

# Latino Immigrant Mental Health *Literature Review*

A Report for the  
**Northeastern Center, Inc.**  
Kendallville, IN

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August 2006

**INTRODUCTION.** The dramatic growth of Latino immigrants in the U.S. seems to have arrived at a “tipping point” so that reference to Latinos, the Hispanic market, and Spanish-language products have suddenly exploded. Long immune to the unfolding blanket of people moving northward, states far away from the U.S.-Mexico border have become a boilerplate for what the future culture holds for America. Indiana leads that challenge, having grown dramatically in its representation of Latino individuals. A recent policy report notes that Mexican immigrants accounted for nearly half the state’s population growth from 2000-2004, and clarifies that despite the debate about illegal entry, only 20% of the 214,000 counted were not legal residents. Emphasizing the economic impact, state budget office head Chuck Here noted that these numbers indicate that the Latino Indiana presence was “increasingly important to the overall economy in Indiana”, and “one that will grow”.<sup>1</sup>

The key findings of this landmark study emphasize the strengths and resources that Latino immigrants bring to a new area, and counter many of the fears and apprehension that emerge when gradual change appears imminent to local communities. Looking to the future is eased by openness to change, and curiosity from local organizations about the *potential* that lies in making services relevant and helpful, especially to a population that traditionally has experienced little access to good care. This report addresses *six key areas*, obtained through review of the professional literature in peer-reviewed journals and internet survey of websites to identify instruments and curriculums. These topics include

- 1) Access to Mental Health Care;
- 2) Help-Seeking Traditions and Behaviors;
- 3) Emerging Practices;
- 4) Empirical research;
- 5) Funding Opportunities; and
- 6) Implementing Discovery of Local Needs.

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To date, published literature on community-based mental health care with demonstrated effectiveness is minimal, and when addressed does not often include behavioral health interventions. Few articles address *Mexican-origin immigrants*, but those that are available offer important insights into the barriers and challenge that behavioral health care providers and program planners will increasingly face in the next decade.

A business plan is often not common among community mental health or substance abuse outpatient clinics, having experienced a history of limited and fluctuating funds that largely rely on state or federal government discretion. This history leaves many administrators feeling powerless to enact change or demonstrate local need effectively to garner fiscal support. Further, given the infusion of managed care models as a way to determine service provision, outline performance measures and aim for cost-containment, community based behavioral health systems are often ill-prepared to encounter change as an *opportunity* rather than a *threat*. It is with the first perspective that this review is submitted. Yet a proactive approach is very necessary to plan for growth, and thus in this report an emphasis is placed on practical information that can easily be linked to implementation.

## **I. ACCESS TO MENTAL HEALTH CARE.**

Mental Health Needs are Often Left Unanswered. The U.S. Surgeon General's Supplemental Report on *Mental Health Care: Culture, Race and Ethnicity* (2001) identified mental health as "fundamental to overall health and productivity", and "the basis for successful contributions to family, community, and society". Yet for 20 years literature has indicated that access to behavioral health care is sparse for many Americans and is especially unavailable to those living in rural areas, members of ethnic minority groups, the poor, the elderly, children, and men. These elements of differential access to care were strikingly portrayed in the Surgeon General's original 1999 *Report on Mental Health*, which laid the groundwork for a lesson on inadequate access to care and in civil rights: factors that had more to do with chance of birth or stage of life rather than individual traits determine who gets what type of care, when, and to what gain.

The 1999 Surgeon General's Report on Mental Health also provided insight into the critical and persistent negative impact that mental illness has on quality of life, mortality, and productivity. Mental health disorders are identified as potent and disabling as cancer or heart disease, yet highly responsive to treatment. Estimates of 80-90% effective response to good care have been evidenced by earlier reports. The prevalence of mental disorders in the American population illustrate why stigma associated with illness is so unbelievable: almost 1/3 of Americans have one or more serious mental disorders during their lifetime and at any one time almost 15% of the U.S. population can be suffering.<sup>2</sup> Further, this report emphasized that data consistently identify substance abuse as positively linked with rates of mental disorders, making separate treatment of the two short-sighted and ill-informed.

Despite Low Access for All, Disparities Exist. The Surgeon General's Report highlighted that for people of color, lack of access is tied to lack of well-trained health care providers. Less than 1 in 11 Latino Americans have contact with a mental health specialist, but among Latino immigrants the rate of access drops to 1 in 20. The lack of bilingual mental health specialists is not limited to any geographical area in America, although especially sparse outside of the Southwestern U.S. However, even along the U.S. – Mexico border, availability of bilingual health care professionals is low, especially in mental health, and medically under-served areas abound.<sup>3</sup> The Institute of Medicine's (IOM) report *Unequal Treatment Confronting Racial and Ethnic Minorities* illustrated how behavioral health care access is inextricably linked to health care access, which was also outside the reach of most individuals of color. A series of IOM educational materials resulted from focus on this reality, producing brief summaries for information necessary for program administrators, health care providers, and consumers. A Spanish version is available for consumers.

Lack of Access is the Norm. Health care access is one of the 10 leading health indicators identified in Healthy People 2010 that can eliminate health care disparities among Americans.

