

Uplifting Voices to Create New Alternatives:

Documenting the Mental Health Crisis
for Adults on Chicago's Southwest Side

A report by the Collaborative for Community Wellness



The Center for Community Wellness

Supported by the financial investment of Saint Anthony Hospital and based on over 20 years of community-oriented development of a variety of social services that make up the Community Wellness Program, Saint Anthony Hospital created the Center for Community Wellness in order to develop new solutions that address the socio-emotional needs of individuals and families dealing with poverty. The Center for Community Wellness advocates in partnership with community stakeholders and organizations for individuals and families whose social condition places them at the margins of society, as manifested by both the challenges of limited access to health and mental health care and dealing with the impacts of violence within and against communities.

The Collaborative for Community Wellness

A collaborative convened by The Center for Community Wellness that brings together mental health professionals, community-based organizations, and community residents to address the lack of mental health access and to redefine mental health to match the needs of the community.

Collaborative for Community Wellness

Partner Organizations

Alas con Valor
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Children's Center for Behavioral Health
Erie Neighborhood House
Healthcare Alternative Systems (HAS)
Heartland Human Care Services, Inc. | A Company of Heartland Alliance
HOPE at St. Pius V
Mount Sinai Hospital: Under the Rainbow
Mujeres Latinas en Acción
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Pilsen Alliance
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Project VIDA
Saint Anthony Hospital: Community Wellness Program
Southwest Organizing Project (SWOP)
Taller de José
Telpochcalli Community Education Project (TCEP)
Un Nuevo Despertar
U.N.I.O.N. Impact Center
Universidad Popular



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The following organizations and people have been committed to seeing this project through since we initiated a drive in 2014 to expand free strengths-based, trauma-focused mental health services from their roots in Little Village to the neighboring communities of Brighton Park and North Lawndale. Collectively everyone has contributed *con su granito de arena*, adding their personal/organizational capacity to the effort. I have been honored to work with each and every one of the following people/organizations listed below. In the words of Martin Luther King Jr., "Human progress is neither automatic nor inevitable... Every step toward the goal of justice requires sacrifice, suffering, and struggle; the tireless exertions and passionate concern of dedicated individuals."

- Arturo Carrillo, PhD, LCSW



Mural by Yollocalli Arts Reach, 1544 W. 18th Street, 2011. Photo by Ken Carl and Kaitlynn Scannell.

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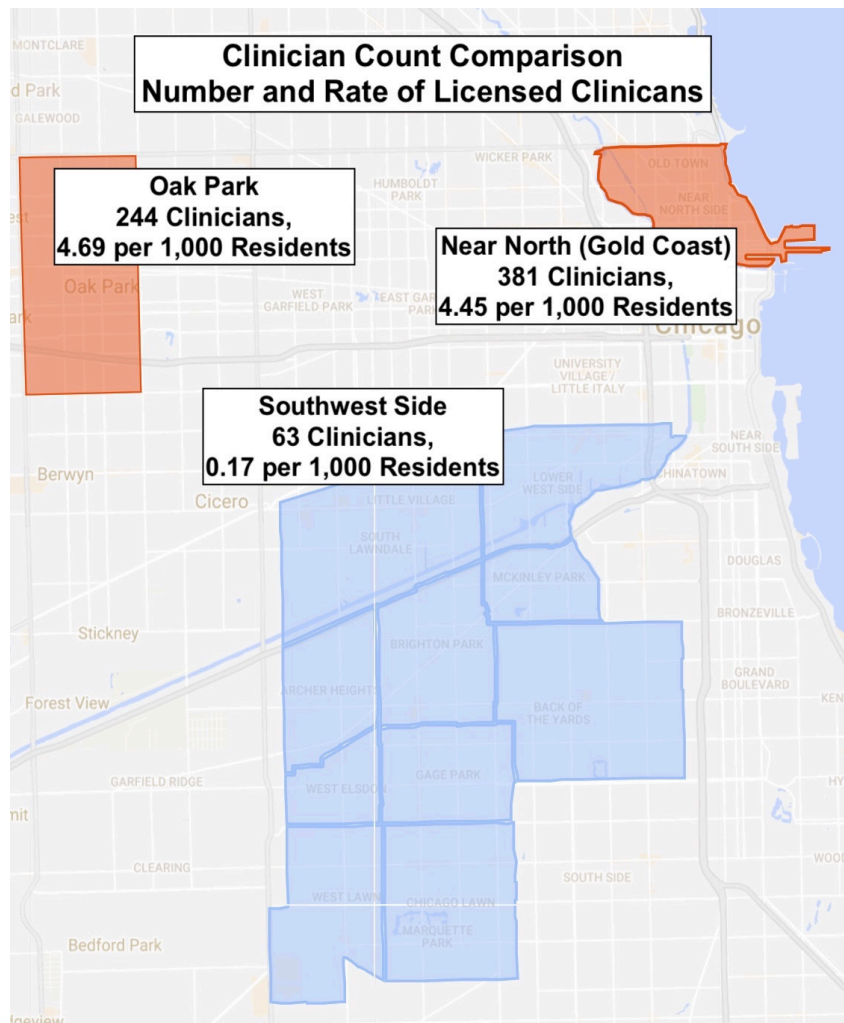
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EXECUTIVE SUMMARY

Community residents living in the city of Chicago's southwest side are disproportionately impacted by poverty, unemployment and underemployment, housing challenges, under-resourced schools, and limited social service infrastructure.^{1,2} Not only do community residents experience these challenges, but the social systems with which they interact also perpetuate conditions of hardship by limiting access to the resources needed to improve their daily lives. This perpetual cycle of hardship caused by social systems is a phenomenon known as structural violence.^{3,4} Community residents impacted by structural violence may experience emotional trauma due to threats to their safety and well-being associated with their living conditions. In addition, within Chicago's current service landscape, multiple barriers exist to accessing affordable mental health services. For example, funding cuts within the state of Illinois have led to the reduction and elimination of mental health services and programs.⁵ Within the city of Chicago, funding cuts starting in 2012 have decreased the number of operating Chicago Department of Public Health mental health clinics from 12 to 5. In FY2017, the Department of Public Health, which contains within it funding for mental health services, only received 0.4% of the total City of Chicago budget expenditures.⁶ As a result of this limited investment by the city of Chicago, treatment options are limited for residents of high economic hardship communities and for the uninsured throughout the city of Chicago.^{7,8} Within the predominantly high economic hardship community areas on Chicago's southwest side, availability of mental health services is limited in comparison to more affluent neighborhoods in the Chicagoland area (see adjacent map).



In response to the mental health needs observed among community residents, a coalition of local organizations on Chicago's southwest side came together to assess mental health needs and access barriers among adult community members. This study offers an important opportunity to increase awareness of the current mental health needs and access barriers among high economic hardship communities on Chicago's southwest side. In addition, the data from this study inform recommendations for promoting emotional wellness. Central to the recommendations outlined in this report is the understanding that the structural context in which community members are situated impacts their emotional wellness. In turn, this report provides an opportunity to raise critical awareness about the importance of challenging this oppressive structural context that prevents community residents from attaining optimal health. Next steps should involve ongoing dialogue regarding processes for implementing the recommendations outlined in this report. Bringing service providers, program administrators, policy makers, and funders to the table with community residents is essential for creating collaborative spaces in which everyone takes ownership for implementing solutions. In so doing, all stakeholders are empowered to become "professional agents of change."

Moreover, while this study focused on ten communities experiencing economic hardship on Chicago's southwest side, it is important to note that economic hardship and marginalization is not confined to these community areas. Although this study assessed mental health needs and access barriers among predominantly Latinx* (Mexican) community residents, community stakeholders identified that African-American communities face similar challenges stemming from structural violence. Stakeholders thus expressed a desire to build inter-community support groups and alliances, as well as to create community-driven initiatives in collaboration with the African-American community.

This report, a product of the Collaborative for Community Wellness, outlines the methods that were used to undertake this assessment, as well as the key findings and recommendations. A brief overview of the study methodology, findings, and recommendations are outlined below in this executive summary. All of these research activities and the ensuing report were completed without external funding.

STUDY METHODOLOGY

This assessment of mental health needs and access barriers occurred in predominantly Latinx (Mexican) community areas and occurred in two phases. During the first phase, we surveyed 2,859 primarily Latinx (91%) adults from ten community areas (Archer Heights, Back of the Yards, Brighton Park, Chicago Lawn, Gage Park, Little Village, McKinley Park, Pilsen, West Elsdon, and West Lawn) to collect quantitative data on their three most pressing emotional needs, desire to access professional mental health services, and barriers to accessing professional mental health services. During phase two of this project, we used qualitative methods to conduct 9 individual interviews and 8 community forums with community stakeholders, where we presented findings from the surveys and further explored mental health needs, access barriers, and solutions for addressing mental health needs. We additionally conducted a community member check comprised of community residents and stakeholders to verify the accuracy of our findings and to solicit additional feedback.

*Throughout this report, we use the term Latinx to be inclusive of individuals of all genders and to recognize their various intersecting social identities (e.g. gender, sexuality, language, immigration history, ethnicity, culture, and phenotype).⁹

KEY FINDINGS

Depression, anxiety, acculturative stress, parenting support needs, and trauma are prevalent mental health concerns.

According to unweighted results from quantitative surveys, slightly less than half of survey respondents reported experiencing depression (49%), over one-third reported experiencing anxiety (36%) and acculturative stress (34%), and over one-fourth expressed a need for parenting support (29%) and reported being impacted by trauma (27%). Qualitative findings from individual interviews and community forums suggested that experiences of trauma may be even higher than reported in the quantitative surveys, as community stakeholders identified trauma as underlying symptoms of depression and anxiety. Furthermore, community stakeholders indicated that experiences of trauma may go unrecognized because trauma is a common part of community residents' daily lives.

Experiences of structural violence impact mental health.

During individual interviews and community forums, community stakeholders described mental health symptoms as stemming from experiences of marginalization within multiple social systems. Community residents are often denied access to employment and educational opportunities, as well as to public benefits such as health insurance coverage, based on immigration status. In turn, limited access to opportunities and supports makes it difficult for individuals and families to meet their material and health-related needs. The current political climate poses an additional stressor to community residents. In the context of increased deportations by the previous and current presidential administrations, there is a heightened fear of deportation and familial separation, a fear that is accentuated when individuals and families come into contact with the criminal justice system. Within the local context of Chicago, community residents are further impacted by ongoing exposure to community violence and limited access to resources in the high economic hardship communities where they live.

There is an overwhelming demand for professional mental health services.

According to findings from quantitative surveys, 80% of respondents reported "yes" or "probably yes" to the question of whether they would seek professional support for their personal problems. These data suggest that it is not a lack of interest that stops community residents from seeking mental health services, but instead that community residents are unable to seek out services due to the structural and programmatic barriers outlined below.

Structural and programmatic barriers, not social barriers, are the primary factors preventing access to mental health services.

According to both unweighted and weighted survey results, respondents overwhelmingly identified structural and programmatic barriers as posing the greatest challenges to mental health service access. The unweighted percentage breakdowns for each category of barriers are reported below.

Structural Barriers.

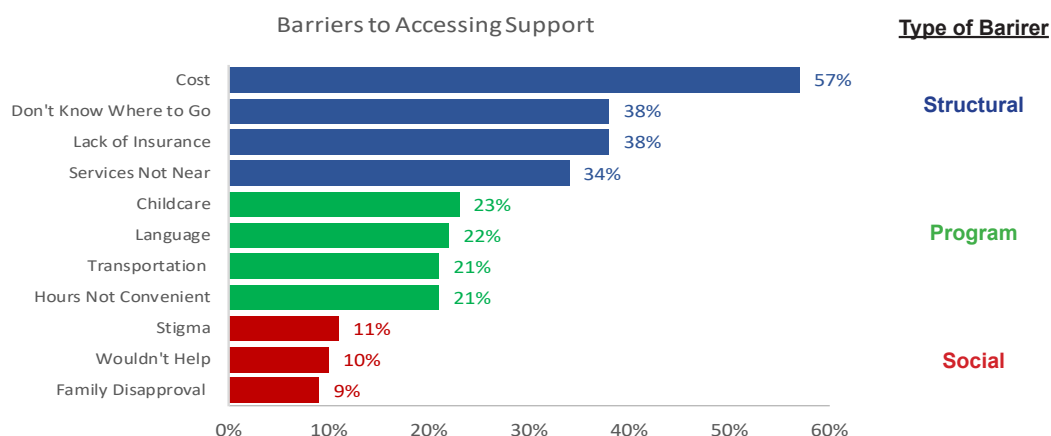
The cost of services was the highest ranked barrier among survey respondents, with more than half (57%) of respondents identifying cost as posing a challenge to mental health service access. Additional structural barriers included a lack of insurance coverage (38%) and a lack of services in close geographic proximity (34%). Among all survey respondents, 38% also identified being unsure where to go to access services as a barrier, confirming a scarcity in resources in the community areas surveyed for this assessment.

Programmatic barriers.

Survey respondents identified a range of barriers associated with organizational operations that limit the ability of community residents to access services. In particular, survey respondents noted barriers stemming from limited organizational infrastructure to facilitate attendance at appointments. The highest ranked programmatic barrier was a lack of childcare (23%), followed by services not being offered in an individual's preferred language (22%), transportation difficulties (21%), and inconvenient hours of operation (21%). Limited availability of culturally and linguistically appropriate services was a related programmatic barrier that emerged during analysis of qualitative findings, with community stakeholders reporting that not only is it difficult for community residents to access services in their native language, but that community residents also encounter challenges with finding providers who demonstrate an understanding of their cultural heritage and their experiences within the local community context in which they live.

Social barriers.

While survey respondents identified barriers associated with how others would perceive them for accessing services, these social barriers were the lowest ranked among all the challenges that respondents reported. Of all survey respondents, 11% reported perceived stigma as an access barrier, while 10% reported that they did not believe services would help and 9% reported concerns about partner or family disapproval.



Organizations can facilitate service access by addressing structural and programmatic barriers.

During individual interviews and community forums, community stakeholders discussed the need for organizations to develop the infrastructure to deliver culturally and linguistically appropriate services. They further discussed that culturally and linguistically appropriate service delivery does not only mean that services reflect an understanding of the individual's cultural values and are delivered in the individual's native language, but also that services are aligned with needs that arise as a result of experiencing economic hardship. With this expanded understanding of what it means to deliver culturally and linguistically appropriate services, it naturally follows that organizations should address the structural and programmatic barriers such as cost, transportation, and child care that prevent community members from accessing services.

There is a need to redefine mental health.

Qualitative findings additionally indicated that community residents may be deterred from seeking mental health services when the primary focus is on reducing symptoms. Community stakeholders recommended shifting the dialogue around mental health to a dialogue around emotional wellness, which focuses on promoting the health of the whole person and addressing the structural context that impacts well-being rather than focusing solely on decreasing symptoms. This focus on emotional wellness also recognizes that short-term services focused on symptom reduction are not enough to promote lasting healing from trauma.

KEY RECOMMENDATIONS

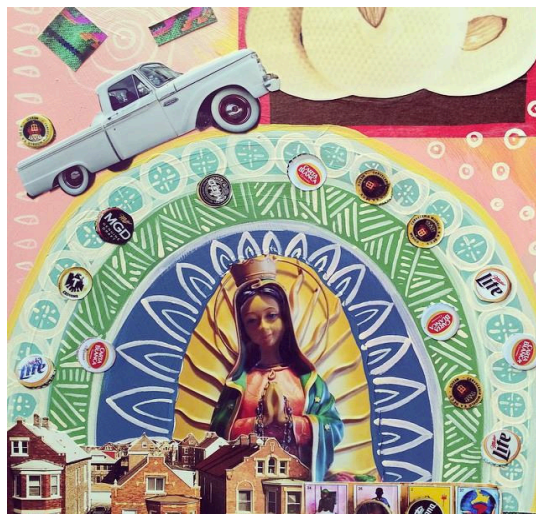
Based on findings from quantitative surveys and qualitative interviews and community forums, our key recommendations for mental health providers and program administrators, policy makers, and funders are among the following:

Key Recommendation for Mental Health Providers and Program Administrators:

Drive the organizational change that is required to deliver culturally appropriate, trauma-focused services.

Findings from this study indicate that limited availability of culturally and linguistically appropriate services is a major programmatic barrier preventing mental health service access among Latinx community residents on Chicago's southwest side. Community stakeholders emphasized that delivering culturally and linguistically appropriate services requires more than simply speaking an individual's native language and demonstrating an understanding of an individual's cultural values. To truly deliver culturally appropriate services, mental health providers must also understand the negative impact of economic hardship on well-being. In turn, because factors associated with economic hardship, including the cost of childcare and transportation, pose barriers to service access, program administrators can play an invaluable role in addressing these barriers in their program design. Offering free, on-site childcare and providing transportation assistance are concrete ways that program administrators can develop the organizational infrastructure needed to deliver culturally appropriate services. It is noteworthy that the demand for professional mental health services among male respondents was on par to that of female respondents, despite mainstream narratives that often portray males as being reluctant to engage with services. Mental health providers must recognize the necessity to develop programming that facilitates men's engagement in services in order to meet this demand.

In addition, as qualitative findings indicated, trauma is a common element of community residents' daily experiences on Chicago's southwest side. It is of critical importance that while organizations operate in accordance with this more expansive cultural and contextual understanding, culturally appropriate service delivery becomes integrally connected to trauma-focused care. Delivering services that are aligned with the needs of community residents therefore requires that program administrators invest in developing their organizational capacity to offer free, long-term mental health services that promote healing from trauma.



Rebel Betty, "Virgencita de la Villita". Mixed Media on Wood. 2015.

Key Recommendation for Policy Makers:

Advocate for structural change.

As findings from this study indicate, it is critical that policy makers advocate for legislation that restructures how mental health services are funded in order to facilitate the accessibility of long-term, trauma-focused services both nationally and in the local context of Chicago. Our data demonstrate that existing systems of service delivery by way of the managed care model are not structured to facilitate access to the comprehensive mental health treatment that marginalized community residents need. The emphasis of the managed care model on reducing cost imposes limitations on the type and quality of care that individuals receive. For low-income and uninsured community residents, the burden of paying out-of-pocket for services makes the possibility of long-term, trauma-focused mental health care unattainable. Policy makers can play an invaluable role in advocating for stable funding for free, long-term, community-based mental health services.

Within the city of Chicago, there is a historical precedent for investing in these services. Utilizing funds from the Community Mental Health Act of 1963, which reflected a national shift from institutionalization to community-based mental health care, the city of Chicago created a system of 19 community mental health centers to address the needs of marginalized community residents in the 1960's and 1970's.¹⁰ While the city has disinvested in these services since the 1990's¹¹, findings from this study indicate that reinvestment in this model of public mental health care is critical to protecting an individual's right to access the care necessary to attain optimal health¹², regardless of income, insurance status, and immigration status. As this study examines the mental health needs of the city's southwest side, home to Chicago's largest continuous segment of Latinx immigrant neighborhoods,¹³ these findings are directly applicable to Chicago's position as a Welcoming City. If Chicago is to truly be a city that is welcoming of immigrants, it is necessary for the city to increase its investment in sustainable funding to ensure that the immigrant community, as well as other marginalized populations, have access to free mental health services.

Key Recommendations for Funders:

Provide funding for long-term, trauma-informed mental health services.

As noted above, within the local context of Chicago, Illinois state budget cuts and Chicago Department of Public Health mental health clinic closures profoundly limit the availability of mental health resources to marginalized community residents. Just as policy makers can play an important role in advocating for funding, private funders can offer invaluable support in providing funds to organizations experiencing fiscal challenges. Community stakeholders have identified that short-term behavioral health services focused on symptom reduction (such as those provided by Federally Qualified Health Centers) are not enough to promote long-term healing from traumatic experiences. Private funders can therefore support initiatives to address the mental health crisis on Chicago's southwest side by funding time-unlimited, trauma-focused mental health therapy services, delivered by licensed clinical professionals, for underinsured and uninsured community residents. It is important to note, that although there is a need for funding for mutual support initiatives, financial investment in these initiatives should not supersede financial investment in formal long-term, trauma-focused clinical services and therapeutic groups facilitated by mental health professionals.

Uplifting Voices to Create New Alternatives: *Documenting the Mental Health Crisis for Adults on Chicago's Southwest Side*

INTRODUCTION

In 2016, a collaborative of local community organizations came together with the aim of assessing mental health needs and access barriers among adults residing in ten predominantly high economic hardship community areas on Chicago's southwest side. Using a community-based participatory research approach and a mixed methods design, member organizations of the Collaborative for Community Wellness undertook this mental health needs assessment in two phases. During the first phase, we surveyed 2,859 predominantly Latinx community residents to learn more about their most pressing emotional needs and the factors that impeded their ability to access formal mental health services. During the second phase of this project, we used qualitative methods to conduct nine individual interviews and eight community forums with community stakeholders, where we presented findings from the surveys and further explored mental health needs, access barriers, and solutions for addressing mental health needs.

This report, a product of the Collaborative for Community Wellness, begins by reviewing the existing literature on mental health access barriers among the U.S. Latinx population prior to discussing the conceptual model and the local Chicago context that informed our research. We then present our research methodology, findings, and recommendations. No external funding was utilized to conduct this research or to compile the report. Throughout this report, we use the term Latinx to be inclusive of individuals of all genders and to recognize their various intersecting social identities (e.g. gender, sexuality, language, immigration history, ethnicity, culture, and phenotype).¹⁴

*we do this for
our community*

BECAUSE MENTAL HEALTH SERVICES
SHOULD BE ACCESSIBLE FOR ALL



Sara Briseño, "We do this for our Community". Mixed Media. 2016.

BARRIERS TO MENTAL HEALTH CARE FOR THE U.S. LATINX POPULATION

There is a well-established body of literature documenting a range of barriers that the U.S. Latinx population experiences in accessing mental health services. While literature cites stigma, specifically a fear of being labeled as “crazy,” as an individual level access barrier,^{15,16,17,18,19} there is also a well established body of literature identifying factors that impede service access across multiple environmental levels. These barriers include lack of insurance coverage, service cost, transportation difficulties, lack of child care, and long work hours.^{20,21,22,23,24,25} Among the undocumented Latinx immigrant population, factors associated with the immigration system, specifically concerns regarding the confidentiality of their immigration status and the fear of being reported to immigration authorities, pose additional access barriers.^{26,27,28,29,30,31,32,33,34}

Organizational capacity to deliver culturally and linguistically appropriate services has also been found to influence mental health service access among the Latinx population. Limited availability of services that are responsive to the individual’s cultural values and that are offered in the individual’s native language is frequently cited as an access barrier.^{35,36,37,38,39,40} Not only has research identified culturally affirming service delivery at the level of the individual service provider as influencing mental health service access, but it has additionally identified that service access may be either facilitated or impeded by the extent to which organizations have developed the infrastructure to deliver services that are culturally affirming and aligned with community members’ needs.^{41,42}

The barriers that the Latinx population experiences in accessing mental health services are in turn associated with higher levels of unmet mental health need among Latinx in comparison to non-Latinx Whites.^{43,44,45,46} Not only has epidemiological research established that Latinx adults with an identified mental health need use specialty mental health services at lower rates than non-Latinx Whites, but analyses across subgroups also indicate lower rates of service use among immigrant Latinx in comparison to both non-Latinx Whites and U.S.-born Latinx.⁴⁷ It has also been noted that unmet mental health needs may be higher among Latinx of Mexican origin in comparison to other Latinx subgroups. Epidemiological data indicate, for example, that Mexican-American and African-American adults diagnosed with major depression had lower rates of therapy use in comparison to Puerto Rican, Caribbean Black, and non-Latinx White adults.⁴⁸

Although epidemiological data capture the disparities in service use among racial minority groups, the literature to date does not fully explain the systemic factors that lead to these disparities. The limited attention devoted to these systemic factors in the literature to date may lead to the presumption that it is mainly individual level access barriers that impede mental health service use. Recognizing the limitations in the existing literature, we use a structural analysis to understand the compounding effects of systemic failures and multiple contributing factors resulting in limited or unfit service access and leading to inappropriate treatment.

