Uplifting Voices to Create New Alternatives: A Critical Assessment of Mental Health Needs and Access Barriers Among Mexican Community Members in Chicago

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Abstract: *The present study used a structural social work theoretical lens to undertake a systematic mental health needs assessment. Using a community-based participatory research approach and a two-phase mixed methods design, the researchers assessed mental health needs and barriers to care among 2,556 adults of primarily Mexican background from ten economically marginalized communities in Chicago's southwest side. Findings indicated that mental health concerns including depression, anxiety, and trauma-related symptoms were prevalent among community members and stemmed from the oppressive national and local level structural contexts in which they lived. Furthermore, data demonstrated that research participants overwhelmingly identified structural and programmatic barriers, rather than social barriers such as stigma, as posing the greatest challenges to mental health service access. Among the structural and programmatic barriers identified were service cost, lack of insurance coverage, and limited availability of services that were culturally affirming and responsive to context-specific service needs. This study has far-reaching implications for understanding the impact of structural factors on mental health. We recommend that social workers advocate for organizational and policy changes that address these structural barriers.*

Keywords: *Critical theory; mental health; adults of Mexican background; access barriers; structural social work*

A growing body of literature documents mental health needs and access barriers among the U.S. population of Mexican background. Critical theoretical frameworks provide a lens for understanding how U.S. social institutions are intentionally designed to perpetuate systems of power, privilege, and oppression that limit access to resources and opportunities among populations who are not members of the dominant cultural group (Mullaly, 2007). Nativist rhetoric and anti-immigrant state and federal policies negatively impact the emotional well-being of both the immigrant and U.S.-born Latinx population (Garcini et al., 2016; Hatzenbuehler et al., 2017; Raymond-Flesch et al., 2014; Salaset al., 2013; Szkupinski Quiroga et al., 2014; Torres et al., 2018; Vargas et al., 2017). Not only does anti-immigrant legislation undermine emotional well-being, but it also limits the extent to which Latinx immigrants can access insurance coverage, mental health services, and other health-promoting resources (Santiago-Rivera et al., 2011).

In an effort to build upon this body of critical scholarship, the present study sought to explore how structural factors impacted mental health and mental health service access

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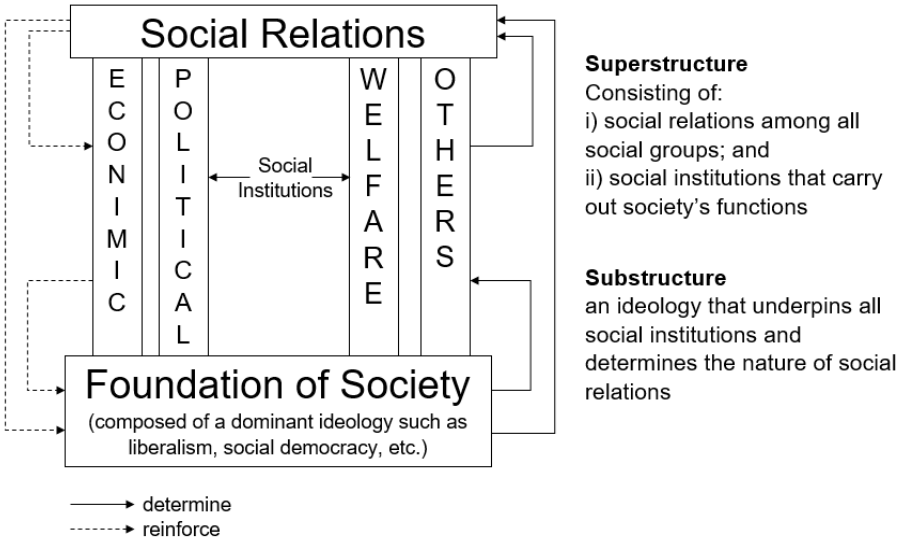
among Latinx adults in the local community context of Chicago, Illinois. More specifically, we used a structural social work (SSW) theoretical framework (Mullaly, 2007) to assess mental health needs and service access barriers among a predominantly Mexican-origin adult population on Chicago's southwest side. Using a community-based participatory research approach and a mixed methods design, this study sought to understand community members' most pressing mental health needs and access barriers, as well as how national and local level structural contexts shaped residents' needs and experiences.

