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**A study of program efforts to facilitate access and increase
the utilization of community mental health services by Puerto
Rican/Hispanic clients**

Vazquez, Rene Gilberto Del Valle, D.S.W.

City University of New York, 1994

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A

A STUDY OF PROGRAM EFFORTS TO FACILITATE ACCESS AND
INCREASE THE UTILIZATION OF COMMUNITY MENTAL HEALTH SERVICES
BY PUERTO RICAN/HISPANIC CLIENTS

by

RENE GILBERTO DEL VALLE VAZQUEZ

A dissertation submitted to the Graduate Faculty in Social
Welfare in partial fulfillment of the requirements for the
degree of Doctor of Social Welfare, The City University of
New York

1994

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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Abstract

A STUDY OF PROGRAM EFFORTS TO FACILITATE ACCESS AND
INCREASE THE UTILIZATION OF COMMUNITY MENTAL HEALTH SERVICES
BY PUERTO RICAN/HISPANIC CLIENTS

by

Rene Gilberto Del Valle Vazquez

Advisor: Professor Mildred Mailick

The purposes of this study were: first to determine if the utilization of services by the Spanish-speaking Hispanic community residents could be increased through active outreach interventions; and second to determine what type of intervention proved to be most engaging for the Hispanic client.

The research questions to be explored were 1) what were the Hispanic patterns of utilization of services both before and after program development, 2) which forms of outreach resulted in increased generation of referrals and admissions of Hispanic community residents in need of mental health services into outpatient treatment, 3) was there any correlation between outreach and level of acculturation, 4) were there any other significant bio-psycho-sociodemographic differences between those who were admitted to the clinic through varying outreach interventions and those who utilize clinic services without outreach.

This program evaluation descriptive study used process analysis in monitoring and measuring the independent variables (no outreach vs. information dissemination vs. outreach to agency directors vs. kiosk outreach) to determine intervention success or failure. The study utilized a combined time-lag non-equivalent comparison group design. The study reported on four separate time phases which comprised the stages of program development.

The results from this study have implications for policy analysis and implementation, program planning, program monitoring, and for clinical psychotherapeutic treatment. Mental health programming and service delivery models which incorporate culturally relevant outreach interventions were shown in this study to be effective for: increasing the outpatient utilization of services by the Hispanic population, overcoming barriers to utilization for patients with numerous hospitalizations and prior histories of treatment, and overcoming the cultural barriers around perceived need experienced by the unacculturated Hispanic client when help seeking.

This program evaluation study showed that access to the mental health delivery system was facilitated and the problem of Hispanic underutilization of services improved through active outreach methods.

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I wish to dedicate this study to the Hispanic patients of the Baltic Street Clinic.

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INTRODUCTION

Hispanic Underutilization of Mental Health Services: The Problem of Access.

Within the last several decades many social scientists as well as administrators of social welfare agencies have expressed concern over the delivery of mental health services to ethnic minority individuals and communities (Karno & Edgerton, 1969; Abad, Ramos & Boyce, 1974; Sue, 1977; Scott & Delgado, 1979; Rodriguez, 1983). Contemporary social work literature reflects the profession's concern with delivering culturally compatible services to racial and ethnic minorities. It has been argued that the needs of minority group people for social services are greater than those of their counterparts in the majority culture because of the long-term effects of discrimination. Yet the use of existing services by minorities is often disproportionately low. The delivery of services have been described as culturally incompatible to the individuals and the community they serve, and are consequently underutilized.

There is documented evidence that ethnic and racial minority groups in the United States are reported to underutilize mental health services when compared to the majority groups (NIMH, 1980). Many reasons have been provided for the underutilization of mental health services by ethnic minority clients. These include the stigma and shame associated with mental illness, unresponsive and inaccessible service

systems, inconvenient location and lack of knowledge of services, the use of alternative resources, and cultural beliefs regarding mental illness and its course of treatment (Flaskerud, 1986).

Traditionally, the assessment and treatment of the Hispanic patient has not systematically addressed the effectiveness of services with regard to engaging clients who are affected by language and cultural differences and or organizational barriers. Appropriate relevant treatments whether they are psychiatric, social, psychological or of a vocational-rehabilitative nature are difficult and sensitive spheres of intervention, but are made even more difficult when language, cultural and institutional barriers exist. Consequently, true access to mental health delivery systems are encumbered by the existence of barriers. This research study monitored the effectiveness of a programmatic effort designed to overcome the barriers to utilization of mental health services, for Hispanic, primarily Puerto Rican community residents.

Specifically, this research study was designed to monitor and evaluate three separate contact phases of a program which began in October of 1989, within the outpatient clinic of the Baltic Street Service of South Beach Psychiatric Center. The program was entitled H.I.S.P. (Hispanic Inten-

sive Support Program). It's creation was designed to serve primarily the Spanish-speaking patients who reside within the catchment area of our clinic. Its goal was the provision of culturally appropriate mental health services to the Hispanic community. This program was developed to address a distinct need in our clinic to employ a service delivery model with workable methods of increasing the utilization of outpatient services by our primarily Spanish-speaking community residents.

CHAPTER I LITERATURE REVIEW AND THEORETICAL FRAMEWORK**Literature on Utilization of Mental Health Services**

Several national surveys about admissions of Hispanic patients to psychiatric facilities indicate that Hispanics underutilize mental health facilities. A study by Bachrach of Hispanic utilization of mental health services concluded that Hispanics were underrepresented in their admissions to inpatient psychiatric units of state and county hospitals throughout the nation (Bachrach, 1975). Other national surveys performed subsequently by the National Institute of Mental Health have found results similar to those of Bachrach's. NIMH's findings indicated that Hispanics were found to underutilize outpatient psychiatric services, private psychiatric hospitals, and the psychiatric services of non-public, non-federal, general hospitals (NIMH, 1980). Yet concurrently, Hispanics were found to overutilize the inpatient psychiatric services of public, non-federal general hospitals (Rodriguez, 1987).

The studies of specific Hispanic populations such as the Mexican American, generally agree with the concept of underutilization of facilities (Karno et al., 1969). They have found that Mexican-Americans, especially the less acculturated, had significantly lower rates of outpatient,

but not inpatient, treatment than did the non-Hispanic white population.

The studies on the Puerto Rican population in New York have mixed indications. The NIMH study of service delivery to the Puerto Rican New York City resident conducted at the Metropolitan Community Mental Health Center indicated higher rates of utilization by the Puerto Rican community resident than by the Non-Hispanic White and Black population (NIMH, 1976). Canino et al. (1980) in a study conducted at the Columbia Presbyterian Hospital about Puerto Rican children, relative to other NYC children receiving services, showed higher rates of outpatient utilization by both Black and Hispanic children than by Non-Hispanic White children.

The most relevant data published by the New York State Office of Mental Health and based on more extensive data collection indicated that Puerto Ricans and other Hispanic groups in New York City have the lowest utilization rates among New York City's ethnic groups (New York State Office of Mental Health, 1982). In addition and subsequent to the New York State Office of Mental Health's published data, underutilization of services by Puerto Ricans in the Fordham-Tremont area of the Bronx was demonstrated by the Hispanic Research Center (HRC), in a profile of service

utilization which they developed for the State Office of Mental Health (Rodriguez,1983).

The utilization patterns of other Hispanics, such as Cubans, Dominicans, and other Hispanic minorities has not been well researched and are not known (Rodriguez, 1987).

A finding which invariably prevails in many of the studies of Hispanic utilization of health and mental health services is the tendency to underutilize preventive as opposed to emergency or primary care facilities. This tendency according to Rodriguez, was similar to the finding in one National Institute of Mental Health study which noted, "Hispanic overutilization of inpatient psychiatric services, which are more oriented toward the resolution of crises and severe symptoms, and to underutilize outpatient services, which serve milder cases" (Rodriguez, 1987, p.3).

To determine the utilization rates of a specific group it has been argued that looking at admission rates is not sufficient. The rate of utilization also has to take into account the need for services based on the epidemiological estimates of the number of people within a given community with some form of emotional or mental illness. The epidemiological studies of Puerto Ricans in New York indicate that they have rates of psychological distress higher than

blacks' or whites' (Rodriguez, 1987). Rodriguez refers to Srole's Midtown study which found that, "Puerto Ricans in his sample had the highest rates of psychological distress of all ethnic groups studied". "Dohrenwend et al., in their studies of residents in the Washington Heights area, using the same psychological distress scale as used in the Midtown study (Langner's 22-item Demoralization Scale), also found that Puerto Ricans had higher distress rates than any of the other ethnic groups" (Rodriguez, 1987, p.36).

He notes that since most epidemiological studies of New York City show that Hispanics have mental illness rates greater than whites', and at least equal to blacks', the admission rates of Hispanics to outpatient mental health services would indicate even more underutilization than the actual numbers indicate. Additionally, if the reported rates of emotional distress are higher among the Hispanics in the inner city and the rates of outpatient utilization are the lowest for Hispanics, this would indicate a higher need for mental health services among this group of community residents.

Researchers attempting to address the issue of utilization of mental health services by Hispanics have generally depicted two different competing theoretical explanations for underutilization - alternative resource and barrier theories

(Rodriguez, 1983). The researchers at the Hispanic Resource Center described within these two theories three factors related to the underutilization of services by Hispanics: "elements of the social organization of Hispanics - the family, friends and neighbors, the folk healing institutions which acted as alternatives to institutional services, and the subcultural factors and institutional characteristics of treatment agencies, both of which are presumed to act as barriers to seeking and utilizing services" (Rodriguez, 1987, p.8).

Barrier theory postulates that Hispanics underutilize services because of obstacles, either institutional or cultural, which prevent them from using services. A barrier which is related to the subcultural values held by Hispanics, could possibly impede those Hispanics from seeking and using services. The HRC noted that certain Hispanic cultural values and the process of acculturation acted as barriers to utilization. Original studies which have related Hispanic cultural values to the utilization of services include those done by Edgerton et al. (1971), Adad, et al, (1974), and Rogler et al.(1985), Wells et al. (1987). According to Wells et al. (1987), language differences may be especially strong deterrents to the use of mental health care since verbal communication is of essence to treatment. The language chosen by Mexican-Americans in interviews was

predictive of their attitudes toward conventional mental health beliefs and treatments according to Edgerton and Karno (1971). To exemplify, Edgerton and Karno noted that those Mexican Americans who answered in Spanish were most likely to utilize prayer and other non-medical treatments for mental illness.

According to Rodriguez, "those studies that have examined Hispanic subcultural values which can act as barriers to treatment have mentioned the value of trust; personalism, trust in the immediate person, not the organization; the value of respect, intrinsically owed to another person; the sense of shame and the value of pride; "machismo", the pride in manliness" (Rodriguez, 1987, p.7). Hispanics identifying with these values are likely to avoid contacts with traditional North American institutions, consequently leading to underutilization of services (Abad et al., 1974). Rodriguez states that prior researchers such as Rogler and Hollingshead (1985), "have identified specific cultural beliefs with respect to mental health that have similar consequences, for example, the stigma attached to mental illness intrinsic in the word loco, which leads to denial and suppression of mental illness symptoms, which can lead to delay in seeking professional help" (Rodriguez, 1987, p.7). The cultural belief in spiritualism has been described by Rogler and Hollingshead, (1961), Delgado (1977),

Comas-Diaz (1980), Canino et al., (1981), as both a subcultural value which could preclude the use of traditional mental health services, as well as act as an alternative resource to treatment. Other writers such as Rivera de Alvarado (1967) and Vazquez de Rodriguez (1973) have described the subcultural value placed on familism which significantly alters decision making and help seeking by Puerto Ricans, whereas the extended family is often viewed as the first and perhaps only source of genuine emotional help.

Other studies have subsumed the subcultural factors specified above into the concept of acculturation. Keefe et.al., (1978), found that placement in the dominant culture side of the acculturation continuum was predictive of mental health service utilization; the more acculturated utilizing service more readily than those who are less acculturated.

The Hispanic Research Center's study entitled "Hispanics and Human Services: Help-Seeking in the Inner City" (1987), emphasized the importance of two factors in the utilization of services by Hispanics: integration into the social network and acculturation. Social network integration frequently was found to render advice and referral information conducive to use of services by Hispanics; and to a lesser degree, the social network provided an alternative to use of

services for Hispanics. The findings also emphasized the significant influence of acculturation in facilitating use of many types of services by Hispanics. HRC's findings supported the theory that cultural barriers impeded the use of services by unacculturated Hispanics (Rodriguez, 1987). The factor which was most positively associated with underutilization in relation to barrier theory was acknowledgement of emotional distress. The difficulty in recognizing feelings of distress as symptoms or reflections of emotional problems which could benefit from treatment, acted as barriers to utilization. According to the HRC, this finding implied that becoming aware of symptoms might be analogous with accepting the need for help, and consequently, seeking it (Rodriguez, 1987).

The Hispanic Research Center, based on the findings of their study, made policy and programmatic recommendations. The recommendations of most significance for this study advocated for and involved the use of information and referral services and continuous outreach efforts to overcome barriers to utilization. In devising outreach strategies agencies were advised to think of ways of engaging potential clients' social networks and consider differences in levels of acculturation. They concluded that the most effective way to increase the utilization of human services lay in the direction of innovations in outreach (Rodriguez, 1987). Specifi-

cally, the HRC recommended: (1) the use of continuous and well thought out outreach efforts in the delivery of services; (2) the development of centralized Information and Referral (I&R) services, with I&R specialists who are sensitive to the implicit cultural needs of clients; (3) modification of agency structure to improve services, and overcome barriers by incorporating an awareness of the diverse cultural perspectives that determine minority clients' views of services; (4) to increase utilization, the outreach that is based on referral mechanisms between agencies needed to be supplemented with interagency cooperative efforts to coordinate services. (Rodriguez, 1987).

Theoretical Underpinnings of Outreach Interventions

To address the problem of creating effective linkages, the concept of an "information and referral" service has been employed. The problem with information and referral is that the client must initiate the request for services. Hence, most of the factors which prevent clients from contacting service providers directly also keep clients from contacting the information and referral service. Those factors are hypothesized to include: unawareness of service; fear or avoidance of unnecessary outside contact; denial of problems; apathy towards service; general misinformation regarding services; and the desire to avoid "social welfare services" (Kusher & Davidson, 1978).

In order to overcome these difficulties, the idea of "out-reach" was utilized to complement "information and referral". It was anticipated that when the information service reached out, contacted and attempted to engage the client directly, most of the above mentioned barriers could be rectified. Many agencies for the aged have used information and referral/outreach approaches as models for their service delivery.

Extensive evidence exists citing the service access facilitated for the elderly as a result of outreach program efforts (McCoy, et.al., 1975; National Council on Aging, 1972). Kushler and Davidson (1978) in a study of alternative modes of conducting outreach in providing access to community resources by low-income elderly persons found considerable differential effectiveness between in-person, telephone, personal mail, and informational mail modes. In all cases, the in-person mode of contact achieved the highest rate of effectiveness with the less personal modes showing gradually decreasing rates of success. Kushler and Davidson based their approach on a general finding of dissemination research, namely that personal approaches generally have more success than impersonal approaches in achieving adoption of an innovation, particularly among disadvantaged clientele (Havelock, 1971).

Outreach was often viewed as one method to promote easy access to service, not only researched in the field of gerontology, but in social welfare as a practice method. Outreach is a social work practice method that attempts to identify clients who are in need of services, inform them of service provisions and benefits, and help them use services that are available. The idea of linkages that moderate the distance between the formal organization and primary groups is one that has seldom been addressed or researched by organizational or family theorists (Litwak, 1977). According to Litwak, practitioners are in fact concerned about and do research on "linking mechanisms", though the concept is often called something other than "linkages" and is so task and situation specific that the general principles governing linkages are overshadowed. Many of the obstacles incurred in closing social distances have been explored in research on mass media in fields of advertising, where the problem was to get in contact with the client but where only minor alterations in a given linkage (i.e. the mass media) were considered. On the other hand, social work practitioners interested in community work have addressed a wide range of linkages to close distance, such as storefront services, indigenous workers, local information centers, or other outreach services (Litwak, 1985). Litwak and Dobrof (1977) referred to a Balance Theory of Coordination between institutions and individuals which specify the types of linka-

ges that could be used to push primary groups away and those that would draw them closer. They suggested that where organizations and primary groups experienced severe barriers, they should utilize linkages that increased the frequency of face-to-face contact, while those that may be too close might fare better by using linkages that decreased the amount of face-to-face contacts (Dobrof & Litwak, 1977).

Yet, to date there has been little systematic research on the effects of varying information referral/outreach interventions not only with the elderly, but as it may apply to other populations, such as Hispanic community residents in urban areas.

Among the research studies conducted, many investigators have proposed various conceptual schemes for the design and reorganization of service delivery systems located within minority communities. Cuellar (1980) underscored the necessity of making changes at all four levels of the social structure- specifically, the individual, the family, the organization, and the community or social system when examining approaches to the intervention and resolution of Hispanic utilization of services (Zane, et.al.,1982). Scott and Delgado (1979) also advocated for modifications in service structure as the main means of increasing utilization of services by Hispanics. Scott and Delgado (1979) and

Scott and Humm (1980) demonstrated that after the active development of interagency collaboration, the increasing of bilingual staff, and coordinating the services offered with the needs of the Hispanic community, their mental health agency in Worcester, Massachusetts, was able to attract Hispanic clientele to mental health services. Cohen (1972) advocated for education in mental health principles to both providers and recipients of service, as a way of improving communication and the resulting services. Two other studies (Bloom, 1975; Trevino, et.al., 1979) with Mexican Americans showed similar findings. According to Rodriguez (1987), these studies implied that positive attitudes towards an agency were acquired by potential clients through a process of diffusion, whereby satisfied clients communicated these feelings onto others in the community who in turn felt inclined to readily utilize the service. These studies did not stress outreach interventions as part of the service delivery model.

