

**STATE OF THE STATE III:  
2012-2013  
Reducing Disparities in Mental Health  
Russian-Speaking,  
Middle Eastern and Southwest Asian Communities**

California Mental Health Services Act Multicultural Coalition  
A project of the Racial and Ethnic Mental Health Disparities Coalition  
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# Table of Contents

Acknowledgements.....3

Executive Summary.....4

Background and Introduction.....6

Methods and Participants.....10

Findings for Russian-Speaking Communities.....12

Results for the Middle and South West Asian Communities.....17

Summary and Conclusion.....22

References.....23

Appendix A.....24

Appendix B.....27

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## Executive Summary

The annual “State of the State” Report on Mental Health Disparities is an effort by the California Multicultural Mental Health Services Act Coalition (CMMC) to shed light on current issues that affect mental health for ethnic and cultural minorities and Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Questioning (LGBTQI) groups in California. In this, the third “State of the State” report, the CMMC explores the needs and challenges of Russian-speaking communities and Middle Eastern/Southwest Asian communities. These groups are growing in numbers in California, and individuals from these communities experience significant risk factors for the development of mental health problems. This report is a brief qualitative survey of these groups intended to raise awareness regarding the characteristics and demographics of these communities in California, their cultures, experiences, and challenges. These efforts are part of an ongoing process of connecting and building relationships with new communities throughout the state of California.

### **Key Findings: Russian-Speaking Communities**

Interviews with four key informants from the Russian-speaking community revealed the following key themes related to community needs and challenges, specific health and mental health concerns, assets, and recommendations.

- **Social and Economic challenges:** Chief among the social and economic issues that affect the Russian-speaking communities are acculturation stress and social isolation, lack of financial stability, and lack of health insurance. These challenges are exacerbated by limited English proficiency of many Russian-speaking immigrants. Furthermore, mental health stigma prevents many from seeking mental health services.
- **Specific Health and Mental Health Concerns:** For key informants, physical health issues emerged as a critical concern for Russian-speaking communities, particularly given a high prevalence of chronic illnesses. Depression was identified as the most pressing mental health concern for Russian-speakers with intimate partner violence, substance abuse, and anxiety also recognized as critical issues for these communities.
- **Community Assets:** According to key informants, Russian-speaking communities are close-knit and cultures emphasize interdependence. This value enables individuals to develop a safety net which buffers community members from stress. Further, many Russian-speaking communities have a number of established organizational resources: grocery stores, community-based nonprofit agencies, and faith-based organizations that are important assets for these communities.
- **Recommendations:** Foremost among the recommendations made by key informants were to increase the Russian-speaking workforce to enable more community members to obtain services in Russian. Participants also recommended addressing other barriers to care by increasing the intensity and number of services offered, improving rates of insurance, conducting culturally responsive outreach, and building relationships with communities.

## **Key Findings: Middle Eastern and Southwest Asian Communities**

Themes that emerged for the Middle Eastern and Southwest Asian (ME/SWA) communities included: the broad diversity of these groups, social and economic issues, and specific mental health concerns. In addition, the key informants provided information on communities' assets and strengths and recommendations for improving mental health.

- **Diversity and cultural values:** One of the most prominent findings of the interviews with ME/SWA participants was the diversity within these communities: there exist vast differences in reasons for immigration, socioeconomic status, religious beliefs, and levels of acculturation. Diversity in views regarding gender roles and in levels of acculturation was also identified as critical themes for understanding these communities.
- **Social and Economic Issues:** For many ME/SWA communities, social isolation, discrimination, stigma, and financial instability are key issues affecting mental health. Particularly in light of the current political climate, many ME/SWA immigrants are isolated and experience discrimination due to their ethnicity or religious affiliation. As in many other communities, mental health stigma prevents many from seeking mental health services. Finally, for refugees and asylees, difficulty establishing financial stability in the US is a significant source of stress.
- **Specific Mental Health Concerns:** Family conflict was identified as a key concern for ME/SWA communities and included tension due to intergenerational acculturation gaps, marital discord, and intimate partner violence. Key informants further noted that depression and post-traumatic stress disorder (in the case of refugees and asylees) are prevalent issues for these communities.
- **Community Strengths:** For many ME/SWA communities, a strong achievement orientation has resulted in success in the areas of business, technology, and education. Further, key informants noted that many successful community members give back generously, volunteering and providing financial support for community programming.
- **Recommendations:** Participants recommended increasing the availability of culturally and linguistically responsive mental health services and conducting targeted outreach, education, and prevention activities. It was recommended that prevention be aimed broadly at health issues to diffuse stigma associated with mental health programs.

This study conducted for the third "State of the State" reported illustrates the diversity of vulnerable communities in California. Within the groups surveyed for this report, there is a wide variety of exposure to risk including acculturation stress, exposure to extreme trauma and loss, and financial insecurity. Understanding the diverse experiences and the range of cultural values and practices is critical to providing effective mental health services and preventing mental illness in these communities.

## Background and Introduction

The Mental Health Services Act (Proposition 63, passed in 2004) has created the opportunity to expand and transform mental health services throughout California. Through the collaboration of stakeholders, community and county mental health services providers, and state level leadership, the MHSA has sought to bring innovative, comprehensive, culturally competent, and recovery-oriented care to the many Californians in need of mental health services. An overarching goal of the MHSA is to bring services to those who have historically lacked access to care, in particular, ethnic and cultural minorities and Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and Intersex (LGBTQI) communities. The formation of the California MHSA Multicultural Coalition (CMMC) is a direct result of efforts to address disparities through the MHSA. The CMMC is a coalition of diverse stakeholders funded by the MHSA that works to address mental health disparities for ethnic and cultural minorities through advocacy, policy, research, mentorship, outreach, and education.

As part of the efforts to address disparities, the CMMC produces an annual State of the State report which sheds light on current issues in ethnic and cultural minority mental health. In the first annual State of the State report, the CMMC reviewed data sources for mental health disparities and provided recommendations for improving data collection practices. In subsequent reports, the CMMC plans to focus efforts on exploring mental health issues of communities for which there has been a relative dearth of research. To this end, the CMMC is conducting a series of brief qualitative studies on communities such as refugees, the Deaf and Hard of Hearing community, women, and individuals with developmental disabilities.

California is home to many diverse communities including new immigrant and refugee communities, and diverse cultural communities. While the CMMC has elected to begin by focusing each of four reports on two underrepresented communities, the Coalition recognizes that there are many communities that could be a focus of these efforts. Many groups are historically underserved, are marginalized or vulnerable, and experience social and civic exclusion due to their race, ethnicity, sexual orientation, or culture. In this, the third State of the State report, the CMMC explores the needs and challenges of Russian-speaking communities and Middle Eastern and Southwest Asian (ME/SWA) communities. This report begins with by providing a brief background and history relevant to the selected groups and then presents methods, participants, and findings of this study.