Structural Social Work Theory

Structural social work (SSW) theory offers a useful framework for helping researchers and practitioners understand how individuals are shaped through their interactions with social, political, and economic systems (Mullaly & Dupré, 2019). SSW conceptualizes society as a bridge structure, where the foundation on which the bridge is built is the ideology underpinning society (Mullaly, 2007). Just as the foundation of the bridge is essential to sustain the structure on which it is built, so too are society's ideologies. Economic, political, and social systems, which can be understood as the pillars of the bridge, reinforce dominant ideologies and transmit these ideologies to members of society. In turn, members of society reciprocally reinforce dominant ideologies through their social relations. When members of marginalized populations are harmed through social relations and through interactions with oppressive social systems, they suffer from what Mullaly (2007) defines as structural violence.

Figure 1. *Mullaly's* (2007) *Structural View of Society*



Not only does SSW provide a descriptive understanding of how social institutions perpetuate structural violence, but it also offers a prescriptive call for practitioners to challenge oppressive systems that impact well-being (Carrillo & O'Grady, 2018). SSW theory posits that there is a need to both provide immediate support to individuals who

have been harmed by structural violence and to transform the systems that harm marginalized populations (Mullaly, 2007). Thus, the SSW theoretical perspective provides a lens to explore the impact of structural violence on mental health and mental health service access, as well as to identify strategies for addressing service access barriers.

Mental Health Needs and Access Barriers Within the Local Chicago Context

Population-based studies have found that approximately 27% of Hispanic/Latinos had a serious mental illness (Substance Abuse and Mental Health Services Administration, 2020) related to poverty and the immigration system. Immigrant legislation and national and state legislation that labels the immigrant population in reference to categories of *legality* and *illegality* is associated with chronic trauma and poor mental health outcomes. The current mental health and social service landscape in Chicago provides an important opportunity to explore mental health needs and access barriers among Chicago's Latinx population from a critical lens. Between fiscal years 2009 and 2012, the state cut $113.7 million in mental health service funding, making it the third highest state in the nation for mental health funding cuts during this period (National Alliance on Mental Illness Chicago, 2015). Furthermore, in 2012 the city of Chicago began to disinvest in publicly funded mental health services, from 12 Chicago Department of Public Health (CDPH) public mental health clinics to five currently operating clinics (Lowe, 2015; Spielman, 2017). On the other hand, expenditures on policing drastically outweigh expenditures in health and social welfare. In fiscal year 2017, the city of Chicago allocated 38.6% of its general fund budget ($3.7 billion) to the Department of Police ($1.46 billion). In comparison, only 0.9% of expenditures ($32 million) were allocated to the CDPH, the department where public mental health centers are housed (Center for Popular Democracy et al., 2017).

The impact of this disinvestment in mental health services is particularly pronounced within Chicago's high economic hardship and underserved communities of color (Acosta-Cordova, 2017; Henricks et al., 2017). Among the high economic hardship communities on Chicago's southwest side that are home to a predominantly Mexican population (Acosta-Cordova, 2017), availability of mental health services is limited compared to more affluent White Chicago communities. CDPH clinic closures have restricted community members' options for accessing free mental health services in close proximity to where they live (Fecile, 2012).

Methods

In order to systematically assess mental health needs and service access barriers, this study used a community-based participatory research (CBPR) approach and a two-phase mixed methods design. CBPR is an approach to research rather than a method in itself (Leung et al., 2004). A central tenet of CBPR is that community members have true decision-making power in all stages of the research, from setting the agenda and planning through implementation and sharing findings. Relatedly, the community should see real benefits from the project beyond simple knowledge generation (Israel et al., 1998).

Wallerstein et al. (2018) also argue that changing the standard power dynamic, seeking to "eradicate the distinction between who does the studying and who gets studied (or decides what gets studied)" (p. 4) is central to CBPR. In many ways, this study turns the traditional academic-community dynamic even further on its head. The genesis of this study was a smaller study in one neighborhood that grew out of conversations between two employees of Mexican background at community-based organizations in these neighborhoods. Community members and staff members of a community-based organization drove all phases of the research. University-based students and researchers followed their lead. Phase one consisted of quantitative data collection, while qualitative methods were used to further explore and expand upon quantitative findings during phase two.

Phase One: Quantitative Methods

A questionnaire was developed to assess community members' desire for mental health services and access barriers. The initial draft of the questionnaire was designed based on programmatic experience in offering free mental health services to uninsured adult immigrant community members (Carrillo, 2014). Meetings were held in which community members and staff members of community-based organizations (CBOs) provided input and feedback. Their input helped ensure the instrument was accessible and culturally appropriate to both English and Spanish speakers. The survey was designed to be brief and administered in a public setting independently or with minimal assistance. The questionnaire focused on basic demographics, mental health concerns, attitude towards seeking professional support, and barriers to accessing services (questionnaire is available in Appendix A). This article reports on the attitudes and barriers to services. Questions were based on straightforward phrasing. For example, the question on stigma as a barrier was asked as, "I would feel judged as 'crazy' or 'weak' or something else. El qué dirán (loco/a o débil o algo así)."

