Latino Outreach Resource Manual

Prepared by:

Majose Carrasco

2004

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Chapter 1

Latino Mental Health

Latino Adults

Several large-scale surveys assessing the prevalence of mental health disorders among Latino adults have been conducted. Rates of Affective disorders (e.g. Major Depression), Substance Abuse/Dependence (e.g. Alcohol Abuse), and Anxiety disorders (e.g. Panic Disorders) are among those reported in these surveys. In these studies, Mexican-Americans in Los Angeles and Fresno, Puerto Ricans in Puerto Rico, as well as Mexicans in Mexico City are compared to other ethnic groups using criteria based on the Diagnostic and Statistical Manual of Mental Disorders (DSM).

In the Epidemiological Catchment Area (ECA) study, conducted in the mid 1980s, Non-Hispanic Whites, Puerto Ricans in Puerto Rico, and Mexican Americans in Los Angeles participated. Mexican Americans and Non-Hispanic Whites had similar overall rates of mental health disorders (34.6% and 35.2%, respectively) and both had fewer rates than the Puerto Rican Island (28.1%) group. Within specific disorders and gender categories, however, Mexican American males, relative to Whites, are at a higher risk for alcohol abuse and dependence (31.3% versus 21.0%). This finding is consistent with results from the National Alcohol Survey for 1995, which found that Latino men had higher alcohol related problems than non-Hispanic White men (23% versus 13%).

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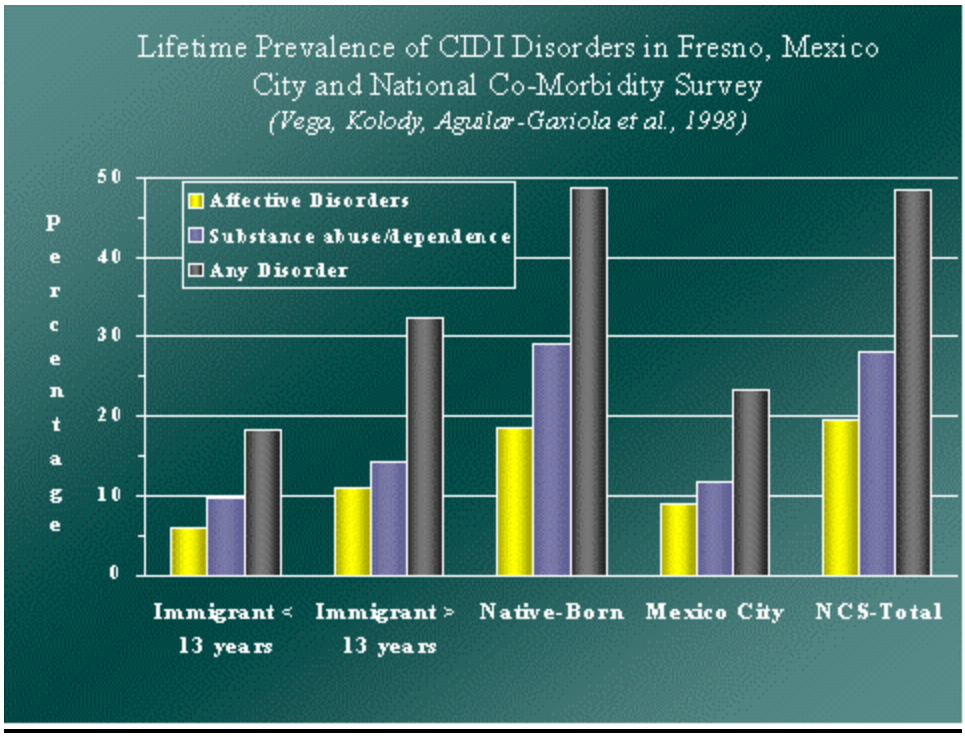


Interventions with Latino Adults

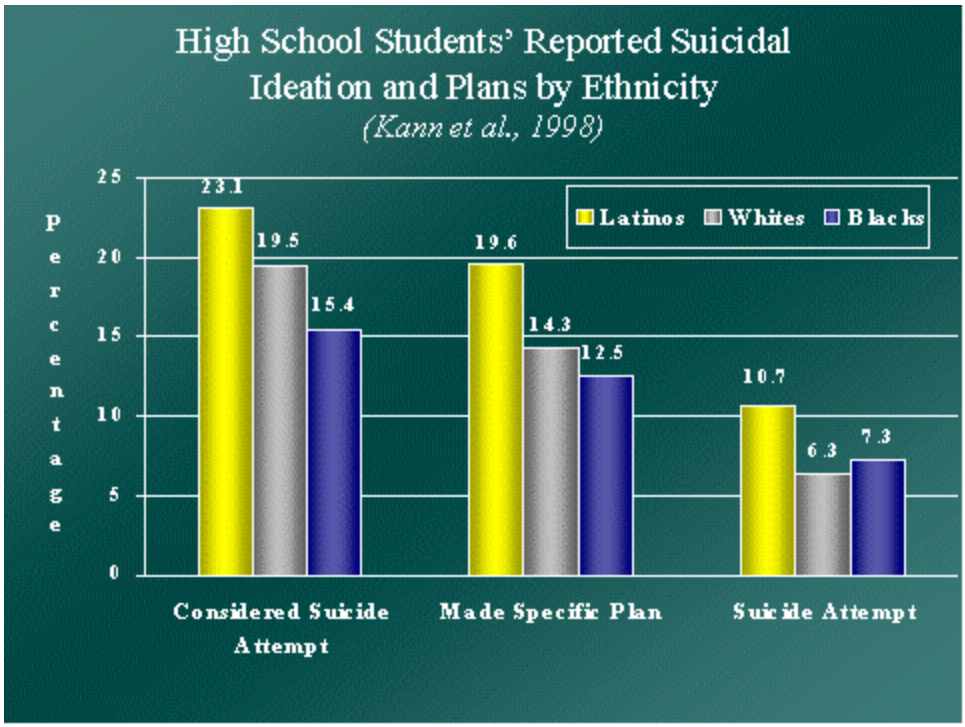
Very little is known about the effects of mental health interventions for Latino adults or children/adolescents. Recent studies do show that Latino adults are being included in effectiveness and efficacy interventions for mental health disorders. One such study consisted of testing the effectiveness of cognitive behavioral therapy for depression among primary care patients (Miranda and Muñoz, 1994) and included a 24 percent Latino sample. The authors found that patients receiving the cognitive treatment improved significantly relative to those receiving little or no intervention. However, analyses were not reported separately for Latinos. A more recent efficacy study (Telles, et al, 1995) of schizophrenia among a Spanish-speaking (primarily Mexican American) group, found that both individual case management and behavior family treatments reduced symptomatology and prevented patient relapse. However, patients in the behavior family intervention were more likely to suffer an exacerbation than those in the case management condition (especially those classified as low acculturated), which was contrary to the author's predictions.

A most ambitious effectiveness study has been recently carried out in 46 primary care clinics across six managed systems of care including one in San Luis, Colorado and one in San Antonio, Texas (Wells et al., 2000). Both cities have large Mexican American communities. Latinos comprised nearly a third (30%) of the enrolled sample (N = 1356). The purpose of the study was to assess the effects of programs to improve the quality of care for depression. Specifically, usual care was compared to two interventions, one for which medication was administered and closely followed-up for 6 or 12 months, and the other for which local psychotherapists provided cognitive-behavior treatment ranging from 4 sessions for minor depression and related problems to 10-16 sessions for major

depression. Although analyses with regard to ethnicity have yet to be published, the initial findings indicate that relative to usual care the quality improvement programs had significant effects on treatment process, clinical outcome, and even social outcomes (e.g., employment).

Latino Adolescents and Children

There is evidence that shows Latino children may be affected by a disproportionate amount of emotional and behavior problems. The 1997 report on the Center for Disease Control's Youth Risk Behavior Surveillance Survey, based on 16,262 high school students of various ethnic groups provides such evidence. Relative to other ethnic groups, Latino male and female adolescents reported higher rates of suicidal ideation and attempts than both White and Black male and female adolescents.



Depressive symptoms, in particular, appear to be high among Mexican American children. In a recent report of over 5,000 middle school children, Mexican American youth had the highest rates of depression relative to other 9 ethnic groups sampled (12% versus 8.4%).

Puerto Rican children on the island of Puerto Rico also reported higher levels of problems. In one study, a higher percentage of Puerto Rican children were classified to be in the clinical range (35.8% versus 8.7%) relative to normative samples from the United States mainland.

Little is known about the mental health status of immigrant versus United States born Latino children. Data from the National Longitudinal Study of Adolescent Health (ADD

HEALTH), a nationally representative study of adolescents in schools (grades 7 through 12), point to a similar pattern to the one found for Mexican American adults. Immigrant adolescents (across several ethnic groups), experience fewer physical health problems, have less experience with sex, are less likely to engage in delinquent and violent behavior, and are less likely to use controlled substances than United States born adolescents.

Interventions with Latino Children/Adolescents

Two groups of investigators have carried out programs of research to develop innovative culturally appropriate treatments for at-risk Latino youth populations. Szapocznik and his colleagues (1997) have designed interventions for Latino families in Miami. These authors combine structural and strategic family approaches with attention to the ecosystems in which families live. The treatments are typically targeted at changing family interactions with the goal of reducing behavior problems in children/adolescents with special attention given to reducing drug use. For example, family effectiveness training (FET) contains three specific components to accomplish these goals: family development, bicultural effectiveness training, and strategic structural family systems therapy. In one study with high risk 6-12 year-olds, children were found to have less behavior problems and higher self-esteem than children in the minimal contact condition. In addition, improvements in the family structure of families in the FET condition were observed (Szapocznik et al., 1989).

Malgady, Rogler and Costantino (1990) have developed innovative treatments for Latino children and adolescents from the New York City area. Their framework draws on social learning theory in which positive models are presented to children and adolescents in addressing problem areas such as anxiety, low self-esteem, and acting out. One such program of intervention is called Cuento therapy and uses Puerto Rican folktales. A second, called Hero/Heroine Modeling uses metaphors. Both treatments have helped in the reduction of depressive symptoms, as well as improving self-esteem and social functioning.

Parent Child Interaction Therapy

PCIT is an integrated and intensive parent-training program intended to enhance parent-child relationships, improve children's behavior, and increase parenting skills. PCIT is unique in that it employs a live coaching procedure. Through the use of a "bug-in-the-ear," the therapist provides direct coaching to the parent in the use of skills such as praise and selective attention while the parent plays with the child. There are two phases to the PCIT program. The first focuses on enhancing the relationship between the parent and child by increasing positive interactions and minimizing negative or coercive interactions. During the second phase, the parent is coached in the use of positive discipline strategies.

PCIT was initially designed as an intensive parenting program for parents who have limited or maladaptive parenting skills and young children (primarily ages 2-8; although

Chaffin and colleagues have extended this age range to 12 years) who are oppositional, defiant, non-compliant, and aggressive. Therefore, the following parent-child characteristics are most appropriate for PCIT:

* Aggressive, defiant, and non-compliant children
* Parents with limited, aggressive, or inappropriate parenting skills
* Parent-child dyads which are characterized as negative, coercive, and/or hostile.

