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ORIGINAL PAPER

A Community Mental Health Needs Assessment of a Racially and Ethnically Diverse Population in New England: Narratives from Community Stakeholders

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Abstract

Despite the existence of numerous efficacious treatments for mental disorders, many individuals in need do not receive adequate treatment particularly racial and ethnic minorities. Community stakeholders can provide: (1) a more nuanced understanding of community mental health needs, and in (2) informing the planning and provision of mental health services. Qualitative data for this mental health needs assessment come from 61 individuals who represent local residents and/or consumers of mental health services, Executive Directors, providers of mental health and non-mental health community based services. We identified systems-related and psychosocial barriers to seeking mental health services: difficulty navigating the mental health system, language barriers, dearth of culturally competent providers; and mental health stigma and mental health literacy and non-Western notions of mental health. Collaborative efforts across stakeholders are called for to address the mental health needs of racial and ethnic minorities in a local community.

Keywords Race and ethnicity · Immigrants and refugees · Barriers to mental health care · Communitymental health needs assessment

Introduction

Results from numerous epidemiological studies suggest that the lifetimeprevalence of any mental disorder is almost 50% of the adult U.S. population (Kessler et al. 2005), with significant numbers of individuals reporting having a serious mental illness (Ahrnsbrak et al. 2018). Unfortunately, despite the availability of effective psychopharmacological and psychosocial treatments (Wang et al. 2002), many individuals in need do not receive adequate treatment. For example, in the National Comorbidity Survey-Replication study, only 41.1% of respondents with a DSM-IV disorder had received mental health services in the previous year (Kessler et al. 2010). Similarly, in the 2014 National Health Interview Survey, among adults reporting serious psychological distress during the previous 30 days, only 35.5% had seen or talked to a mental health professional in the preceding year, and 30.7% were currently receiving no treatment (Cohen and Zammitti 2017).

These low rates of mental health service utilization are even worse for racial and ethnic minorities (Ahrnsbrak et al. 2018; Barnes et al. 2013; Berdahl and Stone 2009; Cook et al. 2007). Moreover, even when racial and ethnic minorities do seek out mental health treatment, they are less likely to receive an adequate dosage of treatment (Fortuna et al. 2010; Simpson et al. 2007), and more likely to prematurely drop out of treatment (Fortuna et al. 2010). These disparities have been found even when controlling for sociodemographic and clinical characteristics (Lagomasino et al. 2005), suggesting that they are not just the result of economic factors like poverty or greater clinical need.

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Efforts to understand racial and ethnic minority disparities in mental health services highlight the importance of attending to factors at different levels of analysis (Cardemil et al. 2015; Leong and Lau 2001; Pumariega et al. 2005). Some explanations have focused on barriers at the level of the healthcare system, including a dearth of community health centers and providers, as well as insurance limitations (Alegria et al. 2012). Explanations that have focused on barriers at the level of the patient have tended to examine logistical barriers and psychological barriers. Logistical barriers include complications such as transportation difficulties, inability to take time off from work, or absence of childcare (Alegría et al. 2008; Bridges et al. 2012; Kouyoumdjian et al. 2003; Miranda et al. 2003; Moos and Moos 1994). Psychological barriers have generally included lack of knowledge about mental health and mental healthcare systems, attitudes towards mental health and help-seeking, past and current trauma, stigma, and cultural values and norms (Alvidrez et al. 2008; Andrade et al. 2014; Chapman and Mullis 2000; Fogel and Ford 2005; Link et al. 2008; Nadeem et al. 2007; Ortega and Alegría 2002).

Despite the surge in research examining these issues, disparities in mental healthcare continue to persist. Indeed, research suggests that in some cases disparities may be worsening (Blanco et al. 2007; Cook et al. 2007). There are many reasons that these disparities are not improving, including the fact that systems-level changes take time to address. However, it is also likely that the lack of progress in addressing these disparities, in part, may be due to difficulties in translating national-level research findings into relevant changes at the local level. Research that identifies general barriers to mental health services may not be as suitable as research that examines barriers that are most relevant to particular communities.