Nevertheless, they called upon the expertise of "key informants" in the Hispanic community in assessing Hispanic mental health needs and employ interagency collaboration to increase resources in serving Hispanics. Interagency collaboration can help to overcome institutional barriers in service delivery. Agencies with expertise in reaching the community or access to the community can work jointly with

agencies that have divergent expertise, resources or organizational mandates (Delgado & Humm-Delgado, 1980). In contrast, the first demonstration project which employed active outreach to enhance the utilization of clinical services by chronically mentally ill (CMI) Hispanic psychiatric patients was reported by the Fordham Tremont Community Mental Health Center's Project COPA (Community Organization for Patient Access) in January of 1983. The Hispanic Research Center of Fordham University monitored the project's outreach interventions by gathering data on the flows of Hispanic inpatients discharged from psychiatric facilities into Project COPA. The study reported on the impact of outreach interventions to inpatients and their families on the followup utilization rates of those patients. COPA was able to increase the outpatient utilization of services by CMI Hispanics in the South Bronx area. The proportion of COPA admissions among those clients who came to the Continuing Care Division of the Fordham Tremont CMHC for an initial visit increased from 79% in the early phases of outreach to 93% at the later peak phases of outreach. Reductions in the intensity of outreach were followed by a decrease in the utilization of services (Rodriguez, 1987).

A study by Watkins and Gonzales (1982) on outreach to Mexican Americans noted that the key element in the use of mental health services by Hispanics is the establishment of

linkages between services and the population targeted. These linkages were created by active outreach. The results indicated that outreach would not be effective with the client until it reached the community. Therefore, the outreach worker had to establish credibility not only with the individuals and groups but with the institutions respected by the target community, otherwise potential clients would not risk turning to the agency when help-seeking.

A model for outreach which attempted to increase access through effective outreach was described by Toseland at SUNY School of Social Welfare at Albany (1981). He argued that conventional methods of access such as information and referral services requires that the client take the initiative in contacting services; whereas outreach methods are characterized by vigorous efforts to locate, contact, and engage potential clients. He advocated for a six step model which defined the purpose of the intervention, identified the barriers and resistances to service delivery, developed a data base, initiated the outreach efforts, evaluated and followed up on outreach contacts (Toseland, 1981).

CHAPTER 2: PROJECT DESIGN**Introduction**

The creation of the Hispanic Intensive Support Program (HISP) in October 1989, provided me with the unique opportunity to create, develop and implement a culturally compatible program for the delivery of services to the Hispanic community of South West Brooklyn. Prior to the creation of the program all Hispanic patients were seen in the outpatient clinic by both Hispanic and Non-Hispanic clinicians. The HISP program exists within the outpatient clinic to service primarily the Spanish-speaking Hispanic client. Prior to the development of the program issues such as patterns of utilization, increasing utilization, issues of access, culturally relevant interventions, and levels of acculturation were never systematically addressed.

The clinic serves the geographic community of South West Brooklyn which is approximately 1/3 Hispanic in population. The Hispanic population of the Baltic Street Clinic prior to the creation of HISP was roughly 1/4 of the total clinic population; 2/3 of the Hispanic clinic population were primarily Spanish-speaking, the remaining 1/3 were either bilingual or monolingual English speaking.

Examination of the clinical intake log for a years period prior to HISP indicated that 50 individual new cases were referred for treatment. Over half (52%) of the referrals of Hispanic patients never resulted in an initial intake appointment. Only 48% resulted in intake screenings. The reasons why these referrals never resulted in an actualized intake were never known. We considered these percentages or dropout rates to be fairly high and hypothesized that an intervention could perhaps effect more positively the utilization rates. Prior studies by other researchers indicated that outreach had been effective with Mexican community residents in California (Watkins & Gonzalez, 1982) and with a group of primarily Puerto Rican inpatients at the St. Barnabas Hospital and the Bronx Psychiatric Center (Rodriguez, 1987). The following program evaluation outreach study, in part, attempted to replicate the findings of other researchers with regard to the effectiveness of outreach to the Hispanic community, by utilizing the outreach model devised at the Hispanic Research Center and Project COPA. The outreach intervention for this study would be targeted at community residents rather than a group of already identified inpatients, like at Project COPA.

Formative Evaluation

Program evaluation is the process by which program effectiveness and or efficiency are assessed. Evaluation involves

the collection, analysis, and interpretation of data bearing on the achievement of program goals. In formative program evaluation, program objectives and interventions are specified and translated in measurable indices. Formative evaluations do not generate knowledge that can be easily applied to other programs. They make possible inferences which are only suggestive of cause-effect relationships since they do not methodically employ control groups or random allocation of subjects according to Epstein and Tripodi, (1977). As a result the knowledge which is obtained about the relationship between program interventions and client outcomes is consequently only correlational. Comparative evaluation designs are used to assess the relative effectiveness of alternative program interventions. They are also used to measure the impact of intervention as compared to nonintervention (Epstein & Tripodi, 1977). A program evaluation can entail comparisons between and among comparable groups that have received different interventions and a comparable group that has received no intervention whatsoever.

Target Population

The target population of this outreach study was all those Hispanic community residents residing within the South Beach Psychiatric Center Baltic Street Service catchment area who may have been experiencing some form of psycho-social distress or major psychiatric illness, but who were then cur-

rently not in any form of treatment. It was assumed that there were potential clients within the community who may have needed or benefited from mental health services but who did not utilize outpatient community mental health services due to either cultural or institutional barriers or use of alternative resources. Therefore the outreach efforts would target the population of clients who were then in no treatment at all or utilizing other non-psychiatric services within the community.

The natural development of the HISP program allowed for a period of six months time in which clients could refer themselves, as was the procedure of self referral prior to program development. The subsequent six months involved the implementation of active networking/outreach to agency staff/directors to generate referrals. After the end of the six months of outreach to agency directors, a new outreach procedure was implemented. This was called "Kiosk Outreach". Kiosk outreach was performed on a once per week basis with the outreach worker situated in a local social service agency located in the Hispanic community. Both types of outreach interventions were designed as part of the model of service delivery to increase the use of services by the Hispanic community.

Goals and Objectives

The goals of the HISP program were twofold. First the program aimed to increase the utilization of services by the Spanish-speaking Hispanic community residents. Second, we wished to determine what type of interventions proved to be most engaging for the Hispanic client. The purpose of this formative evaluation research study was to determine whether or not the goals of the HISP program had been achieved.

The research questions to be explored were: 1) what were the Hispanic patterns of utilization of services both before and after program development, 2) which forms of outreach resulted in increased generation of referrals and admissions of Hispanic community residents in need of mental health services into outpatient treatment, 3) was there any correlation between outreach and level of acculturation, 4) were there any other significant bio-psycho-sociodemographic differences between those who were admitted to the clinic through varying outreach interventions and those who utilized clinic services without outreach.

This program evaluation descriptive study used process analysis as described by Grinnell (1988) in monitoring and measuring the independent variables, i.e. no outreach vs outreach to agency directors vs kiosk outreach, to determine intervention success or failure. Process analysis

monitored and described the process of the different outreach interventions and the precise way in which the interventions were implemented.

The study utilized a combined time-lag nonequivalent comparison group design as described by Epstein and Tripodi (1977) and Grinnell (1988). The study reported on four separate time phases which comprised the stages of program development. Stage I employed retrospective data-prior to program development. Stage II employed data collected during the first six months of program existence, when no programmatic outreach intervention occurred other than dissemination of the new program to existing patients. Stage III employed data collected from outreach to agency directors. Stage IV utilized data collected during "KIOSK" outreach. Comparisons were made between and among two different groups of clients who were admitted within the various stages. In Stage III the two groups consisted of those who were non-outreach cases (i.e. self, other, hospital referred) and outreached agency referred. Stage IV contrasted those that were non-outreach and outreach "KIOSK" referred. The data collected from the groups were first aggregated and then the data from the groups were separated. Differences within and across groups were explored. The limitations of possible ripple effects from agency outreach phase into Kiosk phase were examined.

The standardization of the outreach intervention for KIOSK outreach occurred through the use of a format for structured interviews with probes and possible responses. The format was used to highlight issues which needed to be addressed in outreach to facilitate access. The process analysis for the KIOSK intervention emphasized the style of dress and mode of language used which were relevant to the intervention.

Sample

The total population of the study consisted of the number of cases (N=233) which were referred to the clinic during the course of program monitoring. The actual sample unit consisted of the total number of clients who were admitted to the clinic during the course of the study (N=154), meaning the actual number of admissions generated following referral. It was an all-inclusive sample of all cases admitted during each program stage. The sample unit was subdivided into groups representing the four separate phases of the study.

Sampling Procedure

Since this study attempted to make comparisons between the numbers of referrals received and the actual number of admissions generated, the analysis called for examining the total number of cases available. The sampling procedure involved inclusion of all the available cases that arrived

at the clinic for intake during one year prior to program development, the first six months of program and during the time of agency and Kiosk outreach. This is a nonprobability sampling procedure, which employed purposive sampling. The procedure called for gathering data on and identifying all the cases that were referred to the clinic and quantitatively contrasting this with the data and identification of all the cases actually admitted following intake.

As described earlier, formative evaluation often does not employ control groups or random allocation of subjects, but this study provided for a comparison group within the sample who received no intervention as compared to the sample unit which received an intervention.

Limitations of the Sample

The actual sample under study were those clients who were admitted to the service as compared to those who never came after referral (lost cases). The sample was only representative of those clients that actually followed up upon referral. Little could be inferred about those clients that never followed up.

The sample consisted only of Hispanic clients and no member or comparison group of the majority non-minority population was involved in the study. As a result, the study reported

on Hispanic utilization rates without being able to comment or contrast with other ethnic groups.

Instruments

In order to determine the current patterns of utilization of the Hispanic patients in the clinic, a client census form was developed which provided sociodemographic and treatment characteristics of the client, psychiatric diagnosis and identification of medical, social, economic, migratory problems, language patterns, characteristics of services provided, frequency and duration of treatment, time lapse between onset of illness and help seeking behavior, use of medical and psychiatric services, and information regarding level of functioning and level of acculturation. (See Appendix A). The client census form which was filled out by all clinicians working with Hispanic clients was used for monitoring the patterns of service delivery to the Hispanic patients. The monitoring process would help us delineate service patterns in relation to the Hispanic clients, the route by which clients had come to utilize the clinic, comparing service delivery prior to the program with patterns subsequent to program development. The monitoring continued throughout the cycle of both the research project and the program.

The Client Census Form was developed as a data gathering instrument, which could not only inform us about the psychosocial demographic characteristics of the client population for the purpose of program monitoring and planning, but also as the means by which to infer relationships between those characteristics and the outreach interventions. The client census form was developed by a committee of clinicians, directed by me, to gather as much information as we deemed important to know about our client population. The group consisted of two psychologists, one nurse, one senior recreational therapist, and two social workers, myself included. Ideas were voiced about the nature of the information that could be elicited during an intake procedure, beyond the usual intake screening information related to presenting problem, past psychiatric, family history and diagnostic impression. Issues related to referral sources, immigration/migration status, educational level, literacy, language proficiency, economic status, health condition, social networks, gaps in service provision, level of acculturation, and general level of functioning as determined by the DSMIII R were all deemed as important issues. On the basis of the committee's suggestions I developed the structure of the client census form. Upon completion of the form, it was given to the group of clinicians for feedback and possible revision. Recommendations for revisions were incorporated into the form. These additions were: determining the

patient's family structure, whether intact or single parent, history of substance abuse, and issues of compliance with medical and mental health treatments. The form was also tested on one of the clinicians who had not participated in its construction and it was found to be informative and understandable. The item on the census form which looked at client level of acculturation was a rating scale type question which involved the therapist's perception of the clients acculturation level. It was a global judgement based on what they might have found out about the patients preferences with regard to language, friendships, self identification and perhaps preferences for music and or food. The Likert type scale ranged from "exclusively Hispanic" meaning very low in acculturation, to "predominately Hispanic" meaning low in acculturation, to "totally bicultural" meaning moderately acculturated, to "predominately American" meaning high in acculturation, to "exclusively American" meaning very highly acculturated. Professional judgement on the level of acculturation scale employed in the client census form was a global score based on the therapists' perceptions of the clients' level of acculturation. It was created for clinical use; based on a shorter four item scale version of Cuellar's et al. (1980) Acculturation Scale, created by the Hispanic Research Center and adapted for Puerto Rican and other Carribean populations (see Appendix).

The level of functioning scale was also an adapted measure taken from the DSM III-R's assessment of global functioning. It required that the therapist rate the clients level of functioning, ranging from "very poor" to "poor" to "fair" to "good" to "very good". Each rating was provided with a description or example of general level of functioning so as to facilitate scoring. This information was routinely assessed by the clinician as part of the 5 Axis DSM III diagnosis.

The client census forms which were filled out after outreach interventions began were provided by the treating clinician after admission of the client, coinciding with the time frame in which the psychosocial assessments were to be performed. This time frame was chosen to allow for the clinician's developing of a better client assessment, beyond that of the initial intake impression. The data on the client census form which was obtained retrospectively for the period prior to program development was provided by clinicians based on the clinical record and their knowledge of the patient after the year of admission. The census forms which were provided on clients previous to the one year prior to program development and any after outreach ended, were eliminated, and were not part of the sample used for this study. Nevertheless, data provided on those cases which were removed was used for overall future program planning.

Dependent and Independent Variables

A significant component of the evaluation research project was to determine the effectiveness of outreach to a population of Hispanic community residents and their families as an intervention designed to increase the Hispanic outpatient utilization rates of the HISP program. This part of the outcome study described the results of outreach to Hispanic residents of the Southwest Brooklyn catchment area of South Beach Psychiatric Center. It reported the effects of two types of outreach (independent variable) on clinical utilization (dependent variable), specifically, the number of referrals made by the proportion of admissions generated. This data was compared to the number of Hispanic patients referred to the clinic and the proportion admitted to the clinic within a year's period of time prior to outreach. The numbers of admissions generated from this specific intervention strategy was used to monitor the operations effectiveness of HISP. The relationship of bio-psychosociodemographic, diagnostic and treatment characteristics to the level of utilization, both before and after outreach, was examined.

Design and Data Analysis

The methodological approach employed formative evaluation using a combined lag time series, nonequivalent comparative group design to study the effectiveness of program efforts

to access clients to outpatient services. The program intervention had two objectives, the overcoming of barriers by increasing access to outpatient treatment and the increase in utilization of outpatient service. The study reported on four groups of clients who were admitted during four separate time series. The first phase was one year prior to program (October 1988-September 1989). The subsequent three phases occurred over the course of one and a half years of the program's implementation starting in October 1989; the first six months when no outreach was performed, with only dissemination of the new program's development to the clinic patient population at that time (October 1989-March 1990); the second six months when agency outreach was conducted (April 1990-September 1990); and the last six months when KIOSK outreach was conducted directly with Hispanic clients in a social service agency located in the Hispanic community. KIOSK outreach was conducted from October 1990 through March 1991.

Standardization of Interventions

A standardized schedule for outreach contacts and role playing which was designed by the Hispanic Research Center was modified and adapted for use during the outreach of this study. The outreach schedules focused on the issue of stigma, use of medication, relatives concerns, ignorance of nature of symptoms, alternate resources and barriers experi-

enced. The client census forms were filled out by the clinicians after the initial screening period at the clinic was completed and the patient's case was opened. The staff who implemented the first series of outreach efforts to agency staff/directors consisted of myself as program director, and a community mental health nurse, both fluent in Spanish.

The first outreach intervention to twenty different agencies was designed to target those potential clients who utilized the services of private and public general hospitals, specifically the emergency room and social work services, local private health clinics, local human resources welfare agencies, public legal services, churches, senior citizen centers and prevention programs all located within the clinics catchment area.

The second outreach intervention (KIOSK), was performed only by myself, as Director of the HISP program and initiator of this form of outreach. The word 'KIOSK' according to Webster's Dictionary literally refers to 1) a Turkish open summerhouse or pavilion, as well as 2) a similar light ornamental structure used as a newsstand, display stand, etc. (Webster, p.464). Prior to choosing the site for the KIOSK, a meeting was held with the local councilman who was instrumental in identifying the United Fifth Avenue Coali-

tion which services the targeted population of interest to the program. The site was also chosen because of its location within the Hispanic community and because of the general familiarity with the agency by Hispanic residents. The second series of outreach interventions (KIOSK) was designed to target potential clients already identified by the Director of the United Fifth Avenue Coalition. The director and her staff, who were acquainted with the Coalition's clients, were instrumental in identifying those clients who were possibly experiencing psycho-social dysfunction related to either chronic mental illness or less severe disorders related to individual, family or societal difficulties. She and her two staff members were able to determine if a client could benefit from mental health services.

A schedule for outreach contacts was designed which was standardized so that all Hispanic community residents would receive similar outreach interventions. Role playing was used to envision crucial areas of concern for client/family and to optimize uniformity of response by outreach worker. The role playing guide utilized was delineated further on in this report.

Conceptual Framework for Agency vs. Kiosk Outreach

The two different forms of outreach were designed to take into account the recommendations provided by the Hispanic Research Center's Demonstration Project.

Network/Agency Outreach

The first outreach intervention which we termed network/agency outreach was designed to take into account, specifically, two of the HRC's recommendations. First, that for outreach to be effective in increasing utilization the referral mechanism had to be supplemented with interagency cooperative efforts to provide coordinated services. HRC's second recommendation emphasized providing service which took into account the cultural perspectives that informed the client's view of services (Rodriguez, 1987). The first recommendation, in tandem with the second, led to the idea of doing network/agency outreach to local service providers who had direct access to the Hispanic community. It was hypothesized that access could be facilitated if the referring sources were informed about the organizational and or cultural barriers that impede the utilization of services by the Hispanic client, coupled with a better coordinated referral mechanism. Through education of the referring staff and improved interagency collaboration, an effective closer network of linkage mechanisms could be created.

Kiosk Outreach

The second form of outreach intervention (KIOSK) was designed to programmatically implement certain aspects of other recommendations provided by the HRC. Specifically, the development of centralized Information and Referral Services and the recommendation of devising outreach strategies to: 1) address ways of engaging potential clients' social networks, 2) examine differences in level of acculturation, 3) determine the extent of knowledge about available services and, 4) assess the potential clients' perceived need for services (Rodriguez, 1987).

As mentioned earlier in this report, the word KIOSK refers to an open summerhouse or pavilion, as well as a similar ornamental structure used as a newsstand, display stand, etc. (Webster, p.464). The Spanish word kiosko is also understood to mean a place where people congregate, purchase items and exchange information. As a result of this connotation, it was used for the name of the outreach post, since Hispanic people could understand that it meant a local site where information and referral could be provided. The "Kiosk" was a form of outreach which most resembled a storefront/local information center situated in the Hispanic community, at a site chosen which could reach potential clients and enlist members of their social network.

