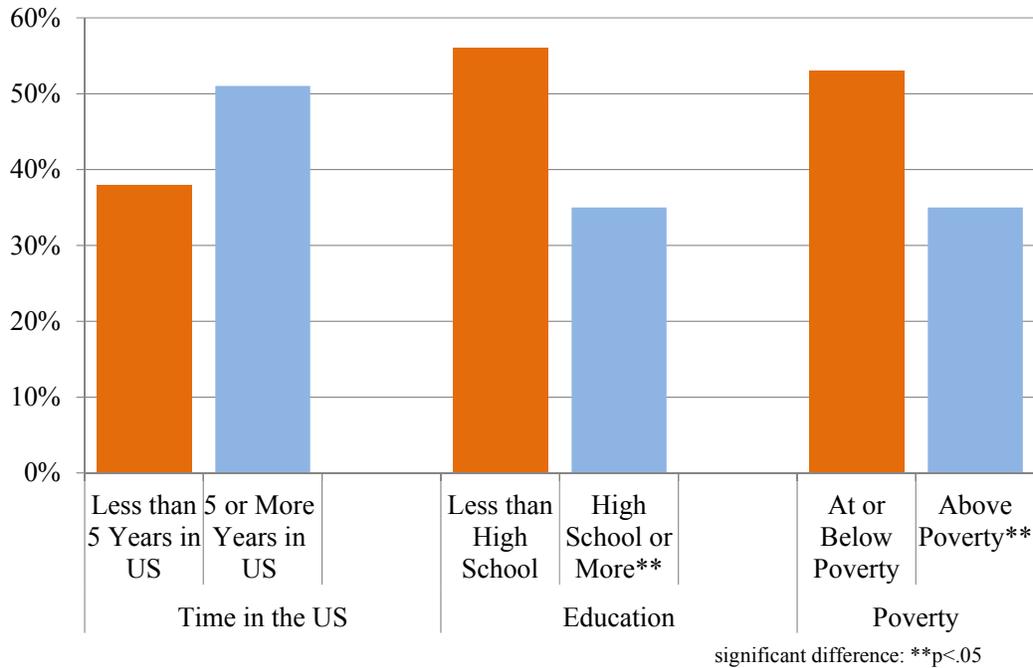
Figure 9. Types of Psychological Barriers to Service Use



As shown in Figure 10, psychological barriers were greater among caregivers who had resided 5 or more years in the U.S. (51%) than those who had lived in the U.S. fewer than 5 years (38%). Barriers were also more prevalent among caregivers that had less than a high school education (56%) than those who had finished high school or post-secondary education (35%). Finally, parents who had a yearly income at or below the federal poverty level were more likely to experience psychological barriers to health service use (53%) than parents who had incomes above the federal poverty level (35%).

These results are consistent with previous research (Portes and Rumbaut 1996, 2001). As Latino immigrants acculturate to life in the U.S., they may encounter pervasive, institutionalized discrimination that increases their fears of providers and other authority figures and leave parents feeling more self-conscious about how providers will react to their child's health concerns. Parents with higher incomes and education levels potentially have more knowledge about medical systems and experience utilizing modern medicine which help to reduce the fear and anxiety associated with obtaining health care in the United States.

Figure 10. Psychological Barriers to Health Care, by Caregiver's Time in the US, Education, and Poverty-Level