Community-engaged research that integrates the perspectives of relevant stakeholders interested in improving the delivery of mental health can play an important role in bridging the gap between national-level research and local systems changes. In particular, community engaged research in the form of a local needs assessment can provide communities with a more nuanced understanding of the needs that are relevant to their particular populations, can lead to collaborative efforts to address mental health needs by encouraging dialogue, and can empower communities to make the changes needed (Barrera et al. 2011; Cardemil et al. 2007; Collier et al. 2012; Doornbos et al. 2013; Post et al. 2016). For example, Collier et al. (2012) conducted a community mental health needs assessment in Wisconsin of the Hmong, a growing immigrant population that was experiencing significant social disadvantages and health and mental issues. Using a community participatory design, Collier et al. held focus groups with residents of Hmong descent and interviews with medical, mental health, education and social service providers in the community. The authors found that despite significant mental health needs, individuals in the Hmong community had low mental health literacy and were reluctant to share personal information about emotional problems. Important recommendations emerged from this study including innovative ideas to increase the mental health literacy, reduce systemic barriers to care, and make greater use of cultural brokers (Collier et al. 2012).

In another study, Corona et al. (2009) conducted a health and social services needs assessment of a Latinx community in Richmond, Virginia. The dearth of culturally responsive health and social services in this nontraditional settlement area led to concerns about the ability to meet the needs of this newly arrived immigrant population. Using principles of community based participatory research (CBPR), the researchers conducted surveys with over 200 Latinx adults and interviews and focus groups that included key informants from a variety of organizations (faith-based organizations, school, law and government, media (print, radio), parents and children). Results indicated that in addition to being concerned about mental health issues, most participants also emphasized parent–child intergenerational conflict that may have been connected to stress and trauma from the immigration process. Findings from this study highlighted the importance of having mental health interventions focus on strengthening family relationships, teaching children skills for engaging in positive health behaviors, and promoting connection to Latinx culture (Corona et al. 2009).

Importantly, community needs assessment studies have demonstrated that perceived needs vary depending on who is participating in the research. For example, in a study assessing the needs of older people with mental health problems, Hancock et al. (2003) noted that the reported level of need varied by who was being interviewed. In particular, the elder participants identified fewer psychological or social needs (e.g., daytime activities, company, or caregiver distress) than staff or caregivers did. Moreover, in contrast to the caregivers' reports, the elder participants usually did not rate their caregivers as having much need. Taken together, these findings support the importance of multi-informant approaches to assessment in acquiring a comprehensive understanding of community needs. When the perspectives overlap, they allow for greater confidence in the findings and when they diverge, they offer important opportunities to further understand viewpoints that may not often receive attention (Hancock et al. 2003).

In this article, we describe a collaborative, community-engaged need ssessment designed to better understand the mental health needs of a racially and ethnically diverse community, which in turn, could improve the delivery of mental health services. The assessment took place in a rapidly changing midsize New England city with a population of almost 200,000. Since 2007, the city has experienced a surge of immigrants and refugees from areas of global conflict with no previous connection to the city. As of 2017, nearly 21% of the residents were born outside of the United States, and slightly over 35% of the residents are speakers of a non-English language (Fábos et al. 2015). According to the 2017 American Community Survey (ACS), nearly 21% of the city population is Latinx and is also home to a growing Asian population (7%), half of which are of Vietnamese origin (Lo and Tran 2012). These trends have prompted greater attention to the mental health needs of immigrant and refugee populations and their families among local stakeholders.

In this article, we have two primary aims: (1) to describe the process by which we conducted the assessment; and (2) to identify the mental health needs of a racially and ethnically diverse local community to help inform the planning and provision of mental health services.

Methods

Participants

A total of 61 individuals participated in the project, including local community residents and/or consumers of mental health services, as well as a broad range of community-based service providers and Executive/Program directors in the community. Inclusion criteria included being 18 years or older. Participants had to be able to speak and understand English, Spanish, or Vietnamese. Individuals were compensated $25 for study participation.

Community Residents and Consumers

In total, 26 community residents and consumers participated in the study. These 26 participants ranged in age from 24 to 74, with a mean age of 56.6 years ($SD = 13.4$). They were racially and ethnically diverse, with 88% of the participants self-identifying as racial/ethnic minorities and just over two-thirds of the sample indicating they were U.S. immigrants. Slightly more than half the sample identified as men (58%), just under half were single (42%), and the majority of participants (77%) had less than a college degree. Participants were also predominantly from low-income backgrounds, with half of the sample reporting that they earned less than $10,000 per year.

