The Mental Health Needs of Mexican-American Agricultural Workers

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We used three measurement procedures to produce a comprehensive profile of the mental health needs of Mexican-American farmworkers and to determine what kinds of mental health services were required to meet those needs. These measurement procedures were a field survey, a key informant survey, and a nominal group process. The results of the field survey indicated that rural Mexican Americans are not being served by mental health providers, despite their having higher symptom levels than would be expected in the general population and their substantial use of rural primary health clinics and private physicians.

The key informant survey included mental health providers, health providers, and community agency personnel. According to these informants, the mental health sector is unable to provide services for the farmworkers; and the ability of other providers to reach them depends on a number of factors, including the nature of the services offered and the socioeconomic characteristics of the farmworker themselves. Key informants identified the environmental conditions implicated in the farmworkers' psychosocial problems and recommended types of services, sites, and key personnel. Key informants concurred that general health settings and multiservice agencies were the most appropriate for reaching Mexican Americans, and that mental health services must include bilingual and bicultural staff members. Key informants disagreed, however, about the relative value of certain kinds of mental-health services. The nominal group process identified 32 design criteria that could be used to improve mental health services for farmworkers. We conclude with recommendations, including a discussion on financing mental health services, the appropriateness of incorporating such services within rural primary health clinics, and using a number of allied professionals and paraprofessionals as mental health adjuncts in an integrated treated environment. [Am J Prev Med 1985;1(3):47–55]

The oppressive environment endured by Mexican-American agricultural workers and the debilitating nature of their lifestyle are chronicled in novels, history books, and television documentaries. That this is a population that remains powerless and destitute needs no reiteration. This paper presents the results of three interrelated studies conducted during 1982 in California's major agricultural area. The overall goal of the research was to improve the quality of mental health care available to rural Mexican Americans in California.

We used a convergent needs assessment strategy to (1) measure the need for mental health services of Mexican-American farmworkers, (2) identify the kinds of services required, and (3) ascertain how mental health services offered within the framework of existing resources could be supported logistically. The assessment procedures included a field survey of farmworkers in labor camps and residential areas, a key informant survey, and a nominal group process with a subsample of the key informants. The results of specific assessment procedures and the recommendations reported below are summarized but the details are available from the authors.

According to 1977 U.S. census data,[1] more than 2 percent of persons in the United States of Mexican origin resided in nonmetropolitan areas, compared to only 3.9 percent of those of Puerto Rican origin and 1.6 percent of those of Cuban origin. A standard metropolitan statistical area (SMSA), by census definition, refers to a county or group of contiguous counties in which there is a city or twin cities with

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a population of at least 50,000. In addition to the 20.5 percent that is nonmetropolitan, another 35.5 percent reside in noncentral areas of SMSAs, i.e., in generally low-income suburban and semirural areas. It has been estimated that, at peak harvest, over one million farmworkers and their family members can be found in California alone.[2]

Despite the fact that biometric data from the California Department of Mental Health indicate that Mexican Americans are seriously underrepresented in the caseloads of all kinds of mental health services, there are compelling indicators that rates-in-treatment data do not accurately reflect need within this population. Several reasons can be cited in support of this contention, including the following.

1. A growing body of epidemiological evidence suggests that Mexican Americans have symptom levels and diagnosable disorders at rates that equal or exceed those of other major subgroups. Three recent California field surveys reported higher levels of depression symptoms for Mexican Americans than for non–Mexican Americans, with the highest rates being reported for middle-aged Mexican Americans.[3–5]

2. Social indicator analysis sponsored by the California Department of Mental Health strongly implies that Mexican Americans are underserved by the publicly funded mental health system.[6]

3. Over the last two decades, a vast literature has developed that attests to the cultural inappropriateness of many mental health services and to other barriers to the use of such services by Mexican-American patients,[7–10] who are believed to be more likely to develop somatic symptoms and advanced psychiatric disorders.[11]

In summary, the existing professional literature suggests that many Mexican Americans have rates of psychiatric disorders that closely approximate other subpopulations having a similar high-risk profile (i.e., migrants and immigrants of low socioeconomic status who are segregated from the larger society within which they reside). Perhaps, even, the rural Mexican-American population best typifies this profile. A large segment of this population migrates between states in search of work, and an unknown percentage entered the United States without documentation. Overall, very few traditional health maintenance resources are regularly available to this group.