Access barriers can be categorized into three groups: structural, programmatic, and social. The barriers related to cost, lack of insurance, services not being in their area, and not knowing where to go reflect larger structural factors. Problems with when services are available, services not being in a respondent's language, lack of childcare while receiving services, and lack of transportation to get to services reflect programmatic barriers that one organization could ameliorate but does not or does not do so on the scale needed. Finally, barriers of stigma, believing counseling would not help, and fears of family disapproval reflect social barriers stemming from one's self and social circle.

Data collection, sampling, and analysis procedures. Survey responses were collected between May 2016 and February 2017 via purposive sampling, defined as a strategy that uses non-probability sampling of cases to ensure representativeness of particular categories in the final sample (Robinson, 2014). A total of 2,556 (male = 611; female = 1,945) community members were recruited across nine community areas. This strategy strengthened the contextualization of findings with the use of a homogenous sample (Robinson, 2014). "The rationale for employing a purposive strategy is that the researcher assumes, based on their *a-priori* theoretical understanding of the topic being

studied, that certain categories of individuals may have a unique, different or important perspective on the phenomenon in question and their presence in the sample should be ensured" (Robinson, 2014, p. 32).

Prospective survey respondents were recruited via direct person-to-person encounters in public spaces, including schools, churches, community events, laundromats, grocery stores, and sports programs. Staff members at community-based organizations, primarily community organizers, explained the importance and goals of the project, as well as information about confidentiality, to all prospective survey respondents. The surveys were completed anonymously and took approximately 5 to 15 minutes to complete. Respondents were given the option of completing the survey on paper or having the survey collector ask the questions and record their answers.

This study focused on ten community areas on the southwest side of Chicago: Archer Heights, Back of the Yards/New City, Brighton Park, Chicago Lawn, Gage Park, Little Village/South Lawndale, McKinley Park, Pilsen/Lower West Side, West Elsdon, and West Lawn. The population of these areas is 74% Hispanic or Latino, of which 93% are of Mexican background (US Census Bureau, 2020). This study used a homogeneous purposive sampling strategy to invite respondents who were Latinx and living in one of the ten community areas of interest to complete the survey (Etikan et al., 2016). A total of 2,987 surveys were collected. Records were excluded if respondents were not Latinx (the phrasing on the questionnaire), if community area or gender were missing, if they did not respond to any substantive questions, or if the survey was identified as a duplicate entry. The final sample was 2,556. Nearly all surveys (90.5%) were completed in Spanish. Most respondents were born outside the United States (73.0%), with 16.2% born in the US and 10.8% not reporting their nativity status. Age was not recorded.

Post-hoc weighting was applied to better approximate the gender breakdown among the Mexican population on the southwest side because females were overrepresented in the sample, 76.1% versus 48.7% in the population (using data from 2010 US Census, 2011). Frequencies were calculated for the substantive and demographic questions (the language and place of birth data above reflect weighted demographics). Analysis was completed in SPSS Statistics 26.

Phase Two: Qualitative Methods

Informed by Phase I of the study, Phase II used qualitative methods to supplement the quantitative data. Semi-structured individual interviews and community forums were employed to amplify community perspectives and gain additional insight (Harvey-Jordan & Long, 2001) into mental health needs, access barriers, and recommendations for facilitating service access. From the narrative data, we allowed themes to develop within these topics. Additionally, we used community forums because they promote "active voices from participants" and empower community members to voice their concerns (Baroutsis et al., 2016).

Eight community forums with 190 participants were held in accessible public spaces across six of the ten community areas where quantitative surveys were administered. Each forum was held in a community setting easily accessible to the public and lasted no more

than an hour and a half. Unfortunately, demographic information was not collected for participants at these meetings. While authors cannot verify participants' demographics, the authors can report that the community demographics across the communities were 75% Mexican, 13% Black non-Hispanic, 9% white non-Hispanic, 3% Asian, and <1% other (Chicago Metropolitan Agency for Planning Data Hub, 2022). These forums were facilitated by the lead author of this manuscript.

At each forum, quantitative findings were presented and community members were asked to offer additional context on mental health needs and access barriers. During the final member checks, the quantitative and qualitative methods were presented to community members in order to triangulate findings. Triangulation is defined as a comparison of quantitative data and qualitative methods to ensure validity of findings during member checks (Denzin & Lincoln, 1994; Harvey-Jordan & Long, 2001). Participants were also asked to provide recommendations for addressing community members' mental health needs and decreasing service access barriers. As community forums unfolded, 1-3 members of the research team wrote field notes on the content of the discussion. Additionally, live emerging themes from discussions were written on a board for all community members to approve or challenge.

