

CULTURAL COMPETENCY AND MENTAL HEALTH IN THE HISPANIC COMMUNITY OF JACKSON COUNTY, MISSOURI

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FOREWORD

Mattie Rhodes Center is pleased to present our first document on the state of mental health services for Latinos. The idea for this document grew out of the realization of the role and expertise that Mattie Rhodes Center has developed in serving residents of the urban core of Kansas City and Jackson County, Missouri. Over the past 20 years Mattie Rhodes Center has developed a unique mental health program for Latinos and especially those with limited English proficiency.

The journey over this period has been a steady progression towards developing a mental health department with highly skilled competent professionals that is responsive to clients' and community needs.

We are privileged to have the trust of clients who are seeking assistance to change and improve their lives. Mattie Rhodes Center has learned and continues to learn to work with diverse populations and communities. This report documents the growth of Latinos nationally and regionally, the need for more research on Latino mental health, and results from Mattie Rhodes Center outcomes and evaluations. Much more work is needed on this topic. This report is a first step in raising awareness and educating others about the need to improve service delivery and funding.

We sincerely appreciate the support of the Jackson County Mental Health Levy Fund to create this document as well as its support of Mattie Rhodes Center in serving residents of Jackson County.

Mary Lou Jaramillo
Executive Director

Cultural Competency and Mental Health in the Hispanic Community of Jackson County, Missouri, is Mattie Rhodes Center's first attempt at influencing public policy and fundraising. The report is a research document that brings together national and local demographics developed by the U.S. Census, information from the Surgeon General, the Center for the Study of Issues in Public Mental Health, the Jackson County Mental Health Levy, and Mid America Regional Council. **This report offers the following to Jackson County and Missouri civic leaders, foundation officers, businesses, public officials, social service providers, consumers, and the Hispanic community:**

Cultural Competency: This section contains a discussion of the importance of cultural competency and an outline of benchmarks for cultural competency in all social services. These benchmarks can be used by any service organization as a standard for providing culturally competent services to culturally diverse populations.

Demographics: This section contains statistics on the Latino community nationally and locally in Jackson County, Missouri, including specific information about mental health care in Jackson County. This information will be useful to any organization looking to demonstrate the growing Latino population nationally and locally, or specific education, poverty, housing or mental health data of the Hispanic community for public policy and funding decisions.

Mental Health and Hispanics: This section contains an overview of mental health and its importance in the general population, a focus on Hispanic mental health, a look at the barriers to service, and effective practices in Hispanic mental health at the Mattie Rhodes Center. Mental Health providers in Jackson County and beyond would benefit from this information.

Outcomes: This section contains a discussion of the importance of assessing the outcomes of a mental health provider and the beginnings of our documentation of outcomes and results of our programs.

Since 1950, mental health has been Mattie Rhodes Center's primary service. Over time this focus has centered on the Hispanic and Spanish speaking population of Jackson County. The report profiles the agency's adherence to cultural competency, successful strategies, and an outcome measurement framework that is used to measure our programming.

It is the hope of our staff and board of directors that this report will increase each reader's awareness of culturally competent services for mental health care in the Hispanic community in Kansas City. In addition, we hope this document will serve as a standard for a variety of culturally competent services nationwide.

The United States Census Bureau recently estimated the Latino population to be 38.8 million, making Hispanics the largest minority population in the United States (U.S. Census Bureau, 2000). This growth happened much faster than authorities anticipated. Nationwide, over the past 10 years, the Hispanic population grew by more than 35 percent and the Asian population grew by more than 40 percent (“New Census,” 1999). Census data shows that at least 3 out of 10 U.S. residents are something other than white (Sealey, 2000). These statistics show that the United States is becoming more and more diverse in race and ethnicity. In fact, by the year 2050, it is estimated that Latinos will constitute nearly a quarter of the U.S. population. These figures are most likely low considering the fact that a large number of undocumented Latinos and members of other populations are not counted by the Census.

The rapid population growth has enriched the diversity of our communities and has also presented unique challenges for service providers in many different fields. As minority populations continue to grow, specific and unique health, social, economic, and educational needs will have more societal impact. Since 1986, the Mattie Rhodes Center has been seeking to meet those challenges and provide culturally competent mental health services to the Hispanic community of Kansas City.

There is a demand by societal groups at all levels for research, best practice models, and evaluation tools, all in an effort to meet the demands of the diverse communities. This demand is documented in *Mental Health: Race, Culture and Ethnicity, a Supplement to the Surgeon General’s Report on Mental Health* (see Cultural Competency). With this in mind, it is apparent that the mental health needs of Latinos, African Americans, Asians and all other minority populations are more than the concern of a particular region or certain states. The supplemental report by the Surgeon General emphasizes the effect of mental health on many different aspects of life, such as: personal well-being, family, interpersonal relationships, and contributions to family and society (U.S. Department of Health and Human Services (DHHS), 2001).

The rapid population growth, along with the various areas of life which are impacted by mental health, has turned mental health care into a national concern. Mental health in minority populations is one of the key areas in which specific information is severely lacking. There are no defined best practices because there is not enough research to define what constitutes a best practice. Although there is not enough empirical evidence, “substantive data suggests that tailoring services to the specific needs of racial and ethnic groups will improve utilization and outcomes” (U.S. DHHS, 2001, p.36). Values for cultural competency do exist and until further research reveals best practices, providers are obligated to make every attempt to offer culturally competent services and to offer practices found to be effective.

CULTURAL COMPETENCY

**CULTURAL COMPETENCY IN HEALTH AND MENTAL HEALTH
BENCHMARKS IN CULTURAL COMPETENCY**

CULTURAL COMPETENCY IN HEALTH AND MENTAL HEALTH

Culture is an evolving concept that involves values, beliefs and practices along with social experience and daily routines. Individuals are more than passive recipients of culture; they actively engage in sorting through countless experiences and messages to identify what matters most. The cultural experience of individuals and groups changes over time, contributing to considerable diversity within any particular group (Viccora, 2001).

Disparities exist in health services ranging from the access of care to the relevance of services. In order to adequately address disparities, efforts must focus not only on equalizing access to treatment but also on equalizing outcomes of care. Outcomes are largely dependent on the quality of service provided. Cultural competence allows for a higher quality of service, and ideally, successful outcomes.

Because culture itself is a dynamic concept, the development of cultural competence within any organization must be an evolutionary process. Fundamental concepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences, and assessing the mental health system's success in addressing cultural differences (Viccora, 2001).

An important document discussing the necessity of cultural competency is *Mental Health: Culture, Race & Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General*. This landmark document provides comprehensive discussion of the affect of culture on mental health and the need to address cultural issues in order to improve the disparities in mental health services in minority populations. According to this document, culture can affect the way in which individuals report their symptoms and which ones they report, the style of coping, family and community supports, and willingness and ability to seek treatment. It is clear that cultural competence is the responsibility of the system, not the individuals seeking treatment. According to the Surgeon General, the best models of mental health service today extend beyond diagnosis and treatment. These models address prevention and the fulfillment of broader needs, including housing and employment (U.S. DHHS, 2001).

A culturally competent organization is committed to more than simply serving diverse clients; diverse staff should be sought and hired and programs should be established that address the needs of different client populations. A culturally competent organization is marked by a culture of openness and respect.

Overview of Mental Health: Culture, Race & Ethnicity A Supplement to Mental Health: A Report of the Surgeon General

Main Points of the Report:

- The cultures from which people hail affect all aspects of mental health and illness.
- There are wide disparities in the kinds of treatment available to members of ethnic minorities in the United States.
- There are significant gaps in the available research about the way in which mental illness affects racial and ethnic groups.
- Exposure to racism, discrimination, violence and poverty place minorities at risk for mental disorders such as depression and anxiety.
- Cultural misunderstandings or communication problems between patients and clinicians may prevent minorities from using services and receiving appropriate care.
- “It is essential that efforts to reduce racial and ethnic disparities in mental health care include strategies to strengthen families” p. 168.
- “The term **competence** places the responsibility on mental health service organizations and practitioners – most of whom are white – and challenges them to deliver **culturally appropriate services**” p.36. Cultural competence is not the responsibility of those seeking treatment.
- Tailoring services to the specific needs of racial and ethnic minority groups will improve utilization and outcomes of services.

(U.S. DHHS, 2001)

Although linguistically appropriate services fall under the broader framework of cultural competency, it deserves special attention because of the legal requirements under Title VI of the Civil Rights Act of 1964. Title VI exists to ensure that no individual be subjected to discrimination on the basis of race, color, or national origin under any program that receives Federal financial assistance.

Title VI requires all organizations that receive Federal financial assistance from the Department of Health and Human Services take steps to ensure limited English proficient (LEP) persons have meaningful and equal access to benefits and services. Organizations that receive assistance, either directly or indirectly, through a grant, contract or subcontract, are covered by Title VI. Some examples of those covered include **hospitals, health service providers, and human service organizations.**

Title VI requires all organizations that receive Federal financial assistance from the Department of Health and Human Services take steps to ensure limited English proficient (LEP) persons have meaningful and equal access to benefits and services.

A program of language assistance should provide for effective communication between the provider and the LEP individual in order to facilitate participation in, and meaningful access to services. At a minimum, effective programs should have four elements: an evaluation of the language needs of the population being served, a written policy on language access, staff training, and monitoring.

Effective communication is the key to ensuring meaningful access to LEP persons. There are various options for providing oral language assistance. Some options include hiring bilingual staff for client contact positions, hiring staff interpreters, contracting for interpreter services, or contracting with a telephone interpreter service.

Four Elements of Effective Programs

At a minimum, effective programs should have:

- An evaluation of the language needs of the population being served
- A written policy on language access
- Staff training
- Monitoring of the program

Studies have shown that psychiatric patients with limited English proficiency underutilized specialty services. Limited English proficiency among poor Latinos may contribute to their lower use of specialty services than that of poor African Americans or whites who have no linguistic barriers. If an LEP individual cannot gain access to a bilingual provider, he or she may not seek specialty care (Alegria, et. al., 2002).

BENCHMARKS OF CULTURAL COMPETENCY

The following are modified benchmarks of cultural competency as developed by the Center for the Study of Issues in Public Mental Health (Siegel, et al., 2002). The Center for the Study of Issues in Public Mental Health (CSIPMH) promotes the integration of research, policy and practice in public mental health. Established in 1993 under a grant from the National Institute of Mental Health, this organization has a very comprehensive list of cultural competency guidelines. The following benchmarks are recommended for organizations that are seeking to create a culturally sensitive environment and provide culturally competent services to ethnic or racial populations.

CSIPMH BENCHMARKS OF CULTURAL COMPETENCY

Mission statement must include a goal of achieving CC - cultural competency

A CC plan must exist if there is at least one threshold-level cultural group in the target population (a threshold level cultural group is a cultural group that numbers 5 percent or more of the target population)

A person responsible for CC must be named and must coordinate with quality assurance

There is an identifiable provision of monies earmarked for CC activities

Board of directors must contain members from the three most predominant cultural groups in the target population

Quality assurance programs must be required to monitor cultural competence

A CC Advisory Committee must exist if there is at least one threshold-level cultural group in the target population

The agency must obtain population-level data for its target population on characteristics such as race, ethnicity, age, gender, education, poverty-level, income, employment, and languages spoken other than English

The agency must have “contact” information on at least one religious/spiritual entity in the service area for each predominant cultural group

The agency must have a systematic way of collecting and aggregating data on its users

Telephone instructions must be available in language of predominant cultural group

Language assistance must be available at all points of service delivery for persons with limited English proficiency

CULTURAL COMPETENCY

The agency must provide evidence that recruitment procedures have been used to obtain bilingual staff of the threshold culture

All persons used as interpreters, including bilingual staff, must be assessed for the competence of language assistance with topics that are specific to the service provided

The agency must provide written information in languages other than English

Vital forms such as applications and consent forms must be available in the language of the threshold cultural group

Culture-specific services and interventions must be provided

Transportation assistance is made available for persons who indicate a need

The service site must be open evenings and/or weekends or special accommodations must be made on an individual basis for persons who indicate a need

In addition to signage and posted information, there must be magazines, newspapers, posters, art work or other decorative features that reflect the cultures of threshold-level cultural groups of service users

Culture/race/ethnicity must be incorporated into continuing professional education and other training

Employee orientation and training material must include CC policies

The agency must have representatives from the predominant cultural group of the target population in leadership and executive management levels

The agency must have representatives from the predominant cultural group of service users among direct clinical staff

Recruitment strategies must mention that bilingual skills and/or prior experience with threshold-level cultural user group is desirable

Staff performance evaluation must include items related to CC

Outcome data can be analyzed for specific cultural groups within programs

Source: Siegel et al., 2002, CSIPMH

DEMOGRAPHICS

OVERVIEW OF DEMOGRAPHICS

NATIONAL STATISTICS

JACKSON COUNTY, MISSOURI STATISTICS

MENTAL HEALTH SERVICES IN JACKSON COUNTY

OVERVIEW OF DEMOGRAPHICS

According to a report done by the Substance Abuse and Mental Health Services Administration (SAMHSA), “Latinos have been adversely affected by under-education, under-employment, inadequate housing, and insufficient access to health care insurance” (SAMHSA, 2000). As the following demographics show, this is not just a problem in a few select areas of the United States; it is a national concern. The state of Latino education, housing, poverty, and other issues discussed in national publications and statistics is also reflected in the local demographics. These issues

“Latinos have been adversely affected by under-education, under-employment, inadequate housing, and insufficient access to health care insurance.”

- SAMSHA, 2000

have real implications in providing a variety of services to Hispanics in Kansas City and beyond. The Census Bureau recently announced that the Hispanic population is the second largest population in the United States, and the largest minority population. This information is reflected in the local statistics showing the rapid growth in the Hispanic population between the 1990 and 2000 census (see Figure 9).

Local service agencies must meet the demands of this rapidly growing Latino population. The housing, education, employment and health care issues affecting the Hispanic population in Jackson County need to be addressed. Immigrants face additional factors. Many enter the country without proper documentation. Lack of documentation makes it difficult to obtain jobs or advance in them, and many live in constant fear of deportation. Many immigrants arrive in the U.S. as unskilled laborers or displaced agricultural workers and lack the social and economic resources that would help to ease their adjustment (U.S. DHHS, 2001).

Nationally and locally, individuals of Mexican origin make up the largest proportion of Latinos (see Table 1). Many Hispanics share the common bonds of Spanish language and cultural influences but there are differences that must be recognized among the groups. Mexicans have been residents of the U.S. longer than any other Latino subgroup. Both push and pull factors have contributed to the growth of the immigrating population. Economic hardships in Mexico as well as the need for laborers in the U.S. have drawn large numbers of individuals. Mexican immigration is distinguished from other subgroups in part due to the great numbers, over seven million, and due to the fact that many individuals come into the U.S. without documentation. Another distinguishing factor is that only 15 percent of Mexican immigrants have become U.S. citizens (U.S. Census Bureau, 1998). This percentage is significantly smaller than other subgroups; slightly more than half of Cuban immigrants have gained citizenship status.

As a group, Latinos have less formal education than the national average. Nationally, of those over 25 years old, 53 percent have graduated from high school, and only 15 percent have graduated from college (see Figure 2). Locally in Jackson County, the numbers are very similar; 42 percent have graduated from high school and 15 percent have graduated from college (see Figure 12). These numbers are contrasted with the national average of 83 percent graduating from high school and 25 percent graduating from college (U.S. Census Bureau, 2000). Latino youth are at an increased risk of dropping out of school. Early identification of mental health problems in ethnic minority youth, combined with effective referral and service delivery have long-term implications for preventing academic failure (Barbarin, 2002).