When asked to describe their mental health challenges, including particular diagnoses they felt fit their experiences, approximately half of the sample ($n = 15$) endorsed having struggled with mental health issues. Among these 15 participants, individuals described their psychological difficulties in a variety of ways: some with diagnoses (i.e., depression, anxiety, bipolar disorder, and post-traumatic stress disorder), others according to symptoms (i.e., trouble concentrating or forgetfulness). Relatedly, 17 participants reported having accessed mental health services, which included both specialty services as well as receiving medication from their primary care providers (PCP). Most of these individuals reported engagement with multiple service modalities (i.e., psychiatry, individual therapy, and group therapy). Specifically, 16 participants had seen a psychiatrist or their PCP for medication, 11 had engaged with psychotherapy, and six had sought substance abuse treatment.

Service Providers and Executive/Program Directors

23 service providers (8 participants were mental health providers, 15 were non-mental health service providers), and 12 Executive/Program directors from mental health or social service organizations participated in this study. All of the mental health providers had received an advanced degree (i.e., Masters or Doctoral degree), and the majority practiced both individual- and group-based therapy. Collectively, they provided services to a broad range of child and adult consumers, with a particular focus on consumers from low-income and racial/ethnic minority backgrounds. The non-mental health service providers encompassed a wide range of community-based services including case management, social services, legal consultation, law enforcement, and faith-based support. Just over half of the non-mental health providers ($n = 8$) supported the immigrant and refugee populations in the community. Similarly, participating Executive/Program Directors represented a breadth of service agencies, including health centers, community mental health centers, a health insurance provider, and social services agencies. The consumers served by their organizations included the following: patients of health/mental health centers (both youth and adult), individuals with serious mental illness requiring employment assistance, immigrant and refugee populations, and victims of violence.

Procedure

As part of a community health initiative, the local Division of Public Health (DPH) identified behavioral health as a top health-related priority of the local community. Specifically, DPH was looking for ways to foster an accepting community that supports positive mental health in a comprehensive and holistic way for all residents. However, DPH also recognized that the changing demographics of the community made it likely that the current mental health system may not have been adequate. In order to help improve the system and enhance community recognition of the importance of mental health, a comprehensive community-based needs assessment was identified as a critical first step. A community stakeholder advisory board was thus established, representing a cross section of the local community, including mental health providers, non-mental health providers, Executive/Program directors from a variety of mental health and social service organizations, and administrators from the DPH and local government offices. The community stakeholder advisory board was actively involved in all phases of the research process, including identifying study questions, recruiting participants, interpreting results, and disseminating findings. The advisory board specifically emphasized the need to focus on understanding the mental health needs of immigrant and refugee populations.

Participants were recruited in a variety of ways. Community residents were recruited via clinician referral, posted flyers advertising the project, word of mouth, and online "listservs." Providers and Executive/Program Directors were recruited via posted flyers, word of mouth, and connections with members of the stakeholder advisory board. In order to ensure that multiple perspectives were considered, we prioritized recruitment of providers across a broad range of service-providing organizations. These organizations included health and mental health centers, social services agencies, immigrant and refugee assistance programs, legal consultation services, faith-based organizations, and law enforcement.

We interviewed participants individually or as part of small focus groups. Focus groups were divided by constituency (i.e., local residents, providers, and Executive/Program Directors) as well as by social and cultural background (e.g., language). Interviews were semi-structured in format and delivered in an open and informal nature that allowed for a dynamic exchange of ideas and a free flowing conversation (Miles and Huberman 1994; Mishler 1991). Among local resident/consumer focus groups and interviews, participants were asked to discuss common challenges experienced in the local community, their ideas about mental health, coping strategies for dealing with stress, their experiences with mental health services, and recommendations for improved service-delivery (see Table 1).

Provider and Executive Director focus groups and interviews explored similar topics, although they also focused on barriers and facilitative factors in delivering care (see Table 2). All individuals provided informed consent prior to participating and agreed to be audio recorded. Following the provision of informed consent, participants completed a demographic questionnaire. Interviews were conducted in the participant's primary language and translated as needed. All procedures and materials were reviewed and approved at Institutional Review Boards at the participating academic institutions, as well as the Massachusetts Department of Mental Health.