Procedure for Network/Agency Outreach

The procedure for agency outreach involved first determining which agencies in the local catchment area were going to be contacted. It was decided that a sampling of different types of agencies, among them social service, prevention, senior citizen, health, education, religious and legal services would be contacted since these were the agencies which were in a position to refer potential clients to the service. Since multiple agencies for the above mentioned types of programs existed within the catchment area of the clinic, it was further determined that one or two of each different type of program would be selected. Those diverse agencies closest in proximity to the clinic were the first to be approached. Letters of introduction which described our interest in meeting them, along with brochures and informational material about the HISP program, were mailed to the Directors of the chosen agencies. These were followed by phone calls to speak directly with the contact person and arrange an appointment to meet with their significant staff. The persons spoken to and or requested were agency Directors in smaller institutions, Directors of Social Work departments within local public and/or private hospitals, and referring personnel within educational, legal and social welfare agencies. Outreach to hospitals was done to the entire social work staff who might have been in any position of providing referral, after having met first with the chief

social worker. Outreach to the local school was done through the school based support teams.

Procedure for Kiosk Outreach

The procedure for KIOSK outreach involved determining the local site which was going to house the outreach post. The United Fifth Avenue Coalition, a N.Y.C. Human Resources Administration social service agency located in the heart of the Hispanic section of Park Slope, was chosen. The Director of the United Fifth Avenue Coalition, Ms Gloria Dixon, was contacted and informed of our desire to work collaboratively with her agency. Ms Dixon, herself Hispanic, was extremely pleased when we had informed her of our desire to set up a outreach post in her agency. Ms. Dixon met with us and told us of the extensive use of her agency by the Hispanic community residents. She was aware of the nature of the social problems needing help that were brought to her local center, and had often been unable to provide many of the services requested by the community residents. The types of problems which were presented were often beyond the scope and mandate of her agency. She and her staff frequently had attempted to intervene in the psycho-social problems of their clients but did not feel effective in helping with the more serious or chronically dysfunctional families. Neither she nor the staff were trained or educated in the Human Services Field. They were employees of HRA who were iden-

tified as knowing how to assist clients in their request for social services and entitlements. The Director and the staff were eager to meet with anyone who could address the more serious problems posed by clients so that they could do their job of providing the required documentation for social services.

The KIOSK post was situated within the agency alongside the other staff. My desk was visible to all the clients who entered the agency. My name along with the title of Social Worker was clearly displayed. The staff workers were able to introduce me to any client they felt had problems which required professional help, beyond the purview of their role of providing concrete services. Due to the nature of stigma associated with mental illness, especially for the Hispanic client, no reference to South Beach Psychiatric Center was visible.

The clients presented to me by the Director or the staff were informed of who I was within the Agency, and were then allowed to meet alone with me in a separate room set aside for interviewing. Upon meeting with the client I would state my name, my profession, and my helping role within the agency. The client was then asked if they had a problem with which they felt they needed help. If the client agreed to accept services, they were then asked the nature of the

presenting problem. If the problem was assessed to be other than a specific mental health problem, i.e. developmental disabilities, substance abuse, etc., I would counsel the client on the nature of the problem and refer the client to the appropriate service. If the presenting problem fell within the scope of mental health services, I would continue with the interview according to the modified HRC standardized outreach schedule.

An important aspect of the KIOSK outreach had to do with the style of dress and use of language. Since outreach took place in a local social service agency, the style of my clothing was casual and not overly dressy, so that the potential client was not intimidated, this also facilitated a more personal, less bureaucratic institutional atmosphere. This was done to avoid any possible barriers that could be created by a highly structured or stylized appearance which might be experienced as cold, distant or terribly removed from the client's lifestyle.

Other clinician/administrators have advocated for outreach persons to adopt an interpersonal method in accord with the interactional norms and or beliefs of the unacculturated Hispanic (Inclan, 1979). This would mean adopting an interpersonal style based on traditional values of deference with first generation clients, and perhaps a more professional

interpersonal style with second-generation acculturated clients who have different perceptions and or expectations of helping professionals.

Agency Outreach Schedule

Outreach to agencies incorporated information about HISP services offered in the form of brochures and promotional mailings episodically updating the services rendered. The monies for the brochures were provided by the Baltic Street Advisory Board. The outreach was informative about Hispanic culture and psychoeducational in nature regarding Hispanic perception of mental illness.

The issues addressed in agency outreach included:

I. Reasons for Hispanic Underutilization of Services

- A. Barriers -Both Cultural and Institutional:
 - 1. Issues of Shame and Stigma Associated with Mental Illness
 - 2. Hispanic Values Which Acted as Barriers
 - 3. Unresponsive and Inaccessible Service Systems
 - 4. Inconvenient Location and Lack of Knowledge of Services
- B. Use of Alternative Resources by Hispanics:
 - 1. Extended Family
 - 2. Religious and Folk Healers
 - 3. Social Networks

II Process of Interagency Collaboration

- A. Creating Linkage Mechanisms
- B. Referral Process on Cases
- C. Contact Persons
- D. Monitoring of Source of Referrals through provision of brochures/referral forms to agencies to access their potential referrals

Proposed Schedule for Kiosk Outreach Contacts

There was a general guide created by Project COPA for outreach to inpatients (See Appendix). It was modified to address outpatient needs by the HISP program. It indicated that it should be followed when contacting clients and their families at the kiosk. That each step should be preceded by an informal assessment of the client, the family and their needs. The next step should be followed when it was determined that the client and his family was able to benefit from it.

The guide directed that individual differences should be taken into consideration as well as special needs of clients and their families. Common difficulties of psychiatric clients such as limitation in attention and concentration as well as limitation in processing information should also be considered. It suggested that the average contact with client be one hour at most. Contacts with relatives might be longer.

Section I: Schedule of Contacts**Section II: Patients and Relatives Emotional Concerns
Regarding Problems/Illness.**

SCHEDULE FOR OUTREACH CONTACTS**Steps**

1. Client is identified by director of social service agency or other staff member.
2. Agency Director contacts outreach worker.
3. Agency Director communicates knowledge of client to outreach worker.
4. Outreach worker meets with client and or family.
5. Outreach assessment is performed
6. Client/Family are evaluated and determination made if services are indicated.
7. Client if in agreement is provided with intake appointment for HISP.

Patients' and Relatives' emotional concerns to be addressed in outreach:

1. Stigma
2. Use of medication
3. Relatives' concerns
4. Use of alternative resources
5. Obstacles and or barriers experienced in attempts at seeking treatment.

Role playing guide to typical statements for affective linkages with client and family:

1. Ignorance of nature of illness and of symptoms.
2. What is treatment?
3. Cost of service.
4. Other services offered.

**SECTION I
SCHEDULE FOR OUTREACH CONTACT**

Steps:

- I. Client is identified by Agency Director and/or agency staff workers
- II. Client is referred to outreach worker at KIOSK
- III. Outreach worker links with potential client
During the initial contact it is expected that the outreach worker:
 - a) Will "join" with the client
 - b) Will introduce him/herself and explain his/her function
 - c) Will explain basic HISP services
 - d) Will address emotional concerns presented by client
 - e) Will address clients concerns regarding possible stigma, shame, inaccessible service systems, lack of knowledge of services, use of alternative resources, and cultural beliefs regarding mental and its course of treatment
 - f) illness and its course of Tx.f
If asked, will provide brief information about nature of emotional illness
- IV. Outreach worker links with family, if appropriate
Outreach worker meets with family at KIOSK and will:
 - a) "Join" family
 - b) Introduce self and explain function
 - c) Explain basic HISP services
 - d) Address families emotional concerns associated with clients's difficulties:
 - Stigma and ambivalence about treatment
 - Concern about managing client
- V. Outreach worker meets with patient and/or family-preliminary screening at clinic--as close as possible to day of KIOSK interview

First Visit:

- a) Intake/Outreach worker will follow-up on emotional issues of stigma, medication, treatment and relatives' concerns
- b) Intake/Outreach worker will explain how therapy works and discuss other HISP services

Second Visit:

- a) Intake/Outreach worker will follow-up on problems addressed in the first HISP visit
- b) Through intake/outreach worker's coordination of efforts client is admitted to HISP

SECTION II
PATIENTS' AND RELATIVES' CONCERNS ADDRESSED IN OUTREACH

Outreach worker needed to address two types of concerns by patients and their relatives. The first type consisted of the emotional problems associated with being seen by a mental health worker. The second type was the lack of information about mental health and illness. This section will discuss emotional concerns. Informational concerns are discussed in Section III.

Chart 1 illustrates some typical expressions or concerns about the emotional problems experienced by patients and relatives. The outreach worker needed to address these concerns in order to motivate the patient and relatives to seek care at HISP.

There was no standardized approach for finding out about and dealing with these concerns. But the main idea was to probe for these concerns and to empathize with the patient and relatives.

The following are three types of emotional concerns by patients and some typical ways of probing for these. By addressing these concerns affective linkages could be established with client and family.
Below are some suggested ways of probing for these concerns.

CHART 11. Stigma associated with mental illness:

- It is our experience that clients refuse to go for treatment after discharge from a hospital because they claim they are no longer "sick".
- Family sees client as incapacitated, unable to take care of his/her needs and or to help the family, as a result they tend to overprotect the client.
- Patients sees him/herself as unable to make any positive contribution to the family.
- Families feel embarrassed or guilt over coming to seek help for emotional problems.
- People often think that only crazy people ("locos") need help with emotional difficulties.

2. Medication concerns:

- It has been our experience that some clients refuse to take medication as soon as they feel better.
- It has been our experience that some clients refuse to take medication because they are afraid of their side effects.
- Certain clients prefer to use the highest dosage of medication available, thinking that it's the best for them.
- Clients and their families refuse changes in medication, even when client has improved, thinking that they will get sick if medication is reduced.
- Some clients are afraid to become addicted to the medication.
- Some clients feel as if medication will be forced onto them even if they don't need it.

3. Relatives' Concerns:

- It is common in families with psychiatric clients to change their habits and behavior around the client.
- Families want to know if client is going to improve or will go back to normal.
- Families are concerned about the duration of the client's condition.
- Family usually does not want clients to go back to school or work, even when clients condition has improved.

4. Alternative Resources:

- It is common for Hispanic families to first go to their own family or extended family first to seek help.
- People often chose to go to either religious leaders or folk healers rather than come to see a psychiatrist.
- People often first go to their medical doctor with problems related to their nerves.

5. Cultural and/or Institutional Barriers Experienced:

- Some people fear coming to a clinic because they think that no one will understand them.
- Some people have been treated indifferently by mental health professionals in the past and feel abused.
- Some families can't speak English well and think that no one will be able to communicate with them.
- -Some people think that if they have no money or Medicaid they will not be treated.
- People often prefer to stay close to their homes for help instead of venturing far away into unknown neighborhoods.
- People often need help when in crisis and think that they can only come by appointment.
- Some Hispanics feel that Hispanic professional who are different from them will not sympathize.
- Some people are not really aware that what they are experiencing is emotional in nature and that it could possible be cured.
- Men feel that they should not discuss their problems with others because it is unmanly, not macho. (Machismo)
- Women may feel that it is the fate of women to suffer. (Marianismo)

ROLE PLAYING GUIDE TO TYPICAL STATEMENTS FOR AFFECTIVE LINK-AGES WITH CLIENT AND FAMILY

	CLIENT	RELATIVES
1. Stigma of Illness	<p>Will I ever be normal again?</p> <p>-Will I ever be cured?</p> <p>-I don't want therapy or treatment because it means that I'm sick.</p> <p>-If I come for counseling does it mean that I am emotionally disturbed?</p> <p>-If I need therapy does that mean I'm not a man?</p> <p>-What if my husband doesn't want me to be in therapy?</p>	<p>-My son's behavior is very embarrassing to us.</p> <p>-My neighbors don't talk to us anymore.</p> <p>-We're afraid of him because he's sick & he can hurt someone.</p> <p>-Should we let others know that we go for help?</p> <p>-What will the people say if they find out?</p>
2. Medication Concerns	<p>-I was doing ok up to the day that I started taking medication.</p> <p>-Now that I'm out of the hospital, I don't need to take medication.</p> <p>-I'm not crazy, I don't need medication.</p> <p>Is it true that meds can make you impotent?</p> <p>-Is there medication that works for all kinds of problems?</p>	<p>-We have to constantly remind him to take medication.</p> <p>-The medication has made him more depressed, lethargic etc., we are worried about him</p> <p>-How does the medication work?</p> <p>-Can our child ever have children or get married?</p> <p>-Will they force him to take meds if he doesn't want to?</p>
3. Relatives' Concerns		<p>-I'm worried he'll get worse since he has too much time on his hands at home. I'd like for him to keep busy.</p> <p>-I'm frustrated and exasperated taking care of him.</p> <p>-Agency staff do not address the needs of families in coping with patients at home.</p>

4. Ignorance of Nature of Symptoms	-I'm not crazy. I'm ok I just have to find a job. I don't need your help.	-He/she only hears voices sometimes. He is not sick, he only needs a job.
5. What is Therapy?	-I won't come here just to talk to you. What else can you offer me?	-Are you able to help him just by talking? -How are you going to help us? How are you going to change his behavior?
6. Cost of Service	-Is this a free service? -Can I get tokens?	-We applied for Medicaid and S.S.I. will that cover for payment? -I can't afford to pay.
7. Other Services	-Could you help me to apply for S.S.I.? -Could you help me to get job training?	-Could you help us to get a Home Attendant? -Could you help us fill out his disability forms? -Could you help us to place our son/daughter in a hospital for the rest of his/her life?

Data Analysis Procedures

The data collection procedure devised by the Hispanic Research Center was modified and used for monitoring the impact of outreach in increasing the use of outpatient services by Hispanics. With respect to the outreach intervention goal, to increase the number of referrals and the proportion of admissions to HISP, monthly information was collected on the number of Hispanics entering the clinic prior to outreach, as well as the number of Hispanics referred and admitted after each type of outreach and the outcomes of these contacts.

Prior to the introduction of the program intervention, a series of baseline measurements were taken which represented the number of cases referred and cases admitted for one year prior to program. This information was shown in the form of a graph. A series of post intervention measurements were taken which were graphed alongside the baseline data. After pre and post intervention data were graphed, the trend lines were visually compared to determine if there were any changes in the magnitude, slope and or pattern of the observations. To determine whether the differences were statistically significant, the standard deviation was calculated, as proposed by Gottman, et al. (1974), to confirm that changes did not occur as a result of chance variations.

Archival data from our clinical intake log was used to count the number of Hispanic referrals generated and the proportion of admissions made per month for one year prior to outreach, as well as those same numbers and proportions after outreach. The number and proportions of lost cases, (cases which never resulted in an intake) were reported. Tables show the monthly Hispanic admission rates of the Baltic Street Service and HISP from OCT 1988 through MAY 1991. Of primary importance for this study were the numbers of referrals generated and the admission rates or the number of outpatient referrals admitted. The percentages of these in relation one to the other were compared to post intervention percentages to determine an increase or decrease in utilization. The data collected on the client census form were tabulated and used statistically to determine any relationship between outreach intervention and items on the census form. Statistical analysis of the data employed crosstabulation and F Test to determine possible correlational associations between bio-psycho-socio-demographic variables by type of outreach.

CHAPTER 3: PERTINENT VARIABLES

This chapter presents the findings of the study in terms of the original programmatic goals and objectives that were explored. The goals of the HISP program were twofold. First the program aimed to increase the utilization of services by the Spanish-speaking Hispanic community residents. Secondly, we wished to determine which interventions proved to be most engaging for the Hispanic client. The purpose of this formative evaluation research study was to determine whether or not the goals of the HISP program were achieved.

The research questions explored were: 1) what were the Hispanic patterns of utilization of services for the period before and after program development, 2) which forms of outreach resulted in increased generation of referrals and admissions of Hispanic community residents in need of mental health services into outpatient treatment, 3) was there any correlation between outreach and level of acculturation, 4) were there any other significant bio-psycho-sociodemographic differences between those who were admitted to the clinic through varying outreach interventions and those who utilized clinic services without outreach.

In order to systematically answer those questions the following data analysis plan was used:

DATA ANALYSIS PLAN

- 1) Description of the utilization rates from clinical intake log: number of referral and admissions, percentages of admissions, percentages of lost cases by program stages and total percentages admitted to HISP program from non-outreach and outreach methods. The standard deviation was used to determine the magnitude of increase or decrease in utilization rates.
- 2) Descriptive statistics: aggregation of data presented by measures of central tendency and univariate analysis from the Client Census Form.
- 3) Examination of relationship among the variables: report on the results of crosstabulations and F Test to determine statistical significance of outreach versus non-outreach intervention stages by variables on Client Census Form.

Table 1 demonstrates graphically the data collection procedure that was utilized to monitor the flow of cases in to the HISP program. Table 1 indicates the HISP program monthly Referral and Admission rates which were monitored and

collected from our clinical intake log by stages of program development. Stage 1 refers to the one year prior to program, from October 1988 thru September 1989. It shows the number of actual referrals and admissions generated by month during that period. Stage 2 refers to the onset of program, October 1989 thru March 1990, during which time no outreach was attempted, just dissemination of information about the program. It indicates the number of actual referrals and admissions by month during that period. Stage 3 refers to the time during which agency outreach began, from April 1990 thru September 1990. It indicates the actual number of referrals and admissions generated for that period both from agency outreach and non-outreach methods. Referrals which were received from the non-outreached agencies were referred to as non-outreach referrals. Stage 4 refers to the last time frame during which data was collected from October 1990 thru March 1991. It indicates the actual number of referrals and admissions generated for that period both from agency, KIOSK, and nonoutreach methods. Agency outreach admissions which overflowed into Stage 4, were collected so as to report on the possible ripple effect of referrals/admissions from agency outreach into the beginning of the KIOSK phase.