High levels of poverty are also prevalent in the Hispanic community. In Jackson County, only six percent of Latinos are unemployed (U.S. Census Bureau, 2000). Unfortunately, Hispanic workers are concentrated in low-paying jobs. Mexicans are the least likely among Hispanic subgroups to work in managerial or professional occupations (NCLR, 2001). Due in part to limited job opportunities, 19 percent of Latinos in Jackson County live below the poverty line (see Figure 11). Their unemployment and low-paying jobs also contribute to Latino's lack of health insurance. Consequently, health issues are also a major concern for the Hispanic population.

Both nationally and locally, Latino culture is rich with tradition and heritage. Unfortunately, many Hispanics in the United States and in Kansas City suffer from low-paying jobs, lack of insurance, low levels of education, and poor access to mental health services. The following pages contain detailed statistics and information from the Census Bureau on the Hispanic community nationally, locally and then information on Hispanics accessing mental health in Jackson County. For more sources of information on Latino mental health, education, health, employment, housing and political representation, see Appendix A.

NATIONAL STATISTICS

From 1990 to 2000, the number of Latinos in the U.S. grew by 58 percent to reach 35 million people. The Hispanic population increase was a substantially larger share than the percentage increase by either white or African American populations. In fact, the Census Bureau estimates as of July 1, 2003, the Latino population will be 38.8 million, the nation's largest minority population.

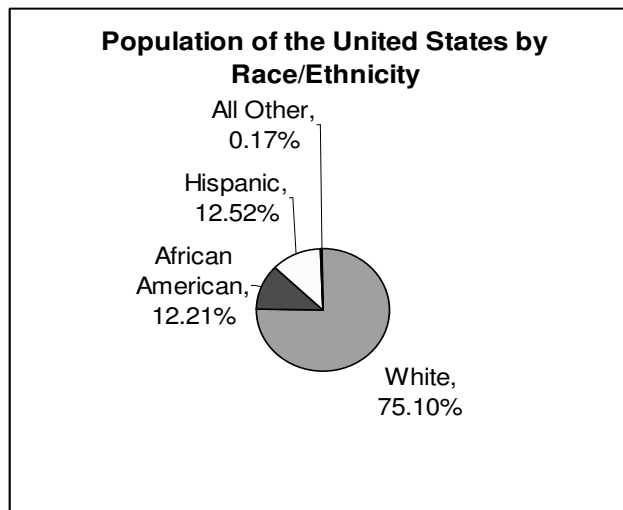
CSIPMH Benchmark of Cultural Competency

The agency must obtain population-level data for its target population on characteristics such as race, ethnicity, age, gender, education, poverty level, income, employment, and languages spoken other than English.

Population of the United States by Race/Ethnicity

As figure 1 shows, the Hispanic population makes up 12.52 percent of the total population of the United States.

Figure 1



Source: U.S. Census Bureau, Census 2000

When the Hispanic population in the United States (13 percent) is combined with the African American population (12 percent) and other minority populations, they make up one-quarter of the United States population.

Distribution of United States Hispanic Population by Subgroup

The following table presents the subgroups of the Latino population in 1990 and 2000, revealing the largest Latino subgroup as Mexicans, which now make up 58.5 percent of the total Hispanic population (see Table 1).

Table 1

Latino Subgroup	1990	2000
Mexican	61.2%	58.5%
Puerto Rican	12.1%	9.6%
Cuban	4.8%	3.5%
Central American	6.0%	4.8%
South American	4.7%	3.8%
All Other Hispanic	8.8%	17.6%

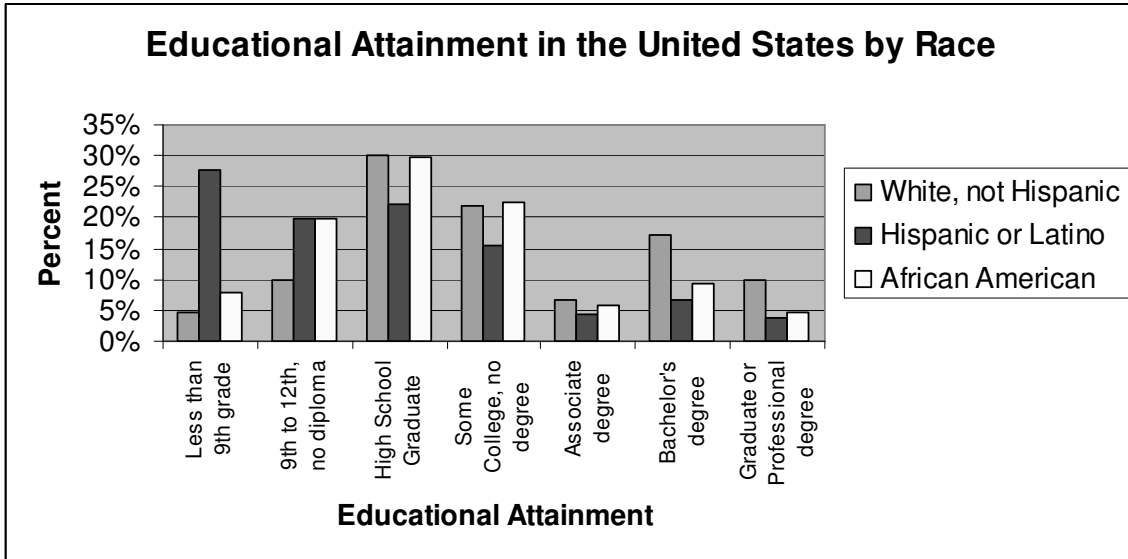
Source: U.S. Census Bureau, Census 2000

In the year 2000, Mexicans made up 58.5 percent of the total Hispanic population. The category of other Hispanics has grown significantly in the past decade from 8.8 percent to 17.6 percent. A possible explanation for this increase is individuals of Caribbean descent.

Educational Attainment in the United States by Race

Figure 2 shows that over 25 percent of the Hispanic population in the United States above age 25 have obtained less than a ninth grade education.

Figure 2



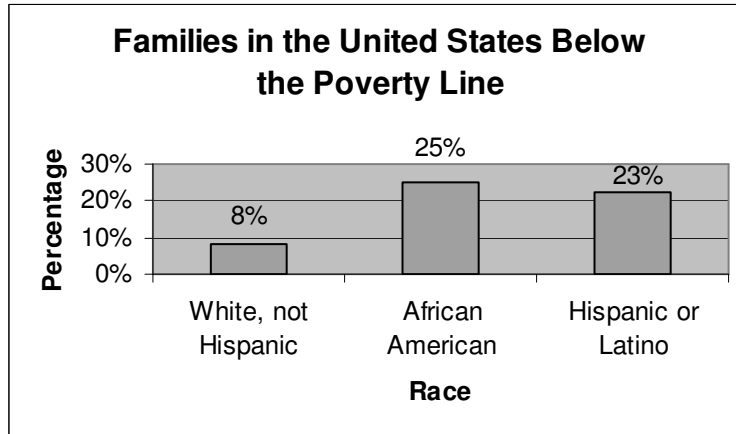
Source: U.S. Census Bureau, Census 2000

There are great differences in educational attainment among the Hispanic, African American and white populations. The Hispanic population has the greatest percentage of individuals with less than a ninth grade education, and the lowest percentage of individuals with a high school diploma and any kind of college education.

Families in the United States Below the Poverty Line

Figure 3 presents the percent of families in the United States below the poverty line. The Hispanic population has 23 percent living below the poverty line.

Figure 3



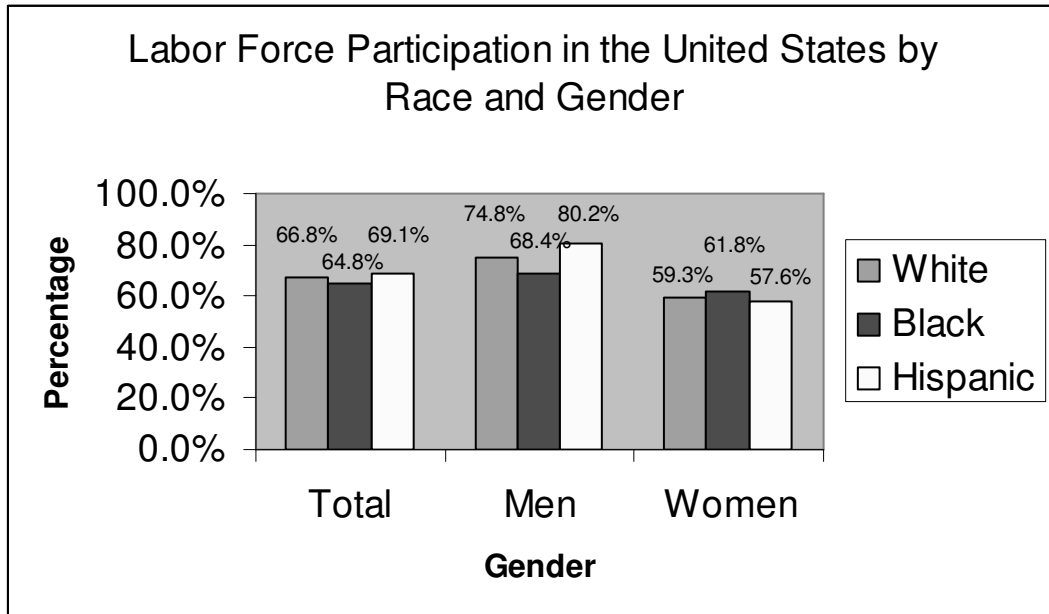
Source: U.S. Census Bureau, Census 2000

Hispanic and African American populations in the U.S. have a much higher percentage of families below the poverty level. Both Hispanic and African American populations have greater than 20 percent living below the poverty line while the white, non-Hispanic population has only 8 percent living below the poverty line.

Labor Force Participation in the United States by Race and Gender

The following figure presents the percentages of the population in the United States participating in the labor force, with the Hispanic population making up 69.1 percent of the labor force.

Figure 4



Source: U.S. Census Bureau, Current Population Survey, March 2000; U.S. Bureau of Labor Statistics

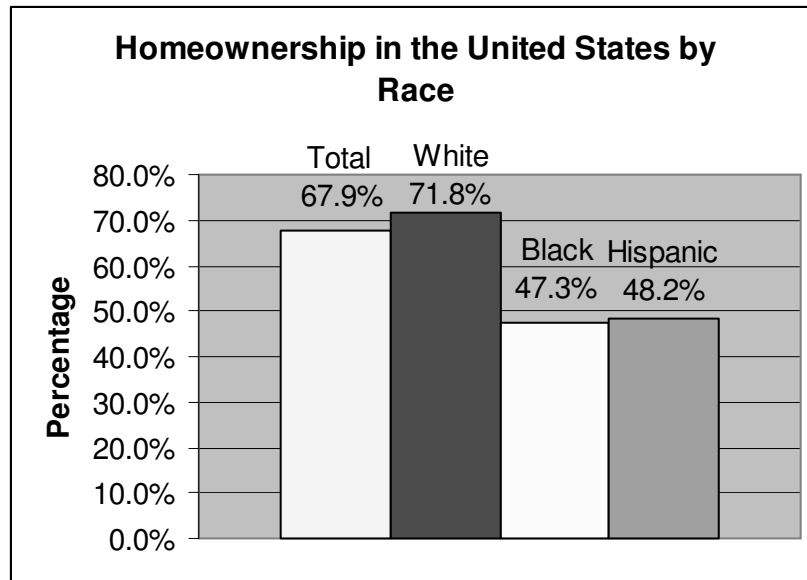
According to figure 4, the percentage of the Hispanic population over age 16 in the labor force (69.1 percent) is the highest total percentage. The percentage of Hispanic men in the labor force is also the highest percentage at 80.2 percent.

The numbers that make up the labor force include civilian, noninstitutionalized individuals currently employed or unemployed, and actively seeking employment.

Homeownership Rates in the United States by Race, 2002

Figure 5 shows the homeownership rates in the United States with the homeownership rate for the Hispanic population at 48.2 percent.

Figure 5



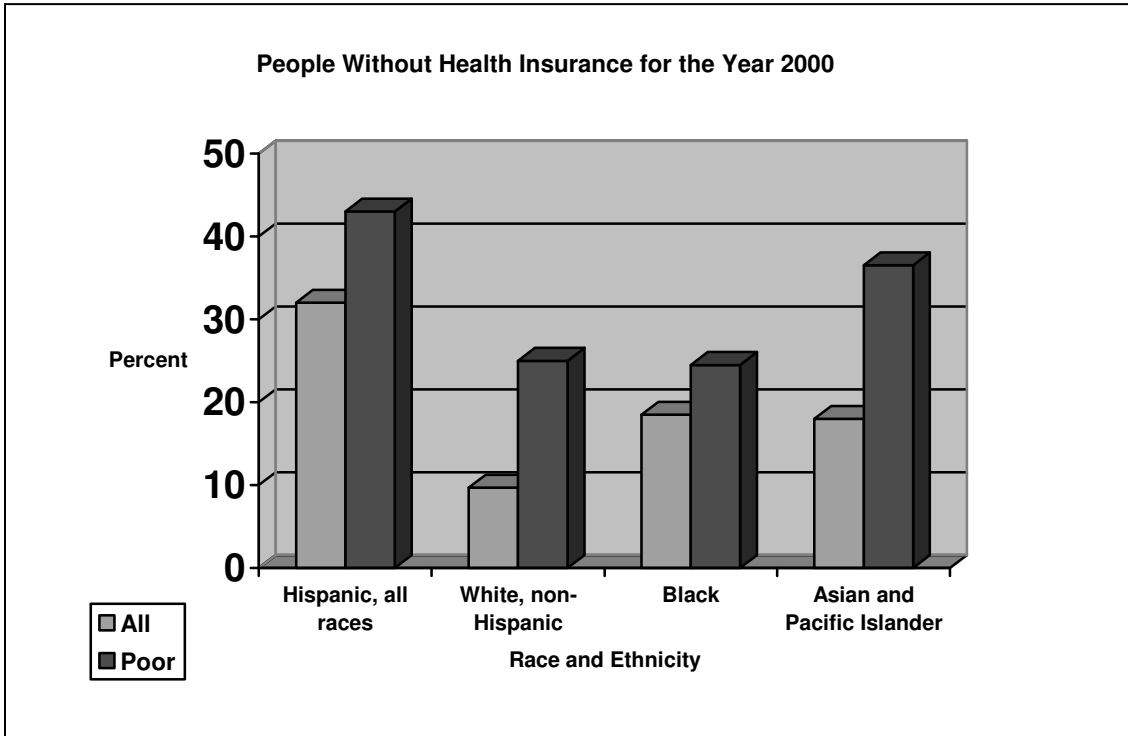
Source: U.S. Census Bureau, Housing Vacancy Survey, 2002

The homeownership rates in the United States are much higher for the White population and the total population when compared to the Black and Hispanic populations (see Figure 5). The homeownership rate for the entire United States is 67.9 percent, while the Black and Hispanic populations are much lower at a rate of 47.3 and 48.2 percent, respectively.

People Without Health Insurance for the Year 2000

The following graph presents the percent of people in the United States without health insurance. The Hispanic population has 32 percent without health insurance.