PCIT has been found to be effective in reducing the parenting stress and potential for abuse in families at risk for child physical abuse. In addition, numerous studies have demonstrated the effectiveness of PCIT for reducing child behavior problems. Currently, several researchers are investigating the use of this treatment with Latino populations across the country.

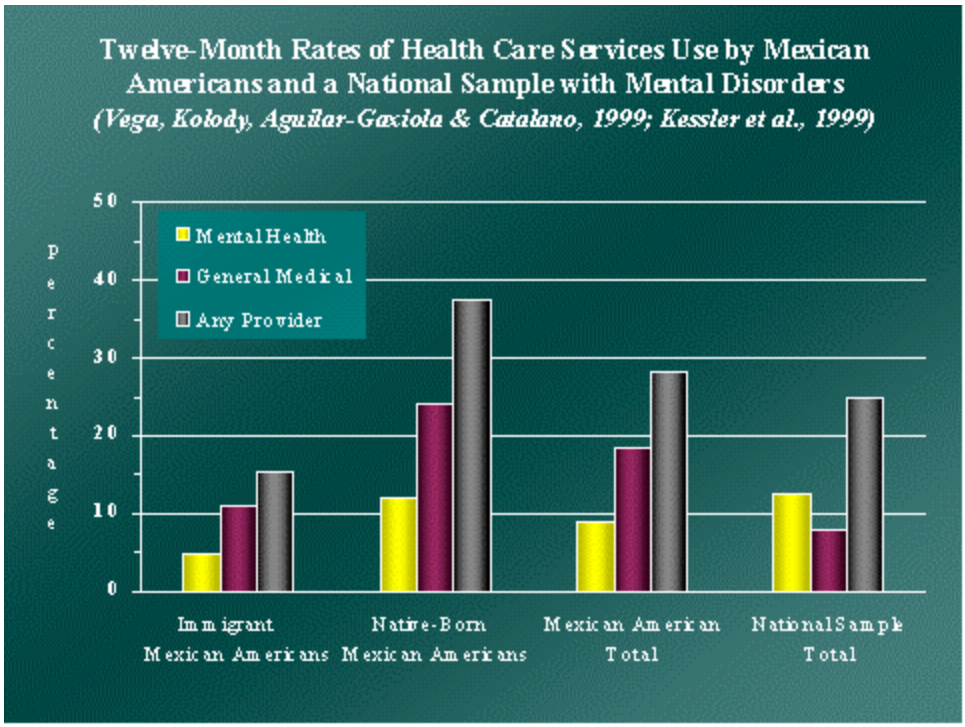
In sum, there is much research that remains to be conducted to determine the most effective way to treat Latino adults and children and adolescents. The adult studies summarized in this section have mostly focused on existing disorders, but have not been tailored to Latinos specifically. The youth treatment programs mentioned above, on the other hand, are mostly preventive efforts aimed at high-risk groups, and represent an emphasis in more culture-specific or culture-adjusted interventions. There is also a need to document the existing practices in treating Latinos, with an emphasis of what actually takes place in both the public and private sector with regard to the provision of mental health services.

Mental Health Services

The available studies of utilization of mental health services indicate that Latinos with diagnosable mental health disorders are receiving insufficient mental health care. In a study using the Los Angeles- Epidemiologic Catchment Area (ECA) sample (Hough et al., 1987), Mexican Americans with mental disorders within six months prior to the interview reported using both health and mental health services at a lower rate than non-Hispanic Whites (11.1% versus 21.7%, respectively). Similarly, in the recent study from Fresno, California (Vega et al., 1999), Mexican Americans with mental health disorders during the past 12 months prior to being interviewed used mental health specialists at a rate of only 8.8 percent.

Country of origin and level of acculturation were important predictors of use of services for mental health problems in both of the studies cited above. For example, in the ECA study, mental health specialists among the low acculturated were used by only 3.1 percent of the sample, compared to 11.3 percent among those categorized as highly acculturated (Wells et al., 1987). In the Fresno study, only 4.6 percent of those born in Mexico with mental health disorders in the past 12 months prior to the interview had sought help from a mental health specialist, compared to 11.9 percent of those born in the United States.

Not all studies of service use among Latinos point to high levels of underutilization. In Puerto Rico, community surveys have indicated that anywhere between 31.5% (Alegria, et al., 1991) and 85% (Martinez, et al., 1991) of those with diagnosable psychiatric disorders received services for their problems.



In sum, these findings indicate that Latinos in the continental United States, particularly those who are immigrants, make very little use of mental health services. One obvious barrier to accessing services for Latinos is their high rate of being uninsured.

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Chapter 2

Cultural Competency

Introduction

The Surgeon General's 1999 Report on Mental Health offered a singular recommendation: People should seek help if they have a mental health problem or if they think they have symptoms of a mental disorder.

This simple statement belies the complex reality underlying it: access to mental health services is fraught with barriers, especially for clients and families whose race, culture and class push them to the margins of U.S. health care systems.

Understanding how issues of race and class create barriers to care is essential to addressing those barriers in a culturally competent way.

The mental health field in the U.S. continues to be dominated by white, middle-class professionals who are primarily English speakers.

What implications does this have for people of color with mental illnesses and their families? This section of the Latino Resources Manual recognizes that tremendous racial and cultural barriers persist for Latino families seeking resources and support.

The following section offers concrete strategies toward reaching out to and serving Latino families dealing with mental illness.

What is Cultural Competency?

Cultural Competency can be defined as:

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations. Cultural competency is the acceptance and respect for difference, a continuous self-assessment regarding culture, an attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations (Cross et al., 1989).

Davis (1997) operationally defines cultural competency as the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the individual's culture and increase the quality and appropriateness of health care and outcomes.

Cultural competency does not refer to the establishment or maintenance of diversity per se. The concept of competency is not related to numbers of representation, either in clients or in service providers. Competency refers more explicitly to folkways, mores, traditions, customs, formal and informal helping networks, rituals, dialects, and so forth. In these areas, knowledge about various cultures and the development of specific skills and attitudes in providing services in a manner consistent with the consumers' needs are essential.

Why is Cultural Competency Important?

The cultural appropriateness of mental health and support services may be the most important factor in the accessibility of services by people of color. Developing culturally sensitive practices can help reduce barriers to treatment. Knowing whom the consumer perceives as a "natural helper" and whom he/she views as traditional helpers (such as elders, the church) can facilitate the development of trust and enhance the individual's investment and access to treatment.

America's population is not only growing, it is changing dramatically. NAMI groups and chapters must reflect this reality. Shifts in ethnic diversity are not just about numbers, but also the impact of cultural differences. New approaches to organizing, support, and advocacy are needed to address cultural differences among consumers.

Essential Knowledge, Skills, and Attributes to Developing Cultural Competence
Ensuring the provision of culturally competent services to potential members places a great deal of responsibility upon the organization. In particular, there are a number of generally expected levels of knowledge, skills and attributes that are essential to providing culturally competent support services. For example:

Knowledge

- Knowledge of members' culture (history, traditions, values, family systems, artistic expressions).
- Knowledge of the impact of racism and poverty on behavior, attitudes, values, and disabilities.
- Knowledge of the help-seeking behaviors of ethnic minority members. Knowledge of the roles of language, speech patterns, and communication styles in different communities.
- Knowledge of the impact of the social service policies on people of color.
- Knowledge of the resources (i.e., agencies, persons, informal helping networks, research) available for ethnic minority families and communities.

- Recognition of how professional values may either conflict with or accommodate the needs of families from different cultures.
- Knowledge of how power relationships within communities or institutions impact different cultures.

Skills

- Techniques for learning the cultures of ethnic minority groups.
- Ability to communicate accurate information on behalf of culturally different families and their communities.
- Ability to openly discuss racial and ethnic differences/issues and to respond to culturally based cues.
- Ability to assess the meaning that ethnicity has for individual consumers and their families.
- Ability to use resources on behalf of ethnic minority families and their communities.

Communication is Key

Obviously, the most fundamental asset to any relationship is communication. We all use verbal and non-verbal ways of expressing ourselves that have been influenced by the culture in which we were raised. These styles can vary dramatically for people from other backgrounds. For example:

Personal Space:
In the U.S. it is common for people to stand about 3 feet apart when having a personal conversation. In other cultures, people may typically stand close, which may feel awkward to someone unfamiliar with this style.

Interruption and Turn-taking Behaviors:
Most Americans have come to expect a conversation to progress linearly, while in other cultures it may be more natural for several people to be talking at once. Listening skills to deal with different turn-taking rules must be developed.

Gesturing:
Hand and arm gesturing can vary quite a bit in different cultural backgrounds. In general, extra gesturing should not necessarily be interpreted as excitement since it can just be an ordinary manner of communication, depending on the speaker.

Facial Expression:
Variance in this form of communication is also common, and again it is important to not assume that someone is cold or distressed based solely on one's own cultural experience.

Eye Contact and Feedback Behaviors:
In the U.S., individuals are encouraged to look each other directly in the eye and participate actively in feedback behaviors (leaning forward, smiling, nodding, etc.). In

contrast, people from other backgrounds may show respect or deference by not engaging in eye contact or participating more passively in their body language.

Silence:
Americans often find it harder to tolerate periods of prolonged silence than do others from different cultures, and may try to fill it in.

Dominance Behaviors:
In the U.S., prolonged eye contact, an erect posture, looking down at someone with lowered lids, hands or hips, holding the head high are all examples of behavior that may be interpreted as assertive or even aggressive but can vary in different cultures.

Volume:
Irritation often results when culturally different speakers consider differing levels of volume acceptable. It is important to remember that each individual may be reacting based on the rules learned in his/her own background and considered normal by his/her peers.

Touching:
Persons from cultures outside the U.S. mainstream may perceive someone as cold and aloof if there is not much touching and standing close, while the American may find someone from a different culture a bit rowdy, intrusive, or rude.

Translator and Interpreter Challenges in Cross-Cultural Settings

The chief concern in communicating across cultures is ensuring that what one person intends is what the other hears. Additionally it is important to consider that communication consists of both verbal and nonverbal transmission of information. For communicating across languages, translation is a very difficult task. Problems are often associated with the interpreter's competence and translation skills, lack of familiarity with psychiatric terms, or with cultural knowledge and attitudes. Frequent errors include distortion, deletion, omission or blocking, exaggeration, incorrect translation, inappropriate cultural interpretation, or lack of translatable words or concepts.

Common pitfalls to avoid:
- Using a family friend or relative to convey information.
- Using secretarial, custodial, domestic staff, or children to assist in translation.
- Providing insufficient time for interpreter and consumer to be introduced and gain basic rapport.

Strategies that can help:
- Talk to the consumer, not the interpreter. Maintain eye contact.
- Use short, simple statements. Ask one question at a time.
- Speak slowly throughout. Try to sit down during the interview.
- Avoid idioms, jargon - speak in plain language.
- Do not raise your voice throughout the discussion.

- Plan for more time: using translators usually doubles the length of the interview.
- Some preparatory questions and ideas to help the discussion go smoothly:
- Do interpreter and consumer speak the same dialect?
- How proficient is the interpreter in the desired language?
- Use body language to accomplish the gains you desire.
- Is everyone's understanding of the point of the discussion clear?
- Use the interpreter as a cultural broker to explain idioms or meanings of particular terms.

