

## **Concurrent Sessions II**

### **Mental Health**

Agnelo Dias. EdD

Thank you. You know I always like to be the middle speaker because I can say whatever I wanted to say, the person before me said, and whatever is remaining the next person will say. But I know that time is very short. Usually my presentation lasts about two hours. First I had credit for 20 minutes, now I was told ten minutes. So I'm going to try as quickly as I can. The way I thought I would present, or bring the issue of mental illness in Asian and South Asian community is to share with you my experience. In 1994 I started as the Director of this Asian outreach program of Queens Child Guidance Center in Elmhurst, Queens, New York. We were struggling to get clients. I was afraid that we would be defunded because we did not have enough clients. So together with my workers I really went out of my way doing outreach and reaching out to community.

Let me briefly share with you what - We have, Queens Child Guidance Center, the Asian Outreach Program, we serve four major Asian ethnic groups. The South Asian American, the Chinese Americans, Korean Americans and Filipino Americans. And we have workers for each group. Initially we struggled. We have four components in this program. That's mental health, substance abuse, outreach and a small after school program. The first component that we really used well was outreach. We spared no effort to go out and reach to the community. And in the first year we were very lucky that we were not defunded because we got about 250 applications. One of the things that we did to outreach is, as we all know, the whole concept of mental is not well accepted in the Asian community. So we knew one place where Asians do value, and that's education. So what we did, placed our workers in schools where there were large numbers of Asian students. And I think that was the core of our success. Besides that we went out to the community, we went out to the churches, temples, mosques, you name it. Anywhere we could set our foot in we did. And initially we had very challenging and we had to be very persistent going again and again. I'll give you an example of the struggles that we had, the challenges that we had. We decided to have a workshop at the library and we said, talking about depression. Guess how many people showed up? Three people. One was the person from the library. Another person was a community person and the third one was a Chinese reporter. So we said we are doing something wrong. From then on we never mentioned the word mental health. We talked about how to help your children to do better in school. We got crowds. And that's how, I think, using innovative ways and means, we reached out to the community. So outreach, as I said, 250 applications in the beginning. Today practically every year we get over 750 applications every year.

It's good but I don't think our work has, is done. There's much more work. There are many many more people. We have much more work to do, we know that. And I'd like to speak more in a positive way. There were 250 people, today there are 700 people that are seeking services.

I have about 135 people on the waiting list, which, in itself, is a good sign that people, we also used ethnic media. We had done radio talk shows, TV talk shows. Again, to educate people. And we educated people using very simple terms that they can understand and they feel comfortable with. Stigma. We all know that's one of the majors, health insurance, people do not have health insurance. Language of course. Just take South Asians alone, there are 14 main languages. And it's very difficult, but the main language that we use is Hindi, Urdu. We have Gujarat speaking, Murati speaking person. I was lucky to have one person who spoke seven languages. She is gone, unfortunately.

Unusual symptoms, we know that South Asians or Asians would somatize a lot, you know, before they allude to any other mental illness they would rather see any other problem than mental health. We all heard this morning, you know, even every discipline feels that this important. This is what we have to emphasize. And we also heard how people were saying why are we considered different than the others. You know, like dentists as opposed to other physicians. I think it's high time that we overcome those differences and work together. Lack of cultural understanding of staff is very important. That people are not familiar with health systems. Different health seeking patterns. In South Asia if you had a problem, you know, you have so much support system. You had a bad day in school, a child had a bad day in school, there would be so much support at home. If the parents are not there, grandparents are there, or their uncles or their aunts. There's so much support. We don't have it here.