## Russian-Speaking Communities

### California Demographics:

Russian-speaking communities in the US are comprised of a diverse group of immigrants, refugees, and asylees from countries of the former Soviet Union including Russia, Belarus, Lithuania, Estonia, Ukraine, and Georgia. US Census estimates indicate that the US is home to approximately 3.5 million Russian-speakers, the majority of whom live in New York (approximately 30%) and California (about 10%; 6.3% in Los Angeles and 3.8% in San Francisco; Shin et al., 2010) and come from Russia and the Ukraine. In addition, Sacramento is home to a sizeable Russian-speaking community; currently about 150,000 Russian-speakers live

in Sacramento, 65% of whom are of Ukrainian origin (Slavic Assistance Center, 2013). The reasons for immigration are varied, including religious persecution, economic opportunity, and political unrest. While many Russian-speakers have resided in California for generations, recent waves of immigration have resulted in a substantial newcomer population. Data from the California Department of Public Health, Refugee Health Center indicates that since the year 2000, more than 10,000 refugees came from Russian-speaking countries with the largest number coming from the Ukraine (6493 individuals) and Russia (2900 individuals).

### **Background:**

The Soviet Union was established following the Bolshevik Revolution of 1917. In 1922 a single-party state led by the Soviet government unified the Russian, Ukrainian, Transcaucasian (including Armenia, Georgia and Azerbaijan) and Byelorussian (what would become Belarus in 1991) Republics. The Bolshevik Revolution also instigated the first major wave of Russian-speaking immigration when property destruction and other forms of political violence brought roughly 30,000 immigrants from the newly formed Soviet Union to the United States. A second wave occurred after WWII, bringing immigrants from the Ukrainian, Russian and Belarusian regions while a third wave of mainly Jewish immigration occurred during the 1970s and 80s as Russian-Jews fled anti-Semitic persecution under the communist government. In 1973 the United States passed a law that raised immigration quotas and permitted the entrance of a significantly higher number of Soviet Jews (181,000) from 1972 to 1991. The majority of these immigrants settled in San Francisco: in 2000 27,243 Russian-speakers from both Ukraine and Russia resided in the Bay Area. The Immigration Reform Act of 1990, passed in response to the end of the Cold War, resulted in the most recent wave of immigrants. Approximately 450,000 documented immigrants from Russia, Moldova, Belarus and Ukraine immigrated since 1990 (Jurcik, et al., 2013; Duncan and Simmons, 1996).

Russian became the official language of every republic unified under the Soviet Union, but characterizing this community is particularly difficult because the former Soviet Union was comprised of fifteen ethnic republics in which over 100 languages were spoken. However, some things do remain constant among many Russian-speaking immigrants in the US. A deep commitment to education, family and friendship bonds this community together as do language and experiences with persecution in the former Soviet Union. Russian-Jews in particular suffered high levels of violence under the communist government and frequently immigrated to the United States as a result. Other immigrants fled the region to escape the violence, destruction and political turmoil of periods such as the Bolshevik Revolution and WWII. Such experiences bond these communities together as do more specific social and educational characteristics. For example, high levels of education are common in these communities: over fifty percent of Russian-speaking immigrants hold a bachelor's degree or higher and many have worked in various professional occupations before coming to the United States. Many also immigrate to the United States with the hope of providing their children with greater educational and occupational opportunities.

Certain family structures and social relationships also characterize Russian-speaking communities. For example, women often take on dual roles, participating in the workforce, raising children and taking care of housework (Leipzig, 2006). Russian-speaking immigrants also include a uniquely substantial number of senior citizens and in 1992 over 20% of the Russian-speaking immigrants in the US were over the age of 65. Families frequently live in

multigenerational households, often due to housing constraints, but nuclear families tend to remain small. Most families have one or two children that can be traced to the Soviet government's promotion of small family size. However, such traditions also fostered the development of strong friendship bonds as citizens of the Soviet Union looked to expand their social circles of support. As a result, deep friendships are an important part of Russian-speaking communities in the US. Lastly, religious institutions also provide a sense of community among Russian-speaking immigrants and churches are often the first sources of both financial and emotional aid. Russian Orthodox, Pentecostal and Baptists churches are prevalent and the church is regarded as an important place to seek guidance with regard to parenting and other matters within the family (Delgado-Gaitan, 1994). Thus, community cohesion and social bonds remain especially important and can also be traced to traditions of community farming, government-run housing and other forms of collectivism in the Soviet Union. Overall, Russian-speaking communities emphasize education, family and deep friendship, rather than individuality as immigrants rely on social relationships to overcome the obstacles of relocation.

## Middle Eastern and Southwest Asian Communities

### California Demographics:

The second group selected for this study, initially entitled the Arab/Muslim populations, presented a particular challenge in this study: that of defining and understanding the composition of these very diverse populations that include groups beyond the Arabic-speaking communities. The CMMC Mental Health Services Act Assessment Committee (MAC) convened several times over the course of six months to reach consensus on the composition of the group for this study. CMMC MAC members and other Coalition members suggested focusing on various subgroups including: Arabic-speaking, Arab American, Muslim, Middle Eastern, Persian/Iranian, and Southwest Asian, particularly Afghani. In the end, developing a coherent and narrow subgroup for which to focus this report proved elusive. As a result, the focus for this qualitative study was on a variety of communities that may be loosely termed Middle Eastern and Southwest Asian (ME/SWA). The findings are based on interviews with individuals who have experience working with a wide range of communities including Persian/Iranian, Afghani, Muslim, Egyptian Christian Coptic, Iraqi, LGBTQ adults, and North African refugees. While each of these groups may be the subject of a larger, more in-depth qualitative study, the current efforts provide a brief introduction to potentially critical issues in mental health for these communities. Furthermore, given the diversity within these communities, it is suggested that the findings are intended as considerations for further study rather than generalizations.

The term "Middle East" has traditionally been defined to include (in alphabetical order) Bahrain, Cyprus, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Northern Cyprus, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates, and Yemen. Some definitions of the Middle East include countries considered "Arab North Africa": Algeria, Libya, Morocco, Sudan, Tunisia, West Sahara, and Mauritania however, for this study only the more narrow definition will be used. The term "Southwest Asian" is used in this context to refer to immigrants from Iran, Pakistan, and Afghanistan. Although Iran has traditionally been considered part of the Middle East, many consider it separate due to differences in language, culture, and religious affiliations. In contrast to Middle Eastern countries, Iran, Pakistan and Afghanistan are not considered Arabic

countries. While Middle Eastern countries generally use Arabic as their official language (with the exception of Turkey and Israel), Southwest Asian countries have a variety of different languages with Pashto and Dari being the official languages of Afghanistan, Urdu and English are the official languages of Pakistan, and Farsi is the primary language of Iran. Nonetheless, Middle Eastern and Southwest Asian groups share some cultural values and customs.

It is difficult to estimate the size of the Middle Eastern and Southwest Asian populations in the US and in California. Systematic data using consistent race, ethnicity, or nationality categories has not been collected. The US census does not provide a separate race or ethnicity category for Middle Easterners, Arabs, or Southwest Asians, however the long form does permit the recording of data on ancestry (Marschner 2003). Population estimates vary widely depending on the definition of the group that is used, however it is estimated that more than 3 million people of Middle Eastern heritage reside in the US today (Center for Immigration Studies, 2002).

