# Culturally Competent Mental Health Practice: A Case Study of an Organization Serving Latino Immigrants

BY

CAITLIN L. O'GRADY
BA, Kenyon College, 2007
MSW, University of Denver Graduate School of Social Work, 2009

THESIS

Submitted as partial fulfillment of the requirements
for the degree of Doctor of Philosophy in Social Work
in the Graduate College of the
University of Illinois at Chicago, 2017

Chicago, Illinois

Defense Committee:

Cassandra McKay-Jackson, Chair and Advisor
Sonya Leathers
Michele Kelley, School of Public Health
Francisco Gaytán, Northeastern Illinois University
Joshua Mersky, University of Wisconsin-Milwaukee

This dissertation is dedicated to the Latino immigrant population and their allies. And to David B. Smith, whose love and guidance has been formative throughout my life and throughout this journey. David, you will forever be my compass.

## ACKNOWLEDGMENTS

Words cannot express how appreciative I am of everyone who has supported me throughout this process. To Dr. Cassandra McKay-Jackson, you have not only been my Chair and Advisor, but you have also been my mentor. Thank you for your unwavering support and encouragement and for your belief in me and my work. You have helped me to become a more critical thinker, a better writer, and a better researcher. You have taught me that passion and commitment are the primary factors driving successful research. And to my faculty committee members, Dr. Sonya Leathers, Dr. Michele Kelley, Dr. Francisco Gaytán, and Dr. Joshua Mersky, thank you so much for your invaluable contributions to this project. Your guidance and commitment to my professional growth have made this experience both rewarding and enjoyable. I would also like to thank the community of professors at the Jane Addams College of Social Work who have offered me so much support throughout my tenure in the doctoral program. Thank you to Dr. James Swartz for your belief in me and my abilities; thank you to Dr. James Gleeson for your guidance in shaping my proposal; and thank you to Dr. Chang-Ming Hsieh for supporting me with my teaching. I would not be the person that I am today without the support of each and every one of you.

From the bottom of my heart, thank you to my family. To Brian and Susan O'Grady, every day I am reminded of how truly blessed I am to have you as parents. From as early on as I can remember, you have taught me the importance of following my dreams and fighting for a better world. Every day I aim to live by your example. Thank you for your love and for believing in me even when I doubted my abilities. And to my sister, Molly Murray, whose brilliance and devotion to a more just world pushes me every day to work just a little bit harder. And to Jesse Lewin, who has been by my side throughout every phase of this journey and whose support

## ACKNOWLEDGMENTS

means more than I can ever express. Thank you for challenging me to more clearly articulate my thoughts and beliefs, and thank you for always being my sounding board.

To my friends and colleagues at the Jane Addams College of Social Work, thank you for accompanying me throughout this doctoral program journey. To Judith Rocha, Suhad Tabahi, Ifrah Magan, Bunmi Oyewuwo-Gassikia, and Roni Diamant-Wilson, your passion and dedication to your work inspire me every day. Your support has sustained me through both the successes and the challenging moments along the way.

Thank you to the Institute for Research on Race and Public Policy at the University of Illinois at Chicago for its financial support of my research. And thank you to the service providers throughout Chicago who have made this research possible. To Maritza Reyes, thank you for so graciously donating your time to provide feedback on my interview guides. To Maria Post, thank you for your generosity in providing me with a space to conduct service participant interviews. And thank you to everyone at the Saint Anthony Hospital Community Wellness Program, who so warmly welcomed me into your space and for all of the support that you provided as I conducted my research. To Arturo Carrillo, I am profoundly appreciative of the time and support that you have invested in me and this project. You and your colleagues inspire me every day with your unwavering commitment to the community members whom you serve and your tireless efforts to promote a more just society. And to the service participants who so openly shared your experiences with me, thank you for allowing me the privilege of documenting your stories. I am honored and humbled by all that you have taught me.

CLO

## TABLE OF CONTENTS

CHAPTER PAGE

## TABLE OF CONTENTS (continued)

CHAPTER PAGE

## LIST OF FIGURES

FIGURE PAGE

## SUMMARY

While there is a well-established body of literature documenting the barriers that the U.S. Latino immigrant population experiences in accessing mental health services, research that identifies strategies for overcoming these barriers and addressing the mental health needs of this population is limited. In particular, while literature identifies the limited availability of culturally and linguistically appropriate services as posing a barrier to service access, there are few empirical examples illustrating what culturally competent service delivery looks like at both the level of the individual provider and at the organizational level.

In an effort to address the gaps in the research, this study explored service delivery at a branch of Saint Anthony Hospital's Community Wellness Program (CWP), located in the Little Village neighborhood of Chicago, Illinois. The Little Village location of the CWP offers mental health services to an uninsured Latino immigrant adult target population, while simultaneously offering a range of on-site supportive social services. The program's exclusive focus on service provision to Latino immigrant community members provides a unique opportunity to study service delivery within the context of an organization that has developed the infrastructure to serve this population.

Using a case study design with a transcendental phenomenological qualitative approach, this study explored the following research questions: (1) How do service providers and service participants describe the services that are delivered at the Little Village location of Saint Anthony Hospital's CWP? (2) How do service providers and service participants experience service delivery within this organizational context? What is their experience with regard to the role of culture in service delivery, the accessibility of services, service engagement, and treatment outcomes? (3) From the perspectives of both service providers and service participants,

## SUMMARY

what are the mental health needs of community members receiving services, and how does the program address these needs? Informed by a Latino critical race theoretical framework, the study sought to document experiences of service delivery not only among service providers, but also among Latino immigrant service participants, a population whose voices and experiences are traditionally ignored in mental health research.

In accordance with a case study design, data were gathered through multiple methods including open-ended individual interviews with 10 CWP service providers and 11 CWP mental health service participants; observation of routine program activities; and collection of agency documents. Using a transcendental phenomenological analytic approach, a description of service providers' and service participants' experiences of service delivery, as well as the context in which these experiences occurred, was generated following an inductive open coding process.

Findings from this study indicated that services at the CWP are community-centered and informed by an understanding of community members' cultural values, beliefs, and lived experiences within the community and sociopolitical contexts in which they are situated. The CWP has developed the organizational infrastructure to deliver services that are aligned with community members' service needs, and supports individual service providers in delivering services that address these needs. The CWP facilitates service access by addressing a range of geographical, psychological, operational, and cultural factors that impact service accessibility; promotes service engagement through its community-based and relationally focused approaches; and addresses community members' mental health needs through its delivery of holistic services, anti-oppressive services, and services informed by an understanding of community members'

acculturative experiences. These access, engagement, and mental health practice strategies convergently promote wellness at the levels of the individual, family, and community as a whole.

Not only does the CWP's model of service delivery have concrete practice implications for practitioners and organizations serving the Latino immigrant population, but it also furthers our understanding of what culturally competent mental health practice with underserved populations entails. The CWP's model of service delivery suggests that culturally competent mental health practice requires an understanding of culture as a dynamic and expansive construct that encompasses not only traditions, values, and belief systems, but also individuals' lived experiences within their communities and the larger sociopolitical context in which they live. In turn, addressing mental health needs requires addressing these multiple environmental contexts. The fact that the CWP operates within the larger context of a community hospital suggests that community hospitals can play a critical role in promoting individual, family, and community wellness within marginalized and underserved communities.

# I. INTRODUCTION

## A. Problem Statement: Mental Health Needs of Latino Immigrants and Culturally Competent Service Delivery

In the year 2014, the U.S. immigrant population reached its highest level in history, totaling over 42.4 million (Zong & Batalova, 2016). Latino immigrants comprise 46% of the U.S. foreign-born population (Zong & Batalova, 2016). Although 28% of the U.S. immigrant population is from Mexico, Latino immigrants trace their heritage to a diverse range of countries of origin including Central and South America and the Caribbean (Zong & Batalova, 2016). In addition, the U.S. immigrant population as a whole includes individuals who are lawful permanent residents, who have become naturalized U.S. citizens, and who reside in the U.S. without documents authorizing their presence (Zong & Batalova, 2016). Reflecting this same diversity in documentation status that characterizes the entire U.S. immigrant population, Latino immigrants include individuals of both documented and undocumented statuses (Zong & Batalova, 2016). In addition to this diversity in country of origin and immigration status, the Latino immigrant population is also diverse with regard to language, educational attainment, socioeconomic status, historical context of migration, and factors influencing the migration journey (Brown & Patten, 2014; Zuniga, 2002). For example, individuals who migrated to the U.S. in the era of the amnesty granted to undocumented immigrants in the 1980's faced a more welcoming public reception than did individuals migrating in subsequent decades, when xenophobia and hate crimes against immigrants became more prevalent (Zuniga, 2002). Individuals migrating to escape violence and civil conflict may also arrive in the U.S. with different pre-migration experiences in comparison to individuals whose migration journey is driven by economic factors (Zuniga, 2002).

While diverse with regard to the aforementioned factors, the Latino immigrant population as a whole is faced with the common task of adjusting to the cultural context of their new country of residence while simultaneously maintaining connections to their cultural heritage (Ramirez Garcia, 2012). In contemporary U.S. society, Latino immigrants are faced with this task in a climate where anti-immigrant sentiment is pervasive (Ayón, 2014; Caplan, 2007; Horevitz & Organista, 2012; Salas, Ayón, & Gurrola, 2013; Zuniga, 2002). To begin, federal legislation restricts access to public benefits for undocumented and newly arrived documented immigrants (Ayón, 2014). In addition, in 2015 a federal district court decision blocked components of President Barack Obama's immigration executive action that proposed to provide temporary relief from deportation for undocumented immigrant parents (Shear & Preston, 2015). Most recently, in November of 2016 Donald Trump was elected to the U.S. presidency following a campaign that was marked by pervasive nationalist and anti-immigrant rhetoric (Collinson & Diamond, 2016). In the week following Trump's presidential inauguration, he signed executive orders to begin constructing a wall at the U.S.-Mexico border and to withhold funding from sanctuary cities that do not cooperate with federal immigration authorities (Benett & Bierman, 2017; Executive Order No. 13, 767, 2017; Executive Order No. 13, 768, 2017). These executive orders and accompanying implementation memos additionally called for increased resources to be invested in immigration enforcement activities (Executive Order No. 13, 767, 2017; Executive Order No. 13, 768, 2017; Kelly, 2017a; Kelly, 2017b; Kopan, 2017). The Trump administration also attempted to implement two different executive orders barring U.S. entry among foreign nationals from specific Middle Eastern and African countries and suspending review of all refugee applications (Executive Order No. 13,769, 2017; Executive Order No. 13,780, 2017; Johnson, 2017). These executive orders, which are widely described as "Muslim

bans," have been blocked by the federal courts from going into effect (Johnson, 2017). As these examples illustrate, Latino immigrants are met with nationalist sentiment and a hostile political environment upon their arrival to the U.S. Not only must they contend with an anti-immigrant political landscape, but literature also indicates that they commonly experience discrimination in the realms of housing, employment, health care, and everyday interpersonal interactions (Aguilar-Gaxiola et al., 2012; Caplan, 2007; Flores et al., 2008; Garcini et al., 2016; Horevitz & Organista, 2012; Raymond-Flesch, Siemone, Pourat, Jacobs, & Brindis, 2014). Latino immigrants additionally experience pressure to assimilate to the mainstream Anglo American dominant cultural norms (Aguilar-Gaxiola et al., 2012).

The stress of adjusting to life in the U.S. while encountering a hostile political climate and experiencing ongoing discrimination has been associated with mental health difficulties for the Latino immigrant population, including depression and anxiety symptoms (Aguilar-Gaxiola et al., 2012; Flores et al., 2008; Garcini et al., 2016; Horevitz & Organista, 2012; Hovey & Magaña, 2000; Raymond-Flesch et al., 2014; Salas et al., 2013; Stacciarini et al., 2015). While prevalence rates for mental health disorders such as depression and anxiety tend to be lower for immigrant Latinos than for U.S.-born Latinos, a phenomenon known as the immigrant health paradox, this trend weakens or disappears altogether when subgroup differences are accounted for in the analyses (Alegría et al., 2008). In fact, when comparing mental health prevalence data among Cuban, Puerto Rican, and Mexican immigrant and U.S.-born Latinos, Alegría et al. (2008) found that this health paradox was only consistently observed among individuals of Mexican origin. While one may interpret these data as suggesting that the mental health status of Mexican immigrants is not a pressing concern, the opposite is actually the case. In their review of the literature pertaining to the Mexican health paradox, Horevitz and Organista (2012) state

that not only does Mexican origin individuals' mental health status become worse over generations, but also that among Mexican immigrants, mental health generally worsens over time in the U.S. This decline in mental health over time is attributed to exposure to chronic stressors such as discrimination (Horevitz & Organista, 2012). Horevitz and Organista's (2012) conclusion mirrors the results of Cook, Alegría, Lin, and Guo's (2009) analysis of mental health prevalence data across Latino immigrant subgroups, in which they found an association between increased time in the U.S. and risk of having a psychiatric disorder. They further found this association to be related to stressors including discrimination and family conflict (Cook et al., 2009). These data on trends for the Latino immigrant population at large and the Mexican immigrant population in particular point to the need for mental health services that protect against the impact of chronic stressors over time in the U.S.

Despite the mental health challenges encountered among the Latino immigrant population, they face multiple barriers to service access (Ayón, 2014; Bledsoe, 2008; Bridges, Andrews, & Deen, 2012; Cabassa, Lester, & Zayas, 2007; Ho, Yeh, McCabe, & Hough, 2007; Kim et al., 2011; Lee & Matejowski, 2012; Martinez-Tyson, Arriola, & Corvin, 2016; Perez et al., 2016; Santiago-Rivera et al., 2011). Among these barriers are those related to citizenship status (Lee & Matejowski, 2012), insurance status and cost of services (Bridges et al., 2012; Cabassa et al., 2007; Santiago-Rivera et al., 2011), work schedule, transportation, and child care (Santiago-Rivera et al., 2011), difficulties navigating systems of care (Ayón, 2014), and, most notably, limited availability of culturally and linguistically appropriate services (Aguilar-Gaxiola et al., 2012; Bledsoe, 2008; Ho et al., 2007; Kiang, Grzywacz, Marín, Arcury, & Quandt, 2010; Kim et al., 2011; Martinez-Tyson et al., 2016; Perez et al., 2016). Aguilar-Gaxiola et al. (2012) speak to this last point in their report on Latino mental health care disparities in the state of

California. More specifically, they found that a lack of attention to cultural values, beliefs, and strengths among both individual service providers and mental health agencies as a whole limited service use among Latino community members (Aguilar-Gaxiola et al., 2012). This finding indicates that when mental health treatment contexts are not culturally appropriate, they pose barriers to accessing needed services.

While there is a relatively well-established body of literature documenting the cultural and linguistic barriers that Latino immigrants experience in accessing mental health services, research identifying strategies for overcoming these barriers and addressing the mental health needs of the Latino immigrant population is more limited. Although an emerging body of literature on culturally competent mental health practice with Latinos emphasizes the importance of integrating cultural values and beliefs throughout treatment, this literature tends to be theoretical in nature, with limited empirical attention to how these concepts are translated into practice (Jani, Ortiz, & Aranda, 2009). In addition, while there is evidence to suggest that mental health services may be more accessible when cultural considerations are addressed at both the level of the individual provider and at the organizational level (Aguilar-Gaxiola et al., 2012), the literature on culturally competent organizational practice with Latino immigrants is even more limited. In one of the few examples of empirical literature on this topic, Uttal (2006) found that when a childcare worker certification program developed and implemented infrastructure at the organizational level to promote the integration of cultural values throughout service delivery, services were perceived as being culturally relevant and meaningful to Latino immigrant participants.

In the realm of mental health treatment, there is a small body of research studying organizations that have developed the infrastructure to serve a predominantly Spanish-speaking,

Latino immigrant target population. In her case study of a mental health clinic serving primarily Latino immigrants in the northwestern U.S., Horton (2006, p. 2707) found that through organizational level efforts to affirm the cultural and linguistic backgrounds of service participants, a service environment was created "where patients…[felt] 'welcomed' and 'at home.' " Similarly, in his case study of an outpatient mental health clinic serving older adult Latino immigrant community members, Ortiz (2012) found that from the perspectives of employees, organizational efforts to create a welcoming physical environment and integrate cultural values throughout treatment facilitated service access and engagement in services. This small body of literature suggests that culturally competent practice at the organizational level may decrease barriers to service access among Latino immigrants and allow their mental health needs to be addressed in a manner that is culturally relevant and meaningful. At the same time, however, the small body of research exploring examples of culturally competent organizational practice warrants the need for further study. While the aforementioned case studies provide reason to believe that developing organizational infrastructure to serve Latino immigrants may facilitate service accessibility and engagement in services (Horton, 2006; Ortiz, 2012), findings are based upon the perspectives of service providers and exclude the perspectives of the Latino immigrant population receiving mental health services. There is thus a clear need for research that seeks the perspectives of both service providers and service participants to better understand the experiences of service delivery within organizations that have developed the infrastructure to serve predominantly Latino immigrant populations.

At a local level, information on Chicago's Little Village neighborhood suggests that community efforts are being undertaken to address the mental health needs of the Latino immigrant community. The Little Village neighborhood, also known as La Villita or South

Lawndale, has a foreign-born population of approximately 43%, with 94.4% of this population identifying Mexico as their country of origin (Statistical Atlas, 2015). An additional 1.5% of Little Village's immigrant community members were born in Guatemala (Statistical Atlas, 2015). Residents face structural inequities related to poverty and limited access to resources (Enlace Chicago, 2013), and a recently conducted mental health needs assessment indicated that of the estimated 10,500 community residents with a mental health need, more than 7,000, or 67%, did not receive mental health services (Roots to Wellness, 2014). Depression and anxiety disorders are estimated to be the most prevalent mental health disorders among adult community residents (Roots to Wellness, 2014). In response to community need, efforts are currently being undertaken that leverage cultural assets to promote well-being (Enlace Chicago, 2013; Roots to Wellness, 2014). Central to these efforts is the Roots to Wellness initiative, a coalition of mental health and social service providers who are focused on increasing service access and identifying strategies for promoting positive mental health outcomes among Latino immigrant community residents (Roots to Wellness, 2014).

Among the Roots to Wellness member organizations is Saint Anthony Hospital's Community Wellness Program (CWP). This program has several branches, including a Little Village location, and is innovative in its efforts to provide free services that promote health and well-being among local residents (Casas & Isarowong, 2015; Saint Anthony Hospital, n.d.). The Little Village location of the CWP provides mental health services exclusively to uninsured Latino immigrant adults, while simultaneously offering access to other social services at the same site. Included in these additional services are health promotion and community nursing services, public benefits assistance, and parenting support and education (Casas & Isarowong, 2015; Saint Anthony Hospital, n.d.). Since the mental health program was established in 2003, it

has provided mental health therapy services to approximately 1,250 community members at its Little Village location, offering services for as long as needed without imposing time limitations on service delivery (A. Carrillo, personal communication, March 20, 2017). In recognition of the program's efforts to increase service accessibility for underserved community residents, the mental health department was awarded the Blue Cross and Blue Shield of Illinois Healthy Community Award in 2017 (Chicago Neighborhood Development Awards, n.d.).

The unique organizational context of service delivery at the CWP Little Village location warrants further study. Not only is service delivery geared exclusively toward a Latino immigrant target population, but the program's provision of services only to the uninsured makes them unique in comparison to other health and mental health clinics serving predominantly Latino immigrants that have been studied in past research (Bachman, Tobias, Master, Scavron, & Tierney, 2008; Horton, 2006). All service participants, who include both documented and undocumented immigrants, are able to receive program services free of charge. Saint Anthony Hospital, as a designated charitable community hospital, allocates approximately 21.1% of its overall annual budget to charity care and free programs such as the CWP. The hospital's Community Development Department, of which the CWP is a part, has an operating budget of approximately $1.2 million, and $312,000 of this budget is allocated specifically for the delivery of mental health services (A. Carrillo, personal communication, March 20, 2017). The Little Village location of the CWP is thus unique in the sense that services were developed specifically for an uninsured Latino immigrant target population and that the program has the capacity to offer mental health and a range of social services free of charge.

Despite the unique organizational context of the CWP Little Village location, it has not been formally studied. Studying this organization provides an important opportunity to generate

what Green (2014, p. 29) defines as “practice-based evidence.” Practice-based evidence refers to the empirical study of practice in the local community setting in which it is implemented, and Green (2014) asserts that this type of research is necessary for ensuring that interventions of relevance to practitioners are identified. Considering the gaps in past research on organizational culturally competent mental health practice with Latino immigrants, further exploration of service delivery at the CWP Little Village location can enhance our understanding of how themes related to the role of culture in service delivery, service accessibility, service engagement, and treatment outcomes manifest themselves within this specific organizational context. In turn, this enhanced understanding can inform practice efforts with Latino immigrants in other settings. In addition, considering that the model of service delivery at this organization has not been explicitly defined (A. Carrillo, personal communication, January 2015), exploration of the meaning that service providers and service participants ascribe to practice in this organizational context is essential to ensuring that components of their model can be translated to other settings in the future. In order to gain a comprehensive understanding of service delivery at the CWP Little Village location, I conducted an in-depth case analysis. Grounded in a Latino critical race conceptual framework, this exploratory study used a transcendental phenomenological qualitative approach to explore the meaning that service providers and service participants ascribed to service delivery and their experiences with mental health service provision. I additionally explored the mental health needs of community members and how the CWP addresses these needs. In the following sections, I will further describe the study’s conceptual framework and qualitative methodological approach. I will then discuss my positionality as a researcher and the measures that I implemented to uphold the study’s rigor.

Lastly, I will conclude this chapter with a presentation of the research questions that this study explored.

## B. Conceptual Framework: Latino Critical Race Theory

Latino critical race theory, also known as LatCrit, informed the conceptualization of this study. LatCrit is a branch of critical race theory (CRT), a multidisciplinary movement that incorporates legal, sociological, historical, ethnic, and women's studies to analyze the institutional mechanisms that create racial hierarchies of power and privilege (Delgado & Stefancic, 2012; Delgado Bernal, 2002; Irizarry, 2011; Solórzano & Yosso, 2002). CRT scholars assert that racism is an inherent part of the U.S. social structure and is reinforced through the creation and telling of a master narrative that gives voice to the experience of Whites and silences the voices of individuals of color (Delgado & Stefancic, 2012; Solórzano & Yosso, 2002). LatCrit expands on the ideas promulgated in CRT by giving particular consideration to institutional mechanisms that oppress the Latino community and silence their voice, including immigration and language policies (Delgado & Stefancic, 2012; Delgado Bernal, 2002; Irizarry, 2011). Garcia (1995) demonstrates how immigration policies promote structural oppression in his analysis of California's Proposition 187, legislation proposed by California voters in 1994 to deny undocumented immigrants access to benefits. According to Garcia's (1995) analysis, legislation such as Proposition 187 is not motivated by concerns regarding the legal status of undocumented immigrants, but is instead motivated by the fear that Latino immigrants threaten mainstream Anglo American culture. Immigration and language policies thus serve to reinforce established hierarchies of power and privilege by attempting to suppress the cultural identity of Latino immigrants and force their assimilation into mainstream society (Garcia, 1995).

In addition to exposing the mechanisms through which social institutions perpetuate racism and maintain hierarchies of power and privilege, another central aim of LatCrit is to change oppressive conditions (Delgado & Stefancic, 2012; Delgado Bernal, 2002; Solórzano & Yosso, 2002). One strategy for promoting social change is the documentation of counternarratives that challenge the dominant sociocultural discourse and provide a space to voice the experiences of individuals whose experiences have been systemically denied and invalidated (Delgado & Stefancic, 2012; Delgado Bernal, 2002; Irizarry, 2011; Solórzano & Yosso, 2002). Considering that empirical research on culturally competent mental health practice with Latino immigrants rarely includes the perspectives of Latino immigrants themselves (Horton, 2006; Jani et al., 2009; Ortiz, 2012), a central aim of this study was to acknowledge the voice of Latino immigrants involved in mental health service delivery at the CWP and to document their experiences as service participants.

A LatCrit conceptual framework also allows for exploration of themes related to service accessibility. As previously discussed, Latino immigrants commonly experience multiple barriers that impede them from accessing mental health treatment, including a lack of culturally and linguistically appropriate services (Aguilar-Gaxiola et al., 2012; Bledsoe, 2008; Ho et al., 2007; Kiang et al., 2010; Kim et al., 2011; Martinez-Tyson et al., 2016; Perez et al., 2016). From a LatCrit perspective, when mental health agencies do not consider the cultural identity of service participants and the context that influences their ability to access services, agencies are denying their experiences as Latino immigrants. I therefore used a LatCrit lens in the present study to assess the extent to which the CWP validates service participants' cultural identities and lived experiences from the point at which they access services and throughout the process of service delivery. Lastly, considering that the hostile political climate and legislative landscape in

the U.S. perpetuate anti-immigrant mainstream narratives that negatively impact mental health (Ayón, 2014; Garcia, 1995; Salas et al., 2013), the use of a LatCrit framework in the present study allowed me to assess the extent to which service providers at the CWP acknowledged and addressed mainstream narratives about Latino immigrants during the process of service delivery.

## C. Qualitative Methodological Approach

This study used a transcendental phenomenological qualitative approach to explore mental health service delivery at the CWP. A central aim of the phenomenological tradition is to describe the lived experiences of research participants and the meaning that they attribute to these experiences (Creswell, 2013; Moustakas, 1994). Transcendental phenomenology in particular aims to understand both what individuals experience with regard to a particular phenomenon and how the context in which they are situated informs this experience (Creswell, 2013; Moustakas, 1994). The transcendental phenomenological research paradigm "emerged out of a growing discontent with a…science that failed to take into account the experiencing person and the connections between human consciousness and the objects that exist in the material world" (Moustakas, 1994, p. 43). Researchers informed by this paradigm reject the claim that there is one objective, universal scientific truth, and instead assert that what one presumes to be true is based on their own lived experience (Moustakas, 1994). Knowledge is generated when the researcher suspends assumptions about what is true and immerses him or herself in the experience of the research participant. Transcendental phenomenological research thus requires that the researcher explore the "internal perception[s]" of research participants to generate a description of their lived experience and the context within which their experience occurs (Moustakas, 1994, p. 45).

In accordance with the tenets of transcendental phenomenology, I generated a portrait of mental health service delivery at the CWP Little Village location by exploring service providers' and service participants' experiences of service delivery and the meaning that they ascribed to these experiences. This qualitative methodological approach coincides with the tenets of a LatCrit conceptual framework. First, by documenting a narrative that is inclusive of the lived experiences of Latino immigrant service participants, this study acknowledged the voice of a population whose perspective is traditionally ignored in empirical mental health research. Second, by documenting the meaning that both service providers and service participants ascribed to service delivery at the CWP, I aimed to generate a description of the CWP's model of service delivery that was informed from within rather than externally imposed. My approach aligns with Irizarry's (2011) study of a teacher education program, where he used a phenomenological methodological approach and a LatCrit conceptual framework to explore the experiences of Latino students enrolled in the program. Through the use of this approach, Irizarry (2011) documented the perspective of a population whose voice was traditionally not acknowledged in empirical research, and he subsequently used this perspective to inform his recommendations for improving teacher education programs.

## D. Theoretical Sensitivity

The transcendental phenomenological tradition requires that the researcher develop an awareness of how their background and experiences may potentially influence the processes of data collection and analysis (Moustakas, 1994). In accordance with a transcendental phenomenological qualitative approach, I will begin this section by describing my positionality. Orland-Barak (2002) describes positionality as referring to the multiple "selves" (i.e. personal and professional identities) that researchers bring to their work (p. 267). While the concept of

positionality focuses on self and identity, theoretical sensitivity refers to both researchers' awareness of how their identities influence the research process and the steps that they take to minimize this influence (Orland-Barak, 2002). After discussing my personal and professional identities, as well as the beliefs and experiences that I brought to my research, I will then discuss the steps that I took to protect the rigor of my data collection and analysis.

To begin, I am an Anglo American, U.S.-born female researcher who speaks Spanish as a second language. While I am an outsider to the Latino immigrant community, my interest in and commitment to understanding the experiences of Latino immigrants began during my undergraduate studies, when I participated in a study abroad program in Santiago, Chile. This experience led me to reflect on the challenges that individuals experience in navigating unfamiliar cultural contexts. I recognized that my experience as a study abroad student was informed by the privilege of having the necessary documentation and having access to institutional support and resources, which led me to reflect on the difficulties associated with migrating to the U.S. without this same level of privilege. This experience largely inspired my decision to work as a mental health therapist with the Latino immigrant community prior to beginning my doctoral studies. During my tenure as a mental health therapist, service participants frequently shared their experiences regarding the dangers of their migration journey and their limited ability to access services and opportunities when they were in the U.S. without documentation. As I heard their stories, I became increasingly aware of the problems with current U.S. immigration policies. I strongly identify with a progressive political ideology and vehemently oppose rhetoric that labels human beings in reference to categories of "legality" and "illegality." I believe that immigration policies must take into account the transnational forces driving migration, and I support legislation that grants amnesty to all individuals living in the

U.S. without documentation. In addition, I believe that all individuals should have access to mental health services, regardless of their immigration status.

My interest in undertaking this study was not only informed by my belief that Latino immigrants have the right to mental health services regardless of their immigration status, but it was also informed by my observations of the organizational context in which I worked as a community mental health therapist. I found myself frustrated with the emphasis on billable hours and productivity in the settings where I worked, an emphasis that I perceived as valuing the quantity of individuals served over the quality of services that they received. I additionally noted the challenges that both service participants and myself as a practitioner experienced when we were situated in an organizational context that did not have the infrastructure to address the linguistic needs of Spanish-speaking immigrant community members. Upon first learning about the CWP after beginning my doctoral studies, I was excited about the opportunity to study an organization that anecdotally appeared to be different from the community mental health settings where I had practiced.

My awareness of my identity, beliefs, and experiences in turn informed my data collection and analysis processes. First, I recognized that my positionality as an outsider to the Latino immigrant community could influence service participants' decisions to take part in individual interviews, as I acknowledged that individuals might be hesitant to speak with me if they did not know who I was or what my intentions were. Coinciding with the approach that Caplan et al. (2011) outline in their study of beliefs about depression among Latino immigrants in a primary care setting, I enlisted support from service providers in introducing my study to service participants. I found that because service participants were introduced to the study through individuals whom they trusted, they felt comfortable speaking with me to learn more

about the study and to subsequently take part in an interview. I also recorded field notes after each interview in order to reflect on the potential impact of my positionality on the interview process. During each interview, I was intentional in my actions to dismantle traditional power hierarchies that could inadvertently be established between research participants and myself as a researcher. Engaging in self-reflection offered the opportunity for me to evaluate the extent to which traditional hierarchies were acknowledged during the interview process. I found that when I informed service participants that the aim of my study was to learn more about mental health interventions that could be of benefit to the Latino immigrant community, individuals were enthusiastic to take part in efforts that could potentially help fellow community members and spoke freely about their experiences at the CWP.

Recognizing how my past experience as a mental health therapist and my beliefs about mental health service delivery could potentially influence the framing of my interview questions and my subsequent analysis, I followed several procedures to minimize this influence. I was particularly concerned with ensuring that I did not idealize service delivery at the CWP. I began by ensuring that the questions in my interview guides not only explored service providers' and service participants' positive experiences with service delivery, but that they also explored challenges and limitations. In addition, writing field notes after each interview and observation activity allowed me to reflect on my thoughts and emotions as they emerged throughout the data collection process. Through this process of self-reflection, I noted personal biases that were evident during an interview or observation, so that I could take measures to address this bias in subsequent data collection activities. Upon beginning my analysis, I kept a research diary where I documented each step of the analytic process to ensure transparency and allow for replication. I consulted with my Committee Chair, who has expertise in phenomenological qualitative

analysis, regarding my analytic methods and my preliminary findings. I additionally conducted member check interviews with service providers and service participants to confirm the validity of my preliminary findings, a process that I will discuss in greater depth in Chapter III.

## E. Research Questions

This study explored the following research questions:

1) How do service providers and service participants describe the services that are delivered at the Little Village location of Saint Anthony Hospital's CWP?
2) How do service providers and service participants experience service delivery within this organizational context? What is their experience with regard to the role of culture in service delivery, the accessibility of services, service engagement, and treatment outcomes?
3) From the perspectives of both service providers and service participants, what are the mental health needs of community members receiving services, and how does the program address these needs?

As this was an exploratory study that aimed to generate an understanding of service provision based on the themes that emerged through qualitative data, no hypotheses were offered regarding expected findings.

# II. REVIEW OF THE RELEVANT LITERATURE

There are four bodies of literature that contribute to our understanding of the current state of the research on culturally competent mental health practice with Latino immigrants. The first body of literature provides an overview of the mental health needs of Latino immigrants and identifies the mental health access barriers and service disparities that this population commonly experiences. The second body of literature explores the conceptualization of cultural competence at both the individual and organizational levels, and considers the application of this concept as it relates to Latinos. The third body of literature focuses more specifically on qualitative case studies of organizations that have developed the infrastructure to provide mental health services to a predominantly Latino immigrant population. Lastly, the fourth body of literature is related to research on service participants' perceptions of and experiences with mental health service delivery. I will discuss each of these bodies of literature in turn in the following sections. Included in the review are empirical reports, theoretical articles, and literature reviews published within the last 30 years. I have elected to include literature dating back to the 1990's to provide relevant historical context regarding the conceptualization of culturally competent practice and its evolution over time. In addition, the inclusion of theoretical and review articles is necessary due to the fact that empirical articles on mental health practice with Latino immigrants are relatively limited.