MENTAL HEALTH ACCESS: A STRUCTURAL ANALYSIS

As conceptualized by this report, access to mental health services and barriers to care are best understood through a structural analysis. Understanding mental health and treatment barriers through a structural lens provides an alternative to the traditional medical model, which emphasizes individual level characteristics associated with mental health symptoms and service use. In contrast to the medical model, a structural analysis seeks to understand the compounding effects of social institutions, social processes, social practices, and social relationships on the individual, along with understanding the impacts that our society's ideologies have on the lives of individuals and communities. As illustrated in Figure 1 below, society is envisioned as a bridge structure, whereby the foundation on which the bridge is erected is the ideology that underpins society. Just as the foundation of the bridge is essential to sustain the structure on which it is built, yet is out of view, so too are the ideologies of society. The pillars holding up the bridge platform are the various social systems created to manage society's primary functions, including but not limited to economic, political, and social welfare systems, among others. As social systems carry out their primary functions, they reinforce dominant ideologies and transmit these ideologies to members of society. In turn, members of society reciprocally reinforce dominant ideologies through their interpersonal interactions. Mullaly explains this process as follows: "the substructures or foundation of society consists of a dominant ideology, which is transmitted to all members of society through the process of socialization and determines the nature of a society's institutions and the relations among its people."⁴⁹

Recognizing that social systems define access to care, our analysis of mental health needs and service use must in turn incorporate an examination of the multiple systems that influence service access. Within the local context of Chicago, literature highlights how the medical, social welfare, criminal justice, and education systems play a role in either facilitating or impeding access to mental health services. In the following section, we analyze how these four social systems play a part in mental health service access among community residents in Chicago.

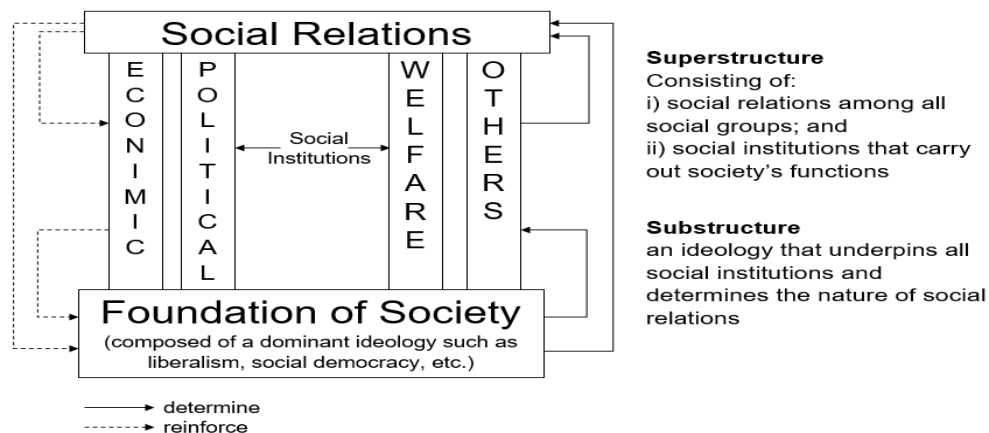


Figure 1. Structural view of society.⁵⁰

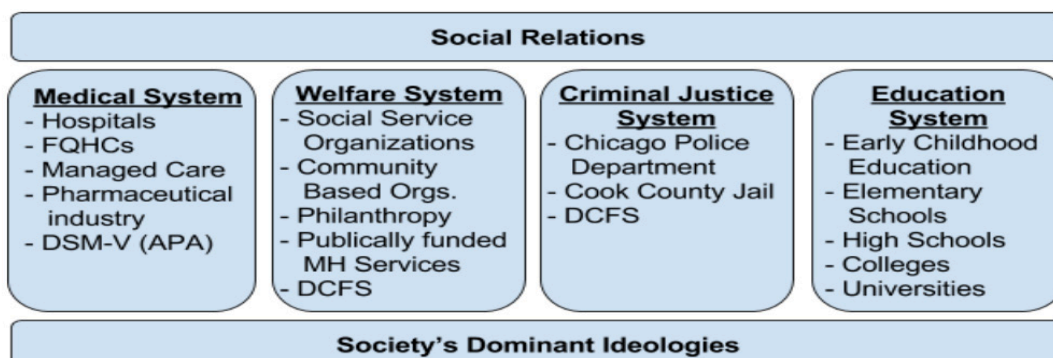


Figure 2. Conceptual model adapted from Mullaly (2007) to reflect the access points to mental health treatment in Chicago.⁵¹

THE CHICAGO CONTEXT

Chicago is an urban area with severe and persistent economic inequality. Any study of mental health access in Chicago needs to take this local context into account. Within the city of Chicago, there are 26 community areas with predominantly African-American and Latinx (majority Mexican) populations that are designated as high economic hardship communities (Figure 2), based on their ratings for six social and economic indicators. These indicators include: the unemployment rate among residents over age 16, the percentage of community residents over age 25 without a high school diploma, per capita income, the percentage of community residents below the federal poverty level, the rate of crowded housing, and the percentage of the population under age 18 and over age 64.⁵² Residents of these high economic hardship communities are impacted by what scholars describe as structural violence.^{53,54} Structural violence is a concept that captures the understanding that systems are designed in a way that create conditions of inequality, and these conditions of inequality cause harm in people's lives.^{55,56}

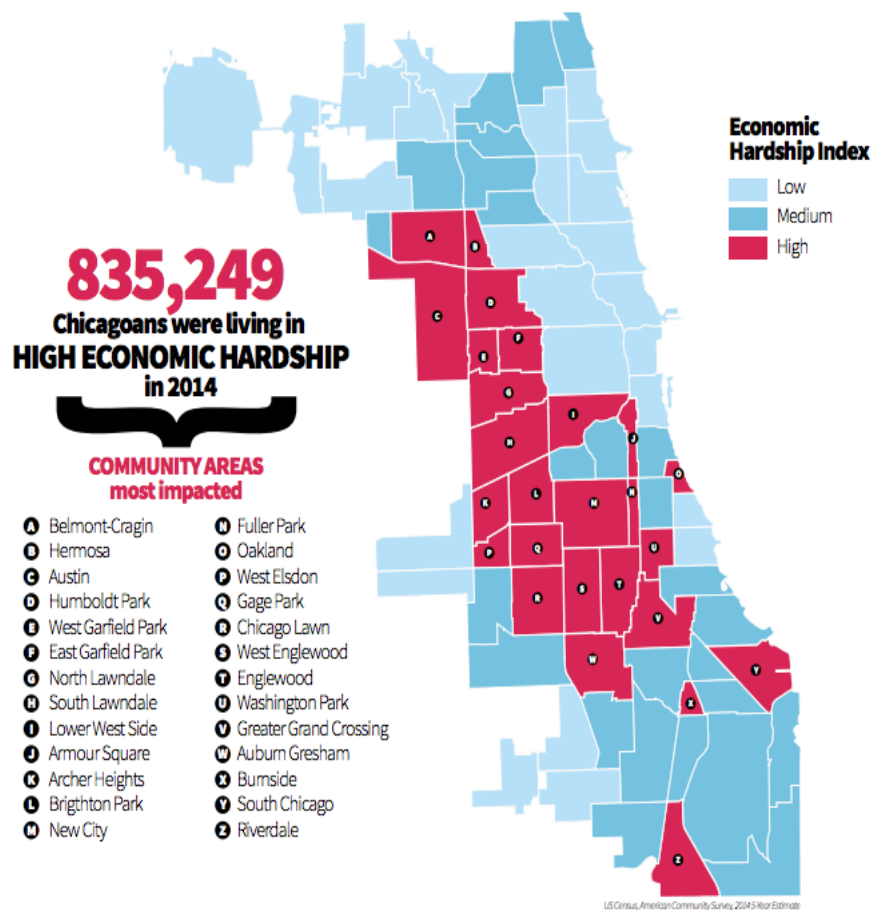


Figure 3.

Structural violence also perpetuates these same conditions by limiting people's access to the resources needed to improve their lived reality. Experiences of poverty, unemployment/underemployment, challenges with housing, attending under-resourced schools, limited social service infrastructure, and ease of access to firearms, among other factors, all have a combined effect on the mental health of individuals and the well-being of families living in these marginalized communities.⁵⁷ The story, highlighted below, demonstrates the profound impact of structural violence.

A Case Example of Structural Violence: **Maria's Family within the Community Context of Chicago**

(all identifiers have been modified to maintain confidentiality)

Maria and her family confront a multiplicity of issues stemming from social systems (economic, political, legal, and cultural) that cause harm and stop individuals from reaching their full potential. Maria immigrated to Chicago from Mexico two decades ago. She is the mother of five children and is currently married. Her spouse is the father of the three youngest children. Her two eldest children are from a previous relationship where Maria suffered from extensive physical, sexual, and emotional abuse in the relationship. In the summer of 2015, Maria's second oldest son was shot and killed. He was just 15 years old. The loss of her son brought forth multiple challenges to the family's already precarious situation, in which they were extremely reliant on their low-wage employment in factory jobs located far from the city. Maria's husband was employed in the same factory for over 10 years as a "temporary worker". Maria, who was also employed in the factory at the time of the loss of her son, was called out by her supervisor for making mistakes at her job. She was pressured to continue working at the same pace or lose her job. When she needed to miss work to attend a school meeting to address the needs of her third eldest son, she was fired.

Their precarious employment situation and the size of their family has made it difficult to find housing in an area where they feel safe. Maria and her husband are currently seeking residence in a different apartment complex, and they are frequently turned away by landlords during their housing search. The family is also undocumented and lives in constant fear of deportation. Their landlord also rents to a man who was recently released from federal prison. U.S. Immigration and Customs Enforcement (ICE) has been searching for this man and has raided the home of the family twice in the middle of the night in addition to searching the entire building. Maria's youngest children suffer from anxiety as a result of these raids along with ongoing exposure to violence in the community.

While acknowledging that she has suffered a lot (the traumas of immigration, acculturation, domestic abuse, and loss of a child), Maria says she worries most about the well-being of her children and their futures. She wants therapeutic and remedial supports for her children, but is unsure how to connect with resources. Her third eldest son Brian, who is currently in eighth grade, has an Individualized Education Program (IEP) and was diagnosed with a learning disorder in fourth grade. Despite the fact that he has an IEP, Maria struggles to obtain the supports and services to which her son is entitled. By seventh grade, Maria did not have access to the most updated IEP, and both mother and son reported services were spotty at best and did not align with what his teachers reported to be outlined in the IEP. Maria was not invited for IEP meetings and evaluations, and as a result, decisions were made without her authorization. In addition to being excluded from IEP meetings, Brian's IEP materials were not provided in Spanish, and Maria therefore was unable to understand what was being discussed around her child's needs. Upon the loss of his brother, Chicago Public Schools did not identify Maria's son Brian as in need of socio-emotional support. In the present day, he has trouble with basic reading and math skills and reads at a first grade level. Instead of offering remedial supports, the school system is threatening to send him to a vocational program because they don't think he will manage well in high school.

The entire family has been impacted by the loss of the second oldest. Maria has attempted to engage in individual outpatient services for Brian to support him with depression and anxiety. Brian's insurance was not accepted in multiple locations and Maria had very few options close to her home. When they did find services for Brian, Maria was unsatisfied with his treatment and Brian's insurance only covered a few sessions. In addition, Brian's pediatrician did not heed Maria's concerns regarding her son's behavior and did not provide support in referring for the necessary services.

Maria's example will be continued on page 62.

Experiences of structural violence are integrally connected to trauma. Trauma refers to the emotional harm that occurs in situations where an individual or collective group is posed with an imminent threat to their safety or well-being.⁵⁸ In light of this definition, there is a growing recognition of the traumatic impact of structural violence and oppression. In particular, this traumatic impact is felt among individuals and communities who not only face physical safety concerns stemming from ongoing exposure to community violence and the constant threat of deportation, but who also encounter interpersonal and societal discrimination and are denied access to the resources necessary to address their material and social-emotional needs.⁵⁹ In high economic hardship communities, the traumatic impact of structural violence and oppression can be compounded by adverse childhood experiences. Not only do these experiences of structural violence impact mental health, but opportunities to access long-term, trauma-focused mental health services are also limited within Chicago's current mental health service landscape. The following sections will explore the mental health service landscape within the context of Chicago as assessed through a structural analysis.

Medical System

It is unquestionable that the psychopharmaceutical industry maintains the dominant influence within the public discourse on mental health. Understanding mental health treatment through the medical system requires a complete understanding of the impacts of the biomedical industrial complex on those it serves, as it maintains a near monopoly on the subject of mental health: "...the biomedical model concedes only minor importance to these [environmental] factors. Rather than striving to improve human relationships or living conditions...the biomedical complex siphons off resources to develop and distribute more psychoactive drugs."⁶⁰ By pathologizing individuals, professionals within the medical system strip social context in favor of a disease-model, thereby minimizing the importance of social efforts in favor of medical treatment. This model overshadows the person-in-environment perspective, a perspective that seeks to improve the environmental context of individuals whose mental state is being affected "by focusing on: people's interpersonal, emotional, educational, and material needs; harmful effects of deprivation, abuse, and trauma; and the benefits of supportive social relationships, self-awareness and self-regulation, constructive thinking and problem-solving, and other coping mechanisms."⁶¹

By way of assessing mental health needs through the dominant system, an analysis of data collected through the medical system provides insight into rates of mental health crisis throughout the city of Chicago. As reported by WBEZ news, rates of ER visits in Chicago increased dramatically following Chicago Department of Public Health mental health clinic closures (please see the Social Welfare System section below for further discussion on the clinic closures): "From 2009 to 2013, 37 percent more patients were discharged from emergency rooms for psychiatric treatment. The biggest jump came in 2012, the same year the city closed half of its mental health clinics."⁶²

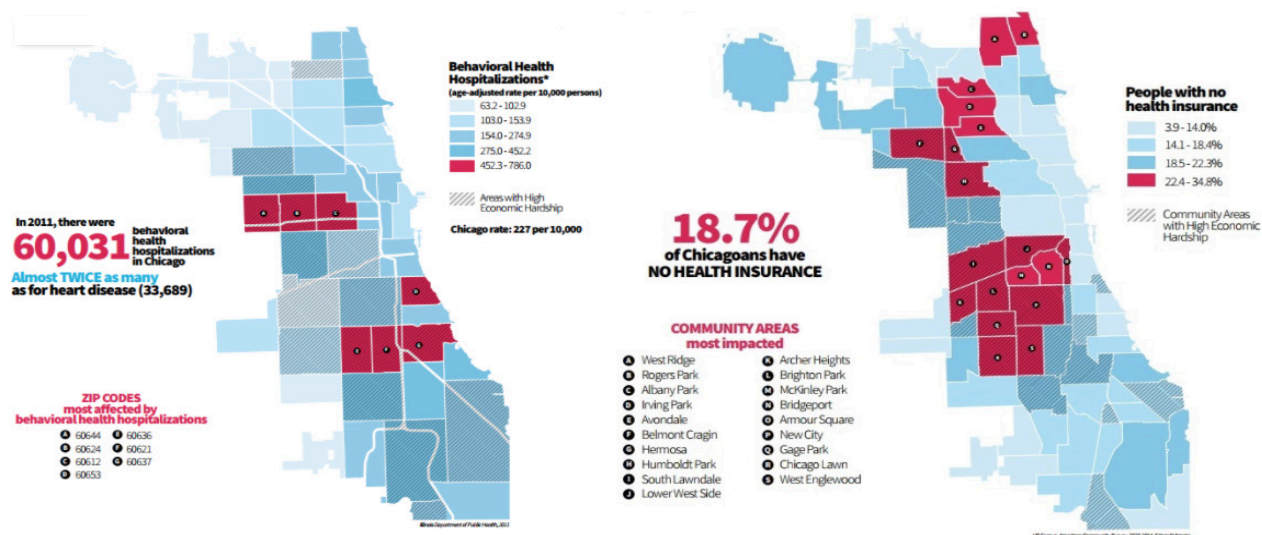


Figure 4 and Figure 5.

Furthermore, Healthy Chicago 2.0 data on behavioral health hospitalizations demonstrated that the zip codes with the highest rates of hospitalization include Chicago's west and south sides, predominantly African-American communities in the heart of the high economic hardship areas of the city (See Figure 4). Although the remaining high economic hardship communities, which are predominantly Latinx, do not record similar rates of behavioral health hospitalizations, it should also be noted that these communities have among the highest uninsured rates in the city (See Figure 5). Considering that health insurance coverage often serves as a prerequisite for obtaining mental health treatment at a hospital, it is likely that high uninsured rates may explain the lower rates of behavioral health hospitalization in these communities.

It is important to consider mental health service access barriers encountered among individuals with and without insurance coverage. A recent survey conducted by the Kennedy Forum highlights the challenges encountered among those with insurance who faced rejections by their managed care organization for mental health and addictions treatment. A research report published in December of 2017 by Milliman, a risk management and healthcare consulting company, highlighted how managed care organizations pose barriers to accessing affordable mental health services by limiting the number of providers in an individual's insurance network. Data from this report demonstrated that at the national level, the proportion of mental health care that was provided by clinicians outside of individuals' insurance networks was 3.6 to 5.8 times higher than rates of out-of-network care for medical and surgical services.^{63,64} These high rates of out-of-network care indicate that insured individuals receiving mental health services are likely still burdened with out-of-pocket service costs.^{65,66} "Because of low reimbursement rates, professionals in the mental health and substance abuse fields are not willing to contract with insurers. The result is insurance plans with narrow behavioral health networks that do not include enough therapists and other caregivers to meet patient demand," says Henry Harbin, former CEO of Magellan Health, a managed behavioral health care company. "Ali Carlin, 28, says she used to see her therapist in Richmond, Va., every week, and had a co-payment of \$25 per session. But in 2015, the therapist stopped accepting her insurance and her rate jumped to \$110 per session."⁶⁷ The emphasis on cost savings and low insurance reimbursement rates for providers thus make mental health services less affordable and may ultimately deter participation in long-term mental health services.

Not only do managed care organizations pose service access barriers among insured individuals, but lack of insurance coverage poses a severe barrier to service access. The Chicago Department of Public Health's Healthy Chicago 2.0 report finds that the highest proportion of Chicagoans without health insurance reside on Chicago's southwest side, a predominantly Latinx (Mexican) area of Chicago. Treatment options in these neighborhoods are extremely limited in comparison to communities where residents have access to private insurance and have the financial means to pay out-of-pocket for mental health services. A recent search of available private practice clinicians in Chicago's wealthy Near North Side community and the wealthy village of Oak Park, adjacent to Chicago, captures the disparity of access. We intentionally selected the Near North Side and Oak Park as areas of comparison due to their proximity and level of affluence. Data indicate that the low economic hardship community of the Near North Side has a per capita income of \$88,669⁶⁸ and that the village of Oak Park has a per capita income of \$49,664,⁶⁹ while the southwest side communities that are the focus of this study have an average per capita income of \$15,094.⁷⁰ Comparing availability of clinicians within areas that have distinct economic profiles thus allows us to assess how affluence influences service accessibility. An Internet search through the websites Psychology Today, the Yellow Pages, Wellness, Goodtherapy, and Yelp, conducted in November of 2017, indicated that after removing duplicate entries from the websites, there were a total of 381 licensed clinical social workers and licensed professional counselors in the zip codes corresponding to the Near North Side community. Nineteen of these mental health professionals indicated that they offered services in Spanish.

Results also yielded a total of 244 providers in the zip codes corresponding to the village of Oak Park, five of whom were identified as Spanish-speaking. In contrast, for the five zip codes corresponding to the southwest side of Chicago, which captures 12 communities, there was a cumulative total of 66 licensed mental health professionals. When calculating the number of licensed clinicians per 1,000 people based on these data, the numbers reveal that there are slightly over 4 licensed clinicians per 1,000 people in both the Near North Side and Oak Park, while there is 0.17 licensed clinicians per 1,000 people on Chicago's southwest side. Furthermore, of the 66 licensed professionals on the southwest side, only 18 indicated that services were offered in Spanish.^{71,72,73,74,75} The marked disparity in mental health providers is alarming, and becomes even more so when considering that the Back of the Yards mental health clinic, one of only two bilingual English and Spanish Chicago Department of Public Health (CDPH) mental health clinics, closed in 2012.⁷⁶ The closure of the Back of the Yards mental health clinic has thus had a profound impact on southwest side community residents whose options for accessing bilingual and culturally appropriate mental health care are severely limited.⁷⁷

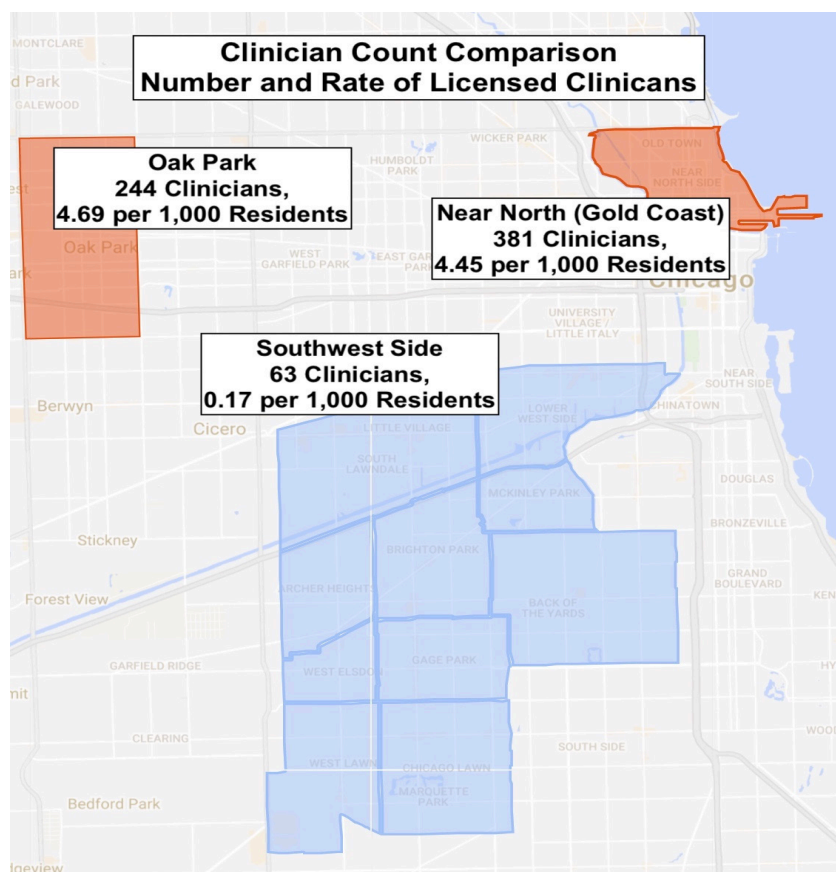


Figure 6. Clinician Count Comparison Map

For those who are uninsured and with limited income, health care access has shifted to receiving medical care at community-based federally qualified health centers. For many in Chicago, this may be the only available resource for mental health services outside of state-funded psychiatric hospitals or the city health system. Mental health service provision within the medical setting has led to the development of integrated models of care which often include short-term mental health services focused on symptom reduction. However, the effectiveness of integrated care models in promoting long-term positive mental health outcomes is questionable, as evaluations of integrated care models in real-world practice settings are limited.⁷⁸ Furthermore, a review of the literature on integrated care models found that practice effectiveness is typically assessed through measures of individual symptomatology and cost effectiveness, while the extent to which integrated care practices promote “equitability or... accessibility or timeliness of care” are seldom explored.⁷⁹ Considering the limitations in the research that has been conducted to date, we have no way of knowing whether mental health services offered through federally qualified health centers are truly accessible and promote positive mental health outcomes among marginalized and underserved community residents.

