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COMMUNITY MENTAL HEALTH SERVICES FOR LATINOS AND LATINAS IN THE RURAL U.S.

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RESUMEN
El aumento de la población Latina rural en EEUU representa un reto para la provisión de servicios de salud mental adecuados. Barreras de acceso como el aislamiento geográfico, limitaciones en el transporte público, escasez de proveedores/as de servicios y su limitada competencia cultural son particularmente marcadas. La psicología comunitaria puede hacer contribuciones significativas para resolver este grave problema de salud pública. En este artículo, nos basamos en nuestra experiencia investigativa y de extensión con inmigrantes Latinos y Latinas en áreas rurales de la región centro-occidental de los EEUU para ilustrar percepciones sobre su situación de salud mental y su necesidad de servicios. También hacemos recomendaciones acerca de los cambios necesarios para aumentar la capacidad técnica de provisión de servicios en salud mental que respondan a las necesidades de esta población. Esto incluye el desarrollo de nuevos programas para responder a las prioridades comunitarias, el entrenamiento de promotores de salud o enlaces comunitarios para facilitar el acceso y la navegación en el sistema de salud, y realizar abogacía.

Palabras clave:
Inmigrantes Latinos y Latinas, condiciones y servicios de salud mental, región central de los Estados Unidos, psicología comunitaria

ABSTRACT
Rapid Latino and Latina population growth in rural U.S. has challenged the provision of adequate mental health services. In these areas, access barriers—geographic isolation, the lack of public transportation systems, the shortage of health care providers and their limited cultural competence—are particularly serious. Community psychology can make significant contributions to address this major public health issue. In this article, we draw on our research and outreach experience with Latino and Latina immigrants in the rural Midwest to illustrate this population's perceived mental health status and service needs. We also provide some possible strategies for bridging gaps and make recommendations regarding much needed changes to augment the technical capacity to serve Latinos and Latinas' mental health needs in rural areas. These include developing new programs around community priorities, training promotores/as or community liaisons to facilitate access to and navigation into the health care system, and engaging in advocacy.

Keywords:
Latino and Latina immigrants, mental health status and service needs, U.S. rural Midwest, community psychology

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The Latino and Latina population is rapidly growing in rural areas of the U.S. (Fry, 2008; Kandel, & Cromartie, 2004). This phenomenon has challenged the provision of adequate mental health services to this population (Betancourt & Fuentes, 2001) particularly in those non-metropolitan counties (79%) that have been designated as mental health professional shortage areas (MH-HPSAs). Even though the reported incidence of mental health disorders in rural and urban areas does not significantly differ (Kessler et al., 1994; Philbrick, Connelly, & Wofford, 1996), access barriers such as geographic isolation, limited information, high cost of mental health services, limited public transportation, and the shortage of bilingual health care providers may negatively impact rural Latinos and Latinas mental health (Gamm, Hutchinson, Dabney, & Dorsey, 2003; Mueller, Ortega, Parker, Patil, & Askenazi, 1999; Murray & Keller, 1991; Ricketts, 1999; U.S. Department of Health and Human Services [DHHS], 1999, 2001). Furthermore, research suggests that current mental health infrastructures are both insufficient and inadequate to meet Latino and Latina population needs (Atdjian & Vega, 2005; López, 2002; Sentell, Shumway, & Snowden, 2007; Stroul & Blau, 2008; Vega & López, 2001; DHHS, 2001, 2003).

In this paper, we draw on our research and outreach experience with Latino and Latina immigrants in the Midwest to illustrate the gaps between this population's mental health needs and the available resources. We also provide some possible strategies for bridging those gaps, and make community-based recommendations regarding needed changes to augment the technical capacity to serve Latinos and Latinas in rural areas.

Rural and rural Latino mental health issues

Several studies have pointed out that rural populations suffer from poorer mental health than their urban counterparts. For example, rural children have significantly higher rates of mental health problems and are more likely to have behavioral problems than urban children (Lenardson, Ziller, Lambert, Race, & Yousefian, 2010). Also, specific mental health issues such as depression, domestic violence, child abuse, substance abuse and suicide are commonly found among rural residents (Bushy, 1993; Cantrell, Valley-Gray, & Cash, 2012; Cellucci & Vik, 2001; Lenardson, Hartley, Gale, & Pearson, 2012). Unfortunately, the mental health of rural residents is affected by the availability, accessibility and acceptability of rural mental health services (Human & Wasem, 1991). According to these authors, availability refers to the existence or not of mental health services and the personnel necessary to provide them. Accessibility refers to the individual person's ability to access those services including costs, insurance, transportation, and so on. Acceptability refers to the extent to which services offered are adapted to local values, cultural norms, lifestyle, and so forth.