Although the category “Arabic-speaking or of Arab ancestry” is more comprehensive and may include individuals from Northern Africa as well as the Middle East, data regarding individuals of Arab ancestry is presented here to supplement the data on Middle Easterners in the US. The population who identified as having Arabic-speaking ancestry in the U.S. Census grew by more than 24% between 2000 and 2010. The number of Californians who claim an Arab ancestry more than doubled since the Census first measured ethnic origins in 1980 and is among the fastest growing Arab populations in the country. It is estimated that the statewide population, adjusting for under-reporting, is close to 817,455. Underreporting may result from methodological challenges. When it comes to how Arab Americans identify themselves, primary ethnic identification is derived from responses to the ancestry question on the long (sample) form of the 2010 U.S. Census. Census data on “Arabs” include the responses Lebanese, Syrian, Egyptian, Iraqi, Jordanian, Palestinian, Moroccan, Arab or Arabic, and the following countries collapsed as “Other Arab”: Algeria, Bahrain, Djibouti, Kuwait, Libya, Oman, Qatar, Saudi Arabia, Tunisia, the United Arab Emirates, and Yemen (Zogby International Survey, 2002; AAI, 2004). In California, according to the 2010 Census, roughly 36% of Arab Americans in the state have Lebanese or Egyptian roots. Since 1990, significant increases appear in the number of Californians who are of Iraqi and Syrian descent.

### **Background:**

As with other immigrant groups, reasons for immigrating are varied and include economic opportunity, joining other family members and community, escape of political unrest, conflict, and war, and political asylum. For example, many highly educated Egyptians, Syrians, and Jordanians immigrated to California in the past few decades to work in the field of technology. Many of these immigrants have been largely successful in business ventures. In contrast, exposure to political unrest and war in North Africa, Kuwait, Iraq and other countries has resulted in an influx of refugees with histories of exposure to war, violence, and trauma. It is expected that in the next few years the number of Syrians seeking asylum in the US will increase dramatically given the current political conflict. In addition, a number of Middle Easterners seek asylum to escape condemnation or persecution for their sexual orientation or gender identity.

ME/SWA communities share some cultural values, including the value of hospitality. Many ME/SWA families welcome guests and strangers and enjoy inviting and having guests at their homes and for socialization. Serving food and sharing a meal are considered joy in these communities. It is part of the cultural obligation of hospitality. As many in these communities honor and value the past as part of their family history and identity, the elderly are respected for their wisdom and life experience.

Understanding the experience of the ME/SWA communities also requires an awareness of the importance and diversity of religious and spiritual beliefs represented. Islam is the largest religion of the Arab Middle East with many countries including Afghanistan, Palestine, Turkey, and Iran having up to 99% of the population identified as Muslim. Other religions are also represented, however and there are sizeable Christian communities in countries such as Palestine, Lebanon, Jordan, Syria, and Egypt. In the Middle East, Islam is characterized by a broad diversity of religious practice and belief. While the majority of Muslims in the Middle East are of the dominant Sunni branch of Islam (which in itself encompasses vastly different interpretations and practices varying according to region, education and socioeconomic conditions) there is a sizeable population of Shiite Muslims making up the majority of the population of Iran and a sizeable minority in Lebanon, as well as a multitude of other sects and sub-groups.

Specific Islamic beliefs influence a broad array of behaviors and cultural practices. For example, in countries that have Islamic law like Iran and Saudi Arabia, veiling (hijab) for women is mandatory, but in countries like Lebanon and Jordan, veiling for women is a matter of choice, belief, and/or family custom. Also, the extent to which strict gender roles/separation are observed may differ within the same society from family to family. While a more liberal Sunni family may invite mixed gender guests to dinner and sit at the same table, a conservative family next door might have men and women congregate in separate rooms. Thus, in reviewing the findings of the interviews, it is important to take into account the diversity of experience, religion, and cultural practices of these communities.

## Methods and Participants

To select the two groups that are the focus of the current study, the CMMC convened the MHSA Assessment Committee (MAC). During a brainstorming session, the MAC members compiled a list of potential groups to be surveyed (see appendix A). The list was comprised of historically marginalized groups who have not been the focus of previous efforts (e.g. the California Reducing Disparities Project). As noted above, the third “State of the State” report focuses on the Russian-speaking communities and the Middle Eastern/South West Asian communities.

To gather information on the socio-cultural background, history, mental health needs, cultural strengths and assets, and barriers to care of the two selected communities the MAC conducted a brief qualitative study. For each group, four key informants were interviewed for approximately one hour. To recruit key informants, MAC members reached out to others in the CMMC as well as organizations and programs (such as the Newcomers Health Program at the San Francisco Department of Health) and colleagues. Interviewees were contacted by email and by phone and

were provided with a description of the study and a copy of the interview questions in advance. Prior to the interviews, the interviewers and researcher discussed the interview protocol and interview techniques to ensure interviewers elaborated on key concepts. During the telephone and face-to-face interviews, the interviewer thanked the participants, briefly described the purpose of the project, the interview, and the benefits of their participation. Each interview took approximately 60 minutes to complete and a note taker took extensive notes. Although previous key informant interviews have been conducted in other languages, for the current study all participants were fluent in English and thus the interviews were conducted in English. Only with the permission of the participants, interview sessions were audio recorded for accuracy. Each participant who agreed to be audiotaped provided a verbal consent. According to Stringer (1999), in qualitative research, it is essential to first build rapport with the participants before engaging in interviews and taping. Therefore, prior to asking the questions related to the study, the interviewer engaged in casual discussion in order to build trust or used open-ended questions that started with “Tell me about your community...”

### **Interview Questions**

The interview questions were designed specifically for the project’s purpose, yet broad enough to capture unexpected but related concepts (Strauss & Corbin, 2007). The thirteen open-ended questions were intended to explore the views, opinions and experiences of communities that have historically been unserved/underserved. These questions were: (1) Tell us about your role in your community. (2) Tell us about your community. (Consider asking about history, geographic distribution, socioeconomic issues, acculturation, etc.). (3) What are some of your community’s greatest concerns? (4) What do you think are your community’s greatest concerns around mental health? (5) Where do people in your community go for help when they have emotional concerns or are worried about a family member with a emotional, relationship, or social issues? (6) What services or programs are available in your community for social and emotional issues (mental health problems)? (7) What barriers exist to accessing services for your community? (8) What kinds of challenges do women in your community face? (9) What kinds of challenges do older adults in your community face? (10) Are there any other groups within your community that face specific challenges? (11) If we had the opportunity to develop programs and services to prevent or treat mental health problems, what recommendations would you give us to do this? (12) Tell me about strengths or assets of your community. (13) Any additional advice that you have regarding mental health?

