

Idaho Hispanic Mental Health Disparities - Ada & Canyon Counties



**Idaho Partnership
for Hispanic Health**

A report from the Idaho Partnership for Hispanic Health



Mountain States Group Inc.



SCHOOL OF SOCIAL WORK
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Idaho Hispanic Mental Health Disparities: Ada & Canyon Counties

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INTRODUCTION/BACKGROUND

The Idaho Partnership for Hispanic Mental Health (IPHMH) is a National Institute of Mental Health (NIMH) funded community-based participatory research (CBPR) project. The project was funded with federal American Recovery and Reinvestment Act of 2009 funds for two years. The purpose of this research was to identify and prioritize mental health issues for Hispanic populations in Ada and Canyon Counties in Idaho. These populations were mainly of Mexican origin.

The CBPR model meaningfully involved Hispanics in the full research process through four primary mechanisms:

- 1) Two Hispanic community based partners participated in project leadership through contractual agreements – Centro de Comunidad y Justicia (Center for Community & Justice) and the Idaho Commission on Hispanic Affairs;
- 2) The IPHMH Community Advisory Board (CAB), composed of 14 southwest Idaho residents of which 86% were Hispanic, guided the assessment and engaged the Hispanic community;
- 3) Six IPHMH Field Researchers, young adult Hispanic individuals from the community, conducted the quantitative and qualitative interviews; and
- 4) A core research team composed of individuals from Mountain States Group, the University of Washington, the RAND Corporation, the Center for Community and Justice, and Dr. Al Sanchez, a Hispanic mental health consultant, planned and led the project.



IPHMH Community Advisory Board meeting in session

All partners participated in formulating the research design and reviewing the findings. Survey tools and methodology were reviewed and approved through the University of Washington Institutional Review Board (IRB).

As barriers to Hispanics' access and use of mental health services are already well-documented, the purpose of this community assessment was to *inform the improvement of mental health service delivery*. The objectives of the IPHMH Community Needs Assessment were to:

- Further knowledge about Hispanics' perceptions and beliefs about mental illness, and behaviors and preferences regarding mental health treatment; and

- Assess southwest Idaho’s mental health provider organizations’ knowledge, attitudes, and practices regarding their services to Hispanic individuals, gaps in service provision for Hispanics, and internal training needs on effectively working with Hispanic clients.

During the two year project, two major phases were accomplished: 1) assessment/data gathering and 2) analysis/education. This report is a synthesis of the assessment and analysis findings. The findings of this CBPR assessment are intended to inform the development of community-based mental health interventions that are accessible and culturally appropriate for this Hispanic population.¹ However, as detailed in the previous footnote, alternative funding sources must be identified and secured to accomplish this next phase.

Assessment/Data Gathering Efforts

- Two hundred thirty-eight (238) Hispanic community members from a two-county area of southwest Idaho (Ada and Canyon Counties) participated in quantitative interviews, completed December 2009.
- A representative sample of 94 of the 238 quantitative interview participants participated in an in-depth qualitative interview, completed January 2010.
- Thirty-five Ada and Canyon Counties mental health professionals participated in key informant interviews, completed September 2010.

All assessment instruments are attached to this report.

This report is organized by themes as identified in the study. It begins with a description of the assessment’s methodologies. Next, the findings for both Hispanic community members and local mental health service providers are summarized by assessment categories:

- Summary of Significant Findings
- Demographics of Hispanic Participants and Mental Health Providers
- Understandings of Mental Health Problems and Their Causes - Hispanic Community
- Experiences with Mental Health Problems – Hispanic Community
- Specific Stressors – Hispanic Community
- Experiences With / Knowledge of Mental Health Treatment – Hispanic Community
- Barriers to Mental Health Treatment – Hispanic Community Perspective
- Barriers to Mental Health Treatment – Mental Health Provider Perspective
- Improving Mental Health Services for Hispanics – Hispanic Community Perspective
- Improving Mental Health Services for Hispanics – Mental Health Provider Perspective

The report concludes by summarizing the study findings’ recommendations and considerations for offering community-based and culturally competent mental health services for Hispanics who are primarily of Mexican origin.

¹ This project was funded under PAR-07-004 Community-Based Participatory Research at NIMH (R21) with the intent of then applying for Community-Based Participatory Research at NIMH (R01) PAR-07-133 funds to implement CBPR interventions. However, in January 2010, NIMH withdrew its participation in PAR-07-133.

METHODOLOGY

This assessment was by definition descriptive and should not be used to formally test hypotheses or posit causality. Any findings that suggested significance should be interpreted cautiously, however, should be considered for further research. Face-to-face quantitative (238) and qualitative (94) interviews were conducted with Hispanic community members and key informant (35) interviews were individually held with mental health providers. Natural settings were used based on the respondent's preference regarding location, language, and schedule. The interviews followed well-established procedures to prevent bias in the collection of information. No identifying information such as names or addresses was gathered. The Hispanic community member qualitative interviews and provider key informant interviews were audio-taped and transcribed. Interviews conducted in Spanish were professionally translated. Data analysis was structured in such a way as to triangulate researcher analysis. Two individuals coded the interview data, and then a third person, trained in qualitative research, analyzed the data and grouped the data into general themes. All names and references that might identify individuals were removed. The software used to code and analyze data was WEFT QDA,² EXCEL, and MAXQDA 10.³

In an attempt to identify issues that need more attention/resources, the provider results were compared with the results from the Hispanic qualitative interviews. Responses from both interviews were grouped by question/theme and compared/contrasted. The following section describes the methods used to collect data from Hispanic individuals and local providers and includes information on data analysis.

Hispanic Community Member Assessment Methods



IPHMH Field Researchers: Alejandra Rojas, Antonio Bautista, Marisol Gonzalez, Mario Sifuentez, Yadiria Juarez, and Maria Martinez

Six field researchers participated in a three-day training led by the core research team on the study's background and objectives, the principles and practicalities of human subject confidentiality, developing proper rapport and boundaries with interviewees, listening skills, problem solving, and data recording.

Quantitative demographic data was collected on the southwest Idaho Hispanic community members, including age, gender, country of origin, length of time in U.S., and educational level, as well as data on acculturation factors, such as primary language spoken and read, social relationships, and social activities.

² Alex, Fenton. (2006). *Weft QDA User's Manual*. Accessed on May 23, 2011 at <http://www.pressure.to/qda/doc/wefthelp.pdf> and <http://www.softpedia.com/get/Office-tools/Other-Office-Tools/Weft-QDA.shtml>

³ MAXQDA, software for qualitative data analysis, 1989-2010, VERBI Software. Consult. Sozialforschung GmbH, Berlin-Marburg-Amöneburg, Germany. Accessed at <http://www.maxqda.com/>

The quantitative and qualitative interview tools (Appendices BI and BII) incorporated and adapted a short explanatory model interview method (Lloyd et al., 1998)⁴ using questions to elicit respondents' beliefs about the nature and causes of mental illness and help-seeking behavior within their cultural context. The assessment instruments also asked about residents' perceptions of barriers in accessing and using services, and their preferences in how they would like assistance with mental health issues. In addition, the interviewers asked questions to identify life-time experiences with clinical and culture-bound syndromes, to identify any home remedies used to treat mental distress, and to identify any stressors that have caused mental distress in the past.

To explore the factors that might contribute to mental health problems, participants in the quantitative assessment were asked to identify events or situations that had caused mental distress in the past. These stressors were categorized into themes and small subscales were created to identify the types of stressor clusters that were prevalent among respondents. Subscales were created as follows:

Immigration Stressors Subscale

Documentation or immigration issues, adapting to life in the U.S., separation from family/friends due to move to the U.S. or subsequently to Idaho, and adapting to life in Idaho

Personal Stressors Subscale

Trouble with boss, job loss, personal injury/illness, and discrimination/racism

Familial Stressors Subscale

Marital separation or divorce, problem with in-laws, marital problems, children leaving home, problems between parent and child, and behavior problems

Emotional or Mental Health Stressors Subscale

Fears or nightmares, problems with alcohol/drugs, behavior problems, abuse (physical/sexual/emotional)

Participants for the quantitative interviews were selected using a convenience sample methodology. The project interviewed 238 Hispanic adults residing in Ada and Canyon Counties of southwest Idaho. Potential participants were Hispanic adults aged 18-70 years of age who spoke English or Spanish. The recruitment process for the sample included a variety of efforts to reach Hispanic adults. A list of places most frequented by Hispanics, as well as upcoming community events, including health fairs and fiestas were developed. The Field Researcher Team then initiated outreach in these identified areas and events. They distributed recruitment flyers, set up booths, and signed up interested individuals for the interviews. Information about the project was aired on two Spanish-speaking radio stations. In addition, mass e-mails were

⁴ Lloyd, K.R., Jacob, K.S., Patel, V., St. Louis, L., Bhugra, D., and Mann, A.H. (1998). The development of the Short Explanatory Model Interview (SEMI) and its use among primary-care attenders with common mental disorders. *Psychological Medicine*, 28, 1231-1237

sent to a network of Latino and Latina professionals and para-professionals announcing the NIMH project goals and encouraging potential interviewees to call the Center for Community and Justice office for more information.

Detailed explanation of the nature and purpose of the study was provided to the interested Hispanic quantitative respondents and written informed consent was obtained prior to their participation. All interview participants who completed just the quantitative interview received \$15 to compensate them for their time and effort.

The 94 Hispanic adults who participated in the qualitative interview were a subset of the quantitative interviewees. At the time of the quantitative interview, individuals were asked if they would be interested in participating in a longer semi-structured interview. The gender and age of each interested person was recorded and assigned a number. The numbers were then placed on a grid representing those two demographic characteristics, and an equitable representation of male/female and age ranges were chosen using the numbers on the grid. Individuals who completed both the quantitative and qualitative interviews received \$25.

Mental Health Provider Assessment Methods

The provider assessment consisted of face-to-face semi-structured qualitative interviews with 20 primary providers of mental health services and 15 representatives of a range of health care provider organizations that offer mental health services in Ada and Canyon Counties, including the Idaho Department of Health and Welfare's regional mental health programs, mental health case management agencies, hospitals with mental health services, community health centers, Family Medicine Residency of Idaho, and nonprofit counseling centers. The purpose of these interviews was to gather providers' and agencies' perceptions regarding:

- Barriers to providing mental health services to Hispanics at the individual, agency, and systems level.
- Availability of mental health services for Hispanics with limited English language speaking and reading skills, current use of bilingual front-line and practitioner staff and trained interpreters, use of culturally-specific outreach, and availability of educational materials in Spanish.
- Existence of organizational policies on cultural competence and communications with limited-English speaking persons.
- Training needs related to providing culturally-relevant care to the Hispanic population, and preferred training formats.

These interviews followed the methodology used in the Hispanic residents' qualitative interviews by using open-ended questions to elicit providers' beliefs and perceptions, as well as some closed-ended questions. The provider interview instrument is included in Appendix BIII.

The mental health providers and organizations were initially contacted by telephone to introduce the Idaho Partnership for Hispanic Mental Health and the purpose of the requested

interview, and to schedule a face-to-face interview time. As reflected in the provider demographics section below, providers engaged one of their Hispanic and/or bilingual practitioners whenever possible to be the person interviewed, believing these individuals would have the most informed perspective. Trained staff conducted the interviews.

Data Analysis

Traditional quantitative and qualitative methods were used to analyze the data from both assessments. For the quantitative community member assessment, PASW Statistics18⁵ was used to obtain descriptive statistics and explore potential relationships between the study variables. For the qualitative community member and provider interviews, the data analysis strategy drew on the principles of grounded theory (Glaser & Strauss,1967),⁴ an approach to text analysis involving examination of narrative data, searching for patterns and themes, and explaining phenomena using the patterns and themes to code the data to further corroborate or modify them. ATLAS and Excel were used for coding and text management. Transcribed documents from the community member and provider interviews were imported into ATLASi for analysis and interpretation. Two trained coders independently analyzed and coded the qualitative data and identified patterns, perceptions, assumptions, actions, consequences and repetitions across participants that indicated relevant themes. A member of the core research team monitored the coding process to ensure validity and conducted further analysis according to grounded theory to identify salient themes regarding participants' perceptions and assumptions about mental health as well as their experiences and recommendations regarding access and utilization of mental health services.