Data Analysis

We used thematic analysis to analyze the data. Braun and Clarke (2006) describe thematic analysis as a ''method in its own right'' (p. 78) for identifying, analyzing, and reporting themes within data; a theme is a cluster of linked categories conveying similar meanings that reflect meaning within the data (Braun et al. 1994). The research team audio recorded and transcribed interviews and focus groups verbatim. Pseudonyms were assigned to protect the confidentiality of the participants. The principal investigators and the graduate research assistant independently analyzed the data, identified codes, and reported themes. The research team discussed disagreements and agreements and mutually agreed on

Table 1 Focus group/interview questions for local City X residents

1 Let's talk about the common challenges people experience on a day to day basis – that you have experienced, your family and/or friends have experienced, or that you've heard other individuals in the community have experienced, and so on

2 You've talked about your life stressors and challenges. As you can imagine, we think that these things are deeply connected to mental health. What do you think about mental health more generally?

3 What are the different ways in which you or other individuals in your community manage these stressors?

4 What have your experiences or others' experiences that you know been with trying to access mental health services in City X?

5 Do you have any recommendations about the provision of services in City X, or services that don't exist that you'd like to see exist, or additional social assistance programs?

Table 2 Focus group/interview questions for Providers and Executive Directors

1	What are the most common challenges you see people experiencing in the City X community?
2	How do you understand consumers' and residents' ideas and attitudes towards mental health? How do you see stigma interfering with help-seeking?
3	What are the most common ways you see people coping with their life stressors and mental health challenges?
4	What are your perceptions of individuals' experiences in trying to access mental health services in City X?
5	What gaps do you see in the system or in your particular organization? How could service provision in the City X community be improved?

themes at weekly research meetings over a 3-month period (Braun and Clarke 2006; Patton 2002). If disagreements arose, the coders discussed the nature of disagreement until consensus was reached. The primary investigators and a graduate research assistant then reviewed the final themes and developed a codebook to define the codes and themes. These final codes became the basis for what we refer to as the final themes.

Results

Three major themes were identified as systems-related specific barriers to seeking mental health services: (1) difficulty navigating the health system, (2) language barriers, and (3) dearth of culturally competent providers. Two major themes were identified as psychosocial barriers to seeking care: (1) mental health stigma and (2) mental health literacy and non-Western notions of mental health.

Systems-Related Barriers to Seeking Mental Health Services

Difficulty Navigating Mental Health Services

Participants consistently described the difficulties experienced when attempting to navigate the complex mental health system. For example, individuals mentioned frustration in not knowing where to fill psychopharmacologic prescriptions. This difficulty was often noted as particularly troublesome for immigrant and refugee populations, many of whom came from countries with very different health care systems. One Vietnamese resident stated:

> When my doctor prescribed a medication I took his prescription everywhere, but no one had it. They kept telling me to go here and there. This caused me so much stress that caused my nerves to stretch thin. I come to this place that was supposed to sell the medication, but I was sent to another place and another place.

Many providers and Executive/Program Directors expressed similar dissatisfaction with the complexity of the mental health system. For example, concerns were expressed about the challenges of coordinating care across providers and organizations. In addition, many providers noted the absence of any centralized system to facilitate coordination of care. Many mental health providers acknowledged that although the community offered lots of good services they lacked coordination. As one mental health provider articulated:

> Amongst the immigrant population we do see the lack of connecting. Because they come here and have no idea where to turn. As good as the social service agencies that we have here in this community there is still—just in terms of language. I see that firsthand ... We get referrals and then we need an interpreter—just getting all these things in place, this poor family has literally been displaced from their country of origin, and now they are here and they have every need you could imagine, we could coordinate that better. I know there are agencies that do great work. There needs to be more coordination.

One Executive Director/Program director also noted the need for better coordination of care between primary care physicians and psychiatrists:

> I can't read a psychiatrist's report as a primary care physician. I don't have their records. We can sign consent for the record, but it can take 3 months or 6 months to get a medical record pulled. They get a psychiatrist that evaluates them the first time and then they follow up with primary care, so if they have problems with their medications, they don't follow up with a psychiatrist because they're in their residential treatment. Accessibility has to be the first thing we address….we need coordination between primary care and mental health.