Figure 6



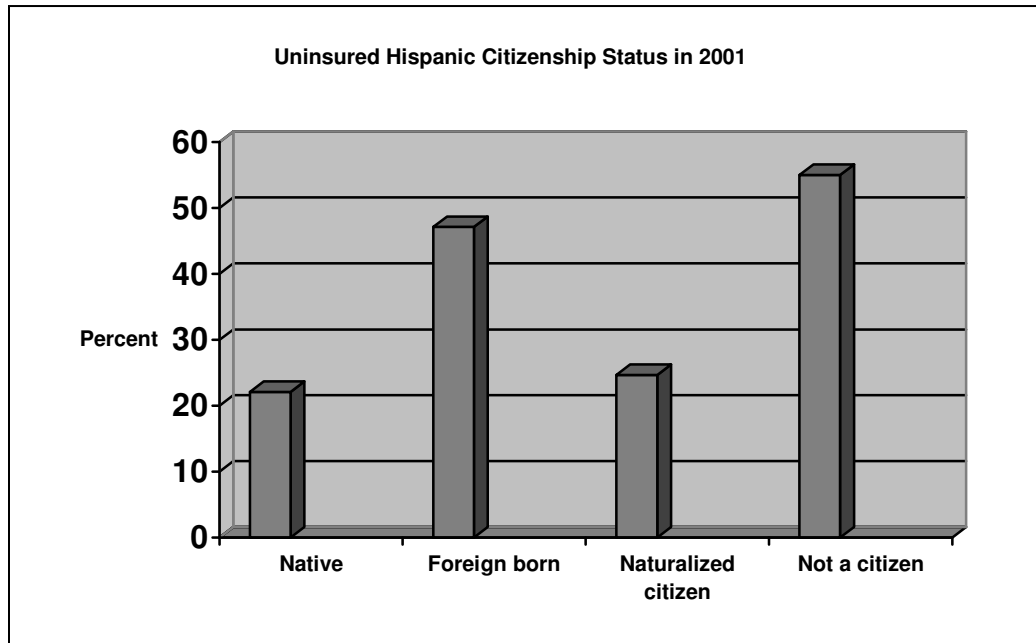
Source: U.S. Census Bureau, Health Insurance Coverage Status, 2001

Figure 6 shows the percent of the Hispanic population without health insurance as 32 percent, the highest percentage of all races or ethnicities represented. The Hispanic poor also make up the highest percentage of poor populations without health insurance at 43 percent.

Uninsured Hispanic Citizenship Status in 2001

Figure 7 shows the uninsured Hispanic population in the United States by citizenship status, with the category of “not a citizen” showing the highest percentage of 55 percent.

Figure 7



Source: U.S. Census Bureau, Health Insurance Coverage Status, 2001

The highest percentages of the Hispanic population without health insurance are those considered “not a citizen” at 55 percent and “foreign born” at 47 percent.

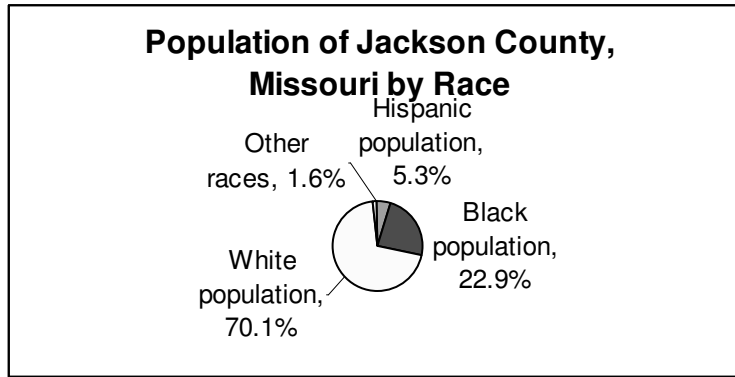
JACKSON COUNTY, MISSOURI STATISTICS

Jackson County, Missouri has a total population of approximately 650,000.

Population of Jackson County, Missouri by Race

The following graph presents the population of Jackson County, where Hispanics make up slightly more than five percent of the population (see Figure 8).

Figure 8



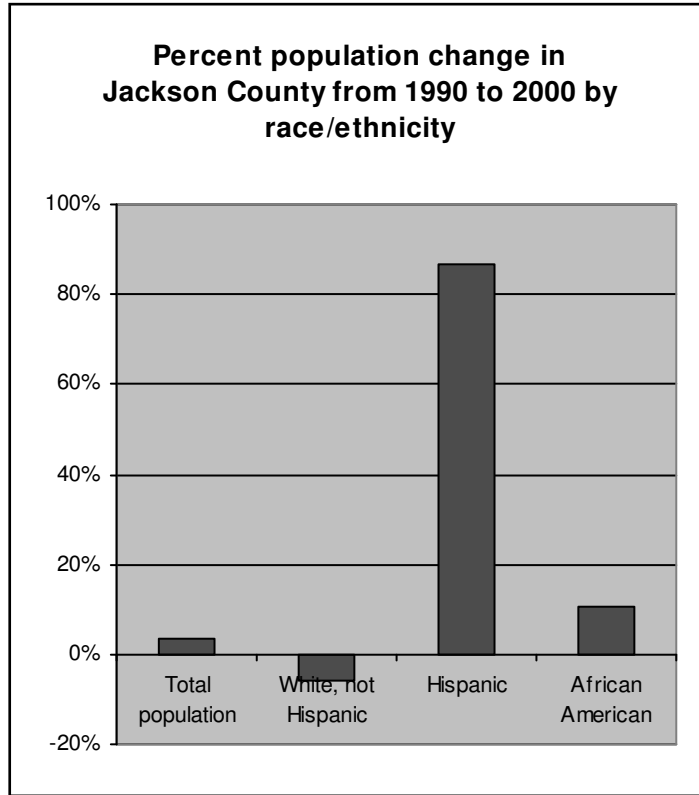
Source: U.S. Census Bureau, Census 2000

The minority populations in Jackson County, made up of 5.3 percent Hispanics and 22.9 percent African Americans along with 1.6 percent other races, are approximately 30 percent of the total population, higher than the national average of 25 percent.

Percent Population Change in Jackson County from 1990 to 2000 by Race/Ethnicity

Figure 9 shows the percent population change in Jackson County from 1990 to 2000, with the Hispanic population increasing by 87 percent.

Figure 9



Source: U.S.Census Bureau, Census 1990, 2000

Immigrant groups are most likely to settle in a place where there is a presence established by their nationality or ethnic background, where the support systems are already in place.

- Manny Trillo, MARC

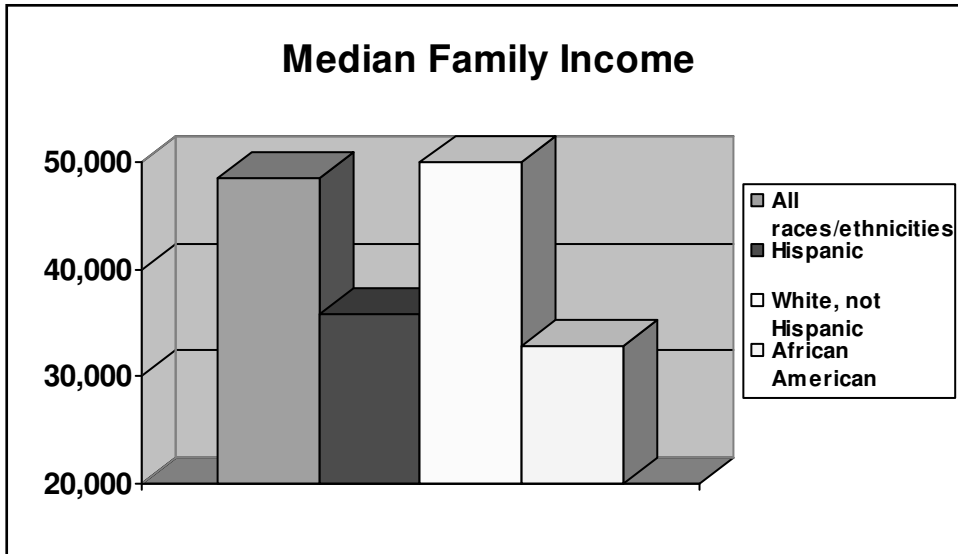
Although 5 percent seems to be a relatively small percentage for the Hispanic population in Jackson County (see Figure 8), it is notable that the Latino population in Jackson County nearly doubled since the 1990 census, growing from 18,689 to 34,925 in 2000. As Figure 9 shows, the Hispanic population has grown noticeably larger while the white population has decreased and the black population has grown slightly.

Manny Trillo from the Mid-America Regional Council (MARC) attributes this rapid growth to the established Hispanic community and supports in place for jobs, education, medical assistance, and other opportunities in the Kansas City area. “All immigrant groups follow this pattern: they settle where there may already be a presence established by their nationality and/or ethnic background because the support systems are already in place” (M. Trillo, personal communication, June 16, 2003).

Median Family Income

The following graph shows the median income of families in Jackson County in 1999, with the median income for Hispanic families at \$35,885.

Figure 10



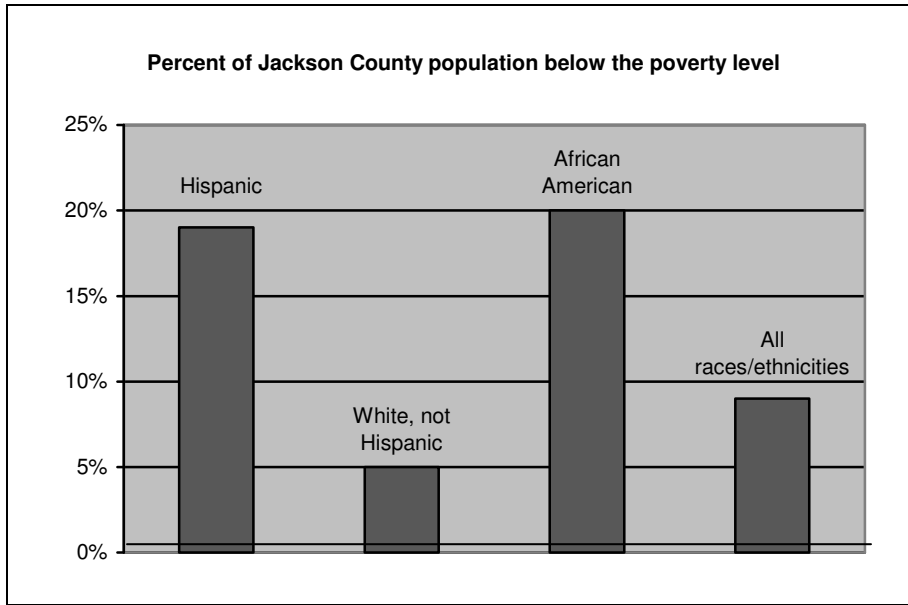
Source: U.S. Census Bureau, Census 2000

In 1999, the median family income for all race and ethnic groups in Jackson County was \$48,435; the median family income for Hispanic families was \$35,885 (see Figure 10), a significant difference of 26 percent.

Percent of Jackson County Population Below the Poverty Level

Figure 11 shows the percent of the population of Jackson County below the poverty level, with the Hispanic population at 19 percent.

Figure 11



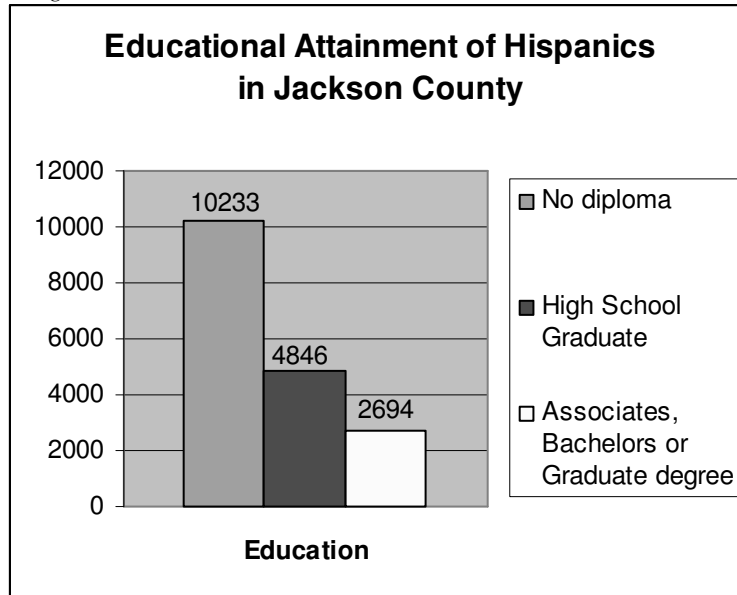
Source: U.S. Census Bureau, Census 2000

Nineteen percent of families with a Hispanic householder were below the poverty level, as compared to the average of nine percent for all races and ethnicities.

Educational Attainment of Hispanics in Jackson County

The following chart presents the educational attainment of Hispanics in Jackson County over the age of 25; 10,233 Latinos or 57 percent of the Hispanic community has not graduated from high school.

Figure 12



Source: U.S. Census Bureau, Census 2000

Figure 12 shows that 10,233 persons or 57 percent of the Hispanic community in Jackson County have not graduated from high school. There are 4846 persons, or 27 percent who have graduated from High School and only 2694, or 15 percent of Hispanics in Jackson County have received an Associates, Bachelors or Graduate degree.

Kansas City, Missouri School District Enrollment 2002-2003

The following chart shows the enrollment in the Kansas City, Missouri School District, with Latino high school enrollment as 588, or 11 percent of total enrollment.

Kansas City, Missouri School District Enrollment 2002-2003

Table 2

	<i>Latino Enrollment</i>	<i>Total Enrollment</i>	<i>% Latino</i>
<i>High School</i>	588	5282	11%
<i>Middle School</i>	632	5059	12%
<i>Elementary School</i>	2667	16812	16%
<i>Total</i>	3887	27153	14.3%

Source: Kansas City, Missouri School District

Latino high school enrollment for the 2002-2003 school year in the Kansas City, Missouri School District, which serves all of Jackson County, was 11 percent of total enrollment. Latino middle school enrollment was 12 percent of the total and Latino elementary school enrollment was 16 percent of the total, showing a growing number of Latino students in the Kansas City, Missouri School District (see Table 2). Latinos enrolled in elementary school make up 69 percent of the total Latinos enrolled in the Kansas City, Missouri School District.

Latino Graduates in the Kansas City, Missouri School District

The following chart shows the Latino graduates from the Kansas City, Missouri School District from 1999 to 2002.

Latino Graduates in the Kansas City, Missouri School District

Table 3

	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>
<i>Latino Grads</i>	63	57	54	56
<i>Total Grads</i>	1077	914	696	885
<i>% Latino</i>	5.8%	6.2%	5.6%	6.3%

Source: Kansas City, Missouri School District

As table 3 shows, the number of Latino graduates in 1999 was 63, and the number in 2002 was 56.

**Latino Enrollment and Graduation for the Kansas City, Missouri School District
2002-2003 School Year**

Table 4 shows the Latino enrollment and graduation for the Kansas City, Missouri School District for the 2002-2003 School year, with the numbers decreasing significantly from tenth grade to students who graduated.

*Latino Enrollment and Graduation for the Kansas City, MO School District
2002-2003 School Year**Table 4*

<i>Grade</i>	<i># Latino Students</i>
7	291
8	236
9	282
10	146
11	89
12	92
<i># who Graduated</i>	59

Source: Kansas City, Missouri School District

For the 2002-2003 school year, there were 291 Latino students enrolled in seventh grade, but only 59 Latino students graduated. These numbers show a very high dropout rate among Latinos in Jackson County, and seem to coincide with the previously shown low economic status of many Latino families in Jackson County.

Heavy Populated Schools in the Kansas City, Missouri School District 2002-2003

The following chart shows the schools in the Kansas City, Missouri School District that are heavily populated by Latino students.