## A. Mental Health Needs of Latino Immigrants and Barriers to Accessing Care

### 1. Mental Health Needs and Prevalence

The most recent prevalence data on mental health disorders among Latino immigrants are presented in Alegría et al.'s (2008) analysis of data collected from the National Latino and Asian American Study (NLAAS) between 2002 and 2003. Based on their age- and gender-adjusted

lifetime prevalence rates from this nationally representative sample, Alegría et al. (2008) found that approximately 24.9% of Latino immigrants reported any lifetime psychiatric disorder. Furthermore, 14.8% reported any lifetime depressive disorder, 15.2% reported any lifetime anxiety disorder, and 7% reported any lifetime substance use disorder (Alegría et al., 2008). Estimates by immigrant subgroup indicated that 23.9% of Mexican immigrants reported any lifetime psychiatric disorder, 12.9% reported any lifetime depressive disorder, 14.2% reported any lifetime anxiety disorder, and 7% reported any lifetime substance use disorder (Alegría et al., 2008). A growing body of empirical literature (Hovey & Magaña, 2000; Raymond-Flesch et al., 2014; Salas et al., 2013) and review articles (Garcini et al., 2016) indicates that depression and anxiety symptoms tend to be the most common or most frequently cited mental health conditions identified among the Latino immigrant population.

Literature also notes that trauma-related symptoms are a concern for Latino immigrants (Garcini et al., 2016; Phipps & Degges-White, 2014; Salas et al., 2013). In their review of the literature, Phipps and Degges-White (2014) identify that Latino immigrants may experience trauma at multiple stages of their migration process. For example, individuals often undertake migration journeys after experiencing trauma related to violent conditions or extreme poverty in their country of origin (Phipps & Degges-White, 2014). Particularly for individuals who are undocumented, the process of arriving at the U.S. border often causes additional trauma, due to perilous natural conditions or physical or sexual victimization during the journey (Garcini et al., 2016; Phipps & Degges-White, 2014). Lastly, the stressors that individuals encounter after their arrival may also be traumatic (Caplan, 2007; Garcini et al., 2016; Horevitz & Organista, 2012; Phipps & Degges-White, 2014; Salas et al., 2013). The fact that the mental health status of Latino immigrants worsens over time in the U.S. (Cook et al., 2009), a phenomenon that is

consistently observed for Mexican immigrants in particular (Alegría et al., 2008; Horevitz & Organista, 2012), points to the negative impact of chronic stressors. In order to fully understand the impact of these stressors as identified in the literature, I will first define the process of acculturation and describe the stressors that Latino immigrants commonly encounter during the acculturation process.

## 2. Acculturative Stressors Impacting Mental Health

In Berry's (1997, 2003) seminal work, he discusses that when individuals come into contact with a new culture, they undergo the process of acculturation. When immigrants migrate to a new country of residence, for example, they carry with them a set of cultural values, beliefs, and customs and encounter a new cultural context in the country where they settle. As these multiple cultural contexts come into contact with each other, changes result within the individual and within society at large. Depending on how closed or open a society is to cultural change, mainstream society may integrate components of the cultural systems of their immigrant populations or may reject their cultural systems altogether. At the individual level, immigrants must make decisions regarding the extent to which they adopt the cultural norms of their new country of residence and the extent to which they maintain their cultural heritage from their country of origin. Berry (1997, 2003) asserts that these individual decisions are manifested in one of four acculturation strategies. Individuals may adopt a strategy of separation when they maintain their cultural heritage from their country of origin and do not engage with the cultural context of their new country of residence, while an assimilation strategy signifies that individuals adopt the cultural values of their new country of residence while disconnecting from their cultural heritage. A marginalization strategy is when individuals are disconnected from both the cultural values of their country of origin and their new country of residence, while an integration

strategy, also known as biculturalism, occurs when individuals redefine their cultural identity so as to incorporate elements of both cultures (Berry, 1997, 2003).

Berry (1997, 2003) asserts that the acculturation strategy of integration will promote the most positive outcomes with regard to an individual's adjustment, health, and well-being. Empirical literature tends to confirm that this is the case. For example, based on their latent class analysis of data from the NLAAS, Bulut and Gayman (2016) found that bicultural individuals reported higher self-rated mental health in comparison to individuals who did not fit into this acculturative category. Similarly, Feliciano (2001) found that immigrant youth who were connected to both their cultural heritage and mainstream U.S. culture were less likely to drop out of school.

Berry (1997, 2003) acknowledges that individuals encounter challenges, also known as acculturative stressors, throughout the process of navigating multiple cultural contexts. The negative impact of these stressors is defined as acculturative stress, and is often manifested in the form of physical and mental health challenges (Berry, 1997, 2003; Horevitz & Organista, 2012). Based on a review of the literature, Caplan (2007) identified three categories of acculturative stressors. The first of these categories is social/interpersonal stressors, which encompasses the stressor of family conflict that oftentimes emerges during the acculturation process. In her theoretical article on family therapy with Latino immigrants, Falicov (2007) notes that migratory and acculturative processes often result in changing family dynamics. Falicov (2007) further explains that family members may migrate to the U.S. in different stages, leading to prolonged periods of separation that change the nature of family relationships and familial roles. In addition to the stress associated with familial separation and the process of redefining family relationships, differential rates of acculturation between parents and children residing together in

the U.S. may also lead to relational tension that contributes to mental health symptoms including depression, anxiety, substance use, and externalizing behaviors (Falicov, 2007). Similarly, Cook et al. (2009) found that family conflict was one of the primary factors associated with worsening mental health outcomes for Latino immigrants over time in the U.S. In addition to the stressor of family conflict, individuals may experience social/interpersonal acculturative stress due to the fact that they leave behind their support networks in their country of origin (Caplan, 2007). In an empirical study exploring the mental health status of newly arrived Latino immigrants, limited social support was found to contribute to depression symptoms (Shobe, Coffman, & Dmochowski, 2009).

In addition to social/interpersonal stressors, Caplan (2007) also outlines that individuals experience instrumental/environmental stressors and societal stressors during the acculturation process. In order to understand the nature of these stressors, it is first necessary to note an important caveat of Berry's (1997, 2003) four proposed acculturation strategies. Berry (1997, 2003) states that individuals do not have complete autonomy in the acculturation strategy that they pursue. Instead, an individual's ability to pursue a given strategy is influenced by the reception they receive in their new country of residence (Berry, 1997, 2003; Horevitz & Organista, 2012). For example, individuals are not able to fully engage with and participate in the cultural context of their new country of residence if they are unable to access services and opportunities (i.e. instrumental/environmental stressors) and face a discriminatory and hostile political climate and legislative landscape (i.e. societal stressors) (Berry, 1997, 2003; Caplan, 2007; Horevitz & Organista, 2012). With regard to the impact of instrumental/environmental stressors, Aguilar-Gaxiola et al. (2012) found that limited access to social and economic

resources was associated with depression, anxiety, and externalizing problems such as violent behavior among Latino immigrant community members.

With regard to the impact of societal stressors, there is a growing body of literature exploring the impact of these types of stressors on the mental health of the Latino immigrant population. Cook et al. (2009) found, for example, that discrimination, coupled with family conflict, accounted for the association between increased time in the U.S. and worsening mental health among Latino immigrants. Horevitz and Organista (2012) state that the association between discrimination and mental health challenges among Mexican immigrants is well-documented in their review of the literature on the Mexican health paradox. In their study of the relationship between perceived discrimination and mental health outcomes among Mexican immigrant adults in California, Flores et al. (2008) found that higher reported levels of perceived discrimination, manifested in the form of disrespect or unfair treatment in everyday interpersonal interactions, were associated with increased levels of depression.

While studies assessing the association between discrimination and mental health outcomes provide some insight into how individuals' reception in their host country impacts their mental health, they do not directly assess how mental health is impacted by anti-immigrant legislation and a hostile political climate. In what appears to be one of the few studies of its kind, Salas et al. (2013) explored the impact of anti-immigrant state legislation, including legislation that ended bilingual education and made immigrants ineligible for state financial assistance, on Mexican immigrant adults and their children in Arizona. Based on the results of qualitative focus group interviews, Salas et al. (2013) found that research participants attributed living in this hostile political climate to mental health challenges including depression, anxiety, and chronic trauma. Using what they defined as a critical perspective, Salas et al. (2013) concluded that

individuals internalized oppressive anti-immigrant narratives, leading to isolation from their community and negative mental health outcomes. Interpreting these results in the context of a LatCrit conceptual framework, this study provides some initial support to the idea that anti-immigrant policies perpetuate anti-immigrant narratives in mainstream society, which perpetuate the oppression and marginalization of Latino immigrants. In turn, oppressive mainstream narratives have the potential to negatively impact mental health.

A growing body of literature also indicates that documentation status is a factor impacting the mental health of Latino immigrants. Considering the extent to which federal and state policies focus on the deportation of undocumented immigrants and systematically deny them access to social services and public benefits (Ayón, 2014; Salas et al., 2013), it is not surprising that research has found undocumented immigrants to experience more instrumental/environmental and societal acculturative stressors in comparison to their documented peers (Arbona et al., 2010). Based on their review of the literature on the mental health needs of undocumented Mexican immigrants, Sullivan and Rehm (2005) determined that undocumented status has the potential to negatively impact mental health. In particular, they concluded that while the literature directly exploring the association between documentation status and mental health was almost non-existent, the literature on the acculturative stressors that undocumented immigrants experienced, including the stressor of living in constant fear of deportation, creates “a unique risk profile, which may contribute to different mental health outcomes as compared to their documented counterparts” (Sullivan & Rehm, 2005, p. 249).

In a more recent systematic review, Garcini et al. (2016) concluded that the literature generally seemed to suggest that undocumented immigrants experience multiple instrumental/environmental and societal stressors that impact mental health. While the authors

noted methodological limitations with the quantitative studies included in their review, such as problems with the way documentation status was measured and limited use of standardized measures to assess mental health symptoms, they were able to draw more definitive conclusions from the empirical qualitative literature (Garcini et al., 2016). Qualitative findings indicated that undocumented immigrants attributed symptoms of depression and anxiety to acculturative stressors including limited resources, living in constant fear of deportation, experiences of discrimination and exploitation, and "internalization of the undocumented stereotype" (Garcini et al., 2016, p. 15). Stacciarini et al.'s (2015) and Raymond-Flesch et al.'s (2014) qualitative studies further confirm the results of Garcini et al.'s (2016) review. Stacciarini et al.'s (2015) ethnographic case study of a single undocumented immigrant research participant found that the research participant attributed their documentation status to discrimination, marginalization, and social exclusion, which they in turn attributed to feelings of depression and decreased self-worth. Raymond-Flesch et al. (2014) yielded similar findings in their focus group research with undocumented immigrant adults who were eligible for temporary protection from deportation under the Deferred Action for Childhood Arrivals (DACA) program. In particular, respondents reported that they lived in constant fear of deportation and had limited access to employment and educational opportunities, health care, and social services. Furthermore, they associated their immigration status with mental health symptoms including depression, anxiety, trauma-related symptoms, and substance abuse (Raymond-Flesch et al., 2014). While the Latino immigrant population as a whole therefore experiences acculturative stressors that negatively impact their mental health, there is reason to believe that the risk for developing mental health symptoms may be even more pronounced among undocumented Latino immigrants.

### 3. Mental Health Access Barriers

Despite the unique challenges impacting the mental health of the Latino immigrant population, a large body of both quantitative and qualitative empirical literature has documented that they face multiple barriers to accessing mental health services (Aguilar-Gaxiola et al., 2012; Ayón, 2014; Bledsoe, 2008; Bridges et al., 2012; Cabassa et al., 2007; Ho et al., 2007; Kiang et al., 2010; Kim et al., 2011; Martinez-Tyson et al., 2016; Perez et al., 2016; Santiago-Rivera et al., 2011; Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008; Wells, Lagomasino, Palinkas, Green, & Gonzalez, 2013). The empirical literature on access barriers coincides with Delgado's (2007) perspective on service access. Delgado (2007) asserts that access to services is either facilitated or impeded by four categories of factors, including geographical factors, psychological factors, operational factors, and cultural factors. Based on this perspective, individuals will not necessarily utilize services simply because they are in close proximity. Instead, the extent to which individuals feel comfortable accessing services (i.e. psychological access), the extent to which organizations address individuals' logistical needs (i.e. operational access), and the extent to which services are culturally appropriate (i.e. cultural accessibility) all convergently influence whether individuals will ultimately access services (Delgado, 2007).

Coinciding with Delgado's (2007) perspective, research has identified psychological, operational, and cultural factors that pose barriers to service access for Latino immigrants. To begin, with regard to psychological access, literature indicates that stigma, particularly a fear of being labeled as "crazy," is associated with hesitancy to seek mental health treatment (Aguilar-Gaxiola et al., 2012; Benson-Flórez, Santiago-Rivera, & Nagy, 2017; Martinez-Tyson et al., 2016; Ortiz, 2012; Perez et al., 2016). However, even when individuals do feel ready to initiate services, they are limited by a range of operational barriers. Quantitative, mixed methods, and

qualitative research documents a range of structural barriers associated with poverty that impede service access for Latino immigrants, including transportation difficulties, a lack of child care, long work hours, and the cost of services (Bridges et al., 2012; Cabassa et al., 2007; Martinez-Tyson et al., 2016; Santiago-Rivera et al., 2011; Shattell et al., 2008; Wells et al., 2013). A convergence of psychological and operational barriers associated with immigration status, including a lack of access to insurance coverage and fear of having one's undocumented status reported to immigration authorities, have also been found to impact rates of service utilization (Aguilar-Gaxiola et al., 2012; Ayón, 2014; Bridges et al., 2012; Martinez-Tyson et al., 2016; Perez et al., 2016; Raymond-Flesch et al., 2014; Santiago-Rivera et al., 2011; Shattell et al., 2008; Wells et al., 2013).

With regard to cultural accessibility, multiple studies have documented that Latino immigrants do not access mental health services because culturally and linguistically appropriate services are not available (Aguilar-Gaxiola et al., 2012; Ho et al., 2007; Kiang et al., 2010; Kim et al., 2011; Shattell et al., 2008; Wells et al., 2013). In their report on the results of the California Reducing Disparities Project, Aguilar-Gaxiola et al. (2012) note how a lack of culturally and linguistically appropriate mental health services pose a barrier to service utilization among Latinos in the state of California. This study used a community-based participatory research methodology to conduct community forums, in which participants discussed key topics related to mental health service access and treatment within smaller *Mesas de Trabajo* (workgroups) and then reported back their main points of discussion to the larger group (Aguilar-Gaxiola et al., 2012). Latino adults from 12 communities in four regions of California were recruited to participate in the forums, with a total of 553 participants. Although participants included both immigrant and U.S.-born Latino community members, findings still

have important implications for understanding the role of cultural competence in facilitating service access. In particular, qualitative data from the forum discussions indicated that participants were "concern[ed] over the misalignment of the culture and context of mental health agencies with the culture and context of the Latino individual and community" (Aguilar-Gaxiola et al., 2012, p. 28). Aguilar-Gaxiola et al. (2012) further specified that "participants say that the procedures and protocol of mental health agencies and providers frequently conflict with the cultural values and beliefs of the Latino consumer" (p. 28). These findings thus suggest that Latino immigrants who are in need of mental health services are deterred from pursuing treatment when the treatment context is not culturally relevant.

**4. Mental Health Service Disparities**

The mental health service access barriers identified above in turn translate to higher rates of unmet mental health need and lower rates of treatment completion for Latinos in comparison to non-Latino Whites (Cabassa, Zayas, & Hansen, 2006; Lagomasino et al., 2005; Ojeda & McGuire, 2006; Owen, Imel, Adelson, & Rodolfa, 2012). There is a well-established body of literature documenting that across subgroups, Latino adults experiencing mental health symptoms use specialty mental health services at lower rates than non-Latino Whites (Cabassa et al., 2006). In a study specifically assessing use of specialty mental health services among a nationally representative sample of adults who met the diagnostic criteria for major depressive disorder or dysthymia, Ojeda and McGuire (2006) found that Latina females had lower rates of mental health service use in comparison to non-Latina White females, even after controlling for demographic factors including educational level and health insurance status. Epidemiological studies that have accounted for subgroup differences among Latinos in their analyses have found that immigrant Latinos have lower rates of mental health service utilization than do both U.S.-

born Latinos and non-Latino Whites (Cabassa et al., 2006). Keyes et al. (2012) similarly found that less time residing in the U.S., strong identification with Latino cultural heritage, and a strong preference for speaking Spanish were associated with a lower likelihood of using specialty mental health services among a nationally representative sample of Latino adults presenting with mood or anxiety symptoms.

Not only does research suggest that the Latino population as a whole, and Latino immigrants as a subgroup, are less likely than non-Latino Whites to have their mental health needs addressed, but evidence also points to disparities in treatment outcomes once individuals do access mental health services. A review of the literature indicates that the Latino population tends to be less satisfied with the mental health services that they receive in comparison to non-Latino Whites (Cabassa et al., 2006). Lagomasino et al. (2005) additionally found that immigrant and U.S.-born Latinos presenting with depression symptoms at primary care clinics across the nation were less likely to receive care in accordance with established treatment guidelines than were non-Latino Whites. Lastly, data from survey research with service participants at a university mental health center in the Western U.S. indicated that racial and ethnic minority service participants, including Latinos, had lower rates of treatment completion in comparison to non-Latino Whites (Owen et al., 2012). Researchers attributed these disparities in mental health service use and quality to a range of psychological, operational, and cultural access barriers (Cabassa et al., 2006; Lagomasino et al., 2005; Keyes et al., 2012; Owen et al., 2012; Ojeda & McGuire, 2006). With regard to cultural barriers in particular, researchers identified limited infrastructure to serve Spanish-speaking community members (Keyes et al., 2012), as well as limited training for providers working with culturally diverse populations (Owen et al., 2012), as potential reasons for observed disparities. As the literature indicates, culturally competent

treatment contexts can thus play an important role in decreasing access barriers and addressing service disparities among the Latino immigrant population.

## B. Culturally Competent Mental Health Practice

The literature on cultural competence suggests that despite the wide application of the term, there is considerable ambiguity regarding its meaning (Davis, 2007; Horevitz, Lawson, & Chow, 2013; Jani, Osteen, & Shipe, 2016; Sperry, 2012). Not only does research on culturally competent practice often fail to provide a clear definition of what cultural competence signifies, but the term is also often used interchangeably with a range of other terms, including cultural humility, cultural sensitivity, and cultural responsivity, without providing a clear rationale for why one term is chosen over another. Despite this ambiguity, the literature that makes the conceptualization of cultural competence its main focus tends to agree that the term generally refers to an evolving body of knowledge, attitudes, and behaviors necessary for practice with diverse populations (Davis, 2007; Horevitz et al., 2013; Sperry, 2012; Sue, 2001).

The concept of cultural competence has been subject to considerable critique. The most commonly cited shortcomings center around the fact that culture is assumed to have a universal meaning for all individuals of a particular racial or ethnic group; the term pays minimal attention to the impact of systems of power, privilege, and oppression on underserved populations; and the term assumes there is a finite body of knowledge that practitioners can attain (Carpenter-Song, Schwallie, & Longhafer, 2007; Fisher-Borne, Cain, & Martin, 2015; Furlong & Wight, 2011; Jani et al., 2016). Critical examination of these critiques, however, suggests that they point to problems with the interpretation and application of the term rather than to inherent shortcomings with the definition itself. For example, Sue (2001), whose conceptualization of cultural competence is considered to be seminal in the fields of social work and psychology (Fisher-

Borne et al., 2015), presents a definition of cultural competence that runs counter to the aforementioned critiques. Sue (2001) states that cultural competence requires an understanding of culture as a fluid construct, involves an ongoing process of experiential learning and growth, and provides a tool for promoting social justice by recognizing and addressing structural inequities. Furthermore, Jani et al. (2016) assert that alternate terms proposed in place of cultural competence merely lead to a shift in semantics, as alternate terms do not provide clearly defined conceptualizations of what appropriate practice with diverse populations entails. In fact, cultural competence is the only term in the literature that provides a well-developed framework for understanding what culturally appropriate practice entails at the level of the individual provider and the level of the organization as a whole. I have therefore elected to use the term cultural competence throughout this document because the literature clearly defines cultural competence as encompassing practice at both the individual and organizational levels (Davis, 2007; Horevitz et al., 2013; Sperry, 2012; Sue, 2001). At the individual level, service providers working with diverse populations are thought to deliver culturally competent services when they recognize that individuals' worldviews are shaped by cultural values, when they possess an evolving understanding of the values important to individuals of specific cultural backgrounds, when they are open to learning more about service participants' cultural values and beliefs throughout treatment, and when they are able to translate their knowledge and attitudes into behaviors that convey respect for service participants (Davis, 2007; Horevitz et al., 2013; Sperry, 2012; Sue, 2001). At the organizational level, culturally competent practice requires the development and implementation of infrastructure that addresses the needs of culturally diverse populations (Cherner, Olavarria, Young, Aubry, & Marchant, 2014; Chun-Chung Chow & Austin, 2008; Delphin-Rittmon, Andres-Hyman, Flanagan, & Davidson, 2013a; Hernandez, Nesman, Mowery,

Acevedo-Polakovich, & Callejas, 2009; Horevitz et al., 2013; Olavarria, Beaulac, Bélanger, Young, & Aubry, 2009; Sue, 2001; Uttal, 2006; Whealin & Ruzek, 2008). This section will address the idea of organizational cultural competence in greater depth, and will then turn to a discussion of how the concept of culturally competent mental health practice has been applied specifically in relation to the Latino population.

### 1. Culturally Competent Organizational Practice

The concept of organizational cultural competence is grounded in the idea that "culture is embedded in a variety of broader domains beyond the micro-level provider-patient relationship" (Horevitz et al., 2013, p. 139). Recognizing that culture is embedded in a context that extends beyond the individual, it logically follows that individual providers must have infrastructural support to implement culturally competent practice. A large body of theoretical literature asserts that agency policies and practices, including their hiring, retention, and training practices, are essential for addressing the needs of culturally diverse populations (Cherner et al., 2014; Chun-Chung Chow & Austin, 2008; Delphin-Rittmon et al., 2013a; Hernandez et al., 2009; Horevitz et al., 2013; Olavarria et al., 2009; Whealin & Ruzek, 2008). Additional elements of culturally competent organizational practice include developing mission statements and establishing physical environments that are culturally affirming of the community members whom the organization serves (Hernandez et al., 2009; Whealin & Ruzek, 2008). Lastly, culturally competent organizational practice entails that organizations establish community partnerships and communicate regularly with community residents regarding their needs, values, and service expectations (Chun-Chung Chow & Austin, 2008; Delphin-Rittmon et al., 2013a; Hernandez et al., 2009). This conceptualization of organizational cultural competence also implies that developing the infrastructure to support culturally competent practice is closely related to

organizational culture. Based on a review of the literature, Glisson and James (2002) define organizational culture as the beliefs, behavioral norms, and expectations shared by employees at a particular organization. Organizational policies and practices that encourage employees to learn about the cultural values of service participants and integrate these values during service delivery thus create a culture where culturally competent practice is the norm (Delphin-Rittmon et al., 2013a).

The theoretical literature on organizational cultural competence suggests that service delivery has increased potential to impact positive treatment outcomes when efforts are taken to address service participants' needs at both the individual and organizational levels (Hernandez et al., 2009; Sue, 2001). Hernandez et al. (2009) and Sue (2001), for example, assert that the impact of interventions delivered by individual providers is connected to the organizational context in which providers are embedded. Therefore, if an organizational context is not culturally accessible and does not offer an opportunity for providers to implement their skills, then the extent to which a provider is culturally competent is irrelevant. As Sue (2001) states: "…it does little good to train culturally competent helping professionals when the very organizations that employ them are monocultural and discourage or even punish psychologists for using their culturally competent knowledge and skills" (p. 802). Conversely, when organizations have developed and implemented the necessary infrastructure, they can support individual providers in acquiring knowledge and practicing skills (Delphin-Rittmon et al., 2013a; Hernandez et al., 2009; Sue, 2001). Based on their conceptual model of culturally competent organizational mental health practice, Hernandez et al. (2009) draw the following conclusion:

> …the success of efforts to develop a culturally competent psychiatric practitioner community or to disseminate culturally competent psychiatric service practices may be meaningfully influenced by the overall ability of the service organization to recognize,

> value, and respond to the needs of the particular cultural communities being served. (p. 1049)

As organizations support service providers in developing and practicing skills, service providers' daily practice thus reinforces organizational efforts to meaningfully address community needs (Hernandez, 2009).

In what appears to be the only empirical study of its kind to explore the link between individual and organizational level cultural competence, Darnell and Kuperminc (2006) found that among 12 public mental health agencies in Atlanta, Georgia, service providers "reported that culturally competent clinical practices were more prevalent" when their agencies had mandatory yearly cultural competence trainings (p. 203). Although training policies and practices represent only one of several elements of culturally competent organizational practice, the authors still assert that their findings offer "initial evidence that cultural competence activities and responsibilities of individuals and organizations are interdependent" (Darnell & Kuperminc, 2006, p. 204). They go on to state that promoting cultural competence at both the individual and organizational level can "improve the well-being of diverse populations" (Darnell & Kuperminc, 2006, p. 205).

Theoretical conceptualizations of culturally competent organizational practice can also be connected to the idea of structural competence. While structural competence is a concept that has primarily been applied to the literature on medical practice (Metzl & Hansen, 2014), it also has implications for the field of mental health. The concept of structural competence is grounded in the idea that individuals are embedded within larger community contexts that impact their health. In turn, communities are embedded within larger sociopolitical contexts that dictate the availability of health-promoting resources. This larger sociopolitical context thus influences the health outcomes of both individuals residing in a community and the community as a collective

entity. At the same time that this larger sociopolitical context influences the health outcomes of individuals and communities, it also influences the process through which practitioners and organizations deliver services. This larger sociopolitical context, for example, influences the amount of time that practitioners are allotted for clinical encounters and also dictates the types of services for which practitioners and organizations are reimbursed (Metzl & Hansen, 2014). While this sociopolitical context may therefore pose some limitations on how services are delivered, Metzl and Hansen (2014) assert that practitioners and organizations have increased potential to affect positive health outcomes when they recognize and address the structural inequities that individuals experience within the community and sociopolitical contexts in which they are situated. Prilleltensky (2008) makes a similar argument for the field of community psychology, asserting that wellness is a state in which needs are addressed at the level of the individual, the level of interpersonal relationships, and the level of the community as a whole. Coinciding with Metzl and Hansen's (2014) assertion, promoting positive mental health outcomes at the level of the individual thus requires that practitioners recognize how individuals' needs are connected to multiple levels of their environment (Prilleltensky, 2008). Both Metzl and Hansen's (2014) and Prilleltensky's (2008) conceptualizations of factors impacting health outcomes and wellness are closely aligned with Bronfenbrenner's (1994) ecosystemic perspective, which posits that individuals are embedded within multiple environmental contexts. Individuals, for example, are embedded within relational systems, the communities in which they live, and the larger sociopolitical context that encompasses legislation, institutions, and mainstream social and cultural norms (Bronfenbrenner, 1994). Metzl and Hansen (2014) and Prilleltensky (2008) assert that wellness and positive health outcomes are achieved by focusing interventions across multiple environmental levels.

Just as the theoretical literature on organizational cultural competence recognizes the increased potential to promote positive outcomes when both individual providers and organizations are culturally competent, Metzl and Hansen (2014) similarly identify the increased potential of coordinated individual provider and organizational efforts in their discussion of structural competence. For example, they state that "the physician who seeks to deliver structurally competent care works best if situated within groups or networks that are also concerned with [structural competence]" (Metzl & Hansen, 2014, p. 132). Synthesizing the literature on organizational cultural competence and structural competence from an ecosystemic perspective, mental health practice that is culturally competent at both the individual and organizational levels has increased potential to affect positive outcomes across multiple environmental contexts. Recognizing that an important component of organizational cultural competence is establishing community partnerships and engaging in reciprocal dialogue with community members regarding their cultural values and service needs (Chun-Chung Chow & Austin, 2008; Delphin-Rittmon et al., 2013a; Hernandez et al., 2009), it follows that coordinated provider and organizational efforts to respond to the service needs of both individual program participants and the community as a whole has increased potential to affect positive outcomes at both the level of the individual and the level of the community. In turn, addressing inequities at the level of the community moves a step closer to addressing inequities within the larger sociopolitical context (Metzl & Hansen, 2014).

Figure 1 synthesizes the theoretical literature on individual and organizational cultural competence from an ecosystemic perspective. To begin, it illustrates that service delivery occurs within the larger sociopolitical context in which individuals, organizations, and communities are embedded. It additionally demonstrates the increased potential to promote positive mental health

outcomes when practice is culturally competent on both the level of the individual provider and the level of the organization (Delphin-Rittmon et al., 2013a; Hernandez et al., 2009; Metzl & Hansen, 2014; Sue, 2001). In particular, because the services that practitioners deliver are connected to their organizational context, organizations that maintain an open dialogue with community partners and develop and implement culturally competent infrastructure are better equipped to support practitioners in developing cultural understanding and delivering culturally tailored interventions (Chun-Chung Chow & Austin, 2008; Davis, 2007; Delphin-Rittmon et al., 2013a; Hernandez et al., 2009; Sue, 2001). In turn, when service providers have the necessary support to deliver culturally tailored interventions, they reinforce an organizational culture in which culturally competent practice is the norm (Delphin-Rittmon et al., 2013a; Hernandez et al., 2009). This reciprocal exchange between service providers and the organization thus supports coordinated efforts to implement culturally competent practices. At the same time, Figure 1 illustrates that individual service participants are impacted by the community and sociopolitical contexts within which they are situated and with which they interact. Because individuals' needs are connected to community needs (Metzl & Hansen, 2014; Prilleltensky, 2008), coordinated provider and organizational practices that impact both individual service participants and their larger communities have increased potential to impact positive outcomes across multiple environmental levels (Metzl & Hansen, 2014).

While Figure 1 provides a useful starting point for understanding the connection between individual and organizational level cultural competence and the resulting impact on treatment outcomes, it is important to note that this model is theoretical in nature. There is a general lack of empirical research exploring how culturally competent practice at the levels of the organization

Figure 1. A Theoretical Model for Understanding the Impact of Coordinated Culturally Competent Individual and Organizational Practice on Mental Health Treatment Outcomes


and individual providers are connected. Darnell and Kuperminc's (2006) study appears to be the only of its kind to explore this connection, and it only linked one of many elements of organizational cultural competence to increased culturally competent practice at the individual level. Furthermore, this study used a convenience sample of mental health agencies in one state and assessed organizational cultural competence a year after data on individual level cultural competence was obtained, which should be taken into account when generalizing the results of

this study (Darnell & Kuperminc, 2006). It also appears that no research to date has assessed the combined impact of individual and organizational level cultural competence on treatment outcomes across environmental contexts. There is a thus clear need for empirical research that further explores the link between organizational and individual level cultural competence and the resulting effect on mental health outcomes.

### 2. Culturally Competent Mental Health Practice with Latinos: Theoretical Conceptualizations

While the discussion on cultural competence thus far has focused on its general conceptualization at the individual and organizational levels, I will now review the literature on cultural competence as it relates specifically to the Latino population. Santiago-Irizarry (1996) provides the historical context necessary for understanding early conceptualizations of culturally competent mental health practice with Latinos in her ethnographic account of two specialized inpatient psychiatric programs for Latino adults in New York City. She states that a subpanel of the presidential commission on mental health with special populations recognized a need for culturally competent mental health services in 1978, after releasing a report that identified Latinos "as 'vulnerable' and a population at risk in all aspects of mental health" (Santiago-Irizarry, 1996, p. 8). The report described Latinos "as suffering the full impact of a so-called culture of poverty," and stated that mental health problems emerged because individuals did not speak English and did not have the education or the skills to function in urban society (Santiago-Irizarry, 1996, p. 8). The report further identified close relationships with family members as a source of pathology (Santiago-Irizarry, 1996). However, despite this racist portrayal of "Otherness," the report recommended that mental health practitioners address the mental health needs of the Latino population by offering services in their native language and recognizing their

cultural traditions and values, particularly the value of close familial relationships (Santiago-Irizarry, 1996, p. 8). This report thus reflects a paradoxical conceptualization of the relationship between culture and mental health, with culture simultaneously viewed both as a deficit and key to recovery (Santiago-Irizarry, 1996).

In Santiago-Irizarry's (1996) analysis of the two inpatient psychiatric programs that were the focus of her ethnography, she notes that these programs, which were established in the late 1980's, reflected the paradoxical conceptualization of the relationship between culture and mental health described above. She additionally identified that the programs reflected a view of culture as a static rather than fluid construct (Santiago-Irizarry, 1996). Administrators of the inpatient programs tended to assume that Latino patients subscribed to a set of cultural values and beliefs that remained constant, regardless of their local context or experiences. Santiago-Irizarry (1996) describes, for example, that program staff identified patients' requests to make St. Patrick's Day decorations as misaligning with their cultural heritage, despite the fact that many patients were long-time residents of New York City and saw St. Patrick's Day as an event of importance in their local environment. Santiago-Irizarry's (1996) commentary on these inpatient programs thus frames culturally competent mental health practice with Latinos as a concept historically rooted in both a deficits perspective and an understanding of culture as a static construct. This commentary aligns with Delgado's (2007) discussion on the historical conceptualization of culture as it pertains to social work practice with Latinos. Delgado (2007) similarly states that literature in the 1960's and 1970's was dominated by a cultural deficits perspective. Furthermore, mention of Latino cultural values during these decades was confined to superficial references to "the importance of family and religion" and "the importance of food

and celebrations" (Delgado, 2007, p. 169). These superficial references served to perpetuate stereotypes rather than promote cultural understanding.