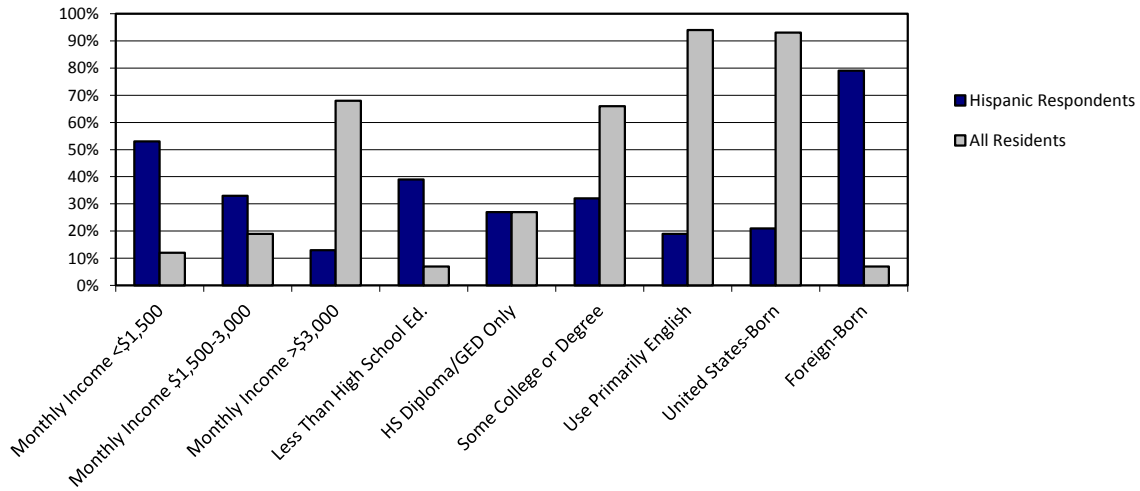
⁵ Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

SUMMARY OF SIGNIFICANT FINDINGS

Selected Demographics

The demographics of the southwest Idaho Hispanic community members who participated in this study vividly portray the economic, educational, and cultural differences between Ada and Canyon Counties’ Hispanics and residents in general.

Table 1. Selected Demographic Differences of Hispanic Interview Respondents Compared to Total Ada and Canyon County Population



Hispanic Qualitative Interview Quotes:

Any efforts to improve mental health service delivery to the local Hispanic community must acknowledge and adjust to these life differences. The design of culturally competent mental health care needs to address cost, literacy and language levels of outreach and treatment information, and sensitivity to acculturation/immigration stresses.

“[Providers] should try to understand our social and cultural situation. The majority of Hispanics are people from humble origins who may not have too much education coming from surroundings very different from where they now find themselves.”

“I think that [providers] should be patient with us and if at all possible have an interpreter or bilingual staff that can help us out with the language issue.”

“People think that because we are Latinos and cannot speak English, that we are ignorant and dense. It is so that there are ignorant individuals, through no fault of their own, but rather due to the situation in Mexico. The majority of them come from villages or farms, but we are all capable of learning and growing.”

Selected Findings – Hispanics’ Understanding of Mental Health Problems and Causes

Overall, the Hispanic community viewed mental health problems as caused by life situations - immigration adjustments, fear of deportation, exposure to violence, lack of a job, family issues - or the behaviors of drug or alcohol abuse.

The most salient mental health problems identified by the majority of Hispanic respondents were the anxiety, stress, and numerous other symptoms caused by immigration issues and fears of deportation. However, this dynamic was not recognized as much by local mental health providers. Only 20% of providers identified the issue of immigration as a major concern for Hispanics, as compared to 57% of Hispanic community respondents. In providing culturally competent treatment, these stress and anxiety issues need to be acknowledged. As the “Detailed Findings” section indicates, the immigration/ deportation stressors continue even with Hispanics who are legal citizens or have been in the U.S. a long time.

“And it does affect me because I do not want my children to suffer and I am always mindful that if their father were not around due to such situations it would be terrible! That causes me a lot of anxiety. I feel helpless due to the fact that I cannot help him obtain legal documentation. I suffer quite a bit of anxiety just thinking about my children alone.”

Some folkloric beliefs about causes of mental illness still exist in the southwest Idaho Hispanic community, which is primarily of Mexican origin. For example, over one-in-five of the 238 quantitative interview respondents identified evil spirits/being under a spell as a cause of mental health issues. This is also an issue for cognizance by mental health professionals.

Selected Findings – Hispanics’ Experiences with Mental Health Problems

Low Level of Diagnosis / Treatment as Compared to Symptoms. In the quantitative survey, when the 238 Hispanics were asked if they ever had a mental health problem, 193 respondents (81%) reported suffering from culturally-defined symptoms, while only 38 (16%) had received a formal diagnosis of a mental health problem. A limitation of the study is that it did not ask about whether the culturally-bound experiences were more acute or more chronic. However, given the recognized barriers to obtaining mental health treatment, the differences in how local Hispanics may express their problems, and the language difficulties in communicating with a health professional, detailed study findings suggests that a significant number of southwest Idaho Hispanics may be living with an undiagnosed mental illness.

Comparing the quantitative interview participants’ undiagnosed versus diagnosed experiences with mental health problems, statistical analyses showed that almost 90% of the respondents who reported having suffered from *angustia* had never received a medical diagnosis for anxiety. A similar relationship was observed with depression. When respondents were asked to indicate any culturally-bound syndromes they had experienced, 41 (21%) entered depression as an open-ended response. Of these individuals, 32 (78%) had not received a medical diagnosis of depression. An additional interesting observation is that of the 193 respondents who reported experiencing mental distress via a culturally-bound syndrome/emotional problem, only 57 (30%) reported that they had received treatment for that problem.

High Stress. Another indicator of mental health problems in the Hispanic community was the frequency in which the quantitative respondents indicated that they had different types of stressors in their lives. Almost half (43%) reported having one to five stressors that caused

emotional distress. One-third (34%) reported six to ten stressors. The average number of stressors reported was 5.84. While many respondents or their family members had experienced significant stressors, the life event that had the most significant emotional and mental health impact upon these Hispanic residents was immigration. Other frequent causes of stress were fear of deportation, separation from family members, unemployment, and poverty. Self-reported symptoms included anguish, nervousness, trouble eating or sleeping, low self-esteem, depression, loneliness, isolation, fear for family members left behind, worry, anxiety, and terror.

Selected Findings – Hispanics’ Experiences With / Knowledge of Mental Health Treatment

Knowledge of Treatment Sources. When presented with a checklist of options, the 238 quantitative respondents identified numerous potential sources for mental health treatment (family doctor, friend, priest, counselor, etc.). However, when the 94 Hispanic qualitative interview respondents were further probed, they most often stated that they really did not know what kind of help or treatment for mental health problems was actually available in their community, or where to find such services. Instead, they indicated that a generic counselor, psychologist, social worker, or clinic could be a source of mental health assistance. This lack of knowledge was a repeated theme in Hispanics’ responses to barriers to obtaining treatment, and in improving service delivery.

Presentation of Physical Symptoms. Interestingly, almost one-fourth of the 94 qualitative interview respondents stated that they or someone in their family had experienced a physical problem a doctor could not explain. When those respondents described their physical problems, many were similar to mental health symptoms: attention problems, nerves, fright, depression, anxiety, chronic pain, headaches, heart problems, fainting, and convulsions. However, the practitioners did not draw a relationship between the physical symptoms their Hispanic patients had described as relating to a mental health disorder. This dynamic holds potential as a component for professionals’ cultural competence training.

Treatment Preferred / Treatment Received. When comparing Hispanics’ preferences for mental health treatment and the type mental health treatment received, a significant difference emerged. Twenty-two (23%) of qualitative interview participants reported that they were treated for a mental health problem, and 36 (15%) of the quantitative interview participants received treatment. The treatment most often given was “medication only” (44% of those seeking help). At the same time, when asked what treatment worked the least or they least wanted, respondents most often identified medication as being what they liked least. The same difference in treatment preference versus treatment received was seen in respondents’ family members. Forty-five percent of the qualitative respondents had a family member who sought mental health treatment. Of these individuals, half were given medication only.

Providers’ frequent use of medication as their first line of treatment may be a significant factor in Hispanics’ compliance/follow-through with mental health care. In looking at reasons given

for not continuing with mental health treatment sought, 71% of the qualitative respondents who discontinued treatment did so because of a medication-related issue (disliked side effects, feared addiction, not helpful, or too costly). With the quantitative respondents who sought but then discontinued treatment, all cited similar reasons related to medication. Hispanic adults' reluctance to take mental health-related medications has been documented in previous studies (Dwight-Johnson, Lagomasino, Aisenberg, & Hay, 2004⁶; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000⁷). Mental health providers may wish to discuss or offer alternative treatment options, such as psychotherapy, that better acknowledge Hispanics' beliefs and preferences.

Selected Findings – Barriers to Mental Health Treatment: Hispanic Community Perspective

Mental health treatment barriers reported by Hispanic study participants concur with previous research findings.⁸ The most frequently stated barrier qualitative respondents named was financial, such as families not having enough money to pay for services, and lack of health insurance to help with the cost. (Many Hispanic residents in Ada and Canyon Counties are low wage earners with nearly 55% earning less than \$1,500 per month.) Hispanic respondents also viewed immigration/deportation issues as a major barrier in using or obtaining mental health services. Many told stories of not receiving necessary services after the provider found out they were undocumented. Respondents shared fears of possible deportation if they sought out mental health services. A related fear was that seeking mental health treatment could jeopardize one's chances for gaining U.S. citizenship in the future.

Nearly half of the 94 qualitative respondents indicated there was a significant lack of mental health services for Hispanics; and approximately a third of the qualitative respondents reported that language-related barriers made it difficult for Hispanics to obtain mental health treatment. Roughly a third of the qualitative respondents also indicated that a general lack of knowledge about available mental health treatment providers or places was a major barrier to accessing services.

⁶ Dwight-Johnson, M., Lagomasino, I.T., Aisenberg, E., & Hay, J. (2004). Using conjoint analysis to assess depression treatment preferences among low-income Latinos. *Psychiatric Services*, 55(8):934-936

⁷ Dwight-Johnson, M., Sherbourne, C.D., Liao, D., & Wells, K.B. (2000). Treatment preferences among depressed primary care patients. *J Gen Intern Med* 15(8):527-534.

⁸ Cooper, L.A., Hill, M.N., & Powe, N.R. (2002). Designing and evaluating interventions to eliminate racial and ethnic disparities in healthcare. *Journal of General Internal Medicine*, 17, 477-486.

Aguilar-Gaxiola, S.A., Zelezny, L., Garcia, B., Edmondson, C., Alejo-Garcia, C., & Vega, W.A. (2002). Mental health care for Latinos: Reducing Disparities in Mental Health Care for Mexican Americans. *Psychiatric Services*, 53,1563-1568.

Cabassa, L., Lester, R., & Zayas, L. H. (2007b). "It's like being in a labyrinth:" Hispanic immigrants' perceptions of depression and attitudes toward treatments. *Journal of Immigrant and Minority Health*, 9, 1-16.

Diaz, E., Prigerson, H., Desai, R., Rosenheck, R. (2001). Perceived needs and service use of Spanish speaking monolingual patients followed at a Hispanic clinic. *Community Mental Health Journal* 37(4), 335-346.

Ell, K., Castaneda, I. (1998). Health care seeking behavior. In: Loue S, ed. *Handbook on Immigrant Health*. New York: Plenum; Guarnaccia, P.P., & Martinez, B.A.

Miranda, J., Azocar, F., Organista, K.C., Munoz, R.F. (1966). Recruiting and retaining low-income Latinos in psychotherapy research. *Journal of Consulting & Clinical Psychology*. 64(5), 868-874.

