Guide to

Migratory and Seasonal Agricultural Worker

Mental Health Equity

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This *Guide* provides health center staff with important resources, information, and tools to address the unique mental health needs of their Migratory and Seasonal Agricultural Worker (MSAW) patients. One of the most crucial resources we explore is the active role of Community Health Workers to bridge the gap between MSAWs and clinical care.

Unique Mental Health Needs—Looking Deeper

Overall Mental Health Outcomes

In MHP Salud's *2020-2021 National MSAW Mental Health Survey*, Migrant Health Centers (MHCs) were surveyed to better capture mental health needs of their MSAW patients and to understand how MHCs are addressing those needs (see Appendix for information about survey). MHCs reported a wide variety of mental health issues experienced by MSAWs. **The more commonly reported mental health issues included depression (98.6%), generalized anxiety disorder (85.1%), and substance abuse (82.4%)**, as seen in *Table 1*. These results also align with the top mental health issues found in the general U.S. population, including anxiety (19.1%), depression (7.8%), and substance abuse (3.8%).[1] This indicates that the mental health issues reported here may be more widespread and not specific to the MSAW population.

Additionally, MHCs reported that mental health issues were experienced by specific subpopulations, including women (89.2%) and men (63.5%), followed by children/adolescents (48.6%) and older adults (33.8%). **The difference in reported mental health issues between women and men is notable and may be due to increased stigma among male MSAWs.** Increased mental health stigma can result in male MSAWs being reluctant to receive care resulting in less representation.[2]

[1] https://www.nami.org/mhstats

[2] https://agrilifeextension.tamu.edu/library/health-nutrition/farm-families-and-mental-health/

Risk Factors

MSAWs often experience *unique challenges* related to their living and working environments. These challenges – or risk factors – emerge from economic, educational, social, and environmental factors, known as social determinants of health, that negatively impact access to necessary resources. The very nature of agricultural work often results in physically demanding labor, long hours, harsh environmental conditions, limited sanitation, and low pay.[3]

Additionally, despite migrant labor laws, MSAWs are still targets of poor work conditions, due to their vulnerability and socioeconomic status, such as:

- Limited English language skills
- Limited formal schooling and/or low literacy levels
- Immigration status, such as temporarily working in US or recent immigration to US
- High socioeconomic need for job and wages
- Rural location of migrant camp/work
- Limited transportation options

Working under these conditions often has a *negative impact* on the mental health of MSAWs.[4] Additionally, it is common for MSAWs to *live* under challenging circumstances that can also negatively impact their physical, mental, and emotional wellbeing including:

- Living in a rural or remote location (e.g., migrant camps, temporary housing)
- Migrating to the US without family (isolation)
- Trying to raise a family in migrant camps and/or while working in the fields

In MHP Salud's 2020-2021 *National MSAW Mental Health Survey*, Migrant Health Centers (MHCs) reported that the **top behavioral risk factors experienced by MSAWs were poverty or economic hardship (95.9%), social isolation or limited social support (93.2%), and poor housing conditions (82.4%).** Outside of the risk factors listed in *Table 2*, MHCs that reported "other" stated that food insecurity and stress over immigration status were additional factors.

MHCs also noted that COVID-19 has brought on additional risk factors that affect the mental health of MSAWs. Mental health issues were attributed to many things like the financial impact of unemployment from business closures and fear of losing work due to infection. One respondent mentioned that **stress among MSAWs had been exacerbated by on-site living conditions**, like close living quarters that did not allow for space to socially distance.[5]

[3] http://www.farmworkerjustice.org/wp-content/uploads/2012/05/FarmworkerJusticeDOLenforcementReport2015-1.pdf
[4] http://www.ncfh.org/facts-about-agricultural-workers.html
[5] www.cdc.gov/coronavirus/2019-ncov/community/guidance-agricultural-workers.html

Additionally, **MHCs reported that natural disasters (e.g., hurricanes, wildfires, blizzards) impact the mental health of MSAWs.** Since Hurricane Maria, more research has confirmed the effect of natural disasters on the mental health of the communities impacted.[6] Respondents commonly reported that a loss of work was a contributor of mental health issues. As MSAWs regularly work on farmland, natural disasters can halt operations and destroy crops. For example, a respondent mentioned that a recent hurricane flooded a large portion of farmland, destroying crops and affecting the work of MSAWs in the community. It was noted that natural disasters in other states or countries could also affect the mental health of MSAWs. For example, MHCs mentioned serving MSAWs originally from Puerto Rico who experienced stress while hurricanes impacted their family living in Puerto Rico.