More recent theoretical literature reflects a shift in the conceptualization of culture and culturally competent mental health practice with Latinos. As previously discussed, conceptualizations in the 1960's, 1970's, and 1980's viewed culture as a source of deficit and pathology, as well as a static construct that simply required a superficial understanding of values and customs (Delgado, 2007; Santiago-Irizarry, 1996). In contrast, more recent theoretical conceptualizations view culture as an asset that can promote positive mental health outcomes, and also recognize that culture is a fluid, dynamic construct that takes on different meaning for different individuals (Añez, Paris, Bedregal, Davidson, & Grilo, 2005; Delgado, 2007; Falicov, 2009). For example, Falicov (2009) asserts that culturally competent individual practice with Latinos requires that providers explore the meaning that individuals attribute to their cultural heritage rather than assuming that they have a particular set of values and beliefs. Culturally competent individual practice is thus rooted in interpersonal exchanges that allow service providers to develop an understanding of service participants' beliefs, values, and worldviews (Falicov, 2009). In addition, while Añez et al. (2005) recognize the heterogeneity of the Latino population, they also recognize that there are several common cultural values that have the potential to promote positive mental health outcomes when they are viewed as assets and integrated throughout treatment. These values include *familismo* (the importance of nuclear and extended family members and close friends), *personalismo* (the centrality of interpersonal relationships and relationship-based exchanges), and *respeto* (respect) (Añez et al., 2005). Añez et al. (2005) discuss that practitioners can integrate these values throughout treatment by ensuring that they respectfully address service participants; exploring how family support can be

leveraged to promote positive outcomes; and developing interpersonal relationships in which the provider "get[s] to know the client as an individual by having a dialogue that goes beyond the chief complaint" (p. 224). While the authors' conclusion is not backed by empirical evaluation, they assert that these practices can lead to increased service accessibility, satisfaction with services, and positive treatment outcomes (Añez et al., 2005).

Lastly, theoretical conceptualizations of culturally competent mental health practice with Latinos also assert that cultural competence does not only entail understanding individuals' values, but that it also entails understanding individuals' experiences within their family, community, and larger societal environmental contexts (Falicov, 2007; Organista, 2009). Drawing from her own practice experience in the field of family therapy, Falicov (2007) states that culturally competent practitioners should explore how immigrant families are impacted by the community and larger societal contexts of their new country of residence. She additionally states that practitioners should support families in navigating unfamiliar contexts and adapting to new cultural systems while simultaneously maintaining their connection to their cultural heritage (Falicov, 2007). In synthesizing the information presented in this section, it is noteworthy that these theoretical conceptualizations of culturally competent practice with Latinos focus on cultural competence solely at the level of the individual provider.

### 3. Culturally Competent Mental Health Practice with Latinos: Empirical Research

While the literature on culturally competent mental health practice with Latinos is largely theoretical, there is a growing body of empirical research identifying and evaluating examples of culturally competent practice. In Antoniades, Mazza, and Brijnath's (2014) systematic review of depression treatments for immigrant populations, which included eight studies on depression treatment for Latino immigrants in the U.S. (53% of all studies included in the review), they

discussed that practitioners delivering the treatment typically modified interventions that were not developed specifically for Latino immigrants so as to increase their cultural relevance. Several of the studies found that culturally adapted interventions were associated with positive treatment outcomes among Latino immigrants. For example, culturally adapted individual (Interian, Allen, Gara, & Escobar, 2008, as cited in Antoniades et al., 2014) and group cognitive behavioral therapy interventions (Gelman, Lopez, & Foster, 2005, as cited in Antoniades et al., 2014; Piedra & Byoun, 2012, as cited in Antoniades et al., 2014) were associated with decreased depression symptoms in several of the reviewed studies, as was a culturally adapted interpersonal therapy intervention (Beeber et al., 2010, as cited in Antoniades et al., 2014). However, the authors noted that methodological limitations including small sample sizes and high attrition rates were common in the reviewed studies (Antoniades et al., 2014). Furthermore, the majority of the studies included in the review used pre-experimental designs that did not compare treatment outcomes between individuals who took part in these culturally adapted interventions and individuals who received the same intervention minus the culturally relevant modifications. Lastly, the specific cultural modifications that were made for each intervention were not well described in this review (Antoniades et al., 2014).

In Healey et al.'s (2017) systematic review, the authors synthesized treatment outcomes across experimental and quasi-experimental studies that compared culturally adapted interventions to interventions that were the same except for the adaptations. Their review included 31 studies that evaluated culturally adapted health and mental health interventions across a range of populations, with seven studies that focused specifically on Latinos. The authors concluded that interventions tended to be effective when they were developed in collaboration with the community members for whom the intervention was intended (Healey et

al., 2017). Although pertaining to health rather than mental health outcomes, Healey et al. (2017) cite as an example an experimental study assessing the effectiveness of providing vouchers for free mammograms among low income Latinas. The study found that individuals who received vouchers were significantly more likely to have a mammogram in comparison to individuals who did not receive vouchers (Skaer, Robison, Sclar, & Harding, 1996, as cited in Healey et al., 2017). Considering that this intervention was developed based on community feedback that cost posed a barrier to participating in preventive health screenings, there is some evidence to suggest that culturally competent interventions are effective when they take into account the environmental context in which individuals are situated and the service needs that emerge within this context (Healey et al., 2017).

In what appears to be the only literature review of its kind to focus exclusively on culturally competent interventions with Latinos, Jani et al. (2009) synthesized empirical articles on health, mental health, and substance abuse interventions published between the years 1999 and 2005. The authors identified 10 studies evaluating mental health interventions with Latino adults, including five articles evaluating depression interventions, two evaluating interventions for individuals with schizophrenia and their family members, and three evaluating interventions for family caregivers (Jani et al., 2009). While nine of the 10 studies noted that the developed interventions were associated with symptom improvement for at least one of the identified mental health outcomes, the descriptions of the cultural modifications are generally so vague that they are of little use to practitioners looking for concrete examples of culturally competent interventions. The one exception is an experimental study of an intervention for individuals with schizophrenia that assessed a culturally modified intervention involving extended family members in treatment. This study found that the culturally modified intervention was more

effective in increasing overall functioning and decreasing hospitalizations than was treatment as usual (Kopelowicz, Zarate, Smith, Mintz, & Lieberman, 2003, as cited in Jani et al., 2009). Overall, however, interventions are poorly described and do not identify whether Latino research participants are immigrants or U.S.-born. Lastly, Jani et al. (2009) state that studies generally use standardized measures of symptomology to assess treatment outcomes and do not seek the perspectives of individuals who participated in the intervention. From a LatCrit perspective, Jani et al.'s (2009) recommendation that research capture service participants' perspectives on culturally competent practice is key to challenging established power hierarchies, defying assumptions about service participants' needs and values, and ensuring that conceptualizations of culturally competent service delivery align with the perspectives of the individuals for whom interventions are designed.

While the reviews of the literature discussed above generally provide limited information on what culturally competent interventions look like in practice, there are several studies published in recent years that warrant further attention due to their detailed descriptions of their interventions and their reports of positive treatment outcomes. To begin, Piedra and Byoun (2012) conducted a pilot evaluation of a group cognitive behavioral intervention, Vida Alegre, that was intended to decrease depression symptoms among Latina immigrant adults in Champaign County, Illinois. The intervention was "tailored to the immigrant experience," with the authors providing a detailed description of how they modified the treatment manual to integrate content on the impact of the migration experience on individuals' everyday lives and personal relationships (Piedra & Byoun, 2012, p. 140). Using a pre-posttest design to assess depression symptoms, as well as conducting a post-intervention focus group to explore participants' treatment experiences, the authors found that the intervention was associated with a

significant decrease in depression symptoms (Piedra & Byoun, 2012). Research participants additionally reported that they experienced the group as fostering a sense of community and support. While this study had no comparison or control group and had a small sample size of 19 women, it does provide some initial evidence pointing to positive treatment outcomes (Piedra & Byoun, 2012). Furthermore, the cultural modifications of this intervention are well articulated, and it is noteworthy that Piedra and Byoun (2012) seek the perspectives of Latina immigrant service participants to assess treatment outcomes rather than relying solely on standardized measures.

In their methodologically similar pilot evaluation of a multifamily group intervention, Valdez, Padilla, Moore, and Magaña (2013) assessed whether the Fortalezas Familiares intervention decreased depression symptoms and enhanced social support among 13 Latina immigrant mothers. The authors described Fortalezas Familiares as a cultural adaptation of a multifamily group intervention originally developed for White and African American mothers, in which content was integrated on acculturative stressors and cultural assets that could be leveraged to cope with acculturative stressors (Valdez et al., 2013). The authors found that the intervention was associated with decreased depression symptoms and an increase in perceived social support. Furthermore, participants reported that “the intervention’s focus on culture, immigration-related losses, and acculturative stressors helped to deepen their understanding of their struggles, and helped them connect as a family” (Valdez et al., 2013, p. 402).

Based on survey results indicating a high prevalence of trauma-related symptoms among uninsured Latina immigrants at a sample of primary care clinics, Kaltman, Hurtado de Mendoza, Serrano, and Gonzales (2016) collaborated with clinic patients and providers to develop a culturally competent mental health intervention to be delivered in a primary care setting. This

mixed individual and group cognitive behavioral intervention integrated culturally appropriate elements including an emphasis on relationship-building during individual sessions; the use of culturally meaningful *refránes* (sayings) and vignettes during group; and dedicating time to making crafts at the start of the group to facilitate connection between group members through a non-threatening activity. Results of pre- and posttest assessments for 28 participants indicated that the intervention was associated with decreased depression and posttraumatic stress symptoms. Findings from post-intervention qualitative interviews additionally suggested that participants felt as if the group intervention offered them the opportunity to develop supportive relationships with fellow group members who experienced similar struggles (Kaltman et al., 2016).

Benson-Flórez et al. (2017) provide additional evidence pointing to the positive impact of culturally competent mental health interventions in their case study of a behavioral activation intervention with a mixed status Mexican immigrant family in Arizona. The authors identified specific ways in which this behavioral intervention was adapted to be culturally appropriate for the family, including increased emphasis on relationship-building; discussing acculturative stressors and the impact of living in an anti-immigrant political environment; safety planning to prepare for the potential event of parental deportation; assisting the parents in navigating unfamiliar U.S. social service systems; and educating the parents about community resources and their rights as community members. Based on the family's qualitative self-reports, this intervention was found to decrease paternal alcohol use and improve communication among family members (Benson-Flórez et al., 2017).

While Antoniades et al. (2014) and Healey et al. (2017) might dismiss the aforementioned studies because they use either single group pre-posttest or case study designs

and have small sample sizes, there are several strengths that should be noted. First, all of these studies clearly describe the process that they followed to develop their intervention and identify specific elements of the intervention that are culturally competent. Second, all of these studies solicited feedback from service participants regarding their experiences taking part in the intervention. While exploratory in nature, the aforementioned studies thus provide initial evidence that interventions have the potential to promote positive treatment outcomes when providers demonstrate an understanding of the environmental context in which individuals are situated and openly discuss cultural assets and acculturative stressors that impact service participants. Although these studies provide some initial support regarding the potential of culturally competent interventions to impact positive treatment outcomes, it should be noted that they focus on culturally competent interventions as delivered by individual providers and do not consider the organizational context in which providers are embedded. Furthermore, these studies only assess treatment outcomes at the level of the individual and interpersonal relational systems (i.e. family systems) and do not explore the impact of the intervention on the community as a whole.

### C. Organizational Practice With Latino Immigrants: Qualitative Case Study Explorations

As noted in the previous section, the empirical literature on culturally competent practice with Latinos focuses primarily on the level of individual providers. One of the few exceptions is Uttal's (2006) qualitative study of a child care worker certification program interested in expanding services to Latino immigrant community members. Uttal (2006) identified several ways in which the organization developed the infrastructure to certify Latina immigrant child care workers. For example, the organization hired a bilingual program director, translated workshop materials to Spanish, and addressed several operational factors that impeded

community members' access to certification workshops. These operational changes included changing the time when the workshops were offered and providing transportation assistance and child care. The organization was also open to changing its own philosophy regarding what child care worker certification services encompassed, and gave the program director flexibility to modify the curriculum based on program participant feedback. The program director was given the flexibility to integrate content on bicultural child rearing practices into the workshops and to support program participants in learning about unfamiliar U.S. social service systems. While Uttal (2006) identifies that this process of tailoring services to address community members' needs was not free of tension, she concludes that "[o]rganizational cultural competency was partially achieved" because the organization was willing to rethink its philosophy and implement some infrastructural changes in response to community members' feedback on their service needs (p. 260). In turn, Uttal (2006) determined from her observations of program activities that program participants seemed satisfied with the extent to which workshops supported community members in developing the skills to raise children in a new cultural context rather than solely providing information on the certification process.

Focusing specifically on the realm of mental health, several qualitative case studies have explored aspects of service delivery within the context of organizations serving predominantly Latino immigrant populations. While these case studies do not explicitly state that the organizations reflect organizational level applications of culturally competent practice, these organizations do meet the criteria for this type of practice when considering that they have developed the infrastructure to serve this target population and have integrated Latino cultural values and beliefs throughout service delivery (Horton, 2006; Ortiz, 2012). In Horton's (2006) case study of a mental health clinic in the northwestern U.S. serving predominantly Latino

immigrants, she identified elements of culturally competent organizational practice even though this was not the primary focus of her study. Horton (2006) describes the mental health clinic and its parent hospital as being part of a safety net system of care that provides services primarily to uninsured and Medicaid Latino immigrant community members. Horton (2006) conducted participant observation and employee interviews to explore her primary aim of understanding how "institutional pressures" affected service delivery (p. 2706). Horton (2006) found that "financial pressures" created demands for clinicians to see a large number of service participants each day in order to meet established billable hours quota, which led to practices such as shortening appointment length, double booking appointments, and stopping services to individuals who no showed three appointments (p. 2709). While clinicians viewed these practices as undermining their ability to engage hard-to-reach service participants, they simultaneously viewed the clinic "as a refuge from an alienating and Anglo-centric public environment" (Horton, 2006, p. 2707). The culture of the clinic was perceived as supporting providers in recognizing the cultural values of service participants and creating a space that was "culturally Latino" (Horton, 2006, p. 2707). Within this treatment context, there was also recognition of "the social, economic, and political factors that affect mental health," and providers therefore often served as advocates who connected service participants with resources and assisted them in navigating unfamiliar cultural contexts (Horton, 2006, p. 2707). While providers expressed concern about the impact of productivity demands on engaging hard-to-reach service participants, case vignettes included throughout Horton's (2006) analysis also suggest that there are elements of this treatment context that positively impact service participants. In particular, through organizational level efforts to promote Latino cultural values throughout treatment and consider the environmental contexts impacting mental health, service

participants engaged with providers, reached out to providers in moments of distress, and ultimately had positive treatment outcomes (Horton, 2006).

Similar to Horton's (2006) methodological approach, Ortiz (2012) employed qualitative methods including employee interviews, participant observation, and analysis of agency documents to study an outpatient mental health clinic serving Latino immigrant older adults. This mental health clinic operated within the context of a larger senior services parent organization (Ortiz, 2012). In his analysis, Ortiz (2012) identified several factors at the organizational level that employees associated with increased service accessibility for an underserved population. To begin, the administration chose to locate the mental health clinic in a remodeled home near the senior services parent organization in order to help participants feel "as if they were at home" rather than at a clinic and to decrease the stigma associated with accessing mental health services (Ortiz, 2012, p. 510). Employees associated these organizational level efforts to create a welcoming environment as facilitating treatment access among a population who might otherwise be hesitant to access services. Second, Ortiz (2012) found that the organization created a culture that supported providers in integrating Latino cultural values such as *personalismo, respeto,* and *familismo* throughout treatment. Based on his observations of waiting room interactions between service providers and service participants, Ortiz (2012) concluded that organizational level efforts to promote the integration of Latino cultural values throughout treatment facilitated service participants' engagement in services. Through his efforts to triangulate data from multiple sources, Ortiz (2012) thus identifies several organizational factors, including physical environment and organizational culture, that are associated with service accessibility and engagement for Latino immigrant older adults seeking mental health services.

While the reviewed case studies provide an important starting point for understanding organizational level applications of culturally competent mental health service delivery, there are limitations that must be noted. In particular, while Horton (2006) and Ortiz (2012) employed multiple methods of qualitative data collection, they only conducted individual interviews with service providers. From a LatCrit perspective, documenting a narrative on service delivery that excludes the perspectives of service participants reinforces traditional hierarchies of power and privilege. Developing a comprehensive understanding of service delivery within organizations serving Latino immigrant target populations requires that research capture both the perspectives of those who are providing the services and those whom the services are intended to benefit. Qualitative case study research exploring how organizations function to address the needs of the population whom they intend to serve would therefore benefit from acknowledging the voices and experiences of both service providers and service participants. In addition, although the theoretical literature identifies the increased potential to affect positive outcomes across multiple levels of the environment when culturally competent practices are coordinated at both the level of the individual provider and the level of the organization (Hernandez et al., 2009; Metzl & Hansen, 2014), the aforementioned qualitative case studies do not consider community level treatment outcomes.

### D. Service Participant Perceptions of Mental Health Service Delivery

Not only is there a lack of research exploring service participants' perceptions of and experiences with service delivery at organizations serving Latino immigrant target populations, but there is also a lack of research exploring how Latino immigrant adults more generally experience formal mental health services. The research that does exist on service participant perceptions of service delivery tends to focus on client satisfaction, and often studies assess

service satisfaction among racial and ethnic minorities as a whole rather than focusing their assessment on specific racial and ethnic groups. Meyer and Zane (2013), for example, found that provider-client racial matching and service provider knowledge of challenges associated with prejudice and discrimination increased the likelihood that service participants would perceive mental health services as aligning with their treatment needs. The researchers did not, however, distinguish between African American, Asian, Native American, and U.S.-born and immigrant Latino service participants in their analysis (Meyer & Zane, 2013). In qualitative focus group research with mental health service participants of diverse racial and ethnic backgrounds across the state of Connecticut, findings indicated that service participants were generally satisfied with services when providers demonstrated that they genuinely cared about them and understood their cultural values and lived experiences within their environments (Delphin-Rittmon et al., 2013b). While some service participants reported that racial/ethnic matching was necessary for providers to truly understand their values and experiences, others expressed satisfaction with providers who did not share their cultural background when they were open to learning about the meaning that service participants attributed to their culture (Delphin-Rittmon et al., 2013b). Conversely, service participants expressed dissatisfaction with services when they felt as if providers did not understand them, discriminated against them, or could not communicate with them in their native language (Delphin-Rittmon et al., 2013b). In addition, at the organizational level, researchers have found that adult service participants with severe and persistent mental illness perceived organizations as being more likely to empower them to manage their mental health symptoms when they had organizational cultures that were open to change and innovation in comparison to when they had rigid organizational cultures (Clossey & Rheinheimer, 2014).

In one of the few studies of its kind, Ishikawa, Cardemil, and Falmagne (2010) explored experiences with help-seeking and service satisfaction among Latino adults with mental health histories of depression, anxiety, and bipolar disorder. Similar to Delphin-Rittmon et al. (2013b), Ishikawa et al. (2010) found that service participants were mixed regarding their preference for Latino service providers. While some service participants reported that shared ethnic heritage facilitated cultural understanding, others stated that providers did not necessarily need to be Latino if they demonstrated an understanding of their cultural values. The factor that appeared to be of primary importance in determining service satisfaction was the relationship between the therapist and service participant. More specifically, service participants tended to express satisfaction with formal mental health services when they had "a client-therapist relationship that was warm, caring, and personable, and in which they felt valued as a person, not just as a client" (Ishikawa et al., 2010, p. 1568). While one may argue that the development of warm and caring relationships is simply good clinical practice and not necessarily culture specific, Ishikawa et al. (2010) assert that cultivating this type of relationship takes on particular significance for individuals who ascribe to the Latino cultural value of *personalismo,* which refers to a "quality of warmth and openness in Latinos' personal and professional interactions" (p. 1567). Furthermore, there is evidence to suggest that the cultivation of warm and caring relationships is also connected to the Latino cultural value of *familismo*. Ishikawa et al. (2010) describe, for example, how one service participant "viewed her therapist as akin to a member of the family," and in turn "that closeness helped her feel comforted" (p. 1566). Ishikawa et al. (2010) thus present evidence to suggest that among the Latino service participants who took part in this study, service satisfaction was associated with the extent to which the cultural values of *personalismo* and *familismo* were embodied in interpersonal interactions with service providers.

The growing body of research that has conducted pilot evaluations of culturally competent mental health interventions in recent years has also begun to include assessments of service participant satisfaction as a component of their evaluations. Based on qualitative assessments of satisfaction with interventions, researchers have found that Latino immigrant service participants tended to report satisfaction with interventions when service providers expressed a genuine concern for their well-being (Kaltman et al., 2016; Piedra & Byoun, 2012) and demonstrated an understanding of their personal lived experiences, particularly their experiences coping with acculturative stressors (Valdez et al., 2013). Synthesizing the limited research on service participants' perceptions of service delivery, it is evident that while perceptions of service delivery appear to be influenced by factors at the levels of both the individual provider and the organization, our knowledge of how Latino immigrants experience service delivery at the organizational level is especially limited. In addition, the gaps in the literature reinforce the need for research acknowledging the voices and experiences of Latino immigrant adults involved in mental health treatment.

## E. Conclusion

A synthesis of the four reviewed bodies of literature suggests that while the barriers impeding access to mental health services among Latino immigrants are well documented, research on strategies for addressing these barriers and facilitating service access is less developed. The literature on culturally competent mental health practice with Latinos has a strong theoretical orientation. While there is an emerging body of literature pointing to the positive impact of culturally competent interventions at the level of the individual provider, there is a need to further solidify our empirical knowledge base (Antoniades et al., 2014; Healey et al., 2017; Jani et al., 2009; Kaltman et al., 2016; Piedra & Byoun, 2012; Valdez et al., 2013). In

addition, while there is reason to believe that applications of organizational level culturally competent practice have increased potential to affect positive treatment outcomes across multiple environmental levels, the theoretical and empirical literature on culturally competent organizational practice with Latino immigrants is even more limited. Moreover, in the few qualitative case studies that do explore mental health service delivery at organizations that serve predominantly Latino immigrant target populations, the voices and experiences of Latino immigrants participating in services are notably absent. The general lack of attention to the experience of Latino immigrant service participants in mental health research reinforces hierarchies of power and privilege and limits our understanding of how specific components of service delivery facilitate service access and engagement and promote positive mental health outcomes. In an effort to address these limitations, this study explored mental health service delivery at an organization serving a Latino immigrant target population, using methods that documented the voices and experiences of both service providers and service participants. Through acknowledging the perspective of a population who is not traditionally acknowledged in mental health research, the study aimed to develop a more comprehensive understanding of the meaning ascribed to service delivery, experiences with mental health service provision, and strategies used to address mental health needs within the organizational context of Saint Anthony Hospital's Little Village location of the CWP.

# III. RESEARCH METHODOLOGY

## A. Research Design

This study used a case study design with a transcendental phenomenological qualitative approach. According to Rosenberg and Yates (2007, p. 448), a case study is not a "methodology in its own right," but rather a broader research strategy. The aim of case study research is to generate an in-depth understanding of a single case at either the individual or organizational level, and literature suggests that this approach is compatible with both quantitative and qualitative research methods (Rosenberg & Yates, 2007; Yin, 2003). I therefore selected a transcendental phenomenological qualitative approach within this case study design for the purpose of generating a comprehensive description of the experiences of service providers and service participants and the meaning that they ascribe to service delivery within this organizational context. According to Creswell (2013), phenomenological qualitative methods are best suited for generating descriptive data on research participants' lived experiences of a phenomenon and the meaning that they ascribe to these experiences. Within the broader phenomenological tradition, a transcendental phenomenological approach allows for exploration of research participants' experiences on two levels. In particular, this approach aims to generate a description of both what individuals experience and how their experience occurs within the particular context in which they are situated (Creswell, 2013; Moustakas, 1994). A transcendental phenomenological approach was therefore well aligned with my aim of exploring the experiences of service providers and service participants at the Little Village location of the CWP and understanding how this unique organizational context informed their experiences.

In order to explore service providers' and service participants' experiences of service delivery and the context within which these experiences occurred, I employed a methodology

closely aligned with Ortiz's (2012) qualitative case study of an outpatient mental health clinic serving Latino immigrant older adults. Ortiz (2012) employed methodology including individual interviews, participant observation in the clinic waiting area, and collection of agency artifacts such as brochures and assessment forms to gain a comprehensive understanding of the agency's functioning. Similarly, I utilized a range of qualitative methods including individual interviews, participant observation, and collection of agency artifacts to gain a more in-depth understanding of service delivery at the Little Village location of the CWP.

## B. Sampling and Recruitment

### 1. Sampling and Recruitment of Service Providers

Sampling and recruitment for this study occurred in two phases. During the first phase, which occurred from March to June of 2016, I invited all employees who were involved in service delivery at the CWP's Little Village location to take part in individual interviews. At the time of data collection, there were a total of 11 full-time employees who worked either exclusively at the CWP Little Village location or who split their time between this office and other CWP locations. Four of these employees were affiliated with the mental health department, with three mental health therapists providing direct services and the program manager overseeing service delivery, supervising and training staff, providing group therapy services, and assisting with individual therapy services as needed. Seven employees were affiliated with the CWP in another capacity, including managing the front desk or working with the community nursing, family support, or public benefits/community resource education departments. In addition, there were three child care providers who worked out of this location through the family support program as needed. Considering that capturing the perspectives of a range of staff members allows for a more comprehensive case analysis (Horton, 2006; Ortiz, 2012), I purposively invited

all employees involved in service delivery in some capacity to participate in individual interviews.

My professional relationship with the program manager facilitated my entrée into the CWP Little Village location. The program manager is my colleague in the doctoral program and was supportive of my research. When I was preparing to begin data collection in March of 2016, the program manager personally introduced me to employees and allowed me to briefly explain my research and distribute English-language informational flyers during these introductions. I was on-site two days per week for the entire month of April 2016, the month when I conducted the majority of the interviews, so that service providers could speak with me directly to learn about my study and to schedule an interview if they elected to do so. Employees also had the option of contacting me via telephone if they preferred not to speak with me on-site. A total of 10 service providers elected to take part in individual interviews. Nine service providers spoke with me in person while I was on-site to schedule an interview and one service provider contacted me via telephone. While I am not disclosing the specific positions of the employees who took part in interviews to protect their confidentiality, employees were represented across all departments that provide on-site services. More detailed information on the demographic characteristics of employees who took part in interviews will be presented in the first section of Chapter IV, my findings chapter.

**2. Sampling and Recruitment of Service Participants**

During the second phase of sampling and recruitment, which occurred between July and September of 2016, I invited all mental health service participants to take part in individual interviews. Findings from past research with Latino immigrants in a health care setting indicated that individuals were initially hesitant to engage with outside researchers, particularly if they

were undocumented and uncertain of the researchers' intentions in collecting personal information (Caplan et al., 2011). Informed by these findings, I enlisted the support of mental health service providers in facilitating my introduction to service participants. As service participants typically had recurring appointments at the same day and time each week, I utilized a staggered recruiting method in which I alternated the day of the week when I was on-site at two-week intervals over a two month period between mid-July and mid-September of 2016. During each day that I was on-site, I asked mental health service providers to distribute Spanish-language informational flyers to each individual with whom they met for an appointment and requested that they personally introduce me to each service participant who was willing to meet me. As a trusted provider facilitated these in-person introductions, service participants appeared at ease speaking with me to learn more about the study and to schedule an interview if they elected to do so. I asked service providers to distribute flyers to any service participant who did not come to their scheduled appointment when I was on-site, and informed them that I could return to the CWP at the service participant's request if they desired to speak with me face-to-face to learn more about the study. I additionally posted a flyer in the program's waiting area and made the flyers available for service participants to take in a section of the waiting area where there were stacks of flyers and brochures. By making information about my study available in the waiting area, my intent was to ensure that individuals with varying degrees of engagement in mental health services had the opportunity to learn about and participate in the study. In doing so, I aimed to capture the experiences of both service participants who were regularly attending appointments and those who sporadically attended appointments or who terminated services prematurely.

I purposively staggered recruitment at two-week intervals to ensure that my sample of service participants was diverse with regard to a range of specified demographic characteristics. During the time between each recruitment interval, I conducted a preliminary review of the interviews that I had completed to date to assess the diversity of the sample. My intent in conducting this review was to determine whether it was necessary for me to focus my recruitment efforts on specific subgroups of the service participant population whose perspectives were not adequately represented. I found that I naturally obtained a sample that was diverse with regard to the mental health therapist with whom they received services, the length of time with which they had been receiving CWP services, and prior experience with mental health treatment. I also found that individuals were naturally diverse with regard to their age and the length of time that they had lived in the U.S. While the service participant population at the Little Village location of the CWP is primarily Mexican, I was able to recruit individuals from other countries of origin. I did note through my preliminary review, however, that males were underrepresented in my sample. While I engaged in purposive efforts to recruit male service participants, including speaking about my study at the start of an all-male therapy group, males remained underrepresented in my sample.

In addition to conducting preliminary reviews of completed interviews to assist in recruiting a diverse sample of service participants, I also conducted these reviews to assist me in determining when I had reached saturation. Saturation has been used as a criterion for determining the number of research participants in similar research exploring Mexican mothers' experiences with a well child nursing care program (Flores-Peña, Ortiz-Félix, & Cárdenas-Villareal, 2012). Saturation occurs when no new themes emerge during individual interviews (Flores-Peña et al., 2012). I determined that I had reached saturation after 11 service participant

interviews, at which point I stopped recruitment efforts. Seven of these interviews were scheduled via face-to-face encounters, while four were scheduled via telephone. An additional two service participants did not attend scheduled interviews and did not contact me to reschedule. Another service participant was not able to take part in an interview because they contacted me after the data collection period had ended. More detailed demographic information on the 11 service participants who took part in individual interviews will be presented in the first section of Chapter IV, my findings chapter.

### 3. Eligibility Criteria

Individuals were eligible to take part in interviews if they engaged in service delivery at the Little Village location of the CWP in some capacity or if they had received mental health services through the CWP on at least one occasion. Service provider eligibility was determined by confirming that they were engaged in service delivery at the CWP Little Village location on a full-time, split full-time, or part-time/as-needed basis. Service participant eligibility was determined by confirming the name of the mental health therapist with whom they had met or were currently meeting for appointments. All service participants were uninsured Latino immigrant adults at least 18 years of age, as this was the criterion for mental health program enrollment. All individuals who expressed interest in taking part in an interview were confirmed to have met eligibility criteria.

## C. Data Collection

As previously discussed, I used multiple methods of qualitative data collection to gain a comprehensive understanding of service delivery at the CWP Little Village location. First, I conducted semi-structured individual interviews with 10 service providers and 11 service participants to explore their experiences with mental health service delivery. Interviews with

both service providers and service participants ranged from 30 to 90 minutes in duration. In accordance with their preference, I conducted seven service provider interviews on-site in their private office and three interviews at a nearby community setting of their choosing. I conducted all service participant interviews at a neutral space arranged by the program manager. Ten of these interviews occurred in a private office at a local agency within walking distance of the CWP Little Village location, and one took place in a private room at Saint Anthony Hospital. Both service providers and service participants had the option to schedule an interview in advance or participate in an interview at the moment that they approached me on-site to learn more about the study. Eight service providers scheduled advance interviews and two service providers elected to take part in interviews at the time that they spoke with me on-site. Nine service participants elected to schedule interviews in advance and two elected to participate at the time that we were introduced on-site, at which point I accompanied them from the CWP to the nearby local agency. All service providers and service participants who took part in an interview were compensated with a $25 gift card to a local grocery store.

In accordance with the tenets of a transcendental phenomenological approach, interviews were comprised of broad, open-ended questions that allowed research participants to speak at length about their experience with minimal intrusion (Moustakas, 1994). Appendix A includes both service provider and service participant English and Spanish-language interview guides. Interview questions for both service providers and service participants began by asking research participants to tell a story about their experience working or receiving services at the organization, and then became more structured as the interview progressed. Interview questions for service providers aimed to capture their perceptions regarding what services were like and how they were delivered, while interview questions for service participants broadly explored

how they perceived all facets of service delivery at this organization. Questions were framed to elicit information on service providers' and service participants' experiences with regard to the role of culture in service delivery, the accessibility of services, service engagement, and treatment outcomes. During the process of developing the service provider and service participant English-language interview guides, I consulted with a staff member at a local CWP partner organization that serves a similar target population. The purpose of this consultation was to ensure that questions were understandable and culturally appropriate.

I conducted all interviews with service providers and service participants. Nine service provider interviews were conducted in English and one was conducted in Spanish, while all 11 service participant interviews were conducted in Spanish. After the University of Illinois at Chicago's Institutional Review Board (IRB) approved both the service provider and service participant English-language interview guides, I translated the guides from English to Spanish. I utilized a back-translation method to translate the service participant interview guide. I first translated the guide from English to Spanish and then enlisted the support of a native Spanish-speaking colleague to translate the guide from Spanish back to English. I then compared the original and back translated English versions to ensure that the meaning of the interview questions was consistent across versions. After completing this process, I consulted with the same individual who had provided feedback on the English-language interview guides to ensure that the wording of all Spanish-language questions was understandable and appropriate. I then submitted the translated Spanish-language interview guides to the IRB for their approval.

I audio recorded all service provider and service participant interviews with an encrypted digital recorder. All recorded interviews were then subsequently transcribed. In accordance with Lopez, Figueroa, Connor, and Maliski's (2008) recommendations for conducting translinguistic

qualitative research, all Spanish-language interviews were transcribed verbatim in Spanish to ensure the authenticity and accuracy of the data. As I was the only researcher coding these transcripts and was comfortable analyzing the Spanish-language versions, after consultation with my Chair I elected not to translate the interviews to English. In accordance with a LatCrit conceptual framework, in my findings chapter I present quotes from all Spanish-language interviews in their original language, so as to document research participants' authentic voice. I additionally translated all presented quotes from Spanish to English and included this English translation to accompany the quote in its original language, in order to ensure that content is understandable to all readers.