In California, a system of rural primary health care clinics provide services for the state's rural low-income populations. Although, unfortunately, they do not provide mental health services, in the past, some clinics did manage to develop links with county mental health providers. Rural clinics are located where there are concentrations of agricultural workers, and they are bilingually staffed; but the vast expanses of productive lands make universal access to these services problematic. More recently, economic considerations have forced county mental health departments to retreat from both the concept and practice of offering services to this group. Since such services were primarily offered through outreach programs, they have become quite vulnerable to recision due to problems in billing for financial reimbursement and formidable resource demands from more powerful and well-organized constituencies.

ASSESSMENT PROCEDURES

Three methods were used to assess the relative need for mental health services among the farmworkers and the types of services that would be most appropriate and effective in meeting such needs. First, a carefully conducted epidemiological survey of 500 farmworkers was carried out in labor camps and residential areas. Second, a key informant survey, using a standard interview protocol, was conducted among mental health providers, general medical providers, and multiservice agency personnel and allied professionals. Third, a nominal group process was used with a subsample of key informants to establish priority among recommended program elements. All facets of the research were carried out using university-based professionals adhering to rigorous standards.

The Field Survey

We conducted a cross-sectional field survey of agricultural workers using a variety of inventories to assess both their health and mental health statuses and their health behaviors. To determine their relative need for mental health services, we used the Health Opinion Survey (HOS).[12] The HOS is a well-known and widely used measure of psychophysiological distress that has been extensively tested for validity and reliability. Though some investigators[13] have criticized the HOS as inappropriate for measuring general psychopathology, these same investigators have found the HOS reliable for screening chronic mental disorders, transitional stress disorders, and bad physical health; all of which are conditions prevalent within the farmworker population. (For further information concerning either these methodological issues or the detailed findings from this survey, readers should

see Vega, et al.[14])

Briefly summarized, the field survey included the following procedures:

1. A university-based research team developed and pretested a bilingual questionaire, including the HOS, which had previously been translated for use in California with Mexican Americans.

2. Bilingual field supervisors were hired and trained. They then assisted in recruiting and training bilingual field interviewers. Pretests were conducted to determine the interviewers' abilities and to acquaint them with the field-interview procedures. Project personnel were all drawn from the local area.

3. A multistage, probability-cluster sampling plan was developed by segmenting the target region into quadrants and identifying all incorporated and unincorporated communities. These communities were stratified by the proportion of farmworkers residing within them, and the labor camps were stratified by number of occupants. From these listings, a stratified probability sample was selected, and the selected blocks were systematically sampled. A total of 500 respondents were interviewed, with refusals under 5.0 percent.

4. All data processing was conducted by a local university's social science laboratory.

The demographic characteristics of the sample were typical for this population, with household incomes averaging less than $8,000. The HOS has a range of 20–60. Generally, the HOS scores were similar for both sexes, with females having a group mean of 28.43 and males, a group mean of 27.77. Given the low socioeconomic level of the respondents, income had little effect on mean score distributions. However, HOS mean scores were highest for respondents of both sexes between 40 and 60 years of age.

The HOS probable case threshold of 35 coincides with one standard deviation (SD) above the group mean in this survey. Extensive validity studies cited above have demonstrated the efficacy of this estimation procedure for discriminating patient from nonpatient populations, with a sensitivity for neuroses of .90 or greater. This is our proxy measure of need for mental health services.