Addressing Cultural Variability

Within each cultural group there is a tremendous amount of variability, or individual differences. It is true that "they are not all alike." Differences arise from a number of factors and should be recognized. Examples include:

Acculturation:
This factor reflects the extent to which a person is familiar and proficient within mainstream U. S. culture.

Poverty:
Poverty creates a unique and formidable set of resourceful behaviors needed for survival. These do not usually include awareness of traditional mental health issues and systems and may override priorities designed by those who are accustomed to and benefit from greater resources.

Language:
Differences exist not only in fluency in the client's native language and English, but also in dialect. For example, among Asians/Pacific Islanders, there are many language sub-groups. Latino groups include Mexican Americans, Mexicans, Central Americans (e.g., Salvadorans, Guatemalans, Hondurans, Nicaraguans) and South Americans (Argentineans, Venezuelans, etc.). The Mexican province of Oaxaca alone has 23 regional indigenous dialects, not including Spanish.

Transportation, Housing & Childcare:
Often associated with poverty or immigrant status, daily necessities and a lack of available supports can interfere with access to treatment and support. It is incumbent on the organization to be culturally competent by addressing these basic needs as part of an outreach plan.

Reading Ability/Educational Background:
Individuals can vary substantially in academic experience and aptitude. This is true within each ethnic subgroup (e.g., Mexican Americans), as well as between subgroups (Guatemalans vs. Argentineans).

Beliefs:
People from diverse cultures vary in their beliefs about what is considered "illness," what causes the illness, what should be done to promote healing, and what the desired functional outcome should be. Do not assume that the consumer's views will match your own.

Physical Characteristics:
People of color differ in their appearance, even within a particular ethnic group. For example, Latinos can have very dark skin, brown skin, or blond hair and blue eyes.

Engaging Latino Families

Providing guidelines for engaging families from other cultures presents a paradox. Making generalizations about people from "other cultures" or about all people from a specific country is just a more sophisticated form of the stereotyping that is the core problem. Imagine a Chinese writer formulating guidelines for being culturally sensitive to Americans. How could the guidelines be accurate about American residents of New York slums, Iowa farms, Alabama small towns, and New England suburbs? Family interventions should not be based on cultural stereotypes. The ultimate in cultural sensitivity is to strive to accept, understand, respect, and affirm the unique culture and values of each family. The best way to engage any family is to respect and work within their beliefs and values.

Nonetheless, organizations must make their best efforts to engage families who speak different languages and have a wide variety of beliefs and values. Therefore, some generalizations about engaging families from other cultures will be presented.
[Author's note: The reader should recognize that these generalizations are inherently inaccurate. The process of using them parallels the process of family education. The author (or educator) can present common phenomena and average data. The reader (or family) must use the pieces of information that fit the unique family. The guidelines provided below could be used as a set of possibilities that the reader can consider as she seeks to understand each family that she serves.]

Latino Families Who Do Not Speak English As Their First Language

Language is a difficult barrier on obvious and subtler levels. Obviously, if no communication occurs, no intervention is possible. More subtly, translation of words and ideas is necessary, but not sufficient for communication. For example, in Spanish there is no word equivalent to "coping," but many family courses are titled, "Coping with Mental Illness." Language is much more than a set of words, it is a set of meanings. Therefore, translations must transform concepts to versions that present the core principles in ways that are meaningful to the family. Guidelines for assisting non-English-speaking Latino families include:

- Speak the language and dialect that the family speaks.

- Be of the same ethic and cultural subgroup as the family so that common meanings and experiences are shared.

- Provide written materials, audio tapes, or videotapes in the family's language.

- Offer support groups in the family's language.

- Have translations read by several people, especially people who have the education and worldviews of the target families. Retranslate materials to English to see if the core meanings are communicated.

- Seek to translate principles congruent with cultural values. For example, mutual interdependence is more highly prized than independence by some cultures.

- Be aware that different generations of the same family may have different primary languages. Address this issue before deciding which language to use for a specific intervention. The language chosen communicates that the family members who speak that language are more highly valued.

- Avoid using a child as an interpreter. This undermines the family hierarchy. Messages delivered through the child may be viewed as impudent or disrespectful.

- Families from cultures reluctant to use psychiatric services

- The meaning and consequences of having a 'family member who has a mental illness' or of attending a support group are different for families from different cultures. For example, mental illness is interpreted in some cultures as the family having 'bad blood.' Therefore, disclosure of mental illness may severely limit the marital opportunities of all members of the family.

- Emphasizing the genetic cause of schizophrenia, for example, only intensifies this discrimination. Families may feel stigmatized or shamed by seeking support. Families may also be uncomfortable with or mistrust white-dominated facilities or programs. They may see these programs as unresponsive to their needs or as threatening to their immigration status or government benefits. Guidelines for engaging these families include:

- Make the initial contact as welcoming as possible. Take extra time to chat about the weather, answer questions, or provide assistance that can form a bond with the family. The initial contact is often a very tentative test of whether the program will be welcoming and provide assistance. Offering a "gift" of reassurance, guidance, or a resource in the initial meeting may be necessary to ensure a second contact.

- Provide support over the phone for families reluctant to come to the group.

- Provide outreach services to the family home to engage reluctant families and to allow as many members of the extended family as possible to benefit.

- Discover who the head of the family or key decision-maker is. As a sign of respect ask her permission to speak to family members.

- Ask the head of the family for his perception of the problem; ask him, "What do you think the problem is?" "What type of support do you think is needed?" "What will make things better?" "Who can help?"

- Accept the family's view of mental illness. They may view it as caused by bad luck, evil spirits, evil eye, punishment by God, or impaired relationships. Other cultures are less focused on the individual as responsible for everything than Anglo-American culture is.

- Recognize that many cultures do not clearly differentiate physical, emotional, and spiritual problems. Describing symptoms through somatic and spiritual complaints may lead to less social rejection and loss of self-esteem.

- Invite, seek input from, and provide assistance to as many members of the extended family and support system as will participate (and as the family wishes to participate).

- Respect healers that the family trusts and values, including: ministers, root healers, family doctors, priests, herbalists, diviners, espiritistas, and santorios. Folk healers are trusted and valued because they use methods and language that parallel family and community beliefs.

- Utilize priests, medical doctors, and other natural caregivers as links between the needs of families and the services of the program.

- Have a family from the same culture and with a similar problem make a telephone call or home visit to form a relationship with the family.

- Have a similar family act as a sponsor. The sponsor can provide regular phone contact and transportation and can accompany families to appointments or classes.

- Provide reminder phone calls and transportation to overcome last minute reluctance and to further strengthen the social relationship element of attendance.

- Provide food to facilitate social interaction and make families feel valued and welcome. Sharing of food and small talk is a critical prerequisite to accepting advice or services in several cultures.

- Offer social events (e.g., family nights, awards presentations, and holiday events) to invite families to the program for a non-threatening activity.

- Accept with great ceremony gifts or food offered by a family. Demonstrating respect for their gift is often a requirement for the relationship to continue. In many cultures receiving services without offering a gift in return would be degrading to the family and indicate that the family had no value or honor.

Latino Families Who Have Few Economic Resources

Some families have so few economic resources that the price of bus fare may prohibit them from attending a group. Travel may not be safe in their neighborhood or in the areas that they must pass through. There may be no one available to supervise the person or other children while parents attend a group. Single parents or parents with multiple jobs and several children may be overwhelmed by competing responsibilities. Programs can improve their accessibility to low-income families by overcoming these barriers. Methods include:

- Provide transportation or bus fare.

- Bring services to the family home or to a neighborhood church.

- Provide activities or childcare for children.

- Do not charge fees, request donations, or "pass the hat." Families unable to contribute may feel shamed and fail to return.

- Do not establish officers and other formal structures that may intimidate families or be perceived as another burden on an overwhelmed family system.

- Be sensitive to the verbal and reading abilities of participants. Families can be shamed by being unable to understand the discussion or to read, and may not return. Each solution may create another problem. For example, audio tape versions of handouts can be distributed, but are useless and produce shame if the family does not have a tape player. Another example is that simplistic language or presentations can be seen as condescending.

Example of a Latino Community

Mexicans Living in America

Cultural values:

- Famialism is critical. Family membership, obligation, and pride are strong values. The family is more important than the individual. Membership not independence is valued.

- Recognize the value of their alternative treatments (i.e. curandero herbs - prayer).

- Recognize the husband is the proclaimer (projects self-assurance and calm when challenged) and the wife is the implementer (active and easier to connect with).
- Recognizing their somatic complaints are manifestations of underlying symptoms.
- Recognize there is a certain quality of fatalism and acceptance of inevitable destiny.
- Acceptance of family - as is.
- Recognize difference between urban vs. rural community.
- Taught to not discuss family matters with outsiders.
- It is shameful for a family not to be able to handle its own problems.
- Spirits (good and bad) intervene directly in people's lives and are the cause of mental illness.
- When a person is seen as locura they are perceived as evil, dangerous, and crazy. Viewing a person as nervios implies a constitutional weakness that is not the person's fault. Altering family and community attitudes to view a person as nervios brings acceptance, empathy, and assistance.
- Feel alienated or afraid of government systems especially if immigration status has been or is a problem for any member.
- The family will be avoided and discriminated against if the community discovers mental illness in the family.
- Will say yes to authority so as to not show disrespect even if have no intention of following through.
- Speak to the head of the family.
- Involve the extended family in services. Often the best method is an initial home visit to which everyone in the family and support system is invited.
- Create a support system by providing a sponsor or indicating that other participants are in the families'social network.
- Cooperate with folk and religious healers. Never contradict or undermine these methods. Offer services in addition to these healers.

Mexican American Acculturated Latino

Guidelines for professionals:

- Recognize and be empathetic to their specific crisis.
- Gain trust.
- Provide services at a time they can attend.
- Don't assume they need "Spanish only" service.
- Make contacts/outreach unexpectedly.
- Offer services that will meet long range goals or provide linkage.
- Encourage members to take an active role in seeking services. Be assertive!
- Provide financial benefit information. Provide information on navigation through the system.
- Understand Myths/Stigma's associated w/mental illness ("Locura's the "Shishshhh", My son "el Muerto").

Questions for Organizations Interested on Latino Outreach

1. What is the ethnic and racial composition of the leaders of this group?
2. Is this reflective of our commitment to cultural competence?
3. What is the ethnic and racial composition of the full group?
4. Is this consistent with our commitment to serving the needs of the Latino community?
5. Is this group's location accessible to Latino families?
6. Is the group's meeting times and childcare arrangements attractive to working families, families living in poverty, and families with children?
7. Is the group accessible to Spanish speakers?
8. If this group were truly representative of the population of this community, how might its support and advocacy functions expand or change?

Chapter 3

Formulating an Outreach Plan

Making the Final Decision to Conduct Outreach

In order to begin planning in earnest for your outreach activities, it is necessary to develop a consensus within the organization to embark on an outreach effort. This phase is crucial to the future development of your project. This is because outreach activities often appear attractive "in theory" when, in actuality, such efforts can be quite time consuming and demanding. For these reasons, it is imperative that unanimous or near-unanimous agreement exists among the organization that an outreach effort is needed and desired.