In accordance with the case study approach, I additionally conducted participant observation and collected agency artifacts to supplement the information obtained from individual interviews (Ortiz, 2012; Yin, 2003). In Ortiz's (2012) qualitative case study, he conducted observations in the clinic waiting area to gain insight into organizational functioning. In Horton's (2006) methodologically similar research, she attended staff meetings as a component of her participant observations. In both studies, the authors described participant observation as a method for supplementing qualitative data gathered through individual interviews and developing a more comprehensive understanding of the organization (Horton, 2005; Ortiz, 2012). Similarly, I used participant observation in this study to supplement the information obtained from individual interviews regarding what services at the CWP are like, how they are experienced, and how they are delivered. Because my aim was to further explore how service providers and service participants experienced service delivery on a day-to-day basis, I elected to observe a range of routine, regularly scheduled program activities and occurrences that offered insight into the CWP's daily operations and functioning. First, during

April and May of 2016, when I was recruiting service providers and conducting the first phase of individual interviews, I observed four staff meetings. Two of these meetings were internal to the mental health department, while two were for providers across CWP departments. Second, during June of 2016 as I was finishing the first phase of interviews and preparing for the second phase, I observed a session of a regularly offered parenting workshop, known as ACT, that was geared toward parents with children between the ages of five and 10.

Lastly, throughout both phases of recruitment and interviews, I conducted observations of the waiting area. I elected to conduct waiting area observations throughout the entire period of data collection so as to ensure that I got a sense of what the waiting area was like during different seasons of the year. I conducted one waiting area observation in March of 2016, one in April of 2016, and two in August of 2016. Each observation lasted an hour in duration. I conducted observations at different times of the day and different days of the week to ensure diversity across observational periods. I used saturation as a criterion for determining when I had conducted a sufficient number of waiting area observations (Flores-Peña et al., 2012). Across all observation activities, I attended to information in the built environment, as well as verbal and non-verbal interactions and behaviors.

Informed by the recommendations for conducting participant observation that Kawulich (2005) outlines in her review of the literature, I recorded the following information during observation activities: information on the physical environment where the observation occurred; brief descriptions of the individuals involved in the activity that did not involve the collection of personally identifiable data; verbal and non-verbal behaviors and interactions that occurred; and reflections on my own thoughts, emotions, and perceptions of how my positionality as a researcher impacted my observations. A detailed observation guide is available for review in

Appendix E. Lastly, in addition to participant observation, I enlisted the support of the program manager in collecting agency artifacts. Yin (2003) defines artifacts as materials or "physical evidence" that supplement our understanding of the case of interest (p. 96). To supplement my analysis of the Little Village location of the CWP, I collected program materials including brochures, logic models, written vision and mission statements, assessment forms, program description and planning documents, work plans, and procedural instruction forms.

**D. Data Analysis**

I conducted my transcendental phenomenological analysis following Moustakas' (1994) guidelines. Moustakas (1994) states that data should be organized so as to provide textural and structural descriptions of the phenomenon being studied. Textural descriptions focus on "*what* [research participants] experience," while structural descriptions provide information on the context influencing "*how*…[research participants] experience *what* they experience" (Moustakas, 1994, p. 142). In this study, textural descriptions generated a portrait of what the experience of service delivery is like and the meaning that research participants ascribe to this experience. Structural descriptions served to provide insight into how the organizational context of the CWP influences the experience of service delivery. I analyzed data from individual interviews, participant observations, and agency artifacts to generate textural and structural descriptions of service delivery at the Little Village location of the CWP. I then integrated these textural and structural descriptions into a single composite description.

Transcendental phenomenological analysis first requires engaging in the processes of horizonalization and clustering of meanings (Moustakas, 1994). Horizonalization refers to the process of identifying all data elements that are relevant to the phenomenon being studied and attributing equal importance to each of these data elements (Moustakas, 1994). I used what I

define as a mindfulness approach to engage in the process of horizonalization for analysis of individual interviews. Using this mindfulness approach, I utilized Atlas.ti software to review each interview transcript segment by segment and generate open codes that described the content of each segment. In order to keep myself grounded in the data and to ensure that my codes did not move from the descriptive to the abstract, I recorded memos outlining thoughts and emotions that emerged for me during the open coding process, including abstract ideas about how different codes were connected. This process closely aligns with what Moustakas (1994) defines as bracketing. According to Moustakas (1994), bracketing is a process in which "everything else is set aside so that the entire research process is rooted solely on the topic and question" (p. 97). In so doing, the goal is for the researcher to suspend their personal thoughts and judgments so that their subjective perceptions yield minimal influence on their analysis (Moustakas, 1994). This was exactly my intention in practicing a mindfulness approach. In particular, by acknowledging, recording, and separating my own thoughts and emotions that did not directly pertain to the data before me, I was able to ensure that my codes were grounded in descriptions of what research participants reported rather than in my own thoughts and perceptions of what their descriptions signified. Central to this process was using research participants' own words, or "verbatim excerpts," to develop codes (Moustakas, 1994, p. 131). Not only did the use of "verbatim excerpts" (Moustakas, 1994, p. 131) ensure that I generated codes grounded in research participants' explicit descriptions of service delivery, but this technique also coincided with a LatCrit conceptual framework. In particular, developing verbatim codes provided a means of documenting research participants' authentic voice from the beginning of the analytic process.

Following this process of horizonalization, I began the process of organizing codes from individual interviews into meaning clusters. This process entailed grouping related codes into

categories. During this phase, I wrote a short descriptive statement about each code and how I observed it to be connected to other codes, drawing largely on the memos that I had created during the horizonalization process. I used the descriptive statements to assist me in categorizing codes into meaning clusters. I kept a research diary where I documented my process and rationale for assigning codes to specific meaning clusters in order to promote transparency and ensure that others could replicate my process. I then further categorized meaning clusters into larger overarching themes, again documenting my process and rationale in my research diary. I subsequently generated separate textural and structural descriptions for service provider and service participant interviews based on the themes that had emerged in each of these groups of interview transcripts. Lastly, I integrated the textural and structural descriptions from the service provider and service participant interviews into one composite description, noting both similarities and differences that emerged among these subgroups.

I used a similar procedure to analyze data from participant observations and agency artifacts. To begin, I took field notes for each of my observation activities. I then followed the same mindfulness approach previously discussed to generate descriptive codes, group codes into meaning clusters, and further categorize meaning clusters into overarching themes. Lastly, I integrated my textural and structural descriptions of my observation activities into the composite description from service provider and service participant interviews. I followed this same process of horizonalization, organizing data into meaning clusters, and identifying themes to generate individual textural and structural descriptions for the collected artifacts. In fact, since I collected agency documents in March of 2016 before beginning interviews, I engaged in this analytic process before analyzing interviews and observation activities. I waited, however, until I had

generated a description across interviews and observations before integrating my descriptions of agency artifacts to yield a final composite description.

## E. Ensuring Trustworthiness of Data

Literature suggests that protecting the rigor of qualitative research entails taking steps to minimize researcher bias during data collection and analysis (Emden & Sandelowski, 1998). In this section, I will outline the steps that I took to minimize bias during the processes of data collection and data analysis respectively.

### 1. Ensuring Trustworthiness During Data Collection

Recognizing my positionality as an outsider to the Latino immigrant community, I took steps during data collection to alleviate Latino immigrant service participants' hesitancy to speak with me about my research and to ensure that they felt comfortable speaking openly with me about their experiences of service delivery if they did elect to take part in an interview. First, I enlisted the support of mental health service providers in facilitating introductions between myself and service participants. I observed that when a trusted provider facilitated introductions, service participants generally seemed open to speaking with me to learn more about my research. Second, I was intentional in my efforts to explain that the purpose of my study was to learn more about service delivery at the CWP, with the ultimate goal of identifying mental health practice strategies that could be of benefit to Latino immigrant community members in the future. Third, I took field notes after each interview that I conducted, during which time I reflected on the interpersonal exchange and ways in which I perceived my positionality as influencing the interaction. What I generally noted during my reflections was that service participants who took part in interviews spoke freely and openly about their personal experiences with service delivery. I observed that when service participants learned that I aimed to use the results of this study to

inform the future development of interventions for Latino immigrants, they were appreciative of my interest in their community and enthusiastic to educate me on a topic that could be of potential benefit to fellow community members. Not only did service participants speak openly and freely about their experiences at the CWP, but they also spoke freely about their experiences as immigrants in the U.S. Despite my positionality as an outsider to the community, service participants trusted me with their personal experiences and provided rich data on service delivery at the CWP.

**2. Ensuring Trustworthiness During Data Analysis**

Not only was I aware of how my positionality as an outsider to the Latino immigrant community could potentially influence the process of data collection, but I was also aware of how my experience as a community mental health therapist and my beliefs about what mental health service delivery should be like could potentially influence the process of data analysis. My mindfulness approach to coding, discussed in section D, played a crucial role in protecting the rigor of my analysis. In keeping with Moustakas' (1994) guidelines, acknowledging and recording abstract thoughts that emerged during coding allowed me to minimize the influence of my own personal judgments and perceptions and ensure that the codes that I developed were grounded in the data. An important component of this process was drawing directly on research participants' own words to generate codes. Developing verbatim codes ensured that codes were informed by research participants' own descriptions of what service delivery was like and minimized the chances that they were informed by my own perceptions of what I expected service delivery to be like or what I believed it should be like. In addition to this mindfulness approach to coding, I further protected the rigor of my analysis by using a research diary to document my process and rationale for organizing data into meaning clusters and overarching

themes. I consulted and debriefed with my Committee Chair regarding my process for developing codes, meaning clusters, and themes to ensure that my preliminary findings logically followed from the preceding phases of my analysis.

Lastly, literature on phenomenological research suggests that member checks, in which preliminary findings are presented to research participants, should be employed when possible to check the validity of results (Irizarry, 2011; Moustakas, 1994). I therefore conducted member checks with service providers and service participants who were available for follow up. All service providers and service participants had the choice of electing to participate in an individual or group member check interview, with the understanding that there would be separate group member check interviews for service providers and service participants. With service providers, I conducted one individual member check interview and one group interview with five providers. Service providers confirmed the accuracy of my findings and offered additional examples of the themes that were presented. I also conducted two individual member check interviews with service participants. While I was able to reach eight of the 10 service participants who had expressed interest in taking part in member checks at the time of their individual interview, six individuals were either unable to attend a member check interview due to personal stressors and busy schedules or did not attend the scheduled interviews and did not contact me to reschedule. It should be noted that I conducted member check interviews with service participants in November and December of 2016, shortly after the election of Donald Trump to the U.S. presidency. Considering the anti-immigrant rhetoric that characterized the Trump campaign (Collinson & Diamond, 2016; Lee, 2016), it is possible that the stress of his election could have impacted the availability of service participants to take part in member checks. However, although the number of service participants who were available for member checks

was limited, the two individuals who did participate overwhelmingly confirmed the accuracy of the findings. One individual even expressed surprise at the extent to which service participants' collective experiences mirrored their own personal experience at the CWP. Just as service providers had offered additional examples of the identified themes, so too did service participants. Member check interviews therefore not only validated my preliminary findings, but they also strengthened my final analysis by providing additional illustrative examples that added depth to my discussion of each of the identified themes.

## F. Protection of Human Subjects

This study received approval from the University of Illinois at Chicago's IRB. I took multiple measures to protect the privacy of research participants and to minimize risk throughout the process of data collection and analysis. To begin, informational flyers distributed to service providers and service participants during recruitment stated that study participation was completely voluntary and would not affect job security or receipt of services in any way. Both service providers and service participants had the option of speaking with me either on-site or via telephone to schedule an appointment. I provided the option of scheduling via telephone to protect the privacy of service providers and service participants who did not wish to be overheard speaking with me on-site. In the case of service providers, I gave them the option of conducting the interview at a community setting in place of their private office so that they did not run the risk of their colleagues seeing me enter their office. In the case of service participants, all interviews were conducted at a neutral location outside of the CWP to protect their privacy and minimize the likelihood that they would feel pressured to speak positively about the program.

I obtained informed consent from all service providers and service participants immediately before beginning individual interviews. Consent procedures were conducted in English for all English-language interviews and in Spanish for all Spanish-language interviews. The process of obtaining informed consent entailed reviewing the information on either the service provider Research Information and Consent form or the service participant Subject Information Sheet, including information on the purpose of the study, potential benefits, potential risks, and measures implemented to protect against risks. For both service providers and service participants, I explained that the purpose of my study was to learn more about their experiences with service delivery within the organizational context of the CWP. I further explained that while there were no direct benefits to research participants as a result of taking part in this study, the study was expected to benefit society at large by providing insight into components of mental health service delivery that can be used to inform future interventions with Latino immigrants. For service providers, I discussed the potential risk surrounding confidentiality and the concern of being discovered and reprimanded if they said something negative about the program. I informed them that to protect against this risk, I would be taking measures to securely store their confidential data (these measures will be further discussed later in this section). Furthermore, I informed service providers that the findings presented in my published dissertation would not be linked to specific individuals. When presenting quotes from service providers in my published work, I ensured that their identity and their position at the agency could not be deduced from the content of the quote. Lastly, I informed service providers that their decision to participate in the interview was completely voluntary and that they were free to skip a question or stop the interview at any time. I provided them with their $25 gift card before beginning the interview so that they understood that compensation was not dependent on

completing the interview in its entirety. After ensuring that service providers understood all of the information in the form, I asked them to sign the informed consent document to indicate their willingness to participate in the study.

For service participants, I discussed the same potential risk surrounding confidentiality and addressed their potential hesitancy to speak negatively about the CWP for fear of losing their services. I reiterated the information presented in the flyer stating that their participation in the study would not impact their service receipt in any way. I informed them of the measures I would be taking to securely store their data and stated that all data included in my published work would be stripped of identifying information. I also addressed several additional risks specific to the service participant population. Because I was interested in assessing the potential impact of documentation status on experiences of service delivery, I included a demographic question in my interview guide that asked service participants to describe their experience as an immigrant. I derived the wording for this question based on consultation with the program manager, who recommended this type of framing to ensure that the question was non-threatening for individuals who did not wish to directly disclose their immigration status (A. Carrillo, personal communication, September 24, 2015). The framing of this question also aligns with past research conducted with undocumented immigrants, where researchers recognized that questions ascertaining information on immigration status should be framed in a sensitive, non-threatening manner (Cavazos-Rehg, Zayas, & Spitznagel, 2007). Despite the framing of this question, however, I recognized the potential risk associated with disclosing sensitive information pertaining to immigration status. I therefore informed service participants that I was only asking this question for my own research purposes, and emphasized that they could choose not to answer this question or to disclose as little or as much information as they felt comfortable

disclosing. In addition, although interview questions did not ask service participants to directly discuss their mental health symptoms or life circumstances that led them to seek mental health treatment, I recognized that individuals could choose to discuss this information and potentially become distressed. I therefore emphasized that individuals could skip a question, take a break from the interview, or stop the interview altogether. Although service participants did choose to discuss their personal reasons for seeking services, there were not any occasions where individuals became overwhelmed and needed to take a break or stop the interview.

Following the same procedure outlined for service providers, I gave service participants their $25 gift card before beginning the interview to demonstrate that compensation was not contingent upon interview completion. I then ensured that service participants understood all of the information on the Subject Information Sheet. However, instead of asking service participants to sign the document, I obtained a waiver of documentation of informed consent from the University of Illinois at Chicago's IRB. I elected to obtain a waiver of documentation of informed consent due to the fact that I was asking about individuals' experiences as immigrants, and I presumed that individuals might be hesitant to provide their full name to an outside researcher if they were undocumented. While I asked all service participants who felt comfortable to provide me with a first name and telephone number that I temporarily linked to their interview transcript in case I had clarifying questions, I deleted this link immediately upon reviewing the transcript and determining that no follow-up was necessary. A waiver of documentation of informed consent thus ensured that I had no record of service participants' full names at any point during the study. There is also no way of linking service participants' interview transcripts to their identity. This protective measure coincides with measures

undertaken in past research with documented and undocumented immigrants (Cavazos-Rehg et al., 2007).

Across my observation activities, I did not collect any personal information on the individuals who were present while I was observing. However, I still took measures to obtain permission before observing when it was feasible to do so. Before each staff meeting that I observed, I distributed a permission form and asked prospective meeting attendees to mark the permission form with an "X" if they agreed to my presence. I informed them that I would only observe if I received unanimous permission. Furthermore, I stated that I would leave the meeting if they needed to discuss a specific service participant case. I followed this same process to request permission for observation of the parenting class. There were not any instances in which I was denied permission to observe. Lastly, informed by research citing concerns with the practicality and feasibility of requesting permission to conduct observations in a similar setting (Moore & Savage, 2002), I did not request permission from each individual present in the waiting area during the time that I conducted waiting area observations. The IRB approved all of these observation procedures.

I took measures throughout the duration of data collection to ensure that all confidential data were securely stored. All service provider and service participant interviews were audio recorded on an encrypted recorder. I then transferred the audio files to a password-protected flash drive and deleted the files from the audio recorder. I used the services of a professional transcription agency, Verbal Ink, to transcribe service provider interviews. There was no identifying information on the audio files that I shared with the transcription agency, and all audio files and transcripts were exchanged through a secure server. I stored all written transcripts from service provider and service participant interviews on the same password-protected flash

drive as the audio files. For both service providers and service participants, I created a Microsoft Word document on a second password-protected flash drive that linked their name (full names for service providers and first names for service participants) and telephone number to a numbered interview transcript. I only created the link in the event that I had follow-up questions on the content of the interview, and I destroyed these links after reviewing the transcript and determining that no follow-up was necessary. I also created a Word document on the second password-protected flash drive with the names (full names for service providers and first names for service participants) and telephone numbers of individuals who were interested in taking part in member check interviews. I deleted names and phone numbers from the document after contacting individuals for member checks. Lastly, I stored all service provider informed consent documents in a locked filing cabinet in my Committee Chair's office. As previously noted, I have taken measures throughout my findings chapter to ensure that individuals' identities cannot be deduced from the quotes that are presented. As an extra measure to protect research participant confidentiality, I have elected to identify interviewees by number rather than by pseudonym, as I was concerned that the use of gendered pseudonyms could compromise confidentiality in a sample where there are a small number of male service providers and service participants.

# IV. FINDINGS

## A. Introduction

Throughout the duration of data collection from March through September of 2016, I conducted 21 individual interviews with service providers and service participants; completed four staff meeting, one parenting class, and four waiting area observations; and obtained 17 agency documents. With regard to individual interviews, I conducted 10 interviews with service providers and 11 interviews with service participants. Of the 10 service providers who took part in individual interviews, eight (80%) identified as Latino/a and two (20%) identified as non-Latino/a White. In addition, eight (80%) of the interviewed service providers were female and two (20%) were male. All mental health service providers who took part in individual interviews had a master of social work (MSW) degree, while service providers across other CWP departments had diverse educational backgrounds ranging from no college degree to a masters degree in their respective field. More detailed demographic information, including the exact job titles of interviewees, will not be provided in order to protect confidentiality.

Of the 11 service participants who took part in individual interviews, nine (82%) were of Mexican origin, one (9%) was of Central American origin, and one (9%) was of South American origin (the names of specific countries are not provided to protect confidentiality). Service participants were predominantly female (91%), with only one male (9%) taking part in the study. The study sample is reflective of the CWP service participant population at large with regard to country of origin, as approximately 92% of the CWP's past-year mental health service participants are from Mexico, 2% are from Central America, and 6% are from a South American country of origin (A. Carrillo, personal communication, March 20, 2017). Males, however, are underrepresented in the study sample, as approximately 34% of past-year mental health service

participants are male and 66% are female (A. Carrillo, personal communication, March, 20, 2017).

Of the nine service participants who reported their age, their ages ranged from 26 to 60 years, with an average age of 37. One additional service participant, while they did not provide their exact age, described themselves as a senior citizen. The average length of time living in the U.S. for the eight service participants who reported this information was 16.75 years, ranging from a low of four years to a high of 28 years. Two service participants reported coming to the U.S. as young children under the age of five, while two individuals reported arriving as adolescents and four reported arriving as young adults. Lastly, while the majority of service participants did not explicitly report their immigration status, two alluded to the fact that they were undocumented and two reported that they had arrived in the U.S. without their documents and had obtained some type of protected status at the time of the interview.

The aim of this study was to gain an in-depth understanding of service delivery at the Little Village location of the CWP. In order to develop this understanding, the study explored the following research questions:

1) How do service providers and service participants describe the services that are delivered at the Little Village location of Saint Anthony Hospital's CWP?
2) How do service providers and service participants experience service delivery within this organizational context? What is their experience with regard to the role of culture in service delivery, the accessibility of services, service engagement, and treatment outcomes?

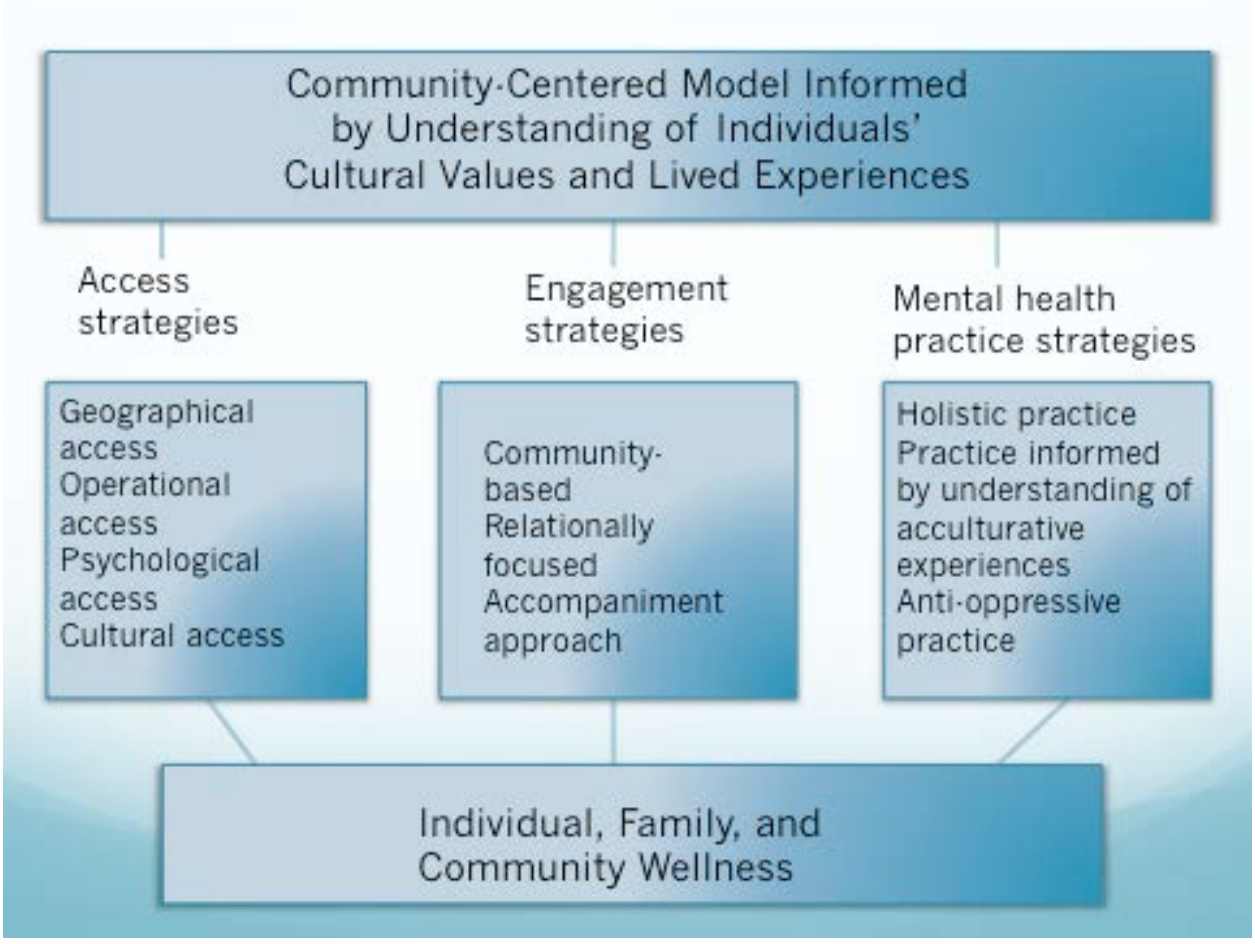
3) From the perspectives of both service providers and service participants, what are the mental health needs of community members receiving services, and how does the program address these needs?

Based on my analysis of data from interviews with service providers and service participants, field notes from observation activities, and agency documents, I determined that the three research questions outlined above are interconnected. Service providers' and service participants' descriptions of the program's model are inseparably linked to the program's strategies for addressing community members' mental health needs. In turn, service providers' and service participants' descriptions of program strategies for addressing mental health needs are closely associated with experiences of service delivery. For this reason, the findings in this chapter are presented thematically rather than linearly by research question. In addition, while I generated both textural and structural descriptions of service delivery at the CWP in accordance with the tenets of transcendental phenomenological analysis (Moustakas, 1994), I have integrated these descriptions throughout this chapter. I have elected to integrate these descriptions because the data on what individuals experience throughout the process of service delivery are interconnected to the context in which these experiences occur.

Figure 2 synthesizes my findings across research questions and provides a framework for structuring my presentation of data throughout this chapter. In particular, Figure 2 offers a visual representation that depicts the CWP's culturally competent model of service delivery. Services at the CWP are community-centered, signifying that they are informed by an understanding of both community members' cultural values and their lived experiences within the community and sociopolitical contexts in which they are situated. Services have been developed directly in response to the needs that emerge in the context of community members' lived experiences. At

both the level of the organization and the level of individual providers, this understanding of community members' cultural values and lived experiences is reflected in the strategies that are utilized to facilitate access to and engagement with mental health services, as well as the strategies that are utilized to address mental health needs. The CWP's model of service delivery and the strategies that are carried out in accordance with this model convergently promote wellness at the level of the individual, family, and community as a whole.

Figure 2. The CWP's Model of Culturally Competent Service Delivery



This chapter elaborates on each component of the model presented in Figure 2. I will begin by providing a brief introduction to service delivery at the CWP and will then discuss the CWP's community-centered and culturally competent model of service delivery in greater depth. During this discussion, I will highlight how the program's organizational infrastructure and the practices of individual providers are informed by an understanding of community members' lived experiences and are intentionally designed to address the needs that arise in the context of these experiences. Next, I will describe how this understanding of community members' lived experiences informs the CWP's mental health service access strategies, connecting these strategies to Delgado's (2007) discussion on the geographical, operational, psychological, and cultural factors that influence service access. I will then present the CWP's community-centered and culturally competent engagement strategies before describing the program's specific strategies for addressing mental health needs and promoting wellness among individuals, families, and communities. My description of the program's strategies for addressing mental health needs will focus on the CWP's efforts at the level of the organization and at the level of individual providers to deliver holistic services, to deliver services that support community members with the acculturative process, and to deliver services that challenge oppressive social structures. I will integrate service participants' descriptions of their lived experiences throughout these sections in order to highlight how services at the CWP are intentionally informed by an understanding of the experiences that service participants articulate. Lastly, I will conclude this chapter with a synthesis of service participants' and service providers' overall experiences of service delivery at the CWP.

## B. The Community Wellness Program: Informed by and Responding to Community Needs

### 1. Program Background

The Little Village location of the CWP provides mental health therapy services to uninsured Latino immigrant adults. The program also serves individuals who are underinsured, signifying that "they have insurance that doesn't cover behavioral health or mental health services. Or if it does, they can't afford their copay or they don't have a Spanish-speaking provider in their network" (Interviewee 7). Mental health services include intakes and assessments for individuals who are interested in initiating program services; individual, couples, and group therapy; and mental health evaluations for individuals who are involved in immigration court proceedings. These services are offered in conjunction with a range of other on-site supportive services including parenting support and education, public benefits assistance and community resource education, and community nursing.

Mental health services are intended to offer support for a range of mental health conditions that commonly lead community members to access services, including anxiety, depression, relational difficulties with spouses or children, difficult life adjustments, and substance abuse. In cases where individuals seek services for substance use, service providers typically request that individuals seek specialized substance abuse treatment through another agency at the same time that they are participating in mental health therapy services. Individuals may also seek services if they are recovering from domestic violence or if they "are by definition, in domestic violence relationships currently that aren't physically harmful, but that are emotionally really harmful" (Interviewee 7). Underyling these mental health conditions are unresolved traumatic experiences, which will be discussed in greater depth in subsequent sections.

### 2. Community-Centered Focus

When asked to describe the CWP's program model, service providers frequently referenced its community-centered focus. In particular, service providers described that the CWP's programming is informed by an understanding of community members' lived experiences. In turn, services have been developed specifically in response to the needs that have emerged in the context of these experiences. Service providers described how this community-centered focus has been at the forefront of program development since the time of the CWP's inception.

The CWP originally developed approximately twenty years ago. In response to their observations of the needs in the surrounding community, nuns who were part of Saint Anthony Hospital began providing mental health services, early childhood intervention services, public benefits assistance, and health education. While the program has undergone several shifts since it was first developed, originating in the site on Cermak Road where it is currently based, moving to a nearby house in the neighborhood, and then moving back to the site on Cermak Road due to a shift in funding in 2009, this core focus of providing services informed by and centered around the needs of the community has remained an integral component of the CWP. Service providers described that their program is unique in the sense that they not only offer mental health services, but that they also offer a range of other supportive services on-site that were developed to address the most pressing needs of community members: "Kind of this idea of wrapping our clients in services that are meeting the needs of the community, some of the biggest needs of the community as we see them" (Interviewee 7). Service providers also described that their program was specifically designed for the community:

> I really think that's what pulled me in. Feeling like I was seeing and hearing the services being provided were really – we were helping at the community, and really responding to

> the community's needs, instead of saying, hey, this is what we do, so you have to adapt to us. (Interviewee 8)

From a transcendental phenomenological perspective, individuals' textural experiences of service delivery at the CWP thus occur within the structural context of a program that was intentionally built around community members' service needs.

This focus on developing programming around the needs of the community is reflected in the attention that the CWP pays to findings from community health needs assessments. Service providers reported that Saint Anthony Hospital is required to conduct a community health needs assessment every three years, and the needs that community members identify are then used to inform programming:

> …we use [the community health needs assessment] kind of as a backbone. So we say these are the programs that we're going to focus on because they were – the community was surveyed, and this is what they identified as the most important need. (Interviewee 2)

This service provider went on to describe that service delivery is not a static process, but rather that programming evolves and changes over time in response to the changing needs of community members:

> Communities are always evolving. People move. New people come in. So the needs of the community will be very, very different from one cycle to another…So [the community health needs assessment] does give us a perspective of the things that we are doing, and if they are being used by the community and if they're still relevant to the community. (Interviewee 2)

From its inception to the present day, the CWP has thus relied on community members themselves to identify their needs and has implemented services in response to these needs.

The community-centered focus of the CWP is integrally linked to their delivery of culturally competent services. The literature describes culturally competent services as services that take into account an understanding of the values, belief systems, and experiences of community members, and that integrate this knowledge and understanding at both the level of

the individual provider and the level of the organization as a whole (Davis, 2007; Horevitz et al., 2013; Sperry, 2012; Sue, 2001). While service providers tended to describe their model as being culturally attuned rather than as being culturally competent, their descriptions still coincide with the definition of cultural competence posited in the literature. One service provider stated, for example, that they define culturally attuned services as reflecting a process of ongoing assessment and learning about community members' lived experiences and service needs. They further stated that they preferred this term over cultural competence, which assumes a level of mastery that they do not believe can be attained. However, as noted in my discussion on the critiques of cultural competence in Chapter II, there is nothing inherent in the definition of cultural competence that values mastery over ongoing learning. Therefore, CWP services can be described as being culturally competent since their ongoing assessment and understanding of community members' lived experiences is at the very core of their model of service delivery. Their understanding of community members' lived experiences includes both an understanding of individuals' broader acculturative experiences and their experiences of structural oppression. At the organizational level, the program model is informed by an understanding and acknowledgement of these experiences, and the infrastructure has been intentionally developed to address community members' needs based on this acknowledgement and understanding. Not only do we see this cultural understanding integrated into the organizational infrastructure, but individual providers also deliver services in a way that parallels and is reflective of this acknowledgement and understanding. The following sections will describe components of the organizational infrastructure and corresponding practice strategies that facilitate service access, that promote service engagement, and that address the mental health needs of community members. Throughout these sections, I will place particular emphasis on the intentionality at

both the organizational and individual levels to provide services informed by an understanding of community members' lived experiences.

**C. Facilitating Service Access**

At the organizational level, the CWP has developed the infrastructure to reduce barriers that community members commonly experience to accessing services. As noted in Chapter II, Delgado (2007) posits that an individual's ability to access services is influenced by geographical, operational/logistical, psychological, and cultural factors. The CWP has addressed all four of these factors through its program model. To begin, with regard to geographical access, the CWP is intentionally located within the community in a place that is close to many community members' homes and accessible by public transportation. While one service participant stated that it can be difficult to get to appointments because the program is far from their home, the majority of service participants stated that either the program is located within close proximity of their home or that the location on a main street, close to both an L station and several bus stops, allows them to easily arrive for appointments. One service participant stated that they think the physical location of the program facilitates service access "porque hay dos avenidas muy transitables, que es la Cermak y la California. Ah, y también está el tren o el metro. Dos están cercas./because there are two very traveled streets, Cermak and California. Oh, and also the train or the Metro are right there. The two are close" (Interviewee 13).