Purposive sampling was adapted to identify nine community leaders (n = 4 female, 5 male; n = 6 Mexican, 3 white) who met the requirements of a minimum 5-year history of involvement in community initiatives with a long-standing relationship with residents in the surveyed community areas and an understanding of community members' psychosocial needs. These community leaders were invited to participate in semi-structured individual interviews to explore topics including the community and societal contexts impacting mental health, commonly encountered service access barriers, and their vision for promoting positive mental health outcomes among community members. From February to October of 2017, nine interviews (each averaging 15 to 20 minutes) were conducted in English and audio-recorded by the lead author.

Analytic method. Qualitative data were analyzed by three coders, using a grounded theory approach, to conduct a thematic analysis (Chapman et al., 2015). Such an approach enabled us to build upon our understanding of the mental health needs and barriers to mental health services (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Audio-recorded interviews were transcribed verbatim using Trint, while written field notes were typed by the second author (CP) and study research assistants. All documents were assigned an ID number and organized within a primary file, according to the date and setting where the data were collected; files were then stored in an encrypted database. Because this project was conducted without any external funding and financial resources were limited, transcripts and typed field notes were manually coded, without the assistance of a qualitative data analysis software program.

A systematic inductive and deductive method of grounded theory approach was used to identify concepts and for theory development (Corbin & Strauss, 2008; Foley & Timonen, 2015). First, the researchers developed codes from previous literature and the quantitative aspect of the study and additional codes that emerged from qualitative data analysis were included. Interview transcripts were independently coded by two coders and

community forum field notes were independently coded by one coder, who each performed open coding as the first coding step. Open coding allowed for initial codes to be identified, organized, and selected based on repetition and constructed meaning. Coders then met with the third author to collaboratively perform axial and selective coding, which involved grouping initial codes to build sub-themes, and organizing these to interpret themes (See Table 2). In line with the grounded theory approach, such coding steps were foundational in generating theory from the collected data, as data were rigorously compared and reduced (Williams & Moser, 2019). Following all independent coding, the three coders met to review and compare the initial codes, then group similar codes into themes, as well as check for wild-codes and consistency, aligned with grounded theory methods.

To validate, verify, and assess the credibility of results, an important component of qualitative work and grounded theory, member checking methods were used (Birt et al., 2016). As described by Birt et al. (2016), "member checking is a means of enhancing rigor in qualitative research, proposing that credibility is inherent in the accurate descriptions or interpretations of phenomena" (p. 1803). They further note that focus groups can be used in member checks to explore the attitudes, opinions, and beliefs of participants. To ensure that the themes aligned with community members' observations and lived experiences, community members were invited to participate in a group member check interview. Member check participants confirmed and clarified preliminary findings and expanded on themes specifically related to understanding the experiences of Latinx subgroups on Chicago's southwest side.

Results

Phase One: Quantitative Results

A large majority of respondents (76.6%) said they would consider seeking emotional support by a professional as a way of dealing with their emotional problems. Survey respondents identified structural and programmatic barriers as posing the greatest challenge to mental health service access (see Table 1). Cost was the most frequently cited barrier, noted by 59.9% of respondents. Conversely, smaller percentages reported social factors such as stigma (12.7%), believing that services would not help (11.7%), and fear of family disapproval (8.7%). Respondents could choose multiple barriers, so percentages add up to greater than 100.

Table 1. *Questionnaire Results*

Category	Response	n (%)
Willingness to Seek Services	No	295 (11.6%)
	Probably No	255 (10.0%)
	Probably Yes	937 (36.7%)
	Yes	1020 (39.9%)
	Missing	48 (1.9%)
	Total	**2556 (100%)**
Barriers to Accessing Services*	Cost	1451 (59.9%)
	Lack of Insurance	1001 (41.3%)
	Don't Know Where to Go	989 (40.9%)
	Services Not Near	825 (34.1%)
	Hours Not Convenient	591 (24.4%)
	Language	589 (24.3%)
	Lack of Childcare	495 (20.5%)
	Lack of Transportation	489 (20.2%)
	Stigma	307 (12.7%)
	Wouldn't Help	283 (11.7%)
	None selected (not included in total)	

*Multiple responses could be selected, so % do not add up to 100

Phase Two: Qualitative Results

Data from individual interviews and community forums provided insight into community members' mental health needs, service access barriers, and community-driven solutions for decreasing service access barriers and addressing mental health needs. Data indicated that community members' mental health needs stemmed primarily from the structural context in which they lived. In particular, respondents described the ways national policies reinforce local policies that foster and exacerbate systematic oppression (see Table 2).