A meeting or several meetings should be held at which the idea of an outreach plan is presented and the pros and cons of developing such an effort is honestly discussed. Be aware that some individuals may hesitate to openly express reluctance or disagreement with the decision to conduct outreach activities. It is important that people be given a chance to express negative feelings about the potential of doing outreach without fear of being accused of insensitivity to the needs of Latino families. It is much better to allow all opinions to be heard before making the final decision to develop an outreach program. Allowing everyone's opinions to be heard will help to ensure that as many members as possible buy into the plan.

Formulating an outreach plan involves three basic steps:
1) Formulating your basic outreach plan
2) Funding your outreach efforts
3) Disseminating and publicizing your outreach efforts.

Identifying the Target Groups

After the affiliate members have made the decision to begin in earnest, it is important to decide which Latino group or groups to target (be specific). This is a very important juncture in the development of outreach plans; the group selected as the focus of activities will shape the nature of the outreach program in a central way. For example, the decision to target Latino families necessarily involves making language a major part

of the outreach effort, since many community members will not speak English as their primary language. Keep in mind that there is linguistic diversity even among Latinos; for example, Brazilians speak Portuguese and different versions of Spanish are spoken in countries such as Mexico, Puerto Rico, and Venezuela. Another good and easy example is the difference in cuisine throughout Latin American. Unfortunately, many people mistakenly believe that if a person is Latino he/she must eat a lot of beans, burritos and fajitas. This is a stereotype that could insult your audience if they are not from Mexico. In reality, the traditional foods of the Latin American countries are very different and diverse.

It is important to be realistic when choosing the target community. Although your group may be quite enthusiastic, selecting more than one ethnic population to work with may drain your resources. Remember, targeting two groups involves doing twice the work. This may not be a good idea if your membership is small, if financial resources are severely limited, or if some members have lower enthusiasm than others. Ultimately, however, the decision is up to you because you will have to live with the consequences.

In making your decision, it may be helpful to consider something we learned when conducting a national telephone survey of NAMI-affiliated minority outreach programs (Cook Knox, 1993). In that survey, representatives of outreach efforts targeting more than one group expressed reservations about their decision. First of all, only a third of the 50 programs contacted were even attempting to work with more than one ethnic group. Those that did reported many problems, including their belief that targeting more than one group meant that neither group was served well.

1. Formulating A Basic Outreach Plan

Once the target group for outreach has been decided, the next meeting should involve members of your group along with a key informant or community gatekeeper and any other members of your target community who are willing to provide you with feedback and suggestions. Identifying these key community agents is a critical part of your early planning process.

It is important to involve community members at *this* stage, in order to ensure that plans are relevant, responsive to the community's needs, and as culturally meaningful as possible. It is not suggested that community members attend the initial planning meetings, because their presence may inhibit people who are opposed to the effort from making their feelings known to the group. However, at this point, group members will have been given ample opportunity to air their opinions and concerns, so that the attendance of community members can enrich the planning process without stifling opposition.

One of the most important parts of developing an outreach plan involves deciding on the major focus of activities. It is recognized that most successful outreach efforts include four basic components of outreach. The first component is education of Latino families about the nature of mental illness, its causes and treatment, available services and

resources, and current research. The second component is formation of ethnic-specific family support groups which are led by and focus on the experiences and problems specific to people of color. The third component is recruitment of community members into the local and national organizations. Finally, the fourth component is advocacy on behalf of mentally ill people and their families through lobbying for better services and a more responsive mental health system.

A particular outreach program can include one, several, or all of these components. In a NAMI national survey, a diverse mix of components in the different outreach programs studied was evident. Interestingly, every program surveyed reported that their outreach efforts included an educational component. Over half of all affiliates (56 %) surveyed reported that their activities involved efforts to recruit people of color as members of the local and/or national NAMI organization Over half (55 %) of the programs surveyed included the formation of ethnic specific support groups. The least frequent component of outreach programs was advocacy, reported by 40% of all respondents.

It is totally up to the group the decision about which components to include in the outreach plan. It is important to solicit the opinions of community members to help make this decision. For example, they may feel that establishing support groups is more important than recruitment. A sole focus on recruitment may convey the impression that the group is only interested in increasing the size of the membership and not in meeting the needs of the target community. Also, members of the target group may not have the financial resources to pay membership dues. If recruitment is a major goal of the outreach plan, it is advised to consider offering free membership for a year to demonstrate sincerity and give people an opportunity to see what services can be provided before they are asked to contribute financially. As another example, your Latino community advisors may feel that their community needs education more than it needs advocacy. Listen to their opinions carefully because they are in the best position to accurately assess needs.

After considering their opinions, the group members' preferences, available monetary resources, and the natural talents of your group's members, the outreach effort will be in a good position to map out the components that you want to include in your planning.

After making decisions about which components will be part of the plan, it is time to identify the specific goals that activities will address. The group should try to identify one or two goals for every component. Keep in mind that goals are statements that say exactly what is expected to accomplish through each component. Listed below are some examples from the aforementioned NAMI national survey of outreach program goals and the component to which they are related.

COMPONENT	POTENTIAL GOALS
Education	-Translation of a pamphlet about the causes and treatment of mental illness into Spanish -Creation of a videotape explaining different types of psychotropic medications and their side-effects

-Compilation of a resource book containing the names, addresses and telephone numbers of all minority mental health treatment professionals and agencies in the community

Ethnic-Specific -Establishment of a Spanish-speaking family support group

Support Groups -Encouragement of attendance at a support group without requiring membership

Recruitment
-Sponsoring the first year of membership for low-income community participants
-Setting a target of increasing minority membership by some proportion
-Making a commitment to increase the representation of minorities on an affiliate's board of directors

Advocacy
-Lobbying state government officials to increase funding for mental health services in the target community
-Meeting with the directors of all mental health agencies serving the Latino community to ensure that Spanish language services are available
-Making surprise visits to state inpatient psychiatric facilities serving Latinos to assess conditions

The foregoing are just samples of the many types of goals that the group may identify in the planning process. The exact nature of the goals is not as important as the requirement that they be specific and realistic outcomes of activities. Start with a potential set of goals, but should not be afraid to add or subtract goals as they proceed in your efforts.

2. Funding an Outreach Effort

The next issue to consider as the group proceeds with planning is how to fund identified activities. This is no easy question given that funding for such programs is quite limited. In the NAMI national survey a variety of funding mechanisms was revealed for existing outreach efforts. Some affiliates used special fundraising efforts (such as street fairs, concerts or silent auctions) or committed a proportion of their operating budget (typically derived from dues paid by members) to pay for outreach activities. Others were able to obtain funds from their state NAMI organizations or from state or local (i.e., city or county government) mental health, child protection, or health agencies. Still other programs had been successful in applying for funds from the federal government, specifically the National Institute of Mental Health Community Support Program (Brown & Ruiz, 1988). Some affiliates were successful in obtaining funds from local philanthropic foundations such as Community Trusts or United Way.

Given the limited funding available, it is a good idea to be aware of funding issues at the outset planning. However, the group may wish to begin developing a plan in the absence of identified funding. This way an "ideal" set of activities can be established and they ca be funded as activities progress. Having plans in place puts the group in a position to apply for money once they learn it is available rather than starting from scratch after they learn of potential funding mechanisms.

3. Disseminating and Publicizing the Outreach Efforts

A final aspect of planning should cover the ways in which the group is going to inform others about the planned activities. The most important group to reach is the community targeted for outreach. The group should pay close attention to how they plan to let community members know that the program is operating and what it has to offer. Another target for dissemination consists of minority mental health professionals and mental health treatment programs serving predominantly Latino and other minority populations. These individuals and organizations are crucial to outreach success because they, in turn, can help reach members of the target community. Still additional target groups for dissemination are local community organizations such as churches, ethnic clubs, sports facilities, and public educational institutions. Many people can be reached through groups such as these, and they should have been identified in the early stages of your planning process.

Finally, the group should make plans for a public relations campaign that accesses the media familiar to the community. Press releases, public service announcements, short newspaper articles detailing your efforts and appearances on local television programs that cover local activities and events should be planned. Other potential media outlets to consider include minority owned radio stations and Spanish-language television stations as well as public access channels on cable television. Pay particular attention to those media outlets that are frequently used by members of the target community; advertising the program in culturally appropriate media will ensure that information reaches the people the group wants to inform.

Case Examples to Use in Outreach

At some point during the planning process, members of the group should read and complete the following case examples. These vignettes illustrate "typical" problems faced by NAMI affiliates who have attempted to outreach to minority communities. Reading and discussing them will help clarify which components the group wants to include in the project, as well as potential barriers the group may need to overcome. Each group member should read each case and record their answers to the questions below.

Case #1: Your organization is a rural self-help group for family members of persons with mental illness. You hold one "multicultural day" at your office, for which you advertise in the newspaper, but attendance is poor. Despite this, your group is determined to try again. What barriers are you facing? What plans will you make for your new efforts? Be very specific.

Case #2: Your urban organization advocates for persons with mental illness and is trying to get started on a Latino outreach program. Although some of your organization members are not enthusiastic about the effort, others support it. However, most are white, with very limited knowledge about cultures other than their own. Organization members want to reach all of the Latino groups in your area. How would you get started? What barriers are you facing? What plans will you. make for your new efforts? Be very specific.

Case #3: You are a small town affiliate wanting to increase your Latino membership. However, your members know very few non-white families. They have difficulty knowing where to find others to invite to a support group meeting. On top of that, you have a very small operating budget and *cannot* afford to spend a lot of money.
How would you get started? What barriers are you facing? What would you plan and how would you locate your target group?

Case #4: Your small city affiliate has been trying to start a Latino outreach program for about four months. You have started a monthly lecture series on Latino mental health issues. Affiliate members have posted signs announcing each month's speaker and topic at various mental health agencies around the city in the hope that a wide range of people would attend. This is not working out as planned because no Latino families have attended *the* first four lectures. What is your next step? What barriers are you facing? What are you going to do next?

Summary

By the end of the planning process, the group will have *accomplished several* major objectives. They will have dealt with the question of whether or not to embark on an outreach program; identified a target group; completed a cultural mapping, found a key informant, and finished participant observation exercises; formulated a basic outreach plan; identified potential funding for the activities; and planned for publicizing efforts to target community members, professionals, and others. The Planning Outreach Pages included on this manual would help accomplish these objectives.

The next steps involve "filling in the blanks" by planning and actually implementing *some specific* outreach strategies. What follows are brief descriptions of successful NAMI Latino Outreach strategies and the Planning Outreach Pages that will aid you in this process.

Mental Health Conference in Spanish

NAMI Connecticut

Latino/Hispanic Outreach in Connecticut
Holding a Successful Conference – What Was the Magic?

The U.S. Surgeon General's report, *Mental Health: Culture, Race and Ethnicity,* issued in August 2001, estimated that as many as 40 percent of Latino/Hispanic Americans report limited English-language proficiency. Because few mental health care providers identify themselves as Spanish-speaking, most Latino/Hispanic Americans have limited access to ethnically or linguistically similar providers.