Access consists of two dimensions, potential and realized. Potential access refers to ways to facilitate resources for health care utilization, such as health insurance and a regular source of care. Realized access refers to actual services used and the satisfaction associated with these services.<sup>4</sup> In ways, potential access determines realized access – this is important when trying to understand how best to improve access for Latinos, of which 62% of adults are estimated to have been without insurance during a year regardless of income, more than 3 times the rate experienced by non-minority Americans.<sup>5</sup>

Crowley (2003) summarizes the variety of factors that impede access to care for Latinos, including cultural isolation, poverty and language barriers. Major barriers include lack of insurance and inability to afford services, lack of transportation, and inability to qualify for most state or federal programs.<sup>6</sup> Knowledge of mental health and its relevance to daily functioning is often low in Latino communities, and may not be a priority when other fundamental needs of survival are paramount. If formal health care is sought, it is often sought late – when severity of symptoms has risen and prognosis has become poorer. When treatment is obtained, it is often of low quality and does not lead to good outcomes. Lack of trained providers who speak Spanish inhibits effective provider-client communication, decreases rapport and contributes to low adherence to treatment. Low adherence often is compounded by negative reactions from providers to patients, sending a punitive message that is not likely to result in returning to care.

These statements are all aspects of low access to care that are true for most Latino groups: certainly access and adherence to care is more difficult for migrants and immigrants. Guarnaccia and Martinez (2002) submitted a comprehensive literature review of Latino mental health issues to the New Jersey Mental Health Institute that examines social and cultural backgrounds of Cuban Americans, Dominicans, Mexican Americans and Puerto Ricans in the U.S. and provides an overview of mental health

utilization and barriers to care. This is a fundamental background resource that has merit for various Latino subgroups.<sup>7</sup> Following are reviews of more recent journal articles continuing to address barriers that Latinos experience in access to mental health care.

#### Workforce Training:

- Alegria recounts patient reports of how culture matters in the clinical encounter:  
*Understanding. Sometimes you come from different backgrounds and different lifestyles. Sometimes they [clinicians] don't get overall picture and think things are easier. They tend to water things down.*  
*Language is always important, but doctors need to be bicultural. The way one thinks and expresses herself has to do with the culture. One is going to feel like she is being understood better. The doctor can visualize it because he or she already lived it or because he/she has a previous knowledge. He doesn't have to be from the same race but to speak the same language and have knowledge of the culture.*<sup>8</sup>
- Non-English speaking patients are more likely to use the emergency room (ER) as a regular source of care, according to reports from the Boston University School of Public Health. The lack of professional interpreters makes providing good care difficult for these patients, who often present with complications or in crisis. In a report by Bernstein and associates (2002), a comparison of care that included use of a trained interpreter for Spanish, Haitian Creole or Portuguese Creole-speakers indicated that Non-English speaking patients without interpreter services had the shortest ER stay, fewest tests, and were least likely to return for outpatient care. Benefits of interpreters were associated with increased ER intensity of services, reduced ER return rate, increased clinic utilization and lower 30-day charges without any increase in length of stay or cost of visit. Thus, use of interpreters does not appear to increase costs but does increase effectiveness of care and retention of patients in treatment.<sup>9</sup>
- To improve work staff readiness to communicate, the North Carolina AHEC has added Spanish language classes including a series of weekly workshops throughout the state and an intensive Health Spanish Immersion Workshop for intermediate level students to refine their communication skills in delivery of behavioral health care. (See description of options at <http://www.ncimmigranthealth.org/>) An evaluation of this training method using a case study design indicated that participants felt that use of Spanish language health related materials were key to the training's success at 1 year follow-up.<sup>10</sup>
- Another case study method was used to assess local health care systems' response to rapidly growing health care needs for Latinos in Iowa, Kansas and Nebraska. Two-day site visits were used to conduct focus groups in Spanish

with 54 Latino patients and 55 health care key informants from health care, social services, public health, education, religious, business and community leaders. Shortage of physicians and other health care professionals, lack of insurance, reluctance of providers to participate in Medicaid and the State Children's Health Insurance Program (SCHIP) were also found to be major barriers to access.<sup>11</sup>

#### Fear:

- A second barrier is the fear among undocumented Latino immigrants to access care who believe they may risk being reported to INS. Berk & Schur (2001) examined this factor in a sample of 756 undocumented Latino adults through a cross-site survey in 4 major communities in two states (Texas and California). Across all four sites, 39% of respondents reported that they had been afraid of not receiving medical services due to their undocumented status. Those reporting fear were more likely to be unable to acquire medical and dental care, prescription drugs, and eyeglasses.<sup>12</sup>

#### Financial and Cultural Barriers:

- Documét and Sharma (2004) conducted interviews with a sample of 206 Latinos residing in southwestern Pennsylvania, most of which were male and younger than 45 years, and had been in the U.S. for less than 5 years. Using the concepts of potential and realized access, authors concluded that time in the U.S. and health insurance determined having a regular source of care. Use of a physician visit during the past year was more likely among women who had a regular source of care. Language and culture did not add statistically significant effect on access, but qualitative data indicated that these were perceived as barriers.<sup>13</sup>
- Despite Documét and Sharma's findings to the contrary, others point out that lack of fluency in English present multiple problems not only during the provider-patient encounter but in understanding treatment recommendations and adherence. Williams and associates (1995) found that the 62% of non-English speakers in their sample could not read instructions on medicine bottles, appointment slips, or hospital financial aid forms; not surprisingly, limited English proficiency reduced use of physician services.<sup>14</sup>
- Hovey and colleagues have addressed the notion of acculturative stress, which includes a variety of factors associated with the process of acculturating to a new country. This includes the breaking of ties to friends and family in country of origin, resulting in feelings of loss and reduced coping. There are also adverse experiences in the new country, including discrimination, difficulty learning a new language, limited financial and social resources, low income, difficulty finding more than menial wage employment, and feeling torn between values and customs of country of origin compared to the new country.<sup>15 16</sup> Hovey and Magaña published a report in 2000 that investigated acculturative stress in Mexican immigrant farm workers in the Midwest, reaffirming that those who experienced high levels of acculturative stress were at risk for high levels of