Heavy Populated Schools in the KC, MO School District 2002-2003

Table 5

High Schools	Number of Latinos	% Latino
<i>Northeast High</i>	298	25%
<i>Van Horn High</i>	214	21%
Middle Schools		
<i>Northeast Middle</i>	258	35%
<i>Rogers Middle</i>	209	33%
Elementary Schools		
<i>Garcia</i>	297	61%
<i>McCoy</i>	184	60%
<i>Scarritt</i>	218	60%
<i>James</i>	219	56%
<i>Gladstone Academy</i>	305	55%
<i>Whittier</i>	203	47%
<i>East</i>	313	40%

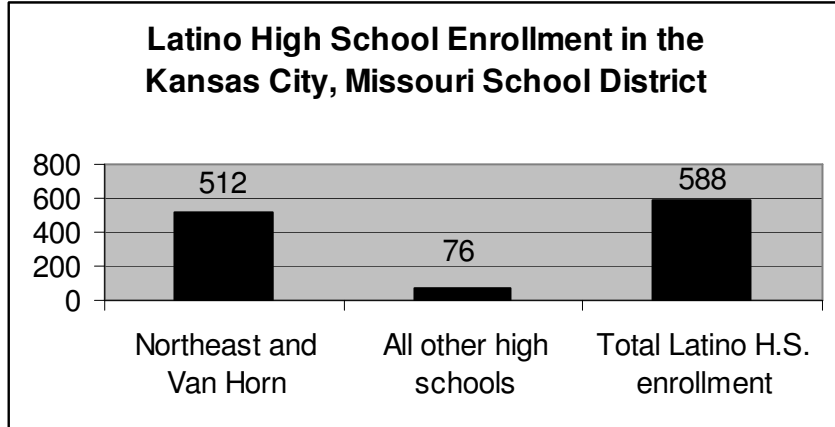
Source: Kansas City, Missouri School District

Table 5 shows several elementary schools in the Kansas City, Missouri School District have a Latino population of 60 percent or higher. Two middle and two high schools have Latino populations of over 20 percent.

Latino High School Enrollment in the Kansas City, Missouri School District

Figure 13 shows Latino high school enrollment in Kansas City: 518 out of 588 Latino students attend Northeast and Van Horn High Schools.

Figure 13



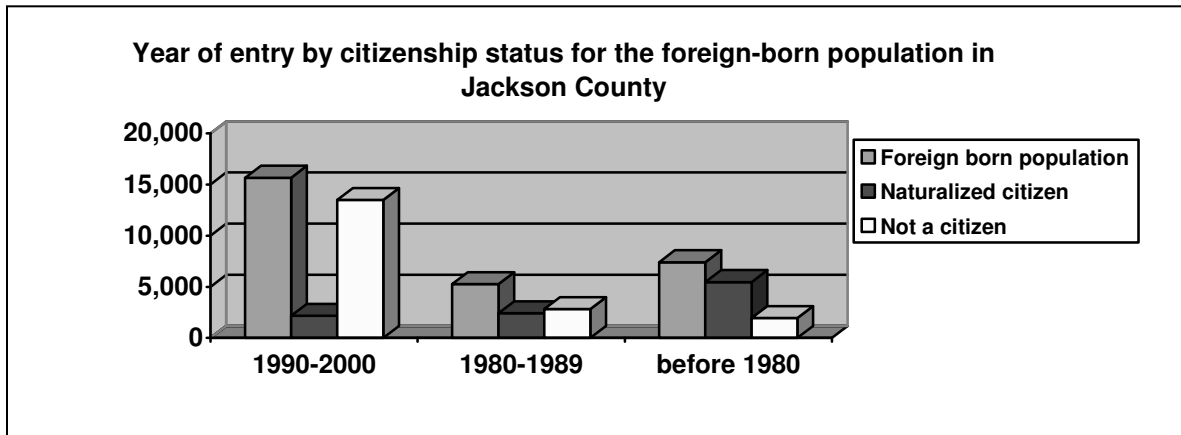
Source: Kansas City, Missouri School District

In the Kansas City, Missouri School District, 2 of the 9 high schools enroll 87 percent of the Latino population. 2 of the 10 Middle Schools enroll 74 percent of the Latino population, and 7 of the 50 Elementary Schools enroll 65 percent of the Latino population.

Year of Entry by Citizenship Status for the Foreign-Born Population in Jackson County

Figure 14 shows the citizenship status and year of entry for foreign-born residents of Jackson County. Of the foreign born who entered the U.S. between 1990 and 2000, 78 percent, or 13,500 are not U.S. citizens.

Figure 14



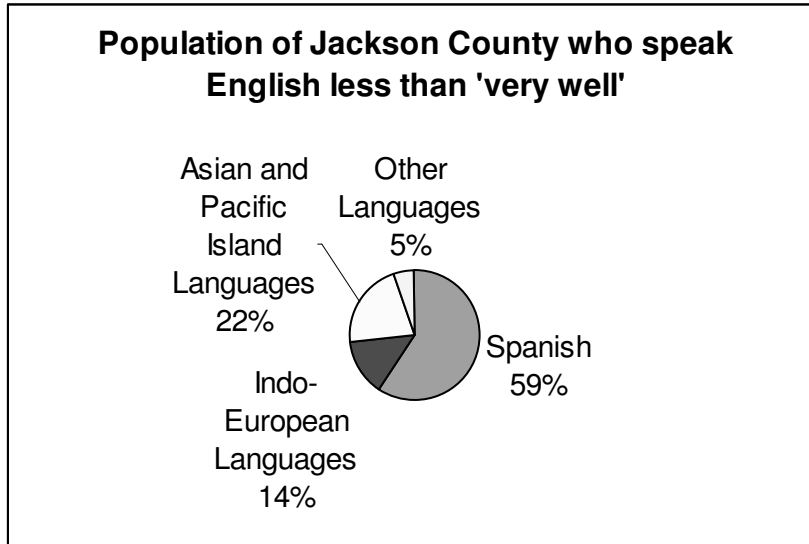
Source: U.S. Census Bureau, Census 2000

Thirty-five percent of Latinos living in Jackson County are foreign born; 78 percent of those individuals are not citizens. That translates into over 9,500 Latinos in Jackson County who are not citizens of the United States.

Population of Jackson County Who Speak English Less Than “Very Well”

The following chart shows individuals in Jackson County who speak English less than “very well” with 59 percent of those individuals speaking Spanish.

Figure 15



Source: U.S. Census Bureau, Census 2000

Of the population five-years-old and over residing in Jackson County who speak English less than “very well” 59 percent speak Spanish (see Figure 15). This is the largest percentage of individuals who do not speak English well in Jackson County. When compared to the total Latino population in Jackson County of 34,925, this statistic is noteworthy.

MENTAL HEALTH SERVICES IN JACKSON COUNTY

The following information documents the number of individuals being served by Jackson County Mental Health Levy Providers in a period of six months as recorded in the organization’s most recent report to the Mental Health Levy. Tables 4 through 8 show the numbers and percentages served in Jackson County and then for each of the four Mental Health Levy catchment areas (#2-5). Pages 40-42 contain maps outlining the catchment areas and the Hispanic population in Jackson County, as well as Spanish and other language speaking individuals.

**Individuals Served by Jackson County Mental Health Levy Providers
Total for Jackson County – All Catchment Areas**

Table 6

Total # of Clients Served	% of Hispanics Served	# of Hispanics Served	% of African Americans Served	# of African Americans Served	% of Caucasian Served	# of Caucasian Served
32616	3.22%	1051	42.00%	13699	53.1%	17320

Source: Jackson County, Missouri Mental Health Levy

Mental Health Catchment Area #2

Table 7

Total # of Clients Served	% of Hispanics Served	# of Hispanics Served	% of African Americans Served	# of African Americans Served	% of Caucasian Served	# of Caucasian Served
24952	3.00%	748	42.47%	10598	52.72%	13154

Source: Jackson County, Missouri Mental Health Levy

Service Providers in Catchment Area #2:

- Budget and Financial Management Assistance
- Catholic Charities of Kansas City
- Child Advocacy Services
- DeLaSalle Education Center
- Goodwill
- Jewish Vocational Services
- Kansas City Free Health Clinic
- Mattie Rhodes Center
- Marillac
- Metropolitan Lutheran Ministry Homeless Services
- MOCSA
- National Alliance for the Mentally Ill in Kansas City
- Niles Home for Children
- ReStart
- Salvation Army Children’s Shelter
- Samuel U. Rogers Mental Health Clinic
- Truman Behavioral Health Network

DEMOGRAPHICS

Mental Health Catchment Area #3

Table 8

Total # of Clients Served	% of Hispanics Served	# of Hispanics Served	% of African Americans Served	# of African Americans Served	% of Caucasian Served	# of Caucasian Served
3352	3.16%	106	74.17%	2486	22.58%	757

Source: Jackson County, Missouri Mental Health Levy

Service Providers in Catchment Area #3:

Genesis School
 Gillis
 Jewish Family and Children Services
 Kansas City Hospice
 Rose Brooks Center
 Swope Parkway Health Center

Mental Health Catchment Area #4

Table 9

Total # of Clients Served	% of Hispanics Served	# of Hispanics Served	% of African Americans Served	# of African Americans Served	% of Caucasian Served	# of Caucasian Served
1479	6.89%	102	22.17%	328	70.84%	1048

Source: Jackson County, Missouri Mental Health Levy

Service Providers in Catchment Area #4:

Crittenton
 Research Mental Health Services
 Spofford
 Ozanam

Mental Health Catchment Area #5

Table 10

Total # of Clients Served	% of Hispanics Served	# of Hispanics Served	% of African Americans Served	# of African Americans Served	% of Caucasian Served	# of Caucasian Served
2833	3.36%	95	10.16%	288	83.36%	2361

Source: Jackson County, Missouri Mental Health Levy

Service Providers for Catchment Area #5:

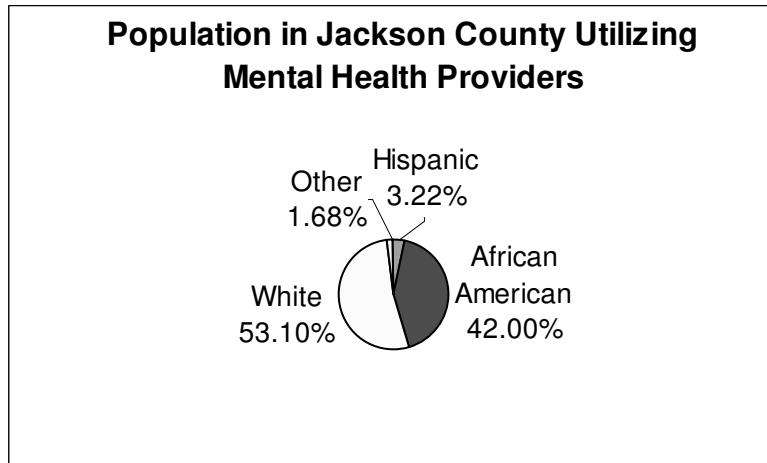
CAPA – Child Abuse Prevention Association
 Comprehensive Mental Health Services, Inc.
 Heart of America Family Services
 Hope House
 Steppingstone

The data for # and % of Hispanics served is high due to several organizations including Latinos in the “other” category for race/ethnicity. For more information on Jackson County Mental Health Levy Providers and their ability to serve non-English speaking clients, see Appendix B.

Population in Jackson County Utilizing Mental Health Providers

The following chart shows that 3.22 percent of individuals utilizing Mental Health Levy providers in Jackson County are Hispanic.

Figure 16



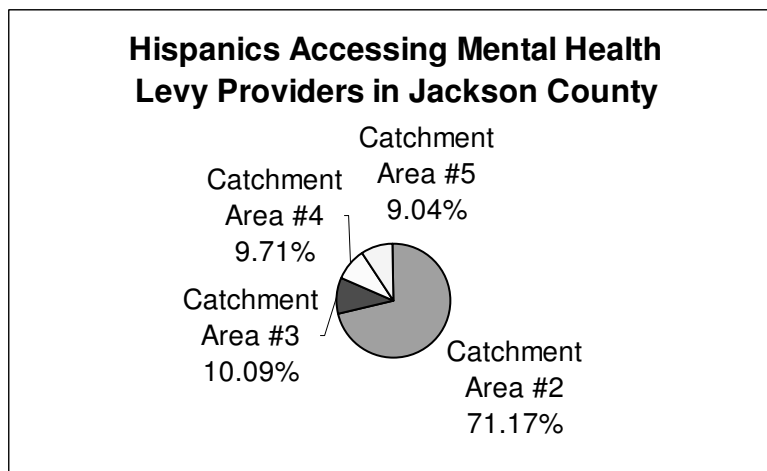
Source: Jackson County, Missouri Mental Health Levy

As Figure 16 shows, of the total population in Jackson County utilizing Mental Health Levy providers, 53.1 percent are white, 42 percent are African American and 3.22 percent are Hispanic.

Hispanics Accessing Mental Health Levy Providers in Jackson County

The following chart shows the number of Hispanics accessing mental health levy providers in Jackson County, separated by Catchment Area.

Figure 17



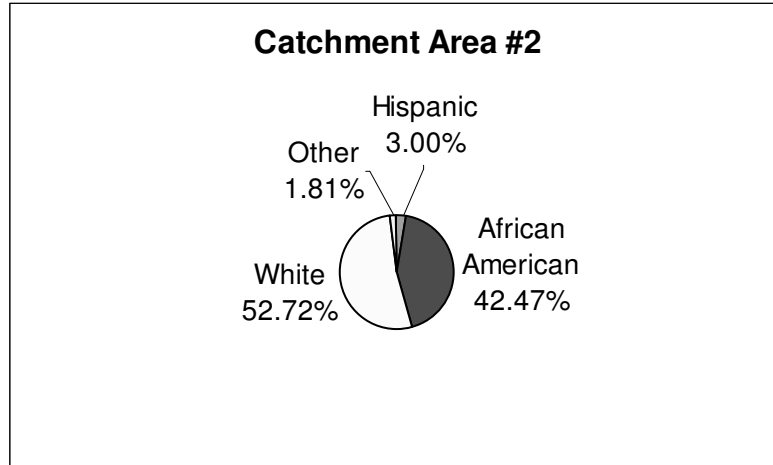
Source: Jackson County, Missouri Mental Health Levy

As figure 17 shows, 71.17 percent of Hispanics in Jackson County are accessing mental Health levy providers in Catchment Area #2.

Catchment Area #2

The following chart shows that 3 percent of individuals utilizing Mental Health Levy providers in Catchment Area #2 are Hispanic.

Figure 18



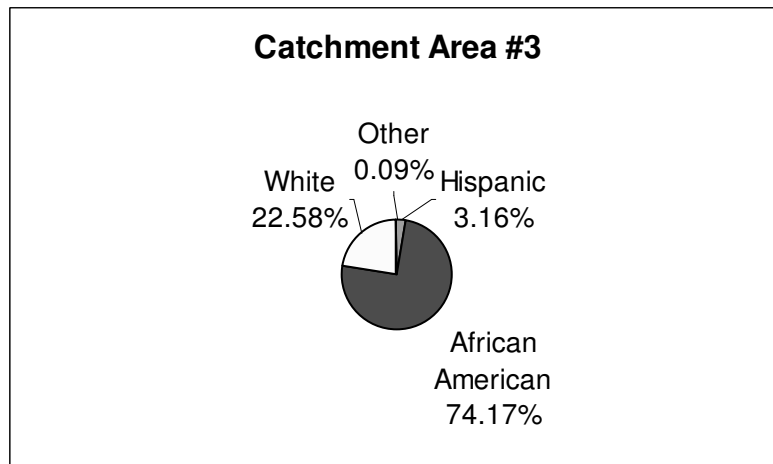
Source: Jackson County, Missouri Mental Health Levy

As Figure 18 shows, of the population in Catchment Area #2, 52.72 percent are white, 42.47 percent are African American and 3 percent are Hispanic.

Catchment Area #3

The following chart shows that 3.16 percent of individuals utilizing mental health levy providers in Catchment Area #3 are Hispanic.