This problem is clearly illustrated in Connecticut. Connecticut has one of the fastest growing populations of Latinos in the United States, and yet there is a severe shortage of psychiatrists and mental health professionals who speak Spanish. In addition to the language barrier, stigma and cultural factors in Latino communities make people even more reluctant to seek treatment for mental illness. Many people are going untreated. To help ease this problem, NAMI of Connecticut and the Yale Medical School Department of Psychiatry set out to coordinate a day-long conference given all in Spanish, featuring Spanish-speaking mental health providers.

The conference, **"Aprendamos de Problemas Emocionales y Adicciones,"** held on 2001, was:

- Free of charge and entirely conducted in Spanish
- Held at a high school in the community, rather than an academic or medical setting.
- It drew about 400 Latinos eager to learn about how to access care.
- Yale and state mental health experts and community organizations presented an overview of "emotional" disorders.
- The goals were to give names to the difficulties Latinos may be experiencing, such as depression, anxiety, schizophrenia and addiction, and to outline treatments.
- The day included breakfast and lunch, musical entertainment during the lunch hour,
- We provided free childcare for children over 3 years of age.
- We utilized hundreds of pamphlets, brochures, and fact sheets from the National Institute of Mental Health, written in Spanish, on various mental health issues and "emotional" disorders for adults and children.
- In addition to several speakers, seven break-out workshop sessions were offered to educate people about psychiatric illnesses and advocacy:

Apoyandonos Unos a Otros -- Supporting Each Other
Familias Bregando con el Sistema -- Families Working with the system
Espiritualidad y Salud Mental -- Spiritual and Mental Health
Sus Derechos con el Sistema de Salud Mental -- Your Rights within the M. H. System
Reforzando la Comunidad con Nuestra Cultura -- Reinforcing the Community with Our Culture

Como el Estigma Impide Buscar Ayuda y Como la Prevención a la Adicción es Acción -- How Stigma Impedes Looking for Help and How to Take Action in the Prevention of Addiction
Servicios para Niños --Services for Children

(The most valuable element of our conference planning included the many volunteers; family members, consumers and professionals, who met on a regular basis to plan all aspects of the conference)

Who

NAMI of Connecticut, Yale University Department of Psychiatry, Department of Mental Health and Addiction Services, State Office of Multicultural Affairs, Hispanic Health Clinic New Haven, Connecticut Mental Health Center, Intercommunity Mental Health - Second Wind Clubhouse, Connecticut Hispanic Addiction Commission

Purposes of the conference

- Educational/Dissemination of research findings
- NAMI and NIMH Information and Resources

Support to draw large Spanish speaking audience to the conference

- Themes
- Location
- Tips to draw large audience
- Transportation
- Promotion
- Food

Conference Committees:

- Audiovisual and Presentation
- Brochure and Flier Design, Printing
- Childcare
  - Liability Insurance
  - Licensed Daycare Workers
  - Structured Entertainment - Peabody Museum
- Conference Registration
  - Conference Packets - NIMH Information in Spanish
  - Spanish-Speaking Volunteers Day of Conference
  - Registration Tables for Attendees, Speakers and Volunteers
  - Guides - High School Students
  - Separate Children's Registration Table
  - Color-Coded Bracelets to Match Workshops
  - Certificates Awarded for Attending Program
- Exhibition Tables for Speakers and Community Services
- Facility, Food and Entertainment
  - New Haven School - Facility Donated

Breakfast, Lunch, Music
Set-up and Clean-up

- Fundraising and Finance
- Mailing and Database
- Outreach, Advertising and Public Relations
  Newspaper, Radio, Faith Community, Local Businesses
- Speakers & Workshops
- Translation Services: Spanish to English
- Transportation - Vans from Mental Health Agencies

Budget

Corporate Donations	$3,900
University & Agency Support	7,917
NAMI Connecticut	1,570
	$13,387

What Was the Magic?

Goal: Community Education about Mental Health and Addiction

Recipe for Success

- Community-friendly conference location
- Program free of charge
- Community leaders and volunteers as organizers
- Spanish-speaking program
- NAMI-CT and NIMH resource materials and handouts in Spanish
- Exhibit tables offering community resources
- Breakfast and lunch included, plus music
- Transportation provided by mental health centers and clubhouses
- Free organized child care
- Open microphone for sharing experiences
- Gifts in kind
- Community spirit
- Volunteers and guides from the community
  Attendance: Over 400 adults and children

For More Information Contact:
NAMI Connecticut
151 New Park Avenue Box 50
Hartford CT, 06106
(860) 586-2319

Spanish F2F in Georgia

NAMI Georgia

Successful Spanish Language *Family-to-Family Program*

By Sandra Bravo, NAMI GA volunteer

Since 2001, **NAMI Georgina and the Dekalb Community Service Board (DCSB),** a local public mental health institution, have partnered to help the Latino Community. Joining resources and strengths, both organizations have helped to effectively reach more families of adults, adolescents, and children with mental illness who need support and mental health services.

The NAMI Family-to-Family Education Program is a free 12-week course for family caregivers of individuals with severe brain disorders (mental illnesses). Trained family members teach the course. All instruction and course materials are free for class participants. The Family-to-Family curriculum focuses on schizophrenia, bipolar disorder (manic depression), clinical depression, panic disorder and obsessive-compulsive disorder (OCD). The course discusses the clinical treatment of these illnesses and teaches the knowledge and skills that family members need to cope more effectively.

The 1st NAMI GA Spanish Family to Family course was so successful that the course participants decided to create a Latino NAMI affiliate. NAMI GA Latino and DSCB have made a commitment: to **"bring out of the hospital"** mental health issues by attending as many health fairs as possible. We are bringing mental illnesses out of the closet into public view and fighting old myths, taboos and stigma. Those fairs are excellent opportunities to share educational materials, and to promote services with others organizations, teachers, churches, social and health services providers, as well as reaching people who need mental health services. At the beginning of 2001 NAMI-GA had only one Latino volunteer. Now the State of Georgia has thirteen Spanish trained teachers, nine for the Family to Family program (F2F) and four for Vision for Tomorrow. Seven of the F2F teachers were trained in Spanish this last November. Also, the F2F program has been taught three times and Vision for Tomorrow has been taught once during these two years.

For more information contact:
Pat Strode
NAMI GA Family-to-Family Program Director
3050 Presidential Drive Suite 202
Atlanta GA, 30340
770-234-0855
or
Sandra Bravo, 770-723-0315

Bilingual Affiliate

NAMI Hudson County

NAMI Bilingual Affiliate

Overview

Hudson County is located on the northeastern part of New Jersey just minutes away from Manhattan. Of the total population of 608,975, 242,123 are Latinos. Back in 1998 Hudson County did not have a NAMI affiliate. Martha Silva, president of NAMI Hudson County, was asked to start a group. Since there was no other group like NAMI her new group was open for the English and Spanish speaking community.

The group now has 37 members 12 of which speak Spanish and very little English. Therefore, the meetings are conducted in English and translated into Spanish. Every activity and all materials are bilingual. For example, the monthly meeting reminder letters and the agenda are written in Spanish and English. This gives the Spanish-speaking members a sense of what the meeting is about and a follow up during the meeting.

How NAMI Hudson County got started

- Reason to reach the Latino community: the large amount of Latinos living in Hudson County, and the need for education and advocacy.
- Since it was created, NAMI Hudson County was established as a bilingual group.
- Developed an outreach plan:
- Designed and wrote brochures in English and Spanish.
- Created different sent of brochures (two complete sets). Note: sometimes it is not nice to do a translation on the same piece of paper that you are handing out, especially a brochure.
- During Mental Health Awareness Week NAMI Hudson County holds a candle light vigil and passes out invitations in both languages
- Organizes holiday dinners where they serve a lot of Spanish food (the Americans love it).
- The phone greeting starts in English and explains to hold for a Spanish greeting.
- English and Spanish language brochures and invitations to speaker's nights are distributed in hospitals, mental health clinics, and some doctors' offices.

Challenges

- Everybody seems to like this format. However, there are few challenges:
- As the group grows it is not easy to keep up with the translations, and of course it can get disruptive.
- When they have speakers, the train of thought can get lost.

- The meeting time is longer.
- There are people (Spanish speaking) that do not feel comfortable with translations therefore not attending the meetings.

Of this challenges Martha Silva says, “As you can see there are some problems, HOWEVER, it is amazing to see how the group that we have now wants to stay as one, they help each other, and there is a nice feeling of friendship.”

Next steps

- Hold meetings in Spanish and in English the same day, and at the same time, but in different room.
- NAMI Hudson County wants to invite Spanish speaking speakers, try to get videos, and materials in Spanish.
- Since the active members do not want to break the group it would function as one and it will be considered one affiliate.

For further information contact:
Martha Silva
President NAMI-Hudson County Bilingual Affiliate
7002 Adams St., Guttenberg, NJ 07093
201-861-0614

Bienestar Mental

NAMI New Hampshire

NAMI New Hampshire Reaches Out to the Latino Community with *Bienestar Mental*

Overview

Working with coalitions in the Nashua and Manchester areas of New Hampshire, NAMI NH has developed a unique program to meet the needs of the growing Latino community in those counties. The program called, Bienestar Mental works to educate Latino communities about mental illness and its effects on families; to improve access to mental health services and; to improve cultural competence of service providers.

To accomplish these goals NAMI NH has been working with the NH Minority Health Coalition, local community mental health centers, local health centers, schools, churches and key individuals from these and other organizations. They have been able to integrate resources from other grant programs, including CARE NH and the Division of Behavioral Health, into this project in order to expand outreach and education and support to Latino children and their families.

Bienestar Mental provides "peer educators" with information and technical support about mental health issues and their impact on families and assists them in becoming better able to identify potential mental health issues in families that they work with in the Minority Health Coalition programs.

The program includes the following resources and initiatives aimed at meeting the needs of the Latino communities in Manchester and Nashua counties:

- Educate the general public about mental health issues
- Train paraprofessionals in the Minority Health Coalition about mental illness and its effect on families
- Provide translation services to Latino families on medical visits
- Develop a resources library of educational materials appropriate for the Latino community
- Work with the community to teach providers culturally competent methods for working with people from other cultures
- Providing transportation and interpretation services to Latino families referred for mental health services
- Providing ongoing educational and information services for Latino families at the community church covering such topics as; *"What is Mental Health?", Depression, Attention Deficit Disorder, Stress and Relationships between Partners.*
- The NAMI NH affiliate in Manchester has created a web site for this program in Spanish.

- NAMI NH discusses in the local Spanish radio station mental health and access to care topics.

New program activities will include:

- Replicating program done in Manchester in Nashua county
- Expanding the use of Family-to-Family program with bilingual volunteers
- Expanding bilingual family partner initiative used to provide the cultural competency training to participants in 'wrap around' teams for children and families
- Continue work through an Advisory committee of local leaders

FUNDING

The program is funded through a grant from the Health Care Fund-Community Grant program in New Hampshire. As indicated above, NAMI NH also uses resources from other grant programs by integrating the issues of Latino community into all program proposals and activities when appropriate.