TABLE 1
HISP MONTHLY REFERRAL AND ADMISSION RATES BY STAGES

Date	STAGE 1 PRE-PROGRAM		STAGE 2	STAGE 3		STAGE 4		
	# ref	#adm		referrals out nonout	admissions out nonout	agcy kiosk	admissions nonout	
Oct 88	3	2						
Nov	4	1						
Dec	3	1						
Jan 89	4	4						
Feb	4	2						
Mar	5	1						
Apr	4	3						
May	5	1						
Ju	6	4						
Jy	3	2						
Aug	5	1						
Sep	4	2						
DISSEMINATION								
			STAGE 2					
			# ref	#adm				
Oct			4	3				
Nov			3	2				
Dec			5	3				
Jan 90			6	1				
Feb			4	1				
Mar			6	2				
AGENCY								
			STAGE 3					
			referrals		admissions			
			out	nonout	out	nonout		
Apr			22	3	21	2		
May			26	4	19	4		
Ju			19	2	18	2		
Jy			14	4	12	1		
Aug			8	5	7	2		
Sep			5	3	5	1		
KIOSK								
			STAGE 4					
			referrals		admissions			
			agcy	kiosk	agcy	kiosk	nonout	
Oct			2	8	2	0	7	2
Nov			0	5	3	0	5	2
Dec			0	7	2	0	7	0
Jan 91			0	7	3	0	7	3
Feb			0	6	4	0	6	2
Mar			0	4	3	0	4	1

Table 2 demonstrates visually the indicators of program outcomes from non-outreach and outreach methods by program stages. It shows the number of cases referred and admitted, the number of lost cases from non follow through after referral, the percentages of cases admitted and lost cases, and it contrasts the total percentages of cases admitted to the HISP program from each stage and from combined outreach and non-outreach methods.

Table 2 indicates that 23 cases were referred during the first six months of pre-program and 27 cases during the second half of pre-program. The following six month period of dissemination only resulted in 28 referrals.

When agency outreach was implemented, this six month period of outreach resulted in a dramatic increase of 94 referrals. The last six month period of KIOSK outreach generated 37 referrals. Agency outreach (Stage 3) generated 2 referrals which were obtained during the KIOSK outreach (Stage 4).

Referrals which were received from the non-outreached agencies, both during the non-outreach and outreach stages of this study, were referred to as non-outreach referrals. Since these non-outreach referrals continued to be generated during the last two stages of agency and KIOSK outreach,

TABLE 2

INDICATORS OF PROGRAM OUTCOMES
FROM NON-OUTREACH AND OUTREACH

	STAGE I		STAGE 2	STAGE 3		STAGE 4	
	PRE-PROGRAM		DISSEMINATION	AGENCY		KIOSK	
Number of cases referred	1st half 23	2nd half 27	28	agency non-out	94 21	agency non-out	kiosk 37 2 17
					total	115	56
Number of cases admitted	11	13	12	agency non-out	82 12	agency non-out	kiosk 36 0 10
					total	94	46
Number of lost cases non-follow thru	12	14	16	agency non-out	12 9	agency non-out	kiosk 1 2 7
Percentage of cases admitted	47.8%	48.2%	42.8%	agency non-out	87.2% 57.1%	agency nonout	kiosk 97.3% 0% 58.8%
Percentage of lost cases after referral	52.2%	51.8%	57.2%	agency non-out	12.8% 42.9%	agency nonout	kiosk 2.7% -- 41.2%
TOTAL Percentages of Cases Admitted to HISP program thru:	Pre program	1 st	7.1%	Combined			
	Pre program	2 nd	8.4%	Non outreach		23.4%	
	<u>Dissemination</u>			<u>Methods</u>			
	Agency		53.2%	Outreach		76.6%	
	KIOSK		23.4%	Methods			

they were mentioned in this study. Those referrals were not included as part of the sample since the pretest-posttest

study called for a comparison of those cases generated during the non-outreach stage with those from the outreach stage. Table 2 indicates that the number of cases admitted during the first and second half of Stage 1 pre-program were 11 and 13 respectively. Dissemination only resulted in 12 admissions. Agency outreach resulted in 82 admissions and KIOSK outreach resulted in 36 admissions. The largest number of admissions resulted from agency outreach. The ripple effect or overflow of 2 referrals from the agency outreach stage into the next stage (KIOSK) resulted in zero admissions.

Table 2 shows the cases that did not result in an intake, in other words, the lost cases. The number of lost cases were: 12 and 14 during the 1st and 2nd half of the pre-program stage, 16 during dissemination only, 12 during agency outreach, and 1 during KIOSK outreach. Two cases from Stage 3 agency referrals were lost when tallied during the active KIOSK outreach stage.

The percentages of cases admitted from each program stage were: 47.8% during the first half and 48.2% during the second half of the pre-program stage, 42.8% during the dissemination only stage, 87.2% during agency outreach and 97.3% during KIOSK outreach. The percentage of cases

admitted from agency outreach rippling into active KIOSK outreach was zero percent.

When comparing outcomes of outreach efforts to the outcomes of non-outreach efforts (TABLE 3), the percentages of cases admitted from non-outreach averaged 48% for Stage 1 and 42.8% for Stage 2, while the percent of admissions after outreach averaged 87.2% for agency and 97.3% for KIOSK outreach. This was an increase in the percentages of cases admitted by agency outreach of 39.2% over pre-program no outreach and 44.4% over dissemination only. KIOSK outreach represented an increase in the percentages of cases admitted by 49.3% over pre-program and 54.5% over dissemination only.

The percentages of lost cases from referral to intake were: 52.2% during the 1st half and 51.8% during the 2nd half of pre-program, 57.2% during the dissemination only stage, 12.8% from agency outreach, and 2.7% from KIOSK outreach. The percentages of lost cases in the clinic prior to this study had been 52%. The percentages of lost cases from agency outreach (12.8%) and KIOSK outreach (2.7%) are notably low when compared to the percentage of lost cases which occurred prior to this study.

The total percentages of cases admitted to the HISP program from each stage were: 7.1% during 1st half and 8.4% during

the 2nd half of the year of the pre-program stage, 7.8% from the dissemination stage, 53.2% from Stage 3 (agency outreach), and 23.4% from Stage 4 (KIOSK).

The data from Table 2 shows significant increases in utilization from pre-program and dissemination stages of program development to agency and KIOSK stages. Whereas agency outreach accounted for 53.2% of all the cases admitted to the program and KIOSK accounted for 23.4% of the cases admitted, this represented a 37.6% increase by agency outreach over non-outreach methods and a 15.7% increase by KIOSK outreach over non-outreach methods. Agency outreach efforts generated 7 times the number of cases admitted over the average number of cases from non-outreach. KIOSK outreach efforts generated over 3 times the number of cases admitted over the average number of cases from non-outreach. The total percentages of cases admitted to the HISP program from combined non-outreach methods (Stage 1 and 2) were 23.4%, and 76.6% from combined outreach methods (Stage 3 and 4). This represented a total percentage of cases increase in utilization of 53.2% following combined active outreach efforts.

The following will report on the non-outreach referrals which were generated during Stage 3 and 4. Non-outreach referrals during active outreach stages generated 21 refer-

rals during Stage 3 agency outreach and 17 referrals during Stage 4 KIOSK outreach. The number of cases admitted from non-outreach referrals during active Stage 3 agency outreach were 12 and 10 during Stage 4 KIOSK outreach. The number of lost cases from non-outreach referrals during active outreach stages were: 9 during agency outreach and 7 during KIOSK outreach. The percentages of cases admitted from non-outreach referrals during active outreach stages were: 57.1% during agency outreach and 58.8% during KIOSK outreach. The percentages of lost cases from non-outreach referrals during active outreach stages were: 42.9% during agency outreach and 41.2% during KIOSK outreach.

Graph 1 shows in the form of stacked bar charts the numbers of cases referred by the number of cases admitted during each program stage. The graph shows that the greatest number of referrals came from agency outreach, followed by KIOSK outreach. Stage 1 and Stage 2 both non-outreach phases generated roughly equal numbers of case referrals and admissions. The numbers of cases admitted were higher in both the agency and KIOSK outreach phases.

Figure 1 in the form of a pie chart demonstrates the percentages of lost cases and cases admitted by program stages. It shows that during the non-outreach pre-program stage,

Graph 1

Number of Cases Referred and Admitted by Stages of Intervention

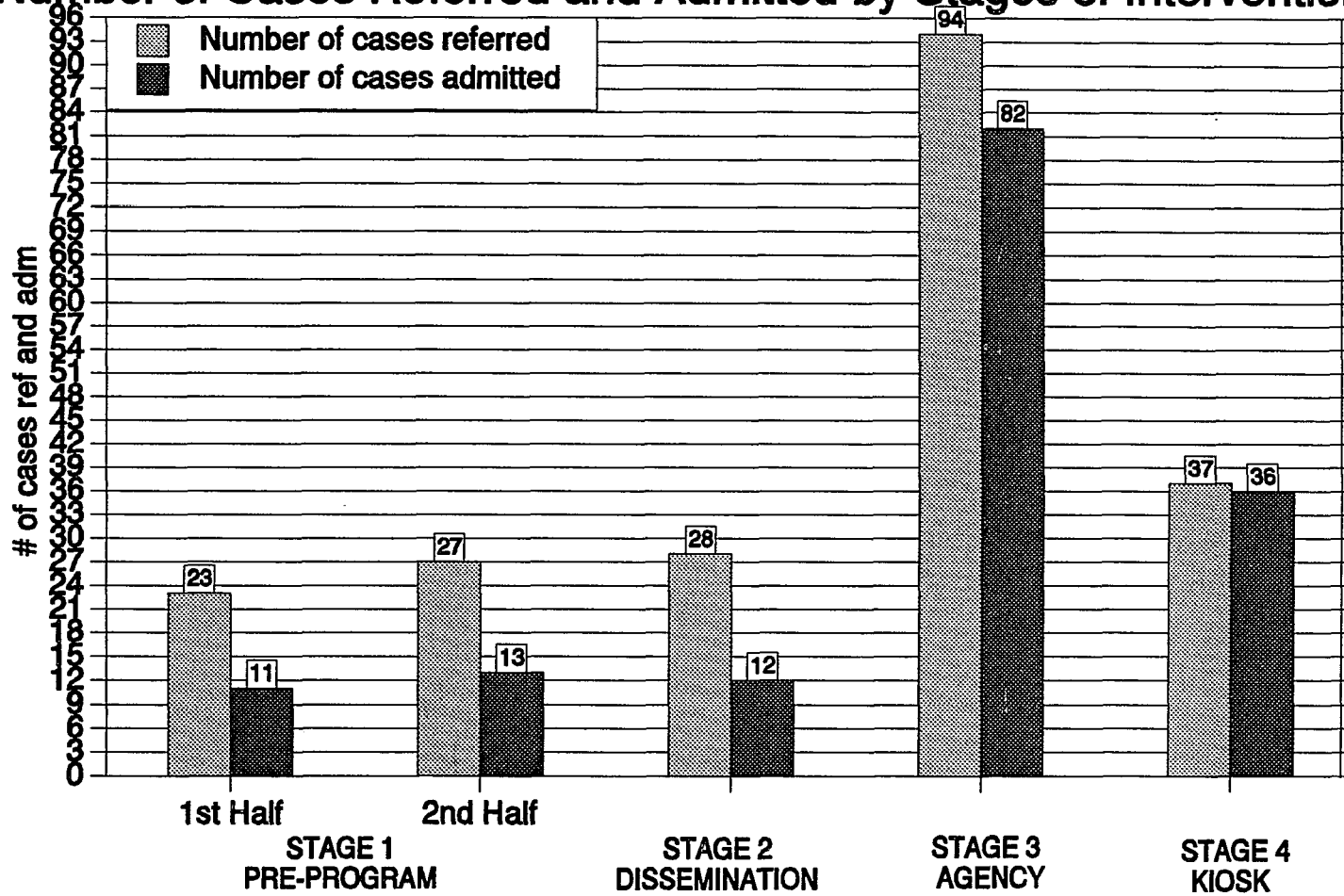
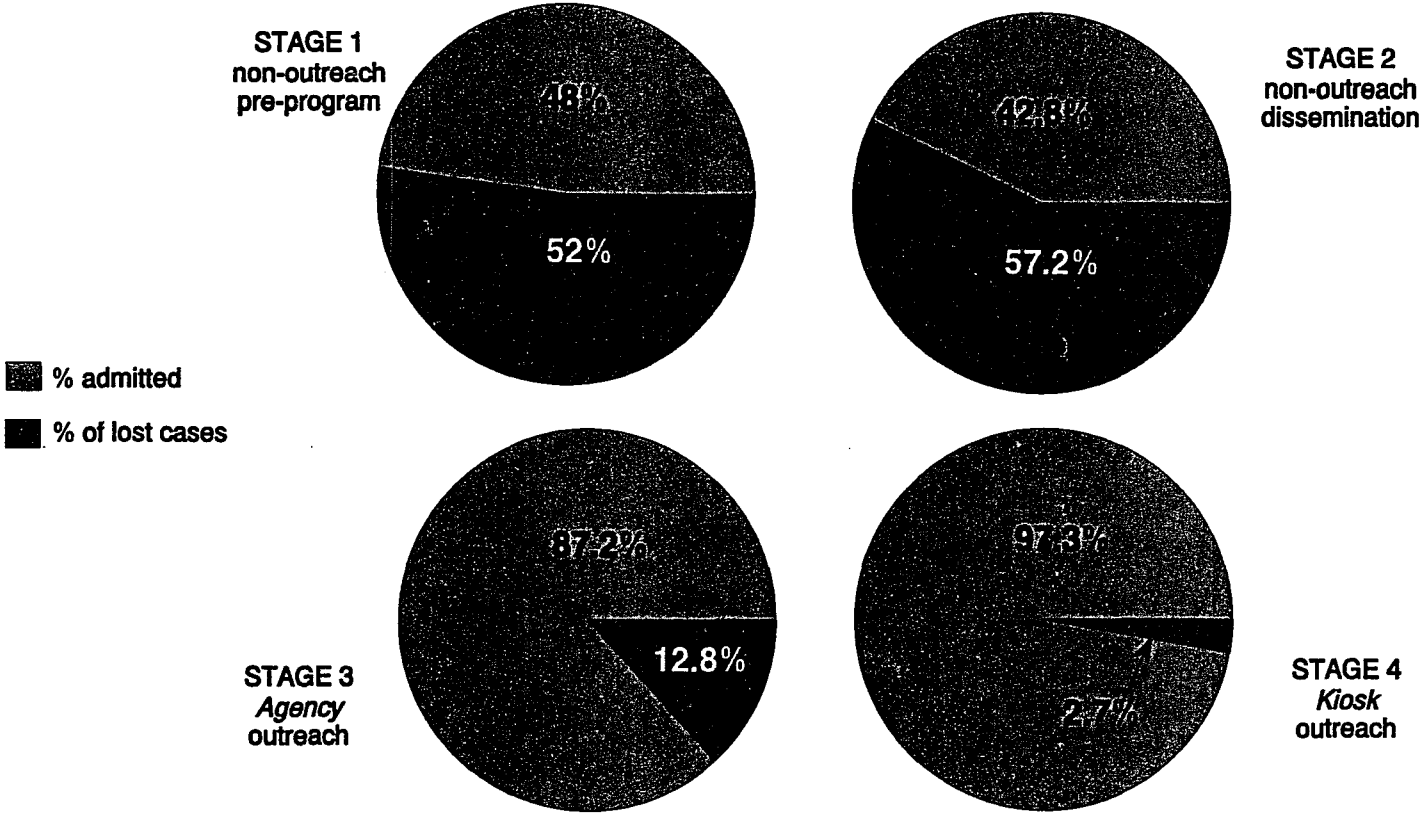


Figure 1

Percentages of Lost Cases and Cases Admitted by Program Stages



52% of the cases referred were lost. The dissemination only stage resulted in 57.2% lost cases. In contrast, agency outreach only resulted in 12.8% lost cases and KIOSK outreach only resulted in 2.7% lost cases. The data indicated that outreach methods resulted in lower percentages of lost cases upon referral than did non-outreach methods. Likewise, outreach methods resulted in higher percentages of admissions than non-outreach methods.

The HRC's data collection procedure was used for monitoring the impact of outreach in increasing the use of outpatient services by the Hispanic community. With respect to the outreach intervention goal, to increase the number of admissions to the HISP program, monthly information was collected on the number of Hispanics entering the program prior to outreach as well as the number of Hispanic cases admitted after each outreach. The results of this part of the study are detailed in this section of the report.

The archival data from our clinical intake log was used to count the number of Hispanic admissions generated during each stage of program development. Of primary importance for this part of the study were the referral and admission rates (Table 1). The percentages of these in relation one to another were compared to post-intervention percentages to determine increase or decrease in utilization.

Graph 2 compares the pre- and post-intervention data to determine the magnitude of the increase after intervention. To determine whether increase or decrease in the rates of utilization were statistically significant, the numbers of admissions were plotted along a graph indicating the base line figures alongside the numbers of cases admitted during subsequent stages. The mean number of admissions for the non-outreach stage were calculated ($X=2$) and the average was 2 admissions. The non-outreach average admission rate was contrasted with the mean number of admissions during outreach stages. The standard deviation for the mean scores ($SD= 1.02$) was determined to see if the numbers generated by outreach fell within 2 SD above ($2 SD=4.05$) or below ($2 SD= -.05$) the mean.

Graph 2 reveals that 100% of the scores fell two standard deviations above the mean for the agency outreach stage. The graph also reveals that 5 out of the 6 scores fell two standard deviations above the mean for the KIOSK outreach stage. In contrast, no scores fell two standard deviations above or below the mean for the non-outreach stage. Visual inspection of the data reveals an increase in the rate of utilization after agency and KIOSK outreach intervention. A positive impact of agency outreach effort on utilization was indicated by the finding that 100% of the scores fell 2 SD above the mean. Likewise, a positive impact of KIOSK

outreach effort on utilization was indicated by the finding that 5 out of the 6 scores (83.3%) fell 2 SD above the mean. During the KIOSK outreach Stage 1 admission score fell slightly below 2 SD above the mean. That score of 4 was in relation to 4.05 which represented 2 Standard Deviations above the mean. The analysis indicated that the increase in utilization rates following both agency and KIOSK outreach efforts were statistically significant.

Description of Population Served From Client Census Form

The client census form was used as the instrument which would determine the characteristics of those Hispanic patients who utilized the program. The results of the client census form indicated that the total population of the study was comprised of 154 clients (N=154); 15.6% (N=24) came during the pre-program Stage 1 part of the study, 7.1% (N=11) during the first half of the year and 8.4% (N=13) during the second half. Stage 2, which was the stage of program development with dissemination of program information only but no outreach, had 7.8% (N=12) of the patients. Stage 3, agency outreach, had 53.2% (N=82) of the patients. Stage 4, Kiosk outreach, had 23.4% (N=36) of the patients.