Social Welfare System

Understanding the complex and intertwined mental health needs of individuals within Chicago's high economic hardship communities requires an assessment of how mental health services are funded as a part of the social welfare system. State funding for mental health supports has continually decreased. As the National Alliance on Mental Illness (NAMI)-Chicago indicated in a 2015 white paper: "Between FY 2009 - FY 2012, Illinois cut \$113.7 million in general revenue funding for mental health services." The white paper further specified that cuts through this period were among the highest in the nation, making Illinois the third highest state in mental health funding cuts.⁸⁰ A key challenge to funding mental health services has been the consistent and limiting low rates of Medicaid reimbursements by the state of Illinois. NAMI-Chicago speaks to the implications of what they describe as the "bare-bones publicly funded mental health system":

"As of the spring of 2015, only 141 agencies statewide are contracted to provide these services [mental health services to adults living with mental illness]. Providers can only afford to offer services that are Medicaid-reimbursable, and, with state Medicaid reimbursement rates remaining relatively stagnant in the past five years, many community-based providers have had to stop delivering all recovery-promoting services that are not Medicaid billable."⁸¹

More recently, the two-year Illinois state budget impasse weakened the current infrastructure of mental health service delivery. A United Way of Illinois survey of human service agencies across the state documented the reduction and elimination of mental health services and programs. The report concludes by stating that: "shifting the State's obligations to private philanthropy is not viable."⁸² Information shared at a public meeting in February of 2018 confirmed the United Way of Illinois' findings. As a result of the budget impasse, programs that provide mental health and psychiatric support to youth experiencing mental health crises have experienced drastic cuts. For example, the organization Ada S. McKinley Community Services Inc., which serves Local Area Networks 77, 79, 80, 82, 84, and 86 (spanning from the northern boundary of Brighton Park to the southern boundary of Riverdale), has lost three quarters of their psychiatric staff. With the number of staff providing psychiatric evaluations being cut from four to one, psychiatric evaluations for individuals ages 20 and under have gone from being offered every day of the week to being offered one day per week. Furthermore, there is currently only one Spanish-speaking worker providing Screening, Assessment and Support Services to youth in mental health crisis across the entire southwest side of Chicago.

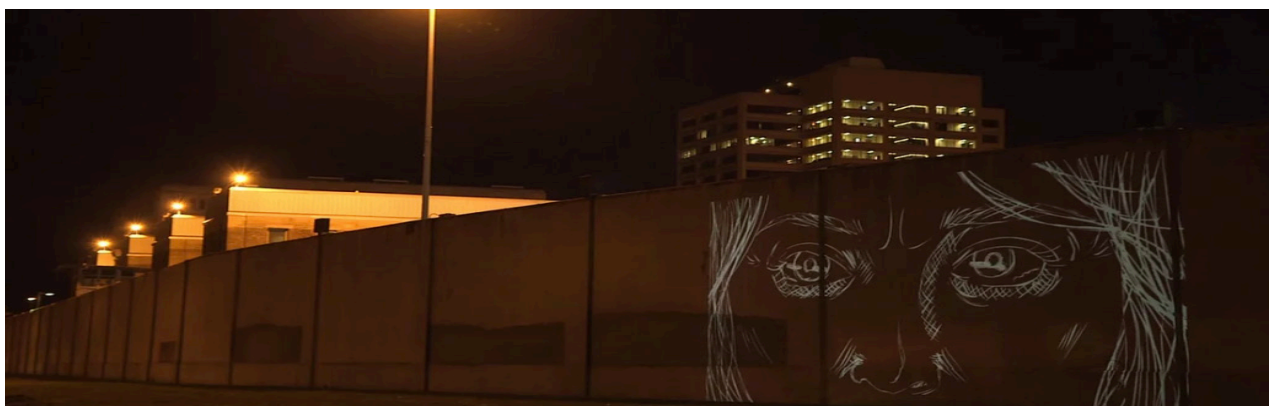
Over the last six years, the CDPH has sought to shift away from offering mental health services through CDPH mental health clinics. While there were 12 CDPH-operated clinics throughout the city in 2011 (at one point 19)⁸³, the number has been reduced to five currently operating clinics, with the first closures initiated with the passage of the 2012 city budget.^{84,85} As previously noted, the Back of the Yards mental health clinic was among the clinics to be closed. Even though the city outlines the need for health reforms within the CDPH mental health services⁸⁶, advocates document the impacts of the closures on those who depended on these services.^{87,88} Additionally, public hearings on the closures were not conducted until August of 2014, two years after the closure of six clinics.^{89,90} A community resident who received services through the Back of the Yards mental health clinic spoke about how she is personally affected by the clinic closure: "I was born like this. But I keep control of myself with medicine. But now that it's [Back of the Yards mental health clinic] is going to close...There's gonna be lots of problems...big problems...Because the disease schizophrenia it's a disease that has a cure. But only if you get the treatment they give you here" [Spanish translation].⁹¹ As illustrated through this quote, the CDPH clinic closures have a life-changing impact on marginalized community residents who have no other recourse for accessing affordable and culturally and linguistically appropriate mental health treatment. While the city of Chicago continues to disinvest in publicly funded mental health services, expenditures on policing drastically outweigh expenditures in the health and social welfare systems. For example, in fiscal year 2017, the city of Chicago allocated 17.6% of its operating budget to the Department of Police. In comparison, only 0.4% of expenditures were allocated to the CDPH and only 0.9% were allocated to the Department of Family and Support Services.⁹²

Criminal Justice System

In the community of South Lawndale (the official community area designation for Little Village), you can find the largest mental health hospital in the nation, Cook County Jail.⁹³ Therefore, mental health needs of the residents of Chicago must also be measured by data collected from the criminal justice system. It is estimated that more than half of the prison population suffers from mental illness.⁹⁴ As stated in NAMI-Chicago's 2015 white paper: "Studies show that over 60% of incarcerated individuals meet diagnostic criteria for mental illness. That means that of the approximately 76,400 individuals people who were admitted to Cook County Jail (CCJ) in 2012, 45,840 were people living with mental illness. It is thus little surprise that, following national trends, many of the jails and prisons in Illinois have become de facto mental health treatment centers. CCJ is now considered the largest mental health care provider in the country. In fact, studies show that for many people living with mental illness, the only time they get treatment is when they are in jail."⁹⁵ As reflected in this quote, within the United States, prisoners are the only population with the constitutional guarantee of health and mental health care.⁹⁶

Cook County Sheriff Thomas Dart directly connects mental health service funding cuts to the growing percentage of incarcerated individuals with mental illness, referencing "shameful and fiscally irresponsible consequences of the criminalization of mental illness."⁹⁷ Furthermore, marginalized community residents dealing with poverty often come into contact with the criminal justice system because the social welfare system does not adequately invest in basic human needs. A case study highlighted through the Sheriff's office website documents an example of a homeless, pregnant woman named M.H. who spent 135 days in jail, at a cost to taxpayers of \$19,305, for stealing two plums and three candy bars. The police report for that arrest gives M.H.'s motive: "She took the food because she is pregnant, and she was hungry." The case study goes on to say that M.H. was booked into the Cook County Jail a total of five times for 14 arrests, with the majority of arrests occurring for the theft of basic survival items. M.H. spent 221 days in Cook County Jail between July 1, 2013 and Aug. 20, 2014, costing taxpayers more than \$50,000. The last 167 days that M.H. spent in jail for stealing these basic survival items cost more than \$23,000, excluding medical and court expenses.⁹⁸ This example highlights the human consequences of increased investment in the criminal justice system at the expense of disinvestment in the social welfare system.

The taxpayer dollars spent on incarceration are disproportionately concentrated in Chicago's marginalized communities. For example, data indicated that between 2005 and 2009, there were 851 city blocks in low income, predominantly African American community areas on the city's south and west sides where taxpayers spent at least \$1 million on the cost of incarcerating community residents in Illinois state prisons. These city blocks are known as "million dollar blocks." Furthermore, in 121 of these million dollar blocks, incarceration costs totaled at least \$1 million for solely nonviolent drug offenses.^{99,100} In an article that appeared in the Washington Post's Wonkblog in July of 2015, reporter Emily Badger posed the following question: "What would happen if we poured the same resources into these same struggling parts of any city in very different ways?"¹⁰¹

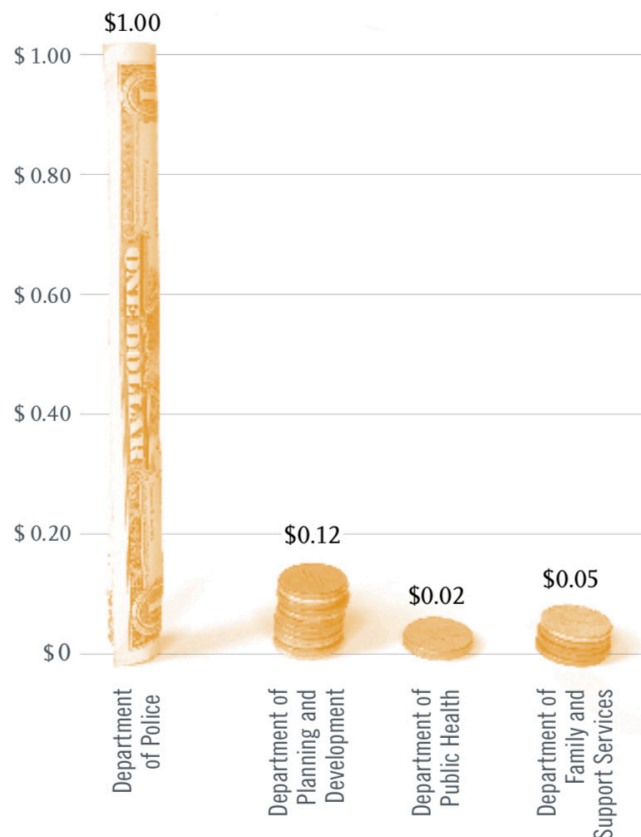


Claudia Rangel, Susan Mullen, Melissa Garcia, Hector Duarte. Video Documentation by Scrappers Film Group. Clip from "Letters Home". Stories from the Inside/Outside: 96 Acres Project. Site Interventions at and around Cook County Jail, Chicago. 2016.

The city of Chicago's increased investment in the criminal justice system is also reflected in the percentage of budget expenditures allocated to the Chicago Police Department. A budgetary analysis of 10 cities and 2 counties across the nation indicated that of the 12 studied jurisdictions, the city of Chicago ranked second in the percentage of its fiscal year 2017 general fund budget allocated to the Police Department (38.6%).¹⁰² As funding is disinvested from the social welfare system and invested in the criminal justice system, the police become de facto mental health intake workers for individuals with mental illness.

"The police department reports some 120 mental health disturbance calls a day, but that grossly underrepresents the problem. In lieu of adequate investment from state, county and local governments, the mental health problem has become more acute, and police officers have become the safety net," states Alexa James, director of NAMI-Chicago. She expands by saying: "The 12,000-plus sworn officers of the Chicago Police Department comprise the largest social service agency in the city. They provide these services at all hours of the day and every day of the year. They are called on to be mental health experts, emergency marriage counselors, child-welfare advocates and juvenile behavior specialists. They are required to triage the full range of ills that crop up daily in a city of 2.7 million people. It's a job they didn't sign up for. And it's a job they aren't trained to do."¹⁰³ Police interactions with those in mental health crisis have ended with their life being taken by police, as in the case of the recent shootings of Quintonio LeGrier and Michele Robey. Another noteworthy case is that of the deceased Philip Coleman, who was arrested while having a mental break in 2012, and while in police custody suffered severe trauma due to police brutality at a Chicago police station.¹⁰⁴

Cents to the Dollar: Investments in Policing to Investments in the Dollar



Source: FY2017 City of Chicago Budget Ordinance

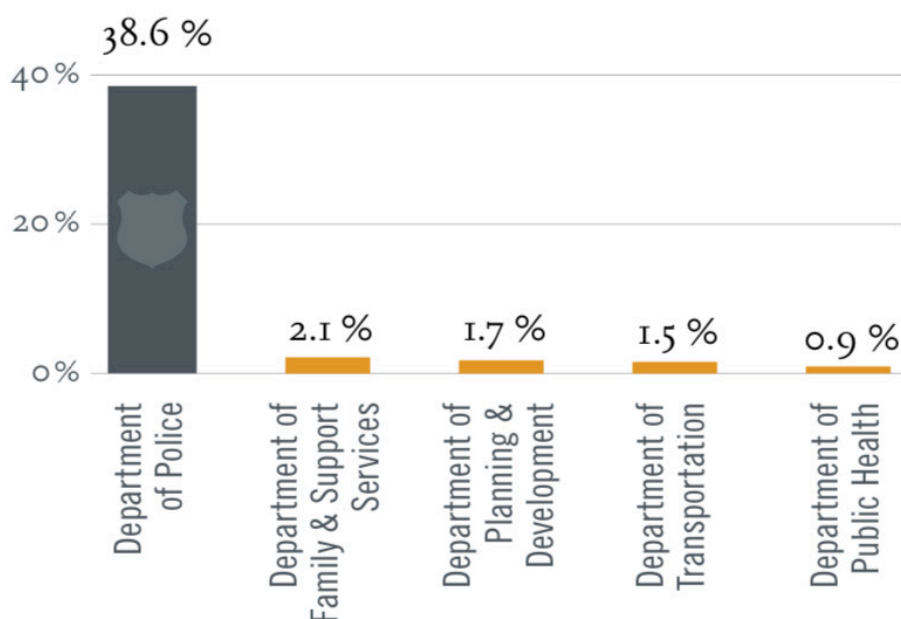
Figure 7. Graph obtained from: The Center for Popular Democracy, Law for Black Lives, and Black Youth Project 100 (2017). Freedom to thrive: Reimagining safety and security in our communities. Retrieved from <https://populardemocracy.app.box.com/v/FreedomtoThrive>, p. 22 (Graph entitled "Cents to the Dollar: Investments in Policing to Investments in the Dollar").

Crisis Intervention Training (CIT) for police officers is a current mechanism for teaching officers to identify cases of mental illness and implement de-escalation strategies. After years of lukewarm commitment to the CIT program,¹⁰⁵ and in the wake of the release of footage of Laquan McDonald's shooting and investigations into the fatal shooting of Quintonio LeGrier and Bettie Jones, Mayor Rahm Emanuel announced plans to require all Chicago Police Department officers and supervisors to attend a two-day mental health awareness and de-escalation training.¹⁰⁶ According to a source within the Chicago Police Department "all officers now complete a basic CIT course and roughly a third of the department receive advanced instruction to make them certified."¹⁰⁷

In Chicago, police response to mental health incidents and suicide attempts can also include the deployment of Special Weapons and Tactics (SWAT) teams, as documented following a Freedom of Information Act request of SWAT deployment. According to a news article published in The Intercept in August 2017:

"As of this spring, 2017 is on track to see more than twice as many mental health-related SWAT raids as the annual average over the past four years. The figures in the documents likely undercount the number of SWAT deployments in response to mental health crises, because not all cases are logged as such in police records."¹⁰⁸

FY17 Selected General Fund Expenditures



Source: FY2017 City of Chicago Budget Ordinance

Figure 8. Graph obtained from: The Center for Popular Democracy, Law for Black Lives, and Black Youth Project 100 (2017). Freedom to thrive: Reimagining safety and security in our communities. Retrieved from <https://populardemocracy.app.box.com/v/FreedomtoThrive>, p. 22 (Graph entitled "FY17 Selected General Fund Expenditures").

Educational System

The educational system offers opportunities for facilitating mental health access within local Chicago communities. At the national level, literature points to the benefits of integrating mental health services into the school setting for youth and their families. A review of the literature indicates that school-based mental health services facilitate service access among underserved children and adolescents whose families might otherwise encounter barriers, including transportation difficulties and lack of childcare.¹⁰⁹ In addition, school-based mental health services have been associated with positive emotional and behavioral outcomes among children and adolescents, as well as increased family engagement with their child's school experience and overall improvements in school climate.¹¹⁰ A range of models exist for providing mental health services in the school setting. Some models ask teachers to deliver interventions in the classroom, which may require coordination with other school officials and further training.^{111,112} In other models, community agencies and providers with expertise in providing mental health support are brought into the school.¹¹³ While both models of service delivery have been found to be promising in promoting positive mental health outcomes and facilitating service access among children and adolescents, challenges still exist in delivering coordinated and comprehensive services.¹¹⁴ Limited financial resources, time constraints, and confidentiality concerns are all factors that may impede interdisciplinary collaboration.¹¹⁵

Within the local Chicago landscape, there is growing recognition of the role that schools can play in facilitating mental health service access among children and families in marginalized communities. Recognizing that resources to address students' mental health needs are limited at Chicago Public Schools due to budget cuts, the city recently applied for and received a \$1.3 million federal grant to expand mental health services in ten high schools on Chicago's south and west side communities.¹¹⁶ While grant funding will increase access to supportive services for students residing in communities impacted by community violence, stakeholders also state that this funding is not enough to address the extent of existing needs.¹¹⁷ In a context where the demand for services exceeds the available resources, there runs the risk of services reaching only those with the highest need.

A 2017 Chicago Teachers Union report found that the number of school social workers across Chicago Public Schools is only 20% of the number recommended by the National Association of Social Workers,¹¹⁸ and a \$1.3 million grant is not in itself sufficient to address the shortage of social-emotional supportive services. Furthermore, a general disinvestment in schools in high economic hardship communities, as reflected through what Pavlyn Jankov, education policy analyst for the Chicago Teachers Union, describes as "rapid charter expansion and destabilizing school closures,"¹¹⁹ cannot be easily reversed through funding from a single grant. The closure of 49 Chicago Public Schools in predominantly high economic hardship communities in 2013 is reflective of this general disinvestment.¹²⁰ Lastly, while school-based mental health service delivery facilitates service access for underserved children and adolescents, it does not address service access barriers that exist for adults seeking mental health services.



Yollocalli Arts Reach. "Together We Fly Higher". Mural outside of Cardenas School, 2406 S. Central Park Ave. Photo by Yollocalli Arts Reach. 2017.

Despite the resource challenges that exist in facilitating mental health service access to underserved community residents through the educational system, local efforts to implement community school initiatives highlight the potential to facilitate service access when community partners join together to leverage existing resources. For example, the community school model exists as a promising opportunity for addressing the holistic needs of students, families, and communities at large. Under the community school model, school staff work in partnership with community members and local organizations to identify the most pressing health and social service needs and develop services within school settings to address those needs. Brighton Park Neighborhood Council provides a local example on the southwest side of Chicago of how the community school model has been implemented to address the lived experiences of community residents. Brighton Park Neighborhood Council has established formal partnerships with six local schools to deliver services that address the needs of the predominantly Latinx immigrant community residents living in these districts, including mental health services for students and a range of health and professional development classes for parents.¹²¹ Utilizing the educational system to provide mental health service access through the community school model has served as one way of addressing the lack of mental health access within a community faced with a myriad of socio-economic challenges.

BRIGHTON PARK: UNDERSTANDING MENTAL HEALTH NEEDS THROUGH AN EXAMINATION OF A COMMUNITY

In the middle of Chicago's southwest side is the neighborhood of Brighton Park, an excellent case study exemplifying how the various structural factors thus far reviewed impact the emotional wellness of community residents. Identified by the Chicago Department of Public Health as a high economic hardship community area, Brighton Park has a total population of 44,202 and is comprised of 85% Latinx and 46.7% foreign-born residents.¹²² An estimated 9,000 residents in Brighton Park are undocumented.¹²³ Brighton Park is second only to South Lawndale (Little Village) in uninsurance rates, with 29.3% of its residents lacking access to health insurance. The individual poverty rate (27.7%) and the household poverty rate (25.2%) are higher than the city averages, 20.9% and 18.9%, respectively. Educational attainment is a pressing challenge for the community, with just 8.7% of Brighton Park residents having obtained a college degree or higher, compared with 36.6% across the city. A total of 13% of community residents are unemployed, as compared to the city average of 9.5%. Housing is also a pressing issue in Brighton Park. Rates of overcrowded housing are the second highest in the city (13.9% in Brighton Park compared to 4.1% in the city of Chicago as a whole). In addition, 46.6% of Brighton Park households reported that they spend 35% or more of their income on housing cost.¹²⁴

The combined socio-economic snapshot captures a picture of what is understood to be the realities of the "working poor". According to the Bureau of Labor Statistics, "[t]he working poor are people who spent at least 27 weeks in the labor force (that is, working or looking for work) but whose incomes still fell below the official poverty level."¹²⁵ Finally, and of particular concern to community residents, Brighton Park has seen a rise in non-fatal shootings in recent years. As displayed in Figure 9 below, there were a total of 63 non-fatal shootings in 2016, reflecting an increase over the last six years.

Non-Fatal Shootings in Brighton Park

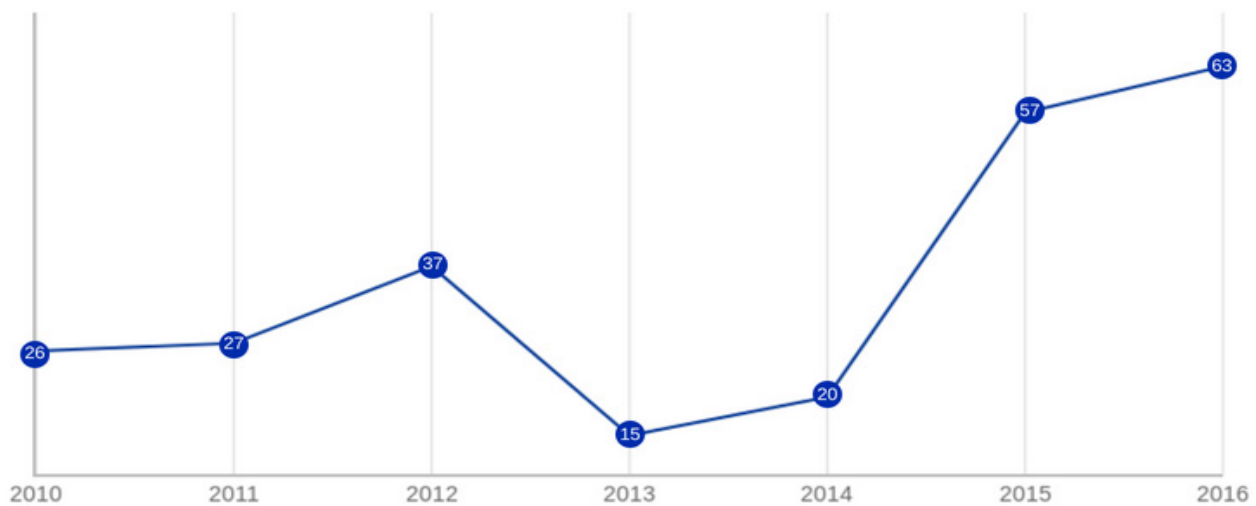


Figure 9 - The Chicago Department of Public Health requested this information from the Chicago Police Department's Research and Development Division.

Recognizing the negative impact of structural violence, in 2014 Brighton Park Neighborhood Council (BPNC) sought to advocate for more mental health therapy services to address the mental health needs they observed among community residents. BPNC partnered with Saint Anthony Hospital: Community Wellness Program (SAH:CWP) to assess mental health needs and access barriers in the Brighton Park community. After developing a culturally and linguistically appropriate survey instrument (a process that will be described in greater detail in the Methods section), BPNC and SAH:CWP administered the instrument to Brighton Park community residents. This mental health survey instrument was administered as part of a larger survey on overall health funded by the United Way, called the Healthy Trends Survey, that asked questions related to physical health conditions, physical activity, nutrition, and access to health care. In-person face-to-face surveying began in 2014 and was replicated the following year. A total of 434 respondents were surveyed in 2014, and an additional 295 respondents completed surveys in 2015. Two years of surveying consistently indicated the following findings: depression was the highest rated mental health issue reported, the overwhelming majority of respondents were interested in professional mental health therapy services, and cost was the highest barrier to accessing care.¹²⁶ The high levels of need and the reported access barriers confirmed what BPNC organizers and SAH:CWP mental health practitioners in the community already observed. Findings from Brighton Park surveys, however, contrasted with the dominant discourse within the field of mental health that emphasized stigma and individual level barriers to care. These findings led to an expansion of this research across multiple community areas, a process that is described below.