Mental health information of rural Latino and Latina immigrants is quite scarce in part due to the barriers cited above but also to additional language and social issues. For example, some studies suggest that perceived discrimination and acculturative stress are related to psychological distress among this population (Torres, Driscoll, & Voell, 2012). In our own observation, additional issues such as language barriers, documentation and immigration status, separation from family members and significant others from the country of origin, and unstable labor conditions may contribute to feelings of anxiety, hopelessness, depression and alcohol abuse. These same issues may further hinder their access to mental health services.

The implications of this situation are serious. Often, the mental health care system remains unresponsive until situations escalate to violence, substance abuse, or other serious family disruptions (Klostermann & Kelley, 2009). Therefore, the need to focus additional attention and resources on minority rural mental health, in general, and on Latino/Latina rural mental health should be prioritized.

The role of community psychology

Due to community psychology's focus on working with communities in order to strengthen their capacity to control social and environmental factors that affect their well-being (Montero, 2004), it may significantly contribute to address this major public health issue. Community psychology research on

Latino and Latina immigrants´ mental health is a field of growing interest. However, published studies are relatively scarce. A few exceptions include studies about the impact of Latino and Latina day laborers' work and life conditions on their mental health (Negi, 2013); about approaches to treating adolescent drug abuse and related problem behaviors (Szapocznik, Schwartz, Muir, & Brown, 2012); about violence prevention (Guerra & Knox, 2008); and about the networks of relations between immigrant populations and the host communities (Domínguez & Maya-Jariego, 2008). Even though these studies have various methodological perspectives, they share a genuine interest in involving community members throughout the research process and in generating or advocating for immediate social transformations at the local level.

Mental health concept: Transcending boundaries

Even though it is not the main purpose of this manuscript to furnish a definition of mental health, we believe that research related to this topic should be based on an appropriate and culturally-relevant understanding of the core concept. The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2001, p.1). This definition encompasses three main mental health components: individual well-being and its awareness, coping ability, and productivity as judged by the immediate community context.

The U.S. Surgeon General's definition adds a social-relational dimension to the concept stating it as the "successful performance of the basic abilities required for normal daily functioning in one's context, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity" (DHHS, 1999, p. 4). Taking into consideration Latinos and Latinas´ cultural orientation towards collectivism (Triandis, 1994) and their resulting conceptions of the self as "interdependent" (Markus & Kitayama, 1991) the social-relational dimension gains special relevance. Furthermore, our experience with rural Latino and Latina populations in the U.S. Midwest suggests that their definition of mental health includes a strong sense of spirituality that is neither explicitly defined in the WHO nor in the U.S. Surgeon General´s definitions.

Based on these definitions, Latino and Latina mental health service improvement efforts should aim at setting the ground for positive psychological development in key areas. These include self-awareness, coping ability, occupational capacity, community ownership, social relations, and spiritual connectedness. This article focuses on identifying what are the major mental health issues of Latinos and Latinas in rural areas of the U.S. and proposed community-based initiatives to address them.

Methods

We used participatory and community-based approaches, which allowed communities to be actively involved in identifying and addressing priority mental health concerns, and empowered community leaders and organizations throughout the research process (Casey, Blewett, & Call, 2004). Specifically, we used an approach we and other scholars (Hills, Mullett, & Carroll, 2007) have named Community-Based Participatory Action Research (CBPAR). CBPAR borrows from Participatory Action Research –PAR– through its commitment to social transformation using research, community engagement, and communicative action (Fals-Borda, 1987; Habermas, 1984; Lewin, 1946). It also draws on Community-Based Participatory Research –CBPR– given that the research is grounded in a social justice agenda, exhibits scientific rigor, involves diverse partnerships, and focuses on an ecological model of health (Israel, Eng, Schulz, & Parker, 2005; Israel, Schulz, Parker, Becker, Allen, & Guzmán, 2003). This type of approach has proved useful for addressing health disparities in minority populations (Wallerstein & Duran, 2006).

CBPAR is methodologically congruent with the social transformation ethics that informs community psychology as a discipline (Montero, 2004) and also embraces the five guiding principles of community psychology research as stated by Dalton, Elias, and Wandersman (2001): (1) community research is guided by community needs and interests; (2) research is an exchange of resources between

researchers and the community in which they are working; (3) research is a tool for influencing political decision-making; (4) research should be conducted to evaluate community decisions, programs and policies; and (5) research needs to produce products that meet the information needs of communities for decision-making and communicate research findings to a variety of audiences and not only to academics.