Language Barriers

Respondents consistently noted that language barriers make it difficult to access services, especially if interpreters are not available. Moreover, they noted the limitations of interpreter services, including interfering with the therapy process in which consumers are expected to share intimate details of their lives with the mental health provider. One elder Vietnamese respondent expressed concern about the lack of interpreters in mental health care settings:

> My difficulties are in daily activities, especially as an elder. I find that because we are an Asian, as a Vietnamese, we speak Vietnamese only and now live in American society; the most difficult is the language barrier. When you go to agencies, some do provide translation but most of them do not. So that will create obstacles when you try to communicate. Even if they have translators, it's still difficult.

One Latinx mental health consumer indicated a strong preference for a Latinx provider and expressed some cynicism with the use of an interpreter:

> I want a Hispanic [provider]… I don't want to be with a person and have to repeat things. Look, you tell one

> thing to the [interpreter] so they can tell the [provider], and don't tell this and they try to say it in their way. But they don't know that I know English. Sometimes, I say to the [interpreter] from the beginning, "Look, I am going to tell you one thing, you are going to be my interpreter, but you are going to tell [the provider] what I tell you, alright?

One Executive/Program director also noted the lack of non-English speaking staff as a barrier to engaging in care. She stated:

> Access is really difficult and probably one of the biggest things I feel like it would stop someone from getting care [is] language barriers. I think we probably want to try to hire staff that fit our population and speak the language that our population speaks. I think that cultural piece, the linguistic piece, is what keep people coming back to see their doctor and keep them engaged in care.

Dearth of Culturally Competent Providers

During the interviews, a consistent theme emerged whereby providers noted that patient engagement in care was affected by not having staff members who could culturally and linguistically relate to them. They felt that establishing a comfortable relationship with staff was key to the client's ability to express their mental health needs and engage in care. One non-mental health provider stated that:

> There isn't the cultural competency once the services are offered. There isn't a comfortable feeling for the other person on the other line to discuss all the other problems you have. No one-on-one comfort level that can definitely develop the relationship, keep them engaged in care.

In general, providers felt that families were reluctant to seek mental health services, but once engaged in services, they were much more open to it. However, this required providing culturally responsive care. As one mental health provider told us:

> In some cultures, parents have a hard time accepting mental health services—once we engage them they see it differently but care has to be done in a certain way—cultural matching helps tremendously; someone who is trained appropriately—leads to good engagement... if people don't feel validated they don't come back.

One Executive/Program director noted that culturally competent providers are often difficult to find. She talked about her experience in working with a Sudanese patient and expressed her concern about a dearth of clinicians who were familiar with Sudanese immigrants and their community. She stated:

> We had a clinician that was in charge of a 'Lost Boy of Sudan.' The clinician was unsure where to send the client and I was like well I've worked with a lot of Africans, not a lot from Sudan…But where do you find a provider? There are no guideline other than word of mouth from being in the field for a million years. There are several issues I'm talking about: availability of clinicians, networking, cultural sensitivity, language. We have one Spanish speaking and one Portuguese speaking clinician out of like forty clinicians.

In general, the participants experienced systemic related obstacles in accessing mental health services. Lack of care coordination among mental health services and primary care, language-related communication barriers, and a dearth of culturally competent health care providers made it particularly more difficult to navigate the mental health system for immigrant and refugee populations.

Psychosocial Barriers to Mental Health Services

Stigma

Interviewees suggested that mental health stigma is much more pronounced in immigrant and refugee populations, many of whom equate mental illness with 'being crazy' and as being inherently shameful. As one non-mental health provider described about some of her clients who are served by her organization:

> There is a lot of stigma—once they are settled—they are still in contact with each other. They feel like they have worked so hard to get to the United States that they cannot have a problem. They can't be looked down upon. They don't want to get help with any of their symptoms because they don't want to be labeled as mentally ill.

Some of the local residents we interviewed, particularly the recent immigrant residents, shared this perspective. One Vietnamese resident clearly described the stigma in her community:

> For my individual opinion, the Vietnamese people usually think mental health issue as they usually think of the word crazy. Therefore, most people are ashamed of having mental illness and deny that they have mental health issue...Because the Vietnamese, including myself, we think mental illness is being insane, crazy.