Management, environment, you know, they want you to bring them in and get them out as quickly as you can. So that becomes, also, another barrier. Some of the special stresses for South Asians, I think, Miss Sadiq did mention about them, and migration, cultural shock. They're culturally shocked. Language, financial issues, immigration status. If they're undocumented they're very frightened to talk about it. Family role reversal. And I want to emphasize a little bit on this. What happens, because of the language issues, there is role reversal between the parents and the children. But then children become the parents. Children are the ones who are guiding. Children are the ones who have to do translations. So two things happen from that. The unreasonable demand on the children to take the role of the parents, so that effects the parents. And I've seen – I was in the hospital one day and the child was translating for the mother. Might have been 12 or 13 year old child. And the mother wanted to ask some questions. The child told her, keep quiet, you know. Again, it's like a child admonishing the parent. So that is a great factor in South Asian families. High parental expectations. All of us came here to this country to do better. And with that in mind, parents sacrifice everything that

they can, working hard hours, long hours, in order to give better education. And sometimes expect too much from their kids. That can breed conflict. We all know boys versus girls. You see, especially, in very strong religious families have great difficulty in making a difference –there's always differences in South Asian or Asian cultures. Boys are given more freedom than the girls. Girls have to come back home at 6:00 maybe but the boy can come back at 10:00. So that in itself creates conflict. We have seen more and more young people who are cutting themselves because their frustration is so much that they cannot take it anymore. So they go and do odd things. Or young girls, 15 or 16, getting hooked or getting acquainted with older people, 22 or 23. The reason being, because the parents are not going to support them. They cannot go out with the other of the same age, so they would rather go out with older people who can give them money, who can entertain them. And our kids and families face racism and prejudice.

Again, in migration what happens? Mental losses, physical losses, spiritual losses and loss of family and friends. As I mentioned, you have a lot of support which our families and children do not get it here. And lots of cultural familiarity.

Major mental health – depression, suicide, PTSD, anxiety disorders, somatization, parent/child conflict, and this is when the parents are so strict that there's a big parent/child conflict. I really feel bad for the kids. Parents have their own values that they want to imbue and I have nothing wrong with it. I think parents should inculcate what they got themselves. But the children are living in two worlds, one at home and one outside. And they're torn between two. Which one will be more attractive? Of course the outside world. So we have young girls, 15 or 16 years, running away from home. This is, perhaps, for us South Asians or Asians, is an unheard concept. Very rarely you may hear it happen. But generally it is becoming a common phenomenon among South Asians. Self-mutilation, I mentioned that. They're so frustrated. Substance abuse. Domestic violence is another big factor which, perhaps we do not want to talk about or we don't want to even think that it could happen in our community but it does happen. And the good thing is, I always like to see the positive. There are more and more women coming out and reporting it. Is it because now there is more domestic violence? No Domestic violence has been in existence for God knows for how many years. But the fact that people are coming out is a good sign and I tend to see that positive. The government is taking more interest in that. There is more money available for domestic violence issues. So that's a good services.

Now what should we do, what can we do? First, educating. Educating ourselves. I have had physicians telling the parents, don't go to mental health services because that would be in your record. And I'm not exaggerating. Physicians telling patients not to do that. So we need to check within ourselves, what is my concept of mental health. How can I encourage or educate someone else? You

cannot do. Gandhi said change begins here. In order to bring about change, you need to change. I need change. I need to change the way I look. Advocacy for more services. We do not have enough services. I wish I could have three more social workers but I can't because of resources. And unless we advocate, unless we do something about it, nothing is going to happen. Questions at the main conference today were how come nothing is happening. Don't expect others to do, let me start with myself. I need to start taking the first step and then something is going to happen. Create an awareness about mental health needs. Create an awareness in myself, as I mentioned. Take care of our own mental health needs. Yesterday, I was supposed to come here. I wanted to leave at 5:00 so I could be here at 6:30. And Thursday is the worse nightmare day for me at the clinic because we have a space problem, because everybody is there that day, we have case conference and everything that could go, goes on Thursday. And I made a call to Linda because I had forgotten to bring my disk with the presentation, just to find out from her whether she had it and whether there was need for me to bring it, because then I had to go home and come back, and I live in Long Island. When I called her I was so stressed out that I picked up the phone and I couldn't get – and I'm saying ha..... We need some space for ourselves. Sometimes talking to a friend or someone else that helps. So we need to take care of our own mental health. And advocacy, advocacy is so important. Sometimes we see other people, families, having problems, but we don't have courage. We think that they may think that we are getting into their problem. When we see people drinking. Someone told me once, if you're passing by and you see someone bleeding, no matter whether you know that person you'll stop and say, Ma'am you are bleeding. You'll inform them. But if you see a drunkard person or you see a person talking to himself or herself you won't talk about it. We wouldn't talk about it in our families. Why? We are afraid. And I think we need to get out of the fear. We can do it. I'm not saying that South Asians are behind. We are moving forward and that's where we need. We need all of you and once we get together, keeping the disciplines aside and saying that we are here for our community. We can do it. Thank you.