Barriers to Mental Health Care

Many MSAWs do not have access to regular, affordable health care. In fact, findings from the Department of Labor's 2015-2016 National Agricultural Workers Survey (NAWS) reported that only 47% of MSAWs report having *any* form of health insurance/coverage.[7] Moreover, the 2020-2021 *National MSAW Mental Health Survey* found that **more than 58% of MHCs reported that lack of coverage** was a major barrier to care for MSAWs. Other very common barriers to receiving mental health services include (see *Table 3*):

- Concern over losing paid work time/wages
- Mental health stigma
- Lack of transportation

Health practices and beliefs, such as going to the doctor or viewpoints/stigma related to mental health, can vary depending on *where* and *how* someone is raised. As MSAWs migrate to the US (either temporarily or permanently), they also *bring* with them their own health practices and beliefs, which sometimes differs or looks different as they try to navigate the US health care system.[8] This is also why it is crucial to include culturally informed outreach and patient education to remove these barriers to care.

Impact of COVID-19

For many special populations, COVID-19 exposed deep-rooted health disparities that limits access to health care and services. **MHCs reported that COVID-19 has further impeded the access to services among MSAWs.** It was commonly noted that fewer MSAWs were seeking mental health care because of fear of catching COVID-19.

[6] Makwana N. (2019). Disaster and its impact on mental health: A narrative review. *Journal of family medicine and primary care*, *8*(10), 3090–3095. https://doi.org/10.4103/jfmpc.jfmpc_893_19

[7] https://www.dol.gov/sites/dolgov/files/ETA/naws/pdfs/NAWS_Research_Report_13.pdf

[8] http://www.ncfh.org/mental-health.html

Although telehealth and virtual care helped bridge the gap for many during COVID-19, **this was often not the case for MSAWs, as many lacked access to required technology**. Overall, findings from the 2020-2021 *National MSAW Mental Health Survey* **strongly suggested that culturally tailored outreach is needed** to educate MSAW communities on general mental health services, as well as COVID-19.[9]

However, national efforts to address the unique mental health needs of MSAWs remain low. In this *Guide*, we take a deeper dive into:

- Tools/resources many health centers already utilize to address mental health disparities of MSAW patients;
- Additional/news resources, including culturally-informed resources, to address these mental health inequities;
- Role of Community Health Workers in bridging the gap between health services and MSAW communities.

Best Practices—Tools and Resources

What is already being done?

The most common strategies used by health centers to address the mental health needs of MSAWs include **providing translation services (85.1%), telehealth (83.8%), and referrals to mental health services (87.8%),** as seen in *Table 4*. Additionally, screening for specific mental health issues among the MSAW population is reported as a valuable strategy for addressing mental health needs. One common example of a screening tool is the **Patient Health Questionnaire-9 (PHQ-9).** The PHQ-9 is a 9-question instrument given to patients in a primary care setting to screen for the presence and severity of depression. In MHP Salud's 2020-2021 *National MSAW Mental Health Survey*, **94.6% of MHC respondents** reported utilizing PHQ-9 to screen for depression among MSAWs.