Selected Findings – Barriers to Mental Health Treatment: Mental Health Provider Perspective

In regard to barriers Hispanic patients face, providers generally brought up similar barriers:

- Cultural differences
- Difficulty navigating the system
- Fear
- Finances
- Stigma
- Lack of knowledge of services and mental illness
- Language
- Transportation
- Legal status

Regarding barriers that were created by the providers themselves, practitioners foremost cited the lack of cultural knowledge/cultural competency training. Twenty-eight percent of organizations interviewed did not provide or support cultural competence training for their staff. Only three (1%) of the 35 providers interviewed clearly knew that their organization had written policies on issues related to staff cultural competency and communication with limited English-speaking persons. Ten (28%) of the providers indicated that their organization did not have these policies.

Language was the second most frequently cited provider-related issue that created a barrier. Practitioners acknowledged the lack of bilingual outreach workers, counselors, and interpreters as a substantial barrier to providing good mental health services, and a primary reason for long waiting lists to get care.

Providers themselves were generally not aware of local mental health services designed specifically for Hispanic clients. When asked to rate other local agencies' mental health services for Hispanics, some cited the lack of cultural sensitivity and discrimination. Regarding systems barriers, providers talked most about inadequacy of public funding for mental health services and the burdensome complexities of Medicaid reimbursement.

Selected Findings – Improving Mental Health Services: Hispanic Community Perspective

Most Hispanic respondents remarked about the importance of disseminating pertinent information to the community about where mental health help can be accessed, as well as educational information about mental health issues. These actions would need to be done in a way that fit the Hispanic culture – language, formats, venues, and use of trusted community members.

A consistent recommendation centered on improving language accessibility of services and cultural understanding by providers. Practitioners and clinic staff should be bilingual or have ready access to bilingual translators as well as have written material available in Spanish. They stated the need for practitioners to be better trained to understand cultural differences and

barriers that are specific to the Hispanic community. In addition, doctors/providers should take more time to listen to persons seeking care.

Hispanics also cited the critical need for more funding to support community mental health services that are affordable to the individual. Numerous respondents indicated that there is a substantial need for low cost or free clinics accessible to Hispanics.

Immigration reform that would help Hispanics who are undocumented to live legally in the U.S. was also named by numerous respondents as a way to overcome Hispanics' reluctance to seek mental health care.

Selected Findings – Improving Mental Health Services: Mental Health Provider Perspective

The most frequent response was improved Hispanic client education on topics such as what services are available, issues of stigma, mental illness, and systems of care. One respondent suggested that providers do a better job of explaining everything that has to do with the client.

Providers struggled with how to make mental health services affordable for Hispanic clients. Many were interested in the expansion of low cost or free services; others suggested the use of shorter-term treatment for those unable to pay.

Service Delivery. Most providers agreed that more bilingual practitioners were needed. Some providers suggested delivering mental health services in the client's home rather than in an office or in institutions. Others suggested having specialized Hispanic services like the *Promotora* programs or *Salud Y Provecho*, a local multi-service agency for Hispanics. In addition, providers suggested having mental health testing and assessments in Spanish. Other improvement ideas included having full services available and strengthening coordination with other providers, especially for clients with co-occurring disorders.

Notably, when asked the question, "If providers did not have to face the [barriers discussed], how would they improve their services for Hispanics," eight (28%) of the 28 providers that responded stated that they would continue to treat their clients the same. They saw no difference in treating Hispanics from any other clients.

DETAILED FINDINGS

Demographics - Hispanic Community Member Assessment

Demographics of the participants are presented in Table 2. Two hundred thirty-eight quantitative interviews with Hispanic adults residing in Ada or Canyon counties were completed in December 2009. One hundred seventy of the interviews were conducted in Spanish and 68 were conducted in English. Ninety-one respondents were from Ada County (38%) and 147 (62%) were from Canyon County.⁹ Respondent ages ranged from 18 to 70 with an average age of 35. Thirty-nine percent of respondents had less than a high school education. Slightly more than 50% were employed with another roughly 30% that reported being out work. Thirteen percent reported monthly incomes of less than \$500, and almost half (48%) of the respondents had a monthly income of less than \$1,500. The 94 Hispanic qualitative interview participants, who were drawn from the 238 quantitative participants, reflected the demographics portrayed in Table 2.

Table 2. Demographic Characteristics of Individual Interviewees

Demographic		Frequency	Percentage
Age	18-24	37	16%
	25-34	92	39%
	35-44	57	24%
	44-54	35	15%
	55-64	11	5%
	65+	6	2%
Gender	Male	117	49%
	Female	121	51%
Income level	< \$1,499	115	48%
	\$1,500-\$1,999	32	13%
	\$2,000-\$2,999	40	17%
	\$3,000-\$4,999	20	8%
	≥\$5,000	9	4%
Education Level	Didn't attend school	5	2%
	≤ 6 th grade	49	21%
	Some high school	39	16%
	High school graduate/GED	65	27%
	Some college	24	10%
	Vocational or technical school	45	19%
Work status	College graduate or graduate school	7	3%
	Employed	121	51%
	Unemployed	71	30%
	Out of workforce (student, retired, disability)	46	19%

⁹ Although the overall population of Canyon County is smaller than Ada County, Canyon County is more predominantly Hispanic (24%) than Ada County (7%).

Acculturation characteristics are presented in Table 3. Most respondents were born in Mexico (73%) with 21% reporting being born in the United States. Several findings related to acculturation were notable. Acculturation levels were lowest for those individuals who reported living in the U.S. for 10 years or less. However, 25 individuals (10% of all respondents) who had lived in the U.S. for more than 20 years also reported very low acculturation levels.

Table 3. Acculturation Characteristics of Hispanic Quantitative Interviewees

Place of birth (n=238)		
	Mexico	172 (73%)
	U.S.	51 (21%)
	Central America	7 (3%)
	South America	5 (2%)
	Other	3 (1%)
Years in country (n=237)		
	10 or less	89 (38%)
	11 or greater	148 (62%)
Language (n=238)		
	Spanish Only	65 (27%)
	Mostly Spanish (some English)	76 (32%)
	Both equally	52 (22%)
	Mostly English	35 (15%)
	English only and other	10 (4%)
Acculturation score (n=238)		Average=2.1
(Scale from 1 to 5)	No acculturation = 1	95 (40%)
	Minimal acculturation = 2	67 (28%)
	Bicultural/mid-way acculturated = 3	49 (21%)
	Moderately acculturated = 4	22 (9%)
	Fully acculturated = 5	5 (2%)

Demographics – Mental Health Provider Key Informant Interviews

The mental health provider participants came from a variety of professional backgrounds ranging from primary care providers, to mental health professionals in private practices, to representatives of health care and human service organizations. These included the Idaho Department of Health and Welfare’s regional mental health programs, mental health case management agencies, hospitals with mental health services, community health centers, Family Medicine Residency of Idaho, and nonprofit counseling centers. Table 4 provides a breakdown of the providers interviewed by discipline.

Table 4. Professional Background of Mental Health Provider Respondents

Type	Frequency	Percentage
Nurse Practitioner	1	3%
Primary Care Physician	1	3%
School Counselor	2	6%
Substance abuse educator	2	6%
Minister/Priest	3	9%
Other	4	11%
Psychologist	4	11%
Director	7	20%
Social Worker/Counselor	11	31%
Total	35	100%

In the “Director” category there were several individuals whose backgrounds included advanced degrees in clinical social work, counseling, or psychology. Individuals in the “Other” category included a mental health Consumer Advocate, a Psycho-Social Rehabilitation Specialist, a Family Support Specialist, and a Certified Parent Educator. Other demographics of the providers interviewed are provided in Table 5 below.

Table 5. Provider Interviewee Demographic Data¹⁰

N=35		
Mean Age	47.7	
Mean Age Hispanic	58.8	
Mean Age Female	39.9	
Age range	23-66	
	Percent	Number
Female	57.1%	20
Male	42.9%	15
Bilingual	54.3%	19
Not bilingual	45.7%	16
Hispanic	37.1%	13
Non-Hispanic White	62.9%	22

Understandings of Mental Health Problems and Their Causes - Hispanic Community

The Hispanic quantitative interview asked 238 respondents about what they believed caused mental health problems (allowing multiple responses), and how serious these causes were. The top five causes identified (with 82-90% of respondents choosing) were being depressed, having stress, experiencing financial problems, abusing drugs or alcohol, and experiencing violence in one’s life. Additional causes that were identified by roughly 60-70% of respondents

¹⁰ As stated earlier, providers typically engaged one of their Hispanic and/or bilingual practitioners whenever possible to be the person interviewed, believing these individuals would have the most informed perspective. These bilingual and ethnic percentages are much higher than the actual composition of Ada and Canyon Counties’ mental health workforce.

were marital problems, medical conditions, parent/child conflict, heredity, and gambling. Interestingly, 28% identified fate/destiny as a cause of mental health problems, and 22% believed that evil spirits/being under a spell was a cause.

When asked how serious these causes of mental health problems were, five causes were ranked significantly higher than the others as being very or extremely serious: drug abuse (80% of respondents), alcohol abuse (74%), being depressed (71%), stress (67%), and exposure to violence (67%).

The 94 semi-structured qualitative interviews further explored Hispanics' perceptions about what a mental health problem was, in what ways mental health problems affected a person, and what the major mental health problems of local Hispanic residents were.

Respondents demonstrated a varied understanding of what constitutes a mental health problem. While they most frequently identified depression or an emotional problem in general, they also specified mental health problems as psychological, medical, and physical issues, as well as drug and alcohol use. In many instances respondents contextualized mental health problems as related to daily life and economic circumstances, and talked about how mental health negatively impacted one's mind, behaviors, attitudes, relationships, physical health, and day-to-day activity. Frequently, qualitative interview participants did not describe what a mental health problem was per se, but rather provided their understanding of factors or causes of mental health problems. Economic issues were a primary consideration for both men and women respondents who emphasized the lack of a job as a cause of mental health problems.

However, the most salient mental health problems identified by the qualitative respondents were related to immigration issues and fears of deportation. A related issue expressed by nearly half of the qualitative respondents was concern for a family member in the U.S. due to immigration and legal documentation challenges. When asked about experiences of mental health problems from physical or sexual abuse, neglect, or abandonment, the most common response was experiencing physical violence, mainly from domestic violence between parents.

Experiences with Mental Health Problems – Hispanic Community

Diagnosed Mental Illnesses. In the quantitative survey, when the 238 Hispanics were asked if they had ever received a diagnosis of a mental illness or mental health problem, 200 participants (84%) responded "No," and 38 (16%) said "Yes." The 38 affirmative respondents were given the opportunity to name more than one diagnosis. Responses included depression (71%); other disorder (39%)¹¹; anxiety disorders (34%); post-traumatic stress disorder (29%); and bipolar disorder, substance abuse, and schizophrenia at each 13% or less.

¹¹ Other disorders named included panic attacks, epilepsy, over eating, psychosis, adult ADHD, post-partum depression, obsessive-compulsive disorder, *desbalance químico* (chemical imbalance in the brain), suicide attempt, *baja autoestima* (low self-esteem), and *migraña* (migraine headache).

When asked if a family member had ever been diagnosed with mental illness or a mental health problem, 78% (179) of the 230 persons who responded to this question said “No,” and 22% (50) “Yes.” The 50 affirmative responders represented 93 family members with diagnoses that included depression (29%); other disorder (27%); anxiety disorder (14%); post-traumatic stress disorder (12%); and bipolar disorder, alcohol or drug abuse, and schizophrenia at each 5% or less.

Non-diagnosed Conditions. Quantitative interview respondents were also asked if they had experienced any culturally-bound mental health syndromes such as *ataque de nervios*, *susto*, *coraje*, *mal de ojo*, or *angustia*, (definitions in Appendix A). As shown in Table 6, 193 respondents (81%) reported suffering from culturally-defined symptoms, while as noted before, only 16% had received a formal diagnosis of a mental health problem.

Comparing the participants’ diagnosed versus undiagnosed experiences with mental health problems, statistical analyses showed that almost 90% of the respondents who reported having suffered from *angustia* had never received a medical diagnosis for anxiety. A similar relationship was observed with depression. When respondents were asked to indicate any culturally-bound syndromes they had experienced, 41 (21%) entered depression as an open-ended response. Of these individuals, 32 (78%) had not received a diagnosis of depression.