For further information contact:

Michael J. Cohen, MA, CAGS
Executive Director, NAMI NH
10 Ferry Street Unit 314 Mailing Room 308
Concord, NH 03301
603-225-5359 phone 603-228-8848 fax
mcohen@naminh.org

Latino Outreach Project

NAMI Oregon

Two-Year Grant Project

NAMI Oregon has a two-year grant project funded by Northwest Health Foundation to outreach the Latino community. The focus of this project is to improve mental health services to Latinos. The project has a coordinator, Delia Lemos, and an outreach worker, Jaime Silva.

The program staff started their outreach by contacting key Latino leaders in the community and agencies who work with Latinos. The focus behind this was to be able to reach more families by first educating professionals who can then go out into the rural areas of Marion County and conduct educational groups to families. This will alleviate most of the transportation problems. Among the organizations that were contacted were Mano a Mano (a social services agency for Hispanics), Nuevo Amanecer Farm Labor Housing Project, YWCA, Salud Medical Clinic, and chemical agencies including Bridgeway, Seasons, and New Step.

Activities:

- NAMI Oregon completed a 12-week Spanish Family to Family series and began a family support group with 10 family members.
- Identified two participants from the Family to Family classes who are interested in becoming teachers. They will be attending the next Teacher's Training.
- Will start soon a 12-week Family to Family class in a Woodburn housing project called Nuevo Amanecer. There is also another class forming in the Tillamook area.
- Experienced an increase of phone calls from family members needing advocacy due to problems with inadequate and culturally inappropriate services.
- Met with students from Portland State University who will be helping to design tools to measure outcomes and goals reached in the project.
- Completed a 12-week Family to Family classes to professionals. Out of that group, four people have stated that they want to become teachers for future classes.
- Jaime has begun visiting a Latino inmate at Oregon State Hospital and has also helped the inmate's family get signed up so that they can also begin visiting him. Through education and support, NAMI Oregon will work with the inmate and the family to help them have a smooth transition when he is released.

For more information contact:
Delia Lemos or Jaime Silva
NAMI Oregon
2620 Greenway Dr. NE
Salem OR, 97301
503-370-7774
d4lemos@earthlink.net

Visiones para el futuro

NAMI San Antonio

Visiones para el futuro
An Educational Program for Young Families

By Lupe Morin, President NAMI San Antonio

In San Antonio, Texas, the Spanish Visions For Tomorrow program has inspired many family members to reach out to other families to share all the knowledge and resources they learn during the VFT training. Many have moved on to advocacy by way of outreaching to schools, non-profits, and behavior clinics to ask for support in referring families to this training. This curriculum is a great tool for families to cope with their loved one's disability and to learn how to advocate for services.

NAMI San Antonio offers VFT in English and Spanish. Having teachers of the same culture as the students is a plus since people appreciate the cultural bond and are encouraged to become teachers too. By empowering these families with the VFT training we are ensuring a brighter future for our children i.e., getting the best educational plan for them, by educating teachers/professionals on how to deal with mental illness and teaching parents how to be the best advocates for their child. Most importantly, through the parents, the child learns that mental illness is a disorder and there is no shame in being ill.

We have gone beyond training and into social functions that include parents, children, and community members. These events help us integrate and break down barriers among the group. For example, we had a Christmas gathering that brought together families, community members, and professionals. The families played a big roll in the planning process and they actively participated in the activities. In the Latino families unity and participation are key factors for recovery. We make sure we include these elements in all our activities.

Frances Wise, NAMI S.A.- Executive Director, Martha C. Alvarado Director of The Edgewood Family Network and I began NAMI San Antonio's outreach to the Latino population. Now we are moving forward and reaching other communities of color that need our support. We are creating a strong and culturally diverse family support network.

For more information contact:
Lupe Morin
Family Resource Coordinator
(210) 436-8018
FAX#: (210) 436-8017
lupe@chcs.hhscn.org

Spanish Speaking Support Group

NAMI San Diego

Spanish-Speaking Family Support Group

El Grupo de Apoyo Familiar, (Family Support Group) has existed for over 20 years. The group meets once a month and some of the members engage in weekly social meetings and special activities. Some members have been there since its beginning.

How The Group Was Formed

Luz Maria Fernandez, MBA, LCSW, helped to create and facilitates this group. This group was created following the advice of Helen Teischer, former NAMI President for the San Diego Chapter in the mid 1980's. She spoke to Luz Maria about the great need in the Hispanic community to understand mental illness and mental health resources in the community. At present the group is known through word of mouth. Initially, however, Luz Maria contacted all County Mental Health providers and received lists of Spanish-speaking family members. Each of these families was contacted by phone initially and invited to a meeting. It took several months to get enough people interested in the group and to plan the first meeting.

One of the most important cultural aspects of this group is that the families have thought it important to bring their ill member to the meeting. This has been true for all the years of the group's existence. At present almost all families are welcome to bring their ill member, once they have shared with the group all they need to share NOT in the presence of the ill member. Afterward, they are welcome to bring in their ill family members, and the group has evolved as a support group for the entire family. This is more appealing and relevant to Latino persons, whose culture involves the whole family in most things, including healing. This is the role that the group plays in their lives.

Activities:

- All activities conducted in Spanish
- Monthly formal meeting
- Mental health education for families and consumers
- Support for families and consumers
- Extended family group dinner twice a year
- Informal weekly social activities (Bible study, family game night, etc.)

For more information contact:

Luz Fernandez
619-401-5500
lfernahe@co.san-diego.ca.us

Outreach to Minority Families

NAMI St. Louis

Family Support Services Multi Cultural Outreach Project Project Description, 2001-2004

Objective: identify and serve diverse families living in the St. Louis area with programs that are sensitive to their heritage and improve the opportunity for successful treatment of their loved ones who are attempting to live with severe mental illness.

Specific Service - Project Goal

- Culturally diverse and economically disadvantaged St. Louis area families that have a loved one stricken with a severe mental illness, with or without co-occurring substance abuse, will:
- Understand the cause of, course of, and treatments for severe mental illness/substance abuse;
- Identify suicide risk factors and know how to access suicide prevention services;
- Know of and how to access comprehensive resources and services necessary for optimum recovery from severe mental illness/substance abuse;
- Be sufficiently stable, emotionally, to provide effective care giving direction to their loved one with severe mental illness/substance abuse, and

Specific Service - Project Objectives

Marketing - Further refine the marketing strategy and develop new-targeted marketing materials designed to reach culturally and economically diverse families.
In order to accomplish this objective NAMI St. Louis is:

- Working with a minority-owned advertising/marketing firm to develop a promotional strategy.
- Develop collaborative programs with community-based organizations, including faith groups.
- Participating in community events and health fairs.
- Distributing brochures in community-based locations.
- Networking and promoting city outreach programs to city community mental health centers, health clinics, and health care centers.
- Utilizing culture-specific media to promote city outreach programs.

Community Endorsement - Further develop and manage the project Advisory Council and recruit effective community and professional representatives to serve on it.

Family Support - Establish and implement culturally acceptable systems of mutual support for targeted families, accommodating both 1) the varying needs of family

members of diverse backgrounds and 2) the various mental illnesses/substance abuse disorders.

Education - Design and implement culturally acceptable strategies for communicating information to targeted families about severe mental illness/substance abuse and how family members can successfully serve as care givers.
In order to accomplish this objective NAMI St. Louis is:

- Referring interested city residents to Family-to-Family Education classes.
- Working with community centers, religious and service organizations.
- Working with substance abuse providers to provide 2 educational programs to the family members of their clients.
- Promoting ongoing programs such as Family Skills Workshops and General Education Programs to ethnically diverse families.
- Promoting and maintaining attendance at current support groups in the target areas.
- Promoting attendance at other current and ongoing "traditional" NAMI support groups.
- Promoting the NAMI Peer Support Program.
- Providing support through NAMI HELP-Line, mailings and educational literature.
- Recruiting and training members of the target audience to serve as NAMI volunteers for the City Outreach Project and at the central office.

E. Advocacy - Develop and train a corps of community representatives to serve as advocates for improved mental health services and expanded accessibility for diverse St. Louis area populations.

F. Volunteerism - Develop and implement systems to encourage people from diverse populations to serve as volunteers in the delivery of family support and psycho education services to families needing such services.

G. Outreach Coordination - Coordinate activities of this Multi Cultural Outreach Project with other outreach projects planned by NAMI St. Louis, including its Suicide Prevention Project, its Family Outreach Project at Metropolitan St. Louis Psychiatric Center, and its Faith Groups Outreach Project.

H. Community Partnerships - Coordinate activities of this Project with those of other organizations with missions overlapping with that of NAMI St. Louis.

Outcome Based Data/Research
Support and Education Services for Multi Cultural Families -

In a needs assessment of multi-cultural families in St. Louis families reported that the most helpful relationship included spouses, other family members, friends, religious leaders, family doctors, counselors, and social workers. Even though these family members had heard about formal education and support services, barriers resulted in only half of them participating in these services. Support group participation for African

Americans and Latinos are affected by location, transportation, facilitators professional background and race, group composition, group dynamics, and program content.

Affiliate Experience and Successes -
The following improved the ability of NAMI St. Louis to reach the Latino population:
Advertising in Latino publications and in the communities
Networking with Latino mental health professionals, public and private sector social service and with public health clinics, emergency rooms and other health care organizations
Increasing diversity of affiliate board of directors and their committees
Speakers bureaus and conference on minority mental health issues
Outreach at Latino festivals and community celebrations
Involving primary consumers in program offerings, provide transportation to and refreshments at every meeting
Setting up information booths at heath fairs and primary health care settings
Establishing relationships with churches and community mental health settings
Participating in community events.

For more information contact:
Margaret Bluett
Director, Multicultural Outreach Project
NAMI St. Louis
314-389-8100
mbluett@namistl.org

Outreach Planning Pages

Identifying Where We Are Now and Where We Want to Go

Complete the following questions to the best of your ability. There is no "wrong" answer, only a way for you and others to determine your group's level of activity.

You will have an opportunity to develop an outreach plan containing ideas and tasks ready for you to implement when you return home to your affiliate group.

Where Are We Now?

What does your group offer to a Latino person or family?

Does your group offer support to Latino family members and consumers? If your answer is positive, what type of services? Yes No

_____

_____

_____

_____

Do you have special committees that address the specific concerns/issues of the Latino population in your area?
Yes No

If yes, which committees?

_____

_____

_____

Is your local newsletter culturally sensitive and appealing to the Latino population?

Yes No

Do you have materials (fact sheets, membership application forms, etc) in Spanish?
Yes No

Do you have education programs or support groups in Spanish?
Yes No

Do you have Latino members?
Yes No

Approximately how many? _____

Some things to consider…
Pay particular attention to your "no" responses. These areas can serve as good starting points for your group to consider implementing programs.

What are the demographics in your area?

Is there a strong Latino population?
Yes No

What is the geographic distribution of this population?

_____

_____

_____

_____

_____

_____

_____

Is there easily accessible public transportation?
Yes No

Where does the Latino population in your area look to get reliable information?
(Please circle all that apply.)

radio	newspaper
television	cinema
place of worship	internet
peers/family	libraries
clinics	professionals (i.e. doctors, lawyers)

Some things to consider…
If you are interested in engaging the Latino population of members, you must provide attractive services and benefits for this population. Review your answers to the above questions. Your answers will help you form the basis for your outreach strategies.