Our research team defined the CBPAR process as consisting of five somewhat overlapping phases: (1) partnership formation; (2) assessment; (3) implementation; (4) evaluation; and (5) dissemination. Partnerships were formed in each participating community with key people interested in improving their community's health and mental health status. Through their participation in all research phases (definition of the research topic, objectives, methods, participation in data collection and analyses, dissemination of findings, implementation of actions, and evaluation) they built their capacity to conduct community mental health research in the future. The assessment included a variety of methods for data collection including surveys, small group discussions and focus groups that were analyzed quantitatively and qualitatively with community members. Results were used to develop community mini-grants funded by various sources including the university that led the process, some local agencies and federal research funding. Each mini-grant was aimed at addressing each community's priority mental health concerns. Such mini-grants were implemented and evaluated using a participatory evaluation approach. Dissemination occurred throughout all project phases and included the development of culturally sensitive materials and educational approaches. These various phases are iterative, suggesting that several cycles are needed to build community capacity around a certain issue.

Under this main CBPAR framework, now we present the specific methods we used during the assessment phase in three related studies. We report research results from various studies in order to avoid data fragmentation and in order to have a broader perspective on the topic we studied.

EXPORT[2] *study*

The assessment consisted of 19 focus groups (n=181) and a community health survey (n=894) developed by the academic research team with feedback from communities that was applied to Latino and Latina adults living in one of the six non-metropolitan counties studied in northern, central and southern Illinois. Participants were recruited with the help of Hispanic Health Advisory Committees (HHACs) that were formed as part of this project. A convenience sampling strategy was used due to the absence of accurate baseline information about the Latino and Latina population in these counties, cultural appropriateness and budget limitations. Data analyses for the focus groups were carried out following a grounded theory approach, identifying emerging themes from raw data. Survey data analyses were descriptive.

"Mentes Sanas, Cuerpos Sanos" study

The assessment was done through 10 small group discussions (n=129) and a 153-item community survey (n=195) that was developed by the academic research team to assess self-perceived mental health and chronic disease status among Latino and Latina adults living in one of the five rural counties in northern, western and southern Illinois that participated in the study. Recruitment was done with the help of HHACs using a convenience sampling strategy and data was gathered in community friendly spaces such as schools, churches and Latino/Latina Community Based Organizations. Snacks and childcare were provided to participants as well as educational activities in Spanish around mental health and chronic disease. Small group discussions data were analyzed using a grounded approach and survey data were analyzed descriptively as well.

Acculturation and cardiovascular disease (CVD) study

The assessment was done through a 57-item community survey (n=273) that was developed in part by the academic research team to assess acculturation (Zea, Asner-Self, Birman, & Buki, 2003) and self-reported CVD risk factors such as smoking, stress, nutritional habits and physical activity. Also,

[2] EXPORT stands for Centers of Excellence in Partnerships for Community Outreach, Research on Health Disparities and Training. These centers were funded through the EXPORT Program by the National Center on Minority Health and Health Disparities (NCMHD), one of the National Institutes of Health (NIH).

CVD measures (BMI and BP) were taken to survey participants. Participants were recruited using two different strategies: (a) Local HHACs and affiliated community organizations from four northern Illinois communities that had identified CVD as a priority health concern in the EXPORT study; (b) University primary care clinics with the highest number of Hispanic patients and bilingual providers in the researched area. Participants received snacks, childcare, individual CVD risk reports based on the Framingham Scale, and a CVD prevention talk in Spanish. Data analyses were descriptive.

All community engagement and recruitment strategies as well as the appropriateness of language use, informed consent and generational considerations of the three studies were agreed upon with the participating communities and received university IRB approval.

Results and Discussion

Due to space limitations, this paper briefly summarizes results of the assessment, implementation and evaluation phases.