Overall, the 193 respondents who reported experiencing mental distress via a culturally-bound syndrome, only 57 (30%) reported that they had received treatment for that problem.

Table 6. Hispanics’ Mental Health Experiences, Both Diagnosed and Undiagnosed

Clinical Diagnosis (38 respondents reporting 83 diagnoses)		
	Depression	27 (33%)
	Anxiety	13 (16%)
	Other	15 (18%)
	PTSD	11 (13%)
	Substance abuse (drug/alcohol)	9 (11%)
	Bipolar	5 (6%)
	Schizophrenia	3 (4%)
Self-reported culturally-bound syndromes (193 respondents reporting 596 syndromes)		
	<u>Syndromes listed on the survey:</u>	
	<i>Coraje</i> (rage)	150 (39%)
	<i>Angustia</i> (anxiety)	127 (21%)
	<i>Susto</i> (fright)	97 (16%)
	Other ¹²	82 (14%)
	<i>Ataque de Nervios</i> (attack of nerves)	51 (8%)
	<i>Mal de ojo</i> (evil eye)	10 (2%)
	<u>Other written in responses:</u>	
	<i>Depresión</i> (depression)	41 (7%)
	<i>Tensión</i> (stress)	30 (5%)
	<i>Tristeza</i> (melancholy, sadness)	8 (1%)

¹² The most frequent “other” responses were sadness (4%), desperation (2%), insomnia (2%), and frustration (2%).

Qualitative Responses on Experience with a Mental Health Problem. Most qualitative interview participants cited specific mental health symptoms that they believed were a direct result of immigration issues, fear of deportation, separation from family members, unemployment, and poverty. Self-reported symptoms included anguish, nervousness, trouble eating or sleeping, low self-esteem, depression, loneliness, isolation, fear for family members left behind, worry, anxiety, and terror. For some, the mental health response was helplessness and anger.

Interestingly, almost one-fourth of the 94 qualitative interview respondents stated that they or someone in their family had experienced a physical problem a doctor could not explain. When those respondents described the presenting physical problems, many were similar to mental health symptoms: attention problems, nerves, fright, depression, anxiety, chronic pain, headaches, heart problems, fainting, and convulsions.

“Yes, a family member has gone in to see a doctor two or three times during the past two years due to a nervous condition and sleeplessness. The doctors ran all sorts of tests on him from blood work to x-rays but to no avail. They cannot find out what is causing it. So he has lost faith in all doctors and has not gone back to see anyone else.”

Specific Stressors – Hispanic Community

Table 7 shows the five most common stressors that quantitative interview participants reported to have caused them mental distress. Nearly two-thirds (64%) experienced mental distress due to a death in the family. Slightly less than half reported distress from leaving family and friends behind when emigrating to the U.S., having a son/daughter leave home, marital problems, and job loss.

Table 7. Hispanic Quantitative Stress-Inducing Events/Problems

	Frequency	Percentage
Death of a family member	152	64%
Separation from family/friends due to move to the United States	116	49%
Son/daughter leaving home	115	48%
Marital problems	102	43%
Job loss	98	41%

Many quantitative respondents reported experiencing multiple stressors. Almost half (43%) reported having one to five stressors that caused emotional distress. One-third (34%) reported six to ten stressors. The average number of stressors reported was 5.84.

As noted in the previous “Methodology” section, the project’s data analysts sorted participant-reported stressors into four categories: immigration, personal, emotional, and family. In order to understand how different types of stressors might impact mental health, relationships between culturally-bound syndromes and stressor categories were explored. Analysis of the quantitative data suggests links between *angustia* and a number of stressor-clusters. Roughly 60% of respondents who had *angustia* also reported multiple immigration stressors; almost half (44%) of respondents who had experienced *angustia* scored high on the personal stressor subscale; nearly 32% experienced multiple stressors associated with emotional problems; and

almost a quarter (23%) of respondents reporting *angustia* had moderate to high numbers of family stressors.

Relationships between *coraje* (rage) and stressor-clusters were also analyzed. More than half (58%) of quantitative interview respondents with *coraje* also had a moderate to high score on the immigration stressor subscale. Links were also observed between *coraje* and stressors related to personal problems (36%) and emotional stressors (31%). There may also be a link between suffering *angustia* and *coraje*. Of the 128 that suffered from *angustia*, 80% also suffered from *coraje*.

Immigration issues appear to be a major Axis IV Psychosocial and Environmental factor contributor to stress-related mental health problems. While many respondents or their family members have experienced significant stressors, the life event that had the most significant emotional and mental health impact upon these Hispanic residents was immigration.

Immigration stress was not exclusive to immigrants and/or the newly arrived. Contrary to expectation, those who have lived in the U.S. more than 13 years reported documentation and immigration stress more frequently compared to those who have lived in the U.S. less than 13 years (15% to 6%). This finding was statistically significant. A similar difference was found based on birthplace. Those who were born in the U.S. more frequently reported documentation or immigration as a stressor compared to foreign born residents (26% to 8%), possibly due to concern for family members still in Mexico or for undocumented family/friends living in the U.S. Another explanation may be linked to perceptions of discrimination and persecution due to their ethnicity. Flores, Tschann, Dimas, Bachen, Pasch, and Groat (2008)¹³ found that perceived and experienced discrimination was a major contributor to chronic stress and compromised mental and physical health in a sample 215 Hispanic adults born in Mexico.

In both the qualitative and quantitative interviews, respondents shared their distress in being separated from friends, parents, children, grandparents, and communities when they came to the U.S. They identified strong feelings of fear, anguish, nervousness, anxiety, low self-esteem, depression, loneliness, and isolation, as well as trouble eating and sleeping.

Many expressed sadness about how hard it was if family members became ill or died in their country of origin. For respondents who volunteered that they were undocumented, they were frustrated and guilt-ridden that they were unable to go home to help or pay respects their loved ones.



<http://rt.com/usa/news/illegal-us-immigrant-detention>

¹³ Flores, E., Tschann, J.M. Dimas, J.M., Bachen, E.A., Pasch, L.A., and de Groat, C.L. (2008). Perceived discrimination, perceived stress, and mental and physical health among Mexican-origin adults. *Hispanic Journal of Behavioral Sciences*, 30(4), 401-424.

Experiences With / Knowledge of Mental Health Treatment – Hispanic Community

What is Available. The 238 quantitative interview participants were asked what kind of help or treatment was available in the community for a person with a mental problem. They were allowed to choose more than one option on a check list. The most frequently selected treatment option was a clinic or health center (67%), followed by friend (64%), family member (60%), priest/minister (59%), and family physician (56%). Other options chosen by more than half of the respondents included counselor, books/magazines, teacher, emergency room, social worker, and internet.

However, when this question was further probed in the qualitative interviews, the respondents most often stated that they did not know what kind of help or treatment for mental health problems was available in their community or where to go for such help. Instead, they indicated that a generic counselor, psychologist, or social worker was someone that could be accessed for help if needed. Some respondents also identified clinics (a few specifically, while most identified generically).

Numerous qualitative interview respondents expressed frustration at the acute shortage of mental health counselors who spoke Spanish.

“In the Treasure Valley, as it is referred to here, the Hispanic population is growing rapidly ... At this one office is a counselor that speaks Spanish, and his caseload is huge! He has people on a waiting list. That is due to there not being sufficient counselors that speak Spanish.”

What Helps – Quantitative Respondents.

Regarding perceptions of what worked best and least regarding mental health treatment for themselves and family members, respondents most often identified counseling or therapy as working best and medication as working the least. This finding is consistent with research that highlights the preference of Hispanics for psychotherapy over medication (Dwight-Johnson, Lagomasino, Aisenberg, & Hay, 2004¹⁴; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000¹⁵).

Of the 38 quantitative interview respondents who had received a medical diagnosis of a mental health problem (16% of 238 participants), 36 sought treatment and reported using 84 different sources of treatment. The most frequent selection was family physician (16), followed by counselor (13), and clinic/health center (10).

The type of treatment that was prescribed most frequently was medication only (16 of 36 persons), followed by combination of counseling and medication (15), and physical activity/exercise (13). Nine individuals participated in counseling and support groups, only two selected home remedies, and five selected prayer/meditation or hospitalization. When asked to rate the effectiveness of the treatment received, 44% rated it as extremely effective, 41% as quite or somewhat effective, and 15% as “a little” or “not” effective.

¹⁴ Dwight-Johnson, M., Lagomasino, I.T., Aisenberg, E., & Hay, J. (2004). Using conjoint analysis to assess depression treatment preferences among low-income Latinos. *Psychiatric Services, 55*(8):934-936

¹⁵ Dwight-Johnson, M., Sherbourne, C.D., Liao, D., & Wells, K.B. (2000). Treatment preferences among depressed primary care patients. *J Gen Intern Med 15*(8):527-534.

What Helps – Qualitative Respondents. Of the 94 Hispanic qualitative respondents, 22 (23%) reported having receiving treatment for mental health problems. When asked what worked best, respondents described a combination of therapy/counseling and medication most often. When asked what worked the least, respondents most often identified medication as being something they liked least.

Approximately one in three of the 94 qualitative interview respondents reported that a family member had received some kind of mental health treatment. Frequently the interviewees identified “nerves” (*angustia* or *ataque de nervios*) as the problem being addressed in treatment. One person stated the family member was afflicted with the evil eye (*Mal de ojo*). In addition, a respondent stated that there were no family members who received treatment because it was seen as culturally unacceptable.

When asked what worked best regarding their family members’ treatment experience, respondents described the combined counseling/therapy and medication most often. Others listed faith healers/home remedies, and hospitalization. When asked what worked least regarding their family members treatment experiences respondents most often identified prescribed medication followed by the doctors and/or the therapists themselves.

Home Remedies. Quantitative respondents also cited the use of home remedies and herbs for mental health problems. The most frequently reported home remedy was chamomile (43%), followed by peppermint (31%) and linden flowers (24%). The table below is a distribution of responses.

“I think that fear is the main thing ... the fear of not being understood by one’s doctor or him not being able to communicate ... so they don’t go! Or else they will wait too long before going in for treatment; or instead use home remedies such as we do in Mexico. Many prefer home remedies to going to the doctor because it is so expensive.”

Table 8. Hispanics’ Use of Home Remedies for Mental Health Problems

Home Remedies	# n=238	%
Chamomile (<i>Manzanilla</i>)	103	43%
Peppermint (<i>Yerba Buena</i>)	74	31%
Other	58	24%
Linden flowers (<i>Tilia</i>)	56	24%
Valerian Root (<i>Valeriana</i>)	24	10%
Other ¹⁶	22	
Oregano (<i>Oregano</i>)	19	8%
Garlic (<i>Ajo</i>)	17	7%
Damiana (<i>Damiana</i>)	14	6%
Passion Flower (<i>Pasionara</i>)	10	4%

¹⁶ Other includes Sapodilla (*Zapote blanco*), St. John’s Wort, Orange blossoms (*azahares*), Alcohol (*cebolle*), Star anise (*Anis estrella*), *Arganica*, *Boldo* (South American herb used in tea), Coffee (*Café*), Cinnamon (*Canela*), Tail of horse to stop diabetes (*Cola de caballo*), other teas.

Treatment Follow-Through. Of those 36 diagnosed individuals in the quantitative interviews who sought treatment, 25 (69%) were able to follow through with their treatment and 11 (31%) were not able to, mainly due to cost, medication side effects, and treatment not being helpful.

Of the 193 quantitative interview participants who cited undiagnosed other or culturally-bound mental health problems, only 58 (30%) reported receiving any treatment.

Of the quantitative interview respondents' 50 family members who received a medical mental health diagnosis, 42 (82%) were treated, using 117 different sources of treatment. The most frequently used sources were psychologists (16), followed by family physicians (14), psychiatrists (11), counselors (10), and clinic/health centers (9). The type of treatment that family members received most frequently was medication only (21), combination of counseling and medication (16), counseling only (12), and hospitalization (9). Eight individuals engaged in physical activity/exercise and seven used support groups. Five drew upon prayer/meditation and four selected home remedies.

“If we are stressed out or anxious we just work it out on our own until it gradually goes away. It is hard to try to seek the help we need because of the high costs and we cannot afford that luxury.”