Graphically summarizing the levels of risk within this sample, Table 1 shows the percentage of persons within each age cohort scoring between one and two SDs above the mean, and the percentage scoring over two SDs. The latter group is considered very symptomatic and at greater risk than the former. The following results are notable: (1) approximately 20 percent of the sample is at risk for needing mental health services; (2) approximately 5 percent of the total sample is at very high risk—scoring over two SDs above the mean; (3) women between 30 and 39 years of age had the highest rates over two SDs and can be considered at highest risk in the sample; and (4) men 18–20 years of age had the highest risk rates overall.

Strong associations between self-perceptions of health status and HOS mean scores were also found in this sample. Although a substantial percentage of respondents reported using either a private physician or a rural clinic, an insignificant number had received treatment from any mental health provider.

These results suggest that higher rates of psychiatric disorders will be found among this rural Mexican-American population than would be expected among either general populations or urban Mexican Americans of higher socioeconomic status. The findings lend support to the central assumptions of the research, that farmworkers constitute a high-risk group and that they are unlikely to receive treatment from mental health providers.

The Key Informant Survey

We conducted this assessment to gain information regarding both the mental health needs of Mexican-American farmworkers and how those needs could be addressed by the human services system. We used procedures and instruments closely following those designed by Warheit, et al,[15] and separated informants into three categories: mental health pro-

Table 1. Farmworkers scoring one or more standard deviations above the mean on HOS

	n	More than 1 SD above mean (%)	2 SDs or more above mean (%)
Males			
under 20	31	19.4	6.5
20–29	97	17.5	4.1
30–39	63	11.1	4.8
40–49	45	15.6	6.7
50–59	25	16.0	4.0
60+	15	13.3	6.7
Total	281	14.6	5.3
Females			
under 20	11	9.1	0.0
20–29	77	19.5	3.9
30–39	56	12.5	1.8
40–49	47	14.9	4.3
50–59	20	15.0	10.0
60+	7	14.3	0.0
Total	219	14.6	4.6

viders (n = 9), general medical providers (n = 7), and community agencies and other professionals who have direct contact with farmworkers (N = 14). All respondents were long-term residents of the region and experienced in providing direct services to the farmworkers.

Mental health professionals. These respondents identified alcohol and family problems, including child abuse and neglect, as the most widespread problems experienced by rural Mexican Americans. They reported a corresponding need for help in coping with marital problems, drug dependence, and acute psychiatric episodes. Harsh living conditions and value conflicts between generations rooted in acculturation differences were cited as major sources of stress. Believing that they only saw a client when the client was experiencing acute psychiatric episodes, none of the respondents felt that they were effectively providing mental health services to this population. Farmworkers accounted for 1–5 percent of the total caseloads of various providers. The only exception to this was the outreach program of the local county mental health program where approximately 25 percent were farmworkers. However, budget constraints had forced the curtailment of these services.

The need for bicultural and bilingual staff was underscored, especially given the observed reticence to use mental health services among low-income Mexican Americans. It is the belief of these informants that mental health services are feared and misunderstood by farmworkers, and that the low availability of Hispanic mental health professionals only compounds this problem. One respondent summarized the problem by saying:

- It seems that when people are really poor and they have lousy living conditions and are struggling to survive and have no power, we don't do much for them. They have needs that are so basic to survival that mental health is almost a luxury. About the only time we come across cases is when they're extremely psychotic and are extremely disruptive to the family. This is an even worse problem for migrants. There's not much you can do for those who are migrant and move on after the season. What can you do?

When questioned about types of services required to adequately serve this population, respondents mentioned mental health education, culture- and language-specific counseling, group therapy, and such emergency services as providing housing and food. Respondents mentioned a strong cultural stigma that the farmworkers attach to mental illness. Additional barriers to the farmworkers using services included the lack of time and money and the geographical inaccessability of providers. Because they perceive the farmworkers as having a greater need than other populations for long-term therapy several respondents felt that these barriers were especially problematical for that population.