Table 2. *Mental Health Needs, Service Access Barriers, and Community-Driven Solutions: Themes, Sub-Themes, and Initial Codes*

Theme	Sub-Theme	Initial Codes
1. Mental health & well-being	a) Mental health b) Social environment c) Legal violence d) Lack of access to basic needs	aa) Depressive symptoms ab) Anxiety ac) Acculturative stress ad) Trauma ae) Anger control af) Isolation ag) Substance abuse & dependence ba) Social support bb) Violence within communities bc) Disconnectedness within communities ca) Documentation status cb) Limited employment opportunities cc) Deportation & family separation

Theme	Sub-Theme	Initial Codes
		da) Difficulty with family provisions db) Food insecurity
2. Structural & programmatic service access barriers	a) Geographic location b) Logistics c) Stigma d) Cost e) Funding allocations & cuts f) Lack of community outreach g) Culturally inappropriate services h) Power dynamics	aa) Safety concerns ab) Proximity ac) Services not within community ba) Childcare bb) Transportation bc) Inconvenient hours ca) Family disapproval cb) Stereotypes cc) Helpfulness cd) Negative perceptions of diagnosis ce) Consider seeking services cf) Gender dynamics da) Underinsured db) Uninsured ea) Wait list for services eb) Funding allocations ec) Funding cuts to mental health & physical health clinics fa) Lack of knowledge about services ga) Language gb) Lack of services that account intersecting cultural identities ha) Voiceless in policy decisions
3. Community-driven solutions	a) Policies b) Community-led intervention c) Community outreach d) Community partnerships e) Infrastructure development	aa) Increase funds ab) Stakeholder inclusion in policy-making decisions ac) Youth involvement ba) Address community needs bb) Address emotional wellness bc) Redefine mental health bd) Raise awareness of racism be) Address men & LGBTQ community wellness/ mental health needs bf) Reflections of experiential knowledge/ storytelling bg) Use of “promotora model” bh) Youth involvement bi) Mental health & legal rights education bj) Services informed by community needs ca) Referrals of services informing of resources/services da) Collaborations with police department db) Collaborations with community-based organizations that address material resource & social needs dc) Collaborations with community leaders & members, including those of other racial/ethnic groups dd) Collaborations with politicians

Theme	Sub-Theme	Initial Codes
		de) Identify community priorities ea) Cost-free services eb) Extend hours of operation ec) Transportation & childcare services ed) Physical space

Mental Health and Well-Being

Respondents conceptualized their interactions with the immigration, criminal justice, and healthcare systems to explain the manner in which these affected their mental health. They indicated that the immigration system's classification of human beings by legal status limited undocumented community members' opportunities for social mobility and led to poor mental health outcomes. One respondent described that undocumented community members were primarily confined to employment in the low wage sector and burdened with significant financial stressors:

> *...there are many who have the ability to work hard but not having insurance, not being able to have food affects us and many [migrants] have been lost...and even though I do not do drugs, drink, or smoke - I still have problems...*

Respondents further described that the immigration system's process of legally marginalizing and economically exploiting undocumented community members affected their experiences within the criminal justice system. In particular, respondents identified that all of their interactions with the criminal justice system, including situations involving redress for exploitation that they had experienced, led to fear of familial separation and deportation. Additionally, respondents shared that they observe the criminal justice system to be used as a first course of action among youth who are demonstrating behavioral challenges that could be addressed through an alternative avenue. Youth involvement with the criminal justice system in turn impacts the entire family system.

> *And we see an immigrant family going through the court system, especially during this time...on its own is a very traumatic experience. And you know, we've seen issues in schools that ended up unnecessarily [in] court...Use and misuse of the judicial system, right. I mean, talk about how the youth oftentimes [are] criminalized.*

Community stakeholders described that experiences of marginalization within aforementioned social systems led to poor mental health outcomes, including: trauma, depressive symptoms, anxiety, isolation, anger-related problems, substance abuse and dependence, and acculturative stress. Respondents additionally described how the impact of oppressive social systems is manifested within the local context of Chicago. Respondents identified violence within communities resulting from limited opportunities to establish enriching social and interpersonal connections as being a prevalent concern. They explained that when families have a lack of safe spaces for emotional support and are coping with relational conflict, youth may turn to gangs as a way of establishing a connection. As one interviewee explained:

> *The biggest problem is that parents need mental health services, and they don't even know it. And they are not receiving it. So now you have young people...get[ting] pushed into the streets, and then they get into gangs. And now you have these kids killing each other.*

Another interviewee spoke about the way that violence within communities is manifested in the form of shootings, and spoke about the traumatic impact of witnessing these events:

I have to be comfortable to recover and heal sometimes from situations that are extremely uncomfortable and traumatizing. I mean, somebody sent me the picture of that guy with his brains blown out……that picture got around the community. …When you see something like that it traumatizes, right.

