D R A F T

A PERSPECTIVE - MIGRANT FARMWORKERS AND MENTAL HEALTH

Mental Health Mental Retardation services since their inception to the present time are unrelated to migrant needs. Even though mental health institutions and the universities prepare practicing psychiatrists and psychologists, special education personnel, to resolve complicated physical and emotional disorders in middle American society, the question remains how and when will migrant farmworkers receive the mental health special education care provided by federal and state government. The answer might be, that the poor are already being served by mental health and mental retardation centers. The ability of rural poor and especially the transient migrant farmworker to receive mental health services is unheard of. Mental health and special education goals and objectives are somewhat provincial in the sense that no real growth has taken place for rural America.

There are one-hundred twenty migrant health clinica funded by H.E.W. for thirty (30) million dollars in 1977 scattered throughout the United States. Its national office in Rockville, Maryland has yet to act or recognize prenatal health needs for migrants. These migrant clinics concentrate on the physical care of the patients such as with upper respiratory diseases, skin diseases, pesticide exposure, malnutrition and post natal care of child rearing females. Mental health care for migrants has never been given consideration or time by the migrant clinics or any other medical system in the United States.

A severe and serious barrier separates the mental health systems and migrant farmworkers. The cultural difference between the dominant anglo

value system and the ethnically different migrant life style adds a dimension of remoteness for migrants. The sensitivity and recognition of these subtle cultural differences plays a critical role in applying middle-class mental health approaches to migrant individuals. The mental helath and special education institutions must then clearly realize the existence of these social gaps and its overtones accompanying inherent cultural differences.

Following are some key questions which will have to be answered and dealt with when and if a mental health and special education system establishes a delivery structure for rural poor and migrant farmworkers:

--Is the ethnically different migrant family background (as nucleus) included in the treatment?

--How can the language barrier between client and mental health staff be bridged? The ability to communicate inner-most thoughts conceptualize and interpret the subtle inexplicable cues in dealing with a migrant client.

--cultural and social alientation

--geographic separation of service facilities and migrant neighborhoods.

Birth defects are higher among children born to poor and consequently migrant females belonging to this group lacking the proper nutritional diets, pre-post natal medical care, well-baby counseling and other preventive measures. It is no surprise that early migrant childhood development stages bypass the attention and care of some health delivery agents. Also, the lack of educational forces retards and may delay the development of a migrant child in the school system. It is unfortunately

common that this child is labeled a "slow learner" or some other euphemism. Thus the individual creates a negative image of herself/himself and almost is destined to stay in the same income and social level as did his/her forefathers. The aforementioned trends have followed many of the migrant families for generations.

Rural residents are not aware of mental health services available to them nor the concepts of good mental health. Traditional mental health systems in the past and present have not reached the rural poor and migrant population. How then do we move, not necessarily the physical mental health facility but its service close to the migrant farmworkers residential areas. Outreach capabilities with a team of specialists can be transported to a centrally located site, unfolding their network to identify those in need of mental health care. Formalizing such a system would bring additional rural community mental health centers' staff with a team of a psychiatrist, psychologist, psychiatrist nurse, social workers and mental health aides. The present mentality of an urban and centralized mental health center undoubtedly will necessitate alteration to fit the unpopulated county area and migrant sectors. Finding the migrant or rural poor client instead of the client locating the mental health center should become the practice and not the exception.

By the nature of migrants' work, constantly found in transient, uprooted from the homebase state and other social factors associated with agriculture labor, an element of deviance crops out from the social strata. Migrant farmworkers spending 2-3 months in the northern states are essentially seen by the community as a lower class lacking the sophistication in today's highly mechanized labor market. But more so

is the migrant life style regarded as ineffectual in coping with the social milieu. All these so-called different ways are cultivated back into the thinking of a migrant family therefore reinforcing a belief that something in the framework of the migrant individual is wrong. The fact that they are poor has greater impact on the migrant individual to experience the depression, unworthiness and all the trauma associated in creating unstable families. Tragically, migrants as any other lower social income group undergo the same vicious circle that links chronic mental and physical illness with the underprivileged.

Mental health institutions are urged to recruit Mexican-Americans into their field. Another recommendation is to increase rural community mental health centers and requiring counties having a sizeable number of migrants to make mental health services available. Organizations wanting to expand into mental health could request that state mental health departments set aside state matching funds, increase screening process for mental health cases, initiate referral systems between migrant health clinics and mental health centers, finance mental health care through private or third-party health insurances. These are but a few ideas that might serve as an embryonic model touching and helping migrant family members who have always been left alone to cure their own growing pains in a society insensitive to them.