When asked what types of personnel were most important for offering mental health services, respondents rated psychiatric social workers and general practitioners as very helpful, and paraprofessionals as only somewhat helpful. (The helpfulness of general practitioners, however, was qualified by the perception that they had good access to the farmworkers but were untrained in dealing with psychiatric symptoms and disorders.) Properly trained clinical psychologists, if bilingual and bicultural, were also believed to be useful. On the other hand, psychiatrists and psychiatric technicians were not rated as highly and were seen as inappropriate for this population. Table 2 lists the environmental and personal problems felt to be most prevalent among this population, ranked in importance by the mental health professionals as well as the general medical providers and the agency personnel.

General medical providers. The respondents interviewed indicated that between 25 and 100 percent of their patients were farmworkers. These respondents reported that, other than health anomalies, the most frequent problems brought to their atten-

Table 2. Six most prevalent problems of farmworkers as reported by three categories of key informants

Mental health professionals	General medical health professionals	Agency professionals
1. families in poverty	1. overcrowded housing	1. overcrowded housing
2. alcohol abuse	2. families in poverty	2. medical needs of poor
3. medical needs of poor	3. medical needs of poor	3. families in poverty
4. overcrowded housing	4. unemployment	4. alcohol abuse
5. unemployment	5. teenage pregnancies	5. family disturbances
6. drug abuse	6. residential mobility	6. medical needs of the aged

tion were symptoms of mental health disturbances and disorders, family planning, family problems, marital problems, and crisis situations requiring intervention. Informants stressed the interwoven nature of these interpersonal problems and complained of not being able to provide continuity of care. This situation was aggravated in the case of migrants. Farmworkers were seen as having an assortment of serious needs that provoked symptomatic stress reactions, but which were beyond the scope of general medicine. As one physician stated:

- I try to tell them medicine itself is not the answer to their problems. You have to find the solution to their problems to deal with their stress and anxiety. Most of them worry about their children and their families, and they try to put up with it as long as they can.

The farmworkers often report somatic symptoms and disorders, but rarely report emotional problems. Typical complaints include low back pains, dizziness, and chronic fatigue.

There was a consensus of opinion that farmworkers actively use the bilingual and bicultural health services of the rural health clinics, and that appropriate mental health services designed to reach this group could succeed in attracting clients. An idea repeated in several ways, was that the farmworkers need a support system to help them cope with their psychological reactions to traumatic life events and persistent life stresses. The deaths of family members, teenage pregnancies and pregnancies in later life, the complex family problems associated with alcoholism, and the deterioration of living standards for the elderly caused by the fragmentation of families were mentioned in this context.

Respondents identified paraprofessionals as very important in meeting the mental health needs of the farmworker population, especially when supervised within an integrated medical treatment setting. Next in importance were general practitioners, especially family practice physicians, followed by psychiatric social workers. Social workers and nurses were considered only somewhat useful, and clinical psychologists and psychiatrists were considered inappropriate for this population.

Community agency personnel and others. This was the most heterogeneous group of respondents, including program directors, a chief of police, a union representative, teachers, an attorney, and a priest. All had extensive experience in the region and with the target population. Over half of the agency personnel interviewed reported that the majority of their clients were farmworkers. Mental health and family problems (many of which were alcohol-related) were the most common problems reported by farmworkers. These were followed in frequency by employment problems, disability, lack of income, marital problems, acute distress, and physical health problems. Again these problems were described as interwoven and as having serious psychological effects on the farmworker population. The following comment is illustrative:

- The depression comes from seeing the father out of work, seeing there isn't enough food for the kids. It's got to be psychologically depressing when kids aren't going to eat. That's when you sometimes get the guys that totally flip out, the 5150s, and you have to put them in G Ward. I saw all of this as a police officer when the mother would call because the child was sniffing glue or the father was an alcoholic. But I think their major problem is that they feel they have no control over their destiny.

