SURVEY OF INDIVIDUALS RECEIVING MENTAL HEALTH SERVICES AND THEIR FAMILIES

This survey was conducted by the California Mental Health & Spirituality Initiative at the California Institute for Mental Health. The purpose of the survey was to document the interests, needs, and experiences of service recipients of the mental health system in California regarding spirituality.

MENTAL HEALTH & SPIRITUALITY INITIATIVE
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The survey was refined with extensive input and assistance from a dedicated group of individuals from our network, including consumers, service providers, and County Liaisons. Key contributors included: JoAnn Johnson (Sacramento County), Gigi Crowder (Alameda County), Kumar Menon (Los Angeles County), Heda Yeter (Santa Clara County), Myriam Aragon and Moses Poite (Riverside County), Jesse Herrera (Monterey County), Sharon Jones (Merced County), David Miller (San Bernardino), Lidia Gamulin (Los Angeles County & National Latino Behavioral Health Association), Susan Reed (San Mateo), and Gilda Zarate Gonzalez (Fremont), Patricia Blum, Crestwood Behavioral Health (Sacramento)

The survey was translated from English into seven key statewide threshold languages (Spanish, Vietnamese, Hmong, Tagalog, Chinese (Cantonese), Farsi, and Russian). We are especially grateful to Alameda, Los Angeles, Riverside, Butte, and Santa Clara Counties for providing the translation services. Khuri Gustafson, CiMH was instrumental in coordinating the diverse effort involved in conducting this survey with limited funding.

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OVERVIEW OF SURVEY FINDINGS

Demographics

Although the survey was available in 8 languages, 90% were filled out in English, 9% in Spanish, and under 1% in Russian, Vietnamese, Tagalog, and Hmong. So we learned that making a survey both in hard copy and online was not enough to get participation from many language groups. It would seem to require a significant outreach effort. Yet the ethnicity data (Q28) shows that there was good representation by minority ethnic groups. Ethnicity was in line with ethnicity representation within the state of California which is very diverse. But Caucasians appear to be slightly underrepresented (39%) relative to the state level of around 50%.

Most of the participants said they took the survey as someone receiving mental health services themselves (63%) and 18% identified themselves as family members (Q2).

There was a wide range of ages represented in this survey. About 90% of the responders said they were receiving or had previously received mental health services (Q31). Most have been diagnosed with a mental disorder although 14% said they had not been (Q26). The most common reported diagnosis was depression with 42% but there were a range of diagnoses including 6% with diagnoses of childhood and adolescent problems (Q27).

Q30 is a table of surveys received by County, from most frequent to least frequent. Riverside and Los Angeles County had the most participants.

Religious/Spiritual Identification

On Q12: Do you consider yourself: (1) religious but not spiritual, (2) both spiritual and religious, (3) spiritual but not religious, (4) neither spiritual or religious, a surprisingly high 48% identified themselves as spiritual but not religious, This is substantially higher than national surveys such as Gallup and Pew have reported of around 30%. Even though this group has been growing substantially from around 10% ten years ago, 48% puts the survey respondents far ahead of this trend.

The distribution on Q13: Do you identify with any of the following? seems to be along the lines of the Pew results in the table below but with Buddhism, shamanism and paganism perhaps a little higher than national averages.
Values and Experience Question Ratings

Overall there was very high agreement by mental health consumers and their families that that spirituality is important to their mental health. On Q4: Spirituality is important to my health/family member's health—over 75% agreed.

Perceived Spiritual Competency

Q9: The mental health care providers I/my family have seen have demonstrated respect for my spiritual life even if it is different from theirs. This question assesses respondents’ perceptions of spiritual competence at the programmatic level. Specifically this question addresses the foundational beliefs or values dimension of spiritual competency as delineated by Sue et al. (1992) who describe cultural competency as an interrelated set of beliefs, knowledge, and skills. The beliefs or values dimension is the most important element in cultural competence since this provides the foundation on which the other dimensions of cultural competence rest. “Shortcomings in skill sets and knowledge of other cultural worldviews are likely to overlooked if the appropriate attitudes exist, but the converse is less likely to occur” (Hodge, 2007, p. 289)

The responses suggest an overall positive evaluation of mental health providers' spiritual competency. But it is noteworthy that the responses were less positive on this question than for questions about whether spirituality is important. The Agree and Strongly Agree totaled 79% for Q4 on importance but only 58% for Q8 & Q9 on perceived respect.

Spiritual Needs and Practices

Q11: The public mental health system in California should do more to support clients and families in utilizing their spirituality as a wellness and recovery resource. Two thirds of participants agreed or strongly agreed that public mental health system in California should do more to utilize spirituality. Most also agreed that on Q5: Mental Health care providers should be willing to discuss spiritual concerns with me or my family if I request it—74%. A similar number, 66%, agreed on Q10: It is appropriate for the public mental health system to address spirituality as part of my/my family’s mental health care. However it is important to note that 12% disagreed with this statement suggesting that around 1 in 8 service users in California do not want spirituality to be a part of their recovery program. This is in line with other surveys of patient preference which have showed around 10-15% do not welcome spiritual discussions or input from their healthcare providers.

Q17: Have you ever turned to a faith-based community or spiritual advisor for help with mental health concerns (e.g., a minister, pastor, rabbi, imam, shaman, elder, spiritual teacher, guru, etc.)? Almost half (46%) had consulted a faith-based community or spiritual advisor about mental health issues.
Q6: Have you or your family member ever talked to a mental health care provider about spirituality? Similarly, 45% reported they had talked with a mental health care provider about spirituality.

On Q21, participants reported a wide range of spiritual practices with prayer being the most popular, which is consistent with national surveys (e.g., Pew). The variety of spiritual and religious practices used was striking including many practices with research-demonstrated associations with well-being and happiness (e.g., yoga and dancing).

Ethnicity Breakdown of Responses (see second set of graphs)

The breakdown of responses by ethnicity did not reveal many striking differences. Overwhelmingly, all of the major ethnicity groups were solidly in favor of spirituality as a source of support and well-being. Some small differences were noted although the statistical significance of these differences was not tested. For example, on Q8: The mental health care providers I/my family have seen have demonstrated respect for my spiritual life. Asian Pacific Islanders strongly disagreed or disagreed with this statement the most—around 10% versus 5% for the other groups. Hispanic/Latino respondents reported the highest level of agreement—almost 80%.

On Q 15: How often do you practice spirituality in a group setting, on average? It appears American Indians and Caucasians practiced less in group settings than the other ethnic groups.

References


For further information, please visit the website of the California Mental Health & Spirituality Initiative at www.mhspirit.org, or contact us at mentalhealthandspirituality@gmail.com.