With regard to psychological factors influencing service access, the CWP's program model also integrates an understanding of how stigma may pose an access barrier. One of the CWP's planning documents, for example, stated that there is "stigma in the Latino community associated with asking for and receiving mental health services" (Document 11). The mental health program logic model also identifies "decreas[ing] the stigma associated with mental health

issues and increas[ing] access to services among Latinos" as one of the program goals (Document 4). This understanding of the potential impact of stigma on mental health service access coincides with service participants' descriptions of the factors that they perceive as influencing community members' decisions to access mental health services. For example, six of the 11 service participants who took part in individual interviews identified stigma as an access barrier. One service participant stated that when people are struggling with mental health challenges, it is common within their community either not to acknowledge that they have a problem or to tell themselves that they are able to cope with their challenges independently:

> …en realidad mucha gente necesita muchísima ayuda. Pero tristamente no la buscamos. Siempre nos guardamos todo. Y igual nos guardamos, porque yo era así, uno piensa que uno puede con todo, pero en realidad no./…in reality many people need a lot of help. But sadly we don't seek it out. We always keep everything to ourselves. And everyone does this, because I was like that, one thinks that they can handle everything, but in reality they can't. (Interviewee 19)

Service participants further discussed that they often choose to keep their problems to themselves because of the perceptions among many community members regarding what it means to receive mental health services. The idea of sharing personal information with a stranger may create feelings of discomfort:

> En México como que nos enseñaban, ¿como le voy a hablar a otra persona que ni conozco, como le voy a decir mis problemas?/ In Mexico they taught us, how am I going to talk to someone who I don't even know, how am I going to tell them my problems? (Interviewee 16)

Extending beyond these feelings of discomfort is a belief among community members that individuals who receive mental health services are crazy:

> …la mayor respuesta de las personas, si dice, ¿quieres ir a la terapia con una persona especializada? La respuesta de ellos es, no estoy loca./…the most common answer among people, if one says, do you want to go to therapy with a person with specialized training? Their answer is, I'm not crazy. (Interviewee 18)

Individuals who do acknowledge that they need support in coping with mental health symptoms therefore may be hesitant to seek services because they fear that they will be labeled as crazy:

> …a veces uno no quiere ir a estos lugares. Porque uno cree que la gente lo va a juzgar uno como loco. Por eso. Por eso mucha gente no pide ayuda./…sometimes one doesn't want to go to these places. Because one thinks that people are going to judge them as crazy. For that reason. For that reason many people do not seek help. (Interviewee 21)

In order to address this barrier of stigma, service providers described that their program is designed to help community members feel comfortable within their space. While the CWP is a part of Saint Anthony Hospital, the fact that it is not located within the hospital's physical structure is intended to increase community members' level of comfort accessing services. Service providers discussed that service participants may be hesitant to seek services directly inside a hospital setting because of the association of a hospital as a place where individuals go when they have a serious illness. As one service provider stated:

> They're not inside the hospital, so that's great, because we're actually in the community. We're in the community, we're accessible. Members of the community don't feel threatened or afraid of coming to a hospital, but it's more like a clinic, a little office in the community where people feel the confidence to come and knock on our door and ask questions. (Interviewee 15)

Not only is the CWP located outside of Saint Anthony Hospital, but the fact that multiple services are offered on-site also decreases the stigma associated with entering the program space. Expanding on this point during member check interviews, service providers noted that their organizational infrastructure offers increased protection to the privacy of mental health service participants who encounter acquaintances in the waiting area, as others do not necessarily know that they are coming to the CWP to receive mental health services. In addition, service providers stated that components of their programming across departments is provided off-site in community locations, such as churches and schools, that are comfortable and familiar to community members. Lastly, because service providers are also present at community events and

festivals such as local health fairs and Little Village's Cinco de Mayo celebration, the CWP's presence within the community serves to make the organization more familiar and less intimidating to individuals seeking services.

Not only does the CWP address geographical and psychological factors associated with service access, but it has also developed the organizational infrastructure to address multiple operational barriers that commonly impede service access among uninsured Latino immigrant community members. Most notably, the CWP addresses the barrier of cost. Cost was one of the most commonly identified access barriers that emerged across service participant interviews. Five service participants stated that because they did not have insurance and had to pay out of pocket for their therapy sessions, they either had not been able to attend mental health therapy prior to the CWP, or had to stop services after initiating them through a different provider because they were too expensive. One service participant described the challenges associated with locating affordable mental health services as follows:

> …los que podían hacer este tipo de terapia pues me cobraba. Me cobraba. Y como pues…y a veces uno no trabaja, o sea uno no busque la situación de no pagar, obviamente no…Pero a veces pues en la oficina te recortan días, puedes trabajar tres días, dos días, entonces ya no puede seguir en terapia pagando tus terapias cada mes o cada 15 días./…those that could do this type of therapy charged me. They charged me. And well…and sometimes one doesn't work, or rather one does not seek out the situation of being unable to pay, obviously not…But sometimes in the office they cut back your days, you can work three days, two days, so then you can't continue in therapy paying for your therapy every month or every 15 days. (Interviewee 13)

Just as service participants commonly referenced cost as posing a barrier to mental health service access, there is an articulated organizational understanding that cost is a common access barrier. This understanding is reflected in the mental health program's logic model, which states that the program was developed to "serve Latino immigrants without insurance, who are low-income and would otherwise have limited access to counseling services" (Document 4).

Informed by this understanding, the CWP provides all mental health and other supportive services free of cost: “But because of the way structurally we're set up, not having – eliminate the biggest barrier to access which is cost, a lack of health insurance, we are able to create a new way of service delivery” (Interviewee 5). Service participants echoed that the provision of free services facilitated access to mental health treatment that they otherwise would have been unable to afford. When asked why they believed that community members sought out services through the CWP, this service participant offered the following response:

> Principalmente pienso que es el apoyo que es gratis, que no te cobren, es un gran apoyo. Porque estamos en una época…pues, para muchos difícil económicamente. Un carecer de trabajo, entonces pienso que este es el principal éxito de este lugar, el que venga la gente y que puede recibir una ayuda gratis. Gratis, sin cobro./ Primarily I think that because the help is free, that they don’t charge you, that is a great support. Because we’re in a time…well, for many that is difficult economically. A lack of work, so I think the primary success of this place is that people come and they can receive free help. Free, without charge. (Interviewee 10)

Service providers also discussed that eliminating the barrier of cost promotes social equity for a population who has traditionally been denied access to services:

> Now if I am a person of means who goes to a therapist on Michigan Avenue and I can pay anywhere from $60 to $150 an hour for counseling I'm not going to get that short-term, very behavioral focused treatment. I'm going to get counseling services. Why does that lower income community can't have that same access? (Interviewee 5)

Offering free services is thus a way of ensuring that community members who are disproportionately impacted by poverty have access to the same type of services as individuals whose ability to access services is not impeded by financial constraints.

Service providers further discussed that in addition to cost, their model is designed to address a range of operational barriers that are commonly identified in the literature as impeding community members’ ability to access mental health services: “…we also address, our service provision addresses all of the known barriers to the Latino immigrant community receiving

services. These are really logistical barriers like hours of operation, child care, transportation" (Interviewee 7). To begin, both service providers and service participants noted that the scheduling options offered at the CWP allowed community members to schedule mental health therapy appointments around their work schedules. In particular, the CWP accommodates individuals' specific scheduling needs by offering appointments early in the morning or later in the evening. Service participants frequently described that they were more inclined to attend therapy sessions because the program was accommodating of their work schedules:

> …lo que me gustó fue que me dieron opciones, horarios, horarios en que podía asistir…Les dije los horarios de mi trabajo, les dije que días podía asistir y a que hora. Incluso me dijeron de que si yo llegara digamos a las 6:00 de la tarde, sí me podían esperar para asistirme./…what I liked was that they gave me options, schedules, schedules that I could attend…I told them my work schedule, I told them the days that I could attend and at what hour. Including they told me that if I were to arrive at, for example, 6:00 in the evening, they would wait to see me. (Interviewee 20)

Not only has the CWP developed the organizational infrastructure to accommodate community members' work schedules, but service participants also described that at the level of individual providers, mental health therapists demonstrate a willingness to be flexible with scheduling. While service participants typically receive an ongoing appointment slot at the same day and time each week, several service participants noted that their mental health therapists were willing to offer them alternative appointment slots if a conflict arose for a particular week. One service participant discussed how her mental health therapist has been flexible with her changing work schedule:

> …entonces ellos dicen no, no haya problema y si hay lugar en esta misma semana, me dan, si no en otra semana o en la mañana o en la tarde. Son muy flexibles. O sea me han tomado muy en cuenta mi trabajo./…so they say it's no problem and if there is a space in that same week they give it to me, if not in another week or in the morning or in the afternoon. They're very flexible. Or rather they really take into account my job. (Interviewee 11)

At both the organizational level and the level of individual providers, flexibility and accommodation with scheduling options thus emerged as a factor that facilitated community members' access to services.

Service providers also collectively acknowledged that child care responsibilities may impede community members from attending mental health therapy appointments. In response to this logistical barrier, the CWP provides free on-site child care for individuals who are without other child care options during the time of their appointment. As one service participant stated:

> …también llevo mis niñas, porque tienen para el cuidado de las niñas. Y eso me ayuda mucho, porque a veces no tengo que me las cuide. So es un buen beneficio que tengan alguien que cuide las niñas./…I also bring my daughters, because they have child care. And that helps me a lot, because sometimes I don't have anyone to take care of them. So it's a good benefit to have someone who watches the children. (Interviewee 12)

Lastly, the CWP also offers bus passes to individuals who are in need of financial assistance to pay for transportation to and from their appointments:

> A mi nunca me han dado, porque nunca lo he necesitado, pero sé que los que necesitan passes para el bus, que los consiguen…Son cosas que me gustan de ellos./ They have never given one to me because I have never needed one, but I know that for those who need bus passes, they are able to get them…These are things that I like about the program. (Interviewee 16)

Service providers discussed that because financial constraints limit them from offering bus passes to all service participants who use public transportation to arrive at their appointments, individual providers are responsible for identifying situations in which transportation costs pose hardships to service participants, and they then provide bus passes in these specific cases.

Lastly, both service providers and service participants described how the culturally affirming physical environment at the CWP facilitates service access among community members. Service providers described that the physical environment at the CWP is intentionally designed to offer an alternative to the "sterile" physical environment that they have observed at

community mental health centers (Interviewee 5). Instead, they have designed their physical environment so that community members are met with a visual representation of their cultural heritage from the moment that they enter the space. Upon entering the waiting area, individuals are greeted by a brightly colored mural that covers the length of the wall on the left side of the room (please see the photograph in Figure 3). The mural incorporates symbols of indigenous culture and scenes of the Mexican countryside on one side of a river, while on the other side of the river are men on the ground with police standing over them (please note that the photograph in Figure 3 does not capture the mural in its entirety). Adjacent to these scenes in the center of the mural is a large, brightly colored image of the Virgin Mary. On the other side of this image of the Virgin Mary is a scene of Chicago's Little Village neighborhood, represented by the arches that welcome individuals to the neighborhood and cars passing by underneath the arches. Below this scene is the image of a nun helping a man to cross the river and a nurse taking a woman's blood pressure. From the moment that community members enter the waiting area, the physical environment thus conveys an understanding of their cultural heritage and their lived experiences as immigrants, and further conveys that they are welcome within this space because Saint Anthony Hospital and the CWP affirm their values and experiences.

Service providers and service participants similarly noted the significance of the mural in creating a culturally accessible environment. One service provider described the mural as being "so vibrant and beautiful. You can just see how it brings in different aspects of specifically Mexican culture" (Interviewee 8). One service participant confirmed that the mural fosters a sense of comfort and belonging:

> Bueno, por lo que yo he visto, tienen un mural donde mezclan muchas cosas de la cultura azteca, mexicana, y incorporan a la religión. Entonces eso también te atrae, que te identifica con la cultura mexicana principalmente./From what I have seen, they have a mural that mixes many elements of Aztec and Mexican culture, and incorporates religion.

> So this also attracts you, that you identify with the Mexican culture primarily. (Interviewee 10)

Figure 3. Mural in the CWP Waiting Area

Not only did service participants discuss that they find the physical environment at the CWP to be culturally accessible, but they also discussed that even if they do not live in the Little Village neighborhood, they feel comfortable traveling to the CWP because of its culturally accessible community location. In the block surrounding the CWP, storefronts and restaurants commonly have signs advertising their services and products in Spanish. There are several Mexican restaurants, as well as a traditional Mexican *heladería* (ice cream shop), within walking

distance of the CWP. Individuals with informal businesses selling tamales and fruit line the main intersecting streets where the program is located. One service participant stated that the surrounding neighborhood contributes to the sense of comfort and belonging that they feel upon entering the CWP: “También yo creo que porque está en el barrio hispano, entonces eso hace que te identifica./I think also because it is in a Hispanic neighborhood, that makes you identify with it” (Interviewee 10).

Service providers and service participants additionally described that the CWP is culturally accessible due to its bilingual service environment. For example, signage and materials in the waiting area are bilingual. During my waiting area observations, I noted that Saint Anthony Hospital’s mission and vision statement was posted on the wall in both English and Spanish. There is also a bulletin board where multiple English and Spanish information flyers are displayed, so that community members can read about relevant resources and supports in their preferred language. In addition, at the level of individual providers, staff immediately greet community members in their native language when they enter the program space and deliver all services in Spanish. One service provider described how, when considering the broader context of mainstream U.S. society where English is the dominant language, being able to speak in Spanish allows community members to feel safe and as if they belong:

> …muchas se enfrentan al idioma, no sabemos hablar el inglés, entonces aquí ellos las aceptan y les hablan completamente en español para que se sientan bien./…many face the language, we don’t speak English, and so here they accept them and they speak completely in Spanish so that they feel good. (Interviewee 9)

Several service participants confirmed that they feel comfortable at the CWP because they are able to speak in their preferred language. As one service participant stated:

> Y otra de las ventajas de este programa es que es en idioma también español. Eso es muy, muy importante para los que no podemos hablar 100% inglés./And another advantage of

> this program is that it's also in the Spanish language. That is very, very important for those of us that cannot speak English 100%. (Interviewee 10)

Another service participant noted that although they speak both English and Spanish, it is comforting to be able to communicate in their native language:

> …entonces uno se sienta a veces un pocito más a gusto. Porque, bueno, yo sí hablo inglés, pero pues mi primer lenguaje es español./…so one feels a little more comfortable. Because I speak English, but my first language is Spanish. (Interviewee 17)

As these data illustrate, organizational and individual provider efforts to create a culturally affirming environment where individuals can communicate freely in their native language thus facilitates service access for Latino immigrant community members.

Synthesizing the data presented throughout this section, it is evident that the CWP's efforts to facilitate service access are directly informed by an understanding of the geographical, psychological, operational, and cultural barriers that Latino immigrant community members commonly encounter when accessing mental health services. An understanding of these access barriers is reflected in program documents and articulated in service providers' descriptions of the ways in which the CWP facilitates service access. Responding to barriers that commonly impede community members from accessing services, the CWP is easily accessible via public transportation and structurally designed to address the psychological barrier of stigma. Addressing a range of operational barriers, the CWP also provides services free of charge, offers extended hours of operation, and provides on-site child care and transportation assistance to those in need. In addition, the CWP has established a culturally and linguistically affirming environment. While the discussion in this section primarily focused on efforts at the organizational level to facilitate service access, it is also important to note the role of individual service providers in supporting organizational level efforts. With regard to operational factors such as scheduling, service participants noted that individual service providers were flexible and

accommodating in offering alternative appointments when conflicts arose with service participants' regularly scheduled appointment slots. Service providers also stated that they are responsible for identifying service participants who are particularly in need of transportation assistance and ensuring that this assistance is made available to them. In addition, service providers reciprocally influence the CWP's culturally and linguistically accessible environment through their efforts to immediately engage with community members in Spanish when they enter the program space. The following section will now turn to a discussion of organizational and individual level provider efforts to engage community members in services, again placing particular emphasis on how these efforts are informed by an understanding of the lived experiences of community members.

**D. Engaging Community Members in Services**

At the organizational level, the CWP utilizes community-based approaches to engage individuals in services. Service providers across CWP departments reported that they offer presentations in community settings to form relationships with the community at large, to ensure that information on community health concerns is accessible to community members, and to disseminate information on CWP services. The mental health program logic model identifies community-based presentations as a program component specifically intended to decrease stigma: "By publicly acknowledging mental health needs, providing accurate information about mental health issues and services, and normalizing the utilization of services, the educational presentations are designed to increase the utilization of services by the target population" (Document 4). Mental health service providers reported that they provide at least one to two presentations each month, typically for parents at schools or at other community-based organizations that host meetings for parents on an ongoing basis. Presentations cover a range of

topics including couples communication and stress and common mental health conditions. In addition to providing content on the identified topic, presentations integrate information on what counseling services are like at the CWP.

At the level of individual providers, mental health service providers carry out community-based presentations in a manner that reflects this organizational understanding of the barrier that stigma poses to accessing and engaging with mental health services among Latino immigrants. In particular, community-based presentations provide an opportunity to dismantle myths about mental health and mental health treatment. Mental health service providers described how disseminating information and developing relationships with community members often influenced community members' decisions to access and engage with long-term services:

> …we see it [community-based education] as an essential part of the work that happens within the actual building. Because it's when we get to connect with people and talk about what mental health is, and what mental health services is, and what it's not, you know? And kind of break down some of those barriers that just within the community maybe where they just don't know what they would come talk about, or why they would come receive our services…And have them know – we're talking to you right now, and you come see us in our building, it'll be us as well you'll have your session with. We're just people. And we're here to support you. And to listen. And to – yeah, to walk with you. And I think it's one of my favorite, favorite things. And you really kind of see people engage and start thinking and relating to the topic you're talking about, and you can see how they're kind of thinking, okay, I want to know more, or I want to access this. And so being that we do the presentations, and that I'm also the therapist, it's been really cool to see people that I first met at a presentation come onto our waiting list, and eventually become a client, and then me get to be their therapist. (Interviewee 8)

Service participants who took part in educational presentations described a process of becoming engaged in services that mirrored service providers' descriptions. Two service participants reported that they learned about the CWP through an educational presentation, one that occurred at their child's school and one that occurred in a local church. The service participant who took part in the presentation at their child's school described the process through which their engagement in the presentation led them to seek out mental health services through

the CWP. They described the presentation, which focused on strategies to assist parents in communicating with their adolescent children, to be dynamic and informative:

> …todo me acuerdo. Era una plática de una hora, por allí, una hora y media. Y se hizo bien cortito el tiempo porque su plática fue muy amena. No fue aburrida. Eramos…yo creo que estamos como los 50 papás a lo mejor allí./…I remember all of it. It was an hour-long talk, an hour and a half. And the time seemed very short because their talk was very pleasant. It wasn't boring. We were…I think there was about 50 of us parents there. (Interviewee 16)

This service participant additionally described that upon learning that the presenters were associated with Saint Anthony Hospital, they decided to seek out mental health services through the program:

> Y ya allí luego también ellos dieron anuncio que era una parte de San Antonio y que ayudan con terapia grupal, individual y de pareja. Entonces allí empecé de allí./ And then later they announced that they were a part of Saint Anthony and that they help with group, individual, and couples therapy. So then from there I began with them. (Interviewee 16)

This service participant's description of taking part in a community-based educational presentation thus illustrates the process through which community members become engaged in the subject matter of the presentations and then in turn engage with the CWP to initiate services. Reciprocally, when service participants initiate services through the CWP and are satisfied with the services that they receive, they may then facilitate increased opportunities for connection between the CWP and community members. Another service participant reported, for example, that after beginning services with the CWP, they played an instrumental role in inviting service providers to present at their children's school.

As mentioned above, once community members initiate services through the CWP, they then facilitate increased community engagement by sharing information about program services with other community members. Not only did one service participant report that they facilitated opportunities for service providers to present at community venues, but eight of the eleven service participants (73%) also noted that they commonly informed family, friends, and

acquaintances about the services available through the CWP and the benefits of participating in these services. One service participant stated that not only did they verbally provide information to friends and community members about the CWP, but they also used social media as a way to circulate information. Referring to a social media site, this service participant reported:

> …veo personas que sufren y hacen preguntas. ¿Qué puedo hacer? Yo me separé de mi esposo y me dejó con tantos niños y me siento así, me siento triste, me siento destrozada. ¿Ustedes me podrían dar un consejo? Entonces yo les digo, ven a los servicio comunitario de la Cermak, está en tal lugar y tal lugar… Yo les pongo el número de teléfono allí…este es el número, llamen. Pregunten cuando les pueden dar una cita./…I see people that are suffering and asking questions. What can I do? I separated from my husband and he left me with so many children and I feel sad, I feel destroyed. Could someone give me some advice? So I tell them, go to the Community Wellness Program on Cermak, it's in such and such a place…I put the telephone number there [on the social media site]…this is the number, call. Ask them when they can give you an appointment. (Interviewee 14)

The number of service participants who reported referring others for services demonstrates that the CWP has developed a trusted reputation within the community. Service providers similarly acknowledged the important role of word-of-mouth referrals:

> I think most of our clients they come through here because they heard somebody or is a friend of a friend that told them to come here. And they come from all over the place. I mean, it's not only this area. (Interviewee 2)

Not only do community members thus play an important role in engaging other community members in services, but they also play a role in decreasing the stigma associated with mental health treatment. As one service provider stated:

> People talk to each other about the services. They don't feel so crazy about coming to therapy…they mention like 'Yeah, I went to therapy here. It was easy. I like my therapist. It's more like talking to a friend or something like that I guess. It wasn't like a clinician exploring my brain.' So they feel more comfortable. They accept coming easier now. (Interviewee 6)

In addition to word-of-mouth referrals, service providers and service participants stated that the CWP's engagement with local news media also contributes to their well-established reputation within the community. Service providers reported that the program has used radio and

television outlets to provide information on their services, and has included testimonials from service participants in these advertisements. Just as community-based presentations and word-of-mouth referrals serve to decrease stigma and dismantle myths associated with mental health treatment, service providers discussed that hearing directly from individuals who have benefited from program services similarly helps community members to feel more comfortable contacting the CWP to initiate services. Service participants confirmed the role of these advertisements in engaging community members in services. One service participant reported that they began mental health therapy at the CWP after a friend heard a radio advertisement about the program and informed them of the services that the program provided. Another service participant discussed that they saw an advertisement about the CWP on the news and found service providers to be attentive and responsive when they called to inquire about initiating services:

> Vi las noticias, y allí apareció la dirección y hablando y pues, yo estaba buscando un lugar y pues era demasiado caro…Y pues cuando llamé, me regresaron la llamada rápido./I saw the news, and there appeared the address and they were talking and I was looking for a place and it was too expensive…and so when I called, they returned my call quickly. (Interviewee 20)

This quote illustrates that when community members are seeking mental health services, receiving information from a trusted and credible media source can be crucial in their decision to initiate services through the CWP. This service participant additionally noted that the treatment they received upon inquiring about services reinforced their decision to engage with the program.

Mental health service providers also identified that the structure of the CWP's intake process is intended to engage community members in mental health services. When community members call to express interest in initiating mental health services, one of the mental health service providers speaks with them over the phone to learn more about their reasons for seeking services and to determine program eligibility. If it is determined that they are not eligible for

CWP services, typically because they are insured, then service providers will refer them to another organization that is able to serve them. In cases where individuals are eligible for CWP services, they will be offered an intake appointment. Because there is currently a wait for services, the initial intake appointment is an opportunity to assist individuals in addressing emergent needs and refer them to other organizations for interim assistance until mental health service providers are able to see them on an ongoing basis.

At the level of individual providers, mental health therapists' use of a relationally focused approach during the intake process allows them to engage with and develop trusting relationships with prospective service participants before ongoing therapy services become available. Mental health service providers described that intake appointments typically help service participants to learn more about the CWP and to feel more comfortable with service providers, which increases the likelihood that they will participate in ongoing services when they are available. As one service provider stated:

> …most of the time, the people just come, meet us, notice that it is for free for real. It is in Spanish. It is easy to access. They see and at least they come after when we call them three months later or four months later. That's usually the process. (Interviewee 6)

Intake appointments are also a way to orient community members to the model of service delivery at the CWP:

> I think a big part of our work is to kind of – I don't know what the right word is – to kind of demystify the whole – I'm going to come in and you're going to tell me what to do because you're the doctor and you know what's best. And so tell me what step one, two, and three are. I think a lot of our clients do come here thinking that's what they're going to find. And we really kind of turn that upside down during the intake process and interview. Just to let them know, no, this is going to be more about sharing the space, and more about listening, and not really maybe even saying anything for a while, listening and supporting, and yes guiding, and giving feedback when necessary, and when welcome, the confidence part coming alongside, and then not necessarily – yeah, imposing a way of thinking, or a way of behaving, or a way of doing. (Interviewee 8)

As described in this quote, service providers begin from the very first appointment to engage service participants as equal collaborators within the therapeutic space, a process that will be described in greater depth in subsequent sections.

Closely connected to service providers' relationally focused approach is the idea of accompaniment. One service provider stated that since the time that the mental health program was first established, "everything around mental health care was designed around engagement, was designed around accompanying" (Interviewee 5). They further described the process of accompanying as one in which they walk alongside community members throughout their journey to recovery: "…we have to accompany people. And we have to accompany them through this healing process that could take weeks, it could take months, it could take years" (Interviewee 5). As illustrated throughout this section, these community-based, relationally focused, and accompaniment approaches inherently function to decrease the stigma associated with mental health treatment. At the organizational level, the integration of community-based education into the CWP's model of service delivery facilitates connections between service providers and community members before individuals even set foot in the CWP's program space. At the level of individual providers, service providers described that community-based presentations offered an opportunity to demonstrate to community members that their role as providers is to walk alongside them throughout treatment. Service providers further demonstrate their treatment philosophy during the intake process, conveying to prospective service participants that they are there to listen, support, and collaborate within their shared therapeutic space. Service providers thus relate to community members as human beings rather than as patients in need of treatment, showing prospective service participants that they will not be stigmatized and labeled if they choose to engage with services.

## E. Holistic Service Delivery

While the previous two sections have discussed organizational and individual provider level efforts to facilitate access to and engagement with CWP services, the following three sections will discuss organizational and individual provider level strategies implemented to address community members' mental health needs. As in the previous sections, this discussion will emphasize how these strategies are informed by an understanding of the lived experiences of community members and the needs that arise in the context of these experiences. When describing the most common mental health needs of community members, service providers frequently identified mental health needs as being embedded within a range of medical and psychosocial needs. This section will therefore describe how the CWP responds to community needs through its delivery of holistic services. I will begin with a discussion of holistic service delivery at the organizational level and end with a discussion of holistic practice strategies implemented at the level of individual providers.

### 1. Holistic Service Delivery at the Organizational Level

My analysis of data across interviews, field notes, and agency documents indicates that the CWP has developed the infrastructure to address community members' mental health needs in the context of a range of psychosocial needs. In particular, service providers at the CWP offered a structural description of their program model that highlighted how mental health services are embedded within multiple organizational contexts. As previously noted, mental health services at the Little Village location are embedded within the context of a program that provides a range of services including family support, public benefits assistance and community resource education, and health education and community nursing services. This model was intentionally developed based on the understanding that community members' mental health needs are closely connected

to other psychosocial needs at the level of the individual, family, and community. This holistic conceptualization of wellness is articulated in the mental health program's strategic planning document created in 2008: "Human beings are created by God to be happy and are equipped with the resources to fulfill their call. Nevertheless, there are several factors such as psychoemotional, physical, biological, genetic, spiritual, and structural not only at the individual, family, and small groups' level, but at a larger societal level, impacting the process to achieve happiness" (Document 17). Service providers' descriptions of wellness as a holistic concept coincide with the description articulated in the strategic planning document. As one service provider stated:

> I worked for the dominant American community where, 'I'm depressed. I know I need to see a mental health provider. I'll go to the clinical space,' and I'd go get assessed, treated and then released, right? But in the Latino community it's almost like needs aren't that separated. They're much more embedded within the family dynamics, within health issues, within – so developing a whole program model as was done back then…and one piece of many other elements it allowed for people to come in and be very much received on all their needs. (Interviewee 5)

This section will now provide an in-depth structural description of the holistic context in which community members experience service delivery at the CWP, highlighting all of the different supportive services that are offered on-site.

**a. <u>Family Support Programming</u>**

The CWP's family support programming includes community-based parenting workshops for parents of children across an expansive age range. These parenting workshops consist of the Little Explorers program, the ACT program, and the APE program. The Little Explorers drop-in group offers an opportunity for parents with children between the ages of zero and four to come together with other parents to engage in interactive activities with their children, thus using play to facilitate the development of the parent-child relationship. In addition to these play-based activities, guest lecturers are invited on a monthly basis to provide information on topics related

to health and education, including nutrition and the use of over-the-counter medications. Parents are also connected with early intervention services as needed. In addition to the Little Explorers group, the 14-week ACT workshop provides psychoeducational content for parents with children ages five through 10 on child development, managing children's aggressive behavior, anger management, and conflict resolution. The APE group, designed for parents of children in the fifth through eighth grades, offers separate programming for parents and children, as well as joint programming for parents and their children together, on similar topics including family communication and conflict resolution that are intended to prepare parents for their children's entry into adolescence. Both the ACT and APE workshops are offered regularly throughout the year. Not only does the CWP's family support programming consist of these ongoing workshops, but service providers in this department will also meet individually with parents who have concerns about their child's development to conduct developmental screenings and refer families to early intervention services as needed. CWP service providers discussed that this range of services is designed to provide support for children and families across the stages of development. A service participant additionally described that family support services "te pueden guiar para tener un mejor ambiente familiar/can guide you to have a better family environment" (Interviewee 10).

**b. <u>Public Benefits Assistance and Community Resource Education Programming</u>**

The CWP public benefits/community resource education department assists community members with determining eligibility for public benefits including health insurance and Supplemental Nutrition Assistance Program (SNAP) benefits. Although community members who seek services through the CWP are predominantly undocumented and therefore are generally ineligible for public benefits, service providers assist community members in

determining eligibility for their children or other family members. In addition, the CWP offers walk-in pregnancy testing and will assist community members in determining eligibility for benefits in cases when they are pregnant. Beyond determining eligibility, the CWP will assist community members in completing benefits applications and following up with the Department of Human Services to check on the status of applications and assist with cases where applications are denied. This department also connects individuals to other community organizations in cases where individuals have resource needs that cannot be addressed on-site at the CWP, including assistance with paying utility bills and referrals for education or employment resources. In cases where community members are not eligible for health insurance benefits but are in need of medical care, service providers also assist in connecting community members to health care providers who charge for services on a sliding scale.

**c. Community Nursing and Health Education Programming**

Lastly, the CWP offers community nursing and health education support. Health education services consist of both community-based and on-site educational presentations on a range of topics that community members identified as priority concerns. Diabetes education is one of these identified priorities, and the CWP has implemented an on-site diabetes class in response to this need. This class focuses on providing culturally appropriate information on nutrition and other components of diabetes management. In addition to this educational component, the CWP community nursing department collaborates with physicians and pharmacists to lower the costs of prescription medications and medical supplies for uninsured community members. The CWP also provides education and support around nutrition and self-care for pregnant women, and may additionally refer them for prenatal classes at Saint Anthony Hospital if needed.

**d. Simultaneously Addressing Mental Health and Psychosocial Needs**

In the context of this range of services, service providers described the CWP's model of service delivery as being global in the sense that it is designed to promote wellness by addressing individuals' needs across all stages of their life span and within the context of the multiple environmental systems with which they interact in their daily lives. Individuals are viewed holistically and are understood as having a range of needs that cannot necessarily be compartmentalized. Service delivery in turn reflects this holistic conceptualization of individuals and their needs. As one service provider stated:

> I would describe the services – I would say…we are meeting the family's needs as a whole. We provide – if they come here looking for services, they can say, 'I'm looking for a doctor.' They come in and meet a doctor. 'Oh, I'm looking for some information about immigration.' Okay, we refer them to one of the agencies that they can talk with. If the family come and say, 'I'm having difficulty with my son,'…we can help them to connect with services…It's the whole picture. It's not just one specific component. (Interviewee 4)

Service participants similarly described the CWP's model of service delivery as meeting their needs holistically rather than compartmentalizing mental health from other psychosocial needs:

> Y esos servicios que dan ellos de todo, allí les ayudan a las personas en todo, en todo. En todo lo que necesiten, tratándose de terapia, de médicos, del hospital, de todo. De todo le ayudan a uno./And they give every kind of service, they help people with everything there, with everything. Everything that people need, related to therapy, doctors, the hospital, everything. They help one with everything. (Interviewee 14)

> …yo diría que el programa me ha ayudado en todo. Sí, en todo. Me ha ayudado a llenar las formas para la tarjeta médica de los niños, o sea, de todo. De todo que el programa puede ayudar. Creo que no hay una persona que diría, no te puedo ayudar en eso./…I would say that the program has helped me with everything. Yes, with everything. It has helped me to fill out the forms for children's medical insurance, or really, with everything. The program can help with everything. I don't think there is anyone who would say, I can't help you with that. (Interviewee 18)

Both service providers and service participants thus described that at the organizational level, the CWP has developed the infrastructure to address a range of needs in order to promote holistic wellness.