anxiety and depression.<sup>17</sup>

- Coping styles in which individuals react to stress also appears related to acculturation. Farley and colleagues examined coping styles among Mexican immigrants, Mexican-Americans and non-Hispanic white Americans, which he acknowledged varied by group as well as by type of stress. Comparisons of these groups to health-related quality of life in a rural sample replicated the relationship of Vega and colleagues' work in physical functioning, but also found differences in coping style. Mexican citizens were more likely to use positive reframing, denial and religion, and less likely to use substance abuse and self-distraction as stress-coping strategies. These adaptive ways of coping seem consonant with cognitive reframing and use of faith-based supports, bearing merit for further investigation.<sup>18</sup>
- A community series of 100 focus groups and community meetings in San Mateo County (California) in 2005 invited input from diverse stakeholders that identified the stigma of mental illness, lack of information, and cultural concepts of health as "internal" or cultural factors that inhibited access to mental health care. External factors that contribute to low access included location of services, confusion and difficulty in navigating the health care system to the extent that even recently developed tools such as a 1-800 number and an "Access Team" were viewed more as ways to keep people out of treatment rather than facilitate entry.<sup>19</sup>

## II. HELP SEEKING TRADITIONS AND BEHAVIORS

- Many of the citations in Guarnaccia & Martinez's (2002) report refer to the fifty year history of non-empirical literature identifying aspects of the Latino culture that should be incorporated into treatment, such as *personalismo*, *respeto*, and *familismo*. However, even today little is known about how immigrants and other Spanish-speaking Latinos obtain formal medical and mental health care.
- Results from a very small case example study provide some insights. Derose used a qualitative approach to understand problems faced by Latinas in obtaining care for themselves and their families, how these experienced affected them, and how they overcame obstacles to receive the care they needed. She used extensive interviews with only 9 women, but gleaned substantial information from these encounters. Aside from barriers associated with language, women reported a variety of problems getting into the health care system. Many reported having to go to the county emergency room where help was often refused due to language differences and Spanish-speakers were not even allowed to sign in on the triage log book. Forms were intimidating, and even when in Spanish daunting and embarrassing for women with few literacy skills. Communication with providers was poor and the women reported verbal and nonverbal provider behaviors that conveyed disdain due to the women's

language and immigrant status. Perceptions of discrimination were reported by all respondents. Anxiety, shame, frustration, and inadvertent or at times deliberate delays in care were experienced. Most often, women said they relied on English-speaking family members to translate, compensating for the lack of bilingual staff or interpreters. The family network often spanned generations, such as women relying on their daughters to communicate effectively when accompanying their own mothers. In the absence of family, the women turned to neighbors and community members for assistance in understanding where to go, how to get there, who to talk to, and what to bring along (medicines, lab results) as well as food or drink in anticipation of a long wait for care.<sup>20</sup>

### III. EMPIRICAL RESEARCH

- Guarnaccia and Martinez's review is also a good resource that summarizes theoretical articles and empirical literature during the 1990's of issues needing more research, including assessment and diagnosis. This information is very useful since little clarification exists of how to incorporate the recognition of cultural influences on recognition of symptoms, expression, and beliefs about cause. These authors also identify the work of other researchers on factors that improve communication and rapport building between providers and clients (e.g., Miranda, Organista, Lopez and their colleagues) suggest that hypothesis-building about potential but as yet untested cultural influences is a good start. Researchers can include these factors in a research design, which may be the most effective way to scientifically assess the impact of and effective benefit from provider response to cultural traditions.
- More recently, work suggests that when offered, effective care may truly provide meaningful benefits. The prevalence of depression in the U.S. population makes interventions in this disease especially pertinent, and identification of cognitive behavior therapy as an evidence-based practice has facilitated its inclusion in studies that address treatment outcomes with Latinos. Work has focused primarily on samples involving Mexican Americans. In fact, the longitudinal EPESE study by Black and colleagues found that treatment for depression had a synergistic effect on health, with reduction in depression linked to better health which in turn was associated with greater mental health. This recycling of benefits decreased the risk for poor outcomes among older Mexican Americans that participated in that study.<sup>21</sup>
- Investigators have also addressed how quality enhancement in either pharmacological or psychosocial mental health care can positively impact treatment outcomes in Latinos. Data from a large cross-national study by RAND and UCLA examining the impact of enhanced care for depression provided a series of reports about its benefits for ethnic minorities. Foremost, investigators noted that selection bias was quite possible in observational studies of diagnosed individuals who actually receive treatment. Given that disparities in care exist, it would be important to include individuals who had not yet been diagnosed, but

were at risk for a clinically significant depressive syndrome. In response, a randomized trial to examine quality improvement in primary care settings among managed care organizations included a naturalistic practice condition (usual providers, patients, payment mechanisms, and patient and provider choice of treatment).<sup>22</sup>

- A series of reports from this study illustrate the benefits of enhanced care for depression and for culturally sensitive treatments. First, findings indicate that quality interventions (QI) - such as training teams of providers and depression nurse specialists to educate and guide patients into mental health care - improved quality of care as well as clinical symptoms, quality of life and employment outcomes for depressed patients over 12 months.<sup>23</sup> However, investigators found that differences emerged on the impact of QI on outcomes. Ethnic minorities experienced stronger clinical improvement than did Caucasians in the study.<sup>24</sup>
- However, while improving in clinical outcomes, minorities had poorer post-care employment outcomes. Investigators noted that in fact this highlighted that factors such as socioeconomic status remain as risk factors for reduced treatment adherence but are not typically addressed by clinical intervention.<sup>25</sup>
- A related report by Wells and associates (2005) found differential response to appropriate care for depression. Although all patients regardless of ethnicity or race were found to be receiving poorer care prior to study intervention, minorities did respond well to good mental health care, but tended to get good care more often if they were older, better educated, unemployed and were in poor health (three or more chronic illnesses). Further, good mental health care reduced the likelihood of probable major depression from about 70% to 20% for both minority and non-minority patients.<sup>26</sup>