One Executive/Program director noted that it was much more difficult for Vietnamese clients especially elders to seek and talk about mental health counseling compared to other racial groups. In her opinion:

> Culturally related stigma is big. The Vietnamese would never talk about therapy—my white friend would—I'm generalizing to myself. The Vietnamese community is not as comfortable—especially the seniors… stigma is more attached culturally.

Mental Health Literacy and Non-Western Conceptualizations of Mental Health

Some immigrants and refugees expressed uncertainty about how to define mental illness and indicated that mental health services did not exist in their home country. Cultural differences in terminology and causal beliefs for mental health disorders was also well noted. When asked how he reacted when he was diagnosed with anxiety and depression, one Latino mental health consumer asserted that he had no idea why he felt the way he did growing up and used drugs and alcohol to cope with his feelings:

> I feel like some people, don't really realize that they have depression or PTSD. They don't know. I've never taken pills in my life, until now. I never knew I had PTSD, depression or anxiety—so all those signs, I didn't realize, it was because of that. I knew something was wrong with me, so I went out and did what I do best—got high. And now I know that I have depression, anxiety, so when I do feel a certain way—I know it's because of that.

One non-mental health provider articulated that Burmese immigrants with whom she works don't describe mental illness in Western terms:

> The Burmese don't have the words in their own language to describe Western notions of mental health… They have their own way of adapting to mental illness. They lack a Western understanding of how the body works in Western terms.

One mental health provider commented on culturally sanctioned belief systems:

> So I work with refugees and immigrants from Vietnam, so many of the individuals they don't know about mental health issues. And their mindset on it is that it's either a demon in control of things. There's some sort of supernatural force that makes you act this way, see these things, hear these things or even a ghost inside you. And there are cures for it at temple ceremonies.

Culturally specific norms, attitudes and beliefs about mental health affected our participants' approach to mental health care. In general, people did not want to be viewed as having a mental health problem. Among immigrant and refugee participants, the mentally ill were viewed as being crazy. Mental health issues were understood as a result of a *supernatural power* taking over the individual—and thus could be addressed through religious ceremonies and not medical doctors.

Discussion

We were interested in identifying the mental health needs of a racially and ethnically diverse local community to help inform the planning and provision of mental health services. In this study of 61 individuals who represented local residents and/or consumers of community mental health services, mental health services providers and non-mental health service providers, and Executive/Program directors, we identified systemic and psychosocial barriers to seeking mental health services. Our findings accentuate the significance of cultural competencies in care, linguistic barriers, stigma, and mental health literacy and non-Western notions of mental health, in seeking mental health services among immigrant and refugee populations.

Navigating complex organizational systems was especially challenging for immigrant and refugee populations who experienced linguistic barriers and who came from countries with different health care systems. Language barriers made it difficult to access services, especially if interpreters were not available on site. Indeed research has well-documented that the presence of language interpreters can facilitate a client's sense of belongingness, bridge cultural gaps and improve communication and engagement in clients (Paone and Malott 2008). For example, Green et al. (2005) conducted a study comparing self-reported communication and visit ratings for Limited English Proficient (LEP) Asian immigrants whose visits involved either a clinic interpreter or a clinician speaking their native language. They found that patients who used clinic interpreters were more likely than language-concordant patients to report having health-related questions they wanted to ask but did not (Green et al. 2005). However, it is important to note that interpreter services can create challenges related to the counselor-interpreter collaboration; these can include counselor discomfort with interpreter's presence and linguistic alterations (Paone and Malott 2008). Nevertheless, given the importance of interpretation, the literature offers several recommendations to improve the effectiveness of interpreters, including pre-session meeting with interpreters to discuss neutral verbatim communication, the importance of therapeutic boundaries, common issues that arise around language, as well as the vital role of interpreters play acknowledging the role of culture (O'Hara and Akinsulure-Smith 2011).