Figure 19



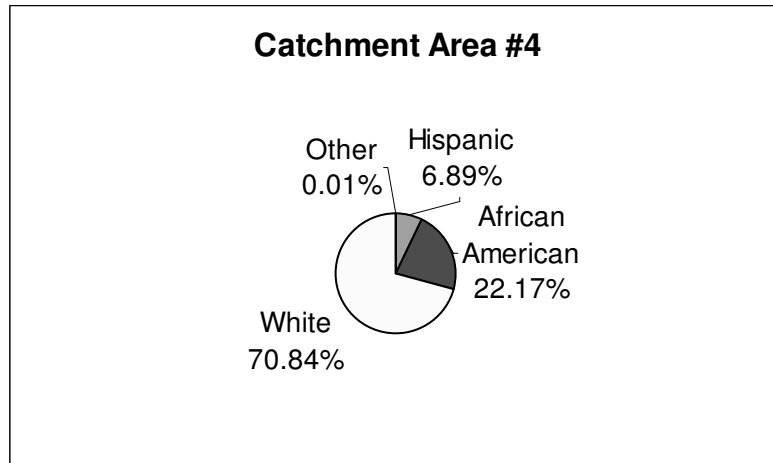
Source: Jackson County, Missouri Mental Health Levy

As Figure 19 shows, of the total population in Catchment Area #3 utilizing Mental Health Levy providers, 22.58 percent are white, 74.17 percent are African American and 3.16 percent are Hispanic.

Catchment Area #4

The following chart shows that 6.89 percent of individuals utilizing Mental Health Levy providers in Catchment Area #4 are Hispanic.

Figure 20



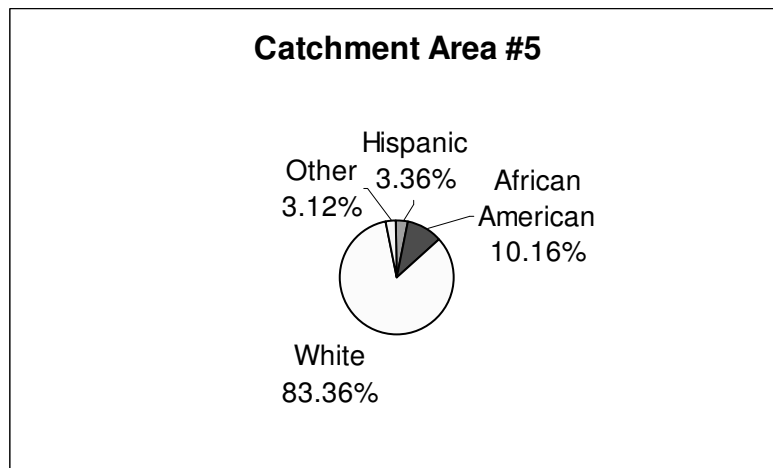
Source: Jackson County, Missouri Mental Health Levy

As Figure 20 shows, of the population in Catchment Area #4 utilizing Mental Health Levy providers, 70.84 percent are white, 22.17 percent are African American and 6.89 percent are Hispanic.

Catchment Area #5

The following chart shows that 3.36 percent of individuals utilizing Mental Health Levy providers in Catchment Area #5 are Hispanic.

Figure 21



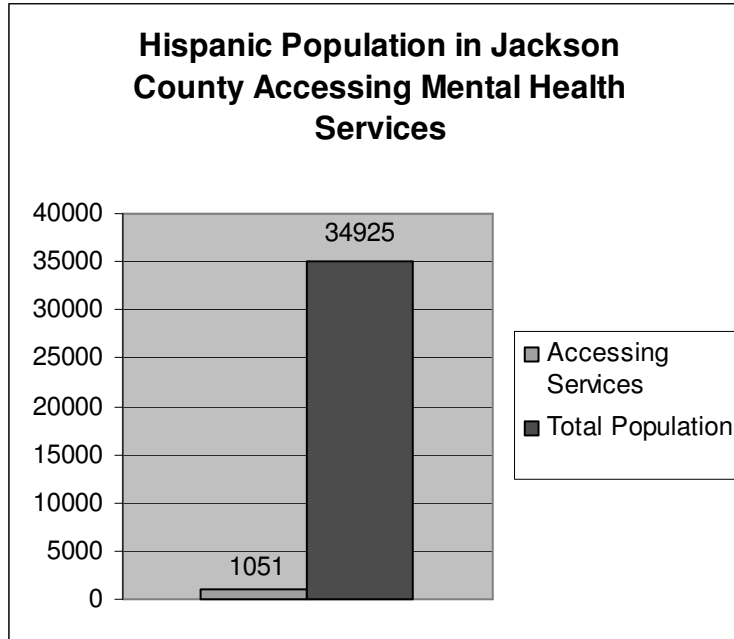
Source: Jackson County, Missouri Mental Health Levy

As Figure 21 shows, of the population in Catchment Area #5 utilizing Mental Health Levy providers, 83.36 percent are white, 10.16 percent are African American and 3.36 percent are Hispanic.

Hispanic Population in Jackson County Accessing Mental Health Services

The following graph shows the number of Hispanic individuals accessing Mental Health Levy services compared to the number of Hispanic individuals in Jackson County.

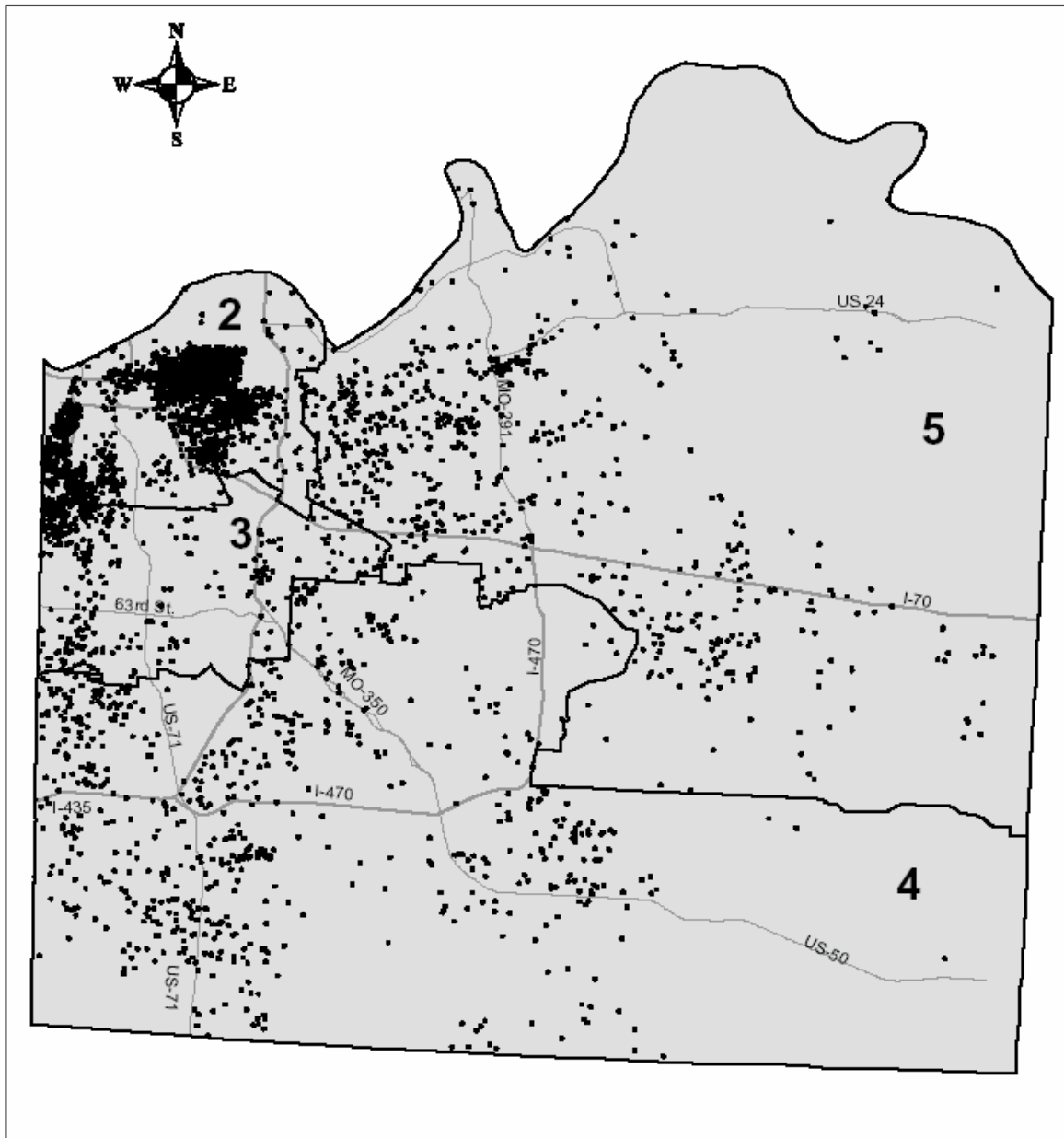
Figure 22



Source: Jackson County Mental Health Levy; U.S. Census Bureau, Census 2000

As Figure 22 shows, the total Hispanic population of Jackson County is 34,925 but only 1,051 Hispanics are accessing Mental Health Levy services, or 3.22 percent of the total population. According to the national average, one in five people suffer from a mental disorder, which equates to 6,985 Latinos in Jackson County, or 5,934 more individuals than are accessing mental health providers at this time.

Hispanic Population by Block Group, 2000



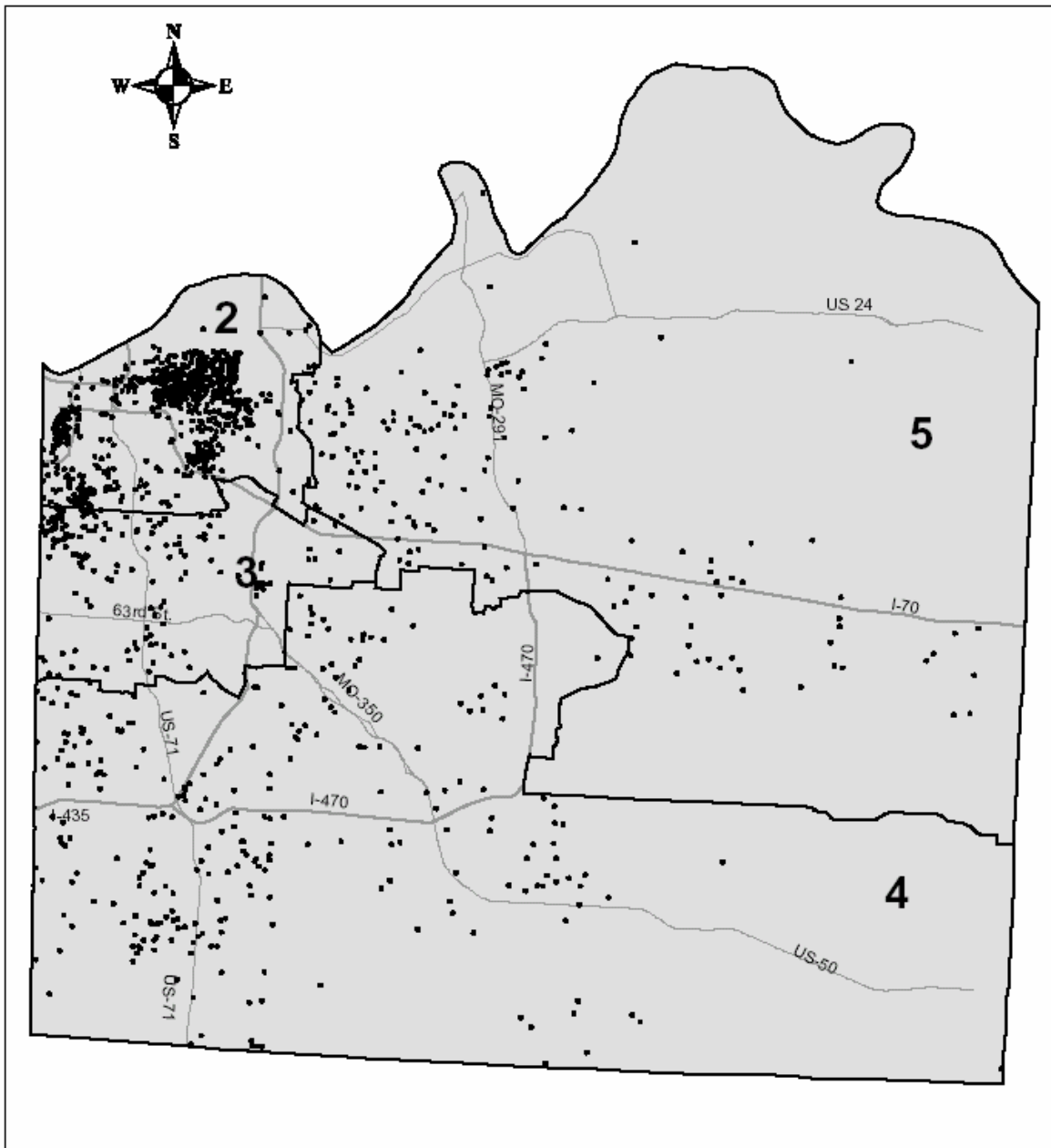
Prepared by Mid-America Regional Council

Legend
1 Dot = 10 People

This map shows the Hispanic population of Jackson County, with the boundaries for the Mental Health Levy catchment areas indicated. As the map shows, there is a concentration of Hispanic individuals in Catchment Area #2. However, the number of Hispanics in all other Catchment Areas is also noteworthy.

DEMOGRAPHICS

Population* Speaking Spanish at Home and Speaking English Less Than Very Well by Block Group, 2000



* Population 5 and Over

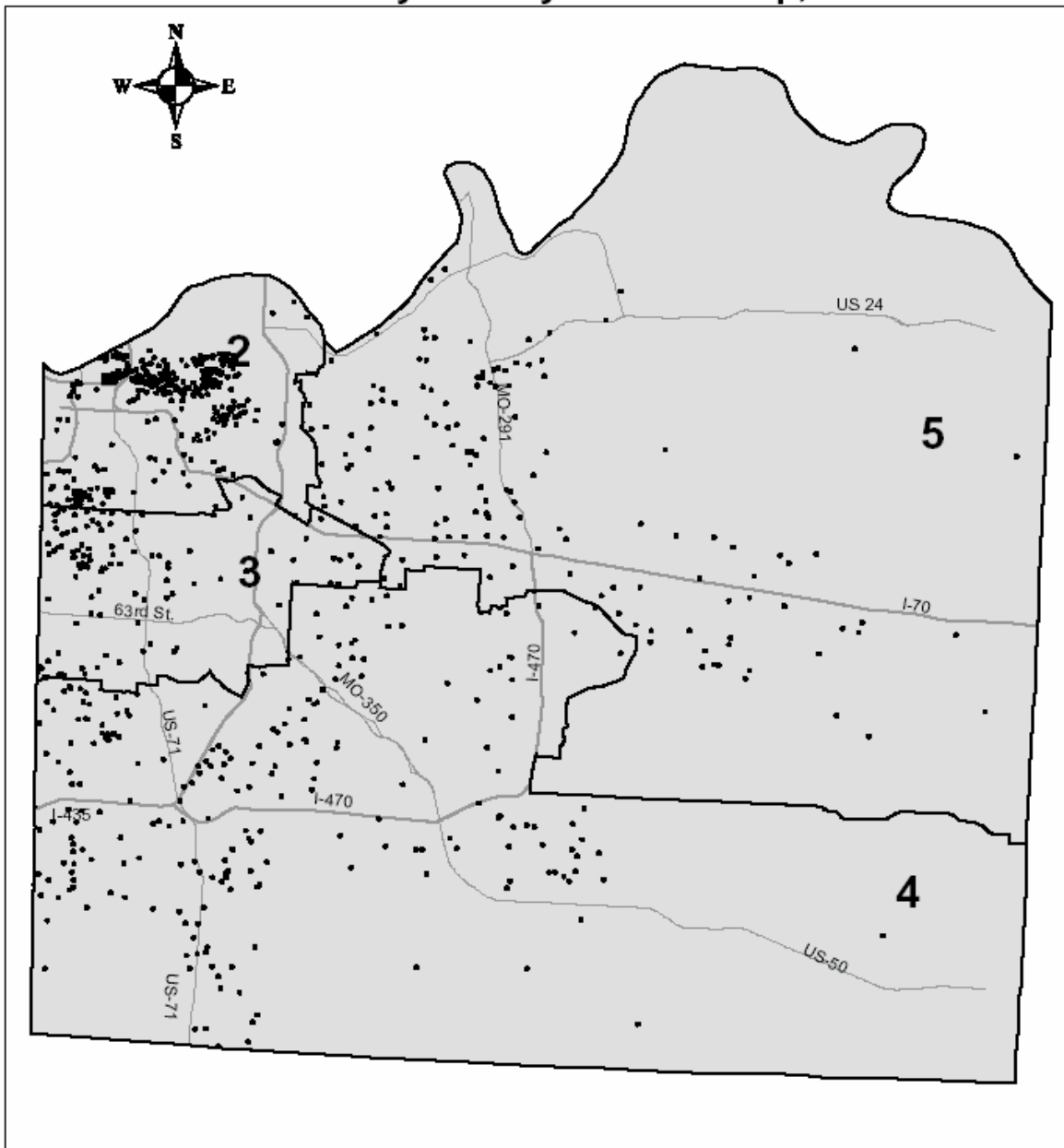
Prepared by Mid-America Regional Council

Legend
1 Dot = 10 People

This map shows individuals in Jackson County who speak English less than “very well” and speak Spanish. Again, the population is concentrated in Catchment Area #2, with numbers in each Catchment Area.