Of those 42 quantitative interview participants' family members who sought treatment, 36 (84%) were able to follow through with their treatment, and six did not, due to a wide range of issues. Some respondents did not like the medications, reported not feeling like they were being listened to, the financial expense, and not having alternative treatments explained.

Barriers to Mental Health Treatment – Hispanic Community

As noted in the “Introduction/Background” and “Significant Findings” sections of the report, barriers to Hispanics' access to and use of mental health services are already well-documented, and this study's findings regarding barriers reported by Hispanic quantitative and qualitative respondents support previous research findings (Cooper et al., 2002; Aguilar-Gaxiola et al., 2002; Cabassa et al., 2007; Diez et al., 2001; Ell & Castaneda 1998; Miranda et al., 1996). Many of the barriers experienced by Hispanics contributed to provider attitudes that Hispanic clients tended to be resistant to or non-compliant with treatment.

Cost. The most frequently stated barrier qualitative respondents named was financial, such as mental health services being too expensive, families not having enough money to pay for them, and lack of health insurance to help with the cost. Many Hispanic residents in Ada and Canyon Counties are low wage earners with nearly 55% earning less than \$1,500 per month. The cost of mental health services and medications becomes a significant burden in this context.

Immigration/Deportation Issues. Not only was immigration experienced as a stressor and cause of mental health problems, but also as a major barrier in using or obtaining mental health services. The impact of immigration was experienced at individual, family and community levels, as well as across generations. Many told stories of not receiving necessary services after

the provider found out they were undocumented or did not have a driver's license or social security card. Respondents shared fears of possible deportation and expressed that if they sought out mental health services they would be refused or reported to U.S. immigration officials. This fear – and the realities of knowing people who have been deported – impacted even respondents who were U.S. citizens. A related fear was that seeking mental health treatment could jeopardize one's chances for gaining U.S. citizenship in the future.

“Well, it is like I told you before; it is stressful to go out anywhere. If you do not have a license or immigration documentation, you may leave your house one day and never come back! Perhaps merely going out to pick your children up from school! That fear is what we have to live on a daily basis.”

Lack of Services. Nearly half of the 94 qualitative respondents indicated they did not believe that sufficient help or treatment was available for a Hispanic person with a mental health problem. Overall, respondents who were younger in age held more confidence in a person's ability to find appropriate care than respondents who were older in age. However, most of the younger respondents had not themselves sought mental health treatment, and their responses were based largely on assumption. As the entire state of Idaho has been designated as a Mental Health Professional Shortage Area (U.S. Health Resources and Services Administration 2008),¹⁷ there is a clear workforce shortage issue that requires systemic attention, not only for Hispanic practitioners, but for mental health professionals overall.

Language/Culture Barriers. Approximately a third of the qualitative respondents reported that language-related barriers made it difficult for Hispanics to obtain mental health treatment. They reported that practitioners and clinic staff were neither bilingual nor bicultural and that made communication and understanding of cultural differences difficult. In addition, several respondents reported that they believed providers were both unable to and uninterested in providing services to undocumented Hispanics.

Lack of Knowledge. Roughly a third of the qualitative respondents indicated that a general lack of knowledge about available mental health treatment providers or places was a major barrier to accessing services. A few further indicated the comparatively low education attainment level of many Hispanics as a barrier. Another noteworthy finding was that among the younger respondents who indicated that there was adequate help in their community, most did not think that there was enough information about these services.

Other barriers noted by both qualitative and quantitative Hispanic responders included the following (with each barrier cited by less than 15% of respondents):

¹⁷State Office of Rural Health and Primary Care, Idaho Department of Health and Welfare. (2008). *Health Professional Shortage Area Designations*. Retrieved from http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=oshv_KaVRiY%3d&tabid=415

- Long wait time for appointment
- Dislike of medications
- Transportation/work/child care barriers
- Distrust of doctors
- Perceptions of discrimination and racism
- Fear of the stigma associated with mental illness

Barriers to Mental Health Treatment – Mental Health Provider Perspective

Patient-related Factors. Providers generally reported the same significant patient-related barriers that they believed affected Hispanics’ access to mental health services:

- Cultural differences
- Difficulty navigating the system
- Fear
- Legal status
- Finances
- Stigma
- Lack of knowledge of the system and mental illness
- Language
- Transportation

There were several notable contrasts between providers’ and Hispanics’ perceptions of patient-related barriers:

- Only 20% of providers identified the issue of immigration as a major concern for Hispanics, as compared to 57% of Hispanic community respondents.
- While a number of Hispanic respondents reported that they believed providers were both unable and uninterested in providing services to undocumented Hispanics, some providers believed that Hispanics simply did not ask for help and that was why providers could not assist them.

“Maybe they are scared they are going to get shunned down, looked down upon, like you can’t handle that, to go get help now (Hispanic community respondent).”

Provider-related factors. The most frequently cited provider-related factor that limited their ability to provide optimal care was the lack of cultural knowledge/cultural competency training. Only three (1%) of the 35 providers interviewed clearly knew that their organization had written policies on issues related to staff cultural competency. Ten (28%) of the providers indicated that their organization did not have these policies. Fourteen providers were able to describe their agency’s procedures for addressing limited English-speaking clients. Most procedures were limited to connecting the client to a person within their office who was bilingual. Protocols ranged from having bilingual counselors on-site, to having clerical staff assist with interpretation, to requesting interpreter services from another agency.

Language was the second most frequently cited provider-related issue. Providers acknowledged the general lack of bilingual or bilingual outreach workers and practitioners as a substantial barrier to providing good mental health services. At the same time, providers seemed to believe that simple language translation was a sufficient resource to overcome language barriers. However, they also acknowledged a shortage of mental health interpreters and ability of their agencies to adequately reimburse interpreters.

Other provider-related barriers in serving Hispanics that mental health professionals cited were rural distances, fragmented resources, lack of outreach, limited scope of practice, long waiting lists (with bilingual/bicultural providers reported being extremely overloaded), lack of quality providers, some providers not being culturally sensitive or very friendly toward Hispanics, and inappropriate use of family members as interpreters.

Providers themselves were generally not aware of local mental health services designed specifically for Hispanic clients.

System-related Factors. Providers identified the inadequacy of funding for mental health services most frequently. This was primarily tied to Idaho's state mental health system and Medicaid regulations. Given state budget cuts, state mental health services have become limited to crisis intervention and mental health court-ordered services. For some providers, it was too expensive and complicated to treat Medicaid clients. Providers also cited the difficulties of navigating reimbursement paperwork and service system restrictions, including the requirement for physician oversight. The lack of compensation for interpreter services by third party payers was seen as another systems issue.

Improving Mental Health Services for Hispanics – Hispanic Community Perspective

Informing the Community. During the qualitative interviews, most Hispanic respondents remarked about the importance of and need for the dissemination of accurate and pertinent information to the community about where mental health help can be accessed. Respondents recommended advertising to the community about mental health problems, treatment options, and available resources. Respondents also stated that it would be very helpful to disseminate educational information about mental health issues that may affect the Hispanic community at events such as community fairs in order to address stigma and encourage individuals to seek help. These efforts and other outreach efforts were seen as crucial to engaging the rapidly growing immigrant Hispanic community in Idaho. They further noted that it would help if information was tailored to the Hispanic community and available in Spanish.

“More than anything else it would be by providing information because as a Hispanic one does not have enough information and that is lacking. Information in the form of an explanation regarding where to go for help or who to go to. Usually people that are ill are afraid to go seek help because they are asked about information regarding their immigration status. So they do not go for help, they are afraid. Also, if you do not speak the language, it is even worse! Everywhere you go you need to know the language in order to communicate with others (Hispanic community respondent).”

Hispanic respondents also felt that it was important for government officials to hold meetings with community members and share information with them about what is going on in the legislature as well as sharing information about mental health resources.

Cultural Competence of Providers. Service system improvement recommendations consistently centered on language and cultural barriers. Practitioners and clinic staff should be bilingual or have ready access to bilingual translators as well as have written material available in Spanish. Hispanic respondents stated the need for practitioners to be better trained to understand cultural differences and barriers that are specific to the Hispanic community. These respondents remarked that if practitioners knew more about the community they would be able to address mental health problems in the community better. In addition, doctors/providers should take more time to listen to persons seeking care. A few respondents stated that it would be helpful to the community for Hispanics to be able to have equal access and for there to be less discrimination against them.

Affordability. Respondents also indicated that community members with mental health problems could best be helped with more financial resources, employment opportunities and transportation assistance. In addition, services need to be accessible and affordable. The most frequently reported suggestion was for government officials and legislators to work on providing more funding for mental health services and to help them to be more affordable to the individual. Numerous respondents indicated that there is a substantial need for low cost or free clinics accessible to Hispanics.

Service Availability. Respondents expressed the need for more clinics to address the mental health needs of the Hispanic community. A number noted that there are no clinics in the rural areas where they live. Respondents recommended that government officials and/or legislators should support more clinics and more

“Funds are needed for programs, but in order to obtain such funds for those programs legislators have to get out of their homes and go into the community so they can see for themselves what the needs are and also so the people in the community can see them out there. Because what they cannot see, they cannot understand. There they are in their cozy homes and do not know about the problems that exist!”

“It would be nice to see a place where doctors could treat both physical and mental health problems. I have not seen such a place here.”

“I would like to see services made available to all. It does not matter what race you are, all should be attended to equally whether one has documentation or not; that would be very good.”

“Yes. I know of a person who was having a problem and went into a clinic to ask for help. He was told to call and set up an appointment. When he called he was asked for his social security number and he said he did not have one. He was then told that they could not help him. I don’t know how much persons are affected when they deny services to people that need them but before asking for things such as a social security number, maybe they should think about the person that needs help.”

“There is no way that I can explain to anyone in English just how I am feeling, what emotions I am experiencing, how much I would like to recover and all that!”

practitioners to help Hispanics.

Immigration Issues. A number of respondents saw it important for government officials to promote immigration reform that would help Hispanics who are undocumented to live legally in the U.S. The two main laws discussed were 1) health care reform that would help make services affordable and accessible regardless of immigration status, and 2) immigration reform that would help Hispanics who are undocumented to live legally in the United States.

Improving Mental Health Services for Hispanics – Mental Health Providers’ Perspective

Providers offered a number of suggestions for improving their services. However, when asked the question, “If providers did not have to face the [barriers discussed], how would they improve their services for Hispanics,” eight (28%) of the 28 providers that responded stated that they would continue to treat their clients the same. They saw no difference in treating Hispanics from any other clients.

Improvements identified by the remaining 20 provider respondents included the following:

The most frequent response was improved Hispanic client education on topics such as what services are available, issues of stigma, mental illness, and systems of care. One respondent suggested that providers do a better job of explaining everything that has to do with the client.

Providers struggled with how to make mental health services affordable for Hispanic clients. Many were interested in the expansion of low cost or free services; others suggested the use of shorter-term treatment for those unable to pay.

Service Delivery. Most providers agreed that more bilingual practitioners were needed. Some providers suggested delivering mental health services in the client’s home rather than in an office or in institutions. Others suggested having specialized Hispanic services like the *Promotora* programs or *Salud Y Provecho*, a specialized multiservice agency. In addition, providers suggested having mental health testing and assessments in Spanish. Other improvement ideas included having full services available and strengthening treatment coordination with other providers, especially for clients with co-occurring disorders.

Other providers mentioned more frequent use of early intervention services, including early educational services to help inform Hispanics about mental illness and treating mental illness of children before they become institutionalized in juvenile detention.

Cultural Competence Training. When asked about their interests in continuing education related to serving Hispanics, providers’ mainly chose the following topics:

- Mental Health Assessment/Diagnosis/Treatment for Hispanics
- Cultural Competence

- Training on Sensitivity to Prejudice/Racism/Bias
- Training on Community Resources to Assist Hispanic Clients

Most preferred traditional workshop formats, either full-day or half-day.