For the total group (N=154) the average age was 46.5 years. Eighty seven (56.5%) were females and sixty seven (43.5%) were males. Most of the clients in the study, fifty seven

(37%) were single, thirty (19.5%) married, twenty four (15.5%) were separated, thirty one (20.1%) divorced, and twelve (7.8%) were widowed.

Seventy eight (50.6%) of the population were reported as heads of households. One hundred and five (68.2%) reported having had intact families of origin. Forty nine (31.8%) reported being a single parent. In regard to living arrangements, thirty two (20.8%) reported living alone, forty (26%) with parents, thirty one (20.1%) with children, thirty five (22.7%) with a spouse, ten (6.5%) with siblings, and six (3.9%) with others. The highest percentage, forty of the 154 clients (26%) in the study resided with parents.

Fifty two (33.8%) of the clients had no children, twenty four (15.6%) had one child, thirty eight (24.7%) had two children, eighteen (11.7%) had three, twelve (7.8%) had four, and ten (6.4%) had five or more children. Clients with children comprised the largest percentage within the study (66%).

The highest percentage of patients in the study were island born Puerto Ricans. The nationality reported consisted of twenty four (15.6%) North American (USA) born of Hispanic descent, one hundred (64.9%) born in Puerto Rico, ten (6.5%) were Dominican, eight (5.2%) were Cuban, seven (4.5%) were

Central American, four (2.6%) were South American, and one (.6%) was "other".

One hundred twenty nine (83.8%) were citizens, eighteen (11.7%) were residents, and seven (4.5%) were illegal immigrants.

The referral sources for the entire population consisted of self, family, friend, community agency, general hospital, psychiatric hospital, other, kiosk post, and outreached agencies. Seventy (45.5%) of the referred clients admitted came from agency outreach, twenty six (16.9%) came from KIOSK, twelve (7.8%) from community agencies, eleven (7.1%) were self referred, nine (5.8%) were family referred, eight (5.2%) were referred from general hospitals, eight (5.2%) were referred from psychiatric hospitals, and four (2.6%) by friends. Among the possible referral sources mentioned, the highest percentage (45.5%) of the referrals were generated from agency outreach, followed by the KIOSK which referred 16.9% of the clients.

Using the DSM III-R Axis I diagnosis, the study population was diagnosed as fifty nine (38.3%) suffering from a psychosis/schizophrenic disorder, forty three (27.9%) from major affective mood disorder, thirteen (8.4%) from anxiety disorders, nine (5.8%) from somatoform disorders, eight (5.2%)

from adjustment disorders, four (2.6%) from organic disorders, three (1.9%) a secondary personality disorder, and two (1.3%) from sleep disorders.

The largest percentage of Axis I diagnostic categories were among the psychotic/schizophrenic disorders (38.3%). There was a slight change in diagnosis when patients were re-assessed one month after intake screening. The number of cases which were initially diagnosed as psychotic disorders within this population was sixty one (39.6%). The percentages went from 39.6% at intake to 38.3% upon completion of client census form one month later. The percentage of mood disorders on initial diagnosis was 25.3%. The diagnosis one month after screening for mood disorders indicated a rise to 27.9%. Axis II diagnoses of mental retardation were reported for seventeen cases (11.0%) of the population. Twenty nine (18.8%) had a dual diagnosis of substance abuse/psychiatric disorder.

For the variable entitled "Onset of Symptoms Prior to Seeking Help", the average response was between three to six months (7.8%) and six months to a year (16.9%). The most frequent response was two or more years (23.4%). Seeking help immediately was the least frequent response, with only one of the cases (.6%) reporting this.

Ninety (58.4%) of the population reported having had a prior history of psychiatric treatment. Sixty three cases (40.9%) reported never having any prior psychiatric treatment.

Regarding hospitalization, fifty eight (37.7%) reported no history of hospitalization; eighteen (11.7%) had one hospitalization; fifteen (9.7%) reported two hospitalizations; twenty two (14.3%) reported three; forty one (26.6%) reported a history of multiple hospitalizations. Clients with no history of hospitalizations (37.7%) represented the largest percentage of the cases within the study sample, yet 26.6% reported having a history of multiple hospitalizations.

After admission, the type of treatment which was provided indicated that ninety clients (58.4%) were in individual treatment; fifteen (9.7%) were in family therapy; twenty nine (18.8%) were in group therapy; sixteen (10.4%) were in day hospital; and three (1.9%) were utilizing the work center in addition to treatment. The largest percentage (58.4%) were clients being seen in individual psychotherapy.

The therapists reported that client's frequency of treatment was: on a weekly basis 52.6%, twice weekly 11.7%, every two weeks 22.1%, and monthly 11.7%. Over half (52.6%) of the clients were being seen on a weekly basis.

The mean number of years of education completed was eight. One case (.6%) reported no education at all; six (3.9%) had a first grade education; seven (4.5%) a second grade education; sixteen (10.4%) a third grade; seven (4.5%) a fourth grade; six (3.9%) a fifth grade; twelve (7.8%) a sixth grade; and thirteen (8.4%) had the mean number of years (8) of education. Only 25 clients (16.2%) had graduated from High School. Nine clients (5.6%) had some college education; one client (.6%) had a bachelor's degree. No clients within the study had gone beyond an undergraduate education.

The variable for functional literacy showed that 111 of the clients (72.1%) were deemed literate, whereas forty three (27.9%) were not literate.

Forty eight (31.2%) of the cases were reported to be monolingual, Spanish speaking only. One hundred and six (68.8%) were considered bilingual. The language dominance for those rated as bilingual was: 43.3% English dominant, 45% Spanish dominant and 11.7% were fluent in both languages.

The variable which reports on the client's employment history shows that ninety nine (64.3%) of the clients had past employment, whereas fifty five (35.7%) had no past employment. Seventeen (11%) of the patients were currently em-

ployed, but the vast majority, one hundred thirty seven (89%) were not currently employed.

One hundred and twenty four of the clients (80.5%) were on some form of social income benefit, be it SSI or Public Assistance. Ninety one (59.1%) were on SSI and sixty three (40.9%) were not on SSI. Thirty three (21.%) were on Public Assistance. One hundred seventeen (76%) received Medicaid. Twenty two (14.3%) received Medicare.

The data from the Client Census Form revealed that thirteen (8.4%) were considered to be in outstanding health, (69%) from good to satisfactory, and thirty three (21.4%) were considered to be in poor health. The most frequent illness reported was high blood pressure (8.4%), followed by asthma (7.8%), heart condition (6.5%), diabetes (3.9%), high cholesterol (2.6%), and the highest percentage (17.5%) reported was multiple illnesses.

The compliance with medical treatment variable showed that 37% always complied with treatment, 57.1% sometimes complied, and 5.8% never complied with medical treatments.

The variable which looked at client's social isolation indicated that roughly equal percentages (50%) were described as being socially isolated and the same percentage

were described as not being socially isolated. The social network variable attempted to determine who were the client's main social contacts. The responses on the client's main social network as viewed by the therapist were: friends (16.9%), the family (54.5%), church (11.7%), neighborhood (15.6%), other (1.3%). The family as the client's main social contact was the modal category.

A total of 55.8% of the clients were believed to be able to benefit from additional forms of treatment which were not being offered at that time. The question phrased "if the client could benefit from an additional form of treatment not currently offered" found that: 7.8% could benefit from ESL (English as a Second Language), 13.% could benefit from a socialization program, 3.9% from a parenting skills program, 5.8% from family psychoeducation on mental illness, 13% from medical seminars on physical illnesses, and 3.2% from an AA or NA program in Spanish, and 9.1% from some other form of treatment not specified.

The question about level of acculturation attempted to determine the client's identification with Hispanic and or American culture based on their preferences with regard to language, music, food, social networks, and self identification. The categories of responses were presented in the form of a Likert scale, reflecting certain attitudinal

dimensions ranging from exclusively Hispanic to exclusively American. Exclusively Hispanic (1) was considered very low in acculturation; predominately Hispanic (2) was considered low in acculturation; totally bicultural (3) was considered moderate in acculturation; predominately American (4) was considered high in acculturation; exclusively American (5) was considered very high in acculturation.

The responses indicated that forty three (27.9%) of the clients were perceived as being exclusively Hispanic along the acculturation continuum; thirty three (21.4%) were viewed as predominately Hispanic; thirty eight (24.7%) were viewed as bicultural; thirty five (22.7%) were viewed as predominately American; and five (3.2%) were viewed as exclusively American. The category with the highest percentage of responses (27.9%) was exclusively Hispanic and the lowest percentage (3.2%) being exclusively American. The average response for the client's acculturation level was between predominately Hispanic and bicultural.

The question on the client's level of functioning is similar to the Fifth Axis DSM 111 score for general functioning. The categories ranged from 'very poor' to 'poor' to 'fair' to 'good' to 'very good', with examples of symptoms and interpersonal functioning. The results from the client census form indicated that three (1.9%) were rated as very poor;

forty two (27.3%) were rated as poor; sixty seven (43.5%) of the cases were rated as fair; thirty nine (25.3%) were rated as good; and three (1.9%) were rated as very good. Fair was the modal response (43.5%) for the variable level of functioning; whereas between poor to fair, but closer to fair, was the mean response.

Quantitative Analysis Relationship Among Variables

The following part of this study addresses the last two research questions: 1) was there any correlation between outreach and level of acculturation and 2) were there any other significant bio-psycho-sociodemographic differences between those who were admitted to the clinic through varying outreach interventions and those who utilized clinic services without outreach.

The relationship between the clients' " Level of Acculturation" was examined with admissions through various intervention stages.

TABLE 3
LEVEL OF ACCULTURATION BY INTERVENTION STAGES

		Level of Acculturation				
		<u>MEAN</u>	<u>SCORE</u>	<u>STD.DEV.</u>	<u>F VALUE</u>	<u>P-Level</u>
STAGE 1	N=24	2.87		1.11	3.23	<.02
STAGE 2	N=12	3.00		.95		
STAGE 3	N=82	2.55		1.11		
STAGE 4	N=36	2.05		1.25		

The analysis was performed to determine if the admissions generated from the four intervention stages were associated with client's level of acculturation.

The rating scale was classified as: (1) exclusively Hispanic, (2) predominately Hispanic, (3) totally bicultural, (4) predominately American, and (5) exclusively American.

Outreach clearly had the effect of reaching a less acculturated client population. Table 3 shows that those who came to the clinic without outreach during Stages 1 and 2 were rated as higher on the acculturation scale than those who came after active outreach (agency and KIOSK) they were rated lower on the acculturation scale.

Stage 1 mean score (2.87) placed clients on the continuum between predominately Hispanic and bicultural, but closer to bicultural. The clients who came during dissemination only (Stage 2) were rated as bicultural (3).

Those who came after agency outreach (Stage 3) were rated between predominately Hispanic and bicultural (2.55) and those who came after KIOSK (Stage 4) were rated as predominately Hispanic (2.05).

Both outreach methods, but especially KIOSK, were more associated with reaching clients who were less acculturated (rated as predominately Hispanic in acculturation by clinicians). Non-outreach methods were closely associated with reaching those clients who were rated as bicultural by clinicians. Dissemination of program existence to the community of patients was most closely associated with having generated referrals of clients who were totally bicultural. None of the program efforts were associated with generating clients who were rated as exclusively Hispanic or exclusively American.

There was a statistically significant association found between the variables of level of acculturation and admissions from intervention stages ($F=3.23$, $p<.02$). Clients who were admitted from agency and KIOSK outreach tended to be rated as lower in their level of acculturation. The clients who came during the non-outreach phase tended to be rated as higher in their level of acculturation.

The relationship between the clients' number of hospitalizations was examined with admissions through various intervention stages.

TABLE 4
Number of Hospitalizations by Intervention Stages

		Number of Hospitalizations			
		MEAN SCORE	STD.DEV.	F VALUE	P-Level
STAGE 1	N=23	.54	1.0	7.3	<.001
STAGE 2	N=12	1.75			1.82
STAGE 3	N=82	2.24	1.59		
STAGE 4	N=36	1.67			1.76

The analysis was chosen to determine if the admissions generated from the four intervention stages were associated with the number of hospitalizations a client may have experienced.

The findings indicate that clients who came on their own, without outreach, tended to have fewer hospitalizations. Those clients who came after agency outreach tended to have a greater number of hospitalizations, averaging between two and three.

Table 4 shows the mean scores or average number of client hospitalizations by intervention stage. The mean score for the group of clients who were admitted during each stage were: .54 from Stage 1 (non-outreach), 1.75 from Stage 2 (dissemination only), 2.24 from Stage 3 (agency outreach), and 1.67 from Stage 4 (KIOSK outreach).

The data indicated that client admissions generated from non-outreach methods (Stage 1) averaged from zero to one (.54) hospitalizations. Those admissions during non-outreach dissemination only (Stage 2) averaged between one and two (1.75) hospitalizations. Those admissions from active agency outreach (Stage 3) averaged between two and three (2.24) hospitalizations. Those admissions from active KIOSK outreach (Stage 4) averaged between one and two (1.67) hospitalizations.

There was a statistically significant association found between the type of outreach and the number of client hospitalizations ($F=7.3$, $p=.001$). Those clients who came on their own without outreach tended to have fewer hospitalizations.

TABLE 5
Prior History of Treatment by Type of Stage Admissions

Prior History	STAGE 1 <u>no outreach</u>		STAGE 2 <u>dissemin</u>		STAGE 3 <u>AGENCY</u>		STAGE 4 <u>KIOSK</u>		<u>TOTAL</u>
	N	%	N	%	N	%	N	%	
YES	7	29.2%	6	50%	58	70.7%	19	52.8%	90
NO	17	70.8%	6	50%	24	29.3%	16	44.4%	63
	--	----	--	----	--	-----	--	-----	-
TOTAL	24	100%	12	100%	82	100%	35	97.2%	153

2
 $X = 17.58$, $df = 6$, $p = .007$

Number of Missing Cases = 1.

Those clients who came after agency outreach tended to have a greater number of hospitalizations, averaging between two and three. The relationship between the clients' "prior history of treatment" and admissions was examined through various program intervention stages.

These variables were examined to determine if there was an association between admissions generated from different types of outreach and non outreach intervention stages and prior history of treatment.

The findings indicate that clients without histories of psychiatric treatment comprised the largest percentage among those clients who came without outreach, whereas clients with histories of prior treatment comprised the largest percentages of those who came after agency outreach and KIOSK outreach.

Table 5 displays the relationship between admissions generated during various outreach and nonoutreach program stages and the indication of prior history of treatment of the patient. The crosstabulation table data indicated that 70.7% of those clients who were admitted from agency outreach (Stage 3) and 52.8% from KIOSK outreach (Stage 4), had prior histories of psychiatric treatment. The data indicated that during Stage 2 which was no outreach, but

dissemination of program to the community, 50% of the clients had histories of prior treatment. The data indicated that of those clients who came during Stage 1 (no outreach) only 29.2% had histories of prior psychiatric treatment.

With regard to clients with no prior histories, the table indicates that 70.8% of clients admitted during Stage 1 (no outreach) had no prior histories of treatment. Equal percentages, 50% having prior treatment history and 50% having no prior treatment, came during Stage 2 (dissemination only). The data also indicated that 29.3% of clients admitted during agency outreach and 44.4% of clients admitted during KIOSK outreach had no histories of prior treatment. Clients without histories of psychiatric treatment comprised the largest percentage (70%) of those clients who came without outreach, whereas clients with histories of prior treatment comprised the largest percentages (70.7%) of those who came after agency outreach and (52.8%) after KIOSK outreach.

There was a statistically significant association between the stage of outreach and clients prior history of psychiatric treatment ($p=.007$). Graphic representation (FIGURE 2) of the crosstabulation data in the form of bar charts of these variables visually indicates that the strongest associations are between admissions generated from agency out-

reach (Stage 3) and having had a history of prior treatment, as well as the association between admissions generated from no outreach (Stage 1) and having no history of prior treatment. Among those who were admitted during agency outreach the bar chart shows that 70.7% had histories of prior treatment, whereas 29.3% had no history of prior treatment. This means that agency outreach was highly associated with having reached clients with prior histories of treatment rather than those who had never been in treatment before. The bar chart shows the inverse of agency outreach for those who were admitted during the non-outreach (Stage 1), where 70.8% had no history of prior treatment and 29.2% had histories of prior treatment. This means that non-outreach methods were highly associated with having reached clients without prior histories of treatment rather than those who had been in treatment before.