**e. Collaboration Across CWP Departments**

Not only are mental health services embedded within a program that offers services to address a range of needs, but service providers also described that they strive to coordinate the multiple services offered on-site. Mental health service providers, for example, often collaborate with their colleagues outside of the mental health department so that they can share information or resources that are outside of their immediate realm of expertise:

> …my clients come with many questions, many, many questions. Like for their children, I asked [staff member] or I refer them to [staff member]. They come like, 'I don't know what to do this summer. I need to send him to camp' or something but they don't have money for a camp of course. [Staff member] will give me the resources or places they can send their children to summer camp or stuff like that or soccer class or stuff like that. Yeah and [staff member] will help me a lot with information around medication or stuff like that. (Interviewee 6)

Collaboration among service providers with different sets of skills and expertise thus facilitates the process of addressing the range of needs among community members who access services at the CWP. As one service provider stated: "We do complement each other, and we do try to work together because we understand not only our strengths but also our limits" (Interviewee 2). If a service provider in one CWP department therefore does not have the information that a community member is requesting, they commonly work across departments to ensure that the requested information will be accessible to the service participant. This teamwork among service providers simultaneously helps to create a safe and welcoming environment for service participants:

> I started noticing that they [service participants] spent some time talking with other people around or a couple of my clients, say hello to her or hello to her because we are kind of

> sharing…My client needs help with her medicine or to understand the effects of the medications. I sent her to [staff member]. Then she recommend her to the parenting group. At the end, she ends up knowing three people. She says hello to her, hello, and she becomes calm. I don't know. It's like at ease here, coming to the services. (Interviewee 6)

As service participants take part in services through one of the CWP departments, their satisfaction with the services that they receive and the trusting relationships that they develop with service providers in that department additionally facilitates the process through which they seek out additional services. I observed this process firsthand while observing an ACT parenting workshop. Although the workshop that I attended was the last in the series, I noted that instead of saying goodbye to service providers at the conclusion of the group, service participants were making plans to stay connected to the program in the future. Service providers were encouraging this ongoing connection by informing service participants of upcoming program activities. When service providers and service participants were sharing a breakfast of tamales together at the conclusion of the parenting workshop, service providers were informing service participants of an upcoming trip to the zoo that they were organizing for parents and their children, during which they would be riding the L to assist parents in becoming familiar with Chicago's public transportation system. Several service participants expressed interest in attending this activity. In addition, service participants asked service providers about other services that were available through the CWP, and one service participant expressed interest in attending the APE group for parents with preadolescent children. I noted that service participants were asking for service providers' telephone numbers and stating that they planned to be in touch in the future to discuss participating in other program activities. These observations suggest that as community members engage with CWP services and develop trusting relationships with service providers, they come to view the CWP as a resource and support that is available for them in the long-term.

Participation in services through one CWP department thus provides an entrée for participation in services across CWP departments in the future.

Trusting relationships with service providers in other CWP departments also facilitate referrals for mental health services. Individuals experiencing chronic illness, for example, may be referred for mental health services if service providers observe that feelings of depression are impeding them from managing their illness. Referrals are especially common among service providers who provide parenting education and support, as parents participating in workshops often disclose past experiences of trauma, including childhood abuse, neglect, or domestic violence, for which they are in need of additional support:

> I think parenting is one of those issues that people seek out all the time. And then we of course get them into a parenting space you realize – they realize or you realize that – or the staff realizes that there's a lot of stuff going on with mom and dad that need support. So it's offer couples counseling or individuals counseling as a resource. (Interviewee 5)

The trusting relationships that service participants form with service providers in other CWP departments facilitates their willingness to initiate and engage with mental health services, despite the stigma that is often associated with mental health treatment. Service providers in other CWP departments acknowledged that they are intentional in the language that they use to recommend mental health services. As one service provider noted, their awareness of the stigma associated with mental health treatment informs how they frame their recommendation that a service participant receive mental health services:

> So when you tell them, hey, do you want to talk to one of our mental health professionals, they're automatically saying, no, I'm not crazy. So if you do something you have to be very careful in how you say that and what words do you use, right. So I don't say, oh, let's go talk to a mental health professional. I'm like why don't you talk to a social worker because the term social worker is a little less intimidating and less stigma attached to it than a mental health professional. (Interviewee 2)

Service participants who initiated mental health services after first receiving support from providers in another CWP department confirmed the importance of these trusting relationships in their decision to begin mental health treatment. One service participant described that although they were unsure what mental health services would be like, they were willing to give them a try based on the recommendation of a trusted provider:

> …yo nada más sabía que me iba a ayudar. Yo iba con los ojos cerrados porque me recomendaba [staff member]./…I only knew that it was going to help me. I went into it with eyes closed because [staff member] recommended it to me. (Interviewee 18)

Another service participant who first began receiving family support services additionally described that even if service providers did not directly recommend that they participate in mental health services, having a positive experience in one department led them to feel more confident seeking out services in another department. This service participant described that they were impressed by the welcoming and supportive environment at the parenting workshop that they attended:

> …yo me siento muy a gusto, me siento cuando yo he ido a este tipo de terapia, yo siento mucha…yo siento mucho cariño, siento mucha unidad entre la gente que está. So a mi me gusta el ambiente./…I feel very pleased, I feel when I went to this type of therapy [referring to parenting workshop], I feel a lot of…I feel a lot of affection, I feel a lot of unity among the people who are there. So I like the environment. (Interviewee 19)

Based on this experience, this service participant then inquired about mental health therapy and chose to initiate this additional support. Service providers and service participants also discussed that just as positive experiences in other departments facilitate engagement with mental health services, positive experiences with mental health services facilitate engagement with other CWP departments. One service participant who first began mental health services at the CWP stated, for example, that they were interested in participating in a parenting workshop based on the recommendation of their mental health therapist. All of these examples of referrals across CWP

departments illustrate that engagement with one department may facilitate subsequent engagement with other departments, thus increasing the likelihood that service participants will utilize the full range of services available to promote holistic wellness.

The CWP's holistic model of service delivery is also reflected in service providers' discussions regarding the importance of educating providers across departments on community members' mental health needs. Mental health providers identified, for example, that providing information on the nature of trauma and trauma responses could help service providers in other departments to contextualize behaviors and patterns of interaction that might otherwise be difficult to interpret. Mental health service providers additionally identified the importance of ensuring that providers in other departments are equipped with the tools to support community members in coping with stress associated with normative life adjustments. While mental health service providers did not discount their training or the complexity of their work, they also recognized that initiating formal mental health services may not always be an immediate option, either due to the current length of the mental health program's waiting list or because individuals do not feel ready to initiate services. In these cases, mental health service providers recognized that education and collaboration across departments provide an opportunity to offer interim support to community members.

**f. <u>The CWP Within the Organizational Context of Saint Anthony Hospital</u>**

The CWP is additionally able to promote the holistic wellness of community members on an organizational level due to the fact that it is embedded within the context of Saint Anthony Hospital. As a part of Saint Anthony Hospital, the CWP both benefits from the investment of hospital resources to support its functioning and the opportunity to refer service participants to other services available through the hospital that are not offered on-site at the CWP Little Village

location. Before further describing how the CWP promotes the holistic wellness of service participants by referring them to other services available through the hospital, I will first explain how the CWP is embedded within the larger organizational context of Saint Anthony Hospital as a whole.

Saint Anthony Hospital is an independent, Catholic community hospital. The hospital underwent a financial shift in 2009, during which time it went from being part of a larger Catholic health network to becoming an independent hospital. This financial shift impacted the CWP. Prior to 2009, the CWP received its funding from the religious order associated with the hospital, with the intention being that funding from the religious order would decrease over time and be replaced with private foundation funding. When Saint Anthony Hospital underwent the shift to becoming an independent hospital, however, the CWP underwent a shift in addition. The funding from the religious order ceased, and the CWP came under the purview of the newly independent Saint Anthony Hospital. Since the time of this restructuring, the CWP has been allocated funding through the hospital's operating budget. The CWP is part of Saint Anthony Hospital's Community Development Department, and the department's overall operating budget is approximately $1.2 million. Approximately 17% of the department's funding comes from grants. Service providers described that because they are part of a larger hospital department, they are afforded financial stability. In particular, although they do receive grant funding, they are not reliant on these funds. Grant funds provide funding relief to the hospital, signifying that when the CWP receives grants, the hospital allocates less money through its operating budget. The CWP's ability to provide services, however, is not dependent on these funds, which offers a level of stability that service providers described as setting them apart from smaller community-based programs. Mental health service providers reported that since the time of the initial

restructuring, the hospital has "doubled the size of our Community Wellness Program, and the idea is that it's still saying that as a community hospital we are here to serve community needs, so therefore we need to commit to that and that has meant that we of course expand in issue areas that are important – mental health is one of them" (Interviewee 5). Over the past several years, the CWP has expanded to offer services in the communities of North Lawndale and Brighton Park in addition to the services that it offers at its Little Village location. All of the CWP sites are part of the hospital's community benefits plan, signifying that each year the hospital reports the free services that are provided and employees' salaries on their taxes. The services that are offered through the CWP are critical to Saint Anthony Hospital's status as a charitable hospital. As outlined by Bourassa (2013), the U.S. government designates qualifying hospitals as charitable organizations when they document a commitment to investing in their surrounding community. In turn, this designation makes hospitals eligible for benefits such as tax exemptions (Bourassa, 2013). The services offered through the CWP are a clear reflection of the hospital's community investment.

The CWP's embedment within the broader context of Saint Anthony Hospital allows service providers to connect service participants with hospital resources that are not offered on-site at the Little Village location. For example, service providers may connect service participants to the hospital to receive medical care, including prenatal and delivery services for service participants who are pregnant. One service participant described that they had the opportunity to take a tour of the hospital while they were pregnant so that they could become acquainted with the services and the physical space before the time of their delivery. Service providers may also connect older adult community members with the hospital's Senior Wellness

Program. One service participant who was connected to this program described the breakfasts that the hospital hosts for seniors:

> [Los desayunos son oportunidades] para orientarnos, darnos consejos de como defendernos, sobre los derechos de nosotros, personas ya mayores, los derechos que tenemos, toca el tema de las seguranzas, y luego los programas que hay en diferentes lugares para uno ir, para nosotros los seniors. Y nos han hablado que alguien, si por ejemplo…los derechos también que nosotros tenemos como inquilinos también, y que tienen abogados gratis allí. Es una cosa muy bonita./[The breakfasts are opportunities] to orient us, to give us advice about how to defend ourselves, about the rights that we have, older adults, the rights that we have, it touches on the theme of insurance, and later the programs that there are in different places for seniors. And they have spoken to us about, for example, if someone…the rights that we have as renters, and they have free lawyers there. It's a very beautiful thing. (Interviewee 14)

Connecting service participants to hospital resources thus promotes holistic wellness not only through addressing a range of medical and psychosocial needs, but also by addressing needs across the stages of community members' life spans.

Not only does the CWP's connection to Saint Anthony Hospital promote service participants' holistic wellness, but Saint Anthony Hospital also recognizes that the services offered through the CWP are integral to its mission. In one of the CWP's strategic planning documents, "further[ing] the mission and vision of the hospital" is identified as a guiding principle for the program (Document 11). By offering services that promote the holistic health and wellness of community members, the CWP thus helps Saint Anthony Hospital to fulfill its mission of "serving the health needs of Chicago's West and Southwest Sides" and "promote health and provide quality care to patients and families of all faiths in our community" (Document 5). The hospital invests in the CWP with the understanding that this investment will have long-term benefits for the hospital at large. In particular, CWP programs are intended to "improve hospital visibility and reputation in the community" (Document 11). As the CWP refers community members for other hospital-affiliated services, Saint Anthony Hospital

expands its reach of community members served and increases the number of community members who are acquainted and familiar with the hospital's services. In addition, when community members have a positive experience at the CWP, this experience may in turn promote a positive reputation of Saint Anthony Hospital at large and increase the likelihood that community members will utilize the hospital for other revenue-generating services. As stated in one of the CWP's strategic planning documents: "Long-term, increased customer satisfaction will result in patient loyalty across generations" (Document 11). One service participant described how their experience at the CWP is connected to their comfort and familiarity with Saint Anthony Hospital at large:

> Saint Anthony es mi hospital preferido…para todo, yo voy a Saint Anthony…porque es como si fuera mi casa. Me ha familiarizado más con todo allá, en el hospital y aquí con ellos [en el CWP]…me siento cómoda./ Saint Anthony is my preferred hospital…for everything, I go to Saint Anthony…because it's as if it were my home. I have become more familiar with everything there, in the hospital and here with them [at the CWP]…I feel comfortable. (Interviewee 14)

Not only is Saint Anthony Hospital expanding its reach of the community members who it directly serves, but its investment in the CWP also reflects its investment in the community at large. One service provider noted the benefits of this community investment:

> And then investing in the community, it does make your communities stronger and better. Yes, there is the additional – a little bit of cost, but it's an investment. You put an effort into this, and then you're going to get rewarded with something else. (Interviewee 2)

As illustrated through this quote, the model of service delivery at the CWP and Saint Anthony Hospital is therefore intended not only to promote the holistic wellness of individuals and families, but also to promote well-being at the level of the community as a whole.

### 2. Holistic Service Delivery at the Level of Individual Providers

Just as the CWP's organizational infrastructure is designed to promote holistic wellness at the levels of the individual, family, and community, individual service providers also promote holistic wellness in their daily practice by delivering interventions at multiple levels of individuals' environments. In recognition of the impact of multiple environmental contexts on individuals' well-being, the mental health department offers individual, couples, and group therapy. While individual therapy provides an opportunity for service participants to process past trauma, service providers recognized that for Latino immigrant community members, individual well-being is also closely connected to relational contexts. In particular, one service provider discussed the connection between individual and family well-being:

> Yeah, speaking of culturally attuned services, the family is the center of Latino community, right. It is all about the family. When we talk about people and context, there is so little individualism in Latino culture, it's really all about family relationships. (Interviewee 7)

Similarly, as one mental health service participant stated: "…tengo que empezar a estar bien yo para poder dar lo mejor a mi familia./…I have to be well in order to give the best to my family" (Interviewee 10). While alleviating mental health symptoms through individual therapy is one strategy for changing individuals' relational patterns with their family members, service providers also recognized that including other family members in service delivery increases the potential to simultaneously promote both individual wellness and wellness among the family system as a whole.

#### a. Intervening with Family Systems

Mental health service providers stated that they personally intervene at the level of the family system by providing couples therapy or offering community presentations on topics such as healthy couples communication. They identified that couples therapy can be particularly

beneficial in engaging males who are hesitant to seek individual therapy services but who are motivated to improve their relationship with their partner. Two service participants who took part in couples therapy as part of their mental health treatment reported that this intervention promoted wellness both for themselves as individuals and for their family unit as a whole. One service participant described that learning strategies for addressing relational conflict not only benefits them and their partner, but also benefits their children:

> …este de la pareja ha ayudado en que pues puedo entender algo mejor a mis niños en cuestión de pareja. En algo de pelear menos, en tratar de solucionar un problema que hay./…couples therapy has helped because I can apply what I have learned as a couple with my children. It helps with fighting less, with trying to solve a problem that emerges. (Interviewee 17)

Mental health service providers also acknowledged that in addition to the interventions that they personally deliver, the interventions delivered through other CWP departments are designed to promote wellness among the family system:

> We can see a family here for any number of needs. We can see them in terms of child services for the children and their development, services for the parents and their parenting, mental health services for the parents so they can heal from past traumas and past emotional wounds, then if the parents start dealing with any sort of medical issues, we can sort of address those there. Getting them the Link card if they are low on funds for just basic needs, basic family needs, doing all the case management for all of the other stuff. We are really trying to connect the families to services and wrap them in the services that could serve to create healthier, happier families. (Interviewee 7)

The role of these family-centered interventions in preventing the transmission of trauma from one generation to the next will be further discussed in the following paragraph.

When service providers at the CWP discussed the connection between individual and family wellness, they frequently identified the potential for individuals' experiences of past trauma to impact the family unit. Service providers noted, for example, that individuals who have experienced violence may in turn use physical discipline with their children, or parents who have experienced neglect may not recognize the importance of communicating with or spending

time with their children. Service providers also noted that when parents have difficulty managing their own emotions, they are less patient in their interactions with their children. The emphasis on family-centered services at the CWP thus not only provides an opportunity for healing from past trauma through individual therapy services, but also allows parents to learn alternate ways of interacting with their children that serve to strengthen relationships between family members. Family-centered services at the CWP are therefore an important component of the CWP's trauma-informed approach to service delivery.

Examples of services that provide information on alternate ways of parenting and promote healthy family relationships are reflected in the multiple parenting workshops offered through the CWP. Grounded in a violence prevention approach, the information provided in each workshop is tailored to the needs of families according to the developmental stage of their children. Little Explorers, which is targeted for parents with children between the ages of zero and four, teaches parents the importance of play and uses play-based activities to promote bonding between parents and children. The ACT and APE groups, which are for parents with children between the ages of five and 10 and grades five through eight respectively, are focused on providing parents with psychoeducational content on their child's stage of development and identifying communication, conflict resolution, and emotion regulation strategies that can facilitate increased understanding and healthy relationships between parents and children. The ACT parenting workshop educates parents about the reasons underlying children's acting out behavior. Through discussion and Spanish-language videos, service providers present content that demonstrates that children may act aggressively when they do not have alternative strategies for expressing their emotions. Service providers thus emphasize that parents can redirect aggressive behavior by giving their children the vocabulary to express their emotions,

encouraging open communication, and modeling emotion regulation skills. Informed by their emphasis on violence prevention, service providers also educate parents on the ways in which relational conflict impacts the family system as a whole. They discuss that children who observe their parents fighting may experience separation anxiety. Service providers also discuss that media coverage of tragic events can be anxiety-provoking for children and speak about the importance of limiting children's exposure to televised news, specifically after the occurrence of tragic events. The presentation of this psychoeducational content equips parents to support their children in expressing their emotions and facilitates healthy communication within the family system.

At the ACT parenting workshop that I observed, which was the last in the series, parents participating in the group spoke openly about the ways in which they were integrating content from the workshop to manage conflict and promote open communication within their families. Parents stated that the psychoeducational content presented in group allowed them to better understand situations from their children's perspectives and to contextualize their children's acting out behavior. Parents identified that when they felt angry in response to their children's behavior, they were able to separate themselves from the situation and calm down by employing strategies such as counting, breathing, or listening to music before returning to the situation to speak with their child about their behavior. Parents discussed that not only did they note changes in the ways that they managed their children's difficult behavior, but they also noted that they were generally able to communicate more openly with their children and solicit their children's feedback regarding what they would like them to do differently as parents. Parents reported that this type of open communication encouraged their children to more freely express their needs and wants. Parents additionally discussed that having the opportunity to speak in the group

facilitated their own emotional expression and helped them to develop increased confidence in themselves and their parenting abilities.

Service providers and service participants noted that just as important as the content addressed in the parenting workshops are the connections that are developed between parents. Through the establishment of a safe, supportive space where the experiences of all parents are acknowledged and validated, group participants feel comfortable to freely discuss their own childhood experiences and the challenges that they face as parents, and can then collaboratively identify strategies to overcome current challenges together with parents who have had similar experiences. Emphasizing the importance of this supportive and collaborative environment, one service provider described the experience of parents who participate in these workshops as an experience of "being with other families and connecting with other families for the experience of learning something, how to relate to kids in another way" (Interviewee 4). Not only are parenting groups a space in which individuals' past experiences as children and as parents are validated, but it is also a space in which their cultural heritage is acknowledged and celebrated. Service providers described that the APE group in particular provides an opportunity for parents and children to navigate acculturative differences and engage in dialogue about their cultural values. Parents are also given the space within this group to teach their U.S.-born children about aspects of their cultural heritage that they do not want them to lose as they become more acculturated to life in the U.S. As one service provider noted:

> I would say still talking about support services like it's very family-oriented, so it's where the family is and where their own values lay as well. And also bringing that for them, being proud of that. So there are APE groups that we do a family shield/coat of arms, where it's almost like a family present, where like they talk about family values and they talk about like things that they want to sort of inherit to their kids, and that's really a way to kind of talk about culture, but also talk about it in a very like positive way and a very non-stigmatizing way as well. (Interviewee 1)

Service providers and service participants' descriptions of parenting workshops, coupled with my own observations of the ACT group, thus suggest a parallel process between the environment created during the parenting workshops and the family environments that the workshops aim to promote. Throughout the parenting workshop, service providers establish an environment in which service participants are respected and valued for who they are and what they have experienced. In turn, these parenting workshops aim to support families in creating a home environment where family members demonstrate recognition, understanding, and respect in their interpersonal communications.

In addition to providing parenting support and education, the provision of child care during mental health therapy appointments reflects another example of the CWP's trauma-informed approach to service delivery. The activities in which children engage during care are intentionally designed to promote wellness. Service providers noted that while the specific child care activities depend on the age of the child, they are always designed to encourage learning and creativity, as well as to facilitate emotional expression. Activities may include pretend play, art projects, and psychoeducational activities designed to help children with emotion labeling and emotion regulation. Children are taught that it is not shameful to experience different emotions and also learn the benefits of expressing what they are feeling. Child care providers also teach children that they are entitled to their own desires and opinions, and assist children in learning strategies to respectfully and appropriately communicate these desires to their parents.

Service providers at the CWP discussed that as a result of taking part in the aforementioned activities during child care, and through watching child care providers model behaviors for respectfully communicating and interacting with others, children leave child care feeling more confident in themselves and their ability to interact with their peers and their family members:

> Pues ya ve que cuando uno aprende es viendo las cosas, los hijos imitan todo lo que uno hace, entonces es lo que le digo a las mamás, que si en casa tienen una buena educación y una buena relación ellos los van a seguir y van a ser unos buenos niños, para que sean unos ciudadanos hay que ponerles cimientos desde chiquitos. Y ya no tienen miedos, no tienen así – se sienten seguros de sí mismos, confortables; porque llegan tímidos, llegan así. Entonces, ya cuando se acaba su terapia, en un año u ocho meses o algo a las mamis, se van bien seguros de sí mismos al kínder, al Headstart, porque eran unos niños tímidos y ya no, salen muy bien preparados para ir allá./So you see that one learns by watching things, children imitate everything that one does, so this is what I tell the mothers, that if they have a good education and a good relationship at home they are going to continue in this way and be good children, so that they are good citizens you have to give them a good foundation from the time they are young. And now they are not afraid—they feel confident in themselves, comfortable; because they arrive timid, that is how they arrive. So then, now when their mothers finish therapy, in a year or eight months, they go confident in themselves to kindergarten, to Headstart, because they were timid children and now they're not, they leave well prepared. (Interviewee 9)

Service participants similarly noted that the relationship between their children and CWP child care providers serves to promote wellness among their children. Of the three service participants who received child care services, all reported that the experience of receiving care has been positive and that their children look forward to seeing their child care provider. Service participants described that although their children may have been hesitant and uncertain when first receiving these services, over time they developed a sense of confidence and security:

> …de primero pues ellos no estaban acostumbrados a quedarse en otro lugar. No les gustaba, casi lloraban. Pero a las dos, tres semanas, hasta abrazaban a la señora que los cuidan, que es muy lindo./…at first they weren't accustomed to being in a different place. They didn't like it, they almost cried. But after two, three weeks, they hugged the woman that cares for them, which is really lovely. (Interviewee 17)

Service participants additionally discussed that child care providers play an important role in their children's development:

> …al traer a mi hija, que a ella le gusta ir. Ella llega feliz y siempre ella sabe la nombre de la persona que la cuida, so…ella pues desde que antes de un mes yo creo empezamos a ir, de que nació. Y ya ella le gusta. Pues, la amiga desde siempre./…bringing my daughter, she likes going. She arrives happy and always knows the name of the person that cares for her, so…since a month after she was born I think we began going. And she likes it. The friend since the beginning. (Interviewee 19)

As illustrated through these quotes, service participants value the fact that their children feel safe and confident during the process of child care and are able to develop a long-lasting, secure relationship with their child care provider.

The transformation that service providers and service participants note in children who participate in child care can be viewed as a parallel process to the transformation that occurs in their parents as they participate in mental health therapy. Not only does mental health therapy provide a space for service participants to recognize and acknowledge their own strength and resilience in overcoming past trauma, but child care providers also provide a space in which children feel safe and confident. Within this space, children learn to recognize their own capabilities and learn that their desires and opinions are valued. Through this parallel process, the entire family unit is exposed to a different way of interacting that is centered around recognizing and valuing the strengths of themselves as individuals and of the family system as a whole. Service providers thus deliver interventions that simultaneously promote individual and family wellness, and in so doing enhance opportunities for Latino immigrant families to collectively heal from trauma, to prevent the impact of past traumatic experiences from being felt across generations, and to affirm their self worth.

**b. <u>Addressing Needs at the Level of the Community</u>**

One way in which mental health service providers address service participants' needs at the level of the community is through the delivery of group therapy interventions. Service providers stated that group therapy is an ongoing component of their work. They offer closed groups for approximately five or six service participants that last for 12 weeks in duration and are facilitated by two mental health service providers. Groups are comprised of both service participants who have received individual therapy services and individuals who are currently on the program's

waiting list. Service providers described their group therapy model as being “based on a mutual aid model that actively explores trauma” (Interviewee 5). The mutual aid model is grounded in the idea that the primary role of service providers is to facilitate the development of relationships between group members, so that they can support each other in processing and healing from past trauma. One service provider described this trauma-informed mutual aid model as follows:

> So people are there to share their lives, about their stories, but they're really there to help support one another. And they find healing…And feeling like they can relate to people, and they can understand people, where they're coming from. It's just been one of my biggest kind of lessons in community mental health work. (Interviewee 8)

While mental health service providers noted that group therapy offers an opportunity for community members on their waiting list to engage in services while they are waiting for an individual therapy slot, they also identified that their provision of group therapy is intentionally informed by the lived experiences of community members. In particular, service providers described that one of the primary goals of group therapy is to build a social support network among service participants who leave behind their family and friends in their country of origin and have limited social support in the U.S. Group therapy interventions thus provide a means for individuals to forge a new community in a place where they were previously experiencing isolation:

> I mean we're talking about migrant populations who, yes, if you have a good support structure you're migrating to great, you have a lot of social connection. Not everyone does. And even if you are part of your church, or you are part of a social space in the community that – social events, right, all these things happen. It doesn't mean you're not socially isolated. And so for me that's why group therapy has been such a crucial model of service delivery. (Interviewee 5)

The community that is created within the group environment allows individuals to access a space where they can freely express themselves and openly share their experiences, and in turn recognize their strength and resilience in overcoming difficult life circumstances. As one service

provider stated, group therapy "create[s] a small community of people and then creating strengths within each of them and also between them. That, I think, too, is truly kind of like a revolutionary way to approach therapy" (Interviewee 7).

Of the 11 service participants interviewed for this study, three reported that they participated in group therapy services in addition to individual therapy services. Two service participants stated that they participated in group therapy services while they were waiting to initiate individual therapy, while one service participant stated that they simultaneously participated in individual and group therapy. All three service participants described group therapy as a positive experience. One service participant who took part in an all-male therapy group discussed that they benefited from the sense of camaraderie in the group and from feeling that they were not alone in the challenges that they experienced. While both males and females may leave behind their friends and family members when they migrate to the U.S., this service participant stated that feelings of social isolation may be further complicated for males, who are often taught that seeking out support for the challenges that they experience is considered a sign of weakness:

> …tenemos esta tradición o esta cultura o esa situación de decir los hombres no lloran. Los hombres no se quejan. Los hombres no chillan. Los hombres se aguantan. Y los hombres están para soportar todo…Porque pues si tú llegas a quejar…bueno, como hombre, si los hombres llegan a quejar, a lo mejor eres maricón. A lo mejor no eres hombre. O sea te matizan. Entonces es muy dificil que un hombre diga, sabes que, tengo problemas. La única manera en que los hombres pueden desahogar sus penas es tomando, drogándose, o a veces hasta llegan a violencia doméstica./…we have this tradition or this culture or this situation of saying that men don't cry. Men don't complain. Men don't show emotion. Men endure. And men are there to put up with everything…Because if you complain…well, as a man, if men complain, you're probably gay. You're probably not a man. Or that's how they portray you. So it's very difficult for a man to say, you know what, I have problems. The only way that men can express their pain is by drinking, using drugs, or sometimes they reach the point of domestic violence. [Interviewee not identified to protect confidentiality]

In this context, having a safe space where men can receive support from each other, see that they are not alone in their struggles, and find alternate ways of solving their problems is a positive experience:

> …a veces decimos que nuestros problemas son únicos y son especiales. No lo va a tener otra persona. Entonces al estar en este grupo de puros hombres que todos eran de diferentes edades, entonces hay que das cuenta que realmente tus problemas pueden ser iguales a otras personas, pero también lo fue en solucionarlo de otra manera./…sometimes we say that our problems are unique and special. That other people don't have them. So being in a group of all men where everyone was of different ages, you realize that really your problems can be the same as others, but also that you can solve them differently. [Interviewee not identified to protect confidentiality]

Service providers' and service participants' descriptions of group therapy interventions thus illustrate that among community members who have limited networks of social support, group therapy provides an opportunity for service participants to support each other in their struggles.

Not only do mental health service providers aim to build community through the delivery of group therapy interventions, but service providers across CWP departments also aim to promote wellness at the level of the community through their efforts to connect community members to community resources and supports outside of the CWP. Service providers recognized that Little Village residents live in a community where formal supportive services are more limited in comparison to communities with higher per capita incomes. Service providers additionally recognized that documentation status may impede community members from accessing services that are available. Lastly, with respect to mental health needs in particular, service providers recognized the multiple access barriers that community members experience. Service providers identified that the responsibility of facilitating service access cannot be assumed by a single organization, and described their efforts to enhance the capacity of the community at large to address individuals' mental health and psychosocial needs. In particular, service providers collaborate with other community-based organizations in order to build a

network of resources and supports to which they can connect community members whose needs cannot be addressed through the CWP. An example of the CWP's efforts to build this network of community-based supports is evident through Roots to Wellness, a collaborative of local organizations that meets monthly to discuss strategies for addressing the mental health needs of Little Village community members. As one service provider stated:

> …needs for any program are overwhelming. Demand is great. And…we need to rely on existing resources in the community, both formal mental health resources but more and more we're talking about informal mental health supports, right, in the community: social supports, you know, social groups, parenting groups, exercise groups, these community spaces that people also rely on for wellness. Integrating that as a network system of referrals is one of the initiatives that we're currently developing through Roots to Wellness. (Interviewee 5)

In addition to integrating this network system of referrals, the Roots to Wellness collaborative has also identified community health workers, community members who are trained to provide health education to fellow community members, as a resource for connecting individuals to mental health services. Roots to Wellness members, including CWP service providers, have developed a training curriculum and provided training opportunities to educate community health workers about the process of identifying community members with mental health needs and referring them for appropriate services. These efforts suggest that CWP service providers are committed to leveraging both formal and informal systems of support within the community to promote the wellness of the community at large.

At the same time that CWP service providers collaborate with partner organizations to facilitate community members' access to supportive resources, they also recognize that collaboration provides an opportunity for different organizations to exchange information on their unique areas of expertise. In so doing, organizations can support each other in delivering high quality services that promote the holistic wellness of community members. CWP service

providers, for example, have offered mental health training for volunteers at a local organization that supports community members experiencing domestic violence. CWP service providers thus aim to promote wellness at the level of the community through their collaborative efforts to connect individuals to formal and informal community supports and through their willingness to provide information, training, and support to partner organizations.

The partnerships that CWP service providers have developed with other community-based organizations allows service providers to connect service participants with local resources and supports that can address psychosocial needs that cannot be addressed on-site at the CWP. Service providers view their partnerships with local organizations as being critical to ensuring that individuals are not turned away without receiving the help that they need:

> The one thing that is very important for me is to never send someone away without the help they need. So even if I don't have the help at that moment, I'll always follow up. I'll always try to find the help they need and then call the client or the person back and let them know, ok, this is where you need to go. There's probably nothing more frustrating than asking for help and not getting the help, so I don't want to put anyone in that position. (Interviewee 15)

As the above quote illustrates, facilitating connections to external resources and supports is an important component of service providers' daily practice. This commitment to connecting community members with external resources was also reflected at a staff meeting I observed in April of 2016 that was devoted primarily to discussing an electronic database that had recently been developed to facilitate referrals to partner organizations. Staff members discussed that the purpose of this electronic database was twofold. First, it would allow them to more easily address service participants' resource needs when these needs could not be addressed on-site. Second, it would allow them to connect community members who did not qualify for mental health services at the CWP to other mental health therapy services for which they were eligible. As my observation of this staff meeting occurred early on in my data collection process when I

was familiarizing myself with the program, I was struck by the amount of time that service providers invested in addressing community members' resource needs. As highlighted in the italicized excerpt from my field notes below, this emphasis on addressing resource needs stood in contrast to my own experience as a mental health practitioner:

> *A few other things that stand out to me from this meeting: the level of connection/engagement with the community (i.e. the importance of having relationships with other organizations and knowing about the work that they do, and in turn ensuring that other community organizations are familiar with the work that they do). I'm also struck by the fact that connecting clients to resources seems to be an important part of mental health therapy and seems to be formally supported (i.e. it is recognized that mental health will not just be promoted by therapy, but by ensuring that clients are operating in a social context that supports their mental health, i.e. need material resources to be emotionally healthy). I think this is particularly striking to me because in past contexts where I have worked, we were told many times to just focus on therapy and not resource needs (focusing on resource needs was considered inappropriate in terms of working toward treatment goals and meeting billable hours).* (Field notes, 4/1/16)

Not only was service providers' focus on facilitating connections to community supports evident early on in my data collection process, but I also noted this focus to be innovative in the context of my own experience with mental health service delivery.

Service participants confirmed that service providers promote their holistic wellness by connecting them to external community resources and supports. Across interviews, service participants identified that service providers are knowledgeable about the services that other organizations provide and are able to offer appropriate referrals for any needs that cannot be addressed on-site:

> Si uno necesita un servicio, ellos podrían dirigirlos también a otro lugar donde puede ofrecer. Tienen otros en que los pueden dar información./ If one needs a service, they can also direct them to a place that offers it. They have other places that they can give information about. (Interviewee 17)

> …si allí ellos no tienen, por ejemplo, la consejería que la persona busca, ellos refieren a otro lugar. La ayuda la buscan allí, y allí ellos les dan opciones a donde…ir, pero ellos les

> ayudan, les dan el número de teléfono y todo./…if they don't have there, for example, the help that one is looking for, they refer them to another place. They look for the help there, they give them options for where…to go, but they help them, they give them the telephone number and everything. (Interviewee 14)

One service participant further explained how this emphasis on enhancing community supports has helped them to become more engaged in seeking out resources, so that they will be prepared to address different needs that arise: "…lo que también la terapia me ha ayudado es tratar de informarme, de estar preparada/what therapy has also helped me with is to try to be informed, to be prepared" (Interviewee 19). The partnerships that service providers at the CWP have developed with local organizations thus allows them to assist community members in connecting with a broader network of resources and supports.