CONCLUSIONS AND NEXT STEPS

The primary purpose of this community assessment was to *inform the improvement of mental health service delivery for Hispanic populations*. Under-use of mental health services among Hispanics has been well-documented in the literature. Among Hispanics in the U.S. with a mental disorder, less than 1 in 11 contacts a mental health specialist, while less than 1 in 5 contacts a general health care provider for services



Image: Cover of "Mental Health: A Guide for Latinos and Their Families"/ *Salud Mental: Una Guía para Latinos y sus Familias* <http://www.psych.org/share/OMNA/latino-mental-health-guide.aspx>

(National Council of La Raza, 2005).¹⁸ An earlier report from the U.S. Surgeon General (2001)¹⁹ stated that, among Hispanic immigrants with mental disorders, fewer than 1 in 20 uses services from a mental health specialist, while less than 1 in 10 uses services from a general health care provider. At the same time, the Hispanic community members who participated in this assessment reported having multiple stressors and high rates of culturally-defined mental health conditions.

The findings of this study indicate that the vast majority of mental health services for Hispanics in southwest Idaho are inadequate, unaffordable, and for the most part, culturally inaccessible. Local mental health and health care organizations lack funding, culturally appropriate outreach and education, bilingual and bicultural staff, and training on working with Hispanic clients. The Hispanic counselors and practitioners that are working in local agencies are overwhelmed by long waiting lists.

Suggested steps for improving mental health care for Mexican-American Hispanics from the systems perspective include:

- Expansion of local sliding fee scale clinics that are welcoming to Hispanic clients and are prepared to bridge cultural and language differences.

¹⁸ National Council of La Raza. (2005). *Critical Disparities in Latino Mental Health: Transforming Research into Action*. www.napolitano.house.gov/mhcaucus/reports/Critical_Disparities_in_Latino_Mental_Health.pdf

¹⁹ Surgeon General, HHS. (2001). *Mental Health: Culture, Race and Ethnicity 2001*. www.surgeongeneral.gov/library/mentalhealth/cre/

- Expansion of culturally appropriate and affordable drug / alcohol prevention and treatment services, as drug and alcohol abuse was presented as a leading mental health concern by the Hispanic community.
- More focused efforts to support the entry of Hispanic students in mental health care careers (for example, through the U.S. Health Resources and Services Administration's Health Professions programs).
- A more informed exchange between policy makers / system administrations and the local Hispanic community on what services are needed and how they can best work for Hispanics.

At the service level, study findings indicate that responsive, community-based mental health services for Mexican-American Hispanics would have these optimal characteristics:

- A much stronger acknowledgement of the impact of the immigration experience on Hispanics, even for those who have been in the U.S. for a long time, or are U.S. citizens. Immigration adjustment and fear of deportation are major causes of stress, anxiety, and emotional trauma; as well as barriers to Hispanics seeking mental health assistance.
- An understanding of how the majority of the Hispanic population perceives and describes mental health problems – more as situational stressors with physical symptoms. A working knowledge of Hispanics' culturally-bound syndromes and how they relate to traditional U.S. mental health diagnoses.
- A conscious effort to really listen to what Hispanic clients are trying to express, and to understand their cultural backgrounds.
- An active community outreach and education program, guided by the Hispanic community, that informs Hispanic residents about mental health issues and how and where to obtain mental health care.
- A conscious effort to design outreach, intake, assessment, and treatment materials and approaches that take into consideration Hispanics' educational levels and language.
- Bilingual / bicultural lay community health workers, mental health professionals, and trained mental health interpreters that are readily available to provide treatment and support.
- An approach to mental health care that is patient-centered in making decisions about treatment options (given Hispanics' expressed aversion to medication-only treatment).
- An approach to mental health treatment that incorporates client follow-up on treatment effectiveness and encourages open discussion of compliance issues.

- Programs that would encourage creative approaches to making mental health services affordable for Hispanics – including types of practitioners used, incorporation of community and family resources, and types of interventions used.
- Active networking and coordination among various local primary care, substance abuse, and mental health treatment providers in providing integrated care for Hispanic persons with co-occurring disorders.
- Internal policies that actively promote staff cultural competence and continuing education on cultural issues; internal protocol that is actively applied to how clients who have limited English proficiency are treated.
- Internal policies that, as much as possible, do not present barriers to persons in need of care that do not have legal documentation.
- An internal cultural environment that does not tolerate expressions of racism, discrimination, or disparities in mental health care, regardless of the client's ethnic/racial background.

APPENDIX A: Glossary of Culturally Relevant Terms²⁰

<i>Ataque de Nervios</i>	Idiom of distress reported among many Latino groups. It is manifested by uncontrollable crying, trembling, experience of heat in the chest rising to the head, verbal and/or physical aggression, shouting, fainting spells, and seizure-like episodes. In some rare cases, suicidal gestures may be present. The person has a sense of being out of control. It appears to occur following a family-related stressful event.
<i>Angustia</i>	An acute but unspecific feeling of anxiety; usually reserved for philosophical anxiety about the world or about personal freedom; extreme distress of body or mind.
<i>Coraje</i>	Fits of irritation, anger, or rage.
<i>Mal de Ojo</i>	A belief that someone has been cursed by another. In children it can be manifested by fitful sleep, crying without apparent cause, diarrhea, vomiting, and fever. In some cultures, it is believed to also possibly affect adults, especially women.
<i>Nervios</i>	A common idiom of distress among Latinos in the United States and Latin America. <i>Nervios</i> refers both to a general state of vulnerability to stressful life experiences and to a syndrome brought on by difficult life circumstances. The term <i>nervios</i> includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. Common symptoms include headaches and "brain aches," irritability, stomach disturbances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and <i>mareos</i> (dizziness with occasional vertigo-like exacerbations). <i>Nervios</i> tends to be an ongoing problem, although variable in the degree of disability manifested.
<i>Susto</i>	This term is use to explain the result of a fear so pronounced that one's soul has left one's body, resulting in unhappiness and sickness. Symptoms include appetite disturbance, inadequate or excessive sleep, vivid dreams, sadness, lack of motivation, and feeling of low self-worth. Somatic symptoms include muscle aches and pains, headache, stomach problems, diarrhea.
<i>Tensión</i>	Stress, tension.
<i>Tristeza</i>	Melancholy, sadness, emotional pain expressed by crying, lack of appetite.; often felt when expectations are not met or when the circumstances of life are more painful than joyful.

²⁰ Definitions of *Ataque de Nervios*, *Mal de Ojo*, and *Susto* from DSM IV, Diagnostic and Statistical Manual of Mental Disorders, Glossary of Culture-Bound Syndromes. Definitions of *Angustia*, *Coraje*, *Tension*, and *Tristeza* from traditional Spanish dictionaries.

APPENDIX B: STUDY QUESTIONNAIRES

I) INDIVIDUAL QUANTITATIVE INTERVIEW

Interviewer: _____ Date: _____ Time: _____

Interview #: _____

These first few questions are about selected population characteristics.

1) Age (Please enter in years) _____ 2) Gender Male Female (*Please choose one*)

3) What is your race? *We are required to collect this information because we received funds from the federal government (Please choose one).*

- American Indian/Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White
- More than one race
- Don't know/not sure
- Refused to answer
- Other (Please specify): _____

4) Do you consider yourself to be Hispanic/Latino, Mexican, or Mexican-American? (*Please choose one*)

- Yes
- No
- Don't know/not sure
- Refused to answer

5) What is your place of birth? (*Please choose one*)

- Mexico
- United States
- Central America
- South America
- Other (Please specify): _____
- Refused to answer

6) What is the place of your mother's birth? *(Please choose one)*

- Mexico
- United States
- Central America
- South America
- Other (Please specify): _____
- Refused to answer

7) What is the place of your father's birth? *(Please choose one)*

- Mexico
- United States
- Central America
- South America
- Other (Please specify): _____
- Refused to answer

8) How many years have you lived in the U.S.? _____ *(Please enter number)*

9) What is your marital status? Are you: *(Please choose one)*

- | | |
|--|--|
| <input type="checkbox"/> Single, never married | <input type="checkbox"/> Member of an unmarried couple |
| <input type="checkbox"/> Single, divorced | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Refused to answer |

10) Who lives in your household? *(Please check all that apply)*

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Alone | <input type="checkbox"/> Others (Please indicate): _____ |
| <input type="checkbox"/> Spouse | |
| <input type="checkbox"/> Children | <input type="checkbox"/> Refused to answer |
| <input type="checkbox"/> Parents | |
| <input type="checkbox"/> Siblings | |

11) Do you have any children? Yes No *(Please choose one)*

If yes, how many? _____ *(Please enter number)*

What are their ages? *(Please enter ages)*

11) Continued

Where were they born? *(Please choose one)*

- All in the U.S.
- All in Mexico
- All in Central America
- All in South America
- Some in U.S.; some in Mexico
- Some in U.S.; some in Central America
- Some in U.S.; some in South America
- Other (Please indicate): _____
- Refused to answer

12) How many years of education have you completed? *(Please choose one)*

- | | |
|--|--|
| <input type="checkbox"/> Did not attend school | <input type="checkbox"/> Vocational/technical school |
| <input type="checkbox"/> Less than sixth grade | <input type="checkbox"/> Some college or university |
| <input type="checkbox"/> Through sixth grade | <input type="checkbox"/> College/university graduate |
| <input type="checkbox"/> Some high school | <input type="checkbox"/> Advanced degree |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> GED | <input type="checkbox"/> Refused to answer |

13) What is your current work status? Are you currently: *(Please choose one)*

- | | |
|---|--|
| <input type="checkbox"/> Employed for wages | <input type="checkbox"/> A student |
| <input type="checkbox"/> Self-employed | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Out of work for more than 1 year | <input type="checkbox"/> Unable to work |
| <input type="checkbox"/> Out of work for less than 1 year | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> A homemaker | <input type="checkbox"/> Refused to answer |

14) If employed, what type of work do you do? *(Please choose one)*

- Administration
- Agriculture (farming, dairy, ranching)
- Armed Forces (military)
- Construction (drywall, framer, concrete)
- Installation (insulation, carpet, plumbing, electrical)
- Landscaping (nursery, gardener)
- Management/Supervisor
- Meat cutter
- Production (manufacturing, printing, woodworking, fabrication)
- Professional-non healthcare (lawyer, teacher, accountant, computer specialist, engineer)
- Professional-healthcare/ human services (doctor, nurse, therapist, counselor, other allied health)
- Sales (retail, real estate, insurance, other)
- Service (waiter, chef, housekeeping, janitorial, daycare)

15) What is your monthly household income from all sources? *(Please choose one)*

- | | |
|--|---|
| <input type="checkbox"/> Less than \$500 | <input type="checkbox"/> \$3,000-\$4,999 |
| <input type="checkbox"/> \$500-\$999 | <input type="checkbox"/> Greater than \$5,000 |
| <input type="checkbox"/> \$1,000-\$1,499 | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> \$1,500-\$1,999 | <input type="checkbox"/> Refused to answer |
| <input type="checkbox"/> \$2,000-\$2,999 | |

16) In general, what language(s) do you read and speak? *(Please choose one)*

- | | |
|--|--|
| <input type="checkbox"/> Only Spanish | <input type="checkbox"/> Only English |
| <input type="checkbox"/> Spanish better than English | <input type="checkbox"/> Other (Please specify): |
| <input type="checkbox"/> Both equally | _____ |
| <input type="checkbox"/> English better than Spanish | |

17) What was the language(s) you used as a child (1-10 years old) *(Please choose one)*

- | | |
|--|--|
| <input type="checkbox"/> Only Spanish | <input type="checkbox"/> English better than Spanish |
| <input type="checkbox"/> Spanish better than English | <input type="checkbox"/> Only English |
| <input type="checkbox"/> Both equally | <input type="checkbox"/> Other (Please specify): |
| | _____ |

18) What language(s) do you usually speak at home? *(Please choose one)*

- | | |
|--|--|
| <input type="checkbox"/> Only Spanish | <input type="checkbox"/> Spanish better than English |
| <input type="checkbox"/> English better than Spanish | <input type="checkbox"/> Both equally |
| <input type="checkbox"/> Only English | <input type="checkbox"/> Other (Please specify): |
| | _____ |

19) In which language(s) do you usually think? *(Please choose one)*

- | | |
|--|--|
| <input type="checkbox"/> Only Spanish | <input type="checkbox"/> English better than Spanish |
| <input type="checkbox"/> Spanish better than English | <input type="checkbox"/> Only English |
| <input type="checkbox"/> Both equally | <input type="checkbox"/> Other (Please specify): |
| | _____ |

20) What language(s) do you usually speak with your friends? *(Please choose one)*

- | | |
|--|--|
| <input type="checkbox"/> Only Spanish | <input type="checkbox"/> Only English |
| <input type="checkbox"/> Spanish better than English | <input type="checkbox"/> Other (Please specify): |
| <input type="checkbox"/> Both equally | _____ |
| <input type="checkbox"/> English better than Spanish | |

In these next questions we want to know your thoughts about any mental health problems or concerns you have. A mental health problem includes mental illness and mental problems that are situational and not just illness based such as experiencing distress or depression if you just lost your job. As you answer these questions, think about your self and your family.