PURPOSE OF STUDY

The groundbreaking findings from the Brighton Park survey led to a commitment among various community partners to join together in scaling up this research, with the aim of assessing whether the data in Brighton Park were representative of other predominantly Latinx community areas on Chicago's southwest side. Our preliminary research in Brighton Park set the stage for the larger scale study outlined in this report, in which we assessed the mental health needs and access barriers across ten community areas on Chicago's southwest side. Further, recognizing the multiple intersecting social identities within the Latinx community, we investigated differences in mental health needs and access barriers by nativity status and gender.

METHODS

Building on preliminary research conducted in Brighton Park, this study used a community based participatory research (CBPR) approach and a mixed methods design to gain a comprehensive understanding of mental health needs, access barriers, and community-identified solutions for facilitating service access across ten community areas on the southwest side of Chicago. We intentionally used a CBPR approach to facilitate collaboration with community stakeholders throughout the process of data collection and analysis. Countering traditional forms of scientific research, a CBPR approach allowed us to highlight the importance of experiential knowledge and community members' expertise throughout all phases of the study.

In accordance with a mixed methods design, our study occurred in two phases. During the first phase of this project, we used survey methods to collect quantitative data on residents' mental health needs and common barriers that they encountered in accessing services. Second, informed by findings from our quantitative data analysis, we used qualitative methods to further develop our understanding of the findings that emerged during the first phase of the project. Each of these phases of the project will be further discussed below.



Rebel Betty, "En toda ocasión." Collage. 2015.

PHASE ONE: QUANTITATIVE METHODS

Survey Methodology

A culturally and linguistically appropriate survey instrument was developed to assess mental health needs and access barriers among adults residing in ten community areas in southwest Chicago, including Archer Heights, Back of the Yards, Brighton Park, Chicago Lawn, Gage Park, Little Village, McKinley Park, Pilsen, West Elsdon, and West Lawn. The SAH:CWP program supervisor developed this instrument, based on years of experience offering free mental health services to uninsured adult immigrant residents in Little Village¹²⁷ (please see Appendix 1). The survey was developed in Spanish using culturally appropriate language, and was intentionally designed to be brief and to be administered in a public setting independently or with minimal assistance. In order to assess for mental health needs, the program supervisor created a list of common presenting problems frequently observed within the mental health program. To capture the barriers to care, a list was developed from barriers commonly documented in the literature and programmatic experience. Each survey item will be discussed in detail below before describing how the surveys were administered. It is important to note that while survey items are presented in English in the following section, all survey respondents had the choice of completing the survey in either English or Spanish, depending on their language of preference.

Survey Items

Demographics

Survey respondents were asked to report on the following sociodemographic characteristics: neighborhood of residence, gender (male, female, or other), nationality, race/ethnicity (European American, African American, Latinx, Asian, Native American and other), and country of birth.

Emotional Wellness Concerns

We provided survey respondents with a list of social emotional challenges and asked them to choose up to three challenges they experienced with the highest frequency or intensity. Recognizing that community residents may have multiple pressing concerns, the survey was intentionally designed to allow respondents to select up to three responses. At the same time, responses were limited to three in order to ensure that respondents focused on what they perceived to be their most urgent concerns. Survey respondents were presented with the following list of social emotional challenges. If they did not mark the concern, it was coded as 0; if they did; it was coded as 1.

Depressive Symptoms. Sometimes I feel depressed or very sad.

Anxious Symptoms. Sometimes I feel anxious, constantly worried or extremely nervous.

Acculturative Stress. Living in a country whose culture and language are very different from mine is stressful.

Parenting Support. I feel I need support as a parent.

Trauma. There are troubling things that have happened in my life that continue to affect me.

Anger Control. I find it hard to control my anger.

Isolation. I feel lonely, I do not feel I have sufficient emotional support in my life.

Relationship Support. I feel I need support in my marriage/ relationship.

Seeking Support. Following the list of emotional wellness concerns, respondents were asked to respond to the following item: “Please choose the option that best reflects your reaction to this statement: ‘I would consider seeking emotional support by a professional (counseling) as a way of dealing with my personal problems.’ ” Response options were No, Probably No, Probably Yes, and Yes.

Barriers. The final survey item read as follows: “What are the things that make it difficult for you to access emotional support by a professional (counseling)? Please select all that apply.” Response choices included the following. If they were unmarked, they were coded as 0; if the respondent marked that concern, they were coded as 1. The survey was intentionally designed so that respondents could identify all of the factors that they perceived as impeding their ability to access services.

- Cost
- Lack of transportation
- Lack of childcare
- Lack of health insurance
- I do not believe those services would help me (coded as wouldn’t help)
- I would feel judged as “crazy” or “weak” or something else (coded as stigma)
- My partner/family would not approve (coded as family disapproval)
- It is difficult finding services in my preferred language
- Those services do not exist in my area (coded as services not near)
- I do not know where to go for those services (coded as don’t know where to go)
- The hours of service are not convenient for me (coded as hours not convenient)

Data Collection Procedures

Upon developing the survey instrument outlined above, recruitment activities were undertaken to invite community residents to complete the survey. Community resident research assistants, who received training in data collection techniques with hard-to-reach populations, used a convenience sampling strategy to invite community residents across the ten community areas to complete a survey. In order to ensure representativeness across community areas, the goal was to get 200 surveys from each community. This goal was achieved in nine communities, with West Elsdon falling just short, at 186 surveys.

Prospective survey respondents were recruited via direct person-to-person encounters in public spaces in all ten community areas, including schools, churches, community events, laundromats, grocery stores, and sports programs, between May 2016 and February 2017. Research assistants explained the importance and goals of the project, as well as information about confidentiality, to all prospective survey respondents. Data on refusal and non-response rates are not available. Community residents who agreed to participate completed the survey independently or were interviewed by research assistants at the request of the individual. Surveys were completed in either English or Spanish, depending on the respondent’s language of preference. The survey took approximately five to 15 minutes to complete. To maintain complete anonymity, respondents’ names were not collected. Major challenges during the data collection process included recruiting male participants and time availability for participation.

Additionally, it was more difficult to recruit from McKinley Park and West Elsdon due to the lack of public spaces in these two community areas.

Through these data collection activities, a total of 2,551 community residents filled out the survey instrument. Data from these surveys were combined with data from 436 Healthy Trends surveys filled out in Brighton Park. After combining survey responses from our own survey instrument and the Brighton Park Healthy Trends survey collected in May of 2017, we obtained a total of 2,987 survey responses for this study. After removing incomplete and duplicate surveys through the data cleaning procedures described below, our final sample for the main analysis was 2,859.

Participants

Of the 2,859 final survey responses obtained for this study, there were 214 respondents from Archer Heights, 365 from Back of the Yards, 445 from Brighton Park, 226 from Chicago Lawn, 277 from Gage Park, 362 from Little Village, 263 from McKinley Park, 204 from Pilsen, 186 from West Elsdon, and 317 from West Lawn. There were 331 respondents (12%) who completed surveys in English, while 2,528 (88%) completed surveys in Spanish. For gender, 2,150 (76% of valid responses) reported female, 684 (24%) reported male, and 25 respondents did not report their gender. The majority of the sample (91%) reported they were of Latinx origin, while 4% were African American, <1% were Asian, 4% were Caucasian, and <1% were Native American; 43 respondents did not report race/ethnicity. For place of birth, the 35 Puerto Rican respondents were classified as immigrants. Though they are U.S. citizens, Puerto Ricans living in the mainland U.S. face many of the same barriers and challenges that people immigrating face; therefore it seemed more appropriate to include them in this grouping. Of the 2,546 valid responses, 80% identified as immigrants (73% from Mexico and 7% from other Latin American countries, including Puerto Rico), while 20% reported that they were born in the United States. Three hundred and thirteen respondents did not report place of origin.

Data Cleaning Procedures

Data from all collected surveys were compiled in an Excel spreadsheet, and data were subsequently checked for duplicate entries. Checking for duplicate entries entailed reviewing each entry and identifying cases where the survey identification number and all responses were the same. Using this review process, a total of 13 duplicate entries were found and removed. In addition, all survey data were reviewed to ensure that respondents' neighborhood of residence corresponded with one of the ten community areas that were the focus of this study. Sixty-one surveys were removed because information on neighborhood of residence was missing. In addition, some respondents indicated multiple residences, which reflects the reality for many people. For clearer analysis, respondents who indicated multiple residences in the target neighborhoods were assigned the neighborhood with the fewest overall responses. If they indicated multiple residences, including a neighborhood or city outside the target area, the out-of-area response was deleted, leaving the in-area response. A total of 19 records were cleaned in this way. Additionally, 24 records were excluded because they only indicated a residence outside the target area (such as Cicero or East Lakeview) or had an invalid response (such as "2 piso"). Finally, 30 responses were removed because they contained only demographic data and no responses to other questions. At the conclusion of this data cleaning process, a total of 2,859 surveys remained for analysis.

Data Analysis

After all survey data were compiled and cleaned, we performed basic analyses using Microsoft Excel for Mac Version 15. Percentages were calculated for the mental health issues that participants reported, whether they would seek professional support, and for the barriers they encountered in seeking support. A composite variable was created to determine what percentage of respondents reported any social barrier (stigma, believing counseling would not help, and fearing family disapproval). These variables were also split and analyzed by gender and by place of birth, with Chi-square values computed to test for significant differences between men and women, as well as between immigrants and U.S.-born residents, in SPSS for Mac 24. For seeking professional support, an additional analysis was conducted to assess whether respondents who did not report any emotional wellness concerns differed from respondents who did report concerns in their willingness to seek support. This analysis was conducted by splitting the respondents into those who listed at least one concern and those who listed none. For the item asking about mental health access barriers, further analysis was done to see if people with insurance still faced cost as a barrier. In order to conduct this analysis, we focused on the subgroup of respondents who did not list lack of health insurance as an access barrier.

In addition to the analyses described above, we also calculated weighted results. Because our sample included overrepresentation among women and immigrants, we wanted to compare the initial results to weighted results. This comparison allowed us to assess whether the patterns that we found in our data remained the same after accounting for concerns with the representativeness of our sample. We calculated post-hoc weights using data provided by the Chicago Department of Public Health (CDPH) and compared these data with the sample proportions we obtained. CDPH provided gender and foreign-born breakdowns for each neighborhood. Adding these across communities, the population demographics indicate that for gender, there are 181,778 females and 190,066 males. For place of birth, there are 138,653 immigrants and 233,191 U.S.-born residents. Using proportional distribution, this allowed us to transform our sample percentages into weighted percentages that more closely reflected the communities we surveyed.

Weighting Values

	Sample Percentages			Weighted Percentages	
	Immigrant	U.S. Born		Immigrant	U.S. Born
Female	62%	14%		18%	31%
Male	18%	6%		19%	32%

These weights were applied after the data had been uploaded to SPSS version 24. Missing information for gender and place of origin indicated for weighted results a sample size of 2,524. Frequencies were then calculated, looking at frequencies for the concerns listed, whether people would be willing to access support, and what barriers kept them from accessing support.

PHASE TWO: QUALITATIVE METHODS

Community Forums

After the quantitative component of the mental health needs assessment was conducted, findings were presented to community members during eight different community forums. Forums were held in accessible community spaces in Back of the Yards, Brighton Park, West Elsdon, Chicago Lawn, Little Village, and Pilsen. During these forums, community members were asked to provide feedback on the findings and to provide additional details regarding the factors underlying mental health needs and access barriers. Participants were also asked to provide recommendations for decreasing service access barriers and addressing community residents' mental health needs. There was a total of 190 participants across the eight community forums, and the majority were women. During each forum, members of the research team took detailed field notes on the content of the discussion, and these field notes were then compiled for subsequent analysis. The table below provides summary information of the forums.

Community Forums Information			
Date	South West Community Area	Participants	Host Organization/ School
11/22/2016	Little Village	12	Enlace Chicago
11/29/2016	Little Village and Marshall Square	16	Telpochcalli Community Education Project (Tcep)
8/12/2016	Brighton Park	20	Brighton Park Neighborhood Council (BPNC)
9/12/2016	Back of the Yards	26	U.N.I.O.N. Impact Center
12/21/2016	Gage Park and Chicago Lawn	26	Southwest Organizing Project (SWOP)
2/2/2017	Pilsen	10	Pilsen Alliance, St. Pius V
10/27/2017	Chicago Lawn, Gage Park, West Elsdon, and West Lawn	60	Southwest Organizing Project (SWOP)/ Pasteur Elementary School
11/1/2017	Archer Heights	20	Edwards Center for Young Learners

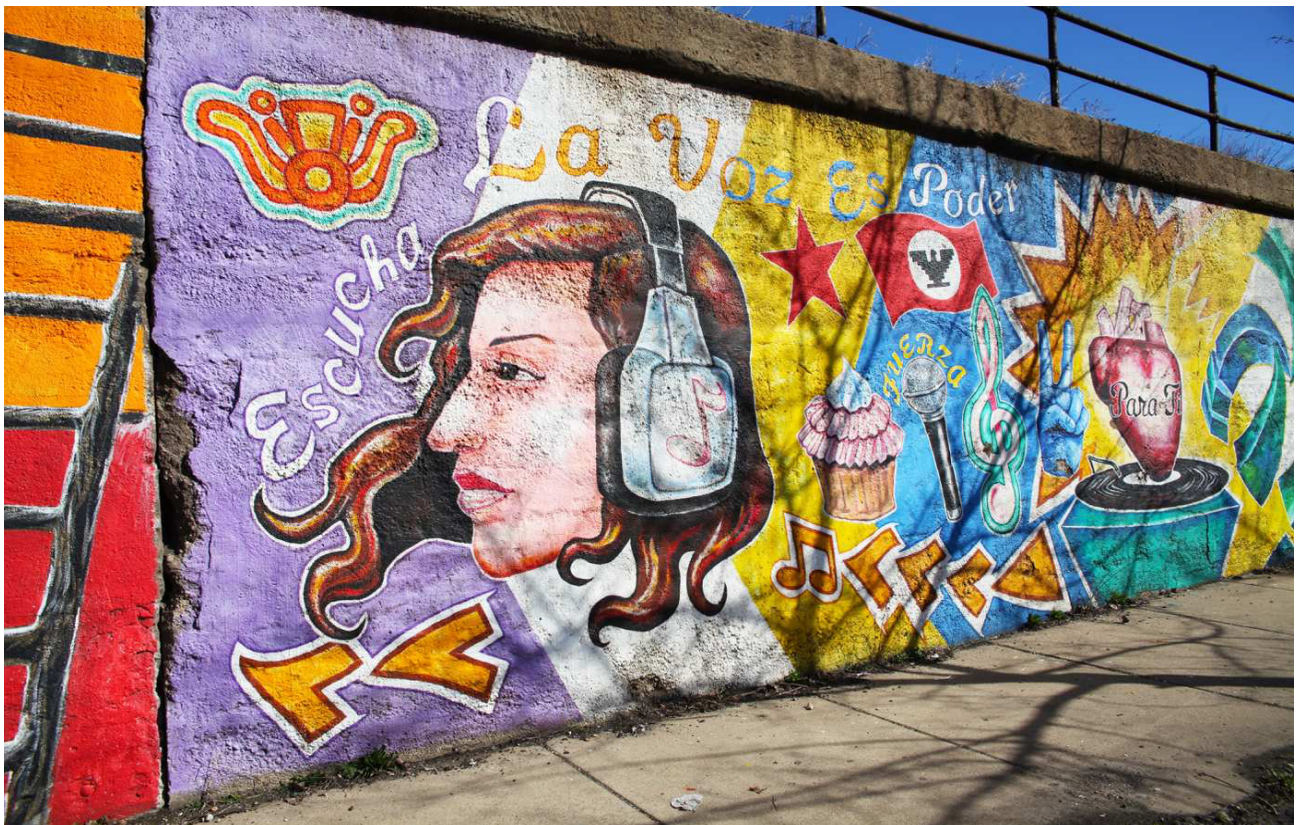
Community Stakeholder Individual Interviews

In addition to holding community forums, nine community leaders and stakeholders were invited to take part in a semi-structured individual interview. Interviews were conducted between February and October of 2017. Community stakeholders were purposively selected based on their long-standing relationships with residents in the surveyed community areas, as well as their history of involvement in community initiatives and their understanding of the needs of community residents. Interviewees included four females and five males. Interviews lasted approximately 15 to 20 minutes, and all interviews were conducted in English. Interviews were audio recorded and transcribed using Trint transcription software. The following questions guided the interview:

- 1) What does mental health mean to your work in the community? How does it connect to other issues?
- 2) How do you see the barriers to mental health access impacting the work and the community residents you have worked with?
- 3) What is possible? What are the next steps? What would you like to see happen to increase access to mental health services?

Data Analysis

Transcripts from all individual interviews and field notes from all community forums were compiled for analysis. Using a modified grounded theory approach, three coders analyzed the data. First, using an inductive open coding process, two coders independently coded all individual interviews. Using the same inductive open coding process, one coder independently coded field notes from all community forums. Next, following this phase of independent coding, the three coders met together to review and compare the generated codes and group the codes into categories. From these categories, salient themes were identified. Lastly, in order to ensure that the identified themes were aligned with the experiences of community residents, a group member check interview was conducted with 39 community stakeholders in November of 2017. During this member check interview, preliminary findings from the qualitative analysis were presented, and interviewees were asked to discuss the extent to which these findings matched their own observations and lived experiences. Member check participants confirmed and clarified these preliminary findings and expanded on themes specifically related to understanding the experiences of Latinx subgroups on Chicago's southwest side. The use of multiple coders and the member check interview were intended to protect the rigor of the analysis by minimizing coder bias and soliciting feedback from community residents themselves on the accuracy of the preliminary analysis.



Mural by Ricardo Gonzalez, 1790 W. 16th Street, 2012. Photo by Ken Carl and Kaitlynn Scannell.

FINDINGS

Quantitative Findings

Responses are reported below for the ten surveyed community areas on Chicago's southwest side. As described in the methods section, 2,859 surveys were analyzed. The distribution is shown in Figure 1.

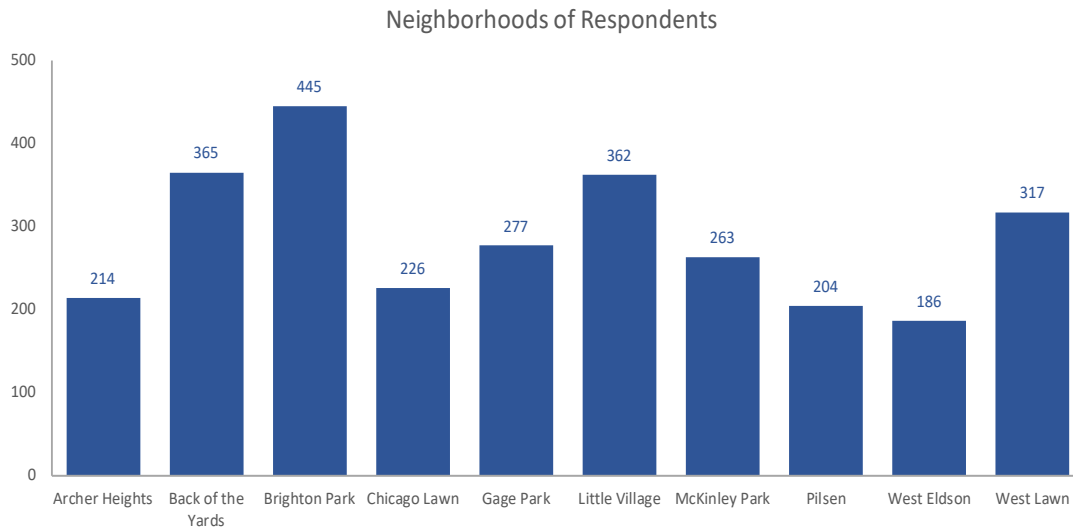


Figure 1

Respondents reported the issues or concerns that they encountered with the highest frequency or intensity. Depression was the highest, with almost half (49%) of respondents reporting this issue. Over one-third of respondents reported anxiety (36%) or acculturative stress (34%). Additional concerns included parenting support (29%), trauma (27%), anger control (24%), isolation (23%), and relationship support (19%). Because respondents could select multiple choices, values add up to more than 100% (see Figure 2). In addition, less than 10% of respondents did not list a concern, suggesting they did not believe they were facing any kind of mental health issue (or, at least, none of the concerns listed).

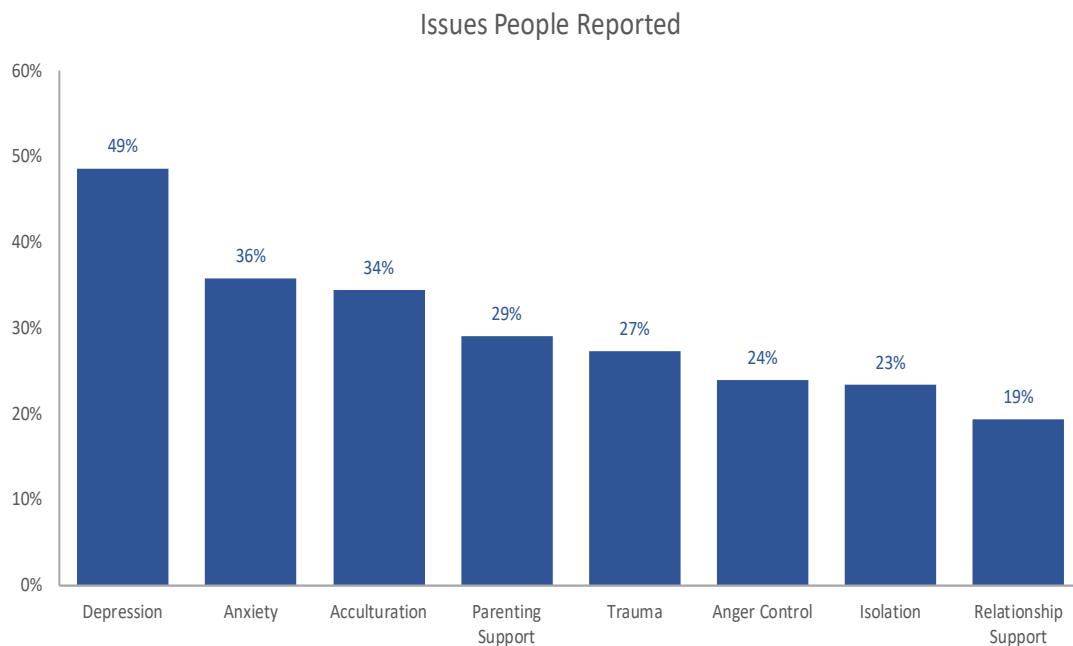


Figure 2

Data were also analyzed by demographic characteristics. When comparing differences between women and men, Chi-square testing showed significant differences (see Figure 3). Women were more likely to report depression and the need for parenting support, while men were more likely to report anger control issues. When looking at differences between immigrants and U.S.-born residents (see Figure 4), immigrants were more likely to report depression, acculturative stress, and a need for parenting support, while U.S.-born residents were more likely to report anxiety and anger control issues.