Unsurprisingly, when asked about attitudes towards mental health, stigma emerged as a common theme across residents, providers, and Executive/Program directors. Mental health stigma was much more pronounced in Latinx and Vietnamese residents, many of whom equated mental illness with being crazy. Several studies have documented greater stigma about mental illness among racial and ethnic minorities than among Whites (Alvidrez et al. 2008; Fogel and Ford 2005; Georg Hsu et al. 2008; Jimenez et al. 2013; Nadeem et al. 2007). For example, in one study of Bhutanese, Karen, Oromo and Somali refugees, researchers documented that the stigma of being seen as crazy or insane was deeply connected to concerns about social perceptions and social standing, as well as fear of being isolated from their communities (Shannon et. al. 2015). Similarly, in another study of immigrants from Cambodia, Eastern Europe, Iran, Iraq, Africa and Vietnam, stigma was identified as a primary barrier to mental health seeking (Saechao et al. 2012). Participants in this study described the cultural unacceptability of seeking mental health treatment as well as being labeled as 'crazy.' Nadeem et al. (2007) also found that stigma related concerns reduced the desire for mental health treatment for low-income immigrant women with depression to a greater extent than it did for U.S. born white women with depression. Thus, it is imperative that health providers understand the role that stigma plays in both its interpretation of mental health and in seeking mental health services for immigrant and refugee populations.

Consistent with findings from other studies, we found that some community residents did not always recognize symptoms of stress as psychological in nature and as possibly treatable by medical doctors (Bhui et al. 2006; Teuton et al. 2007; Keyes 2000). In particular, some immigrant and refugee residents viewed causal beliefs of mental health disorders as rooted in spirituality. The role of evil and unhappy spirits as the root cause of mental illness among Southeast Asians, East Africans, and Bangladeshi (Collier et al. 2012; Parker et al. 2001; Ryder et al. 2008) and its effect on assessment and recognition of mental health problems has been well documented (Teuton et al. 2007; Bhui et al. 2006). Although service providers' beliefs and methods may not always align, across many different countries, pluralistic healing systems including indigenous, religious, and allopathic healthcare systems exist to address ethnic variations in personal explanations for mental health disorders (Teuton et al. 2007). Future research may want to examine how a system of integrated care that includes medical and non-medical explanations and treatment would work in a practical sense.

Practice Implications

Several recommendations emerge from this community mental health assessment that could improve the ability of mental health services to meet the needs of diverse populations, including immigrant and refugee groups: (1) creating a culturally competent mental health workforce (patient navigators and mental health professionals), (2) providing mental health literacy, and (3) delivering culturally competent interventions and treatment.

Culturally Competent Mental Health Workforce

Patient navigation is emerging as an effective intervention to reduce health disparities, as it can identify and target specific barriers to treatment engagement (Druss et al. 2010). Within healthcare linkage models, patient navigators can assist patients with assessment, screening, education, support, coordination of care (Wells et al. 2008) and even change their orientation bout seeking care to a primary care rather than the emergency room (Kelly et al. 2014). Greater use of health professionals (case managers, patient navigators/advocates, community health workers, cultural brokers) could help coordinate outreach to residents who may lack a Western understanding of how the body works or have difficulties attending services due to stigma, linguistic or logistical barriers. Such an outreach program could be tailored to specific communities that might have particularly elevated risk for poor treatment engagement (e.g., LGBTQ refugees; Messih 2016) by working to understand their diverse needs and unique circumstances.

Mental Health Literacy

Mental health literacy has been linked to increased willingness to seek help from a psychiatrist or counselor (Collier et al. 2012; Jorm 2012). In our study, providers, mental health consumers, and residents also felt that there is a need for more mental health literacy about both mental health conditions and services offered in the local community. Many immigrant and refugee residents lacked knowledge of Westerns notions of mental illness, how to recognize early signs, what treatments are available and how and when to seek professional help. Psychoeducation programs, coupled with the attention to cultural norms, can help teach individuals including family members and friends of individuals with a mental illness about the symptoms, link individuals' community supports, and teach individuals about the importance of early intervention (Alvidrez et al. 2009).

Moreover, considerable research has documented the stressors related to migration and readjusting to a resettlement country, perceptions of both traumatic experiences and adaptation processes, gender differences in the presentation of mental health problems, and culturally-informed views of mental health (Bernal and Sáez-Santiago 2006; Cardemil et al. 2007; Hays 2001; Hsu et al. 2004; Sue 2003). Thus, implicit bias interventions that challenge providers' perception of racial/ethnic minorities or informs providers of what is happening in countries where clients emigrated from may help improve patient/provider communication (Zestcott et al. 2016).