Assessment phase: Key findings

The CBPAR assessment phase uncovered a troubling picture, in which residents have great mental health service needs, yet have little access to services in a context ill prepared to meet their needs. The key findings associated with the need for improving access and quality of mental health services from the three studies are briefly summarized as follows:

The majority (52%) of immigrant Latinos and Latinas surveyed in the EXPORT study did not have health insurance. Those who had been in the U.S. for less than five years represented a high proportion of the uninsured (72%). Longer residency in the U.S. increased the likelihood that individuals would have some type of health insurance more than twofold. Regarding their self-reported mental health conditions, the *"Mentes Sanas, Cuerpos Sanos"* survey participants reported greater concern about problems with depression (26%), stress (17%), and anxiety (9%) than with physical conditions such as obesity (8%), diabetes (6%), and cancer (5%). Similarly, they reported suffering from mental problems more often than from physical problems. The majority of them (55%) reported experiencing depression or another emotional problem during the past 30 days. This proportion differed as a function of length of residence in the U.S., with the highest prevalence among those who had lived in the country for less than five years (76%), followed by those who had lived there between five and 10 years (51%), and those who had lived there for more than 10 ten years (50%). Also, compared to men, women reported a lower quality of life, more days with mental and physical health problems, and more sleepless nights. Moreover, small group discussions made evident that as length of U.S. residence increased, so did perceptions of social support from trusted others, close friends, and relatives in the community.

These findings were consistent with and expanded findings from previous studies about health services provision in the same population. For example, Cristancho, Garcés, Peters, and Mueller (2008) found that there is a severe shortage of Spanish-speaking health and mental health providers; furthermore, those who do serve Latinos and Latinas have limited capacity to understand their cultural beliefs and backgrounds. Moreover, there is an alarming lack of interpreters to facilitate patients' communication with English-speaking monolingual providers. Also, Cristancho, Peters, and Garcés (2014) found that rural Latinos and Latinas reported a preference for workshops in Spanish in community settings such as schools and faith-based organizations to obtain health information. A preference for mailed printed materials increased in the second generation, that is, U.S.-born Latinos whose parents were immigrants in the U.S.

Implementation phase

During the implementation phase, community groups analyzed survey, focus groups and small group discussion assessment data, identified main findings, and developed implementation strategies to address their priority mental health service needs (see Table 1). As a result they implemented those strategies with the research team assistance and the project budgetary support. Given the stipulations of a

small grant we had obtained from the CDC/NACDD, the budget for each of the five communities was $5,000, with a one-year implementation period.

Table 1
Community Assessment Findings and Corresponding Implementation Strategies

Community	Assessment Findings	Implementation Strategies
Community A	• High levels of stress, anxiety, depression, and loneliness • Difficulties in family life in United States and distance from social support in home country • Economic pressures due to job loss	• Created speaker series on depression and stress • Sponsored sports leagues • Offered social support groups (gender specific) • Developed health resource directory/newsletter • Offered social activities promoting physical activity through walking clubs
Community B	• Feelings of isolation due to legal status issues and family separation • Language barriers between Latinos and mental health care providers • Lack of health knowledge	• Offered social/recreational activities • Offered classes at the multicultural center (language, cooking, computers) • Offered health fair
Community C	• Concern with mental health issues, obesity, and dental problems • Legal issues • Limited or inadequate medical interpretation • Lack of support groups	• Established social clubs • Sponsored community workshops
Community D	• High levels of stress, loneliness, insomnia, depression, and domestic violence • Discrimination and lack of self-esteem • Lack of community resources	• Provided bilingual counseling services • Sponsored workshops on depression, stress, and anxiety
Community E	• High levels of depression, stress, loneliness, and fear • Concern about substance abuse and violence • Lack of location for activities	• Organized Family Nights at local community center • Sponsored workshops • Sponsored sports leagues

As indicated in Table 1, there are similarities and differences in the way communities addressed their needs. The strategies addressed a wide range of issues. For example, some communities created a speaker series where Latino and Latina health professionals addressed mental health topics and provided the community with a forum to ask questions. Other counties established social clubs based on age groupings to increase the community's involvement in activities that promote mental health and well-being, provided vouchers for exercise and fitness facilities, sponsored "family nights" with movies and family-friendly activities in a local community center, and provided bilingual mental health counseling services at a local community facility free of charge. In our experience, mental health topics prioritized by rural Latino and Latina communities for educational workshops included parenting advice (e.g., cultural norms, substance abuse, cultural identity, academic performance, adolescent sexuality), cultural adaptation, adult sexuality, stress, anxiety (e.g., PTSD as a result of traumatic events in the home country or of the immigration process), and depression (seasonal depression was particularly relevant in the winter months).