Synthesizing the data presented throughout this section, it is evident that the CWP's holistic model of service delivery and service providers' holistic practice strategies are informed by an understanding of the unique needs and experiences of Latino immigrant community members. The process of navigating unfamiliar systems with limited social support impacts the well-being of the individual, family, and community as a whole. In this context, mental health needs cannot be separated from other psychosocial needs. Informed by this understanding, the CWP promotes individual, family, and community holistic wellness through the organizational context in which it is embedded. Service providers similarly promote holistic wellness in their daily practice by delivering interventions at multiple levels of individuals' environments. These interventions promote individual healing; foster healthy and supportive family environments; and bolster community connections and social support.

### F. Integrating Understandings of Acculturative Processes

Data across interviews, observations, and agency documents additionally indicate that the CWP's organizational infrastructure and practice strategies are informed by an understanding of

community members' acculturative experiences. Service participants described the process of navigating an unfamiliar cultural context with limited social support, maintaining their values from their country of origin, and developing a bicultural identity as being central to their acculturative experiences. Informed by this understanding, affirmation of individuals' cultural heritage and support in developing and expressing a bicultural identity are at the core of service delivery at the CWP. As one service provider stated:

> So there's a lot of things that we don't leave, and to be able to go to a clinic or a program that offers services bilingual, bicultural I think is a great, wonderful response to the needs of a community. I think Community Wellness does that very well because not only do we speak the language of the community, but we understand the community because some of us are part of the community and some of us have been to Hispanic countries, so we understand the culture very well, and I think that's a plus. (Interviewee 15)

This section will begin by presenting a description of service participants' acculturative experiences, and will then discuss how an understanding of these experiences is reflected in service delivery at the CWP. Central to this discussion will be a description of the ways in which the CWP affirms the cultural values that service participants have brought with them from their countries of origin and supports them in maintaining these values over time in the U.S. This section will additionally consider how the CWP supports service participants in navigating unfamiliar U.S. social service systems and developing and expressing bicultural identities.

### 1. Acculturative Experiences

Throughout the course of their individual interviews, service participants frequently described their experiences of learning to navigate new cultural systems and familiarize themselves with the social norms of the U.S. They often had to learn to navigate these systems alone, as they left behind their family and friends in their country of origin and had limited social support. As one service participant stated:

> Entonces cuando yo llegué a este país, llegué sola. No tenía amigas, dejé mis amigas, mis amigos, mi mamá, mi papá, mis hermanos, todo para llegar a este país, en un país no siempre es bueno llegar./ So when I arrived in this country, I arrived alone. I didn't have friends, I left my friends, my mother, my father, my siblings, all to arrive in this country, in a country where it's not always a good reception. (Interviewee 16)

Not only did service participants describe the challenges of learning to navigate a new cultural context with limited social support, but they also described the process through which they aimed to adopt mainstream U.S. cultural values while simultaneously maintaining the values that they brought with them from their country of origin. Service participants commonly discussed the importance that they attributed to holding on to the cultural values that they were inculcated with as children. Respect was one of the core cultural values that service participants frequently referenced during interviews. Service participants defined respect as being reflected in cordial gestures, such as greeting others, and also as being connected with the concept of equality and recognizing the value and worth of all people. As one service participant stated:

> No me gusta preciar la gente, todos somos iguales, todos merecemos un mismo respeto. El color de tu piel o tu cultura esos son cosas fijas, pero todos somos seres humanos. En donde por el simple hecho de ser un ser vivo tenemos el mismo valor./ I don't like to put a value on people, we are all equal, we all deserve the same respect. The color of your skin or your culture, these things are fixed, but we are all human beings. Simply by the fact of being human beings we all have the same value. (Interviewee 10)

Service participants also commonly described their family as being of central importance to them. They discussed that they viewed family unity and solidarity as being critical to making it through difficult situations:

> …para mi la familia es algo de lo más importante. En donde una familia sí tiene sus problemas, tiene crises, pero estando juntos en la unidad familiar es lo mejor./ …for me the family is something that is most important. Yes a family will have its problems, it will have crises, but being together in family unity is the best. (Interviewee 10)

Connected to the idea of family unity was the idea that parents had the responsibility to work hard to ensure that their children had the best opportunities available to them: "…uno siempre

tiene que luchar por la familia, trabajar duro para sacar adelante sus hijos./ …one always has to fight for the family, work hard to give opportunities to their children" (Interviewee 16).

Lastly, service participants commonly identified religious values and principles as values from their culture of origin that continued to be central to their identity after arriving in the U.S. While service participants did not all share the same religious affiliation, they commonly discussed devotion to God and a respect for other religious traditions as being central to their beliefs. As one individual stated:

> Mi familia me inculcó la religión católica, cristiana católica, en donde nos regimos por los mandamientos divinos, en donde está respeto al prójimo, en donde amar a Dios, amar a tus padres, lo importante es ser honesto, ser leal a las personas que son buenas contigo, y no hacer el mal./ My family inculcated me with the Catholic religion, Christian Catholic, where we are guided by the divine commandments, based on respecting the neighbor, loving God, loving your parents, the important thing is to be honest, be loyal to the people that are good to you, and don't do bad. (Interviewee 10)

As illustrated through this quote, service participants largely described religious principles as coinciding with values such as respect, love for family, and the importance of honoring interpersonal relationships and treating others well. One service participant also described the importance of remaining thankful to God in difficult material circumstances.

Several service participants discussed that one of the positive elements of their experiences as immigrants was the opportunity to integrate values from their culture of origin with mainstream U.S. cultural values. One service participant described that integrating the most positive elements of both cultures led to interpersonal growth and helped them to become a better person:

> Mi cultura, pues…miro esta cultura también, la de aquí en este país, que me inspira, que me motiva ser mejor. Lo que en mi país no pude encontrar, lo he encontrado aquí. Y aquí, quiero aprender lo mejor de esta cultura. Porque es un país multicultural, en donde puedes conocer de muchas culturas lo mejor. Puedes agarrar lo mejor de todas y ser lo mejor./ My culture, well…I look at this culture as well, the culture of this country, that inspires me, that motivates me to be better. What I couldn't find in my country, I have

> found it here. And here, I want to learn the best of this culture. Because this is a multicultural country, where you can learn the best of many cultures. You can take the best of all of them and be better. (Interviewee 10)

While several service participants described the process of developing a bicultural or multicultural identity as being a positive experience, there was also a tension that emerged regarding the extent to which individuals could truly maintain their values from their country of origin as they began to adopt mainstream U.S. cultural values. One service participant expressed this fear that Latino immigrants are losing their cultural identity in the U.S:

> …desgraciadamente aquí en este país, hay personas que ya ni hablan aunque uno le salude, ya no hablan. Peor creo la gente hispana como yo, ya no les gusta creo hablar. Saludar, yo les saludo, buenos días. Yo trato de hacer amistad donde quiera…Hay unas personas que no quieren saludar, yo no sé por que. Aquí en este país es muy…ya la gente se hizo este…como muy…se pierden los valores morales, se pierden respeto, se pierden las costumbres que uno trae. La cultura se está perdiendo./…unfortunately here in this country, there are people that won't speak to you even if you greet them, they won't speak. Worse I think are the Hispanic people like myself, now they don't like to talk I believe. I will greet them, good day. I try to make friends wherever I can….There are some people that don't want to greet you, I don't know why. Here in this country it's very…the people have become…very…they have lost their moral values, they have lost respect, they have lost the customs that they brought with them. The culture is getting lost. (Interviewee 14)

This service participant thus expressed fear that important cultural values such as respect will become lost over time in the U.S. Another service participant further discussed that the loss of their cultural values in the U.S. is complicated by the fact that oppressive social structures impede them from becoming fully integrated within U.S. society, thus leading individuals to feel as if they can neither fully identify as citizens of their country of origin nor as U.S. citizens.

Among service participants with children, who made up the majority of the sample, there was also discussion regarding the importance of passing on their cultural values to their children. Service participants noted that their children may be more familiar with mainstream U.S. cultural values in comparison to themselves, either because their children were born in the U.S. or

because they had more exposure to U.S. cultural and social systems, thus leading them to become acquainted with mainstream U.S. cultural values more quickly. During my observation of the ACT parenting group, group participants noted that these acculturative differences between themselves and their children were evident in their preferred languages. While parents discussed that they preferred to speak with their children in Spanish, their children often had difficulty understanding them and preferred that their parents speak to them in English. In this context in which their children are well acquainted with U.S. cultural values, service participants identified that passing on their cultural values to their children provided an opportunity to ensure that as they adapted to life in the U.S., they would maintain a connection to their cultural heritage. While several service participants noted that immigrant community members may generally have limited time to spend with their children because they are always working to ensure the material well-being of their family, they also noted the importance of "enseñarles a querer su cultura, sus raíces/teaching them to love their culture, their roots" (Interviewee 11) during the time that they did have to spend together. One service participant described that although they feared that their cultural values would become lost in the U.S. over time, teaching their child about important values such as respect was a way to mitigate this fear:

> Me da una tristeza porque siempre que aquí, nuestras raíces, nuestras costumbres se van perdiendo. Yo trato con mi hijo de inculcarlo, parecido a lo que mi mamá nos inculcó. Porque creo que es importante como el respeto, la vida familiar, que aprenda a trabajar./ It makes me sad because always here, our roots, our customs, are getting lost. I try to inculcate them with my son, similar to how my mother inculcated them with us. Because I think it's important, like respect, family life, learning to work. (Interviewee 16)

Service participants also noted that when their children are born in the U.S., they benefit from the process of adopting a bicultural identity, just as service participants themselves benefit from adopting the best elements of multiple cultures. One service participant described how they and

their spouse, who are from different countries of origin, support their children in learning the customs from both countries:

> …mis hijos están aprendiendo las dos culturas…bueno, tres culturas, porque nacieron aquí. Y mis hijos tienen que aprender la cultura de [país de origen] y aprender la cultura de [otro país de origen]. Entonces es algo muy único para ellos y bonito también, porque se conviven. Se conviven y se aprenden mucho./…my children are learning the two cultures…well, the three cultures, because they were born here. And my children have to learn the culture of [country of origin] and learn the culture of [other country of origin]. So this is something very unique for them and beautiful as well, because they coexist. They coexist, and they learn a lot. (Interviewee 18)

### 2. Integrating Understandings of Acculturative Processes at the Organizational Level

Just as service participants described their acculturative experiences as being defined by the processes of navigating an unfamiliar cultural context, maintaining their cultural heritage, and developing and expressing a bicultural identity, service providers similarly described how organizational and individual provider level practices are informed by an understanding of these experiences. At the organizational level, the CWP has established an organizational culture that intentionally aims to be reflective of community members' cultural heritage and values such as *respeto* and *familismo*. In so doing, the goal is for service participants to feel as if they have a cultural refuge within the broader context of mainstream U.S. society, and to additionally feel that the cultural values that they wish to maintain are reflected and affirmed. One service provider described that although the CWP offers services off-site in accessible community-based settings, they also recognize the importance of having a space where community members can come to feel comfortable and safe:

> I also understand the importance of having a safe space that they could go to. Because that's part of our lives. We get caught up in all of our spaces that can be very hectic and very challenging…And so although we want to go there [off-site community settings] and offer services there we don't dismiss and we don't lose sight of the fact that having a

> space to go to that's peaceful, that's supportive, that you could have child care, that you could feel safe that your child is in good hands while you're getting services yourself, you know, that to me is important. (Interviewee 5)

As this quote illustrates, the CWP intentionally aims to offer a space that serves as a refuge for service participants. I will now describe how service participants feel comfortable and welcome at the CWP as a result of the program's organizational culture. In particular, the CWP's organizational culture is reflective of cultural values such as *respeto* and *familismo* that are important to community members. I will first describe how this organizational culture was established and how it is manifested in interactions between service providers, and will then turn to a discussion of the parallel process through which this organizational culture is reflected in interactions between service providers and service participants.

### a. The CWP's Organizational Culture: Interactions Between Service Providers

Data across interviews, observations, and agency documents indicate that the organizational culture at the CWP is connected to the organization's hiring practices. Several service providers noted that while meeting specified educational requirements is one criterion influencing hiring decisions, an ability to understand and empathize with community members' experiences and develop trusting relationships is a criterion that is given equal importance. As one service provider stated when asked about the hiring criteria for their position:

> I think it was like first of all, having education. But it's also having the experience working with the community, working with the family, and providing the support. And what else do they ask for? The trust. I think it's very important that the families can trust you… you know, this is very important for us, you know, when the client comes they feel welcome. They feel they trust you, that you approach them and you talk to them as you are talking to anyone else. You know? Getting the level. I think it's really crucial for when you meet a client and you are on their level. (Interviewee 4)

Not only is the ability to understand, empathize with, and relate to community members a criterion for hiring decisions, but so too is a dedication and commitment to serving the Latino

immigrant community. This emphasis on hiring staff who are dedicated to serving the community is reflected in a document describing the characteristics, principles, and values of the CWP: “We accomplish our goal through the hard work and dedication of a strong and talented staff who is committed to serving the community and fulfilling our mission” (Document 9). Being united in this common goal in turn cultivates an organizational culture of solidarity and support between coworkers:

> Our team is phenomenal. It's so rewarding to me also to be working with a team who is so dedicated to this work and so dedicated to this community, that inspiration I feel like it's generated between us and the support between us of really feeling like we all have each other's backs really a lot. Yeah, it feels like that. That generates energy. It's kind of an ongoing generator. Its self-generating energy between us is also extremely rewarding. (Interviewee 7)

Service providers further described that their support for each other is reflected in their willingness to listen to each other’s perspectives and learn from their co-worker’s unique expertise. In addition, service providers described their co-workers across CWP departments as being flexible and available to assist them with projects when they are short-handed, even if such assistance falls outside of the purview of their written job responsibilities. I observed this same willingness among service providers to step in and help wherever needed during my observations of the program’s waiting area and staff meetings. If the doorbell rang when there was not a service provider at the front desk to answer the door, service providers from other departments would step in to answer the door and ensure that service participants entering the space for appointments were directed to the appropriate staff member. This willingness to both learn from and help their co-workers extends beyond a culture of support and solidarity and further cultivates what several service providers described as a family-oriented organizational culture: “Here we are like a family. Here we are such a team. We all look forward to come to work. It's nice and we're very family oriented” (Interviewee 3).

The family-oriented organizational culture of the CWP is additionally reflected in warmth and affection in service providers' interpersonal interactions. Service providers noted that upon first beginning their employment at the CWP, they observed an environment where "everyone was very welcoming, very warm" (Interviewee 15). In my observations of both the waiting area and staff meetings, I noted this warmth and affection in the way in which service providers greeted each other and demonstrated a genuine interest in their coworkers' lives outside of the office. In internal mental health staff meetings, service providers spoke with each other with a sense of familiarity and felt comfortable making good-natured jokes and laughing with each other. I also noted that sharing food was common among service providers. At the start of one mental health staff meeting, a staff member came with yogurt and ice cream that they had picked up for their co-workers at the local *heladeria*. This practice did not seem to be a rare occurrence, as I also noted in my waiting area observations that staff would bring coffee to each other and encourage their co-workers to try food that they had brought to the office. Service providers thus demonstrate through their interpersonal interactions with their co-workers that they enjoy sharing with each other and are genuinely interested in their co-workers' comfort and well-being.

Service providers discussed that within the context of this family-oriented organizational culture, they enjoy coming to work and are motivated to perform their job responsibilities to the best of their ability. As one service provider stated: "I think it's very I would say kind of family-oriented, I guess I'd say. Like very supportive, very – I definitely feel valued…so it's been kind of something that I definitely felt a lot more driven within this position" (Interviewee 1). These descriptions of the family-oriented organizational culture at the CWP are reflective of the Latino cultural value of *familismo*. In recognizing the reflection of this value, it is important to note that *familismo* not only refers to the central importance of relationships between family members, but

also refers to the importance of relationships between individuals who are not actually related, but who come to feel like family (Añez et al., 2005). At the CWP, service providers thus described an organizational culture in which they support each other, care about each other, look out for each other, teach each other, and seek assistance from each other to ensure that they can optimally fulfill their work responsibilities. Service providers have thus developed relationships with each other in which they have come to think of themselves as a family. While these relationships have largely been cultivated based on a shared commitment to addressing the needs of community members, service providers also noted that they believe this family-oriented organizational culture has formed in part because of service providers' personal cultural heritage. While not all service providers at the CWP are Latino, they share an understanding of Latino cultural values, whether through their personal upbringing or through their educational and lived experiences. One service provider described that this understanding and reflection of Latino cultural values in the workplace contributes to an organizational culture that feels different from other places where they have worked: "Here it's my culture. I feel more, I don't want to say safe, but more comfortable" (Interviewee 3). This shared understanding of Latino cultural values thus contributes to a family-oriented organizational culture where service providers feel comfortable and supported.

The family-oriented organizational culture at the CWP also promotes a culture of self-care among service providers. While service providers noted that their work can be emotionally draining, they simultaneously noted that they are energized by their coworkers' passion and commitment to their work and feel supported by each other. Whether through sharing a meal, stepping in to help out when needed, or offering words of encouragement, these expressions of concern for each other's well-being are critical to ensuring that service providers have the

emotional energy to fulfill their responsibilities. This organizational commitment to service provider well-being is also evident in mental health service providers' average caseload size. Mental health service providers tend to have caseloads between 25 and 30 service participants, a number that encompasses all of their individual, couples, and group therapy encounters. Service providers stated that the size of their caseloads reflects the fact that they are also responsible for conducting intakes, community-based presentations, and mental health assessments for immigration cases. At the same time, however, service providers noted that in comparison to other community mental health centers where they have observed higher caseloads, the size of their caseload at the CWP also reflects an organizational concern for their well-being. As one service provider stated:

> We try to be really careful to not burn our clinicians out. We work hard. We really do work hard. There is respect for the clinician as also a human being…You look at our clinicians and we are all like I am not going anywhere. We all know how much this is a program that helps us sustain ourselves as people. That's also, I think, different. We are not considered therapy factories. (Interviewee 7)

Not only did service providers describe a family-oriented organizational culture that values employee well-being, but they also described an organizational culture that is reflective of the value of *respeto*. Service providers described that everyone inherently respects and values their coworkers as people, and they treat each other with the same level of respect regardless of their position within the organization:

> Me gusta que ahí donde yo trabajo…que toda la gente es muy bienvenida, que a todos les ponen una atención especial; no es más nadie ni menos nadie, todos somos iguales. Porque hay unos trabajos que, ay, que porque es el jefe, o que tú eres la que limpia – no, eso es lo que me gusta, que ellos todos somos iguales. Si están comiendo nos invitan, si van a hacer algo: "¿Quieres hacer esto?", y me hacen sentir bienvenida, me hacen sentir como ellos, eso es lo que me encanta, porque pues uno no es profesional, entonces eres aceptada./I like that where I work, that everyone is very welcome, that they pay special attention to everyone; nobody is more or less than anyone else, we are all equal. Because there are some jobs where, because they are the boss, or because you are the person who cleans — no, that is what I like, that we are all equal. If they are eating they invite us, if they are

> going to do something: "Do you want to do this?", and they make me feel welcome, they make me feel like them, that is what I love, because if one is not a professional, then you are still accepted. (Interviewee 9)

This inherent respect between coworkers was also reflected in staff meetings. In my field notes, for example, I described the first mental health staff meeting that I observed as follows: "Is a very 'democratic' process- there is not one person who is in charge of or overseeing the meeting, but instead people are collaborating with each other" (Field notes, 4/1/16). Data from this observation thus confirm that employees respect and value their coworker's feedback and perspectives.

### b. The CWP's Organizational Culture: Interactions Between Service Providers and Service Participants

Not only are the cultural values of *familismo* and *respeto* reflected in interactions among service providers, but there is also a parallel process through which this organizational culture extends to inform the treatment that community members receive upon entering the CWP. Service providers described their intentionality to treat each individual who enters the program space with respect. In particular, everyone who walks through the doors of the CWP receives the same reception:

> You really do have to think of that person as a valued member of society regardless where they are in their point of – in their lives, right. It could be a homeless person that's on the street, or it could be the vice president of the hospital. We do treat everybody the same. (Interviewee 2)

> Sea clase social más alta o más baja, o así, todos son iguales, bienvenidos. Por ejemplo, si yo soy un trabajador de fábrica y hay un licenciado que viene a terapia, no dicen: 'Ay, es que primero él porque es licenciado', no; ahí el licenciado es lo mismo que el otro. Entonces, eso es lo que me encanta, que no tienen una preferencia. Todos somos iguales./Whether they're from the highest or lowest social class, all are equal and welcome. For example, if I am a factory worker and there is a college graduate that comes to therapy, they don't say: 'He is first because he is the college graduate', no; there the college graduate is the same as the other. So this is what I love, that they don't have a preference. We are all equal. (Interviewee 9)

Just as service providers described their efforts to treat each individual who enters the CWP with respect, every service participant who took part in an individual interview described the CWP as being defined by respectful treatment. Service participants stated that every time they arrive at the CWP for an appointment, service providers in the waiting area smile and greet them with a *buenos días* (good day) or *buenas tardes* (good afternoon). As one service participant stated: "…todos son muy educados. Bueno, de que atienden, educados que dicen buenas tardes, unas personas muy educadas./…everyone is very polite. In the way that they attend to you, politely they say good afternoon, very polite people" (Interviewee 17). This service participant further described that service providers from different departments who enter the waiting area make a point of greeting them, regardless of whether they know them or will be meeting with them for an appointment:

> …allí uno llega y pues acá tienen diferente citas, y todos van y te saludan. Te ven, y, oh, buenas tardes./…one arrives there and they have different appointments here, and everyone comes and greets you. They see you, and oh, good afternoon. (Interviewee 17)

Service participants further discussed that this respectful treatment leads them to feel valued and important:

> La atención es admirable, es admirable. Te hacen sentir importante, valorado…todos muy buenos, me tratan con una sonrisa siempre presente. Y eso te hacen sentir valorado./The attention is admirable, is admirable. They make you feel important, valued…all are very good people, they treat me with a smile always present. And that makes you feel valued. (Interviewee 10)

Service participants described the respectful treatment at the CWP as standing out from the treatment that they receive in other service settings. Service participants stated that in comparison to other service settings where they feel as if they are taking part in a business transaction, at the CWP they are received with a warmth and respect that is unique:

> …a veces uno va a una cita del doctor o algo así, y pues como que no es lo mismo. No más te piden tu información y ya entras. Y pues en sí no es como que todos están atentos contigo, hablando contigo, o tratan de saludarte, preguntan por los niños./…sometimes one goes to a doctor's appointment or something like that, and well it's not the same. They only ask for your information and then you enter. And really it's not like everyone is attentive with you, talking to you, or trying to greet you, asking about your children. (Interviewee 17)

As another service participant stated, they feel as if at the CWP there is a genuine interest in treating them well and ensuring that they feel comfortable rather than solely performing their job responsibilities:

> Es muy tranquilo, es muy bueno. Con mucho respeto. Y siempre está con una cara alegre, recibe uno bien. No es como otros lugares que bueno, uno paga y llega y el recibe no está tan bien, ¿verdad? Pues es su trabajo y lo van a hacer, pero en este lugar, entra uno con una sonrisa y sale con una sonrisa./It's very peaceful, very good. With a lot of respect. And there is always a smiling face, they receive people well. It's not like other places where one arrives and pays and the treatment isn't as good, right? It's their job and they're going to do it, but in this place, one enters with a smile and leaves with a smile. (Interviewee 20)

Another service participant further described that this warmth and respectful treatment conveys a sense of familiarity that is missing in other settings where they have received services:

> …las personas son más amables, más cordiales, como que estás tratando con las personas que ya conocías. En otros lados, o sea siempre tiene esta situación de aunque hablen español, inglés, o x, son un poco indiferentes, o sea muy distantes./…the people there are more friendly, more polite, as if you are interacting with people that you already knew. In other places, or rather you have this situation of whether they speak Spanish, English, or whatever, they're a little indifferent, or rather very distant. (Interviewee 13)

Service participants again connected this increased respect and warmth that they receive at the CWP as leading them to feel more valued than they feel within other settings that do not treat them with this same respect. As one service participant stated:

> …desde la primera vez, lo tratan con respeto, lo tratan a uno…lo hacen sentir no lo menos, no lo menos, precian, como que…o sea, lo hacen sentir a uno…bueno, yo lo sentí como que…a veces uno va a clinicas, y a veces la gente está de mal humor y entonces como quiere que quitar la rabia con uno. Allí en San Antonio es diferente, fue muy diferente./…from the first time, they treat one with respect, they treat one…they don't make one feel less, they don't make one feel less, they value one, as if…or rather, they

> make one feel…I have felt like…sometimes one goes to clinics, and sometimes the people are in a bad mood and so they want to take out their anger on you. There in Saint Anthony, it's different, it was very different. (Interviewee 18)

All service participants without exception thus identified the CWP as being unique in the level of respect that they afford to everyone who enters the program space, leading community members to feel welcome, respected, and valued.

While one might argue that the examples illustrated above simply demonstrate an organizational culture committed to high quality customer service, these examples, when understood in the context of the acculturative experiences of community members, reflect an organizational culture that is culturally competent in its emphasis on respect. Community members described that respect is not a value that is commonly reflected in other service settings that they attend. Not only did service participants describe treatment in other service settings as being more businesslike, but they also stated that they are excluded from many social service settings due to their immigration status. Service participants noted that because the CWP serves all individuals regardless of their immigration status, they feel as if they are respected as human beings rather than being viewed as less worthy of respect due to labels that they have been assigned. One service participant noted that while they have been denied access to services and opportunities in other settings, the CWP does not discriminate based on their immigration status:

> …estos servicios que dan aquí en Saint Anthony, no discriminan en eso, o no te toman esta información, eres inmigrante, y no te va a tomar./…these services that they give here in Saint Anthony, they don't discriminate about that, or they're not going to take down that information, you're an immigrant, and they're not going to ask anything further. (Interviewee 17)

Several service participants further described that being afforded access to these services regardless of their immigration status demonstrates that they are respected inherently for who they are as human beings. Being treated with this level of respect thus takes on a special

significance for community members who often do not see this value reflected in other service settings.

Considering that service participants identified respect as a cultural value that they fear is being lost over time in the U.S., the CWP's emphasis on respect takes on added significance for community members who are concerned about maintaining their cultural heritage. Service participants explicitly stated that they see *respeto* reflected in service providers' efforts to greet service participants:

> Pues cuando uno llega, te dice buenas tardes o buenos días o hola, ¿cómo estás? Eso sí… tratan con respeto./So when one arrives, they say to you good afternoon or good day or hello, how are you? So yes…they treat you with respect. (Interviewee 12)

Another service participant stated that they see the value of respect reflected at the CWP "porque todos te saludan, te dicen buenas tardes, buenas noches, fin de semana. Como fue tu día./because everyone greets you, they say good afternoon, good evening, good weekend. How was your day" (Interviewee 20). Service participants thus identified these specific actions, which might simply be understood as good customer service in mainstream U.S. culture, as taking on a special meaning because they perceive these actions as being culturally affirming.

In addition to treating community members with respect, service providers described that they strive to make community members feel at home from the moment that they enter the waiting area. As one service provider stated:

> Make yourself at home. Here's this. Here's that. Please help yourself. I would like that if I'd ever go to a place where they make me feel like that. So, it's important that we turn it and say the same thing as well. (Interviewee 3)

Similar to service providers' descriptions, service participants described that when they enter the CWP's waiting area, they feel "como que estoy llegando a mi casa/like I'm arriving at my home" (Interviewee 21) and "como en familia/like I'm with family" (Interviewee 19). Service

participants further explained that just as they would accommodate guests in their home to make sure that they felt comfortable and welcome, service providers take these same steps to accommodate them when they enter the program space:

> …cuando yo vengo en época de calor, en época de calor está fresco, entras, está fresco el ambiente, cuando he tenido sed, te regalo un vaso con agua. Es como un alivio llegar allí. Es agradable, porque sabes que vas a encontrar un trato agradable…Y en la época de frío igual, está calentito, ellos están preocupados porque tu estés a gusto, comodo./…when I come in the season when it is hot outside, when it is hot outside it is cool, you enter, the environment is cool, when I have been thirsty, they give you a glass of water. It's like a relief to arrive there. It's pleasant, because you know that you will be met with a pleasant treatment…And just the same, in the season when it's cold outside, it's warm, they're concerned for your comfort. (Interviewee 10)

My observations of the waiting area coincided with service participants' descriptions. During a cold day when the heat was on in the waiting area, I noted that a service provider asked a service participant to please let them know if they felt too warm so that they could adjust the heat accordingly. These data suggest that although the CWP is no longer physically located in a house, the CWP's organizational culture serves to create a homelike atmosphere.

Service participants additionally described that they felt at home and with family at the CWP because upon entering the waiting area, they experienced affection similar to what they would receive from friends or family members upon being welcomed into their home. Both my own observations in the program waiting area and service participants' descriptions suggested that this affection is reflected in the reception that service participants' children receive when they accompany their parents to appointments. I observed that service providers did not only greet service participants in the waiting area, but that they also greeted their children. Service providers generally conveyed that children were welcome in the program space both through the warmth of these greetings and through the provision of child care during appointments. Although there is a communal space in the back of the building where service providers typically care for

children while their parents are in their appointments, service providers also make accommodations when that space is in use. Service providers may, for example, bring toys to the waiting area and care for the children there when needed. Entering a program space where service providers are playing with children reinforces the fact that all family members, adults and children alike, are welcome. Several service participants similarly described the warm and affectionate reception that their children receive at the CWP:

> Y como llevo mis niños a cuidar, pues ellos todos, oh, ¿como están los niños? Ponen a hablar con ellos./And as I bring my children for child care, everyone is like, oh, how are the children? They begin talking with them. (Interviewee 17)

> Todos son muy lindos, cariñosos. Siempre son muy amables conmigo y pues siempre mi hija va conmigo y todos la quieren mucho. Y uno siente este cariño, es…no sé, esta amistad que le dan a uno, aunque nada más lo mire cada semana, pero uno siente. Y lo conoce y el que se recuerdan de sus nombres y todo eso./Everyone is so nice, affectionate. They are always so friendly with me, and my daughter always comes with me, and everyone loves her so much. And one feels this affection, is…I don't know, this friendship that they give to one, although they only see you once a week, but one feels it. And the fact that they know you and they remember your names and everything. (Interviewee 19)

Service participants thus described this affection for themselves and their children, as well as this general interest for their comfort and well-being, as extending beyond simply being good customer service and instead reflecting the type of treatment that one would give to their family and friends. In this sense, the organizational culture of the CWP reflects the cultural value of *familismo*.

This reflection of the cultural value of *familismo* can again be further understood in the context of the acculturative experiences of community members. While service participants commonly acknowledged the importance of family unity and solidarity within their culture, they also acknowledged that they often lost this support system upon migrating to the U.S. and leaving their family members behind in their country of origin. Service participants thus

explicitly stated that the family-oriented environment at the CWP takes on a particularly significant role for them when they are alone in the U.S. One service participant described how this family-oriented environment provides them with the opportunity to engage in these caring and affectionate relationships that they so value:

> …allí es como llegar a un lugar como si fuera tu familia. So recibe este cariño. Pero yo no tengo familia aquí. Yo no tengo familia aquí en Chicago, todos están en México. Pero yo siento así como al llegar…como en familia./…there it's like arriving to a place as if they were your family. So you receive this affection. But I don't have family here. I don't have family here in Chicago, everyone is in Mexico. But I feel like when I arrive…as if I am with family. (Interviewee 19)

Just as service participants explicitly connected the respectful treatment that they receive at the CWP to the cultural value of *respeto*, they also explicitly connected the caring and affectionate treatment as encompassing the cultural value of *familismo*.

**2. <u>Integrating Understandings of Acculturative Processes at the Level of Individual Providers</u>**

Just as the organizational culture at the CWP is informed by an understanding of community members' cultural values and acculturative experiences, this same understanding informs service providers in their individual delivery of interventions with service participants. One service provider describes how this cultural understanding is at the very core of all the interventions that they deliver:

> I mean culture was, from the start, it felt like the grounding of our work. It wasn't like an added on thing. And I think that sometimes unfortunately in our training, in our education we add on culture to the developed theories of mental health or counseling, right? So it wasn't the case here; it was very much we start understanding, we're working with the Latino, mostly Mexican population, immigrant population. And so everything kind of came from that. (Interviewee 5)

One component of this cultural understanding is a recognition of the values that community members bring with them from their countries of origin. Similar to the way in which the

organizational culture of the CWP reflects values such as *respeto* and *familismo*, service providers acknowledge the importance of these cultural values in their daily practice and deliver services in a way that is consistent with these values. In so doing, service providers recognize that community members will feel more comfortable with the process of service delivery when their cultural heritage is affirmed and when they have the opportunity to stay connected to important cultural values from their country of origin.