#### IV. EMERGING PRACTICES

##### *Assessment and Diagnosis*

- Children & Adolescents
  1. **BIS:** The Brief Impairment Scale is a 23 item instrument that evaluates 3 dimensions of functioning: Interpersonal relations, school and work functioning, and self-care or self fulfillment. This instrument builds on the strengths of existing global measures while addressing some of their limitations. It was validated on cross-sectional parent respondent data from one clinical (N=757) and two community samples (N=1888 & 1132) of children ranging age 4-17. Internal consistency was good, ranging from .81 to .88 and from .56 to .81 on the 3 subscales. Test-retest reliability for individual items ranged from fair to substantial in all but 6 items. The BIS has high convergent and concurrent

validity, demonstrating it as a psychometrically sound tool useful in assessments and as an outcome measure in clinical practice and research. Its short administration time and multidimensional nature together with being respondent based is an improvement over other global impairment instruments.<sup>27</sup>

2. **DISC-IV:** This computerized structured instrument is designed to be administered by lay interviewers. Good test-retest reliability in English- and Spanish-speaking clinical samples yields comparable results. The DISC-IV also assesses impairment associated with school functioning and interpersonal relationships. This instrument is not suggested for use with children less than 11 years since no evidence of reliability with this age group exists.<sup>28</sup> González-Tejera and colleagues report significant impairment and greater use of mental health services among youth with minor depression (not meeting DSM-IV criteria) compared to those with major depression, indicating that preventive interventions with subsyndromal levels of depression are warranted.<sup>29</sup>

- Adults

1. **ASRS:** This brief screen for adult ADHD consists of 18 questions about frequency of recent symptoms that meet DSM-IV criteria. The ASRS screener selects 6 of the 18 questions based on stepwise logistic regression that optimizes concordance with the clinical classification. Blind clinical ratings of DSM-IV adult ADHD in a sample of 154 participants in the U.S. National Comorbidity Survey Replication (NCS-R) were examined, over-sampling those who reported childhood ADHD and adult persistence. The 6-question screener outperformed the original 18-question ASRS in sensitivity (68.7% vs 56.3%), specificity (99.5% vs 98.3%), total classification accuracy (97.9% vs 96.2%), and concordance (Cohen's  $\kappa$  of .76 vs .58).<sup>30</sup>
2. **WHO-DASII:** Developed by the World Health Organization, this measure has been used with mentally ill patients internationally. It is relatively brief in length, and has established face and content validity for Latinos. Sensitive to diverse ways in which impairment in functioning can be demonstrated in different contexts, it assesses both mental and physical health factors related to disability. The instrument showed good to excellent internal consistency in two U.S. and one Puerto Rico site (.72 to .97) except for the Self-Care subscale (.47). Test-retest reliability estimates were mostly moderate to substantial (.57 to .83) again except for the Self-Care subscale (.46).<sup>30</sup>
3. **Lehman Quality of Life:** LQoL is the most widely used quality of life measure in the U.S. including a wide and growing number of Latinos. This tool has been qualitatively assessed to develop a Spanish version using translation and adaptation of the instrument (Matias-Carrelo et al. 2003). Internal consistency ranges from .34 to .98 and test-retest reliability ranged from .40 to .86 across all sites. An initial validation using both LQoL and WHO-DIS suggests promising evidence of the construct validity of both measures.<sup>31</sup>

- Families

1. **Family Burden Scale:** This instrument explores how a family caregiver for a person with serious health problems is affected by this role. Useful with the general population, it has 18 items and administration time is about 10 minutes. Objective dimensions of family burden are aimed at quantifying aspects of burden such as financial cost, days unable to carry out normal activities, days out of work, etc. Slight wording modifications were made to make questions understandable to different Latino groups.<sup>32</sup> Ron Kessler and colleagues are assessing the psychometric properties of this scale. However, Kessler's prior research indicates that the relationship between life events and stress, and the relationship between stress and psychopathology is largely affected by genetics and environment, indicating that for immigrant Latinos it is environmental enhancement that is likely to be linked with reduced stress and mental illness.<sup>33</sup>
2. **Family Environment:** The Moos & Moos Family Environment Scale has survived 20 years of testing with diverse family populations and been extensively used with African American and Latino children. The original scale identified 15 factors, and has been refined to 3-5 factors depending on the study. From these, the strength-based elements of family functioning can be assessed. Bloom (1985) identified 3 factors, the 1<sup>st</sup> of which had high positive loadings on Cohesion (.85), Expressiveness (.79), Family Idealization (.80), and Democratic Family Style (.79) and high negative loadings on Conflict (-.65) and Disengagement (-.68). The 2<sup>nd</sup> factor had high positive loadings on Family Sociability (.59), Intellectual-Cultural Orientation (.61), and Active-Recreational Orientation (.62), and high negative loadings on Enmeshment (-.73) and External Locus of Control (-.64). The 3<sup>rd</sup> factor had high positive loadings on Organization (.62), Religious Emphasis (.51) and Authoritarian Family Style (.78), and high negative loadings on Disengagement (-.53) and Permissive Family Style (-.27).<sup>34</sup> Moos (1990) revisited the history of reliability and validation testing that the FES had experienced, and summed the analyses by focusing on constant updating, given the changing nature of families and varying experiences depending on the members that constitute that "family".<sup>35</sup>

### *Psychosocial Interventions*

- Children and Families

1. **Co-Morbidity – Substance Abuse and Depression.** A high correlation between depression and substance abuse exists, and risk factors include low socioeconomic status, family conflict, and exposure to violence. Programs designed to prevent one disorder may actually prevent or forestall development of the other.