Additionally, respondents reported that a lack of social connectedness resulted from physical fragmentation within communities that are divided by rival gang activity, as community members are unable to move freely within neighborhoods. The inability to travel without fearing for their safety restricted community members' access to mental health services in other communities. Respondents further described that violent responses from the police perpetuate trauma:

…the way we respond to violence is we call the police and the police come in and they use their force and, you know, we hammer things out.

Structural and Programmatic Service Access Barriers

In line with the quantitative findings, respondents noted that within communities affected by poverty and community violence, there is limited public investment—thus impeding access to mental health services. As illustrated in the following quote, respondents stated that due to funding limitations, neighborhood public schools are restricted in the range of supportive services and health-promoting opportunities (e.g., mental health clinics, health educators) that they are able to offer students.

There were counselors in the schools but those were being cut because of funding for CPS. And so there's only like once a week that it's available and that addresses the whole school and so it wasn't really a space the parents felt comfortable...I think, you know, when the city of Chicago takes it upon itself to close mental health clinics and in the Back of the Yards they closed a mental health clinic and, you know, people were upset... And it was not only an issue of access, but it was an issue of, I mean, physical access because it was in the neighborhood.

Respondents further described that undocumented community members do not have a social security number, limiting their access to social services and public benefits, such as health insurance. Participants identified cost as a barrier to mental health, as demonstrated below:

...a lot of the people don't have the means to be able to go to mental health services sometimes because of the cost and also because they don't have health insurance...there's always folks [undocumented community members] that are going to be left out of policy that we also need to consider.

Respondents also identified a range of access barriers connected to the city's mental health service landscape, including a lack of available services within close proximity to their homes.

In addition to the structural barriers noted above, respondents identified a range of barriers associated with limited organizational infrastructure to address community members' context-specific needs. Organizational barriers included a lack of services

outside of traditional business hours and limited outreach. Moreover, respondents explained that the language and framing around mental health and treatment can serve as a deterrent for community members seeking services, as there is a focus on reducing symptoms rather than promoting holistic wellness. Further, challenges related to service access included lack of culturally appropriate mental health services that take into account intersecting cultural identities.

Lastly, respondents confirmed that in accordance with the survey data, they viewed social and interpersonal barriers as being less of an impediment to service access than the structural and programmatic barriers. While respondents did acknowledge that community members may be hesitant to access services due to concerns about being labeled as "crazy," they also noted that this hesitancy stems from the way in which organizations frame mental health treatment in relation to diagnoses and symptomatology. In comparison to barriers related to cost, geographic proximity, and organizational infrastructure, respondents attributed less weight to interpersonal factors in influencing community members' decisions to seek professional support.

Community-Driven Solutions

When offering recommendations for addressing the mental health service access barriers identified above, respondents identified the need to reframe mental health in relation to holistic wellness rather than focusing on symptomatology:

> *... [mental health] means an appreciation of who you are as a person...that you appreciate who you are, that you [are] a treasure to society and to the community.... So, I think mental health encompasses relationships that are understanding and free flowing and supportive and trusting...I think mental health is around connecting the story and bringing meaning.*

Moreover, respondents recommended that practitioners partner with community members to identify community-informed interventions that promote healing from trauma and address a range of psychosocial needs. As suggested by a respondent:

> *...people are experts in their own lives. Experts within their own community. And so how can we uplift those voices of a lot of the community members to really lead us into what is possible…when conversation and dialogue begins to happen, people start really demanding more change and then coming up with solutions....so that we can really create new alternatives.*

Respondents suggested addressing programmatic barriers in order to ensure that services are accessible and aligned with community needs. For example, they suggested that community-based organizations develop the infrastructure to extend hours of operation beyond traditional business hours, offer assistance with transportation and childcare, and tailor services to be culturally and linguistically appropriate. To address structural barriers, respondents highlighted the importance of offering services that are free of charge and advocating for the city to increase its investment in free, long-term, community-based mental health services.