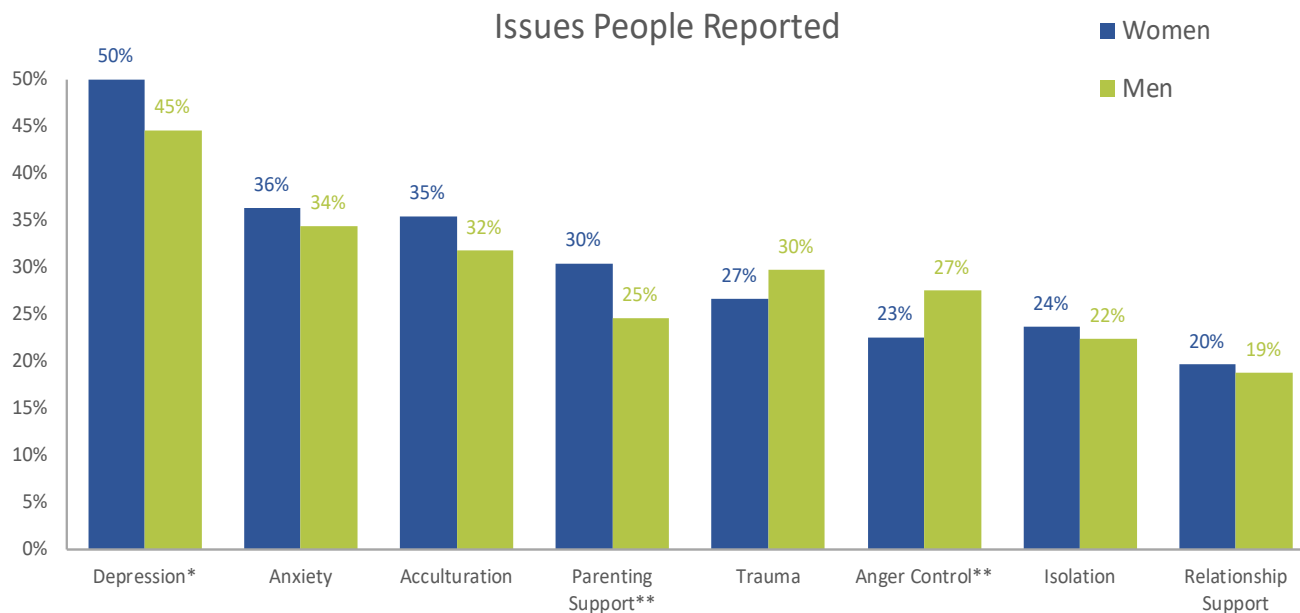


Figure 3

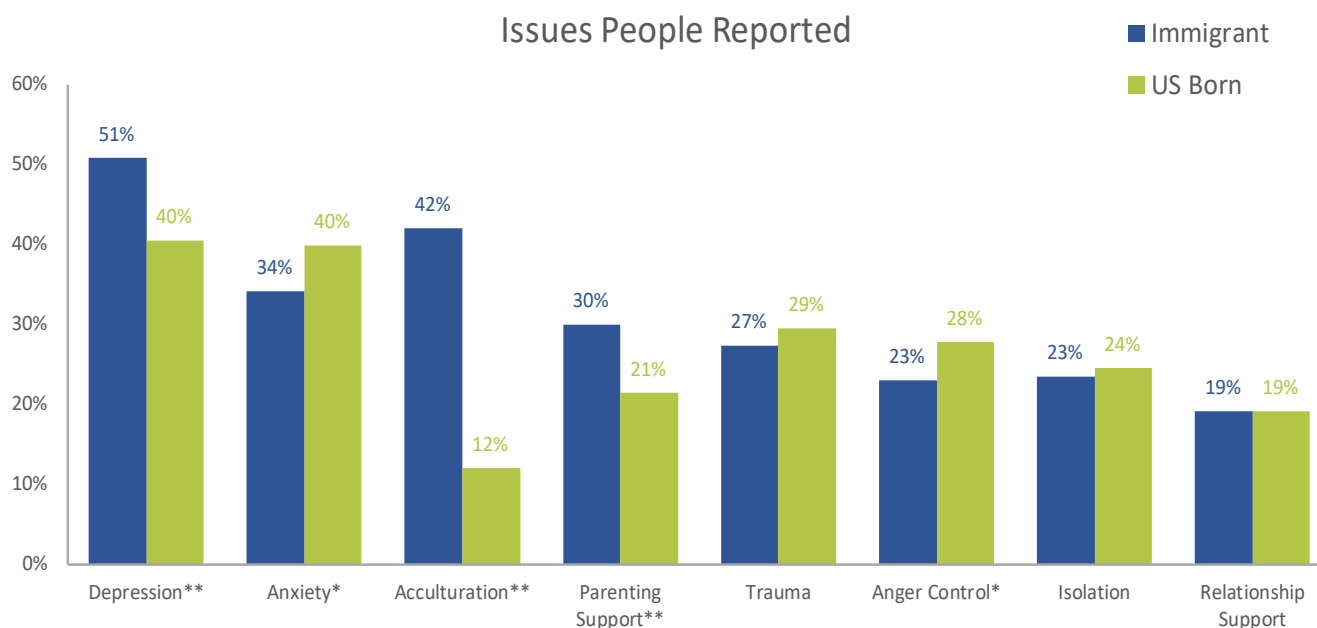


Figure 4

Survey respondents were asked whether they would consider seeking professional support (counseling) for their personal problems. Overall, 80% of participants responded yes or probably yes, as shown in Figure 5. Chi-square tests showed that there were significant demographic differences in respondents' likelihood to seek professional support. When analyzing by gender, women (82%) were more likely than men (73%) to respond yes or probably yes to this question (see Figure 6). When analyzing by place of birth, immigrants (83%) were more likely than U.S.-born respondents (68%) to respond yes or probably yes (see Figure 7). Lastly, respondents who listed at least one concern (82%) were more likely to report a willingness to seek professional support than were respondents who listed no concerns (45%) (see Figure 8). While there are demographic differences in the responses to this question, it is important to note that the overwhelming majority of all respondents reported that they would in fact consider seeking professional support.

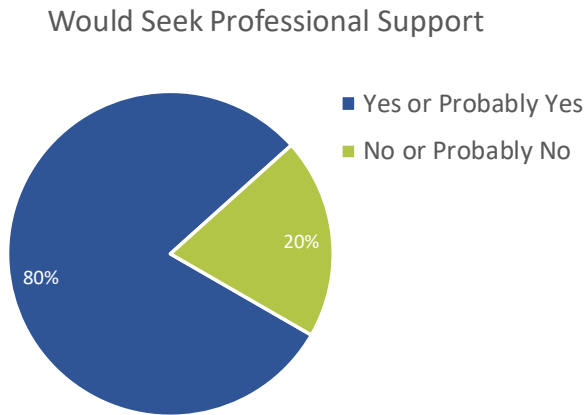


Figure 5

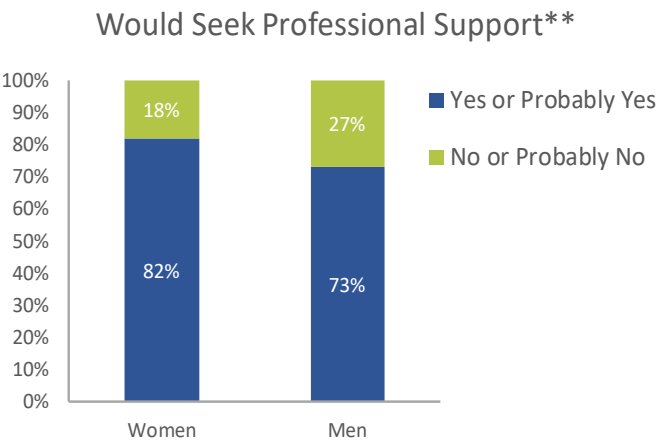


Figure 6

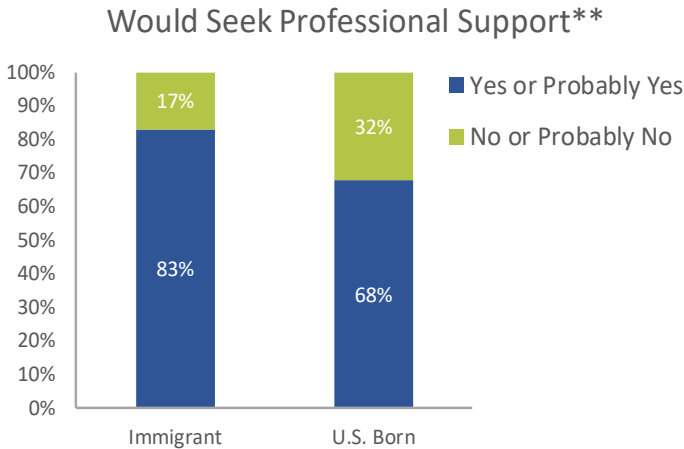


Figure 7

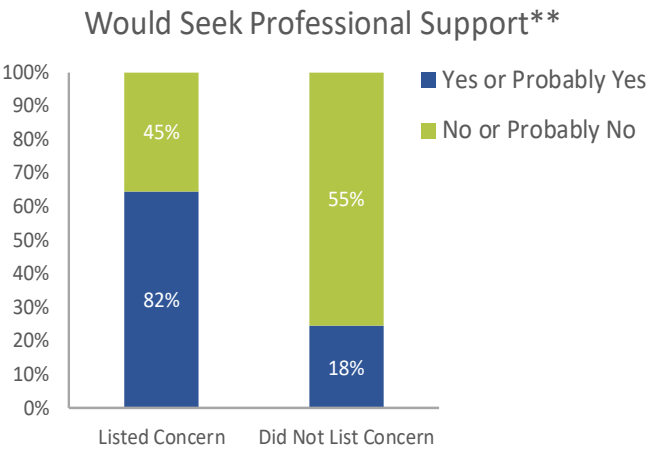


Figure 8

The last question looked at barriers to accessing mental health services. Results indicated that the highest barrier was cost, with 57% of respondents reporting this barrier. Additionally, over one-third of respondents reported lack of health insurance (38%), not knowing where to go (38%), and services not being in close geographic proximity (34%) as barriers to accessing support. Just over one in five respondents reported lack of childcare (23%), services not being in their preferred language (22%), lack of transportation (21%), and the hours not being convenient (21%) as barriers. The lowest reported barriers were barriers related to social perceptions of mental health and mental health treatment, which we define in this report as social barriers. Of the total number of survey respondents, 11% reported concerns about stigma, 10% said services would not help, and 9% were concerned their family would disapprove (see Figure 9). We created an additional variable to assess the percentage of respondents who reported any social barrier. Just 25% of respondents reported any social barrier, less than half the number that reported cost as a barrier.

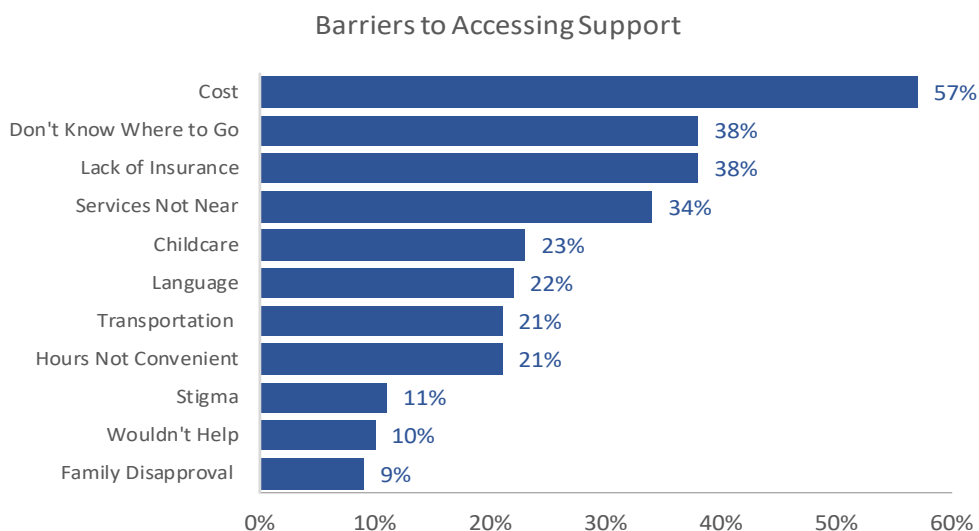


Figure 9

In accordance with our structural analysis, we broke down all of the reported barriers into 3 categories: structural (associated with the larger structural context in which individuals are situated), programmatic (associated with limited organizational infrastructure to provide culturally appropriate services that address community residents' context-specific needs), and social (associated with social perceptions of mental health and mental health treatment). A break down of reported barriers by category type is displayed in Figure 10 below.

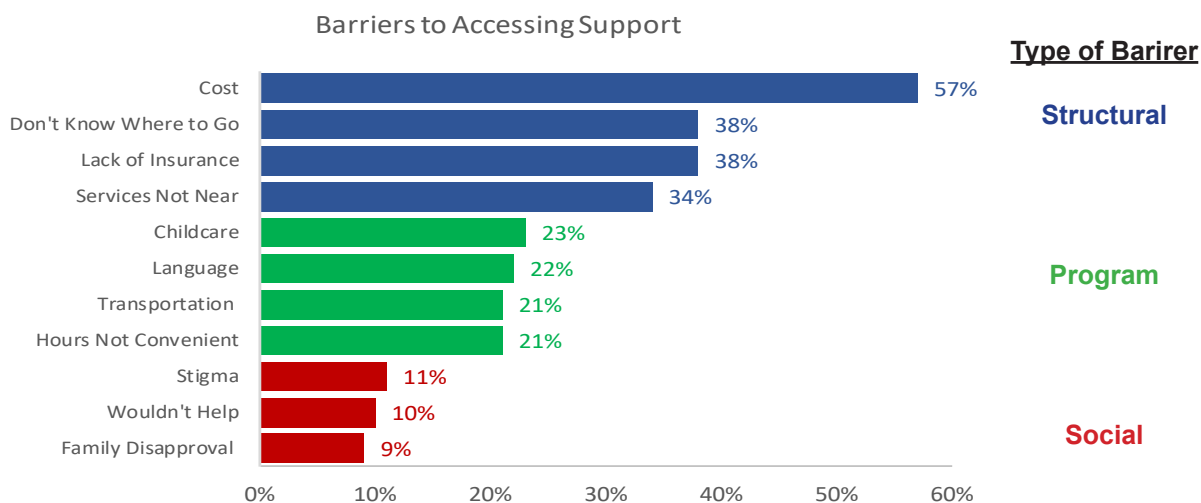


Figure 10

The data on access barriers were also analyzed by gender (see Figure 11) and place of birth (see Figure 12). Chi-square tests demonstrated that there were some significant differences by gender. Women were more likely to face barriers of cost, not knowing where to go, services not being in close proximity, lack of childcare, and lack of transportation. Men were more likely to face the barriers of inconvenient hours of operation, stigma, and not believing counseling would help. Moreover, we found significant differences between immigrants and U.S.-born participants in their reports of access barriers. For example, immigrants reported significantly higher rates of cost barriers, not knowing where to go, lack of insurance, services not being close, and services not being in their preferred language. U.S.-born participants were more likely to believe that counseling would not help.

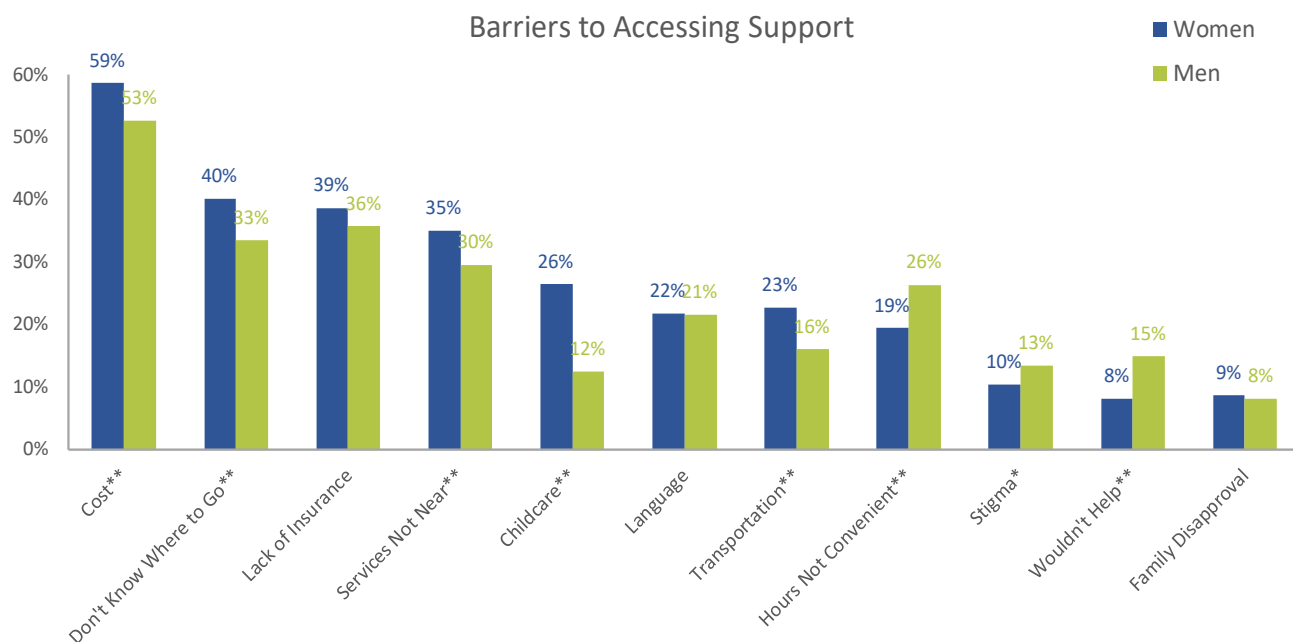


Figure 11

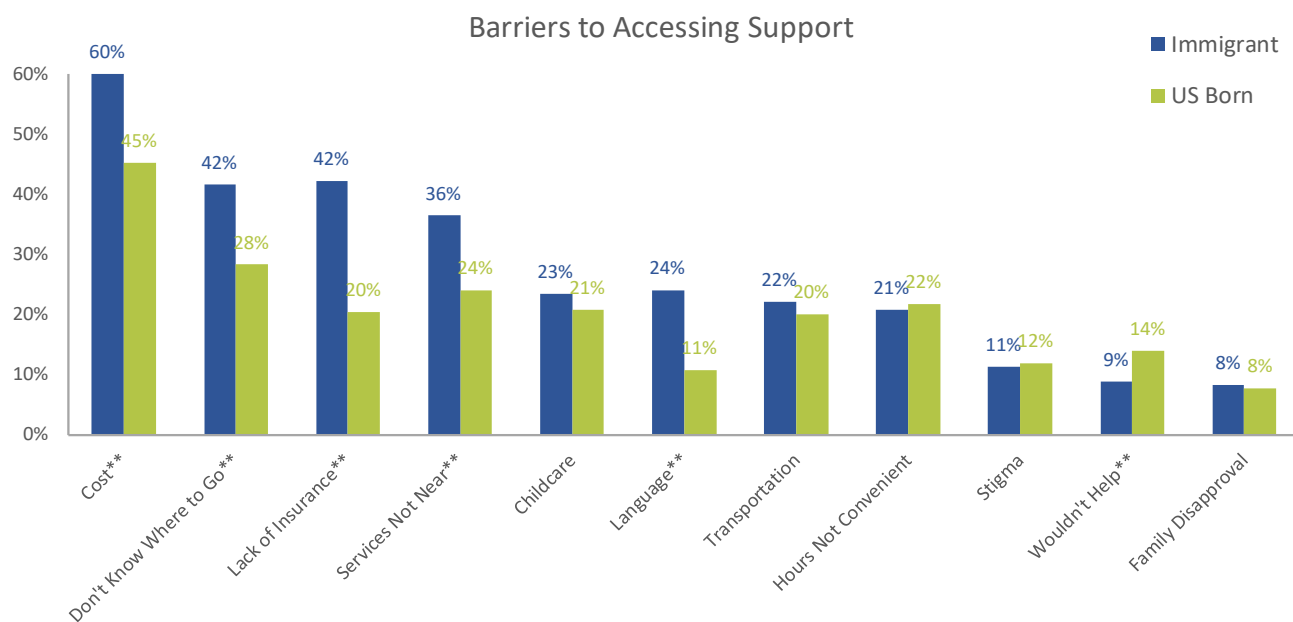


Figure 12

The last point analyzed had to do with the relationship between cost and insurance. We were interested to see if people who had insurance still faced cost barriers. We found cost to be a barrier among nearly half (47%) of all respondents who did not identify the barrier of insurance, thus suggesting that mental health services may be unaffordable even when community residents have insurance coverage (see Figure 13).

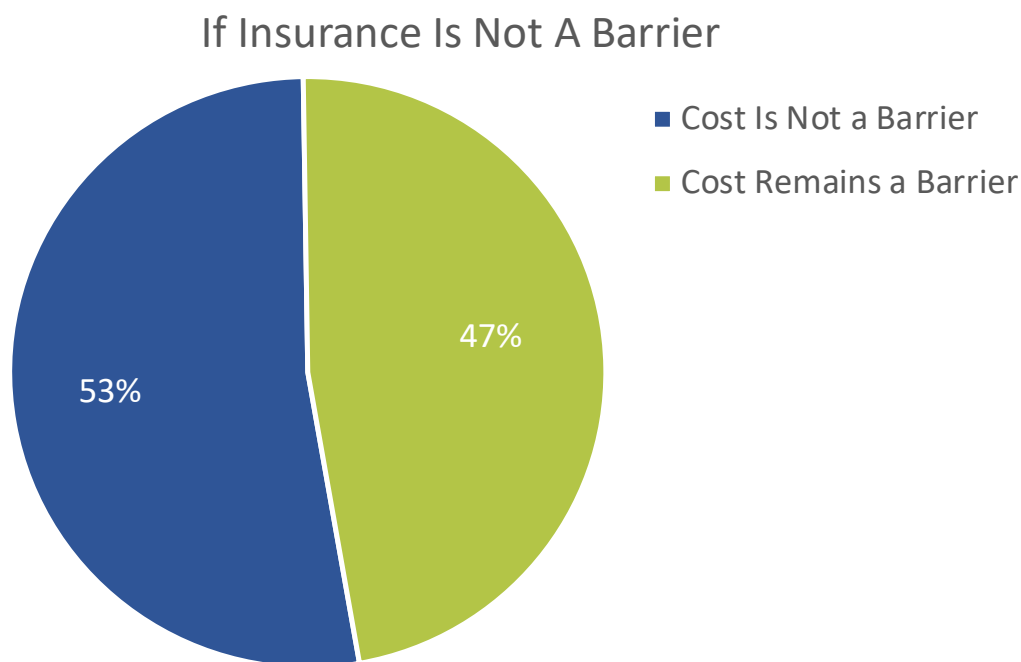


Figure 13

Weighted Results

The weighted results were calculated as a way to check the unweighted results. In particular, because we used a convenience sampling strategy that resulted in overrepresentation of female and immigrant survey respondents, calculating weighted results allowed us to verify that the patterns we found in our data remained the same after accounting for concerns with the representativeness of our sample. The following weighted results were obtained for mental health concerns:

Depression	43%
Anxiety	37%
Trauma	30%
Anger Control	27%
Isolation	24%
Acculturation	23%
Parenting Support	23%
Relationship Support	19%

There was some shift in the middle of the order, with trauma and anger control becoming more common than isolation and acculturative stress. However, overall the weighted and unweighted results were consistent.

When looking at whether respondents would be willing to seek counseling, the weighted results showed that 72% were willing to seek support, while 28% were unwilling. While this is a slight shift from the unweighted results (80% and 20% respectively), a clear majority still indicated willingness to seek professional support.

For barriers, the following results were obtained:

Cost	49%
Don't Know Where to Go	31%
Services Not Near	28%
Lack of Insurance	27%
Hours Not Convenient	23%
Transportation	20%
Childcare	19%
Language	16%
Wouldn't Help	13%
Stigma	12%
Family Disapproval	8%

As with the unweighted results, cost was by far the biggest barrier to accessing support. Following that, other structural barriers (such as lack of insurance) and organizational barriers (lack of childcare) were prevalent. Social barriers, like believing counseling would not help and stigma, remained the lowest.

On the whole, the weighted results paralleled the unweighted results. Though there were some changes in percentages, the main findings of depression and anxiety being the most common issues people face, that a large majority of respondents desired counseling support, and that cost and other structural and organizational barriers were more common than social barriers, remained the same. The similarity in results supports the findings from the unweighted results.