**Project SUCCESS** (Schools Using Coordinated Community Efforts to Strengthen Students) is a model program advocated by SAMHSA that prevents and reduces

substance abuse among high risk, multi-problem middle and high school students. Trained professionals are placed in school to provide a full range of substance use prevention and early intervention services. This includes regular and preventive education, counseling and skills training, problem identification and referral, community-based processes, and environmental approaches. Tested in alternative schools, it has been expanded throughout the U.S. More information can be accessed at:

<http://www.modelprograms.samhsa.gov/pdfs/Details/Success.pdf><http://www.modelprograms.samhsa.gov/pdfs/Details/Success.pdf><http://www.modelprograms.samhsa.gov/pdfs/Details/Success.pdf>

2. **Underage Drinking:** Although rates of alcohol use have declined since recorded highs in 1979, they have stayed level during the past several years, and adolescents still abuse alcohol more than any other substance in the U.S. A 2006 report states that 7 million youth age 12-20 report binge drinking: having 5 or more drinks on at least one occasion during the past 30 days.<sup>36</sup> Moreover, the IOM emphasizes the adult responsibility that should accompany the national problem of underage drinking.<sup>37</sup> SAMHSA has developed a community intervention model that involves community strategies, youth and parent education and activities, and is described at:

[http://www.preventionpartners.samhsa.gov/foc0414\\_alcohol\\_p2.asp](http://www.preventionpartners.samhsa.gov/foc0414_alcohol_p2.asp). A promising program, this model merits application in ethnic minority communities. Bilingual materials to provide parental education and help families intervene effectively to prevent abuse are available at [www.hablemos.samhsa.gov](http://www.hablemos.samhsa.gov).

3. **Healthy Communities Healthy Youth.** The Search Institute developed a strengths-based initiative that focuses on development of mental and social well-being in young people. The initiative includes parental education materials - *Parenting with a Purpose*<sup>38</sup>- that provide a toolkit by which parents can understand the role they and others can play in developing a youth's external and internal assets. This approach provides a "roadmap" that is purposeful and based on planned nurturance. The Search Institute also provides a organizational guide, *Walking your Talk: Building Assets in Organizations that Serve Youth* that helps develop community collaborations that aim at strengthening positive external assets. Both of these resources provide step-by-step worksheets and assessment tools. The merit of this approach is its fundamental emphasis on producing health.

4. **Family Connections:** FC is a promising risk and protective factors strengths-based social services model that uses a comprehensive family assessment, individualized and tailored interventions, and community outreach to establish a helping alliance that empowers families. Outcome-driven service plans are expected to reflect developmentally appropriate and culturally competent needs and reduce risks for child maltreatment. The original Baltimore program achieved these results significantly, encouraging replication in diverse communities. The model has been incorporated in various U.S. communities, and merits review for its

appropriateness and application in distinct community settings. More information is available at the Family Connections program website, located at <http://www.familyconnections.org>. Initiatives involving Latinos exist in San Mateo county and Los Angeles, among others.

5. ***Starting Smart and Bold.*** Latinos often live in high risk communities who have witnessed an explosion of child abuse, teen pregnancy and related challenges. Strength-based interventions that enhance safety, well-being and lasting families for children are a desirable organizational response. A promising curriculum for girls age 6-18 has been developed by Girls Incorporated, a national non-profit organization which addresses issues such as teen pregnancy prevention, substance abuse, money management, violence prevention, leadership skills and self-confidence. Program content includes math and science education, pregnancy and drug abuse prevention, media literacy, economic literacy, adolescent health, violence prevention and sports participation. This resource has been acclaimed nationally, and can be accessed at <http://www.girlsinc.org/gc/>. Most recently, grant initiatives have demonstrated interest in expanding the program to include young fathers.
  6. ***Growing up in a New Country: A Positive Youth Development Toolkit for Working with Refugees and Immigrants.*** BRYCS, a joint project of Lutheran Immigration and Refugee Services and the U.S. Conference of Catholic Bishops, provides technical assistance to “bridge the gap” between child welfare and other organizations, including those that serve refugee communities. A resource toolkit that was produced with DHHS funding offers many references to helpful websites and materials. Available at: <http://www.brcs.org/>
- Adults
1. ***Cognitive Behavior Therapy.*** CBT was included as the psychosocial enhancement examined in reports by Miranda, Wells and their colleagues at RAND/UCLA (see references above), ethnic minorities were found to experience better clinical outcomes compared to Caucasian participants. These findings suggest that Latinos (who comprised 19% of the sample) respond well to good care, and since they and other people of color typically do not have access to good care such as CBT merits replication in a non-managed care outpatient clinic.
  2. ***SAMHSA Implementation Resource Toolkits:*** Evidence-based practices include illness management, assertive community treatment, family psychoeducation, supported employment and psychiatric rehabilitation. Toolkits providing guidelines and case examples are available on the SAMHSA website. Resources for co-occurring disorders can be accessed at [http://www.coc.samhsa.gov/cod\\_resources/PDF/Evidence-](http://www.coc.samhsa.gov/cod_resources/PDF/Evidence-)

[BasedPractices\(OP6\).pdf](#).