Q: I had a few questions. My name is Sufna and I wanted to thank all of you, actually, for all your comments today. I'm with NYU School of Medicine with a program called the South Asian Health Initiative. And one of the big projects that we're working on, if any of you were here in the cancer part, is working on oral cancer, and specifically smokeless tobacco products, and I have these which I can give out, but paan, gutka, etc. One of the things that we've noticed while we're doing outreach is that our program is mainly focusing on screening to find people that have early signs of cancer, putting them into care, etc. But one of my main concerns as we've been doing outreach is we're finding people

that, you know, addicted to these products of course, because there's an addictive quality for both the supari as well as the tobacco that's in the paan. And I was wondering, because you mentioned briefly about substance abuse, and I was curious whether there were any models for how to deal with substance abuse, maybe even taking something like an alcohol abuse program and trying to mold that into something that could be used also for smokeless tobacco products as well. Because there's a psychosocial component and also the chemical component as far as the addiction goes. And I'm really curious about that. That was one question that I had. I have two more, sorry. The other issue is you touched upon elderly health. I'll leave the third one. And I was curious. I've been seeing in New York, for example, rising senior homes around the city, different boroughs. And I think that's a really interesting thing that we have these senior homes, nursing homes for South Asian elderly. And it's been, I think, received with mixed feelings because there's a part of it where it's really great that we have these homes that are close to religious centers, etc. But there's also a part of that which, when I saw it, for example, I thought about neglect and I thought about things like that where it's very easy to just say, okay, let me just put my elderly person in the home and they'll be happier there. I've decided that for them. Is that an appropriate, in your opinion, what's your opinion on the South Asian senior home model and is that an appropriate place to do intervention as far as the mental health of elderly South Asians?

Agnelo Dias: The first question, in terms of – it never struck, and pardon my ignorance. I was not familiar about paan and gutka, it being used here. I was aware of it in India. But yes, a similar program can be developed for if there was addiction and people come forward wanting to get rid of it. Like smoke cessation. You know, it's becoming a bigger thing and more and more is being done. I think the first thing is being aware and then issues will be raised and something will be done. The second question, about the elderly, just at the time of my voice, nothing based on any research, I would assume, depending how long the people, elder people have been here. If they have been here they have known, they have seen other nursing homes, maybe are just much better. Also the connection between the family members and going to see them often or whatever. That would be a big factor. But the person coming new, if you brought a person new and you want to put in the nursing home I don't think that would be an ideal situation for them.

Aruna Rao: I just want to tell you that in New Jersey we have what's called a MICA programs, Mentally Ill Chemically Addicted kind of program that addresses exactly this issue with relationship to chemical dependency and serious mental illness. Again, I don't think they've even considered

addressing paan and gutka, but again, it's something that potentially could be approached with and that model can be used for the same thing. With regard to outreaching elderly people in these homes, obviously you can go back and forth on the merits of having people in homes or not, but that said, in my experience going into senior centers where there's a large South Asian senior population, they are very eager to listen to anything. These are, in many ways these are elderly people who have a lot of time. And so if you're going to go there, and especially if you're going to culture outreach in ways that makes it attractive to them – don't say depression in the elderly. Say are you finding that your family doesn't really have that much time for you. Or basically couch it in ways – or even like, for instance, we have a geriatric psychiatrist, an Indian man that was working with us. He's doing presentations on depression based on Mocatia songs, you know the Rajkumpur Hindi movie songs. So he starts off – he sings songs. So he sings the song and then he talks about, you know, how was this [ ] and what is the situation there. So this is what depression feels like. So I think there are creative ways to get outreach to the elderly. And they're a very ready audience. The problem is not accessing people in the homes, it's accessing people who are shut ins in their own home.