Qualitative Findings

The data presented in this section highlight community residents' and stakeholders' perspectives on community members' mental health needs, barriers to accessing mental health services, and solutions for facilitating service access and addressing mental health needs. Data indicated that community members' mental health needs stem from the structural context in which they live. In describing the structural context that impacts well-being, respondents emphasized the interplay between oppressive social systems at the national level and experiences of oppression and marginalization in local community contexts. Manifestations of structural violence are not only reflected in the negative impact of national and local level contexts on mental health, but structural violence is also perpetuated through local realities where investment in social welfare and health promoting resources is reduced and opportunities to address mental health needs are limited.

This section will highlight how national and local level structural contexts impact mental health. As part of this discussion, the interconnection between oppression, marginalization, and trauma will be highlighted. While respondents did not always explicitly identify these national and local level contexts as being traumatic, they described how these contexts posed threats to community members' safety and well-being on an ongoing basis. After describing how community residents are impacted by this chronic trauma exposure, this section will then describe the factors that impede community members' access to services that address their mental health needs and promote healing from trauma, placing particular emphasis on structural level access barriers. Finally, after exploring mental health service access barriers in the local context of Chicago, this section will discuss community-identified solutions for decreasing access barriers. Central to these identified solutions was the need to reframe how we view mental health and mental health treatment.

STRUCTURAL FACTORS IMPACTING MENTAL HEALTH

Experiences of marginalization at the national level

Individual interview and community forum participants described how community residents' well-being is impacted by their interactions with the following systems:*

The Immigration System

Individual interview and community forum participants described that community members' experiences of marginalization largely stem from the immigration system's classification of human beings into categories of "legality" and "illegality." Respondents described how, as a result of these categorizations, community members with an undocumented immigration status are denied opportunities to fully participate in U.S. society. For example, individuals are denied access to educational and employment opportunities, as well as access to social services and public benefits, for which a social security number is an eligibility requirement. In turn, as undocumented community residents are primarily confined to employment in the low wage sector, they are faced with significant financial stressors. A community forum participant described how limited access to opportunities and services perpetuates economic marginalization and negatively impacts mental health:

*Please note that while minor edits were made to the quotes presented throughout this section in order to increase their readability, none of these edits changed the meaning of the quotes.



La gran mayoría de nosotros somos migrantes y llegamos aquí y es un problema serio... hay muchos que tenemos la capacidad de trabajar duro pero no tener seguro, no poder tener comida nos afecta y muchos han estado perdido... y aunque yo no hago drogas, tomo, fumo - todavía tengo problemas...a mí que no hago esos vicios... me lastima todavía..."

The vast majority of us are migrants and we arrived here and it is a serious problem ... there are many who have the ability to work hard but not having insurance, not being able to have food affects us and many have been lost ... and even though I do not do drugs, drink, or smoke - I still have problems ...I do not have those vices...it hurts me still ..."
(CF BOY)

The Criminal Justice System

Respondents additionally discussed how experiences of marginalization perpetuated through the immigration system were integrally connected to experiences within the criminal justice system. Undocumented community members described that all of their interactions with the justice system, including situations involving redress for exploitation that they had experienced, provoked fear of familial separation and deportation. Individual interviewees additionally discussed that they observe the criminal justice system to be used as a first course of action among youth who are demonstrating behavioral challenges that could be addressed through an alternative venue. Youth involvement with the criminal justice system in turn impacts the entire family system. One community leader described how, among immigrant families who are already fearful of deportation, these interactions with the criminal justice system are a traumatic experience:



And we see an immigrant family going through the court system, especially during this time....on its own is a very traumatic experience. And you know, we've seen issues in schools that ended up unnecessarily [in] court...Use and misuse of the judicial system, right. I mean, talk about how the youth often times [are] criminalized." (I4)

The Health Care System

In the realm of health care, respondents reported that community residents are often denied access to services due to the cost associated with care. Not only does cost pose a barrier to individuals who are uninsured, but it also poses a barrier to insured individuals whose insurance places limits on the type and quantity of services that are covered. Furthermore, converging with the immigration system, undocumented community members stated that they are systematically denied access to insurance coverage due to their immigration status. When community residents living in poverty are asked to pay out of pocket for services that they cannot afford, the result is that their health care needs go unaddressed. One individual interviewee noted how equitable access to health care is impeded by factors including cost and insurance status:



"...a lot of the people don't have the means to be able to go to mental health services sometimes because of the cost and also because they don't have health insurance...there's always folks that are going to be left out of policy that we also need to consider." (I10)

Experiences of marginalization following the 2016 presidential election

While respondents stated that experiences of oppression and marginalization resulting from national policies and social systems are by no means a new phenomenon, these experiences have intensified since the 2016 presidential election. Respondents reported that they have observed increased fear within their communities since the election of Donald Trump. As one individual interviewee stated:



We now entered a new presidency, which at least I think brought light to the huge need for mental health services and emotional wellness support around the community just because a lot of people were expressing fear, anxiety by a lot of stress around the election.” (I10)

Community forum participants highlighted this same sense of fear within their communities, explicitly stating that the election of Donald Trump has been a traumatic experience for community residents:



...por ejemplo ganó Trump [las elecciones], eso fue un trauma para unos.”

...for example Trump won [the elections], that was a trauma for some.” (CF GP/CL)



Creo que si hacemos las encuestas ahora... va ver más depresión y ansiedad por las elecciones.”

I think that if we repeat the surveys now ... we will see more depression and anxiety because of the elections.” (CF BP)



Todos los individuos tienen esa mentalidad a tener miedo de que cosas que no han pasado... tenemos miedo de lo que puede pasar, por la historia de cosas que han pasado en el pasado. Hay otra cosa que estoy pensando. Esta situación pasó hace 8 años con Obama, pero no nos acordamos.”

All individuals have that mentality to be afraid of things that have not happened ... we are afraid of what can happen, because of the history of things that happened in the past. There is something else that I'm thinking about. This situation happened 8 years ago with Obama, but we do not remember.” (CF LV 1)

A community partner similarly recounted the struggles of a program participant and their family in the aftermath of the 2016 elections:



Mis hijos lloraron toda la noche y se fueron a dormir llorando porque ganó Trump. Están preocupados que nos van a deportar porque los niños en las escuelas así se burlan de unos a otros. Ni se cómo explicarles a mis hijos como funciona el sistema político y legal de los estados unidos.”

My children cried all night and went to sleep crying because Trump won. They are worried that they will deport us because of the teasing of children at schools. I do not know how to explain to my children how the political and legal system in the United States works.”

Community residents also stated that since the election of Donald Trump to the U.S. presidency, they have been impacted by the termination of Deferred Action for Childhood Arrivals (DACA). As a community forum participant emphasizes below, the end of the DACA program will increase the number of residents within their communities who are denied access to services and who will live in constant fear of deportation and familial separation:



Yo pensé que la elección no me afectaba mucho. Luego al reflexionar, tuve una visita con mi hija que tiene DACA y empezó a llorar. Y yo no estaba preocupada. Ahora si veo que me afecta. Para todas las personas que tienen DACA que son inmigrantes.”

I thought the election did not affect me much. After reflecting, I had a visit with my daughter who has DACA and she began to cry. And I was not worried. Now I see that it affects me. For all people who have DACA who are immigrants.”(CF LV 1)

Experiences of marginalization at the local level

Respondents additionally noted that the impacts of oppressive social systems are manifested in the following ways within the local context of Chicago:

Community Violence

Individual interviewees and community forum participants identified community violence as generally being a prevalent concern. Respondents described that they perceive community violence as resulting from limited opportunities to establish enriching social and interpersonal connections. Community forum participants identified that there are a lack of safe spaces where community members of all ages can come together to socialize and cultivate these connections. In addition, several individual interviewees stated that when families have limited social-emotional support and are coping with relational conflict, youth may turn to gangs as a way of establishing connection. As one individual interviewee explained:



The biggest problem is that parents need mental health services and they don't even know it. And they are not receiving it. So now you have young people...get[ting] pushed into the streets, and then they get into gangs. And now you have these kids killing each other.” (I9)

Another individual interviewee spoke about the way that community violence is manifested in the community in the form of shootings, and spoke about the traumatic impact of witnessing these events:



I have to be comfortable to recover and heal sometimes from situations that are extremely uncomfortable and traumatizing. I mean, somebody sent me the picture of that guy with his brains blown out....I was just two blocks away and I came by the time I got through they just covered him with a sheet or some lady had covered it... But she took a picture of him and that picture got around the community. And when I saw the picture I was appalled. You know, I mean just ripped apart by bullets...brains over the sidewalk. When you see something like that it traumatizes, right.” (I6)

Respondents additionally described how in the wake of community violence, opportunities for connectedness are limited. Several individual interviewees described the physical fragmentation within communities that are divided by rival gang activity. Interviewees stated that as a result of this physical fragmentation, community members are unable to move freely through their neighborhoods. One interviewee spoke about what this fragmentation looks like in the Back of the Yards neighborhood specifically:



...BOTY [Back of the Yards] is a divided community. You have the Saints and the Raza's that divide the community. Meaning if you live on that side of the neighborhood in BOTY, you can't come to this side." (I9)

Not only does community violence lead to a lack of physical connectedness within communities, but respondents also described how violence perpetuates a lack of social connectedness. Several individual interviewees spoke about how when community residents are coping with trauma, individuals often isolate themselves and are unsure how to connect to others through their pain. One individual interviewee further described that communities often become pathologized in the context of pervasive community violence. They stated that while it is easy to focus on the pain that individuals experience and the way in which communities are torn apart by violence, the challenge for community stakeholders is to facilitate opportunities for connection and healing:



If we focus purely on what we're not addressing, [we miss the opportunity] for healing. And so sometimes we start to say, oh we're too weak to deal with this...We have guilt trips....and we forget that...the opposite of violence [is] peace." (I6)

This same individual interviewee further elaborated that the challenge of facilitating social connection and healing within communities is compounded by systemic responses to violence. They described how these systemic responses can in themselves be inherently violent:



Right now I know in my own culture the way we respond to violence is we call the police and the police come in and they use their force and, you know, we hammer things out." (I6)

As reflected in this quote, this interviewee described systemic responses to violence as perpetuating continued violence and, in turn, perpetuating continued disconnectedness and trauma. Across interviews and community forums, respondents identified that addressing community violence is central to addressing the mental health needs that exist within communities.

Funding Cuts and Limited Resource Investment

Respondents noted that within communities impacted by poverty and community violence, they do not observe public officials as being invested in developing community infrastructure. Individual interviewees and community forum participants cited a general lack of resources and opportunities for personal development in impoverished communities. Within the education system, respondents stated that due to funding limitations, neighborhood public schools are restricted in the range of supportive services and health promoting opportunities that they are able to offer students and families. One individual interviewee provided the following description of the resource limitations in the surveyed communities:

“

There were counselors in the schools but those were being cut because of funding for CPS. And so there's only like once a week that it's available and that addresses the whole school and so it wasn't really a space the parents felt comfortable....I think, you know, when the city of Chicago takes it upon itself to close mental health clinics and in the Back of the Yards they closed a mental health clinic and, you know, people were upset. I mean, I think across the city people were upset.....But I remember that in the Back of the Yards it was a real big issue because the issue then became, where do you go, where do you go for mental health care. And it was not only an issue of access but it was an issue of, I mean, physical access because it was in the neighborhood....You don't have recess in the schools anymore or a limited recess. There were cut backs in gym programs... Teachers were cut out.... or sometimes, you know, the health teacher was a gym teacher and...she could care less about health.... . the county health care system has cut its neighborhood services so you don't even have the kinds of services that you once had, even just 10 years ago.” (I7)

Data clearly indicate that not only does the local context in which community residents live negatively impact their mental health, but opportunities to address the needs of individuals and families are also limited within this local context.



Mural painted by mothers who have lost sons to gun violence. The project was sponsored by the Precious Blood Ministry of Reconciliation (PBMR) Center. Photo by Jessica Day.
Mural located in the neighborhood of Back of the Yards.

MENTAL HEALTH NEEDS OF COMMUNITY RESIDENTS

Respondents described the mental health needs of community residents as stemming from the environmental context discussed above. Individual interviewees and community forum participants identified a range of mental health needs associated with the structural context in which community members live. These mental health needs are outlined below.

Trauma

Respondents stated that underlying community residents' mental health needs were experiences of trauma. Community forum participants discussed how community residents are impacted by trauma that they experienced during their childhood, including experiences of abuse. They further specified that community residents may not always recognize that they are impacted by trauma. As several community forum participants stated:



...muchacha gente tiene trauma desde niños, no tener una familia perfecta. Como [los efectos de] alcoholismo, pérdida de un ser querido, todo eso es trauma. Si no sabes que es, no lo puedes identificar."

...many people have trauma from their childhood, from not having a perfect family. Like the effects of alcoholism, the loss of a loved one, all of this is trauma. If you don't know what it is, you can't identify it." (CF GP/CL)



Casi la mayoría de personas no dejamos ir algo que pasó hace muchísimo tiempo...no se te olvida."

Almost all of us hold on to something that happened a long time ago...you can't forget." (CF LV 2)



Para mí, la depresión viene de la trauma desde cosas que pasaron desde nuestra niñez."

For me, depression comes from the trauma of things that happened in our childhood." (CF LV 2)

In addition to identifying trauma as stemming from childhood experiences, community forum participants stated that trauma stems from the national and local contexts in which they live. As previously described, community forum participants recognized the traumatic impact of community violence. They additionally recognized that it is traumatic to live in an anti-immigrant political climate and to have the constant fear of familial separation and deportation. In fact, community forum participants stated that trauma is such a common element of the daily lived experiences of Latinx immigrants that they often do not recognize that they are experiencing trauma. Considering that many community residents do not recognize and identify that they have experienced trauma, community forum participants estimated that the percentage of individuals coping with trauma as reported in the quantitative survey results (27%) is in reality much higher. As stated below:



Trauma es muy bajo [en los resultados de los cuestionarios] porque lamentablemente todos los hispanos pasamos por eso."

Trauma is very low [in the survey results] because lamentably all of us Hispanics experience it." (CF GP/CL)

Individual interviewees touched on similar themes, describing that experiences of trauma stem from a convergence of factors including intrafamilial violence and the national and local contexts in which community residents live. As one interviewee described:



...I was working within the southwest side of Chicago with our Spanish speaking adult immigrants and, you know, a lot of what we ended up seeing was a lot of people needed emotional wellness support and that ranged from a lot of different things...also in the type of services that they needed how it's connected to other issues in the community, is you know, with community violence, with different trauma that folks experience, with poverty, especially all of these issues are interconnected." (I10)

Not only are experiences of trauma integrally connected to the national and local contexts in which community members live, but individual interviewees and community forum participants also described how trauma underlies the mental health challenges that are described below.

Depression

Respondents described how traumatic experiences, including traumatic childhood experiences and traumatic experiences associated with the larger structural context, underlie feelings of depression. Community forum participants explicitly connected feelings of depression to experiences of marginalization stemming from precarious low-wage work, poverty, and limited access to the resources and services necessary to promote well-being. As illustrated below, a community forum participant described how the immigration system further impacts mental health by posing additional restrictions on the opportunities that are accessible to community members:



La depresión es por el corre corre de los días y cuando no logran metas...La política afecta comunidad, parejas y todo- y por eso le causa el stress. Hay mucha gente sin documentos y están preocupados del trabajo y el si le cojen."

Depression is about the passage of the days without achieving goals ...Policy affects the community, relationships, and everything- and this causes lots of stress. There are many people without documents and are worried about work and if they get caught." (CF WL)

Anxiety

Respondents similarly connected feelings of anxiety and constant worry to trauma associated with the current political climate. Individual interviewees and community forum participants described how the pervasive nationalist and xenophobic political rhetoric ostracizes and demeans communities of color, which in turn undermines community residents' sense of safety and security. Respondents also stated that among immigrant community residents, anti-immigrant sentiment heightens fear surrounding the certainty of their future in the U.S. As one individual interviewee stated:



The levels of anxiety those families live with one and all the time...The meanness and aggressiveness of the current administration, there was an at times palpable sense of anxiety just beneath the surface." (I3)

Substance Use

Just as with feelings of depression and anxiety, respondents identified substance use as stemming from stressors and traumatic experiences associated with national and local level structural contexts. Respondents explained how individuals may turn to alcohol to cope with the stress of being unable to meet the material needs of themselves and their family members. One community forum participant further explained how, among undocumented immigrant community members, substance use may be an attempt to cope with the compounding effects of marginalization resulting from both their immigration status and from living in situations of financial instability:



Como los inmigrantes que hemos venido acá. Que es muy difícil, sobresaltar de encima, que caer en vicio por la presión de no tener un número social o alguien más que trae comida a la mesa."

Like the immigrants who have come here. It is very difficult, it's frightening, one might fall into addictions by the pressure of not having a social security number or not having someone else who can bring food to the table." (CF BOY)

Domestic Violence

Individual interviewees and community forum participants additionally described that when community residents are overwhelmed and unsure of how to cope with the stressors that they are experiencing, difficulties controlling anger may lead to domestic violence. One individual interviewee described the connection between domestic violence and community violence, and further stated that community leaders are faced with the challenge of promoting individual, family, and community healing:



...an issue in the community could be domestic violence, and people say that produces the gang member...and what produces the healing?" (I6)

Acculturative Stress

Respondents described that community residents experience challenges associated with adjusting to the cultural context of the U.S., mastering the English language, and leaving behind their family and friends in their country of origin. For example, several community forum participants stated that they were not surprised that quantitative findings pointed to high rates of depression among community residents, explaining that being separated from their social support networks and learning a new language can feel overwhelming and isolating:



No estamos en el lugar donde nacimos... estamos aprendiendo aquí el lenguaje."
We are not in the place where we were born...we are learning a new language here."
(CF LV 2)



Depresión es normal por emigrar y sentirse solos."
Depression is normal from migrating and feeling alone." (CF GP/CL)

Respondents further described that while these challenges are stressors in themselves, they are further accentuated by the stress of feeling unwelcome in their new country of residence.

Internalized Classism

During several community forums, facilitators observed the manifestation of internalized classism. In particular, community forum mediators observed interactions in which community members blamed fellow community members for the challenges that they experienced in accessing mental health services. For example, a community forum participant questioned why community residents prioritized taking their families out to dinner on the weekends over paying for mental health services, further stating that they perceived services offered on sliding fee scales as being accessible to community residents. This interaction suggests that community residents may place the onus for change on the individual rather than acknowledging the structural context in which challenges arise. In turn, when individuals perceive systemic failings as personal inadequacies, their well-being is negatively impacted. In response to this statement regarding the accessibility of services on a sliding fee scale, the community forum facilitator noted that even with this scale, individuals would typically be asked to pay \$20 on a weekly basis for the length of services, which could last as long as six months to one year for trauma-focused services. Upon calculating the total cost of services, participants subsequently began to recognize the structural issues that impede service access.

MENTAL HEALTH ACCESS BARRIERS

Structural Access Barriers

Respondents identified a range of mental health access barriers connected to the structural context in which community members live. A list of these structural access barriers is outlined below.

Cost

Individual interviewees and community forum participants identified cost as a barrier among uninsured community residents who are asked to pay out-of-pocket for services. Respondents further specified that undocumented community members are particularly impacted by the barrier of cost, as they are typically ineligible for public insurance benefits. Not only was cost identified as a barrier among uninsured community members, but respondents also noted that cost is a barrier for insured community residents who are required to provide a co-pay or whose insurance does not cover mental health services. Even among individuals whose insurance covers the cost of services, how long they may engage in services may be limited by the length of time for which an insurance company will authorize treatment. Several respondents described how cost poses a barrier for community residents:



One aspect is cost because of the lack of public options. [There is a need to] [i]ncreas[e] public options, or insurance that covers undocumented folks.” (I4)



...one of the barriers is not having enough service providers that [provide] to those that do not have health insurance...Also the cost is a big barrier. So while there may be some private counseling services available they're not going to be used because [the] community cannot afford it.” (I1)



...the challenge with the medical model is the billing...You can't really address the mental health issues that exist in people's lives, you can't do it. You know, in the time frame that the insurance company allows.” (I2)

The Chicago Service Landscape

Within the local context of Chicago, respondents identified structural access barriers connected to the city's mental health service landscape. Each of these local context-specific structural access barriers are outlined below:

Geographic Proximity and Safety Concerns

Across community forums, forum participants commonly identified that mental health services were not available in close proximity to their homes. Individual interviewees echoed this point, explaining that with the closure of mental health clinics throughout the city, including the closure of the Chicago Department of Public Health clinic in Back of the Yards, services may not be available in the neighborhoods in which residents live. Not only must community residents pay for transportation to and from appointments when services are not in close physical proximity, but safety concerns arise when residents must cross neighborhood boundaries into rival gang territory in order to access services:



...you're talking lots of different issues...when you talk about access, whether people can actually get there....And, yeah, they could probably physically get there but the issue is whether it's a safe place for them to traverse." (I7)

Community residents elaborated on this theme during a member check interview, stating that residents may also feel uncomfortable going to communities that are of a different racial and ethnic composition, due to feelings of alienation and uncertainty about the culture of these communities.

Availability

Not only are there limited services within close geographic proximity, but respondents stated that the services that are available tend to have long waiting lists. Community forum participants discussed how waiting lists deter them from accessing services, as they often engage with organizations when they have a mental health need that requires immediate attention and lose hope when they are told that it may be as long as six months before their need can be addressed. Individual interviewees echoed this point:



...the waiting list for some of the agencies that do provide services to...those that are uninsured are pretty long. So that's another barrier that is often seen. [When] somebody has a crisis, they can't wait two, three months on a waiting list...they have a crisis in their home and sometimes they need immediate care." (I1)

When discussing the theme of availability with community residents during the member check interview, community residents further specified that not only is there limited availability of formal mental health services, but there is also a general lack of safe spaces within their communities where they may come together to socialize and receive support from fellow community members. Specifically, interviewees discussed limited safe spaces for sexual and gender minority Latinx community members.

Programmatic Access Barriers

In addition to the structural barriers noted above, respondents identified a range of barriers associated with limited organizational infrastructure to address community members' context-specific needs. These barriers are as follows:

Conceptualizations of Mental Health

Across community forums, participants discussed that they are deterred from seeking services in organizational contexts that frame mental health treatment as a process of reducing symptoms. Community forum participants described that their ideal supportive services are those that promote holistic wellness. Therefore, organizational contexts that are focused on assigning diagnoses and set treatment goals emphasizing symptom reduction feel restrictive and uncomfortable to community members. Community forum participants further described that they prefer the term "emotional wellness" in place of mental health:



Salud mental se suena como si alguien está mala mentalmente... loca. Bienestar emocional suena mejor."

Mental health sounds like someone is mentally sick...crazy. Emotional wellness sounds better." (CF BP)

As illustrated through the above quote, the language and framing around mental health and mental health treatment can serve as a deterrent for community residents seeking services. While the term mental health connotes an emphasis on diagnoses and symptomatology, community forum participants described the term "emotional wellness" as being more broadly focused on addressing holistic needs.

Limited Culturally and Linguistically Appropriate Services

Individual interviewees and community forum participants further discussed that community residents face challenges in accessing services when treatment contexts are not culturally appropriate and aligned with their needs. Respondents noted that the provision of culturally appropriate services does not only entail providing services in one's native language, but further requires that providers demonstrate an understanding of their cultural heritage and their context-specific service needs. Respondents stated that based on their personal and professional experiences, the number of providers across the city of Chicago who have both linguistic and cultural understanding is limited:



...you're looking at, you know, the reality of not having bilingual care in mental health... or even culturally appropriate care in mental health... and that is difficult. It is really a difficult area." (I7)

When discussing the barrier of limited culturally appropriate services during the member check interview, community members elaborated on the fact that providers often lack an understanding of individuals' multiple intersecting cultural identities. In particular, even among providers who serve the Latinx community at large, services often are not tailored to address the needs of sexual and gender minority Latinx community members. In other words, there is often limited acknowledgement of the different forms of oppression that individuals face due to intersecting identities.