3. **CMHS:** The Center for Mental Health Services Refugee Mental Health Program offers toolkits, including a video and refugee wellness curriculum and training tools that provide many helpful guidelines and illustrations of effective interventions with traumatized and culturally distinct populations. Information on these products is available at [www.refugeewellbeing.samhsa.gov/products.asp](http://www.refugeewellbeing.samhsa.gov/products.asp).
- Elderly
    1. **Integrated Care:** Suicide rates are highest in late life. The majority of older adults who die by suicide have seen a primary care physician in preceding months. Depression is the strongest risk factor for late-life suicide and for its precursor, suicidal ideation. Two multi-site studies, PROSPECT (Prevention of Suicide in Primary Care Elderly) and PRISM-E (Primary Care Research in Substance Abuse and Mental Health for the Elderly) demonstrated the effectiveness of integrated behavioral health in co-located and enhanced care settings. Mental health intervention was effective in reducing suicidal ideation regardless of depression severity, reinforcing its role as a prevention strategy to reduce risk factors for suicide in late life. Further, primary care clinicians who cared for patients that received integrated care or enhanced referral care preferred the integrated care model for many aspects of mental health care.<sup>39 40</sup>

### *Treatment Utilization*

- **CATS:** The Cultural Acceptability of Treatment Survey developed by the Evaluation Center of the Human Services Research Institute (2005) assesses consumer perceptions of culturally adapted treatment delivery. *Individual preferences* of each consumer are obtained, thus avoiding generalizations of cultural adaptations of what might be appropriate for Latinos and other consumers.<sup>41</sup> The CATS examines: *importance* of various cultural elements in treatment, the *frequency and manner* in which cultural elements are included, *satisfaction* with the manner in which cultural elements are addressed and *satisfaction with frequency of inclusion of cultural elements* in treatments. In particular, consumers identify what components of culturally sensitive elements identified in the literature (e.g., language, ethnic matching, clinic ambiance) seem most important to their own individualized treatment needs. The CATS was designed to be utilized with people from different cultural groups and in health and mental health settings. A more individualized adaptation can enhance the therapeutic alliance, which is seen by many as critical to promoting retention in treatment and ultimately enhance treatment outcomes. In fact, Coleman and Wampold (2003) note that recent examinations of empirically supported treatments have identified that the effective ingredient in treatment may depend on clinicians themselves, and not the treatment protocol or theoretical framework.<sup>42</sup>

- **CCAS:** The Culturally Competent Assessment Scale is an outpatient organizational assessment of behavioral healthcare competence in serving multicultural groups. The scale items specify concrete activities that should take place in an agency to promote cultural competence, using dimensions that comply with the HHS Cultural and Linguistically Appropriate Services (CLAS). The eleven areas and the activities within each of their five point scales are: Organizational commitment to cultural competence, Assessment of service needs, Cultural input into agency activities, Integration of a culturally competence committee/group within organization, Cultural competence staff training, Recruitment, hiring and retention of culturally competent staff, Language capacity/ interpreters, Language capacity/ bilingual staff, Language capacity/ translation of key forms having key forms in languages of prevalent cultural groups, Language capacity/ service descriptions and educational materials, and Assessment/adaptation and introduction of services. The CCAS has been extensively pilot tested for use in multicultural outpatient agencies in 11 randomly selected sites, but only 5% of participants in testing have been African Americans or Hispanics (Puerto Ricans, Cubans). For more information on current development of this scale, contact Gary Haugland at the Nathan Kline Research Institute (NKI: New York State Office of Mental Health).<sup>43 44 45</sup>
- **ADDRESSING.** Hays has adopted a theoretical framework that helps clinicians understand the identities of the individuals they treat as related to various factors: 1) Age and generational influences; 2) Development and acquired Disability; 3) Religion and spiritual orientation; 4) Ethnicity; 5) Socioeconomic status; 6) Sexual orientation; 7) Indigenous heritage; 8) National origin; and 8) Gender. She encourages an explorative process that helps clinicians understand the person's "world view" that is influenced by these factors, and assists in formulating the 5-axis diagnosis.<sup>46</sup>
- **CONNECT:** The Continuity of Care in Mental Health Services Interview is a tool widely used with mentally ill patients that has published psychometric properties in general populations and face validity for Latinos. It is multidimensional – including knowledge, availability, coordination, transitions, and flexibility – and is designed for consumers rather than providers. Consisting of 70 items, the average administration time is 30 minutes. Since continuity of care is a core part of rehabilitation of the severely mentally ill, its' utility for Latino populations is considerable. Adaptation for use with Latinos included relocation of gate questions to facilitate administration, and addition of some questions to clarify the information gathered.<sup>47</sup>

### *Treatment Effectiveness*

- Patient Satisfaction:

1. **MHSIP:** This 21 item self-report scale assesses patient satisfaction in 3 areas: Treatment Environment, “Affiliation/ Self Esteem” (providers’ treatment of patient), and Growth/Self-Actualization (client understood the treatment plan, was involved with treatment planning); and concludes with a single rating of overall satisfaction. Conducted at 2 public-sector psychiatric hospitals, it was limited to 204 inpatients. Nevertheless, findings suggested that inclusion of client and families in treatment planning was critical to effective satisfaction. The scale merits replication in an outpatient setting that involves diverse client and family groups. <sup>48</sup>
- Outcomes:
1. **BASIS-24:** This 24 item self-report scale assesses 6 domains: depression/ functioning, interpersonal relationships, self-harm, emotional lability, psychosis, and substance abuse. Test–retest and internal consistency reliability were assessed in 27 treatment sites across the US and considered acceptable. Tests of construct and discriminant validity supported the instrument's ability to discriminate groups expected to differ in mental health status, and its correlation with other measures of mental health. <sup>49</sup>
  2. **FES:** The Family Empowerment Scale is a 34-item scale with 3 dimensions, one of which assesses a family’s perception of empowerment in relationship to the services they are receiving. A summary score is generated for this dimension, but the entire scale is useful to assess family needs and impact of intervention. <sup>50</sup>