### **Participants**

To gather information on the Russian-speaking population in California, four key informants with experience in working with these communities were contacted and interviewed. These key informants included: an executive director and founder of a local nonprofit community based agency which has been providing services to the Russian-speaking community for over 15 years in Northern California, an associate professor of psychology who is a Russian/Ukrainian immigrant from Northern California, a social service provider with a master’s degree in psychology and experience providing mental health services both in the Ukraine and in San Francisco, and a social service provider with several years of experience in providing mental health services to the Russian-speaking community in the Bay Area.

Four key informants were interviewed to garner information on the Middle Eastern/Southwest Asian communities. Interviewees included: a nurse of Palestinian background with several years of experience providing care through a community based refugee clinic in the Bay Area, a Muslim counselor and founder of a Muslim nonprofit social service agency in Northern California, a clinical psychologist and founder of a community based clinic for Persian/Iranian and Afghani immigrants in Southern California, and an Egyptian licensed clinical social worker with experience working with the Egyptian Christian Coptic community of the greater Los Angeles area.

## Data Analysis

Data analysis followed the interview sessions. After transcribing the notes of each interview session, two members of the research team and a MAC member began coding the transcript/notes to identify themes or patterns in the data. Specifically, when analyzing the data, the researcher and MAC members extracted significant viewpoints and opinions from the transcripts/notes and began looking for categories through a process called open coding, which means forming initial categories of information about the phenomenon being studied by segmenting information (Creswell, 1998). Then using axial coding, the author was able to organize the data in order to obtain a holistic picture of participants' views and opinions. Creswell describes axial coding as a process used to establish themes and patterns in order to build a meaningful story. After the researchers and MAC member read all the individual transcripts/notes marking meanings and themes, each developed a list of possible themes. The group met to discuss the possible themes representing the participants and stopped when consensus was reached.

## Findings for Russian-Speaking Communities:

Key informants identified several concerns faced by Russian-speaking communities in California including social and economic challenges, and specific health and mental health problems. In addition, key informants described assets and strengths, as well as recommendations for improving the mental health of Russian-speaking communities.

### Social Concerns for the Russian-speaking Community

Key informants reported that for many Russian-speakers residing in California, significant social concerns including limited English proficiency, cultural stigma associated with mental health problems, and social isolation coupled with acculturation challenges contribute to mental health problems. These concerns are described in depth below.

*Language:* Language barriers were frequently mentioned as inhibiting access to mental health services. Informants identified a lack of Russian-speaking staff in most mental health facilities and discussed how this issue has worsened due to economic constraints. As one interviewee noted,

*“We used to have much more of these centers and they had bilingual staff. Because of*

*budget cuts they decreased the number. Now at these centers they have Russian-speaking person for 2 hours one day a week.”*

Moreover, informants described mental health care as a particularly sensitive arena, stating that many members of the community are reluctant to disclose sensitive information with a third party present. As one interviewee explained, “Most [members of the community] don’t feel comfortable talking to a psychiatrist through a translator.”

*Stigma:* Various forms of social stigma were highlighted as some of the broadest and most frequent barriers to accessing mental health services. One aspect of this issue relates to a lack of understanding and awareness regarding mental illness and treatment. According to one contact,

*“The majority of the local Russian speaking community do not know important aspects of mental health services such as confidentiality or clients’ rights . . . . So there is a misunderstanding of how mental health services function.”*

Certain national/cultural traditions also contributed to this lack of understanding. Interviewees emphasized experiences with persecution and stigma in the former Soviet Union when explaining barriers to mental health services. As one key informant noted, “Those who came from the former Soviet Union still have a lot of suspicions regarding mental health services because these services were used as a tool of oppression.” According to another interviewee, “In the former Soviet Union, psychiatry is not treated, it’s like punishment. People, even if they have a mental disorder, they are afraid to talk about it, to recognize it.” This stigma prevents individuals from discussing mental health problems, “The stigma is strong partly because it’s coming from your ancestors. . . and partly because it’s silent. People are not aware that they are doing that.”

Other contacts highlighted issues of privacy when discussing social stigma noting, “[In the Soviet Union] people could have been fired from their job if somebody knew they were seeing a psychiatrist.” Privacy was also addressed as a specific concern amongst tight-knit Russian-speaking communities. When discussing the strengths of their community, key informants emphasized the depth and closeness of their social relationships. However, such characteristics also affected access to mental health services, contributing to a fear that one’s treatment might reach friends, family members or colleagues.

Family structure and gender roles also contribute to social stigma regarding mental illness. Once again the centrality and closeness of family relationships was emphasized, but according to key informants, the family is typically viewed as one’s primary avenue for support. This can hinder access to mental health services because as one contact explained, “Traditionally the family was supposed to be the main unit of [support. . . . To talk to strangers about issues can be seen as disloyal to your family.” Contacts also identified gender-related stigmas within the community stating, “Men traditionally prefer not to show any signs of emotional problems so they try to solve themselves individually or sometimes deny them.” Moreover, women are sometimes deterred from seeking mental health services because their husbands maintain a voice of dominance in the family. For example, one interviewee described this situation noting,

*“In the church men are still considered as having the ultimate power in the family and*

*the man can discipline his wife . . . and this is also a barrier to having a discussion with strangers [in the mental health field].”*

*Acculturation/Social Isolation:* Issues of acculturation and social isolation were heavily emphasized by key informants. Members of the Russian-speaking community frequently developed feelings of stress and loneliness when adjusting to life in the United States. According to one interviewee, “[Because of] the stress of the immigration and loss of support, community support, social support, people feel much more isolated.” In addition, isolation was identified as a particular concern among the elderly and this issue is also connected with aspects of acculturation such as language acquisition. For example, as one contact explained, “[Isolation] is also because of a language barrier. . . . Russian-speaking seniors cannot go to regular senior centers because of the language barrier.” Another contact connected this issue with specific mental health concerns noting, “The lack of . . . socializing, that leads to more complicated, more severe depression. I see this as a challenge for elders.”

### **Economic Barriers for the Russian-speaking Community:**

*Financial Instability:* Many contacts suggested that financial stress contributes to the development of mental health problems and poses barriers to obtaining mental health care. This issue was frequently described in connection to housing concerns as Russian-speaking immigrants experienced much more stable levels of housing in the former Soviet Union. According to one key informant, “the sense of instability is quite unfamiliar for Russian-speaking immigrants. . . [Before immigrating] there was no such thing as renting because it all belonged to the government and you paid a minimal fee and no one would ever kick you out of your house.” In comparison, a key informant contrasted this situation with that of California stating,

*“Housing issues is one of the main problems and you know in SF its horrible. Its one of the greatest concern and they have been here almost 20 years. There is not enough subsidized housing. Market rates are crazy. Difficult for people to find housing. Even when they get section 8 voucher it’s almost impossible to find housing.”*

Such issues cause ongoing anxiety and depression and as one contact described, “[Housing instability] creates a very deep, strong underlying stress which affects every single area of people’s lives.”