21) From your point of view, what do you think causes mental health problems?
(Please check all that apply)

- Medical condition
- Evil Spirits/Devil/from being under a spell
- Nature/Hereditiy
- Stress
- Depression
- Financial problems
- Drug abuse
- Alcohol abuse
- Marital problems
- Problems between parents and children
- Gambling
- Exposure to violence
- Fate/destiny
- Other please indicate: _____

22) On a scale from 1 to 5, 1 being not serious at all, to 5, being extremely serious, how serious can these problems be? *(Please circle one)*

	Not at all serious			Extremely serious	
	1	2	3	4	5
Medical condition	1	2	3	4	5
Evil Spirits/Devil/from being under a spell	1	2	3	4	5
Nature/Hereditiy	1	2	3	4	5
Stress	1	2	3	4	5
Depression	1	2	3	4	5
Financial problems	1	2	3	4	5
Drug abuse	1	2	3	4	5
Alcohol abuse	1	2	3	4	5

22) *continued*

On a scale from 1 to 5, 1 being not serious at all, to 5, being extremely serious, how serious can these problems be? *(Please circle one)*

	Not at all serious			Extremely serious	
Marital problems	1	2	3	4	5
Problems between parents and children	1	2	3	4	5
Gambling	1	2	3	4	5
Exposure to violence	1	2	3	4	5
Fate/destiny	1	2	3	4	5

23) In the community where you now live, what kind of help or treatment is available for a person with a mental problem? *(Please check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Emergency room |
| <input type="checkbox"/> Social worker | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Clinic/health center |
| <input type="checkbox"/> Family physician | <input type="checkbox"/> Traditional healer/ curandera |
| <input type="checkbox"/> Nurse/nurse practitioner | <input type="checkbox"/> Books/Magazines |
| <input type="checkbox"/> Teacher | <input type="checkbox"/> Support groups |
| <input type="checkbox"/> Priest/Minister | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Other please indicate: |
| <input type="checkbox"/> Friend | _____ |
| <input type="checkbox"/> Neighbor | |

24) Who would you trust to help you, if you had a mental health problem? *(Please check all that apply)*

- | | |
|---|---|
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Emergency room |
| <input type="checkbox"/> Social worker | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Clinic/health center |
| <input type="checkbox"/> Family physician | <input type="checkbox"/> Traditional healer/ <i>curandera</i> |
| <input type="checkbox"/> Nurse/Nurse practitioner | <input type="checkbox"/> Books/Magazines |
| <input type="checkbox"/> Teacher | <input type="checkbox"/> Support groups |
| <input type="checkbox"/> Priest/Minister | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Other please indicate: |
| <input type="checkbox"/> Friend | _____ |
| <input type="checkbox"/> Neighbor | |

25) Have you ever received a diagnosis of a mental illness or mental health problem?

Yes No (*Please check one*) If no, continue to question #26

If yes, was the diagnosis any of the following? (*Please check all that apply*)

- Depression
- Bipolar disorder (manic-depression)
- Schizophrenia
- Anxiety disorder
- Post Traumatic Stress Disorder
- Alcohol abuse
- Substance abuse
- Other disorder (eating, panic, compulsive-obsessive, adult ADHD, etc.)

Please name: _____

If yes, were you treated for this concern? Yes No (*Please check one*)

If not, why were you not treated? (*Please check all that apply*)

- | | |
|---|---|
| <input type="checkbox"/> Don't know where to seek treatment | <input type="checkbox"/> Inability to take time off from work |
| <input type="checkbox"/> Long wait times to get appointment | <input type="checkbox"/> Lack of appropriate documentation |
| <input type="checkbox"/> Lack of Spanish speaking providers | <input type="checkbox"/> Services not available |
| <input type="checkbox"/> Lack of insurance | <input type="checkbox"/> Don't trust doctors |
| <input type="checkbox"/> Cost of treatment too high | <input type="checkbox"/> Lack of child care |
| <input type="checkbox"/> Fear of family finding out | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Distance to provider | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Work/schedule conflicts | <input type="checkbox"/> Refused to answer |
| <input type="checkbox"/> Lack of transportation | |

If yes, who treated you? (*Please check all that apply*)

- Counselor
- Social worker
- Psychiatrist
- Psychologist
- Family physician
- Nurse/Nurse practitioner
- Teacher
- Priest/Minister
- Family member
- Friend
- Neighbor
- Emergency room
- Internet
- Pharmacist

What type of treatment was prescribed (Please check all that apply)?

- Medication only
- Counseling only
- Combination of counseling and medication
- Home remedies (herbal)
- Physical activity/exercise
- Prayer/ Meditation
- Support group
- Hospitalization
- Other (please specify): _____

Were you able to follow through with your treatment? Yes No (*Please check one*)

If not, why not? (*Please check all that apply*)

- Can't afford medication
- Side effects of medication (dizziness, sleepiness, etc.)
- Afraid of becoming addicted to the medication
- No counseling services available
- Provider spoke only English—did not understand treatment plan
- Counseling/therapy too expensive
- Wasn't helpful/didn't see any improvements
- Took too long/too much time
- Don't know
- Other (please specify): _____

On a scale from 1 to 5, 1 being not effective at all, and 5 being extremely effective, how effective do you believe the treatment was? (*Please circle one*)

1 2 3 4 5

26) Has anyone in your family received a diagnosis of a mental illness or mental health problem?

Yes No Don't know (*Please check one*)

If no, or you don't know, continue to question #27

If yes, was the diagnosis any of the following? *(Please check all that apply)*

- Depression
- Bipolar disorder (manic-depression)
- Schizophrenia
- Anxiety disorder
- Post Traumatic Stress Disorder
- Alcohol abuse
- Substance abuse
- Other disorder (eating, panic, compulsive-obsessive, adult ADHD, etc.)

Please name: _____

If yes, were you treated for this concern? Yes No *(Please check one)*

If not, why were you not treated? *(Please check all that apply)*

- | | |
|---|---|
| <input type="checkbox"/> Don't know where to seek treatment | <input type="checkbox"/> Inability to take time off from work |
| <input type="checkbox"/> Long wait times to get appointment | <input type="checkbox"/> Lack of appropriate documentation |
| <input type="checkbox"/> Lack of Spanish speaking providers | <input type="checkbox"/> Services not available |
| <input type="checkbox"/> Lack of insurance | <input type="checkbox"/> Don't trust doctors |
| <input type="checkbox"/> Cost of treatment too high | <input type="checkbox"/> Lack of child care |
| <input type="checkbox"/> Fear of family finding out | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Distance to provider | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Work/schedule conflicts | <input type="checkbox"/> Refused to answer |
| <input type="checkbox"/> Lack of transportation | |

If yes, who treated you? *(Please check all that apply)*

- Counselor
- Social worker
- Psychiatrist
- Psychologist
- Family physician
- Nurse/Nurse practitioner
- Teacher
- Priest/Minister
- Family member
- Friend
- Neighbor
- Emergency room
- Internet
- Pharmacist
- Clinic/health center
- Traditional healer/curandera
- Books/magazines
- Support groups

26) Continued

What type of treatment was prescribed (*Please check all that apply*)?

- Medication only
- Counseling only
- Combination of counseling and medication
- Home remedies (herbal)
- Physical activity/exercise
- Prayer/ Meditation
- Support group
- Hospitalization
- Other (please specify): _____

Were you able to follow through with your treatment? Yes No (*Please check one*)

If not, why not? (*Please check all that apply*)

- Can't afford medication
- Side effects of medication (dizziness, sleepiness, etc.)
- Afraid of becoming addicted to the medication
- No counseling services available
- Provider spoke only English—did not understand treatment plan
- Counseling/therapy too expensive
- Wasn't helpful/didn't see any improvements
- Took too long/too much time
- Don't know
- Other (please specify): _____

On a scale from 1 to 5, 1 being not effective at all, and 5 being extremely effective, how effective do you believe the treatment was? (*Please circle one*)

1 2 3 4 5

27) Have you suffered from the any of the following emotional or mental problems? (*Please check all that apply*) If none, go to question #28

- Attack of nerves (*Ataque de nervios*)
- Fright (*Susto*)
- Anxiety (*Angustia*)
- The evil eye (*Mal de ojo*)
- Rage (*coraje*)
- Other (please describe): _____

27) Continued

Were you treated for this problem? Yes No (Please check one)

If yes, what county did you receive treatment? (Please check one)

- Ada
- Canyon
- Both
- Other (Please indicate): _____

If yes, who was the provider? (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Emergency room |
| <input type="checkbox"/> Social worker | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Clinic/health center |
| <input type="checkbox"/> Family physician | <input type="checkbox"/> Traditional healer/curandera |
| <input type="checkbox"/> Nurse/Nurse practitioner | <input type="checkbox"/> Books/magazines |
| <input type="checkbox"/> Teacher | <input type="checkbox"/> Support groups |
| <input type="checkbox"/> Priest/Minister | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Other please indicate:
_____ |
| <input type="checkbox"/> Friend | |
| <input type="checkbox"/> Neighbor | |

Did you get the help you needed? Yes No (Please check one)

If no, why couldn't you get the help you needed? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Don't know where to seek treatment | <input type="checkbox"/> Inability to take time off from work |
| <input type="checkbox"/> Long wait times to get appointment | <input type="checkbox"/> Lack of appropriate documentation |
| <input type="checkbox"/> Lack of Spanish speaking providers | <input type="checkbox"/> Services not available |
| <input type="checkbox"/> Lack of insurance | <input type="checkbox"/> Don't trust doctors |
| <input type="checkbox"/> Cost of treatment too high | <input type="checkbox"/> Lack of child care |
| <input type="checkbox"/> Fear of family finding out | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Distance to provider | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Work/schedule conflicts | <input type="checkbox"/> Refused to answer |
| <input type="checkbox"/> Lack of transportation | |

28) Has someone in your family, suffered from the following emotional or mental problems? (Please check all that apply) If none or you don't know, go to question #29

- Attack of nerves (*Ataque de nervios*)
- Fright (*Susto*)
- Anxiety (*Angustia*)
- The evil eye (*Mal de ojo*)
- Rage (*coraje*)
- Other (please describe): _____

28) Continued

Were they treated for this problem? Yes No Don't know (Please check one)

If yes, what county did they receive treatment? (Please check one)

- Ada
- Canyon
- Both
- Don't know
- Other (Please indicate): _____

If yes, who was the provider? (Please check all that apply))

- | | |
|---|--|
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Emergency room |
| <input type="checkbox"/> Social worker | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Clinic/health center |
| <input type="checkbox"/> Family physician | <input type="checkbox"/> Traditional healer/curandera |
| <input type="checkbox"/> Nurse/Nurse practitioner | <input type="checkbox"/> Books/magazines |
| <input type="checkbox"/> Teacher | <input type="checkbox"/> Support groups |
| <input type="checkbox"/> Priest/Minister | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Other please indicate:
_____ |
| <input type="checkbox"/> Friend | |
| <input type="checkbox"/> Neighbor | |

Did they get the help they needed? Yes No Don't know (Please check one)

If no, why do you believe they couldn't they get the help they needed? (Please check all that apply)

- Don't know where to seek treatment
- Long wait times to get appointment
- Lack of Spanish speaking providers
- Lack of insurance
- Cost of treatment too high
- Fear of family finding out
- Distance to provider
- Work/schedule conflicts
- Lack of transportation
- Inability to take time off from work
- Lack of appropriate documentation
- Services not available
- Don't trust doctors
- Lack of child care