DEMOGRAPHICS

Population* Speaking Language Other Than Spanish at Home and Speaking English Less Than Very Well by Block Group, 2000



* Population 5 and Over

Legend
1 Dot = 10 People

Prepared by Mid-America Regional Council

This map shows individuals in Jackson County who speak English less than “very well” and who speak a language other than Spanish. These languages are categorized as Indo-European, Asian or other.

DEMOGRAPHICS

Jackson County Mental Health Levy Catchment Areas Detailed Information

The following chart shows the Mental Health Levy Catchment Areas and detailed information presented on the previous maps.

Table 11

	Area #2	Area #3	Area #4	Area #5
Population	107,567	113,307	238,806	
Hispanic population	18,400	3,682	6,792	
Percent Hispanic	17%	3%	3%	
Hispanics accessing Mental Health Levy Providers	748	106	102	
Speak Spanish, English less than "very well"	7,638	1,487	2,552	
Percent total population speaking Spanish, little English	7%	1%	1%	
Percent speak other language, English less than very well	3%	1%	1%	
Speak Indo-European language	843	500	1,098	
Speak Asian language	1,984	370	790	
Speak other language, English less than "very well"	572	89	258	

Source: Mid-America Regional Council

As the previous table shows, there are 13,079 individuals in Jackson County who speak English less than "very well". The number of those individuals who live in Mental Health Levy Catchment Area #2 is 7,638 and only 748 of those individuals are accessing Mental Health Levy services.

MENTAL HEALTH AND HISPANICS

INTRODUCTION TO MENTAL HEALTH

THE NEED FOR HISPANIC MENTAL HEALTH

THE BARRIERS IN HISPANIC MENTAL HEALTH

MATTIE RHODES CENTER APPROACH

INTRODUCTION TO MENTAL HEALTH

A mental illness is a disease that causes mild to severe disturbances in thinking, perception and behavior which may significantly impair the person's ability to cope with life's ordinary demands and routines. Many mental illnesses are believed to have biological causes, just like cancer, diabetes and heart disease. Depending on the type and severity of the mental illness and with the proper care and treatment, a person can learn to cope, improve, or experience a full recovery ("Resource Guide," 2003).

Twenty-three percent of American adults (ages 18 and older) suffer from a diagnosable mental disorder in a given year, but only half report impairment of their daily functioning due to the mental disorder. Six percent of adults have addictive disorders alone, and three percent have both mental and addictive disorders (Viccora, 2001).

According to the Surgeon General's report, mental health is fundamental to physical health. The qualities of mental health are essential to leading a healthy life. Americans assign high priority to preventing disease and promoting personal well-being and public health. Thus, the task of promoting mental health and preventing mental disorders is an important one. Nonetheless, mental disorders occur, which is why treatment and mental health services are critical to the nation's health (U.S. DHHS, 1999). The National Institute of Mental Health estimates that there are more than three million adults aged 18 to 69 who have a serious mental illness.

The causes of mental illness are not fully understood. It is thought that the brain's neurotransmitters do not function properly due to a biochemical imbalance in the brain. This sort of imbalance is comparable to imbalances in other systems and organs of the body which do not imply any character or spiritual flaw. Other factors may contribute. Heredity may be a factor in mental illness, as it is in diabetes and cancer. Stress may contribute to the onset of mental illness in vulnerable persons. Use of illegal drugs may also contribute to onset but are unlikely to be the primary cause ("Resource Guide," 2003).

Depression is one of the most commonly diagnosed psychiatric disorders. Previous studies have reported that 1 in 10 adults will suffer from depression some time in life. A new study discussed in the Kansas City Star reports that about 1 in 6 adults, or more than 32 million Americans, will experience depression, an alarming statistic. The term "depression" can be confusing, since it is often used to describe a transient and very normal emotion. Everyone feels "blue" or sad occasionally. However, if that emotion continues for long periods, and if it is accompanied by feelings of guilt and hopelessness, it could indicate a major depression. The persistence of such emotions and their severity distinguish the mental disorder of depression from normal mood swings ("Resource Guide," 2003).

Depression is one of the most treatable of mental illnesses. Great strides have been made recently in discovering effective medications for all mood disorders. Research also has revealed that some forms of psychotherapy used with medication are extremely helpful. Approximately 70 percent of all depressed patients respond to psychotherapy, medication, or a combination of these treatments. Many who do not respond to or cannot take antidepressant medication will respond to electroconvulsive therapy, a generally safe and effective treatment for several serious mental disorders. Many patients show significant improvement in their mood after only a few treatments (“Resource Guide,” 2003).

Anxiety Disorders are also very common in the United States. In fact, as a group, anxiety disorders afflict 8.9 percent of Americans. The term “anxiety disorders” refers to a group of illnesses such as: phobias, panic disorders, post traumatic stress disorder and obsessive-compulsive disorders. Under the right circumstances, anxiety is beneficial. It heightens alertness and readies the body for action. Anxiety or fear is often times a protection from danger. Fears and anxiety are not normal however, when they become overwhelming and interfere with daily living. They are then symptoms of an anxiety disorder, the most common and most successfully treated form of mental illness (“Resource Guide,” 2003).

According to the Surgeon General’s report, mental disorders are real health conditions that have an impact on individuals and families throughout the United States and beyond. Appreciation of the clinically and economically devastating nature of mental disorders is part of a quiet scientific revolution that not only has documented the extent of the problem, but in recent years has generated many real solutions (U.S. DHHS, 1999). Unfortunately, these solutions and treatments are not equally available to all Americans. In fact, the supplement to the Surgeon General’s report “documents the existence of striking disparities for minorities in mental health services and the underlying knowledge base. Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they do receive care, it is more likely to be poor in quality” (U.S. DHHS, 2001, p.3).

THE NEED FOR HISPANIC MENTAL HEALTH

One out of every five persons will need mental health services at some point in their lives. Approximately 25 percent of the U.S. population or over 8 million Hispanics are affected by a mental disorder in one year (U.S. DHHS, 2001). The Latino population is likely to use mental health services only in crisis circumstances, drop out of services sooner, and have undesirable treatment outcomes. Relatively low levels of educational attainment as well as the other housing, employment and health care disparities (see demographics section) place Latinos at a greater risk for health and mental health problems than non-Hispanics. Research suggests that there are significant disparities in mental health services in particular for Latino adolescents and youth (Hough, et. al., 2002).

There are several specific mental health issues that deserve attention when discussing Hispanic mental health. These include: depression, post-traumatic stress disorder, domestic violence, and substance abuse. All of these mental health issues have specific concerns in the Hispanic community in the United States.

According to 1980 and 1990 research studies, Latinos experience depression and psychological distress at higher rates than whites. Latino populations and some other minorities express and present symptoms quite differently. Often times, Latinos may come to their medical doctor with physical complaints of stomach pain, headaches, palpitations and chest pain. In the absence of a physical explanation, these individuals may be experiencing depression or anxiety. A study that assessed groups for psychiatric disorders in 2000 found that, after controlling for income and educational disparities, immigrants reported higher rates of somatic symptoms when compared with a U.S. sample. Somatization is the expression of stress through physical symptoms. When no medical cause is detected, a patient may be referred for a mental health assessment. Culturally bound syndromes, recognized in the DSM-IV-TR, are an important part of providing culturally competent care. Examples of common syndromes in Latino culture are *susto* (fright), *nervios* (nerves) and *mal de ojo* (evil eye). “*Ataques de nervios*” is a common problem for immigrant Latinos who report symptoms of screaming uncontrollably, crying, trembling, and physical or verbal aggression with others. Understanding the complexity of cultural bound syndromes and sources of stressors is critical in providing culturally effective treatment.

Post-traumatic stress disorder is the development of physical and psychological symptoms following exposure to an extremely traumatic event. Many Latinos, particularly Central Americans, have come to the U.S. as refugees, and are at higher risk for PTSD and depression. Most likely in this population, the traumatic event is a result of civil war, systematic violation of civil rights, and an accumulation of unresolved pain. The loss of familiarity of culture, community and family may exacerbate depressive symptoms. Latino immigrants also suffer from PTSD and depression due to their migratory route that often times is traumatic, harmful and sacrificial. Understanding and listening to the story of the migratory route or experience in their native language is critical in providing effective treatment to immigrants who are experiencing PTSD.

Immigrants have been particularly vulnerable to becoming victims of domestic violence. Research has found between 34 and 50 percent of immigrant women experience domestic violence over the course of their lifetimes (Rodriguez, 1995). Immigrant married women experience even higher levels of domestic violence at 60 percent (Dutton et al., 2000). Over 50 percent of immigrant women surveyed continue to live with their abusers (Coalition for Immigrant and Refugee Rights and Service, 1990). According to a recent article, “domestic violence within Latino families happens in the context of a community suffering from a legacy of multiple oppressions, some of which go back centuries – poverty, long-term discrimination, racism, and colonization” (Shah, n.d.).

Battered immigrant women face many of the same physical and psychological (verbal, mental, emotional & spiritual abuse) burdens as their American counterparts. However, Latina women have additional barriers associated with culture, language, and immigration status. In addition, most Latina battered immigrant women do not know that domestic violence is a crime and are unaware of the laws that can protect them and their children. Most have no extended family members or relatives and are financially dependent on their abusive partners.

Some of the challenges facing domestic violence service providers are not only those of language, but culture and immigration. Isolation is an enormous barrier at shelters, for example. Once the victim is removed from those who speak her language, she tends to suffer from anxiety and depression, due to the lack of ability to communicate. The effects of abuse include lowered self-esteem, guilt, blame, anger, shame, feelings of helplessness, dependency, isolation, anxiety, and desperation. According to AYUDA, Inc. and the New Jersey Coalition for Battered Women, an immigrant woman defines her identity by her role of wife and mother. “Leaving home is counter to her belief systems about her role and obligations in life. Women are responsible for keeping the family unit intact. The blame for family disintegration is hers” (“Coalition Reporter,” 1998, p.4).

Alcohol and substance abuse and dependence-related problems are more prevalent in Mexican men when compared to non-Hispanic white men (U.S. DHHS, 2001). The Mexican-born male population is at increased risk for death by cirrhosis, possibly due to early age at onset of alcohol use. Hispanic individuals are more likely than Whites to report a primary problem with illicit drugs, such as heroin, cocaine and/or PCP, and adolescents of Mexican descent who are at low socioeconomic levels show increased risk. In the case of marijuana, inhalants, hallucinogens, and non-medical use of prescription drugs, Latinos show lower rates of use than non-Hispanic whites. In part these low rates of use are due to Hispanic women's very low use of any of these substances (SAMHSA, 2000). U.S. born Latinos have slightly higher prevalence rates for substance abuse and alcohol dependence than the general U.S. population (Viccora, 2001). Substance abuse prevention and treatment are effective means to reduce substance dependence. Culturally sensitive treatment lowers the risk of criminal activity, low achievement, and continuing distress in the Hispanic community.

THE BARRIERS IN HISPANIC MENTAL HEALTH

According to a report by the Center for Mental Health Services, Latinos may perceive U.S. mental health models to be unnecessary, unwelcoming or not useful. These perceptions combined with other service barriers result in disproportionately low rates of mental health service utilization (U.S. DHHS, 2001).

Barriers of service in Hispanic mental health can be grouped in several dimensions. The barriers include lack of health insurance, language barriers, discrimination from the system, and lack of information about services, particularly in Spanish. It is these structural barriers that are the greatest deterrent for accessing formal mental health services. Community-level barriers include stigma of mental illness and the density of family and support networks. Person-level barriers include lack of recognition of mental health problems, stigma and general self-reliance (Guarnaccia and Martinez, 2002).

Lack of health insurance is thought to be one of the major barriers to accessing services. Nationally, a third of all Latinos do not have health insurance. Among the Hispanic poor, 44 percent are uninsured. Language barriers are another major barrier. Generally, there are few if any bilingual/bicultural staff members in mental health agencies and even fewer masters and doctoral level professionals (Guarnaccia and Martinez, 2002). One study involving Mexican Americans found that when the clinician was of the same ethnicity as the client, there were fewer dropouts, more sessions, greater improvements in global assessment scores, and greater improvement in overall functioning. This seemed to be the case particularly for non-English-speaking patients (Guarnaccia and Martinez, 2002).

While there is limited research data on Hispanic mental health, existing data indicates that Latinos are generally not accessing mental health services. The Mexican American Prevalence and Services Survey (MAPSS) is a landmark study of the mental health needs of Latinos in California. The data reveals the underutilization of mental health services by Latinos. Thirty-three percent of Mexican Americans or other persons of Mexican descent had one or more diagnosable mental disorder but 73 percent did not receive services for their condition. According to Viccora (2001), only 27 percent obtained care from the following sectors:

- Mental health providers: 9 percent
- General medical providers: 18 percent
- Other professionals, including counselors: 13 percent
- Informal providers: 3 percent

Barriers for immigrants are even greater. Of Mexican Americans or other persons of Mexican descent identified with one or more diagnosable mental disorders, less than five percent contacted mental health service providers and less than eleven percent contacted general health care providers (“Creating a Vision,” 2000).