Gender-related issues were also identified when discussing financial stability and mental health. As one interviewee noted, “Many males are depressed because they can’t provide for the family...so depression is more severe and pronounced here.” Women in the Russian-speaking community also articulated specific financial pressures. In the United States a lack of maternity leave is very difficult to adjust to because according to one contact, “Back in Ukraine normal maternity leave is a year. You have a year, you get your one hundred percent pay and your work spot is held for you.” Considerably shorter periods of maternity leave and a lack of job security create both psychological and economic issues. As one contact described, “[Women] are stressed out before they even start thinking about marriage, so they prefer not to even go that route. I never heard back in Ukraine, ‘I’m not going to get married.’ We as a culture are very much

family-oriented.”

*Access to Insurance:* Access to medical insurance and inadequate medical coverage were emphasized time and again. Informants explained that financial instability in the community inhibits the acquisition of insurance while also emphasizing the inefficiencies of state-run insurance programs such as Medi-Cal. As one interviewee explained, “We are at the mercy of the medical insurance program. . . . [And many facilities] only take one or two types of Medi-Cal.” Another contact highlighted similar concerns stating, “Another issue is access to medical services and medication because of medical changes and because of the Medicare prescription program . . . . It’s just too complicated and inefficient.”

### **Specific Health and Mental Health Concerns:**

*Physical Health Problems:* Interviewees suggested that physical health problems and chronic illness are key concerns of Russian-speaking communities. According to key informants, Russian-speaking immigrants, in particular older adults have high rates of chronic illnesses such as cardiovascular disease and diabetes. One participant stated,

*“Older adults came to the US. They used to work very hard and their physical health is very poor. They suffer from many chronic diseases such as blood pressure diabetes, arthritis, asthma, heart issues. Ninety percent have depression.”*

Obtaining adequate and timely medical care is challenging for many immigrants, particularly because of differences in health care systems between the US and their country of origin. In addition to lack of insurance mentioned above, understanding and navigating the MediCal system and paying for medications present significant challenges for these communities. For example, when asked about overall concerns for Russian-speakers in California, one informant suggested,

*“Physical health would be the first one. It’s not because people are sick. It’s because the practices. How it’s set up on a social level is very different. What we used to have...was free medicine.”*

Furthermore, as noted above, the dearth of bilingual/bicultural providers prevents many Russian-speaking immigrants from accessing health care. Many immigrants are reluctant to disclose health or mental health issues through interpreters.

*Mental health problems:* When asked about specific mental health concerns commonly found in the Russian-speaking community, participants identified depression, anxiety, substance abuse and domestic violence. Social stressors mentioned above such as acculturation, isolation, chronic health problems, and financial stress and instability contribute to the development of mental health problems. Many participants noted the direct link between social stressors and depression. For example, one participant stated,

*“The live alone. If they live in the house with family members, their children go to work and grandchildren go to school and they stay at home all day alone with their diseases. They are taking medicines they go to the doctor and prescribes them the medicine and*

*they go home. This is a triangle. Home, doctors office, home. And they go once a week to church. The lack of other things, socializing. That leads to more complicated, more severe depression.”*

Participants noted that many immigrants had government subsidized housing in their countries of origin. In contrast, in the US, many Russian-speaking immigrants experience the potential loss of housing as a real and true threat. One participant noted that this housing insecurity “creates a very deep and strong underlying stress.”

Stressors were also seen as contributing to elevated levels of substance abuse (particularly among teens), anxiety, and intimate partner violence (IPV). Moreover, cultural norms that grant greater power and authority to men in relationships may contribute to an elevated incidence of IPV in Russian-speaking communities. One participant stated,

*“Many churches still see that the man can discipline the wives. So domestic violence happens. And you will not discuss this with strangers.”*

Participants suggested that while there is a dearth of statistical data to confirm the prevalence of IPV, anecdotal evidence suggest that it is a significant concern for this community, and one that is generally hidden.

Thus participants identified several specific health and mental health concerns common in Russian-speaking communities. These problems are exacerbated by difficulties obtaining health and mental health care as well as cultural norms prohibiting disclosure of these problems outside of the family.

### **Communities’ Strengths**

Key informants identified several community and individual characteristics that help to buffer Russian-speaking immigrants from stress and trauma. Participants reported that a degree of interdependence is expected within their communities, and this interdependence enables individuals to reach out and obtain help from others. Because of the relative isolation as well as the shared culture and history, Russian-speaking immigrants are often able bond easily with other members of their community. Thus, participants described Russian-speaking communities as close-knit and socially active.

In addition, several resources such as churches, grocery stores, and community-based organizations provide services in Russian to the Russian-speaking community. Many immigrants from Russia and the former Soviet Union have strong spiritual beliefs. California is home to large communities of Russian Jews and Christians, and churches and synagogues often play a key role in providing support and social connections for immigrants. In addition, community-based organizations have been established in several geographical locations (Los Angeles, San Francisco, Sacramento) to provide services to these communities. These organizations have been instrumental in addressing mental health problems as well as social and economic challenges. Finally, local communities have established businesses that have become resources for Russian-speaking communities. One participant noted,

*“Here in Sacramento there are several Russian grocery stores. There is a lot of information, a newspaper and a magazine which is published in Russian and they have advertisement about different services available, dental services...”*

## **Recommendations**

The most common recommendation made by participants was to increase the availability and accessibility of linguistically appropriate and culturally responsive health and mental health services for Russian-speaking immigrants. Key strategies recommended by respondents included 1) increasing the Russian-speaking mental health workforce (recruiting psychiatrists in particular as well as other clinicians), and 2) increasing the number of hours and services available.

*“Also what is very important is to somehow have more Russian speaking specialists, psychiatrist who would be able to work with this population and accept medical and Medicare. There should be some way to do something about this.”*

One participant noted that adult day programs had been effective in treating severely mental illness in this community, however many such programs had been shut down due to budget cuts. This interviewee suggested,

*“Day treatment programs for SMI [severely mentally ill]... what would be important would be to go somewhere to have something to do. It would be some structure to them. It’s very important. They should be able to go for years, not a month. Just a regular activity, no graduation. An important part of rehabilitation process for SMI.”*

Other recommendations addressed cultural barriers to care. Participants suggested that building relationships with churches and synagogues and building trust within communities would increase community members’ willingness to seek services, “Work with the church leaders. So they can find out about mental health issues. It takes time.” Further, given the broad diversity of the Russian-speaking community, it was recommended that services be tailored to meet the specific needs and cultural values of local communities, “When doing any programs or services it’s important to tailor them to local communities, local culture and those cultures can differ tremendously.”

## **Findings for the Middle Eastern and Southwest Asian Communities:**

Review of the interview data for the four Middle Eastern/Southwest Asian participants yielded themes regarding cultural characteristics of the communities, social and economic barriers to mental health care, specific mental health issues, community strengths and assets and recommendations for programs and services.

### **Cultural Factors:**

Interviewees discussed the importance of key cultural factors such as the differing levels of

acculturation, different views regarding gender roles, and a wide variety religious and spiritual (faith) beliefs.