Respondents drawn from traditional agencies and university personnel are least likely to think that they are addressing the needs of farmworkers. On the other hand, respondents whose agencies deal almost exclusively with this population think they are satisfying those needs that their agencies are designed to address, by providing income assistance, employment, crisis intervention, women's counseling, family planning and other forms of assistance. Given the scarcity of resources and the magnitude of the problems, several respondents indicated that only a mental health component directly related to the lifestyle of the farmworkers could hope to make any difference. This implies offering services in nontraditional settings and using innovative mental health interventions. The fact that many of the farmworkers migrate from state to state reinforces these ideas.

This group of respondents did not include professional health and mental health providers, and they expressed frustration at the lack of well-trained bilingual and bicultural professionals available to provide badly needed services. The problem of workers not being able to get to providers due to the isolation of the agriculture sites was also mentioned. Many migrating workers lack any support system and are unknown in the local communities. A lack of financial resources was also seen as a barrier to mental health and general medical services.

Alcohol consumption—and the social role it plays—was linked to a variety of interpersonal problems and was seen as triggering acute psychiatric episodes. Alcohol is allegedly used by some growers as a consolation for low wages. For

younger migrant workers, social drinking constitutes virtually the only recreation available. A similar rationale is given for teenage alcohol and drug use. Universally, the relationship between economic hardships and family structure is thought to be central to the pathogenic process.

The respondents report that offering physician services within comprehensive health clinics is the most realistic way to provide mental health services to farmworkers. Paraprofessionals, psychiatric social workers, and public health nurses are seen as very helpful, and social-work outreach and paraprofessional multiservice agencies are also perceived as helpful in supporting mental health interventions. Churches and other religious settings are also important sites. On the other hand, county mental health workers, private physicians, psychiatrists, and clinical psychologists are not considered to be helpful.

An overview of the results indicates that:

1. The commonly reported psychosocial problems of farmworkers are related to family and marital problems. Mental health professionals think that child abuse and neglect are priority areas, but health professionals stress family/marital conflicts and the emotional problems of children and adolescents.

2. Although no service sector claims to be offering adequate services to the farmworker population, as a group, medical care professionals are most likely to believe that they are offering necessary and relevant services. Mental health professionals report the lowest use levels, with poor outreach and inaccessibility identified as the greatest barriers.

3. All informants agree that the most persistent life stresses for this population result from poverty, overcrowded housing, and unemployment.

4. Whereas mental health professionals rate psychiatric social workers and general practitioners as very helpful in dealing with the mental health needs of rural Mexican Americans, they consider paraprofessionals as only somewhat helpful. Physical health professionals rate paraprofessionals as very helpful, followed by general practitioners. No one rates psychiatrists and psychiatric technicians as very helpful, but the highest ratings come from mental health professionals.

5. Factors universally cited as barriers to mental health services include a lack of bicultural and bilingual personnel, a lack of awareness of services, the stigma the farmworkers put on such services, a lack of transportation, and an inability to pay for services. All respondents agree that comprehensive health clinics are the most realistic setting in which to reach this population.

The results of this assessment indicate that farmworkers are not integrated into any facet of the mental health system, and that the contacts that currently exist revolve primarily around the paraprofessional agencies and rural primary care clinics.

The Nominal Group Process

In order to interpret and synthesize the key informant and field survey findings, six individuals from the pool of informants were designated as a final expert panel. The group consisted of a physician, a psychiatrist, a psychologist, and three paraprofessionals. All were Mexican Americans. They were screened using a modified Delphi panel process that facilitated ordering highly competitive recommendations.

The group identified 32 design criteria for planning any mental health system to serve the farmworker population. The results of this panel process can be seen in Table 3.