Find out what prompted your current Latino members to join your organization and what encouraged them to remain.

What attracted them to join your group?

_____

_____

_____

_____

_____

How did your group reach these individuals?

_____

_____

_____

_____

_____

Why did they remain active?

_____

_____

_____

_____

Are they happy with their membership or participation? Why? Why not?

_____

_____

_____

_____

_____

Some things to consider…
Think about ways to make your Latino members feel welcome, supported, and needed. Structure support groups and program meetings so that all those who attend feel part of the group. Find out what your Latino members need and try to supply that. Also find out what skills and resources they have so you can get them involved in helping others.

Do you have the necessary resources?

Do you have resources to reach the Latino population?

Yes No

If yes, please list all the resources that you have. Please be specific.

_____

_____

_____

_____

_____

If not, what resources will be needed?

_____

_____

_____

_____

_____

Some things to consider…

Once you have considered the best vehicle for communicating with them, it is time to look for tools to help market your affiliate.

Where Do We Want to Go?

DEVELOPING A STRATEGIC OUTREACH PLAN TO INCREASE LATINO MEMBERSHIP

This assignment is designed to help develop an outreach plan to enhance a Latino outreach campaign. Here you are going to develop a strategy to reach the Latino population in your area. The goal of the exercise is to have at least a 10% increase in your Latino membership or service recipients by the end of 12 months.

Use the 12-month Strategic Outreach Plan Form.

Twelve Months Strategic Plan

Current number of Latinos in your group _____

Your goal is to increase this group by _____%

MONTH	Identify what tools and strategies you will use to reach the Latino population in your area. Try to approximate costs involved. Include the materials that you will need and the assistance that you will need.

Looking Ahead

Question: Looking ahead to next year and beyond, what new and innovative ways can you identify to enhance your Latino outreach activities? Think of the different approaches that you could use to include potential members in your affiliate activities.

Identify three different Latino outreach approaches:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Identify three different Latino membership-retention approaches:

_____

_____

_____

_____

_____

_____

_____

_____

_____

When a Latino contacts you, how could you respond to his/her emotional support needs and provide information about mental illnesses and your organization in a culturally sensitive manner?

What kind of resources can you provide to Latino consumers and their families?

Enlisting Latino Community Leaders

To reach the Latino community in your area, you need to identify what their needs. To perform a needs assessment, you should partner with community leaders that will help you understand the Latino culture and guide you through cultural differences so that you become culturally sensitive and competent. Latino community leaders can help you establish bridges of communication and trust between you and the rest of the community.

Identify the Latino community leaders in your area. Make sure you have all their contact information.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How can you establish a working relationship with them?

_____

_____

_____

_____

_____

_____

_____

_____

Chapter 4

Evaluating Your Outreach Efforts

Introduction

Whatever activities the group decides to include in their outreach project, they should plan to evaluate them. Although the idea of evaluation is threatening or intimidating to some people, it need not be. The basic idea of evaluation is to gain an understanding of how well activities worked and how participants perceived them. This kind of feedback can then be used to redesign program components that were unsuccessful and to improve activities that were successful. Another reason to evaluate activities is to show potential funding agencies that the project is successful in accomplishing its goals. This chapter offers some suggestions regarding how to plan and conduct both global and strategy-specific evaluations. The intent here is to set up a rudimentary evaluation component that provides feedback about participant satisfaction and evidence of the project's effectiveness.

Type of Program Evaluation

There are many types of program evaluation strategies and levels of analysis. It's suggested that evaluation plans include at least the following two: client (or participant) satisfaction, and outcome assessment. Participant satisfaction assessments directly question the target population about whether or not they found the group's services or activities helpful, what could be done to improve them, and what positive parts of the program should be retained and/or expanded. Client satisfaction information is usually gathered through a brief questionnaire, completed by individuals who have participated in one of the program's activities. This method of evaluation is appropriate for support groups, conferences, trainings, presentations, newsletters, celebrations, and companion programs.

Satisfaction Surveys

A major requirement of using a satisfaction questionnaire is that people should be easily able to receive, complete, and return it for analysis. Although questionnaires can be send directly to individuals via the postal system, this decreases the chances that they will be returned. Sending questionnaires through the mail also requires that names and addresses be obtained, which may be difficult or may raise issues of confidentiality for some respondents. One relatively foolproof way to administer questionnaires is by handing

them out at the end of an event while people are still gathered together, asking the group to complete them, and then collecting them as people leave.

The questions or statements to which people respond on a satisfaction questionnaire are called “items.” Some items force the respondent to choose between a number of pre-specified answers; these are referred to as forced-choice items. Some examples of this type of item include: true/false questions; statements with which the reader "strongly agrees," "agrees, " "disagrees," or "strongly disagrees;" or items which ask the reader to pick one of a series of alternative answers. Another kind of item asks for a written opinion or statement from the respondent; these are referred to as open-ended items. Some examples of open-ended items include: those which ask individuals to say what they liked or disliked about something; those which ask for suggestions for improvement of a program or service; and those which ask individuals to speculate about how they will use something they gained from an activity. It is a good idea to include both types of items in any satisfaction questionnaire you design.

If open-ended items are being used it is important that enough space is allowed below the item for people to write their answers; encouraging people to write on the back of the page is another way to ensure that there is enough room for feedback. When using forced-choice items it is important to make sure that the choices you provide are relevant to all of the items. For example, some items are aimed at eliciting the intensity of respondents' reactions to a statement; in these cases, it is important to be sure that the potential responses that people have to choose from make sense in terms of the wording of the statements. The example below illustrates this principle. Note that the first two items are answerable according to the available response categories while the third and fourth items are not.

Possible Format:

Strongly Agree Agree Not Sure Disagree Strongly Disagree

The training held my interest throughout the afternoon.
I learned things in this training that will help my family.
How satisfied were you with this training?
How relevant was the information to your own family's needs?

Appropriate response categories to the third and fourth items might be the following:

Very Somewhat Not Sure Minimally Not at All

3. How satisfied were you with this training?
4. How relevant was the information to your own family's needs?
Here is another possible format:

strongly somewhat somewhat strongly

	agree (a)	agree (b)	agree (C)	disagree (d)	disagree (e)

(Please circle the best response.)

This group will have a positive effect on my family's experience with mental illness.	a	b	c	d	e
The meeting location is accessible and comfortable.	a	b	c	d	e
3. I feel comfortable talking in this group.	a	b	c	d	e

Please provide brief responses to the following questions.

What topics or issues are most important to your family?

What changes would make this group more helpful to your family?

What sections did you find the least beneficial?

Please feel free to make any additional comments. Thank you for your input and participation.

Once the completed questionnaires have been received, assessments of current efforts can be made.
One consideration in using forced choice items is to word some of them negatively and some positively. This is because some respondents have a tendency to agree with most statements (these people are called "yea-sayers" by researchers) while other respondents tend to disagree with most statements (termed "nay-sayers). Given this, you may want to include items such as the second and fourth statements shown below:

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

The group held my interest throughout the afternoon.
Many of the topics covered were not relevant to my own needs.
I learned things in this group that will help my family.
The translation services were not adequate; I didn't understand much of the discussion.

By assigning numbers to the response categories, averages can be created that capture the reactions of all respondents in a single figure. Simply add up the ratings of a single item across all respondents and then divide by the number of respondents to arrive at the average. The following example uses the items listed above:

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
(1)	(2)	(3)	(4)	(5)

The group held my interest throughout the afternoon.
Many of the topics covered were not relevant to my own needs.
I learned things in this group that will help my family.
The translation services were not adequate; I didn't understand much of the discussion.

For item number one, above, a score of 4.5 would indicate that the average respondent fell in the range between agreement (a "4") and strong agreement (a "5") that the group held their interest. For item number two, a score of 2.1 would indicate that the average respondent disagreed with the notion that the group's topics were not relevant to his or her needs. Using averages in this way can help summarize the views of the multiple persons reached by the outreach activities.

Outcome Assessment

Another type of evaluation to consider is to measure the degree of change that occurs as a result of the project's activities. This is a way to measure the outcome of efforts. In order to assess change, however, it is important to measure a desired outcome before the project begins and again at some point in time after activities have occurred. Researchers refer to this as a pretest/posttest design because there is a measure ("test") before ("pre") and then after ("post") activities. For example, suppose one of the project's goals is to increase the number of calls for information received from the target population. Here, an assessment will want to measure the volume of calls from Latinos before outreach efforts begin and then after efforts are underway. One way to do this is to use a telephone log. The person taking every call would record the date, racial or ethnic identity, and nature of the request for a month or two before efforts begin and then perhaps six months after activities commence. Better yet, calls can be monitored throughout the entire period that the project is operating, so that changes in calling volume from month to month can be monitored. The minority outreach project of NAMI-Greater Chicago used this method and found that the proportion of minority callers rose from 5 % before their project began to 10 % after one year of operation, 15 % after two years of operation, and 25 % at the end of their third year of operation. Another type of pre- and post- project evaluation would concern outcomes such as the proportion of people of color serving on the group's board of directors before and after the project begins or the proportion of group members who are people of color before and after your project begins.

The simplest type of outcome evaluation is to count the number of people reached by the outreach efforts, and the numbers of different types of activities that occurred as a result of the project. For example, you might wish to keep a simple count of the number of times that requests for information where responded to or the number of training sessions

the group conducted in a given year. This way the group can tell interested parties that they responded to over 250 requests for written materials, say, or that 25 training sessions at local mental health organizations over a twelve-month period were held. Such figures go a long way toward convincing funding agencies that the project is organized enough to track its outcomes and that there is evidence of the concrete outcomes of the efforts.

Conclusion

Whatever type of evaluation the group conducts, remember that the most important considerations are that they are done accurately and fairly. The group will want to collect information that provides an honest idea of how well the efforts are accomplishing set goals and ways in which activities could be improved. The group will also want to share the results of the evaluation with the target population, which helps to enhance the project's legitimacy. When the group is willing to entertain both negative feedback and praise, they increase their chances of developing activities that are truly responsive to the needs of the target group.

References

The materials from this manual were adapted from:

Cook, Judith; Knox, Jesse (1993). *Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates.*

Guidelines for Engaging Families from Diverse Cultures Who Have a Member With a Mental Illness. Compiled by Christopher S. Amenson, Ph. D. Pacific Clinics Institute.

Latino Mental Health Net. www.latinomentalhealt.net

Saldaña, Delia (2001). *Cultural Competency. A Practical Guide for Mental Health Service Providers.* Hogg Foundation for Mental Health.

Appendix

I. Glossary of Terms

II. Reading List

III. NAMI National Spanish Language resources

Glossary of Terms

Spanish people

This term is used frequently in the U.S. to refer indiscriminately to any person that speaks Spanish. The term is imprecise and often inappropriate since it includes people from more than two dozen countries, across North, South, and Central America, the Caribbean and Spain. Spanish is the proper name for the native people of Spain, and for this reason it is as incorrect to use it to refer to any and all Spanish-speakers as the term "English" would be to refer to citizens of New Zealand, Australia or the U.S..