Additionally, Migrant Health Centers (MHCs) indicated that the **staff most commonly providing mental health services to MSAWs included social workers (68.9%), physicians (55.4%), and advance practice nurses or physician assistants (54.1%),** as seen in *Table 5*. Of respondents that indicated "other," common staff members mentioned included peer support specialists and licensed mental health counselors. These results may

[9] This was also extensively mentioned in MHP Salud's *MSAW Mental Health Learning Collaborative* that ran from March-April 2021, further demonstrating the high need for these types of resources.

be due to the availability of these staff members in MHCs. For example, **when examining health centers nationally, social workers are the most common mental health staff type.** Additionally, physicians and nurses are common staff/practitioners, and traditionally the main point of contact for mental health services.[10]

However, there is **a growing need, and desire, to employ health center staff who have the skillset to more effectively deliver culturally-informed outreach, education, and care**, especially resources to assist in addressing the mental health of MSAWs.[11,12] For instance, while Community Health Workers were reported to be utilized by *only* 23.0% of MHCs, they have been shown as a useful workforce to address the needs of MSAWs.[13,14]

Integrating Community Health Workers

Community Health Workers (CHWs) are trusted members of the community they serve. CHWs are widely known to improve the health of their communities by linking their neighbors to health and social services. They mobilize their communities to create change by educating their peers about disease and injury prevention. CHWs meet participants where they are – at home, at work, or out in the community – to better reach and meet their unique needs.[15]

CHWs can *effectively* communicate and connect with MSAWs' cultural norms, due to shared culture, language, and identity. CHWs are equipped to provide community-based, health-related services, such as assistance with translation, case management, and advocacy. CHWs can assist individuals that may not have access to information and resources either because they live in rural areas or due to their immigration status, language barriers they experience, lack of transportation, and/or knowledge of services. CHWs can provide referrals to local organizations that can assist with legal representation, health care applications, and housing or utility assistance.

CHWs can successfully work in a variety of settings, like hospitals, clinics, community centers, and migrant camps (e.g., out in the field/community). In hospitals or health clinics, CHWs can be integrated into a healthcare team. They work both in this healthcare setting

[10] Health Resources and Services Administration, Bureau of Primary Health Care. 2019 Uniform Data System. Published 2020. https://data.hrsa.gov/tools/data-reporting/special-populations
[11] https://www.migrantclinician.org/blog/2016/may/community-health-workers-essential-link-farmworker-health-care.html
[12] This was also extensively mentioned in MHP Salud's *MSAW Mental Health Learning Collaborative* that ran from March-April 2021, further demonstrating the high need for these types of resources.
[13] https://www.ruralhealthinfo.org/toolkits/community-health-workers/4/adapting-programs
[14] https://mhpsalud.org/la-esperanza-winter-2021/
[15] https://mhpsalud.org/our-chw-initiatives/community-health-workers

and within the community by assisting with the discharge process and serving as the "warm handoff," ensuring that patients understand discharge instructions, follow-up appointments, and general overall wellness information. **This is especially important when working with special communities, like MSAWs, and sensitive health topics, like mental health.**

CHWs can also support follow-up medical appointments and connect individuals to helpful social services that can improve quality of life, including mental health counselors/therapy, support groups, or social workers**. CHWs working in community centers or out in the field can even facilitate support groups among MSAW communities, as well as educational classes on managing common mental health challenges.**

Future Implications—Looking Ahead

Given the rising national interest and investment in CHWs, especially to deliver care on special topics like mental health among MSAWs, this is a crucial area for continued growth, development, and future resources.

For example, MHCs were asked to report additional training and technical assistance (TTA) support that would assist in addressing the mental health needs of MSAWs.[16] The **most reported need was TTA regarding the specific mental health needs of MSAWs, including topics like breaking the mental health stigma among MSAWs and providing transportation.** Additionally, MHCs noted the need for TTA around best practices to address the MSAW mental health needs. Finally, workforce TTA was commonly requested, including guidance on developing a multicultural/bicultural team and providing cultural sensitivity training to equip staff to serve MSAWs.[17]

As nonprofit organizations, like MHP Salud, continue to develop resources and training aimed at addressing mental health disparities among MSAWs, it is essential to center culturally-informed tools and perspective, such as employing CHWs or alike roles, to successfully get at the root of the inequities that MSAW communities face. MHP Salud offers free resources for developing Community Health Workers programs specifically related to mental health, these resources can be accessed here.

[16] 2020-2021 National MSAW Survey

[17] These TTA requests/needs were also mentioned in MHP Salud's *MSAW Mental Health Learning Collaborative* that ran from March-April 2021, further demonstrating the high need for these types of resources.