TABLE 6
Residency Status by Program Stages

Residency Status	STAGE 1 no outreach		STAGE 2 dissemin		STAGE 3 AGENCY		STAGE 4 KIOSK		TOTAL
	N	%	N	%	N	%	N	%	
Citizen	15	62.5%	12	100%	72	87.8%	30	83.3%	129
Resident	6	25.0%	----		7	8.5%	5	13.9%	18
Illegal	3	12.5%	----		3	3.7%	1	2.8%	7
TOTAL:	24	100%	12	100%	82	100%	36	100%	154

²
X = 11.99, df=6, p=.06

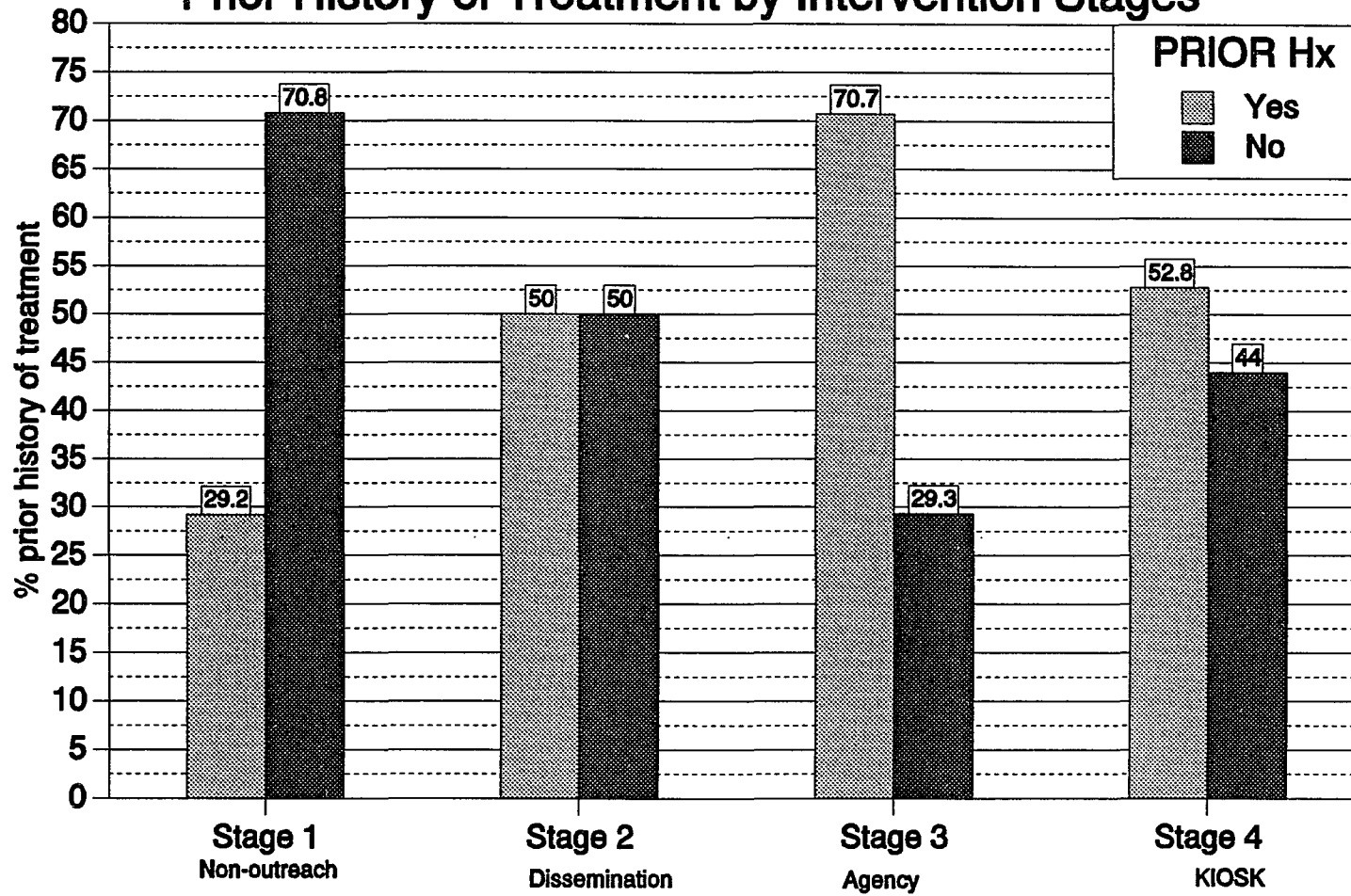
The relationship between the clients' "residency status" and admissions from program intervention stages was examined. These variables were examined to determine if there was a correlation between admissions generated from different types of outreach and non-outreach intervention stages and client residency status.

The findings indicated that outreach was not strongly associated with generating admissions of illegal aliens. Table 6 displays the crosstabulation data between admissions generated during various outreach and nonoutreach program stages and the residency status of the clients. High percentages of those clients who were admitted during all intervention stages were citizens. The table shows that 12.5% of the clients who were admitted from Stage 1 (non-outreach) were reportedly illegal, whereas only 2.8% and 3.7% of the clients who were admitted from KIOSK and agency stages were illegal. This means that outreach was not strongly associated with generating admissions of illegal aliens.

The relationship between intervention stages and residency status were not found to be statistically significant ($p=.06$). Nevertheless, it may be practically significant to note that outreach was not as effective as non-outreach in

Figure 2

Prior History of Treatment by Intervention Stages



generating higher percentages of clients who were illegal aliens.

The relationship between clients' "SSI beneficiary status" and admissions from intervention stages was examined.

TABLE 7
SSI Benefit by Type of Stage Admission

SSI BENEFIT	STAGE 1 no outreach		STAGE 2 dissemin		STAGE 3 AGENCY		STAGE 4 KIOSK		TOTAL
	N	%	N	%	N	%	N	%	
YES	6	25%	7	58.3%	58	70.7%	20	55.6%	91
NO	8	75%	5	41.7%	24	29.3%	16	44.4%	63
TOTAL	24	100%	12	100%	82	100%	36	100%	154

$\chi^2 = 16.32, df=3, p=.0009$

These variables were examined to determine if there was an association between admissions generated from different types of intervention stages and social benefit status. The findings showed that the largest percentage of admissions of clients with no SSI benefits were generated during the pre-program non-outreach stage. The post program stages were associated with having reached larger percentages of admissions of clients with SSI benefits.

Table 7 displays the crosstabulation data between admissions generated during various outreach and

non-outreach program stages and the clients SSI benefit status. Among the clients who were admitted during Stage 1 (no outreach) 75% reported having no SSI benefit. The remaining findings were as follows: Stage 2, 41.7%; agency outreach, 29.3%; and KIOSK outreach, 44.4%.

The largest percentage (75%) of admissions of clients with no SSI benefits were generated during the pre-program, non-outreach stage. The post program stages were associated with having generated larger percentages of admissions of clients with SSI benefits, 58.3% during the program dissemination stage, 55.6% during the KIOSK outreach and 70.7% during agency outreach.

The crosstabulation test indicated that there was a statistically significant association between the type of outreach and clients having SSI benefits ($p=0009$). Higher percentages of patients without SSI benefits utilized the clinic when no Hispanic program existed. Post program the trend was the opposite, higher percentages of patients with SSI benefits utilized the program.

SUMMARY OF THE FINDINGS

Client Census Form

The findings from the clients census form regarding who utilized the service of the clinic indicated that one hun-

dred and fifty four patients were registered during the course of the study. The average age of the client was 46. The largest group of clients were those who were 34 years of age. There were 56.5% females and 43.5% males. Most of the clients in the program were single (37%). There were 50.6% who reported being heads of households. Roughly 32% reported being single parents. Most of the clients resided with their parents (26%). Clients with no children comprised the largest percentage within the program (33.8%).

The highest percentage of patients in the program were island born Puerto Rican in origin (64.9%), followed by Dominican (6.5%), Cuban (5.2%), Central American (4.5%), and South American (2.6%). Most of the patients (83.8%) were citizens, 11.7% were residents and 4.5% were illegal.

Among the referral sources, the highest percentage (45.5%) of the referrals were generated from agency outreach, followed by the KIOSK which referred 16.9%. Other sources of referrals each accounted for smaller percentages.

The largest percentage of Axis I diagnostic categories were among the psychotic/schizophrenic disorders (38.3%). Axis II diagnoses of mental retardation accounted for 11% of the population and 18.8% were dually diagnosed as substance abuse/psychiatric disorder. For the variable entitled onset

of symptoms prior to seeking help, the average response was between three to six months (7.8%) and six months to a year (16.9%). The most frequent response was two or more years with 23.4%.

There were 58.4% who reported having had a prior history of treatment. Clients with no history of hospitalizations (37.7%) represented the largest percentage of the cases, yet 26.6% reported a history of multiple hospitalizations.

After admission most of the clients were seen in individual psychotherapy (58.4%), followed by group therapy (18.8%), and family therapy (9.7%). Only 1.9% were referred for work center vocational rehabilitation simultaneously with treatment. Over half (52.6%) were being seen on a weekly basis.

The average years of education completed was eight. Only 25 clients had graduated High School (16.2%). Only 5.6% had some college education, one client had a bachelor's degree and no clients had any schooling beyond college.

There were 72.1% who were reported as functionally literate, whereas 27.9% were not literate. Monolingual Spanish as the language spoken was reported for 31.2% of the cases, 68.8% were bilingual.

The currently employed comprised 11% of the cases. Those employed in the past comprised 64.3%. Whereas 35.7% had never been employed.

There were 59.1% who were on SSI and 21% on Public Assistance. A total of 80.5% were on some form of social income benefits.

The health condition variable showed that 8.4% were considered to be in outstanding health, 69% were reported as being from good to satisfactory health, and 21% were considered in poor health. The most frequent illness reported was high blood pressure (8.4%) and the highest percentage reported multiple physical illnesses (17.5%).

The compliance with treatment showed that 5.8% never complied with medical treatment. The vast majority either always (37%) or sometimes (57%) complied.

The variable which looked at client's social isolation indicated that roughly equal percentages (50%) were described as being or not being socially isolated. The family as the client's main social contact was the most frequent response.

The variable which looked at whether patients could benefit from other treatment not currently offered indicated that a total of 55.8% of the clients were believed to be able to benefit from some other form of treatment not currently offered. The treatment suggested were: ESL, a socialization program, a parenting skills program, multi-family psychoeducational treatment, and AA or NA in Spanish.

The question on level of acculturation indicated that the category with the highest percentage (27.9%) of responses was "exclusively Hispanic", and the lowest percentage (3.2%) being "exclusively American". The average response for the client's acculturation level was between predominately Hispanic and bicultural.

The variable which looked at level of functioning indicated that "fair" was the modal response (43.5%), whereas between poor to fair, but closer to fair was the average response.

Findings on the Rates of Utilization

The following summary reports the results of the second research question which determined which forms of outreach resulted in increased generation of referrals and admissions of Hispanic community residents in need of mental health services into outpatient treatment.

The percentages of cases admitted during the course of the study from each program stage were: 47.8% during the first half and 48.2% during the second half of the pre-program stage, 42.8% during the dissemination only stage, 87.2% during agency outreach, and 97.3% during KIOSK outreach. The percentages of cases admitted from non-outreach methods during active outreach stages were: 57.1% during agency outreach and 58.8% during KIOSK outreach. The percentages of cases admitted from agency outreach rippling into active KIOSK outreach was zero percent.

When comparing outcomes of outreach efforts to the outcomes of non-outreach efforts, the percentages of cases admitted from non-outreach averaged 48% for Stage 1 and 42.8% for Stage 2, while the percent of admissions after outreach averaged 87.2% for agency and 97.3% for KIOSK outreach. This was an increase in the percentages of case admitted by agency outreach of 39.2% over pre-program no outreach and 44.4% over dissemination only. KIOSK outreach represented an increase in the percentages of cases admitted by 49.3% over pre-program and 54.5% over dissemination only.

The percentage of lost cases from referral to intake were: 52.2% during the 1st half and 51.8% during the 2nd half of pre-program, 57.2% during the dissemination only stage, 12.8% from agency outreach, and 2.7% from KIOSK outreach.

The percentages of lost cases in the clinic prior to this study had been 52%. The percentages of lost cases from agency outreach (12.8%) and KIOSK outreach (2.7%) are notably low when compared to the percentage of lost cases which occurred prior to this study.

The percentages of lost cases from non-outreach methods during active outreach stages were: 42.9% during agency outreach and 41.2% during KIOSK outreach.

The total percentages of cases admitted to the clinic from each stage were: 7.1% during 1st half and 8.4% during the 2nd half of the year of the pre-program stage, 7.8% from the dissemination stage, 53.2% from the Stage 3 (agency outreach), and 23.4% from the Stage 4 (KIOSK).

The analysis showed significant increases in the rates of outpatient utilization from the pre-program and dissemination stages of program development to agency and KIOSK stages. Whereas agency outreach accounted for 53.2% of all the cases admitted to the program and KIOSK accounted for 23.4% of the cases admitted, this represented a 37.6% increase by agency outreach over non-outreach methods and a 15.7% increase by KIOSK outreach over non-outreach methods. Agency outreach generated 7 times the number of cases admitted over the average number of cases from non-outreach

efforts. KIOSK outreach generated over 3 times the number of cases admitted over the average number of cases from non-outreach efforts.

During the course of the study the total overall percentages of cases admitted to the clinic from combined non-outreach methods (Stages 1 and 2) were 23.4%, and 76.6% from combined outreach methods (Stages 3 and 4). This represented a total percentage of cases increase in utilization of 53.2% following combined active outreach efforts.

The findings indicated that both HISP program outreach efforts were successful in increasing the rates of utilization by the Puerto Rican/Hispanic community residents. The analysis indicated that the magnitude of the increases in rates of utilization were found to be statistically significant. The HISP program efforts were not only able to significantly increase the percentages of cases referred but also the outreach was influential in increasing the percentages of cases admitted. Both outreach efforts were associated with lower percentages of lost cases following referral. The KIOSK outreach, although not generating significantly greater number of referrals than agency outreach, was able to surpass the agency outreach method in terms of percentages of cases admitted from KIOSK as well as result in substantially fewer percentages of lost cases.

Examination of Relationship Among the Variables

The test of statistical significance which were used were crosstabulation and F test to answer the last two research questions: was there any correlation between outreach and level of acculturation and were there any other significant bio-psycho-sociodemographic differences between those who were admitted to the clinic through varying outreach interventions and those who utilized clinic services without outreach.

Outreach was found to be associated with the clients level of acculturation. Both outreach methods, but especially KIOSK, were more associated with reaching clients who were less acculturated, (rated as predominately Hispanic in acculturation by clinicians). Non-outreach methods were closely associated with generating those clients who were rated as bicultural by clinicians. Dissemination of program among the community of patients was most closely associated with having generated referrals of clients who were totally bicultural. None of the program efforts was associated with generating clients who were rated as exclusively Hispanic or exclusively American.

There was a statistically significant relationship found between the level of acculturation of those who were admitted according to intervention stages ($F=3.23$, $p<.02$). Those

clients who were admitted from agency outreach tended to be rated as lower in their level of acculturation (closer to predominately Hispanic) than those who referred themselves or came without outreach. The clients who were admitted from KIOSK outreach also tended to be rated as lower in their level of acculturation (predominately Hispanic). The clients who came from non-outreach tended to be rated as higher in their level of acculturation (from predominately Hispanic to bicultural for pre-program and totally bicultural for dissemination only).

The clients' "number of hospitalizations" was found to be associated with admissions from type of intervention stage. There was a statistically significant relationship found between the admissions generated from the different program stages and the number of client hospitalizations experienced ($F=7.3$, $p=.001$). Those clients who came on their own without outreach tended to have fewer hospitalizations. Those clients who came after agency outreach tended to have a greater number of hospitalizations, averaging between two and three.

The clients' "prior history of treatment" was found to be associated with admissions by intervention stage. There was a statistically significant association between the different outreach stages and having had a prior history of psy-

chiatric treatment ($p=.007$). The strongest associations were found between admissions generated from agency outreach (Stage 3) and having had a history of prior treatment, as well as the association found between admissions generated from no outreach (Stage 1) and having no history of prior treatment. Among those who were admitted during agency outreach the results indicated that 70.7% had histories of prior treatment, whereas 29.3% had no history of prior treatment. This would mean that agency outreach was highly associated with having reached clients with prior histories of treatment rather than those who had never been in treatment before. The results indicated the reverse for those who were admitted during the non-outreach (Stage 1), where 70.8% had no history of prior treatment and 29.2% had histories of prior treatment. This would mean that non-outreach methods were highly associated with having generated clients without prior histories of treatment rather than those who had been in treatment before.

The relationship between intervention stages and "residency status" was not found to be statistically significant ($p=.06$). The data indicated that high percentages of those clients who were admitted from all stages were citizens. The data showed that 12.5% of the clients who were admitted from Stage 1 no-outreach were reportedly illegal, whereas only 2.8% and 3.7% of the clients who were admitted from

agency and KIOSK stages were illegal. Non-outreach was more associated with admissions of illegal aliens (12.5%). This would imply that if illegal aliens came to the program they arrived without outreach. It may be practically significant to note that outreach was not as effective as non-outreach in generating higher percentages of clients who were illegal aliens.

The clients' "SSI beneficiary status" was found to be associated with admissions by intervention stages. There was a statistically significant association between admissions generated during the pre-program, non-outreach stage and clients having had no SSI benefits, as well as a significant association between admissions generated from the post program stages and clients having had SSI benefits ($p=0009$). When no Hispanic program existed, higher percentages of Hispanic patients without SSI benefits utilized the clinic. Post program the trend was the opposite, higher percentages of Hispanic patients with SSI benefits utilized the program.

In summary, with regard to the first program goal, it was shown that both forms of outreach, over non-outreach, clearly had the effect of facilitating access and increasing the utilization rates of outpatient mental health services by the Hispanic/Puerto Rican community resident. With regard to the second goal, it was shown that non-outreach methods

were associated with attracting clients who: had higher reported levels of acculturation, had few if any hospitalizations, reported fewer prior histories of treatment, and were among those with no SSI benefits. Dissemination of program existence as an intervention was associated with attracting clients who: were rated as totally bicultural in their level of acculturation, had a history of between one and two hospitalizations, had a 50% rate of prior history of treatment, and had SSI benefits. Agency outreach was associated with attracting clients who: had lower perceived levels of acculturation, had the highest number of hospitalizations, reported having prior histories of treatment, and were on SSI. KIOSK outreach was associated with attracting clients who: were lower in their level of acculturation, had a history of between one and two hospitalizations, reported having prior histories of treatment, and were on SSI.

Implications and Recommendations

The results from this study have implications for policy analysis and implementation, program planning, program monitoring, and for clinical psychotherapeutic treatment.

Equity in the provision of service

A program planner attempting to develop programs providing clinically relevant treatment services to ethnic minorities would have to determine if the population currently being

served is proportionately representative of the need for services in the community at large. Policy questions to be considered regarding proportional representation of ethnic minorities in mental health treatment would involve issues such as parity and, more importantly, equity in the provision of services. Is it enough to say that a certain percentage of the minority population lives within a catchment area and that that proportion is adequately represented within the clinic census figures? The question of whether or not a disadvantaged minority is adequately represented is certainly not addressed by their mere proportional representation in the clinic census figures, especially if perceived need and actual need are not taken into consideration. The minority, unacculturated, Hispanic inner city community resident has been shown to have higher incidence and prevalence rates of mental illness than the Black and White American population (Rodriguez, 1987). Greater rates of mental illness coupled with low outpatient utilization rates would indicate a greater need for services, yet at the same time, the Hispanic clients were found to be less likely to recognize their emotional distress and consequently their possible need for services.