Discussion

A synthesis of quantitative and qualitative data indicates that among community members of Mexican background on Chicago's southwest side, mental health needs stem from the structural context in which community members live. In describing the structural context that impacts well-being, respondents emphasized the interplay between oppressive interactions with the immigration, healthcare, and criminal justice systems and experiences of oppression and marginalization in local community contexts.

Respondents additionally described how national and local level structural contexts pose barriers to accessing the services necessary to promote well-being. Structural barriers, primarily cost of services, lack of insurance coverage, and lack of services in close geographic proximity, were identified as playing a larger role in impeding service access than were social barriers such as stigma. Community members also identified programmatic barriers related to limited infrastructure to provide culturally and linguistically appropriate services as impeding service accessibility. Respondents emphasized that providing culturally appropriate services does not simply entail that providers can communicate with community members in their native language and articulate an understanding of their cultural values. Instead, culturally appropriate service delivery requires a commitment to understanding community members' experiences in the context of their environment. Community-identified solutions for facilitating mental health service access further indicated that organizational efforts to decrease structural and programmatic barriers, as well as efforts to advocate for funding for free, long-term, trauma-focused mental health services, are key to promoting structural transformation.

Implications for Mental Health Practice

Although this study was conducted in the local context of Chicago, it still has important implications for more broadly understanding barriers to mental health service access. Our data demonstrate that we must look beyond social barriers such as stigma to truly understand deterrents to mental health service access. In addition, this study contributes to the literature by conceptualizing access barriers from a critical perspective and recognizing the need to challenge oppressive social systems that impede service access among the Mexican population.

Mental health practitioners and program administrators can play an invaluable role in promoting structural transformation by driving change within their organizations. It is essential that organizations develop the infrastructure to deliver culturally appropriate services that recognize the impact of structural context on well-being and address structural and programmatic access barriers. Considering that service cost, inconvenient hours of operation, and difficulties with childcare and transportation were identified as posing barriers to care, organizations can develop the infrastructure to deliver culturally appropriate services by providing free, long-term services regardless of insurance and immigration status; offering services outside of traditional business hours; offering free, on-site childcare; providing transportation assistance; and increasing access to telehealth services (including access to internet connection), when clinically appropriate.

Furthermore, recognizing the interplay between national and local level structural contexts in this study, organizations can benefit from working in partnership with Mexican communities to assess local context-specific needs and tailor their programs accordingly.

Implications for Mental Health Policy

This study identifies the need for policies that can facilitate mental health service access in Mexican communities impacted by high economic hardship. Assessing mental health needs and access barriers through a critical lens exposes the structural challenges to accessing care that are often overlooked when the emphasis is on stigma and other social barriers. Our research recommends the expansion of policies that can establish access to care that is not impeded by cost or lack of health insurance and instead can promote emotional wellness through a community-centered, holistic approach. Various examples of public policy campaigns have demonstrated the public support for tax-funded strategies to financially sustain and develop mental health centers to benefit communities of high need. Among these examples are ballot initiatives such as California's Proposition 47, passed in 2014, which lowers sentencing of non-violent crimes, allows for resentencing, and uses savings to fund mental health among other priorities (Alliance for Safety and Justice, 2016).

Additionally, the passage of the Community Expanded Mental Health Services Act of 2011 in Illinois allowed community members to establish a binding referendum, giving them the ability to raise property taxes in order to fund community mental health centers to serve those within the designated service area. Since its passage, three mental health centers have been created through this legislation in Chicago (Coalition to Save Our Mental Health Centers, n.d.). Finally, the findings from this study have led to the passage of a resolution in the city council of Chicago calling for the creation of a Public Mental Health Clinic Service Expansion Task Force. The purpose of this Task Force is to reexamine the re-opening of public mental health clinics in Chicago and identify budgetary and operational recommendations for expanding and improving services at existing facilities. Such campaigns to expand safety net services are critical to facilitating service access among Mexican community members who encounter structural barriers to care such as cost and lack of insurance coverage.

Finally, social workers are ethically obligated to engage in social and political action "to advocate for living conditions conducive to the fulfillment of basic human needs" under section 6 of the social work code of ethics (National Association of Social Workers Code of Ethics, 2021). Specifically, section 6.04 calls for social workers to

> …engage in social and political action that seeks to ensure that all people have equal access to the resources… Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions to meet basic human needs and promote social justice. (para. 1)

Several social workers, including some authors of this article, were involved in various capacities throughout the long arc of this research initiative and subsequent policy

campaign to increase public investment in mental health services as a basic human right through the Collaborative for Community Wellness. Efforts through this coalition have resulted in significant gains and pushed for equity in funding and investment in the rebuilding of the decimated public system through neoliberal policies of current and past mayoral administrations. The campaign #TreatmentNotTrauma has also forced the current administration to implement a non-police crisis response pilot in Chicago, when only a co-responder model (where social workers and police officers work together) was proposed by Mayor Lightfoot (Collaborative for Community Wellness, n.d.).