In our research, we noted that mental health promoters helped serve as liaisons between the partnerships and community members, and also acted as mental health educators. To avoid the negative stereotyping associated with the concept of mental health, we suggest calling these persons "*promotores/as de bienestar*" (which literally translates to "promoters of well-being"). Moreover, our research communities succeeded in developing community-based mental health infrastructure and created a coalition known as the *Alianza [Alliance]*. Members of the *Alianza*, in collaboration with the research team, shared their experiences with federal government agencies and other local and state venues, and they advocated for the local development of infrastructure to facilitate the delivery of services. The lack of an existing transportation infrastructure generated particular concern among the *Alianza*. The resolution of transportation barriers remains critical in the development of infrastructures that address mental health and health care needs of rural populations.

Taken together, the assessment data and implementation experiences of the communities involved underscore the need to conceptualize rural Latinos and Latinas mental health as a complex and multifaceted construct: (a) encompassing both positive and negative dimensions, (b) having various social determinants, (c) involving not only individuals but also their unique social environment (e.g., family, community), (d) being context-dependent, and (e) being inclusive of acculturation processes. For example, Community B (see Table 1) prioritized services to address social isolation because many of its members suffered from family separation, language barriers, and legal status issues. They also prioritized lifestyle issues, including diet, exercise, and sleep. Based on this prioritization, they proposed an action plan that included social/recreational activities, classes in the multicultural center (e.g. cooking, swimming, martial arts, nutrition, legal issues) and a community health fair. They used mini-grant resources to provide incentives to community members to attend the activities (e.g., monthly gift cards) and to pay for two *promotores/as de bienestar* who helped recruit community participants and implement the exercise component. As a result, 20 people (10 adults and 10 children) are exercising regularly at local recreation facilities. They also paid for 200 copies of an exercise brochure and a community newsletter. Finally, they paid for health education activities, including workshops on depression and immigrant legal issues. The variety of actions implemented by this community highlight the importance of developing mental health infrastructure for rural Latinos and Latinas based on a multifaceted definition of mental health.

Evaluation phase

Our evaluation showed that the programming implemented in the five participating communities was very effective in addressing basic mental health infrastructure needs among local Latino and Latina community members, despite the limited budget we had at our disposal. For example, local health committee members emphasized community empowerment to provide services and public participation in such programs stating: "*We can provide services to the community and the opportunity to receive professional help with mental health problems*"; and "*Youth leaders participated freely and with great enthusiasm, kids, teens and elderly participants.*"

Recommendations for service improvements

We draw on our results about perceived mental health status and the community-based initiatives as well as on our direct experience working with rural Latino and Latina immigrants in order to provide some basic recommendations mostly aimed at public health agencies and service providers. Given the complex and multifaceted nature of mental health as a construct and the many mental health issues faced by rural Latino and Latina communities, we advocate for strengthening the provision of services along a prevention-oriented continuum. Consistent with the Institute of Medicine (IOM), we conceptualize prevention for the mental health field in terms of three core activities: prevention, treatment, and maintenance (IOM, 1994). Broadly, *prevention* is aimed at avoiding the onset of mental health problems, whereas treatment and maintenance are aimed at minimizing their impact at the individual, family, and community levels. As a result, *prevention* should encompass mental health promotion and education, patient navigation services, and effective patient-provider communication strategies. *Treatment* and *maintenance* should include a focus on inpatient and outpatient treatment services and the coordination of mental health care plans and systems for follow-up. In addition, part of the infrastructure to support the provision of these activities requires attention to *program administrative* elements, including ongoing service evaluation, dissemination of program or treatment options, advocacy for mental health awareness raising, and access to treatment and competent care. In the remainder of this section, we provide recommendations organized by prevention levels.

Prevention activities

We urge the development of new programs and the tailoring of existing programs to reflect the priorities of the particular communities, as indicated by community-focused assessments. Current mental health promotion and patient education efforts assume that Latinos and Latinas have high levels of health literacy and reflect a preference for printed materials and other impersonal strategies. In most cases, these printed materials are just a literal translation of those available to the majority population, and thus fail to influence Latinos and Latinas. The absence of basic prevention-oriented services through community-level mental health promotion and educational outreach warrants attention. However, offering these services requires access to bilingual and bicultural mental health professionals, or at least to qualified interpreters, as well as extensive outreach efforts. To implement these services, we recommend hiring a coordinator (to handle recruitment, logistics, etc.) and Spanish-speaking (and ideally also bicultural) mental health professionals (e.g., psychologists, counselors, social workers, nurses, educators).