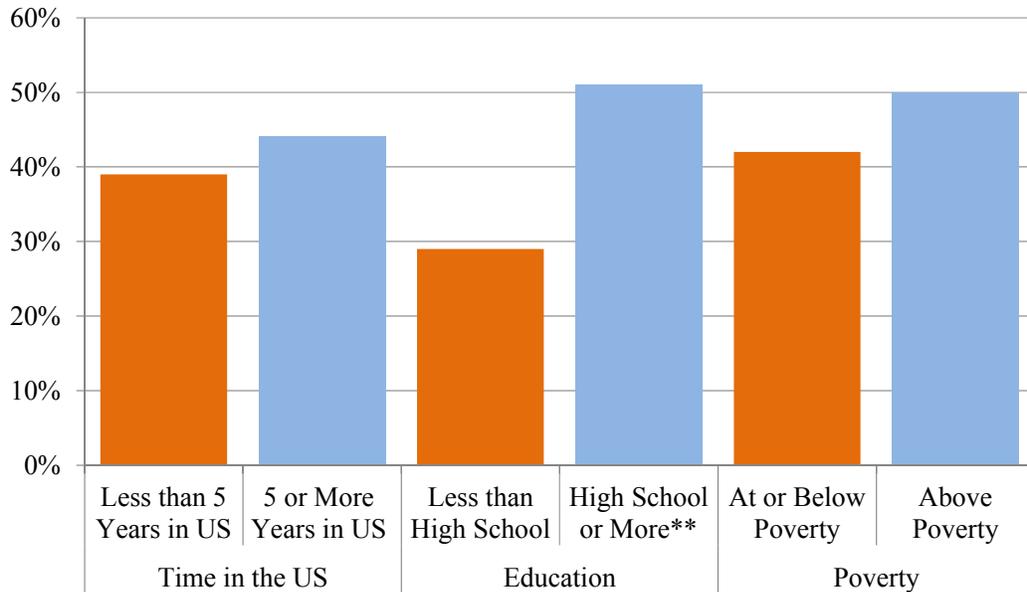


Absence of Desired Services

Although ranked near the bottom of the list of barriers to care, 43% of immigrant parents indicated that they could not find the types of health care services they needed in their communities. This was a concern throughout both rural and urban North Carolina. Parents in rural areas reported only slightly more of a problem with service availability than those in urban areas (47% vs. 41%). However, frustrations with the types of services available did vary by socio-economic status. Specifically, immigrant Latino parents with more education expressed significantly more frustration with the types of health-related services available in their communities (51% vs. 29%).

When asked what kinds of health-related services they and their children needed but could not find in their communities, these parents indicated that they could not find professional counselors such as psychologists and social workers (30%); could not locate recreational facilities or health clubs (26%), were having trouble identifying drug, alcohol, and sexual health education and treatment programs (26%), and were not able to find traditional healers in their communities (13%).

**Figure 11. Desired Services Not Available,
by Caregiver's Time in the US, Education and Poverty Level**



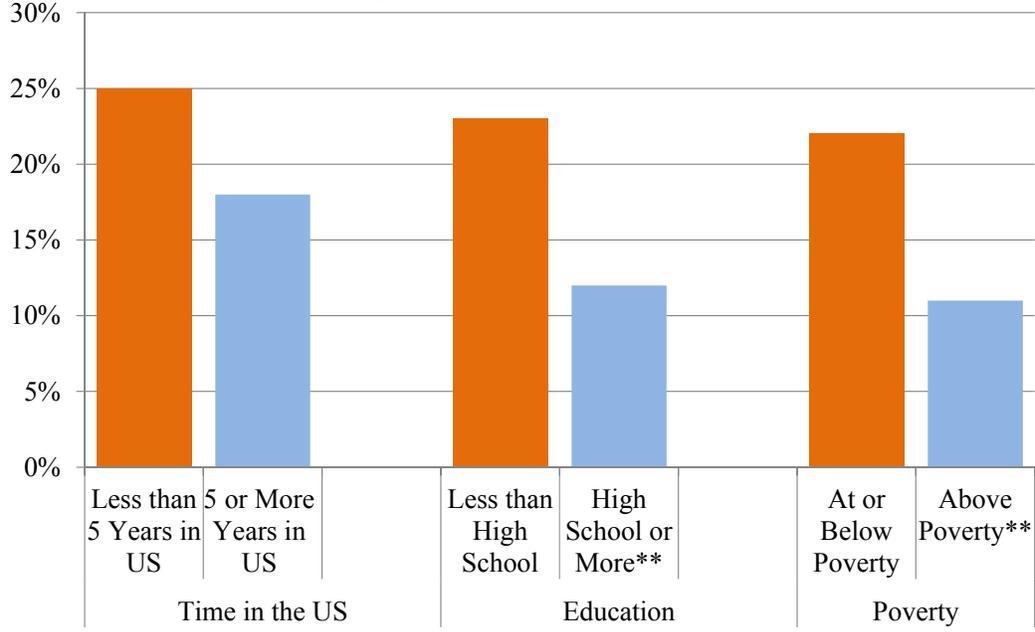
significant difference: **p<.05

Transportation

Finally, even when services were available in their communities, immigrant parents had difficulty accessing those services due to a lack of reliable public or private transportation. Parents in rural and urban areas were equally likely to report that the lack of reliable transportation limited their access to care (18% and 20%, respectively). In most cases, the lack of reliable transportation typically stemmed from a lack of access to a car. Nearly 60% of those caregivers without reliable transportation did not have access to a car.

Even with access to a car, however, some immigrant parents were not able to legally drive to medical appointments. In North Carolina, residents must provide a social security number to obtain a driver's license (Congressional Research Services 2005). Without a driver's license immigrants cannot register a car or obtain insurance. Thus, public transportation services to and from medical providers is an increasingly essential component of medical services for immigrants who do not have a valid social security number.