The overriding concern of the panel was to integrate mental health services into primary health care in order to provide continuity of care, and to do so within the framework of fully bicultural and bilingual programming (including staffing and administration). The primary care physician was seen as a leader in providing services to the Mexican-American community, however, the panel recognized that physicians can not work in isolation, but must have access to a support team in order to deal with the mental health needs of that community. There was also a belief that existing community resources should be integrated into any program serving the farmworkers.

DISCUSSION AND RECOMMENDATIONS

In their survey of beliefs and attitudes toward mental disorders in east Los Angeles, Karno and Edgerton[18] found that unacculturated Mexican Americans who are exclusively or predominantly Spanish speaking (like non-Mexican Americans from rural and small-town backgrounds) are much more likely than urban non-Mexican Americans and acculturated Mexican Americans to believe in the heredibility of mental illness and to identify the symptoms of depression as representing illness. Karno and Edgerton proposed that such conservative folk beliefs are actually more congruent with emerging biomedical understanding and pharmacologic treatment of mental disorders than the formerly dominant psychological concepts that were considered more "sophisticated." Other findings from their study also support the appropriateness

Table 3. Design criteria for rural farmworker mental health services

Average rating	Criteria	Average rating	Criteria
10	Bilingual, biculturally and culturally sensitive staff	8	Emphasis on family approach to treatment
10	Incorporation of bilingual bicultural perspectives into professional training	8	Strong educational component for professionals and farmworkers; mental health promotion, education about cultural values, use of media
9.4	Team care of the patient	7.8	Career development for farmworkers both adults and children
9.2	Primary care physicians who are sensitive to mental diagnosis and treatment	7.8	Ongoing training for community workers in diagnosing and referring mental health problems
9	Available on nights and weekends	7.8	Ties to non-health-related farmworker organizations
9	Knowledge of and sensitivity to farmworker problems, including occupational stress	7.8	Ability to communicate
9	Low cost, high quality	7.8	Appropriate training for professions, students, and in-service.
9	Services provided through and with established community organizations that work with farmworkers.	7.6	Ability to deal with nontraditional mental health areas, e.g., jobs, housing
8.8	Located in multiservice center	7.6	Priorities among other programs for health and mental health services for farmworkers.
8.8	Outreach component, use of Spanish media in the home and in the educational system.	7.4	Twenty-four hour, seven day per week hotline
8.8	Ability to deal with alcohol problems and domestic violence.	7.4	Programs for adolescent children of farmworkers.
8.4	Counseling available to families of patients.	7	Financial reimbursement for education prevention/counseling services
8.4	Accessible to the farmworker community, available either in the community or easy transportation access, farmworker awareness of services.	6.8	Research on cost effectiveness of different interventions and placing these in the service to be provided.
8.2	Paraprofessional staff who are bilingual/bicultural, drawn from the community	6.6	Research on farmworker mental health.
8.2	Uses of existing community resources; churches, family services.	5.4	Records system, simplified intake, privacy, and confidentiality; explanation of process, file development.
8.2	Community input and control of administration; bilingual and binational administrators.		
8	Gender parity in staff		

of the general health care setting for providing mental health services to rural, low-income Mexican Americans. In their study, Mexican-American respondents, predominantly from rural and small-town backgrounds actually made more regular use of general physicians than did non–Mexican Americans of comparable socioeconomic status from the same community. Karno and Edgerton also report a very high degree of trust and confidence in physicians for both general and mental health care, and the use of general physicians more than any other resource for first-line mental health care.[17] The findings from our needs assessment study support these conclusions.

A major impediment to an integrated system of health and mental health care is the communication barrier between rural Mexican-American patients and their physicians and other general health care providers. Although a specific model for overcoming such barriers is described for a physician group serving Mexican Americans in rural Washington,[18] American medical education gives relatively little preparation in effective crosscultural medical practice or the skilled use of psychiatry in general medical care. Strong leadership is required to incorporate both sociocultural sensitivity and psychiatric knowledge into training programs in the health care disciplines. Even greater wisdom and effort is required to assure that socially marginal groups such as rural Mexican Americans receive more, rather than less, mental health care through an integrated health care system.