*Diversity* As noted above, Middle Eastern and Southwest Asian communities include individuals with high levels of education and income, as well as refugees and recent immigrants with very few economic resources. Immigrants come from various countries with different languages and dialects that vary from region to region and social strata, histories of oppression, political unrest, war, and economic status. In addition, the reasons for immigrating vary widely. While there are well-established and affluent Middle Eastern communities in California, there is also a growing refugee and asylee community with exposure to trauma from war and political and religious persecution. Thus, to understand the needs of these communities, it is critical to keep in mind the broad diversity represented in this group.

*Gender Roles* Participants also discussed the importance of understanding gender roles when providing services to these communities. While the extent to which strict gender and generational roles are emphasized varies by community and by the family/individuals' level of acculturation, for many immigrants in these communities, gender and generational roles are critically important in determining behavior. For example, one participant described the challenges faced by some Muslim refugee women who obtain housing in shelters,

*“Muslim women pray and wear the hijab. They need a space to pray, they need a private bathroom. They cannot stay with men who are drinking and eating dinner at the same table. I [work with] a family, they take turns sleeping at the center and the mothers sleep and then the girls sleep, they take turns. They would rather stay on their own and be outside.”*

In response to this quote, one cultural broker suggested that in addition to concerns regarding culturally inappropriate sleeping arrangements, Muslim women may feel compelled to watch over their children at night.

*Acculturation* Participants also discussed the process of acculturation and enculturation relevant to familial adjustment and conflict. According to key informants, for Middle Eastern/Southwest Asian families and for new immigrants in particular, stress related to acculturation is two-fold: parents worry about their children losing their connection to their culture of origin (enculturation), and the resulting acculturation gaps create conflict and distance between parents and children. One participant stated,

*“[Families] are very concerned about raising their children in a very different culture, the fear of their children really not adopting their culture and growing up being ‘American.’”*

Generational differences in acculturation, or the degree to which parents and children adopt new cultural values and behaviors, are a source of distress for many immigrant parents. This theme was mentioned by many of the interviewees. According to one participant,

*“With immigration there is a structural change in families where children get more power in that process. They learn the language faster. They get more power. That creates chaos.”*

Furthermore, adjusting to culture in the US may entail adopting values that encourage independence and freedom, values which may be contrary to those espoused at home. While many Middle Eastern/Southwest Asian families may expect interdependence and may restrict extracurricular activities for their children, younger generation immigrants exposed to culture in the US may desire more freedom to date and leave the home. One participant stated,

*“[Problems increase among] teenagers, young adults where according to American culture they’re independent, and according to Egyptian culture, they’re not. . . . These are the ones that face a lot of pressure, pressure from parents, pressure from society and reaching an age where they are deciding what they want to do.”*

Thus, for many immigrant families, adjusting to different cultures while maintaining family cohesiveness and cultural traditions is a significant challenge.

### **Social and Economic Issues:**

Many ME/SWA immigrants also experience significant stressors which contribute to the development of mental health problems including social isolation, discrimination, and social stigma regarding mental illness as well as difficulties with employment and finances.

*Social Isolation* As is common in many immigrant communities, older adults experience social isolation. For many older adults in these communities, difficulty learning to speak English is a barrier that prevents them from being active, from finding work outside the home or productive occupation, and from developing a network of social relationships. Many rely on their children or relatives for transportation and translation. One participant also mentioned that children who immigrate experience isolation as they adjust to a new language and new culture:

*“The major issue is that [the elderly] are very isolated because of the language barrier they are not able to be active in the mainstream culture so they feel very useless. . . . That sense of being useless and losing meaning and goals for life.”*

*Discrimination* For some ME/SWA immigrants isolation may be exacerbated by the experience of discrimination. Since the September 11th attacks, anti-Muslim and anti-Arab sentiment has increased in the US and numerous hate crimes have been documented. Participants reported that for immigrants with whom they work, discrimination, bullying, threats, and intimidation are common experiences. One participant stated,

*“...youth are going to schools and there is a lot of bullying, hatred and racism. And they suffer a lot from that... And the parents [who] are refugees and immigrants are way too scared to do anything about it.”*

*Stigma* When family members experience psychiatric symptoms, many are reluctant to seek help due to the stigma associated with mental illness. As is common in many communities, mental health problems are viewed as shameful for many ME/SWA immigrants. For example, one interviewee stated,

*“The barriers are the culture that comes with it, coming from Egypt where people with mental illness are shameful to the family. And the belief that someone with mental illness*

*will not be able to do anything and will not get better.”*

This quote illustrates the difficult emotions experienced by family members of individuals with mental illness. However, it should be noted that one of the cultural brokers who assisted in data analysis for this community clarified that it was not the *individual* with mental illness that families are ashamed of, but rather the *illness*. The cultural broker stated that in general in ME/SWA communities, family members experience mental illness as a burden, but are supportive as best they can within the home and family structure.

*Financial difficulties* Finally, financial difficulties following immigration may lead to significant stress. While many ME/SWA communities have been economically successful, establishing thriving businesses in several areas of California, some Middle Eastern and Southwest Asian immigrants, particularly refugees and asylees, experience extreme financial hardship. Refugee resettlement programs offer temporary assistance (approximately 6 months) with the expectation that newcomers will acquire English language skills and employment during this period. However, following this period, many families still find themselves with limited English proficiency and no employment options. The resulting financial burdens create significant strain and may lead to the development of mental health problems. For men in these communities, the strain may be particularly severe, as they are often expected to provide for their families. Participants reported that the experience of depression and anxiety related to financial difficulties is common for men in these communities.

### **Specific Mental Health Issues:**

When asked about specific mental health issues, participants reported that family conflict, depression, and Post-traumatic Stress Disorder are common problems affecting their communities.

*Family Conflict* All of the participants expressed concern over family conflict in their communities. Family conflict encompassed issues such as parent-child difficulties, marital discord, and domestic violence arising from various stressors. One participant described a survey they had conducted with their local Muslims community. The most frequently cited problems were parent-child conflict and marital problems. In this survey, respondents identified the need for counseling to improve family functioning.

*“We did a needs assessment 6 years ago and we found that about 70% of people (Arabic, English) were concerned with the relationships between parents and children. . . . The other issue was marriage relationships. 70% said that they would like us to offer marriage counseling.”*

*Acculturation Gaps* As noted above, differences in acculturation between parents and children accounted for some of the family conflict identified. Participants suggested that youth in the US are allowed to engage in more extracurricular social activities than is customary in many ME/SWA cultures. Immigrant youth often adjust quickly and expect to engage in similar activities as their peers in school. Parents face the challenge of reconciling new cultural expectations with values and customs of their culture of origin that may be in conflict with these new expectations.

*Domestic Violence* In addition to family discord, many participants expressed concern over high levels of domestic violence that is largely hidden due to cultural norms which discourage disclosure.

*“We have a lot of domestic violence [within] the Arabic groups here. For us to get them to the center it’s really hard because the husband thinks that they will start talking.”*

According to key informants, domestic violence may arise in part due to cultural norms that emphasize hierarchical family relationships, however participants asserted that domestic violence is not prevalent in all ME/SWA communities, and is not culturally sanctioned.