Implications for Future Research

Findings from this study highlight the importance of conducting research on mental health needs and access barriers among Mexican communities from a critical perspective. As our data demonstrated, national and local level structural contexts have a profound impact on the well-being of Mexican communities and influence the extent to which individuals can access the services necessary to heal from structural violence. To truly identify healing interventions, researchers must conceptualize the challenges that Mexican community members experience in relation to the larger structural context in which they are situated.

This study also demonstrates the power of community-driven research initiatives in promoting structural transformation. Through our CBPR approach, researchers and community members collaboratively identified solutions for facilitating mental health service access, and have additionally initiated a public campaign to engage in city-wide reform. Future research efforts can benefit from implementing similar community-driven, action-oriented approaches that leverage community members' expertise to identify innovative solutions for transforming oppressive national and local contexts.

Limitations

The study has several key limitations that should be considered. First, even though our sample may have been heterogeneous, we did not examine differences by Latinx background. Prior work shows that social groups' experiences with racial marginalization (Molina et al., 2013) and mental health varies by Latinx background (Cook et al., 2009; Lorenzo-Blanco & Cortina, 2013). However, given the community makeup of the Latinx population being 93% Mexican, the authors believe it is appropriate to describe the sample as predominantly Mexican. Secondly, the instrument used to examine barriers and access to services and mental health has not been psychometrically tested and validated. However, the study authors developed the survey collaboratively with community organization staff and neighborhood residents. Finally, the use of purposive sampling limits generalizability of results to other Latinx subgroups in the US.

Conclusion

Recognizing the shortcomings in the literature to date in analyzing mental health needs and access barriers among the U.S. population of Mexican background from a critical perspective, this study used SSW to explore mental health needs and access barriers among predominantly Mexican adult community members on Chicago's southwest side. Findings

indicated that community members' mental health concerns stemmed from the oppressive national and local level structural contexts in which they lived. Furthermore, data demonstrated that research participants overwhelmingly identified structural and programmatic barriers, rather than social barriers such as stigma, as posing the greatest challenges to mental health service access. This study has far-reaching implications for understanding the impact of structural violence on mental health and recognizing that efforts to facilitate service access among the population of Mexican background must be focused on the systemic rather than individual level. To truly promote structural transformation, mental health practitioners, program administrators, policy makers, and researchers must collectively advocate for increased investment in free, long-term mental health services that are aligned with the cultural values and context-specific service needs of Mexican communities.

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Appendix A

Emotional Wellness Survey

The information collected in this survey will be kept confidential.

Demographic Questions

1. Gender (please mark one):
❑ Female ❑ Male ❑ Other: _____

2. Race (mark one):
❑ Caucasian (White) ❑ African-American ❑ Latinx ❑ Asian ❑ Native American ❑ Other

3. What is the country in which you were born?: _____

4. In which neighborhood or community do you live in?
❑ Back of the Yards
❑ Brighton Park
❑ Chicago Lawn
❑ Gage Park
❑ Little Village
❑ McKinley Park
❑ Pilsen
❑ Other: _____

Emotional Wellness Questions

5. From the following list, please select up to 3 situations in which you experienced frequently:
❑ Sometimes I feel depressed or very sad
❑ Sometimes I feel anxious, constantly worried, or extremely nervous
❑ I find it hard to control my anger
❑ I feel I need support as a parent
❑ I feel I need support in my marriage/relationship
❑ There are troubling things that have happened in my life that continue to affect me
❑ I feel lonely, I do not feel I have sufficient emotional support in my life
❑ Living in a country whose culture and language are very different from mine is stressful

6. Please choose the option that best reflects your reaction to this statement.
I would consider seeking emotional support by a professional (counseling) as a way of dealing with my personal problems:

❑ Yes
❑ Probably Yes
❑ Probably Not
❑ No

7. What are the things that make it difficult for you to access emotional support by a professional (counseling)? Please select all that apply:

❑ Cost
❑ Lack of transportation
❑ Lack of childcare
❑ Lack of health insurance
❑ I do not believe those services would help me
❑ I would feel judged as "crazy" or "weak" or something else
❑ My partner/family would not approve
❑ It is difficult finding services in my preferred language
❑ Those services do not exist in my area
❑ I do not know where to go for those services
❑ The hours of service are not convenient for me