Appendix 1 - 2020-2021 National MSAW Mental Health Survey Methods

Methods

Information was gathered through an electronic survey distributed nationally to health centers (HCs) that serve the MSAW population. The 13-item survey included multiple-choice and open-ended items focused on the mental health needs of MSAWs served by HCs. Data collection began in December of 2020 and ended in February 2021. A total of 73 HCs completed the survey, representing 31 states with the majority located in California (*n*=9, 29.0%), Florida (*n*=7, 22.6%), and Texas (*n*=6, 19.4%). The most common job titles of respondents were program supervisor (35.1%), administration (13.5%), and social worker (9.5%).

Analysis entailed running frequencies for each multiple-choice response. Additionally, HCs responded to three open-ended questions, covering the effect of COVID-19 and natural disasters on the mental health of MSAWs as well as the training and technical assistance needs of HCs. The analysis involved identifying commonalities across responses representing the perspective of HCs. This information is dispersed throughout the document alongside quantitative findings.

Appendix 2 - 2020-2021 National MSAW Mental Health Survey Data Tables

Table 1: Mental health issues experienced by MSAWs

Mental Health Issue	Percent
Depression	98.6%
Generalized Anxiety Disorder	85.1%
Substance Abuse	82.4%
Post-Traumatic Stress Disorder (PTSD)	73.0%
Social Anxiety	64.9%
Perinatal or Postpartum Depression	45.9%
Suicidal Ideations	45.9%
Attention Deficit Disorder/ Attention-Deficit Hyperactivity Disorder	45.9%
Bipolar Disorder	44.6%
Obsessive-Compulsive Disorder	27.0%
Schizophrenia	27.0%
Eating Disorders (e.g., anorexia, bulimia, binge eating disorder)	24.3%
Borderline Personality Disorder	23.0%
Disruptive Mood Dysregulation Disorder	20.3%
Autism	16.2%
Other	9.5%

Table 2: Risk factors experienced by MSAWs

Risk factor	Percent
Poverty or economic hardship	95.9%
Social isolation or limited social support	93.2%
Poor housing conditions	82.4%
Physical illness	81.1%
Stressful or unsafe working conditions	78.4%
Acculturation (cultural assimilation)	77.0%
Domestic violence or sexual assault	71.6%
Discrimination and harassment	68.9%
Death of a loved one	64.9%
Patterns of mobility	55.4%
Other	8.1%

Table 3: Barriers to receiving mental health services

Barriers	Percent
Concern of losing paid work time	85.1%
Mental health stigma	82.4%
Lack of transport	74.3%
Fear of using health care due to immigration status	73.0%
Lack of knowledge on mental health services	68.9%
Cultural and language barriers	59.5%
Lack of healthcare coverage	58.1%
Inadequate access to mental health care	37.8%
Other	4.1%

Table 3: Strategies employed to address the mental health of MSAWs

Preventative strategies	Percent
Providing referrals to mental health services	87.8%
Providing translation services	85.1%
Offering telehealth	83.8%
Developing and/or providing culturally and linguistically specific resources	81.1%
Providing eligibility assistance	78.4%
Providing culturally sensitive mental health education and outreach	71.6%
Collaborating with other agencies serving migrant populations	71.6%
Providing transportation services	44.6%
Allowing service delivery during the evening and/or weekend hours	37.8%
Other	4.1%
Health center is not utilizing strategies to address the mental health needs	1.4%

Table 4: Staff addressing the mental health of MSAWs

Staff Member/Practitioner	Percent
Social Worker	68.9%
Physician (non-Psychiatrist)	55.4%
Advanced Practice Nurse or Physician's Assistant	54.1%
Case Manager	41.9%
Outreach Worker	33.8%
Clinical Psychologist	32.4%
Medical or Nursing Assistant	29.7%
Nurse	29.7%
Psychiatrist	29.7%
Community Health Worker (CHW)/Promotora de Salud	23.0%
Program Supervisor	18.9%
Other	18.9%
Patient and Community Education Specialists	9.5%

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