*PTSD* For refugees and asylees, post-traumatic stress disorder (PTSD) as well as post-traumatic symptoms are common. Interviewees reported that many community members continue to suffer from anxiety, grief, and depression related to trauma and loss experienced in home countries. Further, one respondent reported that immigrants condemned or discriminated against due to sexual orientation experience continued fear for their safety even after immigrating.

*Depression* Finally, participants reported that depression is a significant issue affecting many ME/SWA immigrants. The numerous stressors noted above: financial difficulties, the experience of discrimination, and isolation may contribute to or exacerbate symptoms of depression.

*“The biggest mental health issue, especially among seniors, is depression. “Nine out of ten [times] the presenting problem is depression.”*

Participants mentioned that some individuals may cope with depression and stress through substance use.

### **Communities’ Strengths**

When asked about communities’ strengths and assets, participants reported that community and family cohesiveness as well as achievement orientation are key strengths. Within the ME/SWA communities, there is a strong sense of responsibility and willingness to provide assistance to community members in need.

*“There is within in the community great desire to help each other, a great desire to serve the church. Many, many youth are eager to volunteer. Families are very close, tight-knit structure, extended family is very crucial.”*

Furthermore, in many ME/SWA groups, achievement in business, technology, and education is emphasized. This achievement orientation has led to significant success for many ME/SWA immigrants in these sectors. Participants reported that successful immigrants are eager to give back to their community.

### **Recommendations:**

To address mental health in their communities, participants recommended that efforts be directed at increasing the availability of culturally responsive (ie having and honoring cultural awareness) and language appropriate services as well as increasing prevention, outreach, and education programs.

Participants reported that many individuals from ME/SWA communities do not access needed mental health services because there are no providers that speak their language or understand their cultures. Because of the stigma associated with mental illness, immigrants may feel reluctant to discuss mental health issues particularly with a provider who does not understand aspects of their culture such as gender issues and generational roles. One participant suggested,

*“[We need] Arabic-speaking providers to help those people. . . . Some place where they can feel safe and they have professional people who speak the language . . . . So we need someone who understands the culture and the language.”*

In addition, to address mental health stigma interviewees recommended implementing prevention programs to provide supportive services and psychoeducation to community members. According to interviewees, many immigrants may feel uncomfortable seeking help for mental health problems but may be willing to attend workshops or educational sessions for general health matters. Integrating information about mental health with information about other relevant topics such as general health is a recommended strategy for increasing access to psychoeducation. In addition, participants suggested providing support groups for youth, women and older adults.

*“I would want first preventive programs which is mostly supportive groups where [transition age youth] can freely talk about that conflict that is going on within them and at home, but also the same for the parents because the parents also need to be educated.”*

Groups may serve to decrease isolation, improve coping with the stress of acculturation and family discord, and improve awareness and understanding of mental health problems.

## Summary and Conclusions:

One of the greatest challenges to eliminating health disparities is learning about and respecting the pride, values and practices, both generational and historical, that ground individuals, families, and communities in their native diverse cultures. The findings of the third State of the State report provide insight into the cultures and needs of communities that have received little attention in previous research and outreach efforts. The study is brief and qualitative in nature, and future work is necessary to “drill down” and gain a deeper understanding of the issues that affect these communities, in particular the various subgroups that are represented in these populations. For example, refugee communities from Iraq and Syria may face different challenges than Egyptian Coptic immigrants. Post-traumatic stress disorder may be common in those exposed to war, whereas anxiety regarding persecution for religious affiliation or sexual orientation may be more common among Muslim and asylees respectively. Similarly, many Russian Americans have resided in California for generations and may not face the language and acculturation challenges that other Slavic immigrants face. As new refugees arrive from Syria and other countries with political conflict, continuing to build awareness of the issues that face these groups and base services and policy on these needs will be critical.

Nonetheless, the findings of the current study illustrate some common themes in the experiences of California immigrants. For Russian-speaking, Middle Eastern and Southwest Asian communities, themes of culture diversity and acculturation as well as social determinants of

mental health were emphasized. The challenges of adjusting to new cultures and the family conflict this can create as well as the difficulty establishing financial stability as an immigrant were cross-cutting themes.

Most notably, across communities, key informants emphasized the importance of increasing the availability of linguistically and culturally appropriate services for these communities. Moving forward, it will be critical to improve access to care with a multi-pronged approach: addressing stigma, increasing diversity in the mental health workforce, and offering linguistically and culturally appropriate services (based in awareness of the culture's history and values) that are affordable.

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- Center for Immigration Studies (2002). Immigrants from the Middle East.  
<http://www.cis.org/MiddleEasternImmigrantsProfile> Retrieved on January 8, 2014.
- Corbin, J., & Strauss, A. (2007). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Sage.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five designs*. Thousand Oaks, CA: Sage.
- Delgado- Gaitan, Concha. "Russian refugee families: Accommodating aspirations through education." *Anthropology & Education Quarterly* 25.2 (1994): 137-155.
- Duncan, Laura, and Mary Simmons. "Health practices among Russian and Ukrainian immigrants." *Journal of Community Health Nursing* 13.2 (1996): 129-137.
- Jurcik, Tomas, et al. "Russians in Treatment: The Evidence Base Supporting Cultural Adaptations." *Journal of clinical psychology* (2013).
- Leipzig, C. (2006). When Russians come to therapy. *The American Journal of Family Therapy*, 34(3), 219-242.
- Marschner, J. (2003). *California's Arab Americans*. Coleman Ranch Press, CA.
- Shin, Hyon B. and Robert A. Kominski. 2010. *Language Use in the United States: 2007*, American Community Survey Reports, ACS-12. U.S. Census Bureau, Washington, DC.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five designs*. Thousand Oaks, CA: Sage.

APPENDIX A

Table 1: Quotes for Russian-Speaking Participants

Themes	Quotes
<p><b>Social Factors</b></p> <p>Language</p> <p>Stigma</p> <p>Acculturation/ Social Isolation</p>	<p>“Very few [facilities] have Russian-speaking staff.”</p> <p>“Most [members of the community] don’t feel comfortable talking to a psychiatrist through a translator.”</p> <p>“The majority of the local Russian-speaking community do not know important aspects of mental health service such as confidentiality rights. . . . So there is a misunderstanding of how mental services function.”</p> <p>“[In the Soviet Union] people could have been fired from their job if somebody knew they were seeing a psychiatrist.”</p> <p>“Traditionally the family was supposed to be the main unit of [support]. . . . To talk to strangers about issues can be seen as disloyal to your family.”</p> <p>“In the church men are still considered as having the ultimate power in the family and the man can discipline his wife. . . and this is also a barrier to having a discussion with strangers [in the mental health field].”</p> <p>“[Because] of the stress of immigration and loss of support, people feel much more isolated.”</p> <p>“[Isolation] is also because of language barrier. . . . Russian-speaking seniors cannot go to regular senior centers because of the language barrier.”</p>

Table 1 (Cont.)