Respondents also noted that organizational treatment contexts often are not aligned with community residents' service needs. Community forum participants recounted, for example, the challenges that they have experienced in accessing services that are accommodating of their work schedules, stating that it is difficult to secure mental health therapy appointments outside of traditional business hours. Individual interviewees noted this same challenge. In describing examples of culturally appropriate services, one interviewee stated how an important component of culturally appropriate services is ensuring that services are accommodating to the needs of community residents. They define what it means for services to be aligned with community residents' needs as follows:



They're able to take the opportunity to receive these services in their language at [convenient] hours...they have evening hours and Saturday hours. And [services are offered] within that community of course." (I1)

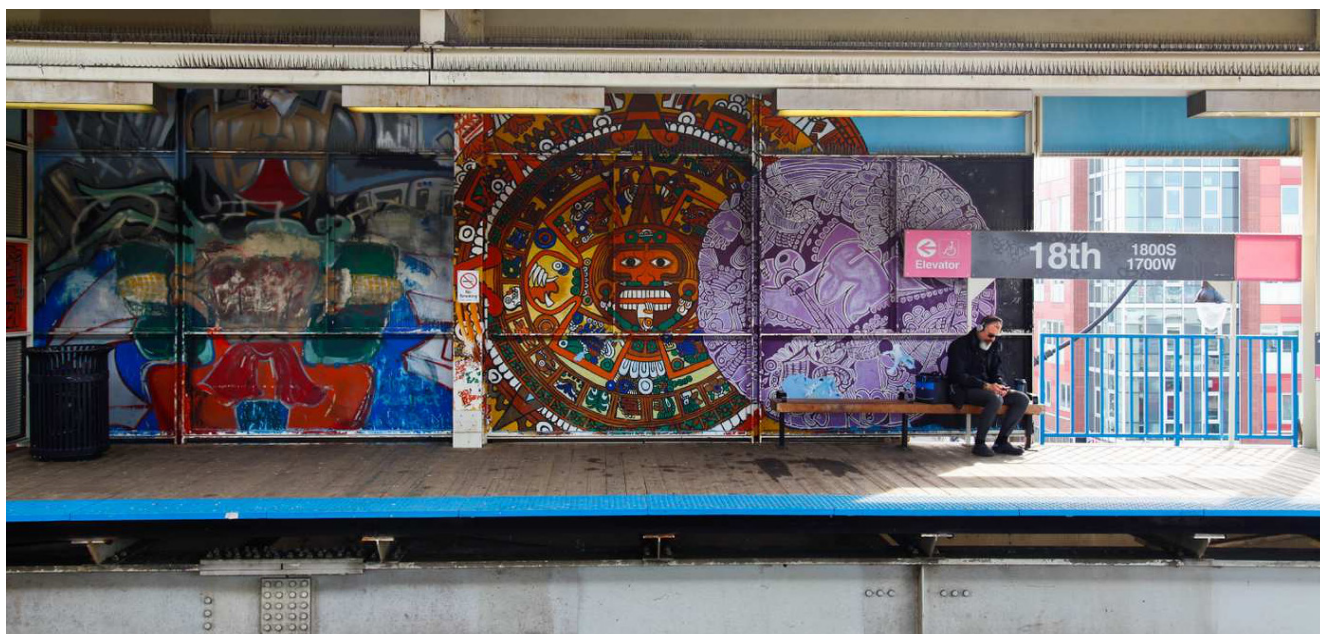
Childcare and Transportation

In discussing the access barriers that community residents experience when treatment contexts are not aligned with their service needs, respondents made specific reference to barriers associated with childcare and transportation costs. One individual interviewee stated that when organizations are unable to provide transportation assistance, the financial burden of traveling to and from appointments may be insurmountable for community residents:



I remember working with a woman and her telling me that sometimes she had to decide whether to get a gallon of milk or pay the \$2 CTA fee (bus fare) to go to her appointment." (I10)

As this quote illustrates, when organizations lack the infrastructure to address poverty-related factors impacting service access, including needs related to transportation and childcare, the extent to which community residents can participate in services is limited.



Mural by Francisco Mendoza, 1706 W. 18th Street, 1998. Photo by Ken Carl and Kaitlynn Scannell.

Social Access Barriers

In addition to the range of structural and programmatic barriers identified above, respondents identified several access barriers related to social perceptions of mental health and mental health treatment. Respondents identified the following social access barriers:

Perceptions of Mental Health and Mental Health Treatment

Respondents noted that community residents may be deterred from seeking services due to the perception that mental health treatment is for individuals who have a severe illness. More specifically, community forum participants described that when mental health treatment is framed in relation to diagnoses and symptomatology, there is a hesitancy to access services due to concerns about being labeled as “crazy.” It is also noteworthy, however, that individual interviewees seldom referenced stigma and perceptions of mental health as barriers impeding service access. One individual interviewee stated that they believe stigma has become less of a concern within the Latinx community:



...from our perspective, you know, I think the community understands more and more that [mental health is]...important. So now we have to make sure that we do the advocacy piece [to] make it happen.” (I4)

During the member check interview, community residents further validated that stigma is becoming less of a concern among the Latinx community over time. In particular, community residents noted intergenerational changes in which younger generations are more open to participating in mental health services.

Gender Role Expectations and Stereotypes

While the theme of gender role expectations received minimal mention during individual interviews, it was a subject of debate during community forums. For example, when presented with quantitative findings demonstrating that the majority of male survey respondents (73%) reported “yes” or “probably yes” to the question of whether they would seek professional support for their emotional needs, forum participants frequently expressed surprise. Community forum participants stated that they perceived men to be hesitant to seek help due to dominant ideologies framing emotional expression as a sign of weakness. One forum participant stated that men do not express their emotions to family members because they are expected to be the pillar of strength within the family system:



*El yo, yo soy el hombre de la casa. Entonces ellos cargan todo ese peso y no lo expresan con la pareja. Quieren ellos ser el pilar y el fuerte de la casa...El stress del hombre es diferente porque el hombre se aguanta y se lo guarda para no preocupar a las parejas.”
There’s the idea that I am the man of the house. So they carry all of that weight and don’t express it with their partner. They want men to be the pillar and strength of the home...
The stress of men is different because men carry it with them and keep it to themselves so that they do not worry their partners.” (CF WL)*

At the same time, however, that forum participants acknowledged that gender role expectations may deter males from expressing their emotions, they also acknowledged that men have mental health needs. Although men may not express their emotions within their families, this does not mean that they are not open to receiving professional support. As one community forum participant stated:



Tanto hombre y mujeres, estamos por lo mismo. Son los factores, o experiencias, que son diferentes, [pero] estamos al nivel de las mismas necesidades."

Both men and women, we have the same needs. The factors, or our experiences, are different, [but] our needs are the same." (CF CL/GP)

While community forum participants therefore identified that gender role expectations may pose a barrier to males in expressing their emotions, they simultaneously acknowledged that men are still open to receiving professional support. Furthermore, participants acknowledged that although gender role expectations may pose a barrier to service access, they still perceived barriers stemming from structural and programmatic factors to play a larger role in impeding service access.

Community-Identified Solutions

Respondents identified multiple innovative solutions for facilitating mental health service access and addressing mental health needs among community residents. Each of these solutions are outlined below.

Redefining Mental Health

Central to respondents' identified solutions was the necessity of redefining mental health. Individual interviewees and community forum participants discussed that when mental health is defined in relation to diagnoses and symptomatology, community members may be deterred from engaging in services. In contrast, respondents identified that services defined as promoting "emotional wellness" spoke to the importance of addressing the needs of the whole person. One individual interviewee proposed the following redefinition of mental health:



...[mental health] means an appreciation of who you are as a person...that you appreciate who you are, that you [are] a treasure to society and to the community. I think mental health has to rotate around those kinds of concepts...I've come to appreciate mental health as the...understanding...of a person who lives out of that sense of appreciation on the one hand and at the same time I think who...lives, hopes, and finds joy in giving back. So I think mental health encompasses relationships that are understanding and free flowing and supportive and trusting...I think mental health is around connecting the story and bringing meaning. A person brings meaning to their lives by connecting with the other. And they walk away strengthened." (I6)

This reframed definition of mental health is trauma-focused, as it focuses on fostering healing and enriching interpersonal connections.

Establishing Community-led Initiatives

Individual interviewees and community forum participants described the importance of establishing gathering and healing spaces where community members themselves take the lead in offering support to fellow community members. Respondents suggested developing programs in which community members receive education on mental health needs, available resources, and the legal rights of the immigrant population, and then in turn provide this education to fellow community members. There was the additional recommendation to offer gender-specific support groups. Respondents discussed that in the context of the anti-immigrant climate in which they live, having a supportive environment to engage in dialogue with fellow community members regarding the stressors that they are experiencing is critical to promoting emotional wellness. Respondents additionally spoke about establishing healing spaces that are multi-purpose and provide opportunities for residents to connect with their cultural heritage and participate in literary projects, dance, sports, and other recreational activities. Respondents described the importance of establishing spaces that are inclusive of the entire family system and that provide age-specific programming. Individual interviewees and community forum participants additionally recommended that this range of programming be offered in accessible community settings and that opportunities for implementing emotional wellness programs in schools be further explored.

In emphasizing the importance of community-driven interventions, respondents are ultimately asking for a deinstitutionalized form of service delivery that distributes power equitably among service providers and community residents. Within this system of shared power, organizations invest in building social capacity within communities and recognize that although service providers have a unique set of expertise, so too are community residents experts in their own life experiences. During their individual interview, one community leader spoke to the importance of recognizing community members' expertise in order to facilitate healing connections between organizations and communities:



...And this came from listening to another young man his age, who was not Catholic but connected with the Aztec grandfather he had in Mexico. I think all of that is part of the telling of the story and how we conduct ourselves. As the community connects to that, they're able to tell their own story. And pretty soon we had an enactment in the sanctuary of the Church of domestic violence. What was happening at home and how they prayed to the Virgin of Guadalupe....But... that sort of reflection draws us [into] the contemplation of who we are as a people, how we suffer and how we respond to care for one another. You know, that starts to restore mental health to us... So I think that kind of culture of connectivity and teaching, that we have to come together in and recite the stories, tell the heritage. I think that's the greatest connective response we can have. And for me, institutions that lose that ability and capability [of] retelling the story have lost... affirmation and connectivity is helpful." (I6)

Implementing Organizational Change

Respondents offered multiple recommendations for local organizations and service providers on facilitating service accessibility and providing high quality mental health services for Latinx community members. Central to their recommendations was ensuring that treatment contexts are aligned with the service needs of community residents. As one individual interviewee stated:



...we create spaces for community residents to voice their concerns, to voice their need on what services they want to see, what services make sense for them... And so how can we talk about providing services that are accessible to [the] community but also that are relevant to community need." (I10)

Individual interviewees and community forum participants identified several ways in which organizations can provide services that are aligned with community need. These recommendations are provided below.

Addressing Structural and Programmatic Barriers to Service Access

Community forum participants identified that organizations can address many of the structural and programmatic access barriers that community members experience by developing the infrastructure to offer services free of charge, extend hours of operation beyond traditional business hours (for example, offer weekend appointments), and offer assistance with transportation and childcare. Individual interviewees echoed these points, with a particular emphasis on the importance of organizations addressing the access barrier of cost. When asked to describe their recommendations for facilitating service access, one individual interviewee provided the following recommendation for organizations:



Now expanding the capacity they have to make it into a site that is usable for mental health counseling sessions. But that people also know where it is at in the community, [are] able to access it with a lot less challenges. And of course the key word, free." (I1)

Providing Culturally Affirming and Linguistically Appropriate Services

Considering the limited availability of culturally and linguistically appropriate services, respondents identified that organizations can facilitate mental health service access by investing in the hiring of bilingual and bicultural service providers and ensuring that their service environments are culturally and linguistically affirming. Providing culturally affirming services does not only require an understanding of community members' cultural values, but also requires an understanding of the local context in which community residents live. Respondents discussed that service providers and program administrators can develop this understanding by looking for opportunities to engage with the community outside of their work. When asked what their ideal mental health system would look like, one individual interviewee provided the following description of services that are grounded in an understanding of the community they are serving:



...one that it would be community based. And then the large health care institutions need to understand that there needs to be a community health care component to whatever it is that they're doing, OK, and they can't be isolated from the places that they're at." (I7)

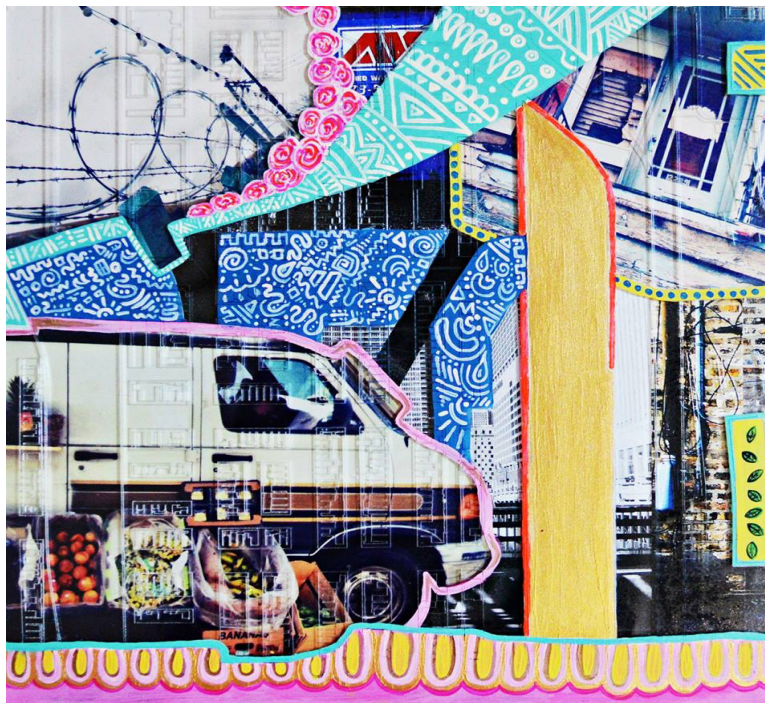
Redefining Mental Health through the Provision of Trauma-Informed, Holistic Services

Respondents also discussed the importance of mental health clinicians adopting a more expansive understanding of mental health that is not limited to offering support in decreasing symptoms. Not only did community forum participants describe that they are often deterred from seeking services when the focus is on symptom reduction, but individual interviewees also described that short-term services often do not adequately address the trauma underlying individuals' symptoms. Instead, when services are focused on facilitating personal expression, cultivating interpersonal connection, and promoting holistic wellness, increased opportunities exist for personal healing. Central to this model of service delivery is continuity in an individual's relationship with a mental health professional. Respondents noted, for example, that safety and trust within the therapeutic relationship are essential to processing and healing from traumatic experiences. In turn, establishing safety and trust within the therapeutic relationship requires that service providers and organizations offer consistent and stable support.

Respondents additionally described that practicing in accordance with this reframed definition of mental health requires that service providers recognize that community residents are experts in their life experiences and their service needs. Practitioners are thus given the charge of partnering with community residents to identify community-informed interventions that promote holistic wellness and healing from trauma. When organizations and community residents work in partnership, new alternatives for individual and community healing emerge:



...I strongly believe that people are experts in their own lives. Experts within their own community. And so how can we uplift those voices of a lot of the community residents to really lead us into what is possible. And I think at the beginning, people feel unsure about that question, what is possible. But when conversation and dialogue begins to happen, people start really demanding more change and then coming up with solutions. And so I think...What's next, what's possible is creating these spaces and uplifting those voices to lead us into that work....so that we can really create new alternatives. With community residents leading us. And really uplifting and...having community residents train each other and lead this work." (I10)



Rebel Betty, "De aqui pa'lla igual." Mixed Media. Original Photography. 2014.

SUMMARY OF FINDINGS

Findings from this mixed methods study provide important insight into the mental health needs and service access barriers of Latinx community residents on Chicago's southwest side. A synthesis of findings across quantitative and qualitative data demonstrated that within the national and local contexts in which community members are situated, experiences of trauma may underlie mental health challenges including depression, anxiety, difficulties with anger management, relational conflict, substance use, and domestic violence. When interpreting these findings, it is important to note that the last three months of quantitative data collection, as well as almost the entire period of qualitative data collection, occurred following the 2016 presidential election. As community forum participants made specific reference to the trauma of the presidential election, findings from this study are illustrative of the convergent negative impact of national and local level contexts on the well-being of individuals, families, and communities on Chicago's southwest side. Additionally, findings point to the limitations of the medical model in understanding community members' mental health needs. Considering that the social systems with which individuals interact were identified as convergently impacting well-being, findings from this study confirm the importance of using a structural analysis to develop a comprehensive understanding of the mental health needs of residents living in marginalized communities.

Not only did community residents identify the ways in which the national and local level contexts impact their well-being, but they also described how these contexts pose barriers to accessing the services necessary to promote emotional wellness. Findings indicated that community residents perceived structural barriers, primarily cost of services and lack of insurance coverage, as playing a larger role in impeding service access than did social barriers such as stigma. In synthesizing these data and discussing the limited availability of free services at a community meeting, a community stakeholder summarized a key message of the findings as follows: "It's not that we don't want services, it's that the services don't exist."

It is also noteworthy that community residents identified programmatic barriers related to limited infrastructure to provide culturally and linguistically appropriate services as impeding service accessibility. Not only did language emerge as an access barrier through survey data, but community stakeholders further elaborated on this theme through individual interviews and community forums. In particular, community stakeholders emphasized that the provision of culturally appropriate services does not just entail that providers can communicate with community residents in their native language, but rather that both providers and organizations as a whole are committed to developing an understanding of community residents' cultural values and their experiences in the context of their environment. Data gathered through interviews and community forums pointed to the importance of organizations making the infrastructural investments necessary to address common structural and programmatic access barriers and to ensure that community members have access to high-quality services that are aligned with their context-specific needs. A synthesis of these data therefore indicates that facilitating mental health service access among residents in communities with high levels of trauma and unmet mental health need is key to addressing the structural violence that community residents experience when the resources and services necessary for them to reach their full potential simply do not exist.

LIMITATIONS AND STRENGTHS OF THE STUDY

Although this study is unique in its focus on examining mental health needs and service access barriers among community residents on Chicago's southwest side, several limitations should be acknowledged. First, one of the main limitations is the cross-sectional nature of the data. For example, we are not able to make inferences about changes in mental health needs and access barriers to mental health care over time. Specifically, the study assessed current service access barriers and mental health challenges, but did not examine previous ones.

Second, the study utilized a convenience sample when administering the surveys. Convenience sampling has several limitations, including possible limitations in capturing representation of diversity within the community and therefore the ability to generalize the findings to other populations. All participants were recruited by community members and leaders in public community settings. Community members and leaders primarily recruited community members that they had ties with, which may also exclude non-Latinx residents within the surveyed communities. This resulted in oversampling of women and immigrants, and additionally resulted in other racial and ethnic groups besides Latinx not being surveyed as extensively. Further, study efforts were not directed at recruiting sexual and gender minority Latinx community members. The current study did not focus on the experiences of specific Latinx subgroups. In addition, the generalizability of the current study is limited by location of recruitment. Participants were only recruited from the southwest side of Chicago, limiting generalizability of findings to other contexts across the U.S.

For the qualitative component of the study, it is important to note that even though community forums were not audio recorded, multiple note takers were present to record comprehensive notes. Notes were then compared and reviewed for consistency. Similar to the quantitative component of the study, community forums were predominantly composed of women, which limited our understanding of male experiences. However, among individual interview participants, there was equal representation among women and men.

Lastly, data obtained for the quantitative and qualitative components of the study were self-report. For example, we did not conduct neighborhood audits of the built environment. Retrospective self-report may influence self-report bias. In particular, participants may not remember or be aware of barriers or how their mental health and well-being were impacted by intersecting systems.

Despite some limitations, the current study has major strengths that should be highlighted. To begin, our mixed methods design allowed us to obtain rich data documenting the lived experiences of Latinx community residents on Chicago's southwest side. In addition, our CBPR approach ensured that we worked in partnership with community residents across all stages of the research process. This approach allowed us to gather quality data due to the positive rapport and trust that was established between community leaders involved in data collection and community members who took part in research activities. Furthermore, countering traditional forms of scientific research, within our CBPR approach we highlighted the importance of experiential knowledge and leveraged community members' expertise. The qualitative component of the study uplifted community residents' voices by acknowledging and documenting their lived experiences, histories and testimonies. In addition, community members and leaders were involved in conceptualizing all survey questions. Recognizing the marginalized status of community residents who took part in this study, the quantitative survey was intentionally designed to be short and items did not assess symptoms of mental health conditions. Our research approach and study design therefore allowed for unique insight into the mental health needs and service access barriers among a population whose needs are seldom explored within the structural context in which they are situated. It is our hope that this study paves the way for future research exploring the manifestations and impacts of structural violence.

CONCLUSION AND RECOMMENDATIONS

Prioritizing Mental Health: Examining Chicago's Mental Health Crisis Through a Rights-Based Lens

Within the international community, there is growing recognition that access to health care services is not a privilege, but rather is a fundamental human right. The World Health Organization (WHO) asserts that all human beings are entitled to “the highest attainable standard of health,” which requires that services are accessible, affordable, and of high quality.¹²⁸ A rights-based approach to health care, including mental health care, thus entails addressing disparities in service access, quality, and ultimately, health outcomes. Paul Farmer further specifies that a rights-based approach to health care does not only require that all human beings have access to the services needed to promote optimal health outcomes, but also requires that the underlying social and economic conditions that lead to disparate health outcomes be addressed.¹²⁹ Applying a rights-based lens to the current findings, it is clear that this approach has important implications for the local context of the southwest side and other high economic hardship communities in Chicago.

As reflected in this study's findings, Latinx residents in the surveyed community areas are too often denied of their fundamental right to accessible mental health care that is aligned with and responsive to their service needs. The mental health needs and access barriers that community residents experience are integrally connected to social and economic conditions. In particular, community residents identified their experiences interacting with oppressive social systems and living in communities with limited resources and infrastructural investments as negatively impacting their well-being. From a rights-based perspective, the implications of these findings are twofold. First, these findings are a call to action for stakeholders throughout the city of Chicago to advocate for the expansion of free, trauma-focused mental health services for marginalized and underserved adult community residents, regardless of insurance and immigration status. This call to action entails advocating for funding for professional mental health services and investing in organizational infrastructure that decreases structural access barriers.

Second, findings from this study are a call to address the social and economic inequalities that impact well-being. Recognizing that community residents identified their mental health needs as stemming from the structural context in which they live, this context must be addressed if we are to truly promote healing among underserved community residents who have experienced trauma. As Paul Farmer states, we must advocate for change within the very systems that oppress and marginalize community residents and limit their opportunities to attain optimal health.¹³⁰ Within the local context in which community residents live, there is the need for increased investment in local infrastructure and resources. Community stakeholders recognized that in place of increased policing to address the violence that negatively impacts community residents, there is a need for increased investment in economic, educational, and personal development opportunities to decrease community violence.

Responding to these calls to action requires a clear vision of what it means to provide accessible, high quality, trauma-focused services. According to Mattaini and Holtschneider, trauma-focused practice recognizes the impact of structural violence and works to ameliorate its impact. Mattaini and Holtschneider thus advocate for practice that “challenges oppression and structural violence, offers care and accompaniment for casualties of that oppression, and co-constructs a society of individual and collective well-being and liberation.”¹³¹

Returning to Maria's story presented in the introduction, we are able to see an example of how this vision for service delivery is translated into practice. Maria and her family initiated services through Saint Anthony Hospital: Community Wellness Program (SAH:CWP), a fully funded department of Saint Anthony Hospital that offers a range of free supportive services to uninsured and underinsured community residents on Chicago's west and southwest sides. Operating two fully staffed community centers in Little Village and North Lawndale, as well as two satellite locations in Brighton Park and Gage Park, SAH:CWP offers support with health care access and navigation, family support services, health education, and mental health services. Operating from the belief that all individuals are entitled to high quality services that promote healing from trauma, mental health services are not only provided free of charge, but they are also long-term. Furthermore, child care and transportation assistance are offered to program participants who are in need of these supports, and appointments are offered outside of traditional business hours to facilitate service access. Mental health services are also offered in the context of a range of supportive services in order to promote holistic wellness at the level of the individual, family, and community. As illustrated through Maria's story below, SAH:CWP recognizes that all individuals and families have a fundamental right to attain holistic wellness. Therefore, SAH:CWP works in collaboration with community partners to wrap individuals and families in services that are reflective of this vision. While SAH:CWP does provide an alternative model of trauma-focused mental health service delivery within the current Chicago service landscape, there is a need for increased investment in services that carry out this vision to ensure that organizational capacity keeps pace with the demand for services.