Hispanics

This term is often used to refer collectively to all Spanish-speakers. However, it specifically connotes a lineage or cultural heritage related to Spain. This term is incorrect as a collective name for all Spanish speakers (It could even be offensive) because many Spanish speakers are not of true Spanish descent (e.g., Native Americans), and other people who live in the Americas do not speak Spanish or claim Spanish heritage (e.g., Brazilians). Hispanic is the term that the U.S. has adopted to refer to and describe Spanish speakers from North, Central, and South America.

Latino

This term is used to refer to people originating from, or having a heritage related to, Latin America, in recognition of the fact that this set of people is actually a superset of many nationalities. Since the term "Latin" comes into use as the least common denominator for all peoples of Latin America in recognition of the fact that some romance language (Spanish, Portuguese, French) is the native tongue of the majority of Latin Americans, this term is widely accepted by most. This term is not appropriate for Native Americans of these regions.

Latino is how Americans of Central/South American-ancestry refer to and describe themselves. It delivers much more immediacy, authenticity, and receptivity to that culture than Hispanic, which is derived by North Americans.

Mexican

Specifically, the nationality of the inhabitants of Mexico. This term is used appropriately for Mexican citizens who visit or work in the U.S., but it is insufficient to designate those people who are of Mexican ancestry but who are citizens of the U.S. (they were born in the U.S. or are naturalized citizens). The terms used to properly designate such people are described below, however, it is important to explain why these people feel it is important to make such a distinction. U.S. citizens who are troubled by this often point out that most immigrants do not distinguish themselves by point of origin first, (i.e., German-

American), but simply as "Americans." Here are some reasons why many U.S. citizens of Mexican extraction feel that it is important to make the distinction:

Not "Americans" by choice

A scant 150 years ago, approximately 50% of what was then Mexico was appropriated by the U.S. as spoils of war, in a series of land "sales" that were coerced capitalizing on the U.S. victory in that war, and in Mexico's weak political and economic status. As a result, a sizable number of Mexican citizens became citizens of the U.S. from one day to the next. The treaty declaring the peace between the two countries recognized the rights of these people to their private properties (as deeded by Mexican or Spanish colonial authorities), their own religion (Roman Catholicism) and the right to speak and receive education in their own tongue (for the majority, Spanish). The descendants of this population continue to press for such rights, and many hold that theirs is a colonized land because their territory and population was taken over by military force.

Mexicans first, "Americans" second

Another and more numerous class of U.S. citizens of Mexican origin are either descendants of, or are themselves, people who think of themselves as temporarily displaced from Mexico by economic circumstances. As opposed to the waves of European migrants who willingly left their countries due to class and religious discrimination, and sought to make their lives anew in the "new world" and never to return to the "old land," these displaced Mexicans usually intend to return to Mexico provided they can become economically secure. This group typically maintains strong family ties in Mexico (by visiting periodically and by investing their incomes in homes or kin in Mexico), and maintains and nurtures their children in their language, religion and customs.

However, there is great tension within this population between those of Mexican birth who conceive of themselves as temporary guests in the U.S. and their descendants who are born in the U.S., are acculturated with the norms of broader U.S. society in public schools, and are not motivated by the same ties that bind a migrant generation of Mexicans. This creates a classic "niche" of descendants of immigrants who are full-fledged U.S. citizens, but who typically do not have access to all the rights and privileges of citizenship because of the strong cultural identity imbued in them by their upbringing and the discriminatory reaction of the majority population against a non-assimilated and easily identified subclass. This group of people feels a great need to distinguish itself from both its U.S. milieu and its Mexican "Mother Culture," which does not typically welcome or accept "prodigals." This is truly a unique set of people in that it endures both strong ties and strong discrimination from both U.S. and Mexican mainstream parent cultures. The result has been the creation of a remarkable new culture that needs its own name and identity.

Mexican-American

This term is commonly used to recognize U.S. citizens who are descendants of Mexicans, following the pattern sometimes used to identify the extraction of other ethnic Americans

(e.g., African-American). This term is acceptable to many Mexican descendants, but for those who do not identify with a Mexican heritage, but rather with a Spanish heritage, it is unacceptable (cf., "Hispano," below). Also, for those who do not view themselves as "Americans" by choice, this term is problematic. For others the implication that the identity of the bearer is unresolved between two influences, belies their self-concept as a blend that supersedes its origins and is stronger, richer and more dynamic than either of its cultural roots.

Hispano

This term is preferred by that subpopulation, located primarily in the U.S. southwest, who identify with the Spanish settlers of the area, and not with the Mexican settlers (specifically, the Creole Spanish-Native American race). There is in fact an important number of these people located along the Rio Grande Valley of New Mexico and in the northern Sangre de Cristo mountain range of the same state. This group has been traditionally a very closed and conservative one, and recent evidence provides important explanations for this: they seem to be descendants of persecuted Jews who fled Spain during the 16th and 17th centuries and sought refuge in what were then the farthest reaches of the known world. They survived by minimizing their contact with outsiders and by hiding or disguising their religious and cultural identities as much as possible. Historical researchers call them "cryptic Jews."

Chicano

A relatively recent term that has been appropriated by many Mexican descendants as unique and therefore reflective of their unique culture, though its first usage seems to have been discriminatory. The most likely source of the word is traced to the 1930 and 40s period, when poor, rural Mexicans, often Native Americans, were imported to the U.S. to provide cheap field labor, under an agreement of the governments of both countries. The term seems to have come into first use in the fields of California in derision of the inability of native Nahuatl speakers from Morelos state to refer to themselves as "Mexicanos," and instead spoke of themselves as "Mesheecanos," in accordance with the pronunciation rules of their language (for additional details, refer to the file MEXICO on this same subdirectory). An equivocal factor is that in vulgar Spanish it is common for Mexicans to use the "CH" conjunction in place of certain consonants in order to create a term of endearment. Whatever its origin, it was at first insulting to be identified by this name. The term was appropriated by Mexican-American activists who took part in the Brown Power movement of the 60s and 70s in the U.S. southwest, and has now come into widespread usage. Among more "assimilated" Mexican-Americans, the term still retains an unsavory connotation, particularly because it is preferred by political activists and by those who seek to create a new and fresh identity for their culture rather than to subsume it blandly under the guise of any mainstream culture.

*For additional information and resources on Chicano Studies, a good starting point is the Chicano-Latino Network (CLNET) accessible through the University of California - Los Angeles Gopher Server. http://www.azteca.net/aztec/chicano.html

READING LIST

CULTURAL COMPETENCY, MENTAL HEALTH, AND LATINO DISPARITIES IN CARE

Books/Articles:

Burlingame, Virginia (1998). Ethnogerocounseling: Counseling Ethnic Elders and Their Families. Springer Series on Life Styles and Issues in Aging, Springer Pub Co.

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Web Sites:

The Office of Minority Health (OMH)
Web Site: http://www.omhrc.gov/

National Technical Assistance Center for Children's Mental Health
Georgetown University Child Development Center
Web Site: http://www.georgetown.edu/research/gucdc/cassp.html

Center for Mental Health Services (CMHS); Knowledge Exchange Network (KEN)
Web Site: http://www.mentalhealth.org

Resources for Cross Cultural Health Care
Web Site: www.DiversityRx.org

U.S. Surgeon General's Office
Web Site: www.surgeongeneral.gov

Latino Mental Health
Web Site: http://www.latinomentalhealth.net/

The Latino Research Program Project
Web Site: http://latino.rcm.upr.edu/

National Latino Behavioral Health Association
Web Site: http://nlbha.org

League of United Latin American Citizens
Web Site: http://lulac.org

Article: Mental Health Services Issues for Hispanics/Latinos in Rural America
Web Site: http://www.inmotionmagazine.com/soto4.html

NAMI
Spanish Language Resources

To get copies of these materials contact the NAMI Multicultural & International Outreach Center at 703-524-7600 or visit the NAMI public web site at www.nami.org.

Currently, NAMI National has the following Spanish language resources:

Brochure

- Las Enfermedades Mentales (Mental Illnesses)
- El Desorden Bipolar (Bipolar Dissorder)

NAMI Spanish Language Fact Sheets

- Depresión Severa (Major Depression)
- Cosas importantes que debe saber si su familiar tiene depresión. (Things You Need to Know if Your Loved One Has Major Depression).
- Diagnóstico doble: Abuso de drogas y enfermedad mental (Dual Diagnosis: Mental Illness and Substance Abuse)
- Esquizofrenia (Schizophrenia)
- Nuevas opciones para el tratamiento del trastorno bipolar (New Treatment Options for Bipolar Disorder)
- Cosas importantes que debe saber si su familiar tiene trastorno bipolar. (Things You Need to Know if Your Loved One Has Bipolar Disorder).
- Trastornos de ansiedad (Anxiety Disorders)
- Trastorno de estrés postraumático (Posttraumatic Stress Disorder)
- Trastorno de la personalidad fronterizo (Borderline Personality Disorder)
- Trastorno de pánico (Panic Disorder)
- Trastorno obsesivo compulsivo (Obsessive Compulsive Disorder)
- Trastorno por déficit de atención con hiperactividad (Attention-Ddeficit/Hyperactivity Disorder)
- NAMI: Como detener la criminalización de los consumidores de salud mental. (NAMI´s Views on How to Stop the Criminalization of People with Mental Illness).
- Cómo tratar con el sistema de justicia penal. (Dealing with the Criminal Justice System)
- Consejos para los hermanos e hijos adultos de las personas que tienen enfermedades mentales. (Coping Tips for Siblings and Adult Children of Persons with Mental Illness)

- Mitos y Realidad: Síntomas de violencia y agresividad en las personas que tienen enfermedades mentales severas. (Myths and Facts: Symptoms of Violence and Aggressiveness).
- Qué hacer durante una crisis psicótica. (What To Do During a Psychotic Crisis).
- Realidades sobre las enfermedades mentales severas. (Facts About Mental Ilness).
- Suicidio: Señales de peligro. Preguntas que usted tiene que hacer. (Suicide: Signs of Danger. Questions You Have to Ask).
- Tratamiento eficaz. ¿Qué es el Tratamiento Asertivo Comunitario (ACT)? Preguntas y respuestas. (Effective Treatment. What is Assertive Community Treatment (ACT)? Q & A).
- El Tratamiento Asertivo Comunitario promueve la recuperación: Una Entrevista con Joe Phillipps. (ACT Promotes Recovery: An Interview with Joe Phillips).
- ¿Sabía usted que el Tratamiento Asertivo Comunitario ayuda a los consumidores de salud mental a conseguir vivienda? (Did You Know ACT Helps Consumers to Find Housing?).
- ¿Todos los consumidores que participan en los programas de Tratamiento Asertivo Comunitario tienen que tomar medicamentos? (ACT and Medications).
- DIAGNOSTICO DOBLE EN LA ADOLESCENCIA

The NAMI HelpLine

We have Spanish speaking staff ready to answer calls from Latino families and consumers. You could your this resource to the Latino community you are trying to reach. The toll free Helpline number is 1-800-950-6264.

Spanish Family to Family Education Program

We currently have the 2nd edition of our Family to Family program. Different states are already using this edition. We also have posters and brochures.
For information contact Lynne Saunders at 703-524-7600.

NAMI National Public Web Site

We have a Spanish Language section where we describe all the resources NAMI offers to Latinos and their community. This section will keep growing.