The sites where these activities are held should be Latino-friendly, with culturally sensitive staff; ideally, the physical environment would recreate Latinos and Latinas' favorite decoration patterns, music, videos, and other elements, thus developing a sense of identity and ownership. For example, there should always be Spanish-speaking staff available to Latino and Latina patients in the reception area. Bilingual signage would help guide the rural Latino and Latina consumer within the facility. Institutional waiting rooms may provide mental health promotion materials in Spanish other than printed materials; these might include videos or other interactive strategies to present mental health promotion information. Offering a means for transportation to community activities is highly desirable, as distance from the workplace or home to community sites may be a barrier to accessing these services in rural contexts.

Facilities within the existing infrastructure (e.g., clinics, schools) should broaden their activities and collaborate with other organizations to meet mutually compatible goals. For example, health care clinics could meet the interests of schools by promoting early childhood literacy and giving parents and children books (Butera, McMullen, & Phillips, 2000; Willis, Kabler-Babbitt, & Zuckerman, 2007). Likewise, schools could offer physical space for satellite clinics for health screenings for parents and tailored health promotion materials for both children and their parents. By sharing resources across physical spaces and coordinating services through enhanced communication systems (Leisey, 2009), a rural infrastructure could be developed to better serve the community. Because of language barriers and the shortage of bilingual providers, such coordination is essential in assisting Latino and Latina immigrants who live in rural parts of the country (Partida, 2007).

Treatment and maintenance activities

Health care organizations should supplement their current outreach strategies by recruiting, hiring, and training promotores/as or community liaisons who could assist rural Latinos and Latinas to access the local resources that are available to them and help them navigate the U.S. mental health care system. Such a remedy would go far in helping rural Latinos and Latinas acquire a basic understanding of the health and mental health care system, especially given the alarming scarcity of bilingual health and mental personnel. Therefore, efforts must prioritize making navigation services more readily available to this population.

We propose the name of "*promotores/as de bienestar*" (well-being promoters) for peer community workers (Arcury & Quandt, 2007; Rhodes, Foley, Zometa, & Bloom, 2007; Swider, 2002). *Promotores/as* can go door-to-door in Latino and Latina neighborhoods to assess each household's specific needs and offer resources to address their needs. They can also offer advice to community members on issues such as basic health rights, transportation, insurance, access to psychotherapy and medications, support groups, and referral and translation services. Based on their knowledge of the mental health care system and of the local social service institutions, *promotores/as* can advocate for patients who have had difficulties accessing mental health care or promotion services. They can also develop access plans, disseminate maps to the local mental health care facilities, and deliver educational workshops to community members regarding how to access these resources. Finally, a strategy that we think might help with the navigation component is to provide Hispanic community-based organizations (HCBOs) and mental health care providers with support through small mini-grants to develop these access and navigation plans and their related resources, as we have done in the upper Midwest.

Program administration

Engage in advocacy at the policy level to increase funding for, and awareness of, mental health risks of and treatment options for rural Latinos and Latinas. Policy advocacy is essential for mental health service development in rural areas. Community organizations should engage in advocacy at local, state, and national levels to promote culturally-sensitive mental health services. For example, advocating for linkages that bridge service sectors is essential to improve the delivery of health and mental health services (Probst, Moore, Glover, & Samuels, 2004). Among these linkages, we recommend the creation of satellite clinics in schools and churches and the use of mobile units, to increase the number of service entry points and facilitate triage of less serious problems.

In addition, community members themselves can have a powerful voice in advocacy at the policy level. For example, through the *Alianza* coalition, community members have advocated at the local, state, and federal levels for actions such as the creation of public transportation systems and the recruitment of bilingual mental health care providers. They have also applied for larger funding opportunities and exchange experiences and resources to improve and enhance the impact of their local action plans.

Conclusions

The influx of new Latino immigrants to rural areas presents both additional challenges to and exciting possibilities for community psychology today. An effective mental health program for Latinos and Latinas must include a continuum of services for promoting well-being and prevention, and should allow patients to access treatment at multiple sites in the community. Traditionally, mental health service treatment has focused on the individual, without regard for the social determinants that may cause or exacerbate the individual's condition. Creation of effective mental health services for Latino immigrants in rural communities must take into account the social and environmental life circumstances that impinge upon individuals' lives. Through our experiences, we found that the CBPAR approach, which allows the community to be proactive and participate in social change, can effectively diminish the health disparities experienced by rural immigrant Latinos and Latinas. The availability of high-quality services for all community members, including those who newly arrive, is a social justice priority and will be a critical and necessary contribution to the restoration and well-being of rural communities.

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