## V. FUNDING OPPORTUNITIES

- There are many opportunities to address the national benefit gained from health care reform by examining the topics that have been outlined in this review. In particular, two seminal reports outline the rapidly growing rate of Latinos in the U.S., their lack of access to health insurance, prevalence in low-wage jobs, lag in education, poor socioeconomic status, and over-representation in vulnerable high need groups such as the homeless and the incarcerated. These include the *National Action Plan for Hispanic Mental Health* developed by the National Congress for Hispanic Mental Health (2000) and the *Healthy People 2010* Initiative of the U.S. Department of Health and Human Services. Evaluators and researchers who work with behavioral health organizations should be familiar with these documents.
- A follow-up report to Guarnaccia and Martinez’ 2002 literature review was prepared by Acosta (2003) that outlined recommendations to improve access and quality of mental health care. <sup>51</sup> This New Jersey strategic plan provides a helpful example of how to synthesize the literature and combine it with a concurrent assessment of local needs and resources to customize the implications of national trends to local realities. Of primary relevance to Indiana are the recent data emerging from Vega and colleagues’ international study elaborating on prior models of the “acculturation paradox”. This model

recognizes that although Latinos have a litany of health and life experience traumas that place them at greater risk for adverse health, it is only with acculturation that poor health outcomes meet or exceed the generally poor health of U.S. Caucasians.<sup>52 53</sup>

- Acculturation and its impact on parent-child relationships have recently been examined in Mexican Americans as this relates to mental health and management of chronic illness. Differences were found among boys and girls in the impact on mental health, with girls evidencing more depression and boys increasing use of tobacco. New studies to better document the strengths of immigrants and find ways to maintain these elements as indices of resiliency would help inform behavioral health care more generally for U.S. populations.<sup>54</sup>
- **NIH Health Disparities Research Plan:** The Institute of Medicine issued a 2006 report brief lamenting the lack of progress in the Strategic Plan for 2002-2006 developed for the National Institutes of Health (NIH), including the stalled official recognition of the 2004-2008 plan for implementation of the original declaration. Since NIH ranks disparities third of its top five organizational priorities, there are still significant needs for new research on social and behavioral determinants of health and their interaction with biological factors; the characteristics of populations affected by poor health; the relationship between population disparities in health care and differences in health status; and causes of disparities in health care.<sup>55</sup>
- **Co-Occurring Illnesses.** Dually diagnosed individuals pose a particular problem since drug of choice influences the persistence and severity of mental illness. Relying on a substance to feel better is much easier than learning to cope in ways that allow the individual to experience anxiety and discomfort while in the process of obtaining skills. Relapse into substance abuse is common, especially if the drug is easily available. For Latinos, other risk factors such as poverty or discrimination may predispose a person's choice to distance him/herself from the adverse effect by turning to drug use. National studies in fact show that Latinos (12.5%) are more likely than whites (10.4%) or African Americans (6.4%) to binge drink and are more likely to be injured while drinking. Deaths related to drinking and driving, riding in a vehicle with a driver who has been drinking, or alcohol-related homicide are higher among Latinos than among whites and African Americans (CDC, 2001).
- **Triple Diagnoses.** AIDS and HIV infection disproportionately affect both the African American and Hispanic populations of the United States, and are often accompanied by substance abuse and mental illnesses. Over 60% of all new AIDS cases in the U.S occur among minorities, including 45% among Blacks and 21% among Hispanics. In 2001 the rate of AIDS cases among Latinos nationwide was 28.0 per 100,000, a rate more than three times higher than that among non-Hispanic whites.<sup>56</sup> Three interrelated issues seem to account for the high rates of HIV/AIDS in minority communities; 1) inequities in the general

health status in economically disadvantaged communities, 2) problems controlling substance abuse in minority communities, and 3) the role of substance abuse in the spread of HIV. Families can be destroyed and fragile employment arrangements can fall apart. Day treatment centers where socialization and rehabilitation promote mental health can be effective. HIV risk has also been linked to locus of control in Latinas in the U.S. Loss of locus of control in a sexual relationship may be associated with high risk behavior. Loue and associates in fact found that risk rose with length of time in the U.S. and level of acculturation, advocating increased attention to younger women.<sup>57</sup> These authors also offer a brief assessment instrument in their article that assesses HIV-related attitudes, particularly relevant to women.

- **Forensic Collaborations.** People with mental illness are significantly overrepresented in jails. The U.S. Department of Justice reports that about 16% of the population in jail or prison has a mental illness. This compares with only 5% in the general U.S. population.<sup>58 59</sup> The revolving door phenomenon compounds this social and economic tragedy. Seventy two percent of people with mental illness were re-arrested within 36 months of release in a recent report.<sup>60</sup> National interest in establishing “sequential intercept points” to establish community collaborations that divert individuals from jail has resulted in various programs funded in the U.S. Extension of this model to juvenile justice has also received interest. (See <http://www.gainscenter.samhsa.gov/html/default.asp>).
- **Collaborative Care.** Interest in integrated health care has evolved over the past 20 years. The integrated care model refers to a systematic coordination of mental health and physical health care to increase access to those services, improve the quality of services and reduce the stigma of seeking mental health treatment. The basic model of *collaborative care*, evidenced to be the most effective application of integrated health, includes the essential elements of a valid mental health assessment tool, a clinical care manager, a patient registry, and psychiatric consultation. *Collaborative care* offers opportunities for care partners to manage the treatment of mild to moderate mental health disorders in a primary care setting. An enhanced model of integrated health adds evidence-based psychotherapy or behavioral management protocols, such as nurse specialist follow-ups. Combination of these core elements is associated with coordinated, clinically and cost-effective care and reduced relapses. Co-location with mental health services increases access and promotes retention by providing patients with a “medical home”.<sup>61 62</sup>
- **Community Based Intervention.** It is clear that most individuals do not receive adequate mental health care; this is even more so for people of color. Increasing access and improving quality of care is the major goal of health services research. There is increasing need to disseminate and implement evidence-based practices, promoting access and increasing efficiency to reduce social and fiscal costs. Community agendas that use multi-organizational and multi-

disciplinary approaches to find preventive ways of identifying and intervening with sub-syndromal levels of distress offer findings that are of interest to the nation.<sup>63</sup> Environmental and community-wide educational and intervention collaborations are thus of key interest.