Culturally Competent Interventions and Treatment

Given the data suggesting that immigrant and refugee populations are experiencing numerous stressors, as well as substantive barriers to mental health care (Collier et. al. 2012, Corona et. al. 2009; Hancock et. al. 2003), it is imperative that the appropriate mental health interventions and treatment be developed and implemented in immigrant and refugee communities. There is often the assumption that evidence based practices will work across all racial and ethnic groups (Barrera Jr. and Castro 2006). Yet, the key to successful interventions relies on the ability to engage and influence racial and ethnic groups and these practices are often developed and implemented without consideration of cultural and community context (Barrera and Castro 2006; Cardemil 2010; Lopez et al. 2002). There is evidence that culturally adapted psychosocial interventions yield positive results on outcomes of depression particularly for Latinx and African American adults (Miranda et al. 2005). Guidelines that outline the best process for conducting cultural adaptations to existing treatments are well documented (Barrera Jr. and Castro 2006; Cardemil 2010). However, as noted in one study on the mental health needs assessment of the Hmong living in a Midwest community, lack of funding available to develop and implement culturally competent interventions can often hinder efforts to meet unmet needs (Collier et al. 2012).

Limitations and Strengths

Our study has some limitations. First, this study was conducted with a purposive adult sample of 61 [City X] community residents/and or consumers, a broad range of services providers, and Executive/Program directors who reported on different experiences with the mental health care system; and thus findings from this study should not be generalized to all adults in this local community. Second, given time and budget constraints, our sample was limited to residents who were able to speak one of three languages (English, Spanish, or Vietnamese). Thus, there are particular immigrant and refugee communities whose perspectives were underrepresented in this study (e.g., Africans, Black/African Americans, and/or Afro Caribbeans and Arabs). However, we were able to recruit and interview Burundi- and Arabic-speaking providers in an effort to overcome this limitation. Nevertheless, future research should find ways to include individuals from these backgrounds. Third, it is likely that aspects of our findings may be only relevant to the specific community in which the study took place. However, as we have noted, there are some important lessons that are likely relevant to other similar communities with growing immigrant and refugee populations. Finally, it is likely that most of the individuals who participated in this community mental health needs assessment had strong opinions about mental health and mental health care that they wished to share with the researchers. This unavoidable characteristic raises the risk of bias in our findings, especially since it is more likely that individuals will hold strong, negative opinions. However, we mitigated these concerns by recruiting a wide range of participants through word of mouth, clinician referrals, and flyers. We also focused our analyses on those themes that were identified across the three groups i.e., community residents/and or consumers, providers and Executive/Program directors.

Despite these limitations, our study also has several strengths. First, the study was a community-engaged project that was successful in integrating the perspectives of community residents and consumers, mental health and social services providers, and Executive/Project directors. This multi-informant approach provided a more nuanced understanding of the mental health needs of the community of focus. Second, the collaboration with the local Division of Public Health has promise for translating our findings into initiatives designed to improve the mental health system and enhance recognition of the importance of immigrant and refugee mental health. Lastly, the assessment took place in a midsize city in New England that has experienced a surge in Asian and Latinx immigrants similar to trends at the national level. These trends suggests that many of the issues facing the participants in our study may also be relevant to other communities in the United States. Our findings accentuate the significance of cultural competencies in care, linguistic barrier, mental health literacy and stigma in seeking mental health services among immigrant and refugee populations.

Future Directions

To date, the City continues to address key issues identified in this study. As part of the Community Health Improvement Plan (CHIP), the City collaborated with the Coalition for a Healthy Greater [City X] and mental health agencies to create a career pipeline for a more culturally diverse mental health workforce. They have written and received grants to alleviate barriers to enter the mental health field. In addition, the City's Department of Health and Human Services (HHS) Commissioner, co-leads the Mayor's Mental Health Task Force with the City Mayor and a myriad of mental health organizations. This group recently merged with the CHIP mental health work group to build capacity around this issue but also to strengthen the workforce pipeline for clinicians—to include pay equity and reimbursement gaps. In summary, the positive steps that have resulted from this needs assessment are encouraging, and we look forward to continued work that advances efforts to reduce disparities in mental health treatment.

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Compliance with Ethical Standards

Conflict of interests The corresponding author declare no conflict of interests. The content does not necessarily reflect the views of the funding agency.

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