29) Have you ever used home remedies to treat mental problems? *(Please check all that apply)*

- Garlic (*Ajo*)
- Damiana (*Damiana*)
- Chamomile (*Manzanilla*)
- Oregano (*Oregano*)
- Passion Flower (*Pasionara*)
- Valerian Root (*Valeriana*)
- St. Johns Wort

- Linden flowers (*Tilia*)
 - Peppermint (*Yerba Buena*)
 - Sapodilla (*Zapote blanco*)
 - Don't know
 - Other (Please indicate):
-

30) Have any members of your family ever used home remedies to treat mental problems? *(Please check all that apply)*

- Garlic (*Ajo*)
- Damiana (*Damiana*)
- Chamomile (*Manzanilla*)
- Oregano (*Oregano*)
- Passion Flower (*Pasionara*)
- Valerian Root (*Valeriana*)
- St. Johns Wort

- Linden flowers (*Tilia*)
 - Peppermint (*Yerba Buena*)
 - Sapodilla (*Zapote blanco*)
 - Don't know
 - Other (Please indicate):
-

31) Have you experienced emotional or mental distress from the following events or problems? *(Please check all that apply)*

- Son/daughter leaving home
- Problem with in-laws
- Problems between parents/children
- Trouble with their boss
- Fears or nightmares
- Adapting to life in Idaho
- Adapting to life in the United States
- Death of a close friend
- Death of a family member
- Unwanted pregnancy
- Abuse (physical/sexual/emotional)
- Separation from family/friends due to move to the United States
- Separation from family/friends due to move to Idaho
- Documentation or immigration issues
- Behavior problems
- Marital problems
- Marital separation or divorce
- Problems with alcohol/ drugs
- Job loss
- Personal injury or illness
- Jail term

32) Have any members of your family experienced emotional or mental distress from the following events or problems? *(Please check all that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Son/daughter leaving home | <input type="checkbox"/> Behavior problems |
| <input type="checkbox"/> Problem with in-laws | <input type="checkbox"/> Marital problems |
| <input type="checkbox"/> Problems between parents/children | <input type="checkbox"/> Marital separation or divorce |
| <input type="checkbox"/> Trouble with their boss | <input type="checkbox"/> Problems with alcohol/ drugs |
| <input type="checkbox"/> Fears or nightmares | <input type="checkbox"/> Job loss |
| <input type="checkbox"/> Adapting to life in Idaho | <input type="checkbox"/> Personal injury or illness |
| <input type="checkbox"/> Adapting to life in the United States | <input type="checkbox"/> Jail term |
| <input type="checkbox"/> Death of a close friend | <input type="checkbox"/> Natural disaster (flood, earthquake, |
| <input type="checkbox"/> Death of a family member | <input type="checkbox"/> Political violence, persecution, civil |
| <input type="checkbox"/> Unwanted pregnancy | <input type="checkbox"/> war and abuse in home country |
| <input type="checkbox"/> Abuse (physical/sexual/emotional) | <input type="checkbox"/> Discrimination/racism |
| <input type="checkbox"/> Separation from family/friends due to | <input type="checkbox"/> None of the above |
| move to the United States | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Separation from family/friends due to | <input type="checkbox"/> Refused to answer |
| move to Idaho | <input type="checkbox"/> Other (Please indicate): |
| <input type="checkbox"/> Documentation or immigration issues | |
-
-

Thank you for your cooperation. None of these answers contain your name; and all your answers are held in confidence so that no one can know what you have said.

II) INDIVIDUAL QUALITATIVE INTERVIEW

Interviewer: _____

Date: _____ Time: _____

Interview #: _____

- 1) In your own words, what do you think a mental health problem is?
- 2) In what ways do mental health problems affect a person?
- 3) In the community where you live, what kind of help or treatment is available for a person with a mental health problem?
- 4) Do you believe the help for mental health problems is adequate in your community?
If not, why not? If so, why?
- 5) Have you been treated for a mental health problem in your country of origin?
In Idaho? *How would you describe your treatment experience? a) What worked the best? b) What worked the least?*
- 6) Has a family member been treated for a mental health problem in their country of origin?
In Idaho? *How would you describe their treatment experience? a) What worked the best? b) What worked the least?*
- 7) Has someone in your family, including yourself, suffered from a physical problem in which the doctors could not find a cause? (If not, go to the next question) *Describe the symptoms, your treatment experience and the outcome.*
- 8) If you do have children, are any of your children experiencing difficulties at school or home or exhibiting behaviors that are a concern? (If no children, go to question #10).
- 9) Do you believe there is conflict or tension between you and your children because they believe your behavior (for example, cultural values) are different from those of their friends in the United States? *Can you describe how this emotionally affects you?*
- 10) Have you or a family member experienced emotional or mental distress from political violence, persecution, civil war, or abuse in your home country? (If not, go to the next question) *Can you describe? What did you or your family member do to alleviate this distress? How did it affect you emotionally?*
- 11) Have you or a family member experienced emotional or mental distress from a natural disaster, such as an earthquake, a hurricane, or a flood? (If not, go to the next question) *Can you describe? What did you or your family member do to alleviate this distress? How did it affect you emotionally?*

12) Have you or a family member experienced emotional or mental distress from physical or sexual abuse, neglect, or abandonment? (If not, go to the next question) Can you describe? *What did you or your family member do to alleviate this distress? How did it affect you emotionally?*

13) If you were not born in the United States, have you or a family member experienced emotional or mental distress from being separated because of your move to the United States? (If not, go to the next question) *Can you describe? What did you or your family member do to alleviate this distress? How did this affect you emotionally?*

14) Are you concerned over someone in your family who lives in the United States due to any immigration and documentation issues? (If not, go to the next question) *How has this affected you emotionally?*

15) In your opinion, what do you think are the major mental health problems for Latinos in your community?

16) In your opinion, what are major issues, problems, or fears for Latinos in using or getting mental health services in your community?

17) What things do you try or do to stay emotionally/mentally healthy?

18) How can a person with mental health problems best be helped or treated in your community?

19) What should providers/doctors do to improve the care of Latinos in your community who has mental health problems?

20) What should government officials/legislators do to improve the care for Latinos in your community who have mental health problems?

21) From your perception, what issues/barriers exist that make it difficult for Latinos to receive mental health treatment here in Idaho? a) What personal barriers do you think keep you from receiving mental health treatment? b) What barriers do you think keep the provider from treating Latinos with mental health problems?

22) What would you like to see in your community regarding mental health services for Latinos here in Idaho?

Thank you for your cooperation. None of these answers contain your name; and all your answers are held in confidence so that no one can know what you have said.

III) INTERVIEW WITH MENTAL HEALTH PROVIDER

CLINIC NAME: _____

INTRODUCTORY SCRIPT: Thank you again for agreeing to participate in this interview. As I mentioned when we reviewed the informed consent, the goal of this study is to obtain information from mental health providers regarding care for Hispanics. We are interested in your opinions about mental health care and the resources and barriers for such care here at your clinic/agency. Please be as honest, forthright, and realistic in your responses as possible. We will audiotape the interview. After the interview, we will review the tape and make notes from the tape. All names and references that might identify individuals will be removed from the written notes of the interview. The audiotape will be destroyed by April 2011. This information is important to understand various perceptions of mental health care here in Idaho for Hispanics. We begin with a vignette as a launching point or base for our interview. It is not to judge or evaluate your competency of assessment. There is no right or wrong answers, only your perceptions and understanding. Before we get started, do you have any questions?

First, we would like to ask you a few demographic questions.

How old are you? _____

Gender? Male Female (Interviewer to check)

What is your ethnic or racial background?

- Non-Hispanic White
- Hispanic
- Asian or Pacific Islander
- African American
- Native American
- Other: (please specify) _____

Are you bilingual (Spanish/English)?

To get our discussion started, I would like to read a description of a patient to you. *A Hispanic woman in her late 30s who is uninsured comes into your office today with multiple nonspecific somatic complaints, including headache and back pain. On further questioning, she reports that she has not been herself for the past two months. She has not been sleeping well, has little appetite, does not have the interest or energy to take care of the housework as she usually would, and has difficulty making decisions about small tasks such as what to cook or what to wear. She becomes tearful during the interview and admits to feeling sad and nervous. Her husband recently lost his job and her son has dropped out of high school to help with family finances. Her physical examination and laboratory findings are normal.*

1. What is your understanding of this client's/patient's problem? Probes:
What is your diagnosis? On what do you base this diagnosis? What will happen over time if she does not get help? What is the likelihood that treatment could improve her symptoms?

2. If you saw this client/patient on a typical day in your clinic, what would you do? Probes:
Would you do a further work-up? Would you assess but not treat at this time? Would you initiate treatment yourself? If so, what treatment would you start?

Would you refer her to another provider for treatment? What follow-up care would you provide? When would you have her return to the clinic/agency? How often would you see her over the next 6 months? What do think other providers in this clinic/agency would do?

3. What gets in the way of your Hispanic clients/patients receiving good mental health care?

Probes: Are there patient-related factors that interfere with your ability to provide optimal treatment for mental disorder such as depression, schizophrenia? (Examples include patient reluctance to accept diagnosis or treatment, patient psychosocial problems, cultural issues such as language barriers or different cultural beliefs about depression, stigma). Are there provider-related factors that limit your ability to provide optimal care? (Examples include needing to tend to other medical problems, limited information about treating depression and other disorders, limited time). Are there system-related barriers? (Examples include restricted formularies, lack of access to mental health professional, and lack of reimbursement for mental health care)

4. If you and your Hispanic clients/patients did not have to face these obstacles, how would you prefer to treat clients/patients with mental disorders? *Probes: Would you prefer to initiate treatment yourself? If so what? Would you prefer to refer to another provider? If so, to whom and for what services?*

5. On a scale of 1-5, with 1 being most satisfied and 5 being most dissatisfied, how do you rate your satisfaction with the care Hispanic clients/patients receive from your clinic/agency? *Probes: What worked best? What didn't work? What impacted adherence to treatment?*

6. On a scale of 1-5, with 1 being most satisfied and 5 being most dissatisfied, how do you rate your satisfaction with the care your Hispanic clients/patients have received from other mental health professionals? *Probes: What worked well and contributed to your satisfaction? What was less effective and contributed to your level of satisfaction regarding care to your Hispanic patients? Have you spoken with any mental health professionals about your clients/patient?*

7. What additional resources would help your Hispanic clients/patients get better care for depression or other mental disorders? *Probes: Examples of resources might include additional staff, more time for patient visits, easier referrals to mental health clinic or the availability of a case manager? How would you improve mental health care at this agency/clinic if you could? What kind of resources would you see as needed or helpful? What are the competing priorities?*

8. Please describe the organizational policies on cultural competence and communications with limited-English speaking persons your agency has. *Probes: Are client language skills assessed on intake? Are there protocols in place when clients are identified as limited-English speaking? How does your agency handle interpretation needs?*

9. Please describe the training on cultural competency provided or supported by your agency for staff members. *Probes: Do you receive any training in-house? Does your agency support your attendance at training functions on cultural competency either financially or through time off?*

10. If training was available to mental health providers, please name up to three continuing education topics that you would find most useful to your practice in serving Hispanic clients.

11. Please indicate what type of formats for continuing education (CE) programming you prefer. If you have multiple responses, please prioritize by the order in which you prefer them- for example if you have three preferences and your favorite is grand rounds- rate grand rounds as "1" the second preferred as "2", etc.

Grand Rounds 1 hr. (local) _____
One-half Day Conference (local) _____
Full-day Conference (local) _____
Multi-day Conference (local) _____
Multi-day Conference (resort) _____
Other: _____

12. Please indicate what type continuing education (CE) venues you prefer. If you have multiple preferences, please prioritize by the order in which you prefer- for example if you have three preferences and your favorite is traditional lectures- rate traditional lectures as "1", the second preferred as "2", etc.

Traditional Lectures _____
Journals _____
Computer Interactive CD ROMs, On-line) _____
Video/Audio Tapes _____
Teleconference (Satellite) _____
Other: _____