## **VI. IMPLEMENTING DISCOVERY OF LOCAL NEEDS.**

- Ways to use new research to inform local policy is well illustrated by a report by Napolitano and colleagues (2002), who outline particular methods in which cultural and lifestyle considerations can be taken into account in the planning and implementation of focus groups. The daily impact of these experiences affect recruitment into studies, reflect environmental context, affect the selection of an appropriate convener, influence selection of questions and vary depending on within-population differences. Focus groups provide a helpful technique to empower local communities by using fairly straightforward methodology and obtain pilot data that can serve as the basis for further research inquiry.<sup>64</sup>
  - The investigators point out the need for a neutral environment that attends to time of meeting, transportation, food, child care, visitors, and overtime pay for community partners.
  - Recruitment poses a challenge; fliers may be limited in their usefulness given varying literacy levels in adults. Word of mouth or working with local community partners may be a better approach.
  - Selected focus group questions should be reduced to core key issues that provide ample room for elaboration and discussion by group participants. Use of introductory questions and paying attention to the ordering of questions is important.
  - The authors urge caution in changing questions, arguing that consistency between group yields more information about a particular area of inquiry.
  - Using a well trained moderator whose skills can elicit group information can be enhanced by inclusion of an assistant moderator to observe and record group dynamics. A male-female partnership may give permission for both genders to participate in conversations. Training of the moderator is elaborated in the article to assess familiarity with questions, attendance at formal focus group training, and senior observer feedback during sessions.
- Individual interviews are another measurement option, but agencies should be careful to use measures that minimize burden on subjects and are adapted for the literacy level and informality that participants may appreciate. Wallen and associates (2002) described the development of a brief language scale to serve as an acculturation measure in Central American women. While the measure itself is useful (and helps validate the Short Acculturation Scale with migrant workers), an even greater gain from this article is the description of method used to develop the scale. Face to face interviews conducted in Spanish were

conducted with 197 immigrant women in their homes. Wallen's study collected data as part of a larger project assessing a peer education model for infant feeding, a personal and intimate topic best addressed in person-to-person dialogue.<sup>65</sup>

- Methodologies such as home visits that put the individual at ease facilitate highly personal interviews. Saldaña (1995; 1999) has also adopted the individual home-based interview to assess highly personal and potentially stigmatized reports of beliefs about mental health and illness, ideas of causation, social supports, and stress associated with care-giving of a severely mentally ill relative. By working with local community mental health clinics, obtaining administrative support, and working closely with case managers to refer subjects and serve as brokers to provide introductions, she has obtained significant participation (200-300 individuals) in an extended and geographically remote rural area in South Texas.<sup>66 67</sup>
- Secondary databases offer a third technique to illustrate local needs. An important consideration in accessing data from different sources is recognizing that how data is organized can vary depending on the information source. For example, some national data can be categorized by state but not by county. Other databases may rely on regional service areas or on zip codes. Multiple sources of data can be used to serve as proxies for behavioral health risk and concurrent environmental risks. However, analysts must be aware of how the data were collected (who was counted or not), whether the numbers refer to cases or to individuals, factors that impact how data is recorded, etc. Merging databases is often difficult due to differences such as these factors. Saldaña provides a training manual for local communities who are interested in combining quantitative and available information such as secondary databases with more personal qualitative data gained in focus groups or individual interviews.<sup>68</sup>

## SUMMARY

**This review identifies various resources for use in novel ways to prevent, identify early and intervene effectively. Tools for client, family and community-wide education are available at many of the websites mentioned. NEC and other community stakeholders are encouraged to collaborate in implementation of these interventions. Well-planned efforts accompanied by program evaluation prepare the community to seek support for new investigations that can lead to discovery of effective services that are of interest to other populations in the U.S. Particular journals, such as the *Journal of Immigrant Health*, the *Journal of Immigrant Mental Health* and *Journal of Immigrant and Refugee Services* also provide pertinent articles to clarify risks and promising interventions, and should be considered as resources worth subscription.**

**Proactive organizational response is key to effective adaptation to the multicultural demands that form the new transcultural population of the U.S. Latino migrants and immigrants are certainly the most current “wave of change” that has received media attention, but during the past decade attention has grown toward the personalized influences of identity that affect all clients. Genetic influences, developmental factors, age and generational differences, bi- or multi-racial individuals, gender and sexual identity, physical challenges, poverty, and rural or urban differences are among several key features that merit administrative attention in designing culturally appropriate services.**

**Developing a business plan is key to operational success. Strategic design in assessing local community needs and marketing services to adapt to that population niche will be an important way in which health and mental health access is determined in the very near future. Collaborative ventures with other community partners are increasingly evident in developing effective and efficient services, and preventive designs fit well in this perspective. Models of evidence-based practices urgently require application to different communities, and funding depends on discovering local implementation methods that can translate to replication elsewhere. The theme of leadership and readiness for future capacity building now is finding solutions that work.**

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