The survey also elaborates on some of the service barriers as perceived by the population. Barriers as identified by those who had one or more diagnosable mental disorder:

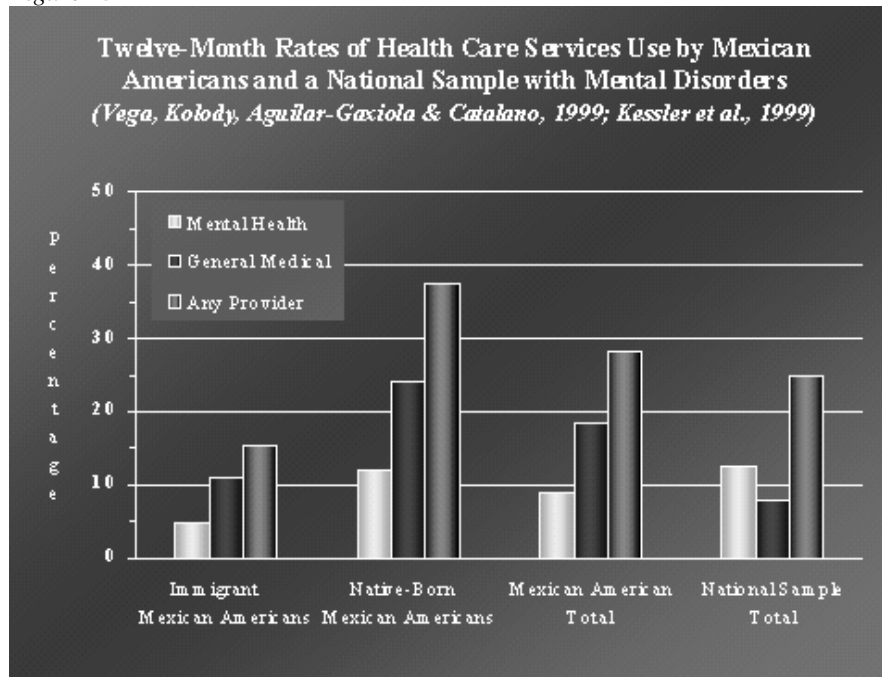
- Knowledge: 58 percent reported that they did not know where to obtain treatment
- Language: 50 percent reported that if they sought services, they would prefer to speak in Spanish
- Proximity to care: 37 percent reported that they would not consider obtaining mental health services if services were not available near their home
- Transportation: 19 percent reported that they did not have access to transportation to obtain treatment (Viccora, 2001)

In order to increase access and willingness of immigrants to use these services, the delivery of services needs to be tailored to the needs of specific immigrant groups. At the very least, interventions are needed that could explain the purpose and value of mental health care and where to receive it.

MENTAL HEALTH AND HISPANICS

Studies indicate that Latinos with mental health disorders do not receive sufficient mental health care (Vega et. al., 1999). Figure 23 indicates the degree to which Mexican Americans, both immigrants and native-born, access services.

Figure 23



The statistics show that Latinos, as a group, are not accessing mental health services. They cite various institutional, community and personal barriers for reasons why they do not seek services. Many of these barriers, such as language and the culture of the clinician, are unique when serving the Hispanic community. Mental health service providers that specifically address these barriers in a consistent way will make an impact in addressing the mental health needs of the Hispanic community.

MATTIE RHODES CENTER APPROACH

The skills of empathic listening and establishing a therapeutic alliance are universally helpful in the provision of mental health services. However, cultural competency extends these skills. “A therapist’s given or acquired sensitivity to culturally diverse values and the affects of social stressors make those general principles more effective in the evaluation and treatment of specific groups” (Falicov, 1998, p.6). Mattie Rhodes makes every effort to be sensitive to both the culturally diverse values and the social stressors of the Latino community.

The provision of effective mental health services for Latinos involves both the provider and the system. Barriers to service exist at multiple levels, not just at the provider level. The issue goes beyond the question of whether or not there are isolated bilingual competencies available within an agency, and the willingness to provide services to individuals who may lack health insurance. Effective service to limited English proficient (LEP) clients begins when a client calls the agency and the person on the other end is able to respond to them in their language. Mattie Rhodes has not always had that capability. It has taken years to build the capacity to create a system that not only offers linguistically appropriate services but that is built around an entire infrastructure that welcomes Latino clients; an environment that essentially says “*bienvenidos*.”

CSIPMH Benchmark of Cultural Competency

Language assistance must be available at all points of service delivery for persons with limited English proficiency.

Incorporating culture into practice is essential. Cultural competence is more than what happens between a client and provider. The entire service environment should embrace the concept that “*mi casa es su casa*” (my house is your house). The signs, symbols, art, and décor are all part of what make people feel welcome and help them feel they belong. *Personalismo* (the need to relate in personal terms) and *familism* (the importance of family) are two concepts confirmed in the Surgeon General’s report that are imperative for effective service to Latinos. Mattie Rhodes is committed to going beyond lip service in the development and provision of these concepts.

Personalismo involves a sense of warmth and personal interest that is more engaging than a typical therapeutic alliance between a therapist and an Anglo American client. Clients are respected and served in a manner that assists the family. This may seem like a given, but traditionally, mental health practices in the U.S. are based on an individual treatment plan approach. Staff at Mattie Rhodes recognizes the importance of intentionally integrating the family into treatment and service provision.

Mattie Rhodes operates from a strengths-based approach. The strengths-based approach is currently popular among many helping professions. Many groups will admit that the Latino population has many strengths to offer. They are commonly thought of as family-oriented and hard workers. Yet it is common for mental health providers to have an unconscious bias that tailors services towards acculturation. The linear acculturation framework assumes that the life struggles of immigrants will gradually be resolved by increasing acculturation or assimilation to the dominant culture. Therapists in effect become acculturation agents helping the family/client adapt to the new country and values such as individualism, feminism, and democracy.

Regardless of their good intentions, acculturation-oriented therapists may create more emotional distress by stripping away the protection of the old culture too quickly. The best outcomes result from those who retain their language, cultural ties, and some traditions while simultaneously learning the new language and customs. At Mattie Rhodes, clients receive the message that they have many strengths, both culturally and otherwise. Services build upon those strengths to overcome challenges and act as a bridge between both cultures.

Mattie Rhodes makes every attempt to understand the difference between normal reactions to the stresses of immigration and traditional mental health problems. Treatment is obviously impacted accordingly. Many of these issues are transitory and providers must be careful not to pathologize. People benefit so much from hearing validation and normalization of their experiences, for example “No, you are not going crazy. You are having a typical reaction!”

In order to effectively serve clients, a combination of approaches must be provided. At Mattie Rhodes, case management, group work, and individual/family therapy all work together to provide a holistic approach. Case management is important because the presenting problems often go beyond the needs of therapy. Clients need assistance and it often needs to be gained in a creative manner because the typical

The best models of mental health service today extend beyond diagnosis and treatment. These models address prevention and the fulfillment of broader needs, including housing and employment.

Mental Health, Culture, Race and Ethnicity, U.S. DHHS, 2001

resources are not always available to clients because of their immigration status. Group work is important because it provides the power of belonging and offers a sense of place for people who may be dealing with the devastation of isolation. The strengths of each individual group member add to the whole and create an environment where people can learn from each other and grow together. Individual and family therapy provides a place for clients to address the aforementioned problems.

Competencies at Mattie Rhodes extend to understanding the role that client expectations play. Many clients are initially unfamiliar with the therapeutic process. The therapist explains the process and asks about expectations, all in an informal conversational setting. Credibility is fundamental to treatment success. Therapists can gain credibility if they develop culturally appropriate conceptualizations of problems, problem resolution strategies, and treatment goals. There must be a match between the therapist and client regarding the way that the problem is conceptualized. In many cases, a Latino client will not contradict his or her therapist. Instead, the client will not come back for additional sessions because of the respect he or she has for the therapist and cultural values.

According to Anna Maria Bellatin, Ph.D., Clinical Director at Mattie Rhodes Center, it is the entire philosophy of treatment for the Latino community that sets the agency apart from other service providers. Mattie Rhodes adheres to a philosophy that places knowledge of and respect for culture, ethnicity, and religious beliefs as essential to successful treatment. The agency consciously and continually strives for cultural competence that is based on viewing clients' culture as an asset – not a liability. Mattie Rhodes also adheres to a holistic philosophy that values moving beyond the individual and family to include interactions with outside systems, institutions, and agencies as an effective way to address the needs of clients.

Studies show that once Latinos are in treatment, they benefit from it (Guarnaccia & Martinez, 2002). The key issue is not only getting Latinos into treatment, but providing meaningful access that is culturally competent and family centered. Mattie Rhodes Center believes in the client's right to self-determination and strives to provide a welcoming environment where they can develop a sense of connectedness and ownership. It is that connectedness and ownership that keep clients coming back for treatment which ultimately results in an improved quality of life.

OUTCOMES

INTRODUCTION TO OUTCOMES

MATTIE RHODES CENTER OUTCOMES

OUTCOME MEASUREMENT FRAMEWORKS

- Individual and Family Therapy – Adult
- Individual and Family Therapy – Child/Youth
- Domestic Violence
- Parenting Group

INTRODUCTION TO OUTCOMES

Information is the intelligence of an organization (Rapp & Poertner, 1992).

Collecting and managing information is critical to carrying out the vision of an agency. Information is important in shaping and maintaining client centeredness within an organization. While it is apparent that agencies need information of a variety of types, it is far less apparent what exactly the right information is. Determining what information to collect is a continuous process of responding to changes within the organization as well as those changes in the surrounding environment.

Client outcomes are the bottom line for human services similar to the way that profits are the bottom line for business. Information on client outcomes is important to judge program performance, motivate and direct staff, and acquire resources. All too often, social service providers are not asked how their consumers have improved. Instead, reports focus on the number of clients served, dollars spent, and amount of service activity.

A learning organization uses the information collected to improve performance. In order to assess, adjust and improve performance, there must be an organizational culture that supports learning. Organizational culture goes beyond the mere desire to learn when data are interpreted and action is taken.

Measuring client outcomes is the most important and most difficult part of managing results in social service programs. The first challenge is that typically, agencies do not have existing data on client outcomes. Second, most programs involve work towards many different types of outcomes. Third, it is often difficult to determine how to measure a particular type of client outcome. The last challenge involves cost; it can be an expensive process to design and collect client outcome information (Poertner, 2000).

MATTIE RHODES CENTER OUTCOMES

The Jackson County Mental Healthy Levy Category IV grant provided to Mattie Rhodes Center has been used in part to hire a consultant to provide technical assistance in the design and development of quality assurance within the outcome measurement efforts. This will ultimately allow for the collection of information related to the treatment of behavioral health to assess and, when necessary, adjust in order to provide more effective programs for the population served.

CSIPMH Benchmark of Cultural Competency

The agency must have a systematic way of collecting and aggregating data.

Quality assurance and outcome measures are the basis for analysis which can assist the efforts of behavioral health in Mattie Rhodes programs. Quality assurance efforts are designed to learn through benchmarking the population characteristics and the treatment modes that provide effective outcomes. The use of surveys and data collection is a component in the development of informational systems.

As a piece of the outcomes process, Mattie Rhodes Center has been working on the development of a database. Developing a database for clinical records is critical for learning as well as reporting. Each of our varied funding sources requires different outcomes, reporting and information. This database will allow information to be gathered as needed and separated according to billing source. The database will also provide a true picture of the demographics of the population served.

The first step taken by Mattie Rhodes in this process was to collect all the reports and outcomes needed from each program. The next step was to create a comprehensive variable list for the database designer. This variable list will serve as the blueprint from which the database will be built.

The current process that Mattie Rhodes is undergoing is piloting the outcome tools and collecting preliminary results. In the pilot stage, we have found that outcome measurements traditionally developed for the majority population are not effective for immigrant populations. In response to this, the process involves almost constant reworking and reframing as items are clarified in order to attain the most accurate measure possible.

OUTCOME MEASUREMENT FRAMEWORKS

Individual and Family Therapy—Adult

Table 12

Outcome	Indicators	Data Source	Data Collection Method
80% of clients will report treatment expectations met	Client will report positive connection with therapist and knowledge gained in treatment.	<i>Post-Session Cards</i> (1 st & 4 th sessions)	Therapist/Client
70% of clients will improve problem-solving skills	Client will demonstrate a two-item improvement in Problem Resolution Outcome Survey (PROS) score between initial/second session and the fourth/fifth session.	New PROS*	Pre/Post Test Therapist/Client (1 st & 4 th session)

Current Outcome Results – *Adult Therapy*

Standard: 80% of clients will report treatment expectations met.

Actual: 94% of clients reported treatment expectations met.

Standard: 70% of clients will improve problem-solving skills.

Actual: 71% of clients improved problem-solving skills.

OUTCOMES

Individual and Family Therapy—Child/Youth

Table 13

Outcome	Indicators	Data Source	Data Collection Method
80% of clients will develop at least two assets	Client will report the attainment/development of at least two assets.	Asset Scale for Individual Clients	Pre/Post (1 st and 8 th session)
70% of clients will gain knowledge of self and family	Client will indicate learning something about themselves or their family after session.	Post-Session Card (1 st session)	Therapist
70% of clients will gain knowledge regarding expression of feelings	Client will indicate that they understand all feelings are appropriate, and it is what they do with the feelings that matters.	Post-Session Card (8 th session)	Therapist

Current Outcome Results – *Child/Youth Therapy*

Standard: 80% of clients will develop at least two assets.

Actual: 75% of clients developed at least two assets.

Standard: 70% of clients will gain knowledge of self and family.

Actual: 84% of clients gained knowledge of self and family.

Standard: 70% of clients will gain knowledge regarding expression of feelings.

Actual: 92% of clients gained knowledge regarding expression of feelings.

OUTCOMES

Domestic Violence

Table 14

Outcome	Indicators	Data Source	Data Collection Method
90% of clients (in a current domestic violence situation) will report gaining knowledge about safety	Client will report gaining knowledge about safety following initial session.	Post Session Card (1 st Session)	Therapist/ Client
80% of clients will report being able to express their feelings	Client will report being able to express feelings.	Post Session Card (1 st session)	Therapist/ Client

Current Outcome Results – Domestic Violence

Standard: 90% of clients (in a current domestic violence situation) will gain knowledge about safety.

Actual: 87% of clients gained knowledge about safety.

Standard: 80% of clients will report being able to express their feelings.

Actual: 96% of clients were able to express their feelings.

OUTCOMES

Parenting Group

Table 15

Outcome	Indicators	Data Source	Data Collection Method
75% of participants will use positive parenting techniques	Participants will improve in their use of positive parenting techniques by three or more items.	Pre/Post Survey	Therapist
80% of participants will feel better about self and increase self-care practices	Participants will feel better about self more often and will utilize one or more self-care practice more frequently.	Pre/post survey	Therapist
70% of participants will do activities more often with their child(ren)	Participants will show an increase in the frequency in which they read, hug, and/or do play activities with their child(ren).	Pre/Post Survey	Therapist

Current Outcome Results – Parenting Group

Standard: 75% of participants will use positive parenting techniques.

Actual: 85% of participants use positive parenting techniques.

Standard: 80% of participants will experience improved sense of well-being and increase self-care practices.

Actual: 85% of participants experienced improved sense of well-being and increased self-care practices.

Standard: 70% of participants will do activities with their child/children more often.

Actual: 69% of participants do activities with their child/children more often.

CONCLUSION

CONCLUSION

The development of *Cultural Competency and Mental Health in the Hispanic Community of Jackson County, Missouri* coincided with the adoption by Mattie Rhodes Center's Board of Directors of three strategic initiatives that seek to respond to the increased demand for accountability and entrepreneurial operation among not-for-profit organizations. These initiatives were: to expand Mattie Rhodes Center as the leading information and advocacy source for the Hispanic community, to identify emerging community needs and future business opportunities, and to strengthen Mattie Rhodes Center's capacity to provide high quality services.

The development of this document started with an investment from the Jackson County Mental Health Levy Fund Board followed by a commitment by our managers, our staff, and board to contribute time and energy towards research, the compilation of client data, writing, editing, and moral support.

Indeed the information contained in this report was preliminary and is available via research to the general public. However, the compilation of this information by a local Hispanic-serving organization in one comprehensive document is a first.

The report chose to profile mental health, cultural competency benchmarks, and offer demographics on the Hispanic population. Also presented were the standards from which our programs operate, those strategies that have shown progress, and the outcomes we use. Our recommendations are as follows:

- Policy makers, public officials, foundation officials, consumers, and the local Hispanic leadership request additional information on any one or all of the main topics discussed: cultural competency, Hispanic demographics, outcome measurement, and Hispanic mental health.
- Other non-profit organizations use this document as a model for assessing the needs of their constituency.
- In their transition to an issues-based way of doing business, United Way use this as a primary tool for understanding the issues faced by the Hispanic community and in developing program strategies.
- Jackson County Mental Health Levy continues to find ways to advocate on behalf of the local Hispanic community.