Themes	Quotes
<p><b>Economic Factors</b></p> <p>Financial Instability</p> <p>Access to Insurance</p>	<p>“Housing issues is one of the main. Housing problems, and you know in SF it’s horrible. It’s one of the greatest concerns.”</p> <p>“Many males are depressed because they can’t provide for the family . . . so depression is more severe and pronounced here.”</p> <p>“Back in Ukraine normal maternity leave is a year. You have a year, you get your one hundred percent pay and your work spot is held for you . . . [Women] are stressed out before they even start thinking about marriage, so they prefer not to even go that route.”</p> <p>“Another issue is access to medical services and medication because of medical changes and because of the Medicare prescription program . . . It’s just too complicated and inefficient.”</p>
<p><b>Specific Health and Mental Health Concerns</b></p> <p>Physical Health</p> <p>Depression</p> <p>Anxiety</p> <p>Domestic Violence</p> <p>Substance Abuse</p>	<p>“Older adults came to the US. They used to work very hard and their physical health is very poor. They suffer from many chronic diseases such as blood pressure diabetes, arthritis, asthma, heart issues.”</p> <p>“They live alone. If they live in the house with family members, their children go to work and grandchildren go to school and they stay at home all day alone with their diseases. The lack of other things, socializing. That leads to more complicated, more severe depression.”</p> <p>“[Housing instability] creates a very deep, strong underlying stress which affects every single area of people’s lives.”</p> <p>“Many churches still see that the man can discipline the wives. So domestic violence happens. And you will not discuss this with strangers.”</p> <p>“Drugs for the young population, abusing drugs. This a great concern of the community.” “[There are no services for substance abuse], specifically with Russian speaking staff.</p>

Table 1: (Cont.)

Themes	Quotes
<p><b>Community Strengths</b></p> <p>Social Relationships</p> <p>Community-based Resources</p>	<p>“Humor helps us survive . . . strong family bonds, very deep friendships.”</p> <p>“There are several centers [in LA] which help the Russian speaking population. In LA there are many Jewish centers which support the local community. Here it is called the Slavic center, it is for the Ukrainian, Russian. And they are most affiliated with churches. And they help with employment. They help with social resources.”</p> <p>“Here in Sacramento there are several Russian grocery stores. There is a lot of information, a newspaper, a magazine which is published in Russian and they have advertisement about different services available.”</p>
<p><b>Recommendations</b></p> <p>Russian-speaking services</p> <p>Adult/Peer Programs</p> <p>Community Outreach/Education</p>	<p>“Also what is very important is to somehow have more Russian speaking specialists, psychiatrist who would be able to work with this population and accept Medi-cal and Medicare.”</p> <p>“Day treatment programs for SMI [severely mentally ill]. . . it would be structure to them. They should be able to go for years, not a month.”</p> <p>“Develop peer programs for adults for people who are in isolation to decrease their depression.”</p> <p>“Work with the church leaders. So they can find out about mental health issues. It takes time.”</p> <p>“[We need] community members, parents and young people to educate people about mental health.”</p>

APPENDIX B

Table 2: Quotes for ME/SWA Participants

Themes	Quotes
<p><b>Social Factors</b></p> <p>Gender Roles</p> <p>Acculturation/ Generational Differences</p> <p>Isolation</p> <p>Discrimination</p> <p>Stigma</p>	<p>“Muslim women pray and wear the hijab. They need a space to pray, they need a private bathroom. They cannot stay with men who are drinking and eating dinner at the same table. I [work with] a family, they take turns sleeping at the center and the mothers sleep and then the girls sleep, they take turns. They would rather stay on their own and be outside.”</p> <p>“[Families] are very concerned about raising their children in a very different culture, the fear of their children really not adopting their culture and growing up being ‘American.’”</p> <p>“[Problems increase among] teenagers, young adults where according to American culture they’re independent, and according to Egyptian culture, they’re not. . . . These are the ones that face a lot of pressure, pressure from parents, pressure from society and reaching an age where they are deciding what they want to do.”</p> <p>“We can’t send [the elderly] to those big care center for seniors because they don’t speak the language or eat the food. so they are isolated.”</p> <p>“Because youth are going to schools and there is a lot of bullying, hatred and racism. And they suffer a lot from that... And the parents are refugees and immigrants are way too scared to do anything about it.”</p> <p>“The barriers are the culture that comes with it, coming from Egypt where people with mental illness are shameful to the family. And the belief that someone with mental illness will not be able to do anything and will not get better.”</p>
<p><b>Economic Factors</b></p> <p>Financial Hardship</p> <p>Access to Insurance</p>	<p>“[There is] special medical [aid for immigrants] for 8 months, cash aid and food stamps. Cash is like \$300. you can’t find housing in SF. They expect them in 8 months to be able to work, find housing, which is impossible.”</p> <p>“Most Persians, more recent waves of immigration, they are not insured. The underserved community is not insured and seeking help through private practice is not affordable.”</p>

Table 2: (Cont.)

Themes	Quotes
<p><b>Specific Mental Health Concerns</b></p> <p>Family Conflict</p> <p>Domestic Violence</p> <p>Depression</p> <p>Substance Abuse</p>	<p>“We did a needs assessment 6 years ago and we found that about 70% of people (Arabic, English) were concerned with the relationships between parents and children. . . . The other issue was marriage relationships. 70% said that they would like us to offer marriage counseling.”</p> <p>“We have a lot of domestic violence between the Arabic groups here. For us to get them to the center it’s really hard because the husband thinks that they will start talking.”</p> <p>“The biggest mental health issue, especially among seniors, is depression. Nine out of ten [times] the presenting problem is depression.”</p> <p>“There’s is a great deal of work in our community with substance abuse. That mental health component is very strong.”</p>
<p><b>Community Strengths</b></p> <p>Social Cohesiveness</p> <p>Achievement Orientation</p>	<p>“There is within in the community great desire to help each other, a great desire to serve the church. Many, many youth are eager to volunteer. Families are very close, tight-knit structure, extended family is very crucial.”</p> <p>“These are high functioning people. They are achievement oriented. We are collectivistic but also extremely competitive with the right support they do very well. Most of the children are doing well academically.”</p> <p>“There is a large percentage of the community that is highly educated and that are professional so if their assistant input is need, it’s there.”</p>

Table 2: (Cont.)

Themes	Quotes
<p><b>Recommendations</b></p> <p>Culturally Responsive Services</p> <p>Community Outreach</p> <p>Prevention/ Education</p>	<p>“[We need] Arabic-speaking providers to help those people. . . . Some place where they can feel safe and they have professional people who speak the language . . . . So we need someone who understands the culture and the language.”</p> <p>“We need to have more reach out into the community and more education around mental health.”</p> <p>“Developing a volunteer network. Funding is important but having a strong volunteer network, developing that sense of volunteerism. That would be something that I am looking forward to engaging the community to help.”</p> <p>“I would want first preventive programs which is mostly supportive groups where [transition age youth] can freely talk about that conflict that is going on within them and at home, but also the same for the parents because the parents also need to be educated.”</p>

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