One central feature of the current situation is the lack of interest in and awareness of the problem by health authorities charged with the responsibility of providing publicly funded mental health services. This indicates the importance of designing an alternative system where the locus of control resides within structures that are more likely to be responsive to the needs of the farmworker population. His-

torically demonstrated and confirmed in our assessments, rural Mexican Americans will not use mental health services as currently constituted. Our informants mention inaccessibility, stigma, and cost as causes of this situation. On the other hand, our informants are in accord that this population is responsive to health providers and multiservice agencies, and that some type of network linking existing community resources is needed. Underscoring these thoughts is the very consequential role of bilingualism and biculturalism that must pervade all aspects of any delivery system.

Community clinics and private general practitioners who are already in touch with rural Mexican Americans and treating their health and psychological problems could augment and support the mental health services they provide through the use of adjuncts. These adjuncts include nurse practitioners, physicians assistants, and paraprofessionals, who could extend the case finding, referral, and home visitation functions of the primary care provider for clients with psychiatric symptoms and syndromes. Special training is required to familiarize the clinic workers and general practitioners with psychiatric phenomena and various intervention techniques. Adjunct helpers, especially paraprofessionals, are very important since they are more likely to be bilingual and bicultural and from similar socioeconomic and ethnic backgrounds as their clients. Another important role for them would be supporting programs with specific target groups identified in the needs assessment, such as alcoholics, battered spouses (and battering spouses), the recently widowed, young-adult substance abusers, high-risk adolescents, etc.

For very good reasons, a final comment concerning the financing of services is perhaps more likely to dominate the attention of providers. Though funding problems are difficult to discuss in generic terms, some broad points can be made to frame the issue and to offer some suggestions. Public funding mechanisms have usually proven to be too rigid to offer innovative services such as those required for the rural Mexican-American population. Criteria for reimbursement for services and the use of public monies, as well as separating general medical services from mental health services, requires the development of new payment methods to overcome the artificial and quite unrealistic restraints currently imposed. To do so, new criteria for payment eligibility will have to be developed, funding sources integrated, and flexible subcontracting procedures instituted.

Charitable contributions are another important source of revenues for financing mental health services and pilot projects, and they have already an established performance record in this area. Employee health insurance is another important source of support, but would probably be available only to unionized workers. A general plan for insuring migrant workers is currently being developed by a consortium of southwestern states, under the leadership of Dr. Tomas Gonda of California. However, specific attention should be given to the financing of mental health services. Clearly, a broad-based insurance program could be an important improvement over the current situation.

CONCLUSION

With few exceptions, rural Mexican Americans are not being served by the mental health systems of the United States. We used several convergent assessment procedures to determine first the parameters of the problems and then, how mental health providers system could successfully address those problems. These procedures included an epidemiological field survey, a key informant survey, and a nominal group process. Our findings indicated that a substantial proportion of the population are experiencing high levels of psychiatric symptoms (20 percent are in the at-risk range on the HOS), but, despite their considerable use of health services, are not being treated by the mental health system. Some of the major recommendations made by key informants include: the use of bilingual and bicultural mental health professionals; the use of properly trained general practitioners, paraprofessionals, and psychiatric social workers for providing mental health services; the development of innovative intervention methods for providing comprehensive social and medical support and continuity of care.

We used the combined findings from the three needs assessment to make a series of recommendations for improving services to Mexican-American farmworkers, giving special attention to the use of rural primary health clinics as the loci of services and specially trained adjunct helpers for outreach to the target population. Recognizing the current crisis in funding human services programs and the powerlessness of the farmworkers to lobby in their own behalf, we make recommendations in this paper that can be approached incrementally and that involve new applications of extant human resources.

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