The non-profit community is diverse, complex, and ever changing. No longer are grants issued but instead "investments" are made. Foundations, businesses and even the government are acknowledging the importance of needs assessments, cost-effective strategies, objectives, and results. These have become the new buzz words for communities and organizations around the nation struggling to address low levels of educational attainment, poverty, inadequate health care, public safety, alcohol and substance abuse, and other socioeconomic issues. The efforts made by communities and organizations to address these social issues should be commended!

The following is a list of resources and research found as the result of an internet search on Hispanic-related issues. The key issues of mental health, education, health, labor/employment, housing and political representation are included.

Most of the following resources were found by a basic search including “Hispanic” and other topics, such as “Education.”

Hispanic Education

➡ **SEARCH**

MENTAL HEALTH

- National Congress for Hispanic Mental Health Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Mental Health Services. March 2000.
- National Association of State Mental Health Program Directors (NASMHPD) Latino Mental Health Panel. December 2000.
- *Mental Health: Culture, Race and Ethnicity*, the 2001 supplement to the landmark *Mental Health: A Report of the Surgeon General* published in 1999. August 2001.

EDUCATION

- National Council of La Raza (NCLR). *Latino Education: Status and Prospects*. July 1998.
- The President’s Advisory Committee on Educational Excellence for Hispanic Americans. *From Risk to Opportunity: Fulfilling the Educational Needs of Hispanic Americans in the 21st Century*. March 2003.
- California Legislature - Assembly. Committee on Higher Education. Informational hearing on "underrepresented minorities in higher education." Assembly Committee on Higher Education, 2002.

HEALTH

- National Alliance for Hispanic Health. A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics.
- United States Department of Health and Human Services. *Healthy People 2010*.
- United States. Congress. Senate. Committee on Health, Education, Labor, and Pensions. Subcommittee on Public Health. *Hispanic health: problems with coverage, access, and health disparities: hearing before the Subcommittee on Public Health of the Committee on Health, Education, Labor, and Pensions*. September 23, 2002.

LABOR/EMPLOYMENT

- National Council of La Raza (NCLR). *Moving Up the Economic Ladder: Latino Workers and the Nation's Future Prosperity*. July 2000.
- Julian Samora Research Institute. *Income Differentials in the U.S.: Impact on Latino Socio-Economic Development* by Marcelo E. Siles. Working Paper No. 33. December 1997.

HOUSING

- National Council of La Raza (NCLR). *Locked Out: Hispanic Underrepresentation in Federally-Assisted Housing Programs*. July 1997.
- U.S. Department of Housing and Urban Development Issue Papers on Demographic Trends Important to Housing. *Projections of U.S. Households by Race/Hispanic Origin, Age, Family Type, and Tenure to 2020: A Sensitivity Analysis*, by George Masnick and Zhu Xiao Di. February 2003.
- U.S. Department of Housing and Urban Development. *Discrimination in Metropolitan Housing Markets: National Results from Phase 1 and Phase 2 of the Housing Discrimination Study (HDS)*. 2000.

POLITICAL REPRESENTATION

- National Council of La Raza (NCLR). *Preliminary Analysis of 2000 Latino Vote*. November 2000.
- The Tomás Rivera Policy Institute. *A Glimpse into Latino Policy and Voting Preferences*. Matt Barreto, Research Associate, Rodolfo O. de la Garza, Ph.D., Jongho Lee, Ph.D., Jaesung Ryu, and Harry P. Pachon, Ph.D. March 2002.

The following is a list of Hispanic organizations with locations on the World Wide Web. This list can be found at the website for the League of United Latin American Citizens, www.lulac.org.

HISPANIC ORGANIZATIONS

American GI Forum
ASPIRA
Congressional Hispanic Caucus
Congressional Hispanic Caucus Institute
Cuban American National Council
Fundación Solidaridad Mexicano Americana
Hispanic Association of Colleges and Universities
Hispanic Association on Corporate Responsibility
Hispanic Employment Program
Hispanic Federation
Hispanic Heritage Awards
Hispanic National Bar Association
MANA A National Latina Organization
Mexican American Legal Defense and Education Fund
National Alliance for Hispanic Health
National Association of Latino Elected and Appointed Officials
National Council of La Raza
National Hispana Leadership Institute
National Hispanic Council on Aging
National Hispanic Leadership Agenda
National Latino Children's Institute
National Society of Hispanic MBA's
National Society for Hispanic Professionals
Nosotros
SER-Jobs for Progress
Society for Advancement of Chicanos and Native Americans in Science
Society of Hispanic Professional Engineers
Southwest Voter Registration & Education Project
TAMACC
United Farm Workers
United States Hispanic Chamber of Commerce
United States-Mexico Chamber of Commerce

APPENDIX B

The following is a resource providing information on Jackson County, Missouri Mental Health Providers as provided by the Jackson County Mental Health Levy. Please refer to the map (on pages 39-41) designating the four mental health catchment areas in Jackson County. The general phone number listed, from the Jackson County Mental Health Levy Directory, was called and each organization was asked about their ability to serve individuals who do not speak English. The way in which the organization serves non-English speaking individuals was put in one of three categories:

Outside Interpreter – It would be arranged for someone outside of the organization to interpret – a third person translates between clinical staff and client.

Interpreter on staff – A third staff member translates between clinical staff and client.

Bilingual staff – Clinical members are able to communicate one on one with a client.

Mental Health Catchment Area # 2	General Phone # * all #s are area code (816)	Do you have the ability to serve non-English speaking clients?	In what way? / Additional Comments
Budget and Financial Management Assistance	474-2972	Yes	Interpreter on staff - Spanish
Catholic Charities of Kansas City	221-4377	Yes, No	Bilingual staff – Spanish, referral
Child Advocacy Services	363-1898	No	Referral
DeLaSalle Education Center	561-4445	No	
Goodwill	842-7425	Yes	Interpreter on staff – Spanish and Sign Language
Jewish Vocational Services	471-2808	Yes	Outside interpreter
Kansas City Free Health Clinic	753-5144	No	Not at the front desk
Mattie Rhodes Center	471-2536	Yes	Bilingual Staff - Spanish
Marillac	508-3300	Yes	Would need to make accommodation
Metropolitan Lutheran Ministry Homeless Services	931-0027	No (Yes in Wyandotte County)	
MOCSA	931-4527	Yes	Bilingual Staff or Interpreter on Staff (depending on case) – Spanish, Outside interpreter
National Alliance for the Mentally Ill in KC	931-0030	No	
Niles Home for Children	241-3448	Yes	Outside interpreter
ReStart	472-5664	Yes	Outside interpreter
Salvation Army Children's Shelter	756-2769	Yes	Bilingual staff -Spanish
Samuel U. Rogers Mental Health Clinic	474-4920	Yes	Interpreter on Staff - Spanish
Truman Behavioral Health	467-1400	Yes	Interpreter (From Truman Medical Center)

APPENDIX B

Mental Health Catchment Area # 3	General Phone # * all #s are area code (816)	Do you have the ability to serve non-English speaking clients?	In what way? / Additional Comments
Genesis School, Inc.	921-0775	No	Does outreach to the Hispanic community
Gillis	508-3500	Yes	Interpreter or Bilingual Staff – depends on service, Spanish
Jewish Family and Children Services	333-1172	Yes	Interpreter on Staff - Russian, Outside interpreter
Kansas City Hospice	363-2600	Yes	Bilingual Staff - Spanish
Rose Brooks Center, Inc.	523-5550	Yes	Bilingual Staff – Spanish, Outside interpreter
Swope Parkway Health Center	923-5800	Yes	Bilingual Staff - Spanish, outside interpreter

Mental Health Catchment Area # 4	General Phone # * all #s are area code (816)	Do you have the ability to serve non-English speaking clients?	In what way? / Additional Comments
Crittenton	765-6600	Yes	Bilingual Staff - Spanish, Outside interpreter
Research Mental Health Services	246-8000	Yes	Outside interpreter
Spofford	508-3400	Yes	Interpreter on Staff or Outside interpreter
Ozanam	508-3600	Yes	Interpreter on Staff or Outside interpreter

Mental Health Catchment Area # 5	General Phone # * all #s are area code (816)	Do you have the ability to serve non-English speaking clients?	In what way? / Additional Comments
CAPA (Child Abuse Prevention Association)	252-8388	Yes	Outside interpreter
Comprehensive Mental Health Services, Inc.	254-3652	No	Referral, outside interpreter
Heart of America Family Services	418-8400 871-7104 753-5280	Yes, No	Bilingual Staff - Spanish, at Family Focus Center and Housing Authority No – Mid-town office
Hope House	461-4188	Yes	Outside interpreter
Steppingstone	356-0187	Yes	Outside interpreter

REFERENCES

- Alegria, M., Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D., et al. (2002). Inequalities in use of specialty mental health services among Latinos, African Americans, and Non-Latino whites. *Psychiatric Services*, 53(12), 1547-1555.
- Barbarin, O. (2002). Culture and ethnicity in social, emotional, and academic development. Used in Executive Summary – The Ewing Marion Kauffman Foundation; The Kauffman Early Education Exchange; Set for success: Building a strong foundation for school readiness based on the social-emotional development of young children.
- Coalition for Immigrant and Refugee Rights and Service (CIRRS). (1990). *A needs assessment of undocumented women*. San Francisco: Author.
- Coalition Reporter. (1998, December). New Jersey Coalition for Battered Women.
- Creating a vision for the 21st century. (2000). Proceedings of the National Congress for Hispanic Mental Health (pp. 23-30). Available at: <http://www.mentalhealth.org/cmhs/SpecialPopulations/HispMHCongress2000>
- Dutton, M., Orloff, L.E., Hass G.A. (2000). Characteristics of Help-Seeking Behaviors, Resources and Service Needs of Battered Immigrant Latinas: Legal and Policy Implications. *Georgetown Journal on Poverty Law & Policy*, 7(2).
- Falicov, C.J. (1998). *Latino Families in Therapy: A Guide to Multicultural Practice*. New York, NY: The Guilford Press.
- Guarnaccia, P.J., & Martinez, I. (2002). Comprehensive in-depth literature review and analysis of Hispanic mental health issues with specific focus on members of the following ethnic groups: Cubans, Dominicans, Mexicans and Puerto Ricans. New Jersey Mental Health Institute, Inc.
- Hough, R. L., Hazen A. L., Soriano, F. I., Wood, P., McCabe, K., Yeh, M. (2002). Mental health services for Latino adolescents with psychiatric disorders. *Psychiatric Services*, 53(12), 1556-1562.
- Lawrence, D. (2003, June 18). Treatments for depression faulted: Costs of illness noted by studies. *The Kansas City Star*, pp. A1, A10.
- Lopez, S. (2000, March 20-21). The mental health needs of Hispanics in the United States. Paper presented at National Congress for Hispanic Mental Health, Washington, D.C.
- National Council of La Raza. (2001). *Beyond the Census: Hispanics and an American Agenda*. Washington, D.C., Author.

REFERENCES

- New Census Study Shows America's Changing Face. (1999, September 16). San Francisco Chronicle.
- Office of the County Executive. (2003). Jail diversion by law enforcement crisis intervention teams: Proposal for a capacity expansion grant. Jackson County, MO: Author.
- Poertner, J. (2000). Managing for service outcomes: The critical role of information. In R. Pattie (Ed.), *The handbook of social welfare management* (pp.267-281). Thousand Oaks, CA: Sage Publications.
- Rapp, C., & Poertner, J. (1992). *Social administration: A client-centered approach*. White Plains, NY: Longman.
- Resource Guide to Mental Health Care in Virginia. (2003). Retrieved on February 11, 2003 at www.mhav.org/requide4.htm#five.
- Shah, N. (n.d.). Domestic Violence: A Public Health Issue With No Boundaries. pp.10-11.
- Sealey, Geraldine. (2000, March 15). America's Changing Face. Experts: Census 2000 Will Reveal Ethnic Shift. [Electronic version]. <http://abcnews.go.com/sections/us/DailyNews/censurace000315.html>.
- Siegel C, Haugland G. & Chambers E. D. (2002). Cultural competency methodological and data strategies to assess the quality of services in mental health systems of care. A project to select and benchmark performance measures of cultural competency. Orangeburg, NY: Nathan Kline Institute for Psychiatric Research, Center for the Study of Issues in Public Mental Health.
- Substance Abuse and Mental Health Services Administration. (2000). Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. Retrieved October 14, 2002, from <http://www.mentalhealth.org/publications/allpubs/SMA00-3457/intro.asp>.
- U.S. Census Bureau. (1990). *Hispanic Origin*. (Table P011). Retrieved from: www.census.gov.
- U.S. Census Bureau. (1998). *Current population survey, March 1997*, Ethnic and Hispanic Statistics Branch, Population Division. Retrieved from: www.census.gov.

REFERENCES

- U.S. Census Bureau (2000a). *Educational attainment in the United States: Population characteristics, March 1999*. Washington, DC. Retrieved from: www.census.gov.
- U.S. Census Bureau (2000b). *Hispanic or Latino by Specific Origin*. (Table PCT11). Retrieved from: www.census.gov.
- U.S. Census Bureau (2000c). *Median Family Income in 1999*. (Table P77, P155). Retrieved from: www.census.gov.
- U.S. Census Bureau (2000d). *Nativity by Language Spoken at Home by Ability to Speak English for the Population 5 years and Over*. (Table PCT12). Retrieved from: www.census.gov.
- U.S. Census Bureau (2000d). *Poverty Status in 1999 by Age*. (Table P159). Retrieved from: www.census.gov.
- U.S. Census Bureau (2000e). *Poverty Status in 1999 by Family Type by Presence and Age of Related Children < 18 Years*. (Table P160). Retrieved from: www.census.gov.
- U.S. Census Bureau (2000f). *Race*. (Table P6). Retrieved from: www.census.gov.
- U.S. Census Bureau (2000g). *Sex by Educational Attainment for the Population 25 Years and Over*. (Table P148). Retrieved from: www.census.gov.
- U.S. Census Bureau (2000h). *Sex by Employment Status for the Population 16 Years and Over*. (Table P150). Retrieved from: www.census.gov.
- U.S. Census Bureau (2000i). *Year of Entry by Citizenship Status for the Foreign-born Population*. (Table P040). Retrieved from: www.census.gov.
- U.S. Census Bureau. (2001). Current Population Survey, March 2000. U.S. Bureau of Labor Statistics.
- U.S. Census Bureau. (2001). *People without health insurance for the entire year by selected characteristics: 2000*. Retrieved from: www.census.gov.
- U.S. Census Bureau. (2002). Homeownership rates by race and ethnicity of Householder: 1994 to 2002. (Table 20). *Housing Vacancy Survey. Housing Vacancies and Homeownership Annual Statistics: 2002*. Retrieved from: www.census.gov.
- U.S. Dept. of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Author.

REFERENCES

- U.S. Dept. of Health and Human Services. (2000). *Healthy People 2010*. Rockville, MD: Author.
- U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, race, and ethnicity – A supplement to mental health: A report of the Surgeon General*. Rockville, MD: Author, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Vega, W.A., Kolody, B., Aguilar-Gaxiola, S., & Catalano, R. (1999). Gaps in service utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry*, 156, 928-934.
- Viccora, E. (2001). *Creating culturally competent mental health systems for Latinos: Perspectives from an expert panel*. The National Technical Assistance Center for State Mental Health Planning.

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Kristin D. Wing
RSM McGladrey, Inc.



The Mattie Rhodes Center provides a comprehensive network of family and youth services. The mission of the Mattie Rhodes Center is to strengthen Kansas City children, families and community by providing social services, mental health counseling, and art experiences in a bilingual, culturally sensitive environment.

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