Consequently, an administrator of a mental health program would be ethically compelled to ascertain whether or not the total population the program was treating was truly repre-

sentative of the minority and or disadvantaged population's need for services. Program planning which is based solely on achieving numerical parity doesn't take into account whether certain minority groups have higher levels of needs than others. Program planning for ethnic minorities should be based on epidemiological needs assessment studies to determine actual needs. When needs assessment can not be performed, other indicators of need should be pursued so as to address the issue of equity in the provision of service.

Prior to this study, our clinic served the geographic community of South West Brooklyn which was approximately 1/3 Hispanic in population. Yet, the Hispanic population of the Baltic Street Clinic prior to the creation of HISP was roughly 1/4 of the total clinic population. This meant that the Hispanic population was not proportionately represented within the total clinic population.

The findings of this study indicated that the Hispanic utilization rates prior to HISP program development represented neither parity, meaning proportional representation of the Hispanics within the community being served by the clinic, nor equity in the provision of services when considering possible need for services.

A model of program planning and service delivery for the Hispanic community would have to take into account: 1) the reasons for possible underutilization of services whether due to cultural or institutional barriers that deter the use of services and 2) whether underutilization was related to The Hispanic population not perceiving a need for services.

Program planning which is based on achieving mere parity doesn't take into account different levels of actual and/or perceived needs of the Hispanic community nor if the intended population may be experiencing barriers to utilization.

The Outreach Programs

With regard to the first program goal of increasing the utilization of services by the Hispanic community residents, the findings indicated a substantial increase by outreach methods over non-outreach methods and dissemination of program information only. The non-outreached Hispanic client who came prior to program development, had come to the clinic in fairly low numbers, and that trend continued throughout the course of the study. The finding showed that had outreach not been implemented the rates of utilization would have remained the same as before. The findings that the utilization of service increased by a total of 37.6% after agency outreach and 15.7% after KIOSK outreach attests to the fact that outreach is an effective means of increas-

ing the rates of utilization of mental health services by the Hispanic community residents and is effective in addressing the issue of equity in provision of services. Non-outreach implies a passive approach to attracting potential clients who may be in need of service. Whereas the outreach approach is a pro-active method or intervention which had evident success with the Hispanic community in this study.

The fact that agency outreach was even more successful at increasing the use of services possibly attested to the ability of community leaders to influence positively the recognition of need by the Hispanic clients who came into contact with them. Additionally, the role of education of community agency leaders about the cultural and institutional barriers perceived by the Hispanic client, was an integral factor in getting them to make referrals which resulted in admissions. The increased interagency collaboration in the process of referral of clients was crucial in facilitating access and increasing the rates of utilization.

KIOSK outreach did not generate as many referrals as agency outreach, perhaps due to it not having reached as broad a base of people the way agency outreach did. Agency outreach created a network of expanded resource professionals aware of the needs and better able to make referrals to an existent program. Nevertheless, the high percentages of clients

admitted and the low percentage of lost cases resulting from KIOSK outreach over agency outreach, attested to the positive effect of face to face contact with the potential client.

The KIOSK outreach effort was effective in closing the social distance and eliminating the barriers which existed between the organization and the Hispanic community resident, through utilizing linkages that increased the frequency of face to face contacts, a concept that was originally espoused by Dobrof and Litwak (1977).

KIOSK outreach was also able to follow the client from the first contact through admission and was able to address directly any barriers or obstacles experienced by the client. This could account for the low percentages of lost cases and higher percentage of admissions from KIOSK outreach.

The Social Work theoretical framework of most significance and applicability to this study was the six step model proposed by Toseland at SUNY School of Social Welfare at Albany. He advocated for an outreach model which defined the purpose of the intervention, identified the barriers and resistances to service delivery, developed a data base, initiated the outreach, evaluated and followed up on the

outreach contacts (Toseland, 1981). This model for outreach, along with the Project COPA outreach schedule and the HRC data collection procedure, is what framed the methodological approaches involved in the agency and KIOSK outreach methods.

The findings of this study seem to agree with those of Rodriguez, (1987), Delgado and Humm-Delgado, (1980), as well as Cohen, (1972). The outreach method created by the HRC and Project COPA, and adapted by the HISP program, was effective in increasing the outpatient utilization rates of the HISP program when utilized with clients at the KIOSK.

The HISP program had increases in utilization when outreach was provided to community residents, analagous to the findings of Project COPA, whose outpatient rates increased when outreach was performed with inpatients (Rodriguez, 1987).

The HISP program had increases in utilization when agency outreach combined the method of outreach to "key informants" within the community, advanced by Delgado and Humm-Delgado (1980), with the method used by Cohen (1972), who advocated for education of mental health principles to both providers and recipients of service as a way of improving communication and resulting services.

The findings indicated that both outreach methods, and especially KIOSK outreach, were effective at reaching those potential clients who were among the less acculturated. The finding that each type of outreach was associated with increased admissions of a specific group of clients according to level of acculturation would imply that outreach was effective in reaching those patients whom we had perceived were not utilizing the service because of some cultural barrier. This finding confirmed the notion that those who were less Americanized needed specific outreach services in order for them to utilize the service in numbers equal to or greater than the more acculturated Hispanic client. Both outreach methods were able to help overcome a barrier which had existed for the less acculturated Hispanic client.

Program planning for the Hispanic client would need to take into consideration those groups of unacculturated patients who, by virtue of their cultural belief systems, can be unintentionally excluded from the provision of services. The KIOSK outreach was able to attract those clients who were among the least acculturated. The implication of this would be that those clients perhaps trusted and felt most comfortable with a local social service agency which was situated in the community and with having a face to face contact with a Hispanic representative of the clinic.

The Hispanic clients' help seeking patterns which were associated with the United Fifth Avenue Coalition were utilized for creating linking mechanisms between the Hispanic client, the KIOSK and HISP mental health services. The implications for program planning are clear if the goal is to increase the utilization of service by a particularly underserved population. Outreach when situated in the community positively connects with the specific client group, which studies have shown are most in need of services (Rodriguez, 1987), but who are underserved within the public and private outpatient mental health systems.

The finding that agency outreach was able to attract clients with a greater number of psychiatric hospitalizations indicates that it was more effective with those clients who were likely to be suffering from some form of chronic mental illness. It would appear that these patients were using different services within the community, perhaps avoiding using the traditional outpatient mental health system. Outreach was able to reconnect them with the continuity of care offered by the outpatient system. This has implications for reducing the rate of recidivism and emergency room usage which is often associated with the Hispanic chronically mental ill patient. If agency outreach can help to reconnect the Hispanic CMI patient with treatment, this intervention could be implemented on an ongoing basis as a means of

facilitating access to appropriate outpatient mental health services.

There is evidence from the literature on the use of psychiatric inpatient services by Hispanics that there is a tendency on the part of Hispanics to equate a discharge from a hospital with cure from illness (Rodriguez, 1983). The implication is that if you are discharged it must mean that you are no longer sick. Rodriguez also noted that the "failure to seek followup services upon discharge is also related to the patients's inability to recognize feelings of distress as symptoms of a condition requiring care", (Rodriguez, 1983, p.7).

It would appear that agency outreach was able to convince those referring persons of the difficulty patients experience in recognizing the need for services and was able to facilitate access by providing the client with acknowledgement and recognition of symptoms which could benefit from treatment. This perhaps helped to change the perception of need for services among those patients with numerous hospitalizations.

The finding that agency outreach, more than non-outreach, was able to attract clients with a prior history of psychiatric treatment would imply that community leaders referring

clients were able to get patients whom they perceived as requiring renewed or continuous treatment to return to the clinic for services. The client's access to outpatient treatment was in some manner facilitated by the relationship that the client had with these providers and by the increased interagency collaboration which followed the patient through the process. Non-outreach was shown to have exactly the reverse outcome. Fewer percentages of clients with histories of prior treatment came without outreach. Those who reported no histories of prior treatment seemed more able to access clinical services. Interestingly, dissemination of program information as a method falling somewhere between non-outreach and active outreach, brought in exactly equal percentages (50%) of clients who reported prior history of treatment and no history of treatment. This could imply that dissemination of program information to the community regarding services designed specifically for the Hispanic client helped to overcome a possible institutional and or cultural barrier for some of those who had been in treatment previously. The information did note the availability of Spanish speaking clinicians, the crisis services offered and the no waiting list policy. These factors may have been influential in overcoming a perceived barrier for some clients who had prior histories of treatment.

The KIOSK as a form of outreach associated with attracting clients with prior histories of treatment or clients with histories of numerous hospitalization, was only slightly more effective than the dissemination of program method. One could infer that the KIOSK was slightly more effective than the dissemination method and that the KIOSK site was not necessarily the place where people with prior histories of treatment or histories of numerous hospitalizations tended to go when help seeking.

Although client admissions from outreach was not found to be strongly associated with the clients' residency status, the finding has practical significance for programming and utilization. The numbers of admissions of illegal aliens in this study was relatively low, nevertheless, the findings showed that outreach did not attract illegal aliens any more than non-outreach. This would imply that outreach is not necessarily the method for attracting those clients who may be illegal aliens into treatment. Since those illegal aliens who came on their own were equal in numbers to those who came following outreach, this would imply that a different intervention would have to be created to generate referrals of clients who may need service but who are illegal aliens. Despite the ever growing numbers of illegal aliens in the area surrounding the clinic, it would appear that outreach did not reduce or eliminate the possible barriers to utili-

zation experienced by illegal aliens. If they came to the service they came despite any fear or barrier that may have existed for them.

The clients SSI beneficiary status was differentially associated with admissions during the non-outreach and outreach stages. Clients who had no SSI benefits tended to come during the non-outreach stage, whereas clients on SSI were associated with coming during the outreach stages. Social Security SSI benefits specifically refers to the patients economic resources. With regard to this study, I attempted to determine if it was associated with utilization of mental health services. If clients were receiving SSI prior to coming to the clinic, it would mean that they already had a record of serious mental and or physical illness. But not all clients who have SSI necessarily have Medicaid, although they may be eligible for it. Our experience with chronically mentally ill patients has been that they often do not attend the necessary appointments for Medicaid recertification and get knocked off the entitlement for failure to comply. Patients can often have financial benefits from the Social Security Administration and have no health coverage. They usually perceive their financial entitlements as a necessity, but their health benefits are often not viewed in the same light. As a result, the finding which showed an association between patients with SSI and admissions from

both dissemination, agency and KIOSK outreach could imply that a possible barrier related to the perceived cost of treatment was overcome. Patients at the KIOSK often had questions regarding the cost of treatment and whether or not they would have to pay from their SSI benefits or if Medicaid paid for mental health treatment.

The dissemination of program information stage could have resulted in clients telling other clients that they would be treated regardless of whether or not they had the ability to pay. Equally, agency outreach would have resulted in informing patients of the existence of a program which accepted patients whether they paid or not, and KIOSK outreach would have done the same. The interventions from the outreach stages all could have resulted in a change in the clients perception with regard to costs involved in treatment.

Implications and Recommendations from Client Census Form

Examination of the descriptive data from the Client Census Form had implications for the development of culturally relevant clinical psychotherapeutic treatment.

The findings with the most clinically practical implications were among the following: that roughly 32% of the clients reported being single parents, 26% percent reported living

with parents, 38% of the cases had a psychotic schizophrenic disorder, 18.8% were dually diagnosed, 23.4% took from two or more years before seeking help with symptoms, 26.6% reported multiple hospitalizations, only 1.9% were in psychiatric vocational rehabilitation, 47.4% had less or up to the average eight grade education, 27.9% were functionally illiterate, 31.2% were only Spanish-speaking, only 11% were currently employed, 21% were considered to be in poor health, 57% sometimes and 5.8% never comply with medical treatments, 50% were socially isolated, 55.8% were believed to be able to benefit from other forms of treatment, 27.3% were rated as poor in their level of functioning, and 27.9% were rated as exclusively Hispanic and 21.4% predominately Hispanic in their level of acculturation.

All of the above mentioned variables had implications for designing treatments to address those specific issues. These issues could be addressed in traditional forms of psychotherapy or in the creation of adjunctive treatments to traditional therapy. The fact that 32% of the cases reported being single parents would indicate a possible need for supportive services to this group of patients in the form of parenting skills groups or support groups to address the specific difficulties of being a single parent and perhaps the dual difficulty of suffering from a mental illness, in

the case of those patients who are mentally ill single parents.

The figure which indicated that 38% of the clients suffered from some severe form of psychosis/schizophrenia had indications for family support services, psychoeducational treatment and education about the psychological/social/biological nature of severe mental illness. These supportive services would be even more indicated if those patients suffering from the illness were also among those fairly high percentages of clients reported to be either functionally illiterate, uneducated, socially isolated, only Spanish-speaking, reported as low in their level of functioning or not as Americanized in their level of acculturation.

The data which indicated that 18.8% were dually diagnosed also had indications for specific treatment of the MICA (mentally ill chemical abusing) patient. Adjunctive treatments which address the dual nature of the illness in the patient's primary language, if necessary, are indicated. An additional avenue for treatment, such as AA or NA in Spanish could complement the therapy offered to the Hispanic MICA patient.

The finding that indicated that 23.4% of the clients took from two or more years before seeking help with their symptoms, indicated a need for outreach to help identify and

engage clients through earlier intervention. The Hispanic community could benefit from education in mental health principles through community based seminars and presentations, as a method of early recognition of psychological distress in the process of help seeking. This had implications for the role of members of the community mental health advisory boards, in terms of fostering efforts at Hispanic community involvement, education and recruitment of Hispanic residents for participation in the city's ongoing mental health planning process.

The data which indicated that 47.4% had less than an eight grade education, coupled with 27.9% being functionally illiterate, 31.2% being exclusively Spanish-speaking, indicated a need for educational services to be provided to the Hispanic patient population in the form of literacy classes, ESL classes, and GED services. Our experience had been that often the Hispanic patients were either too emotionally ill or felt to inhibited or experienced barriers in the past when attempting to seek these type of educational services outside of the mental health system. They had experienced difficulties which often kept them from either enrolling or remaining in educational programs which didn't or couldn't also address or take into consideration aspects of their emotional disturbance. The traditional mental health system could address these difficulties for the Hispanic client

through funding educational services through the Psychiatric Rehabilitation Program.

The finding that 50% of the Hispanic clients were perceived as being socially isolated had implications for the development of socialization programs, such as psychosocial clubs, with an emphasis on the building of interpersonal skills.

The finding that 21% were considered to be in poor health, coupled by the figures which indicated that 57% sometimes and 5.8% never complied with medical treatments had indications for the development of group educational treatment. These treatment would be psychoeducational in nature, taking the form of medical seminars for the Hispanic patients which explain the relationships between physical health and emotional well being.

Group therapy could be utilized to address the issue of the clients' level of acculturation. Roles for group therapists would involve acting as acculturation specialists, mediators, interpreters, and advocates in understanding and explaining American culture among and between the group members. All forms of family and individual therapy could address the process of assimilation and acculturation for the Hispanic, actively probing for possible conflicts in

value orientations which occur intrapsychically and interpersonally for the unacculturated Hispanic client. The role and type of treatment is analagous to that offered by social workers within the Settlement House framework.

Policy and Program Recommendations

Mental health programming and service delivery models which incorporate culturally relevant outreach interventions were shown in this study to be effective for: increasing the outpatient utilization of services by the Hispanic population, overcoming barriers to utilization for patients with numerous hospitalizations and prior histories of treatment, and overcoming the cultural barriers around perceived need experienced by the unacculturated Hispanic client when help seeking.

A service delivery model of clinical treatment for the Hispanic client could not only address the active symptoms of psychopathology and or dysfunction of the client but also their acculturative, psychosocial level of functioning. This should be the expertise of clinical social work, which incorporates both psychological and sociological theory into the method of practice with clients. The kinds of adjunctive treatments for the Hispanic client considered from the client census forms, could be further researched within social work. Future research can compare treatments which

address multiple areas of dysfunction to treatments which address solely the psychiatric symptoms presented by the Hispanic client to determine treatment effectiveness.

Future social work research could also examine outreach efforts at multiple sites to determine the effect on utilization. The difficulty with determining all of the potential effects of the KIOSK outreach effort was the fact that it reached only a small percentage of the Hispanic community. An outreach model which attempts to intervene more broadly into multiple areas in which the Hispanic clients reside could be employed to determine if access to the mental health delivery system is facilitated. Multiple types of outreach efforts could be examined further to determine which types of outreach efforts are more effective in creating linking mechanisms between the formal organization and the Hispanic community.

Future social work research could do policy related research which look at different models of determining utilization of mental health services by ethnic minorities, contrasting models which employ parity as a measure of utilization versus those which determine equitable service utilization and goals based on prevalence rates and needs assessments.

If utilization of services is to have policy and program relevant significance it must be determined against some measure of need for service by the intended population. The development of programs to service the Hispanic ethnic minority population needs to consider policy provisions which address not only the proportional representation of minorities within the provision of services, but also provisions which address the issue of equity in the provision of services. Equity needs to be a concern especially for those who have been shown to underutilize a particular social service. Program planning for the Hispanic client would especially need to take into consideration those unacculturated clients who, by virtue of their cultural belief systems, can be unintentionally excluded from the provision of services.

The experience of the HISP program evaluation study showed that access to the mental health delivery system was facilitated and the problem of Hispanic underutilization of services improved through active outreach methods.

APPENDIX

FORDHAM TREMONT COMMUNITY MENTAL HEALTH CENTER**PROJECT COPA****PROPOSED SCHEDULE FOR OUTREACH CONTACTS**

This is general guide for outreach to inpatients. It should be followed when contacting clients and their families at the inpatient unit. Each step should be preceded by an informal assessment of the client, the family and their needs. The next step should be followed when it is determined that the client and his family is able to benefit from it.

Individual differences should be taken into consideration as well as special needs of clients and their families. Common difficulties of psychiatric clients such as limitation in attention and concentration as well as limitation in processing information should also be considered. One can expect the average contact with client to be at most one hour. Contacts with relatives may be longer.

Section I: Schedule of Contacts
Section II: Patients and Relatives Emotional Concerns Regarding Problems/Illness.

SCHEDULE FOR OUTREACH CONTACTS**Steps:**

1. Client is identified by hospital clinician.
2. Hospital contacts Project COPA.
3. Project COPA Director communicates knowledge of client to outreach worker.
4. Outreach worker meets with client and or family.
5. Outreach assessment is performed.
6. Client/Family are evaluated and determination made if services are indicated.
7. Client if in agreement is provided with intake appointment for Project COPA.