Figure 12. Limited Access to Transportation Creates Barrier to Health Care, by Caregiver's Time in the US, Education, and Poverty-level



significant difference: **p<.05

STUDY LIMITATIONS

These final results should be read and used with some caveats in mind. The first set of cautions relates to sampling strategies and our ability to contact potential respondents. Our respondents were initially contacted and recruited by phone and many could not be contacted because their phone lines had been disconnected, phone numbers changed, or they did not answer the phone after repeated attempts. Thus, our sample may not reflect Latino families without telephone access. In addition, due to the sampling strategy and sampling frame, this study does not fully capture youth who live with parents who are migrant farm workers.

Our sampling frame also included only Latino youth who were attending school. Many youth migrate to the U.S. and never attend a U.S. school system (Fry 2005). In addition, of those that do enter school, many may drop out to enter the workforce at age 16. Therefore, our survey lacks the perspective of these youth who may be more vulnerable than those who are attending school.

Finally, though informative, our sample was small and cross-sectional. Only 166 parents who participated in the LAMHA general survey elected to answer questions about themselves and their adolescents' health service use. This small, cross-sectional sample limits our ability to detect significant statistical relationships and to identify causal relationships. Nevertheless, the data do provide critical insights into patterns of health service use among immigrants.

CONCLUSIONS

Though Latino immigrant adolescents in North Carolina and their caregivers report good physical health, the relatively high instance of anxiety (30%) and depression (18%) within the adolescent population and the low use of physical and mental health services by adolescents will likely lead to poor health outcomes in the future.

The high cost of medical care together with the lack of health insurance coverage prevented many parents from obtaining health care for their children. In addition, parents considered the need to take time off work or children out of school, the limited availability of Spanish-speaking providers, and the lack of information about the types of services available critical barriers to care.

Improving the health service use of the growing population of Latino immigrant adolescents and their families involves targeting the specific psycho-social and structural barriers that limit their access to health services. Adolescents and caregivers are clearly receptive to the idea of using services, but lack the basic resources to make seeking health services possible. We hope that this report and the recommendations we provide will be helpful in expanding state and community efforts to assist this population.

RECOMMENDATIONS

Develop outreach efforts to inform immigrant caregivers and adolescents about the services available in their communities and help teach them how to navigate complex US health care systems.

Latino immigrant parents reported knowing little about the types of health care services, especially mental health care services available in their communities. Before feeling comfortable utilizing mental health services they wanted to know more about mental health treatments and the type of care they and their children would receive. Thus, outreach efforts to better help new immigrant better understand the US health care system generally and mental health services more specifically can facilitate the use of these services when needed.

Build partnerships with community leaders to facilitate cross-cultural exchanges that promote understanding, reduce fear and de-stigmatize the utilization of mental health services.

Latino immigrant parents reported high levels of fear and discomfort when asked about interacting with medical professionals. They also expressed concerns about the stigmatization of children seeking mental health services. To help ease these fears and assuage concerns about stigmatization, community-based forums bringing together immigrant parents and providers could promote mental health service utilization. Immigrant parents were quite receptive to the use of mental health services but needed some guidance and support before feeling comfortable accessing these services.

Establish early morning and late evening health clinics for low-income working parents and their school-aged children.

Latino immigrant parents could not afford to take time off work to help their children access health services. Moreover, they believed that it would be necessary to pull their children out of school to access services. Thus, to promote access among this low-income population office hours outside of the standard work week are necessary. Immigrant parents and their children may be more able to access health care during early morning and late evening clinics.

Locate health clinics on public transportation routes and offer transportation to and from clinics serving immigrant populations.

Latino immigrant parents also lacked reliable transportation and many cannot legally drive in North Carolina. To help ensure these parents and their children can access

services, health clinics should be located on public transportation routes or health clinics should offer transportation to and from appointments.

Develop continuing education curriculum to improve cultural competence among health and social service providers.

To address immigrants' concerns about the linguistic and cultural competence of providers, community colleges, professional associations, and community-based organizations should work together to develop rigorous continuing education programs for all health and social service providers. Providers need to know how to work well with individuals from a variety of cultural backgrounds and, when they do not speak the same language as their clients, they need to know how to work well with translators. Attention to these aspects of provider education is essential in an increasingly global world where providers must interact with individuals from a variety of backgrounds.

Recruit and retain multi-lingual and multi-cultural providers.

While continuing education curriculum for health and social service providers currently practicing in North Carolina can improve the quality of care to immigrants and facilitate the utilization of services, it does not provide a long-term solution. In the long term, North Carolina and other states with emerging immigrant communities must educate, recruit, and retain multi-lingual and multi-cultural providers.

NOTES

- (1) Please refer questions regarding the adolescent interviews to this study to the Principal Investigator, Krista M. Perreira
- (2) More information on this study and previous publications can be found on the web at www.cpc.unc.edu/projects/lamha. As additional publications and data become available, they will be disseminated through this website.

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