Creating New Alternatives:

Community-Based Trauma-Focused Care for Maria and Her Family

(all identifiers have been modified to maintain confidentiality)

After the death of her son, Maria was introduced to a range of supports within the Little Village community. Among these supports was Padres Angeles, an organization that accompanies families during their time of need. Doris Hernandez, founder of Padres Angeles and mother of Freddy Cervantes (murdered November 2012), organized a community prayer vigil immediately following the homicide of Maria's son. After the prayer vigil, Doris invited Maria to attend Grupo Consuelo, a support group for families who lost a loved one to violence which counts on three volunteer LCSW's to process grief and strengthen ties within families. Maria was especially interested in attending because she wanted her children to receive support in the traumatic loss of their brother.

Since fall of 2015, Maria has been faithfully attending Grupo Consuelo with her three youngest children. Once engaged in the group, Maria began to disclose a multiplicity of issues facing her family. Through Grupo Consuelo, a part of Saint Anthony Hospital: Community Wellness Program, Maria was connected to other free services offered by the Community Wellness Program, including the Adolescent and Parent Education (APE) program, where she participated with her third eldest child. APE employs four clinical staff members. Upon completion of the program, Maria began seeking individual therapy services at the Community Wellness Program. She participates in individual therapy services with an LCSW clinician and has the option of utilizing the free childcare that is offered on-site. She has additionally begun to receive family therapy with an LCSW, which includes all those in her household. Also within the context of individual services, Maria consistently brings up the needs of her children and advocacy support with their schools. This advocacy support is made available to her at the Community Wellness Program. Staff at the Community Wellness Program provide this advocacy support by informing Maria of her rights within the educational system and speaking with school staff as needed.

RECOMMENDATIONS

Ensuring that community residents have access to the high quality mental health services to which they are entitled requires efforts on the part of mental health service providers and program administrators, policy makers, and funders. A list of these recommendations is provided below.

Recommendations for Mental Health Service Providers and Program Administrators

Work in Partnership with Communities

As findings from this study indicated, it is critical that organizations work in partnership with communities to deliver culturally affirming, trauma-focused services. While clinicians' workloads and productivity expectations typically do not allow them to be active in various community forums and to explore collaborative opportunities, data suggest that this level of engagement with the community is necessary to implement services that are aligned with the needs of community residents. In addition, collaborative partnerships play a crucial role in building social capacity to address conditions of structural violence that impact well-being. Program administrators can facilitate these partnerships by creating an organizational culture that values ongoing community engagement and encourages service provider involvement in these collaborative spaces. Lastly, working in partnership with communities entails working in partnership with other organizations. Recognizing that each organization in Chicago's social service landscape has a unique niche with regard to service expertise and populations served, collaborative partnerships will facilitate referrals in cases where the needs of an individual or family cannot be addressed through a single organization. The Collaborative for Community Wellness has developed a system to facilitate referrals among member organizations, in which an organizational representative may complete an online form on behalf of a community member who is seeking mental health services. Staff at Saint Anthony Hospital: Community Wellness Program, who oversee the referral system, then reach out to a partner organization whose services are aligned with the community member's needs to facilitate the connection to services. This referral system reflects just one example of the opportunities that exist to build collaborative partnerships across organizations on Chicago's southwest side.

Change the Narrative around Stigma

This study's findings clearly demonstrate that contrary to popular belief, social barriers such as stigma are not the primary factors impeding mental health service access among community members on Chicago's southwest side. Instead, community residents overwhelmingly identified structural and programmatic barriers as posing the greatest challenges to mental health service access. When service providers and program administrators emphasize stigma as a main deterrent to service access, they are placing the onus to engage with services on the individual rather than recognizing the structural and programmatic contexts that need to be addressed. It therefore is imperative that we shift the narrative from one that blames the individual to one that emphasizes the need for organizational and structural change.

Recognize and Address the Structural and Programmatic Barriers that Impede Service Access

If we are to truly address Chicago's mental health crisis, mental health service providers and program administrators must assess their organization's current infrastructure and advocate for infrastructural changes aligned with community needs. Offering services free of charge, expanding hours of operation, and providing child care and transportation assistance are critical to facilitating mental health service access for marginalized community residents.

Invest in Culturally Appropriate, Trauma-Informed Interventions

While community stakeholders identified a clear need for increased culturally and linguistically appropriate services for Latinx community residents on Chicago's southwest side, they also advocated for a more expansive understanding of what culturally and linguistically appropriate service delivery entails. Not only is there a need for service providers to demonstrate an understanding of an individual's cultural values and to deliver services in an individual's native language, but there is also a need for service providers to understand the community context that informs the individual's needs and experiences. Program administrators can play a vital role in promoting this more expansive understanding of culturally appropriate service delivery within their organizations. For example, program administrators can drive organizational efforts to facilitate ongoing community engagement and to systematically assess context-specific service needs. In community contexts where needs related to transportation and childcare pose barriers to service access, program administrators can facilitate culturally appropriate service delivery by ensuring that their organizations offer free, on-site childcare and provide transportation assistance. In addition, program administrators can foster collaboration with community residents in order to develop and implement community-driven interventions. In so doing, organizations become actively involved in generating practice-based evidence, in which treatment approaches are derived from practices that have been established to be relevant and meaningful to practitioners and local community members.¹³² In addition, operating from this more expansive understanding of what culturally appropriate service delivery entails, it naturally follows that in the context of Chicago's southwest side, culturally appropriate service delivery is also trauma-focused service delivery. As qualitative findings indicated, community forum participants identified trauma as being a common element of community residents' daily lived experiences. Delivering services that are aligned with the needs of community residents thus requires that program administrators develop the organizational infrastructure to support mental health service providers in delivering services that not only provide symptom relief, but that also cultivate interpersonal connection and promote long-term healing from trauma. Considering that consistency in the therapeutic relationship is critical for long-term healing, program administrators can play an invaluable role in creating organizational cultures that promote program stability and that in turn encourage staff retention.



Walls of Hope. Brighton Park. Mural by ElevArte Community Studio: <http://elevartestudio.org>

Respond to the Mental Health Needs of Men

A noteworthy finding from the quantitative survey data was the fact that the demand for professional mental health services among male respondents was on par to that of female respondents. In particular, quantitative findings demonstrated that the majority of male survey respondents (73%) reported “yes” or “probably yes” to the question of whether they would seek professional support for their emotional needs. Considering that mainstream narratives often portray males as being reluctant to engage with services, it is critical to highlight this finding. In order to facilitate service access for male community members, service providers and program administrators must recognize and address the structural and programmatic barriers that impede men from accessing services. Although men were more likely than women to report social access barriers including a belief that counseling would not help, these social barriers were still minimal in comparison to structural and programmatic barriers. If service providers are to more effectively respond to the mental health needs of men, they must first and foremost address structural and programmatic barriers impeding service access.

Redefine Mental Health

As noted during individual interviews and community forums, community residents can be deterred from seeking mental health services when mental health is framed in relation to diagnostic criteria and when service providers approach treatment with a focus on reducing symptoms. Community stakeholders recommended that service providers focus more broadly on promoting holistic well-being rather than solely on decreasing symptoms, and further recommended that service providers reframe their language so that discussions around “mental health” shift to discussions around “emotional wellness.” Program administrators can play an important role in this reframing process by promoting an organizational culture that actively rejects pathologizing individuals through diagnoses.



Jeff Zimmerman, 2039 S. Wolcott Ave, 2007. Photo by Ken Carl and Kaitlynn Scannell.

Recommendations for Policy Makers

Advocate for Funding for Mental Health Services

Findings from this study indicate that funding cuts within the state of Illinois and mental health clinic closures within the city of Chicago have a profound impact on service accessibility. As noted in individual interviews and community forums, the demand for services far exceeds organizational capacity. In Chicago's southwest side communities, mental health services simply are not available within close geographic proximity, a problem that has been exacerbated by the closure of the CDPH clinic in Back of the Yards. Not only should policy makers advocate for the reopening of the Back of the Yards mental health clinic, but they should also advocate for stable, long-term funding to build up the public community-based mental health system that has been disinvested in the city of Chicago since having a renowned mental health system in the 1960s-70s.¹³³

Advocate for Change Within the Medical System

Harkening back to the words of the World Health Organization¹³⁴ and Paul Farmer¹³⁵, access to high quality health services, including mental health services, is not a privilege but rather is a fundamental human right. The current medical system poses restrictions on the extent to which Chicago's southwest side community residents are able to access high quality mental health services. Our data demonstrate that existing systems of service delivery by way of the managed care model are not structured to facilitate access to the comprehensive mental health treatment that marginalized community residents need. Not only do uninsured community residents face barriers to accessing affordable services, but insured community residents also face restrictions based on where their insurance is accepted and the number of sessions that their insurance will authorize. It therefore is imperative that policy makers advocate for legislation that restructures how mental health services are provided.

As noted above, policy makers can play an invaluable role in advocating for stable funding for free, long-term, community-based mental health services. In addition, policy makers should explore opportunities to integrate free mental health services within the medical system. Saint Anthony Hospital's Community Wellness Program provides an example that can guide other hospitals at the local and national levels. The Community Wellness Program is a fully funded department of Saint Anthony Hospital, and through its provision of free, trauma-focused holistic services to marginalized community residents, Saint Anthony Hospital is designated as a charitable hospital. Policy makers can play a critical role in incentivizing hospitals to invest in similar broad-based community health initiatives that promote emotional wellness.¹³⁶

Advocate for Immigration Reform

Community stakeholders noted that among immigrant community members on Chicago's southwest side, individuals commonly experienced oppression and marginalization stemming from the immigration system's classification of human beings into categories of "legality" and "illegality." Community stakeholders further specified that chronic stressors associated with limited access to resources, services, and education and employment opportunities, as well as living in constant fear of deportation and familial separation, negatively impact mental health. Considering the negative impact of the immigration system on mental health, policy makers can play an invaluable role in both advocating for comprehensive immigration reform at the national level and driving local level legislation that facilitates access to resources and services regardless of immigration status. If Chicago is truly to be a city that is welcoming of immigrants, then it is imperative that immigrant community members have equal access to resources and supports within the local service landscape.

Recommendations for Funders

Provide Funding for Long-Term, Trauma-Informed Mental Health Services

Recognizing that budget cuts within the state of Illinois profoundly impact organizational capacity to deliver mental health services, private funders can offer invaluable support to organizations experiencing fiscal challenges. Community stakeholders have identified that short-term mental health services focused on symptom reduction are not enough to promote long-term healing from traumatic experiences. Private funders can therefore support initiatives to address the mental health crisis on Chicago's southwest side by providing stable funding for time-unlimited services for community residents both who are uninsured and whose insurance does not cover long-term services.

Mutual Support Models without Professional Mental Health Support are Insufficient

While respondents voiced a desire for more safe spaces to engage in personal enrichment activities, as well as spaces where community residents can come together to offer mutual support and provide mental health education, it is also important to note that these resources in themselves are not sufficient to address the mental health needs of community residents and to address the trauma underlying these needs. Research has found, for example, that social support did not moderate the positive relationship between adverse childhood experiences and health conditions including depression, obesity, alcohol use, smoking, coronary heart disease, chronic obstructive pulmonary disease, and cancer among a diverse sample of Latino adults.¹³⁷ Social support in itself therefore is not enough to address the needs stemming from traumatic experiences. Similarly recognizing that social support cannot take the place of specialized trauma-focused clinical professional services, one community stakeholder noted the limitations of mutual support groups. This individual stated that when community members discuss traumatic experiences without the guidance of a mental health clinician who has experience in this area, these discussions are overwhelming for community leaders facilitating the group and can trigger traumatic memories for other group participants. For this reason, mental health professionals should be involved in facilitating therapeutic group healing spaces along with community leaders and connect community members to formal trauma-focused services when individualized care is needed. While informal supports and resources can supplement clinical services, they cannot and should not serve as a stand-in for long-term mental health therapy services that allow community residents to process past traumatic experiences in a safe and healing therapeutic environment. Just as the treatment of a gunshot wound requires intervention from a trained medical professional, so too do the emotional wounds of trauma require care from trained mental health professionals. Therefore, although there is a need for funding for mutual support initiatives, financial investment in these initiatives should not supersede financial investment in formal long-term, trauma-focused clinical services and therapeutic groups facilitated by mental health professionals.

PROPOSED NEXT STEPS

This study offers an important opportunity to increase awareness of the current mental health needs and access barriers among high economic hardship communities on Chicago's southwest side. In addition, the data from this study inform recommendations for promoting emotional wellness. Central to the recommendations outlined in this report is the understanding that the structural context in which community members are situated impacts their emotional wellness. In turn, this report provides an opportunity to raise critical awareness about the importance of challenging this oppressive structural context that prevents community residents from attaining optimal health.

Next steps should involve ongoing dialogue regarding processes for implementing the recommendations outlined in this report. Bringing service providers, program administrators, policy makers, and funders to the table with community residents is essential for creating collaborative spaces in which everyone takes ownership for implementing solutions. In so doing, all stakeholders are empowered to become "professional agents of change."

Moreover, while this study focused on ten communities experiencing economic hardship on Chicago's southwest side, it is important to note that economic hardship and marginalization is not confined to these community areas. As the community areas included in this assessment were comprised of predominantly Latinx (Mexican) populations, future research efforts should focus on assessing mental health needs and access barriers among predominantly African-American community areas in the south and west sides of the city through a structural lens. Such research efforts would allow us to develop a more comprehensive understanding of the mental health needs and service access barriers across a range of high economic hardship communities within Chicago. In addition, these research efforts would also ensure that local context-specific solutions are implemented in each community area in accordance with residents' service needs. It should also be noted, however, that while community stakeholders identified the importance of assessing the unique needs of residents in predominantly African-American community areas, they also recognized shared experiences of marginalization across communities. Stakeholders thus expressed a desire to build inter-community support groups and alliances, as well as to create community-driven initiatives in collaboration with the African-American community.



Sara Briseño, "Como un Pájaro Libre" Watercolor. 2016.

CONCLUSIONS

As highlighted throughout this report, addressing the mental health crisis on Chicago's southwest side requires that service providers, program administrators, policy makers, and funders work in partnership with communities to challenge structural violence and facilitate access to culturally affirming and trauma-focused services that are aligned with community residents' needs. Central to delivering culturally affirming and trauma-focused services are the acts of recognizing an individual's lived experience in their environment and establishing connections that promote long-term healing.

As Ignacio Martin-Baro stated:

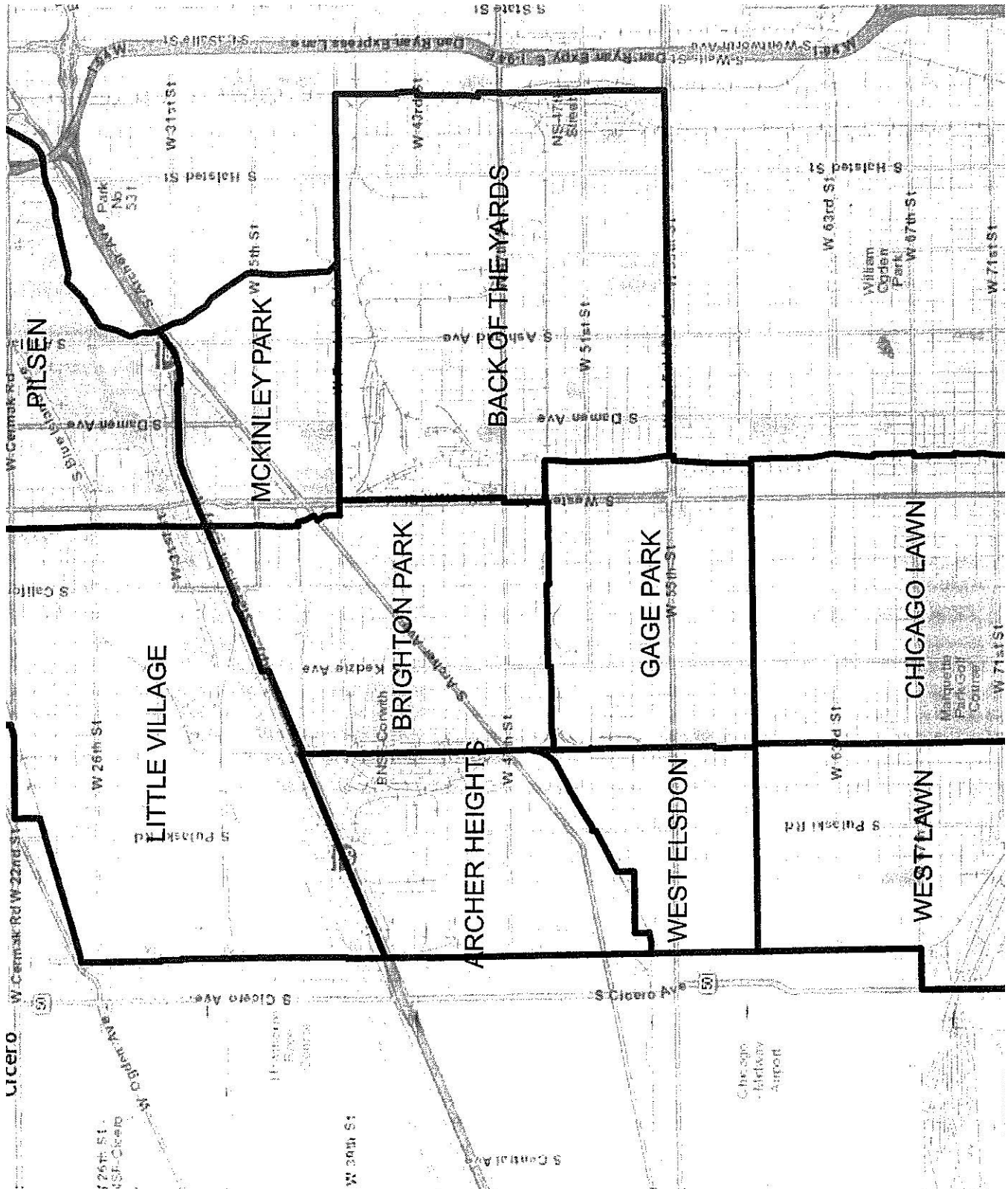
*"If the foundation for a people's mental health lies in the existence of humanizing relationships, of collective ties within which and through which the personal humanity of each individual is acknowledged and in which no one's reality is denied, then the building of a new society, or at least a better and more just society, is not only an economic and political problem; it is also essentially a mental health problem."*¹³⁸

When we collectively recognize both existing social injustices and untapped opportunities for healing, we move one step closer to building a society that is reflective of this vision.



Mural located inside the waiting room of Saint Anthony Hospital: Community Wellness Program's Little Village office.

APPENDIX 1



Emotional Wellness Survey

The information collected in this survey will be kept confidential.

Demographic Questions

1. Gender (please mark one):

☐ Female ☐ Male ☐ Other: _____

2. Race (mark one):

☐ Caucasian (White) ☐ African-American ☐ Latinx ☐ Asian ☐ Native American ☐ Other

3. What is the country in which you were born?: _____

4. In which neighborhood or community do you live in?

- | | |
|--|---|
| <input type="checkbox"/> Back of the Yards | <input type="checkbox"/> Archer Heights |
| <input type="checkbox"/> Brighton Park | <input type="checkbox"/> West Elsdon |
| <input type="checkbox"/> Chicago Lawn | <input type="checkbox"/> West Lawn |
| <input type="checkbox"/> Gage Park | |
| <input type="checkbox"/> Little Village | |
| <input type="checkbox"/> McKinley Park | |
| <input type="checkbox"/> Pilsen | |
| <input type="checkbox"/> Other: _____ | |

Emotional Wellness Questions

5. From the following list, please select up to 3 situations in which you experienced frequently:

- ☐ Sometimes I feel depressed or very sad
- ☐ Sometimes I feel anxious, constantly worried, or extremely nervous
- ☐ I find it hard to control my anger
- ☐ I feel I need support as a parent
- ☐ I feel I need support in my marriage/relationship
- ☐ There are troubling things that have happened in my life that continue to affect me
- ☐ I feel lonely, I do not feel I have sufficient emotional support in my life
- ☐ Living in a country whose culture and language are very different from mine is stressful

6. Please choose the option that best reflects your reaction to this statement.

I would consider seeking emotional support by a professional (counseling) as a way of dealing with my personal problems:

- ☐ Yes
- ☐ Probably Yes
- ☐ Probably Not
- ☐ No

7. What are the things that make it difficult for you to access emotional support by a professional (counseling)? Please select all that apply:

- ☐ Cost
- ☐ Lack of transportation
- ☐ Lack of childcare
- ☐ Lack of health insurance
- ☐ I do not believe those services would help me
- ☐ I would feel judged as "crazy" or "weak" or something else
- ☐ My partner/family would not approve
- ☐ It is difficult finding services in my preferred language
- ☐ Those services do not exist in my area
- ☐ I do not know where to go for those services
- ☐ The hours of service are not convenient for me

Encuesta sobre el Bienestar Emocional

La información colectada en esta encuesta se mantendrá confidencial

Preguntas Demográficas

1. Genero (marque uno):

☐ Femenino ☐ Masculino ☐ Otro: _____

2. Raza (marque uno):

☐ Blanco ☐ Afro-Americano ☐ Latino/a ☐ Asiático ☐ Nativo del Norte ☐ Otro

3. Cual es el país en que nació: _____

4. En qué vecindario o comunidad vive?

☐ Back of the Yards | "Las Empacadoras" ☐ Archer Heights
☐ Brighton Park ☐ West Elsdon
☐ Chicago Lawn ☐ West Lawn
☐ Gage Park
☐ Little Village | "La Villita"
☐ McKinley Park
☐ Pilsen
☐ Otro: _____

Preguntas sobre el Bienestar Emocional

5. De la lista, por favor seleccione máximo 3 situaciones que usted experimenta con mayor frecuencia o intensidad:

☐ A veces me siento deprimido/a o muy triste
☐ A veces me siento ansioso/a, continuamente preocupado/a, o extremadamente nervioso/a
☐ Se me hace difícil controlar mi enojo
☐ Siento que necesito más apoyo como madre/padre
☐ Siento que necesito más apoyo con mi matrimonio/relación
☐ Me han pasado cosas fuertes en la vida que a pesar del paso del tiempo me siguen afectando
☐ Me siento solo/a, no siento que tengo suficiente apoyo emocional en mi vida
☐ El vivir en un país con cultura y idioma muy diferente a la mía, me estresa

6. Por favor escoja la opción que mejor refleja su pensamiento de la frase:

Yo consideraría buscar apoyo emocional de un profesional (consejería) como una manera de lidiar con los problemas que tengo en la vida:

☐ Si
☐ Probablemente si
☐ Probablemente no
☐ No

7. Cuales son las cosas que le hacen difícil recibir apoyo emocional (consejería) de un profesional?

Por favor seleccione todas las que apliquen:

☐ El costo
☐ Falta de transporte
☐ Falta de cuidado de niños
☐ Falta de seguro medico
☐ No pienso que esos servicios me ayudarían
☐ "El qué dirán" (loco/a o débil o algo así)
☐ Mi pareja o familia no estarían de acuerdo
☐ Es difícil encontrar servicios en mi idioma
☐ No hay servicios de esos en mi comunidad
☐ No sé a dónde ir para encontrar esos servicios
☐ Las horas de servicio no me convienen

ENDNOTES

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