Patients' and Relatives' emotional concerns to be addressed in outreach:

1. Stigma
2. Use of medication
3. Relatives' concerns

Role playing guide to typical statements for affective linkages with client and family:

1. Ignorance of nature of illness and of symptoms.
2. What is treatment?
3. Cost of service.
4. Other services offered.

SECTION I
Schedule for outreach Contract

Steps:

- I. Client is identified by hospital clinicians.
- II. Client is referred to outreach worker.
- III. Outreach worker links with potential client.
During the initial contact it is expected that the outreach worker:
 - a) Will "join" with the client
 - b) Will introduce him/herself and explain his/her function
 - c) Will explain basic COPA services
 - d) Will address emotional concerns presented by client
 - f) Will address clients concerns regarding possible stigma, shame, inaccessible service systems, and lack of knowledge of services
 - e) If asked, will provide brief information about nature of emotional illness
- IV. Outreach worker links with family, if appropriate. Outreach worker meets with family and will:
 - a) "Join" family
 - b) Introduce self and explain function
 - c) Explain basic COPA services
 - d) Address families emotional concerns associated with clients's difficulties:
 - Stigma and ambivalence about treatment
 - Concern about managing client
- V. Outreach worker meets with patient and/or family- preliminary screening at clinic- as close as possible to day of COPA interview.

First Visit:

- a) Intake/Outreach worker will follow-up on emotional issues of stigma, medication, treatment and relatives' concerns.
- b) Intake/Outreach worker will explain how therapy works and discuss other COPA services.

Second Visit:

- a) Outreach worker will follow-up on problems addressed in the first outreach visit.
- b) Through outreach worker's coordination of efforts client is admitted to COPA.

SECTION II
Patients' and Relatives' Concerns Addressed in Outreach

Outreach worker needs to address two types of concerns by patients and their relatives. The first type consists of the emotional problems associated with being seen by a mental health worker. The second type is the lack of information about mental health and illness. This section will discuss emotional concerns. Informational concerns are discussed in Section III.

Chart 1 - Illustrates some typical expressions or concerns about the emotional problems experienced by patients and relatives. The outreach worker needs to address these concerns in order to motivate the patient and relatives to seek care at COPA.

There is no standardized approach for finding out about and dealing with these concerns. But the main idea is to probe for these concerns and to empathize with the patient and relatives.

The following are three types of emotional concerns by patients and some typical ways of probing for these. By addressing these concerns affective linkages can be established with client and family. Below are some suggested ways of probing for these concerns.

CHART 1**1. Stigma associated with mental illness:**

- It is our experience that clients refuse to go for treatment after discharge from a hospital because they claim they are no longer "sick".
- Family sees client as incapacitated, unable to take care of his/her needs and or to help the family, as a result they tend to overprotect the client.
- Patients sees him/herself as unable to make any positive contribution to the family.
- Families feel embarrassed or guilt over coming to seek help for emotional problems.
- People often think that only crazy people "locos" need help with emotional difficulties.

2. Medication concerns:

- It has been our experience that some clients refuse to take medication as soon as they feel better.
- It has been our experience that some clients refuse to take medication because they are afraid of their side effects.
- Certain clients prefer to use the highest dosage of medication available, thinking that it's the best for them.
- Clients and their families refuse changes in medication, even when client has improved, thinking that they will get sick if medication is reduced.

3. Relatives' Concerns:

- It is common in families with psychiatric clients to change their habits and behavior around the client.
- Families want to know if client is going to improve or will go back to normal.
- Families are concerned about the duration of the client's condition.

**ROLE PLAYING GUIDE TO TYPICAL STATEMENTS FOR
AFFECTIVE LINKAGES WITH CLIENT AND FAMILY**

	CLIENT	RELATIVES
1. Stigma of Illness	-will I ever be normal again? -will I ever be cured? -I don't want therapy or treatment because it means that I'm sick.	-My son's behavior is very embarrassing to us. -My neighbors don't talk to us anymore -We're afraid of him because he's "sick" & he can hurt someone
2. Medication Concerns	-I was doing OK up to the day I started taking medication	-We have to constantly remind him to take medication.
3. Relatives Concern		-I'm worried he'll get worse since he has too much time on his hands at home. I'd like for him to keep busy. -I'm frustrated and exasperated taking care of him. -Agency staff do not address the needs of families in coping with patients at home.
4. Ignorance of Nature of Symptoms	-I'm not crazy. I'm ok I just have to find a job. I don't need your help.	-He/she only hears voices sometimes. He is not sick, he only needs a job.
5. What is Therapy?	-I won't come here just to talk to you. What else can you offer me?	-Are you able to help him just by talking? -How are you going to help us? How are you going to change his behavior?

6. Cost of Service

-Is this a free service?
-Can I get tokens?
ment?

-We applied for Medic
aid and S.S.I. Will
that cover for pay

-I can't afford to pay.

7. Other Services

-Could you help me to
apply for S.S.I.?
-Could you help me to
get job training?

-Could you help us to
get a Home Attendant?
-Could you help us fill
out his disability
forms?
-Could you help us to
place our son/daughter
in a hospital for the
rest of his/her life?

**FORDHAM TREMONT COMMUNITY MENTAL HEALTH CENTER
HISPANIC RESEARCH CENTER
PROJECT COPA**

Acculturation Scale

Your answers to the four questions below will help us in selecting the best services for you. Please answer each question by checking the answer which best applies to you.

1. Which language do you speak better?

- | | |
|---|--|
| <input type="checkbox"/> 1. Only Spanish | <input type="checkbox"/> 4. English better than Spanish |
| <input type="checkbox"/> 2. Spanish better than English | <input type="checkbox"/> 5. Only in English <input type="checkbox"/> |
| <input type="checkbox"/> 3. Both Spanish and English equally well | |

2. What is your music preference?

- | | |
|---|---|
| <input type="checkbox"/> 1. Only Spanish | <input type="checkbox"/> 4. Mostly Spanish |
| <input type="checkbox"/> 2. Mostly Spanish | <input type="checkbox"/> 5. English only <input type="checkbox"/> |
| <input type="checkbox"/> 3. Equally Spanish and English | |

3. What was the origin of the friends you had from ages 6 to 18?

- | | |
|--|--------------------------|
| <input type="checkbox"/> 1. Almost exclusively Puerto Rican, NyorRicans/Domincans/Others | |
| <input type="checkbox"/> 2. Mostly Puerto Rican/Dominican | |
| <input type="checkbox"/> 3. About equally Puerto Rican/Dominican | |
| <input type="checkbox"/> 4. Mostly Anglos, Blacks, or other ethnic groups | |
| <input type="checkbox"/> 5. Almost exclusively Anglos, Blacks, or other ethnic groups | <input type="checkbox"/> |

4. How do you identify yourself?

1. Puerto Rican/Dominican/Other

2. Nuyorican/Dominican

3. Puerto Rican American/Dominican American/Other

4. Spanish American, Latin American, Hispanic
American, American

5. Anglo American or Other

/4 =

HISP CLIENT CENSUS FORM

Patient's
Name: _____ Age: _____

Address _____

Sex: ___M ___F

Marital Status:
___Single ___Married ___Separated ___Divorced ___Widowed

Is Patient Head of Household?: ___Yes ___No

Was Patient's Family of Origin Intact? ___Yes ___No

Is Patient single parent? ___Yes ___No

Who does patient live with?

Number of Children: _____

Country of Origin?

Residency Status?

Referral Source:

Self___ Family___ Friend___ Community Agency_____

General Hospital___ Psychiatric Hospital___

Other (Indicate) _____

Patients Psychiatric History:

Diagnosis: Initial Admitting: Axis I _____
Axis II _____

Current Diagnosis: Axis I _____
Axis II _____

Substance Abuse:
 (Drugs/Alcohol) _____
 Length of treatment at this Clinic? _____

Onset of Symptoms Prior to Seeking Help
 (Length of Length of Time) _____

Prior History of Psychiatric Treatment:
 Yes _____ No _____
 Approximate # of Hospitalizations: _____

Type and Frequency of Treatment:
 Individual _____ Family _____ Group _____
 Day Hospital _____ Work Center _____ Other _____

Education: Grade Completed _____
 Is Patient Functionally Literate? Yes _____ No _____

Language: Bilingual _____ Monolingual _____
 If Bilingual, language dominance _____
 If monolingual, any receptive or expressive
 skills _____
 Is family bilingual or monolingual? _____

Economic Status:
 Has patient past employment? Yes _____ No _____
 Currently Employed:
 Yes _____ No _____ Full Time _____ Part time _____
 Does patient work regularly? _____ intermittently? _____
 Social Security Disability (SSI): Yes _____ No _____
 Public Assistance: Yes _____ No _____
 Medicaid: Yes _____ No _____ Medicare: Yes _____ No _____

Health:
 General condition: Outstanding _____ Good _____
 Satisfactory _____ Poor _____
 Outstanding problems (illnesses): _____

Does patient comply with recommended medical treatments?
 Always _____ Never _____ Sometimes _____

Is Patient socially isolated: Yes _____ No _____

Social Network: Patient's main social contacts are:
 Friends _____ Family _____ Church _____
 Neighborhood _____ Other _____

Does patient attend this clinic:
 Regularly _____ Infrequently _____ Crisis _____

Would patient benefit from any services not currently offered him/her?

Yes No

If Yes, What service or treatment? _____

Level of Acculturation: (consider preferences in language, music, food, social network, self identification)

- | | | |
|---------------------------|-------|-----------|
| 1) Exclusively Hispanic | _____ | Very Low |
| 2) Predominantly Hispanic | _____ | Low |
| 3) Totally Bicultural | _____ | Moderate |
| 4) Predominantly American | _____ | High |
| 5) Exclusively American | _____ | Very High |

General Level of Functioning:

Very Poor Poor Fair Good Very Good

Example of general level of functioning:

Very Poor: persistent danger to self and others; inability to maintain personal hygiene, no social supports.

Poor: major impairment in reality testing, hallucinations, serious symptoms, suicidal, drug use, major impairment in social functioning (no friends, no family, unable to keep job).

Fair: moderate symptoms (depression, anxiety, somatization). Some difficulty in social, occupation, at school functioning; distanced from family, few friends.

Good: Some mild symptoms (depression, insomnia); transient and expectable reactions to psychosocial stressors. Meaningful family and interpersonal relations.

Very Good: Absent or minimal symptoms; functioning well in all areas, social occupational and familial relations.

REFERENCES

- Abad, V., Ramos, J., & Boyce, E. (1974) A model for delivery of mental health services to Spanish-speaking minorities. American Journal of Orthopsychiatry, 44, 584-595.
- Bachrach, L. (1975) Utilization of State and County Mental Hospitals by Spanish-Americans in 1972. Washington, D.C.: U.S. Government Printing Office, NIMH Division of Biometry, Statistical Note 116, DHEW Publication No. (ADM) 75-158.
- Bird, H.R., & Canino, I. (1981) The Sociopsychiatry of spiritismo. Journal of the American Academy of Child Psychiatry, 20, 725-740.
- Bloom, B. (1975) Changing Patterns of Psychiatric Care. New York: Human Sciences Press.
- Calsyn, R.J. (1989) Evaluation of an Outreach Program Aimed at Increasing Service Utilization by the Rural Elderly. Journal of Gerontological Social Work, 14, (1/2). 127-135.
- Canino, I., Brian, E., & Rogler, L.H. (1980) The Puerto Rican Child in New York City: Stress and Mental Health. Monograph of the Hispanic Research Center, Fordham University, 4.
- Cohen, R. (1972) Principles of Preventive Mental Health Programs for Ethnic Minority Populations: The Acculturation of Puerto Ricans to the United States. American Journal Psychiatry, 128, (12), 81.
- Comas-Diaz, L. (1981) Puerto Rican Espiritismo and Psychotherapy. American Journal of Orthopsychiatry, 51, (4), 636-645.
- Cuellar, I. (1980) An acculturation scale for Mexican American normal and clinical populations. Hispanic Journal of Behavioral Sciences, 2(3), 194-217.
- Delgado, M. (1977) Puerto Rican Spiritualism and the Social Work Profession. Social Casework, 58, 8, 451-458.
- Delgado, M., & Humm-Delgado, D. (1986) Gaining Community Entree to Assess Service Needs of Hispanics. Social Casework, 67, (2), 80-89.

- Delgado, M., & Humm-Delgado, D. (1980) Interagency Collaboration to Increase Community Resources in Serving Hispanics. Hispanic Journal of Behavioral Sciences, 2, (3), 269-285.
- Delgado, M., & Scott, J.F. (1979) Strategic Intervention: A Mental Health Program for the Hispanic Community. Journal of Community Psychology, 7, 187-197.
- Dobrof, R., & Liwak, E. (1977) Maintenance of Family Ties of Long Term Care Patients: Theory and Guide to Practice. NIMH, DHEW Publication No. (ADM) 77-400. pp 80-116.
- Edgerton, R., & Karno, M. (1971) Mexican-American bilingualism and the perception of mental illness. Archives of General Psychiatry, 24, 286-290.
- Flaskerud, J.H. (1986) The Effects of Culture-Compatible Intervention on the Utilization of Mental Health Services by Minority Clients. Community Mental Health Journal, 22, (2), 127-141.
- Grinnell, R.M. (1988) Social Work Research and Evaluation 3rd Ed. F.E. Peacock Publishers, Inc. Itasca, Illinois, p. 230.
- Gottman, J.M. & Leiblum, S.R. (1974) How to Do Psychotherapy and How to Evaluate It. New York: Holt, Rinehart, & Winston, 47-63, 138-51.
- Karno, M., Hough, R.L., Landsverk, J.A., Burman, A., Timbers, D.M., Escobar, J.L., & Regier, D.A. (1987) Utilization of Health and Mental Health Services by Los Angeles Mexican Americans and Non-Hispanic Whites. Archives General Psychiatry, 44, August, 702-709.
- Karno, M., & Wells, K., Hough, R.L., Golding, J.M., Burman, A. (1987) Which Mexican Americans Underutilize Health Services? American Journal of Psychiatry, 144, 7, 918-922.
- Karno, M., & Edgerton, R. (1969) Perception of mental illness in a Mexican American community. Archives of General Psychiatry, 20, 233-238.
- Keefe, S., Padilla, A., & Manuel, C. (1978) The Mexican American extended family as an emotional support system. In J. Manuel and S. Keefe (eds.), Family and Mental Health in the Mexican American Community. Monograph of the Spanish-Speaking Mental Health Research Center, University of California, 7.

- Kusher, M.G., & Davidson, W.S. (1978) Alternative Modes of Outreach: An Experimental Comparison. Gerontologists, 18, 355-362.
- Litwak, E. (1985) Helping the Elderly: The Complementary Roles of Informal Networks and formal Systems. The Guilford Press, NewYork.
- McCoy, T., Penick, E.C., Powell, B.J. & Read, M.R. (1975) Clients' Reactions to an Outreach Program. Social Work, Nov. 442-444.
- National Institute of Mental Health (1976) Services to the Mentally Disabled of Metropolitan Community Mental Health Catchment Area. Washington, D.C.: U.S. Government Printing Office, Series B. No. 10.
- National Institute of Mental Health (1980) Hispanic Americans and mental health facilities: A comparison of Hispanic, black and white admissions to selected mental health facilities. Washington, D.C.: U.S. Government Printing Office, Series CN, No. 3, DHHS Publication No. (ADM) 80-1006.
- New York State Office of Mental Health. (1982) Survey of Patient Characteristics, 1981. Series of Ethnic Groups, Table S5220. Albany, NY: Author.
- Marin, G., & Sabogal, F. (1987) Development of a Short Acculturation Scale for Hispanics. Hispanic Journal of Behavioral Sciences, 9, 2, 183-205.
- Patrick, C.A. (1990) The consequences of acculturation to service delivery and research with Hispanic families. Child and Adolescent Social Work Journal, 7, (2), 147-159.
- Rivera de Alvarado, C. (1967) Changing Values of Puerto Rican Culture. Journal of Social Work Processes, 6, 132-136.
- Rodriguez, O. (1983) Barriers to clinical services among the chronically mentally ill Hispanics. Research Bulletin of the Hispanic Research Center, Fordham University, 6(3-4), 1-14.
- Rodriguez, O. (1987) Hispanics and Human Services: Help-Seeking in the Inner City. Monograph of the Hispanic Research Center, Fordham University, 14.

- Rodriguez, O., Banks, L., Burger, W., Cabrera, E., & Martinez-Ward, Y. (1988) Project COPA Evaluation: Final Report. The Hispanic Research Center, Fordham University.
- Rogler, L.H., & Hollingshead, A. (1985) Trapped: Puerto Rican Families and schizophrenia. Maplewood, N.J.: Waterfront Press, 1985.
- Rogler, L.H., & Hollingshead, A. (1961) The Puerto Rican Spiritist as Psychiatrist. The American Journal of Sociology, 87, (1), 17-21.
- Rogler, L.H., Cortes, D.E., & Malgady, R.G. (1991) Acculturation and Mental Health Status Among Hispanics. American Psychologist, 46, (6), 585-597.
- Scott, J.F. & Delgado, M. (1979) Planning Mental Health Programs for Hispanic Communities. Social Casework: The Journal of Contemporary Social Work, Oct. 451-456.
- Toseland, R. (1981) Increasing Access: Outreach Methods in Social Work Practice. Social Casework: The Journal of Contemporary Social Work, April. 227-234.
- Trevino, F., Bruhn, J., & Bunce, H. (1979) Utilization of Community Mental health Services in a Texas-Mexico border city. Social Science and Medicine. 13A: 331-334.
- Vazquez de Rodriguez, L. (1973) Social Work in Puerto Rico. Social Work, 3, 35-39.
- Watkins, T.R., & Gonzales, R. (1982) Outreach to Mexican Americans. Social Work, January. 68-73.
- Webster, M. (1956) Webster's New Collegiate Dictionary, 2nd Ed. G&C Merriam Co., Publishers. Springfield, Mass., U.S.A. 464.
- Zane, N., Sue., Castro, E.G. & George, W. (1982) Service System models for ethnic minorities. In L.R. Snowden (Ed.) Reaching the Underserved: Mental health needs of Neglected Populations. Beverly Hills, CA: Sage Publications. 229-258.