### a. *Respeto* in Service Providers' Daily Practice

With regard to the cultural value of *respeto*, service participants described that individual service providers demonstrate respect by beginning appointments on time. Several service participants reported that this punctuality is important to them, as it shows that service providers respect and value the time that they set aside to attend appointments. Furthermore, they discussed that when service providers are unable to start appointments on time due to unexpected circumstances, they either inform them as soon as they are able or apologize for the delayed start. One service participant stated that not only is their mental health therapist punctual, but that their general demeanor is also reflective of *respeto*:

> Pues como para mi es así bien respetosa porque le hace…como le digo, así como, oh sorry que estuviste esperando aquí, o sea como que se disculpa pues. Y luego, este, pásale, vente, pásate, siempre cuando vamos a entrar el cuarto, siempre me dice, pásate. Y ella hace, tú pasas primero, y ya me voy a pasar./So for me it's very respectful because they…as I said, they're, oh sorry that you were waiting here, or that they apologize. And afterwards, it's, enter, you come first, enter, always when we are entering the office, they always say to me, you enter. And they make it so that it's, you pass first, and then I will enter. (Interviewee 16)

### b. *Familismo* in Service Providers' Daily Practice

Service providers and service participants additionally described that service provider-service participant relationships are not only defined by respect, but also by a deep sense of warmth, caring, and affection that is reflective of *familismo*. In particular, service providers

strive to develop relationships that extend beyond businesslike interactions and that are instead simply characteristic of relationships between human beings. In this effort to develop relationships that extend beyond businesslike transactions, one service provider described that they challenge “some of these rigid rules I know we’re taught, that we can't receive gifts from people, that you can't hug people” (Interviewee 5). This emphasis on developing relationships that extend beyond businesslike transactions was reflected in my observation of the ACT parenting workshop. Upon finishing their closing ceremony at the end of the final workshop session, service providers invited service participants to join them for a meal of tamales and coffee. Sharing a meal together at the end of the workshop was an opportunity for service participants and service providers to enjoy each other’s company as they spoke about their children and the schools that their children would be attending the following school year, as summer vacation had just begun. It was during this meal that service providers also spoke with service participants about additional services and upcoming activities offered through the CWP. Through this shared meal and informal conversation, service providers conveyed a genuine interest in the well-being of service participants and their families that extended beyond the exchange of information through the parenting workshop. This genuine interest in service participants’ well-being in turn cultivates long-term, trusting relationships with service providers and the CWP at large.

In addition to challenging what they perceive as being rigid professional boundaries, service providers discussed the importance of engaging in conversation about individuals’ hobbies and interests rather than focusing discussion solely on mental health concerns: “I need to provide space for that, too, be a little bit more relaxed with this structure and the goals” (Interviewee 6). In addition, service providers also discussed their emphasis on showing warmth

in their interpersonal interactions: “We I think all have a lot of warmth and kindness that we exercise with our clients… I think that our clients see this as a space where they can truly feel kind of recognized and understood” (Interviewee 7). This service provider additionally described the depth of their relationships with service participants as one of the most rewarding aspects of their work:

> So getting to formulate deep personal relationships with people that feel truly personal and intimate and trusting. They are full of warmth and humor and love and feeling that trust from someone so that I am in a position where I am feeling to challenge them in a certain way in a way of pointing out a blind spot they may be having or pushing them to get past a certain emotional barrier that they might have. Feeling that the trust is there that they are allowing me to help them through that without it feeling threatening is also I think also really lovely and rewarding. It's the trust. That feeling of trust. (Interviewee 7)

Service participants’ descriptions of the service provider-service participant relationship closely align with service providers’ descriptions. For those service participants who had received mental health services at other agencies prior to receiving services through the CWP, several identified the relational approach of service providers at the CWP as standing apart from the approaches of their previous providers. Six of the eleven service participants (55%) interviewed for this study reported that they had participated in previous mental health services, either individual or family treatment, on at least one occasion prior to initiating services at the CWP. While two service participants reported that they were satisfied with these previous services and felt that their reason for seeking treatment had been adequately addressed, four individuals reported being dissatisfied with treatment. Two service participants specifically identified their dissatisfaction as stemming from the fact that mental health providers did not understand them, did not listen to them, and did not express interest in their well-being. One service participant described their first appointment with a mental health provider outside of the CWP as follows:

> …no resolucioné nada. Pienso, el hombre que él me dijo que era el problema, y pienso que yo ya sabía cual era el problema y yo quería una solución para salir del problema, como salir del problema./…I didn't resolve anything. I think that the man told me what the problem was, and I think that I already knew what the problem was and I wanted a solution to solve the problem, how to solve the problem. (Interviewee 20)

Underlying this service participant's disappointment with their treatment experience is the implication that the mental health therapist did not seem to understand why they were seeking services.

Another service participant described how in their previous treatment experience, their mental health therapist did not listen to what they had to say and did not appear to be interested in providing support:

> Si yo vengo aquí es porque necesito ayuda, ¿verdad? Y me dicen que va a ayudar, pero no lo toman en serio. Entonces en realidad no me están ayudando, ¿entonces como para qué seguir?/ If I come here it's because I need help, right? And they say that they're going to help me, but they don't take it seriously. So in reality they're not helping me, so why am I going to continue? (Interviewee 11)

This service participant additionally described feeling stigmatized and labeled during this previous experience:

> Entonces uno no se abre con ellos porque también ellos nos tratan como si estuvieramos locos. Entonces estoy cerrada cuando desde esta perspectiva uno ve. Y dice, ¿no cree que es sicológico lo que usted siente? Así me decían, ¿verdad? Entonces lo que me pasa es sicológico, pero sí lo siento. Pero no es algo que estoy inventando… Entonces ya me sentía ofendida y no regresaba. No les tomara importancia lo que yo estaba sintiendo, ¿entonces para qué regreso?/So one can't be open with them because they also treat us as if we are crazy. So I'm closed off when one sees me from this perspective. And they said, you don't think it's psychological what you're feeling? That's what they said to me, right? So what I'm going through is psychological, but I feel it. But it's not something that I'm inventing…so I felt offended and I didn't return. If what I feel isn't important to them, then why should I return? (Interviewee 11)

While both service participants terminated services prematurely with these providers, they noted that they consistently attend appointments with their mental health therapists at the CWP,

because they feel as if CWP providers listen to them, understand their experiences, and are invested in their well-being.

Service participants who had no previous experience with mental health treatment similarly described that their relationships with their mental health therapists at the CWP are defined by caring, warmth, affection, and trust. Service participants described that they perceive service providers as being interested in getting to know them as people rather than simply being interested in doing their job: "…entonces lo que hicieron sinceramente es conocer a las personas que están tratando./…so what they genuinely did is get to know the people who they are treating" (Interviewee 13). Service participants further described how this genuine sense of caring and interest in their well-being is reflected through warm and affectionate interactions:

> Incluso hasta un abrazo, un abrazo sincero. Y eso es algo que usted lo siente, cuando un abrazo de verdad es de corazón. Entonces el cariño que uno siente./Including a hug, a sincere hug. And that is something that one feels, when a hug truly is from the heart. (Interviewee 19)

Service participants explicitly equated this warm, affectionate treatment to the treatment that they would receive from friends or family members. One service participant described how they received this affection from a service provider when they met them on the street outside of the CWP at a time when they were going through a difficult personal situation:

> Me hacía sentir como que no era una trabajadora y no era más que yo…sino quedaba que…siempre saluda como familia. Me hacían sentir en familia. Recuerdo que este día [staff member] estaba en la salida con otra trabajadora [staff member]…Entonces ella iba de prisa, so se detuvo y me dijo, ¿que pasó? Cuentame. Entonces yo le conté…El punto más bonito es de que yo sentí de que [staff member] tenía que irse a una junta, entonces por escucharme, por apoyarme, no fue a esta junta, se quedó conmigo…Y gracias a [staff member], porque si era otra persona, ella no le importaba…tengo que ir, punto. Pero yo me sentí muy especial./They didn't make me feel like they were a worker and I was nothing more than…rather it remained like…they always greeted me like family. They made me feel among family. I remember that this day [staff member] was leaving with another worker [staff member]…they were in a hurry, so they stopped and asked me, what happened? Tell me. So I told them…The most beautiful part was that I felt, they had to go to a meeting, but because they were listening to me, because they were supporting me, they

> didn't go to this meeting, they stayed with me…And thanks to [staff member], because if it were another person, it wouldn't have mattered to them…I have to go, that's it. But I felt very special. (Interviewee 18)

This quote illustrates that service participants perceive service providers to be genuinely concerned for their well-being beyond the confines of the office setting. Not only did this service participant describe this service provider as being like a family member in the way that they greeted them and attended to their needs, but they additionally described that this treatment led them to feel valued and important.

Service providers also show genuine concern for service participants' well-being in the support that they provide when service participants are experiencing mental health crises. For example, at one of the staff meetings that I observed, service providers discussed that in cases when service participants have needed to be hospitalized due to mental health symptoms, they accompanied them to Saint Anthony Hospital's emergency room and waited with them until they were seen. Service providers described that they accompanied service participants to the emergency room rather than sending them on their own because they recognized that this process is unfamiliar and could potentially be frightening. Service participants further described that service providers show genuine concern for their well-being in their efforts to ensure that emotional support is consistent and available outside of therapeutic sessions. One service participant noted, for example, that their mental health therapist gave them the name and telephone number of a coworker who they could call for support as needed while their therapist was out of the office on vacation. Another service participant stated that if they call the CWP in crisis and their mental health therapist is not available, staff will find another mental health service provider who they can speak with. A third service participant described how their mental health therapist has offered telephone support in emergent situations:

> …sientes…pues el interés por ver que tú te sientas bien. Eso. Porque muchas veces como profesional, como prestador de servicio, a lo mejor nada más te interesa hacer tu trabajo, pero ellos no…como que ellos están allí en el momento humano. Son humanos. Ellos están haciendo su trabajo, pero también se preocupan porque te puedas sentir mal afuera de las horas de trabajo. Entonces sabes que si tú…cuando yo me sentía mal, ella me dijo, si usted siga sintiéndose mal, puedes volverme a llamar, y yo estoy pendiente de ti. Entonces este es como de amistad también, ¿no? Te hace sentir querida, te hace sentir…pues, valorada./…you feel…the interest in seeing that you feel well. That. Because many times as a professional, as a service provider, you're only concerned with doing your job, but not them…they are there in that human moment. They're humans. They're doing their job, but they're also concerned about whether you might feel badly outside of business hours. So if you…when I felt bad, she said to me, if you continue feeling badly, you can call me, and I am here for you. So this is like friendship, right? They make you feel loved, they make you feel…well, valued. (Interviewee 10)

This quote provides an illustration of service providers' accompaniment approach. As this service participant described, service providers accompany community members throughout their healing journey by offering consistent support. This accompaniment approach cultivates service provider-service participant relationships that are reflective of *familismo* in the sense that they are defined by caring, warmth, and affection that extends beyond a businesslike service transaction. Service participants perceive a genuine concern for their well-being and an interest in accommodating their needs that they equate as being similar to the support that they might receive from a friend or family member. At the same time, however, service participants do not perceive this support as blurring the boundaries of the therapeutic relationship. Across interviews, service participants commonly referenced the level of professionalism that they observed among service providers. One service participant stated that there was no question that their relationship with their service provider was a professional relationship between a "paciente/patient" and "doctor" (Interviewee 13), but rather that the difference lay in the extent to which their service provider was genuinely interested in them as a human being within the context of this relationship. It is therefore important to note that service participants do not

confuse service providers as *being* family or friends, but rather that their expressions of support and concern are comparable to *what they might expect* from family and friends.

Service participants stated that the warm and caring relationships that they develop with service providers are in turn associated with positive therapeutic outcomes. Service participants discussed that as a result of service providers' constant support, they feel better equipped to solve problems that arise because they know that they are not alone in the process. One service participant discussed how feeling supported leads her to feel more confident that she will be able to find solutions to problems that arise:

> …el apoyo que yo siento, la paz que yo siento ahora, simplemente que no me cierran las puertas si me pasa algo. Antes era de ponerme llorar, sentirme que el mundo ya se me cerraba, y ahora no./…and the support that I feel, the peace that I feel now, simply that doors don't close on me if something happens. Before I would start to cry, feel that the world was closing in on me, and now that's not the case. (Interviewee 19)

This quote illustrates that having a relationship that is perceived as being constant and supportive can instill a sense of confidence and trust that service participants have the necessary resources to manage challenging situations.

Service participants additionally described that their relationships with their mental health therapists facilitate their emotional expression. Service participants stated that because they feel comfortable, safe, and cared for within the therapeutic space, they can freely express themselves "sin pena de nada/without any hesitation" (Interviewee 16) because they know that they will not be judged or criticized for what they express. One service participant stated that although they did not feel comfortable sharing their personal matters with others before initiating mental health services at the CWP, the trusting relationship that they developed with their therapist gave them the confidence to freely express themselves within the therapeutic space. Another service participant stated that "como uno se empieza a abrir con la confianza que la otra persona le da, y

con el trato/one begins to open up with the trust that the other person gives you, and with the treatment" (Interviewee 16). Several service participants explained that in the context of the relationship that they have with their service provider, the therapeutic space becomes a place to "desahogar[se]/unburden oneself" (Interviewee 19; Interviewee 20) so that they are not holding in or internalizing their emotions. One service participant further described this process of emotional expression as follows:

> So yo puedo ir y expresar todo lo que siento, tanto bueno como malo. Y es como un desahogo para mi. Y me siento muy cómoda, al gusto. Y siento que no estoy juzgada ni criticada. Al contrario, me siento demasiado comprendida y apoyada en todo lo que ha pasado en este transcurso de tiempo desde que yo estoy yendo a estas terapias./So I can go and express everything that I feel, both the good and the bad. And it's like a relief for me. And I feel very comfortable. And I don't feel judged or criticized. On the contrary, I feel so understood and supported in everything that has happened over the time that I've been coming to therapy. (Interviewee 19)

Service providers similarly described how their relationships with service participants facilitate emotional expression:

> …they're just so excited and in tune, and they know what they want to share, and how they want to share it. And so to see that transformation. Even people becoming more comfortable with this space, I find that really rewarding that they…To like, yes, this is my space, and I made it, and I'm feeling better because of it, and I want to continue using it. It can make things very rewarding. (Interviewee 8)

Even when service participants have not gotten to the point of expressing emotions pertaining to past trauma that they have experienced, having the opportunity to express emotions related to daily stressors can help them to feel less overwhelmed and burdened in their daily lives:

> Not everyone gets to the point of solving everything, but we have clients that have very high levels of anxiety. They start finding that they need periods of therapy to relax, to let go the emotions and like feel lighter. They can keep going with in a healthier way that way. Not always do you solve the whole trauma history, but you can help them have a more manageable life. (Interviewee 6)

Service participants additionally described that part of the process of unburdening themselves is feeling the freedom to express emotions that they may have never before had the

opportunity to express. As a result of this process, service participants reported that they have become more self aware and are able to work through emotions that have been affecting or paralyzing them in other areas of their lives. One service participant described how this process of working through their emotions has led to a sense of peace:

> …atreviendo el programa, pues he estado más tranquila, ya he podido desahogar y sacar lo que tenía adentro/…taking part in the program, I have been more at peace, now that I have been able to unburden myself and express what I had inside. (Interviewee 20)

As this service participant alludes to in this quote, the trusting relationship that is developed between mental health providers and mental health service participants allows for the establishment of a safe therapeutic environment where individuals can then begin to process past trauma. One service participant more explicitly made this connection between their trusting therapeutic relationship and their ability to heal from past trauma, stating that because they were always received with support and affection when they were suffering, “poco a poco se fueron sanando mis heridas/bit by bit my wounds healed” (Interviewee 14).

As a result of the relationships that they developed with their mental health therapists, service participants described that they have become more confident in their abilities to solve problems and are able to more freely express and process their emotions, including their emotions related to past traumatic experiences. Not only did service participants explicitly equate the support they received from mental health service providers with the level of support they would expect to receive from friends or family, but they also discussed that this support takes on an added significance when they do not have family in the U.S. who can offer this support. One service participant described that because they left their family behind in Mexico and view themselves as being relatively alone in the U.S., their mental health therapist’s support and genuine concern for their well-being has been especially important to them:

> …para mi, es como si estuviera sola aquí. Tengo amigos, pero en realidad hermanos, primos, mamá y papá, tantos, no. Entonces sentir a que alguien me escucha y que alguien realmente se preocupa por mi ha sido muy importante en todo este trayecto./…for me, it's as if I am alone here. I have friends, but really siblings, cousins, mother and father, no. So to feel like someone listens and that someone really is concerned for me has been very important in this whole trajectory. (Interviewee 16)

The relationships that service providers develop with service participants are thus reflective of the value of *familismo* in the context of the lived experiences of community members who have left behind their families and find themselves with limited social support in the U.S.

### c. Supporting Service Participants in Navigating Unfamiliar Systems

Not only are service providers affirming of service participants' cultural values in their daily practice, but they also support service participants in navigating unfamiliar U.S. social service systems. In particular, service providers and service participants described that service providers frequently give information about U.S. social service systems in a way that is meaningful and understandable to service participants. Service providers acknowledged that providing information about U.S. social service systems in Spanish is one of the primary ways in which they achieve this aim. Because mainstream U.S. health care and social service systems predominantly provide information in English, monolingual Spanish-speaking service participants often have questions about the information that they were provided during their interactions with these systems. Service providers at the CWP are able to translate this information so that it is meaningful to community members. One service provider discussed that because they were able to provide a service participant with Spanish-language information about a health care procedure, the service participant "was prepared to make a more informed decision now… It's great. That's something that I love about this that you can get them the information and good quality information" (Interviewee 6). With regard to public benefits in particular, service participants identified that service providers play a crucial role in providing culturally

and linguistically appropriate information about the process of applying for benefits and navigating the Department of Human Services. This assistance includes support with completing benefits applications: "Les ayudan a llenar unos papeles, si uno no puede llenarlos, allí les ayudan a llenar los papeles/They help you to fill out forms, if one can't fill them out, there they help you to fill out the forms" (Interviewee 14). In ensuring that information is culturally and linguistically accessible, service providers thus support service participants in navigating and becoming acquainted with unfamiliar U.S. social service systems.

**d. <u>Supporting Service Participants in Developing and Expressing Bicultural Identities</u>**

Service providers at the CWP additionally support service participants with the process of developing and expressing bicultural identities. As service participants described, the acculturative process entails reflecting on the values and belief systems that they bring with them from their countries of origin. While individuals identify values and beliefs from their country of origin that they wish to maintain as they adapt to U.S. culture, they may also identify values and belief systems that they do not wish to maintain. As individuals engage in the process of integrating the most meaningful elements of multiple cultures into their identities, they may thus challenge or reject cultural elements that hinder their personal growth. Recognizing this component of the acculturative experience, service providers offer a space for service participants to actively explore their values and belief systems. As part of this exploration, service providers engage in reflective discussion about belief systems that are often considered taboo or off limits in other service settings, including beliefs about gender roles or religion. As one service provider stated:

> Another way that we are culturally attuned model is we make room for discussions around religion, religiously. We make room for discussions around machismo, which is a huge

> part of Latino culture. When we make room for discussions around cultural aspects, that may in other agencies be overlooked, bypassed, considered not ethical or considered not normative in a therapeutic setting. We sort of make sure that we are intentional about discussing those issues. (Interviewee 7)

As illustrated through this quote, service providers thus recognize that culture is a dynamic construct, and they intentionally offer a space for service participants to explore and engage with their values and beliefs.

As noted, service providers discussed that belief systems surrounding gender roles and machismo is one cultural element that they commonly explore during the therapeutic process. With regard to the concept of machismo, mental health service providers acknowledged that this cultural construct has a negative connotation within mainstream U.S. society. Service providers discussed, however, the importance of understanding how service participants conceptualize gender role systems and having a discussion about these systems in a way that gently challenges but is still respectful of their beliefs:

> …in the Latino community there is a space where women have to maintain a position within the family of servitude, right? You can't say, no, you have to tell all the men in your house to cook for themselves, right? You can't take that active resistance role. That being said, you can offer a challenge today, you can say, "Well, why can't your son cook for himself over the weekend so you can go to school, or so you can do this? It will teach him to be independent because if you want him to go to college he's going to have to learn to cook on his own." You challenge, very subtly. (Interviewee 5)

One service participant discussed that having the space to explore gender role systems has helped her to critically reflect on how she views her role as a woman and to challenge the beliefs about gender with which she was raised:

> Y también me ha ayudado allí la terapia decir, ¿por qué nosotras las mujeres tenemos que ser sumisas, verdad? Y no, eso estoy en contra de ser sumisa. Y son cosas que nosotras en México, las mujeres tienen que callar, ¿verdad? Si eres golpeada, tienes que aguantar. No. Entonces eso me ha ayudado por identificar las partes de la cultura que son erroneas, pero las buenas me las quedo./And therapy there has also helped me to say, why do we as women have to be submissive, right? And no, I'm against being submissive. And they are things for us in Mexico, women have to be quiet, right? If you're abused, you have to take

> it. No. So that has helped me to identify the parts of the culture that are erroneous, but the good stay with me. (Interviewee 11)

Not only did this service participant describe how her conceptualization of her role as a woman has changed since she began mental health services, but she also contextualized this conceptualization in relation to her acculturative experience. In particular, she described the process through which participating in mental health services has helped her to engage with her belief systems so as to hold on to the values that are important to her while letting go of beliefs that did not coincide with how she currently views herself.

Service providers and service participants identified that topics related to gender role systems and machismo are not only topics that are discussed with female service participants, but are also topics that are discussed with male service participants. One male service participant described that while his mental health therapist did not directly challenge his beliefs that men should not show vulnerability or express emotions, his therapist allowed him the time and space to reflect on his beliefs and draw his own conclusions:

> …porque todo estaba en mi mente de mi educación, de…¿cómo te podría explicar? De mi cultura, de mi…digamos de la manipulación inculcada que se me asembró a tener simplemente amigos…o sea como decir que los amigos simplemente están allí y no puedes ni decir, no puedes comentar nada. O sea tuve eso digamos esa basura que había mi sociedad, como lo que fue sacando [staff member] poco a poco. O sea [staff member] obviamente ha hecho su papel correctamente como terapista, me dio mi tiempo, me dio mi espacio, y poco a poco./…because everything was in my mind from my education, from…how can I explain it to you? From my culture, from my…let's say from the manipulation inculcated within me that to have friends…or rather that you have friends simply to have them there but you can't say or comment anything to them. Or rather I had all of that garbage that there is in my society, that [staff member] took away bit by bit. Or rather [staff member] obviously did their job correctly as a therapist, they gave me my time, they gave me my space, and bit by bit. [Interviewee not identified to protect confidentiality]

For this service participant, the therapeutic process thus gave him the opportunity to reflect on and challenge his beliefs about what it means to be a strong male.

Service providers additionally described that they use all-male group therapy interventions as an opportunity to challenge service participants' conceptualizations about what it means to be a strong male. Service providers discussed that while Latino males traditionally do not have social spaces where it is acceptable for them to come together and express their emotions, all-male groups at the CWP both provide this space and challenge the belief that expressing emotions is a sign of weakness. Service providers discussed that in the most recent all-male group that they conducted, service participants' response to the opportunity for self-expression was overwhelmingly enthusiastic and positive, leading service providers to decide to schedule a monthly social event for males at the conclusion of the group. Service providers described that with this ongoing opportunity for socialization, they aim to assist male service participants in developing a social support network that encourages emotional expression and that conceptualizes expressive capabilities as a reflection of strength rather than weakness.

While the examples above illustrate ways in which service providers and service participants collaboratively challenged service participants' conceptualizations of gender role systems, service providers cautioned against simply thinking about the concept of machismo in negative terms. In particular, while service providers do offer all-male and all-female group therapy interventions, mental health service providers also described that having a non-judgmental stance toward machismo informs their decision to offer group therapy for males and females together. One service provider described that offering mixed-gender groups can provide important opportunities for healing:

> …if we're looking into [an] American feminist lens of course machismo's horrible and therefore should be addressed and therefore services should be separated between men and women because God forbid a machismo plays into reinforcing oppression in a setting where – in a therapeutic setting, right?...So we do group therapy with men and women because when trauma happens it doesn't just happen – and especially trauma does not just happen to any one gender. Men have been sexually abused throughout their lives and

> probably have additional layers of stigma to ever report or share that but you put this in a space where it's safe and supportive and women are exploring that and expressing that and men then often follow the lead. And that becomes such a healing therapeutic space. But again, this fear that machismo and male dominance can then interfere in that process is much more – I don't think it's that black and white. And I think we can't, as providers, limit ourselves to a very kind of black and white cultural understanding of things. (Interviewee 5)

While service participants did not specifically mention taking part in discussions about their religious beliefs during therapeutic sessions, mental health service providers did discuss that in their daily practice with service participants, religious beliefs are actively discussed rather than simply treated "respectfully and with deferment" (Interviewee 5). As one service provider stated:

> …you don't separate people's identity from their culture from the religion, and especially in Mexico where you have 90 percent of the population being Catholic or Christian, mostly Catholic, you know, even if you're not a believer, or actively practicing any religion, it's so part of the culture it's inseparable. (Interviewee 5)

Similar to discussions about gender role systems, service providers stated that they discuss religion with service participants in a way that is respectful of their beliefs, but that also challenges aspects of religion that are oppressive. Interviewee 5 went on to discuss how they would engage in these conversations with service participants using a feminist theological lens:

> …in this case the one that I found the most important to use is feminism within theology to rescue the voice of women within the biblical teachings and scripture…So I've used very much different writings from different theologians around reestablishing a more equitable and really challenging narrative of – as I personally believe was very much intended – in the teachings of Christ, so challenge established levels – establish situations that were oppressive 2,000 years ago in that part of the world. (Interviewee 5)

As service providers and service participants discussed, actively engaging in dialogue about gender role systems and religious beliefs is key to supporting individuals as they reflect on their cultural values and renegotiate their cultural identities during the acculturation process.

Parenting workshops also provide an opportunity for service providers to support service participants with the process of integrating elements of multiple cultures into their identities. Service providers recognized that when service participants are raising children in the U.S., there is a need for them to integrate elements of U.S. culture with cultural elements from their country of origin so that they can support their children in developing and expressing bicultural identities. This attention to biculturality is reflected in the Little Explorers parenting group:

> Lo hacen sentir bienvenido por el idioma y también las costumbres, pero a la vez tratan de inculcarles la cultura de aquí, porque los niños nacieron aquí, entonces las dos culturas van de la mano. El idioma de los niños también lo respetan, les hablan inglés, les leen libros en español y en inglés, les cantan cancioncitas en inglés y en español./They are made to feel welcome because of the language and also because of the customs, but at the same time they try to introduce them to the culture here, because the children were born here, so the two cultures go hand in hand. They respect the language of the children, they speak English, they read them books in Spanish and English, they sing them songs in English and Spanish. (Interviewee 9)

Rather than imposing mainstream U.S. cultural values on service participants, service providers thus introduce service participants to these values while simultaneously acknowledging and affirming the values and customs of their culture of origin.

Among service participants who have lived in the U.S. since they were young children, they noted that the biculturality of service providers at the CWP also facilitates the expression of their own bicultural identity. As one service participant stated:

> Y pues el hecho que también sepa inglés, pues a mi de repente como también sé ingles a veces se me pierda unas palabras en español y digo en inglés y ella [staff member] me entienda perfecto./And well the fact that they also know English, for me because I also know English, sometimes I lose some of my words in Spanish and I say them in English and she [staff member] understands me perfectly. (Interviewee 17)

This service participant thus acknowledges that having the ability to switch back and forth between languages as they choose during sessions facilitates their emotional expression. In this

manner, service providers' familiarity with both Latino and mainstream U.S. culture facilitates the development and expression of service participants' bicultural identities.

**e. <u>Service Provider Positionality</u>**

Mental health service providers at the CWP, who are both non-Latino/a White and Latino/a, described that they are aware of their own positionality as they support service participants throughout the acculturative process. This awareness of their positionality signifies that they understand how their own cultural values, beliefs, and experiences have the potential to inform their interactions with service participants. Service providers stated that self reflection is critical in being aware of what they are bringing to the therapeutic encounter, and further identified that individual and peer supervision allows them to develop their self reflective capabilities:

> Having to be constantly hyper aware of your own opinions, your own cultural norms, and not overlaying them onto the client. Furthermore, understanding and having an open, never ending curiosity about your clients' own perspectives and ideas. Having lots of check ins with one another in peer supervision, in individual supervision around what are the cultural differences and barriers between yourself and your client, keeping in mind really where our clients are coming from. When they present with ideas, opinions, and belief systems that we feel are harmful to themselves or others or that we don't agree with because we come from a different context, then choosing to work with the clients with and through that belief system. (Interviewee 7)

Service providers also recognized that part of this reflective process is understanding that both their own beliefs and the beliefs of the individuals whom they serve are equally valid:

> …I think my own experience, life experience and values and culture plays into that therapy relationship. I don't think we can totally strip ourselves of that. I don't think we should. But yeah, really making it a priority to be thinking through what my clients and the community in general kind of – what that lens would be more like. And putting those on equal – seeing them as equal and not one better or bigger than the other. (Interviewee 8)

While service providers in other CWP departments also acknowledged the influence of their own cultural beliefs, values, and experiences in their relationships with service participants,

their conceptualizations of this influence differed from that of mental health service providers. In particular, service providers in other CWP departments acknowledged that their own cultural heritage and their familiarity with Mexican cultural values and traditions, including their ease communicating in Spanish, facilitated the development of trusting relationships with service participants:

> I'm a native speaker, so I feel like that kind of gives me a little bit of an edge over somebody that is not because I feel like I can relate to the community. So we have a lot of the shared experiences and because of that I feel that my job kind of has been very easy. So I have been – I feel like I have been accepted into the community and everywhere I go because not only the language but because some of my experiences are very similar to theirs. So that is – I think that's definitely a plus. (Interviewee 2)

Whereas mental health service providers identified that an awareness of how they were culturally different from service participants was critical to the process of service delivery, service providers in other CWP departments identified that they were able to develop trusting relationships with service participants in part because their own personal experiences allowed them to better relate to community members. When synthesizing these differing perspectives, it is important to note that the majority of service participants did not identify shared cultural heritage between themselves and service providers as facilitating the development of trusting relationships and associated positive therapeutic outcomes. While one service participant noted that the Latino cultural heritage of the majority of the CWP's service providers likely informed their understanding of the values that are important to community members, the majority of service participants described that it was service providers' understanding of their experiences, not necessarily their ethnicity or cultural background, that facilitated trusting relationships and that subsequently promoted positive mental health outcomes.

As described throughout this section, during the acculturative process Latino immigrant community members navigate unfamiliar systems; identify the values and beliefs from their

country of origin that they wish to maintain; explore and challenge values and beliefs that hinder their personal growth; and integrate meaningful elements from multiple cultures as they develop and express their bicultural identity. Informed by an understanding of this acculturative process, the CWP supports service participants with these tasks at both the organizational level and at the level of individual providers. At the organizational level, the CWP's organizational culture is affirming of community members' cultural heritage. At the level of individual providers, staff members implement practices that are attuned with individuals' values; that facilitate exploration of values and belief systems; that promote the development and expression of bicultural identities; and that support community members in navigating unfamiliar social service systems. Service participants described that as a result of these efforts, they feel comfortable and valued in the program space and develop trusting relationships with service providers that facilitate their emotional expression.

### G. Anti-Oppressive Service Delivery

While the previous section discussed CWP practice efforts that are informed by an understanding of community members' acculturative experiences, this section will describe practices informed by an understanding of community members' experiences coping with societal level acculturative stressors that perpetuate structural oppression. When I asked service participants to describe their experiences as immigrants, they commonly shared experiences of discrimination, exploitation, marginalization, and exposure to negative mainstream narratives about immigrants. Service providers also made frequent reference to community members' experiences interacting with oppressive social structures. The CWP's organizational understanding of the impact of structural oppression on well-being is articulated in a CWP strategic planning document: "A mental health program working with minority/oppressed

populations must be particularly sensitive and responsive to the effects that social forces have upon individuals" (Document 17). Service providers expressed this same understanding that culture does not only encompass individuals' values and belief systems, but also encompasses the sociopolitical context in which they are situated. As one service provider stated:

> …culture is not just understanding what people's traditions and foods are about, or language, there's so much embedded into it…there's a lot of elements here that we can't lose sight of when we think about culture. It's sociopolitical as much as it is understanding culture itself. (Interviewee 5)

This understanding of the effects of social forces on well-being and the sociopolitical elements of culture is at the core of the CWP's anti-oppressive practice efforts. In particular, the CWP's anti-oppressive practice efforts are grounded in an understanding of the ways in which U.S. social institutions and mainstream narratives about immigrants contribute to community members' experiences of discrimination, exploitation, and marginalization. This section will first describe service participants' experiences of structural oppression. Next, I will discuss the anti-oppressive practice model that has been implemented at the organizational level and will conclude with a discussion of how this anti-oppressive model of service delivery is reflected in service providers' daily practice to address community members' mental health needs.

### 1. Experiences of Structural Oppression

While the data presented in this section are primarily centered around individuals' experiences of structural oppression following their arrival to the U.S., it is also important to make mention of individuals' pre-migration experiences. Both service providers and service participants discussed that Latino immigrant community members are often living in situations of extreme poverty prior to their migration to the U.S., and further connected these living situations to experiences of childhood trauma. Among the traumatic experiences that service providers and service participants identified were experiences of childhood abuse and neglect,

including being orphaned or "given away" by one's parents at a young age. One service participant stated that individuals carry the memories of these traumatic events with them during their migration journey, and they continue to be impacted by these traumatic experiences as they begin their lives in the U.S. When asked to describe the mental health needs of community members, this service participant stated:

> …cosas que nos pasa de niños y que todavía los seguimos cargando porque no lo hablamos, no tuvimos la ayuda cuando tuvimos el problema o así./…things that happen to us as children and that we still continue carrying because we don't talk about it, we didn't have the help when we had the problem. (Interviewee 11)

Not only are community members impacted by these experiences of childhood trauma, but their well-being is additionally impacted by experiences of discrimination, exploitation, and marginalization upon their arrival to the U.S. For individuals who are already coping with trauma-related symptoms, these post-migration experiences may further exacerbate these symptoms. I will now describe service participants' post-migration experiences of structural oppression and discuss how service participants described these experiences as impacting their well-being.

Service participants described that throughout the process of learning to navigate a new cultural context upon their arrival to the U.S., they were often made to feel as if they were of less value. With regard to language acquisition in particular, service participants described that they were made to feel of less value if they were unable to communicate in English:

> …lo más difícil de ser inmigrante es…el idioma. Porque muchas veces puedes conocer el idioma, estudiarlo en tu país, pero cuando vienes aquí no es como lo aprendiste. Es completamente diferente. Entonces es muy, muy difícil comunicarte. Yo me sentí menos preciada en este país, porque pienso que la gente pensaba que yo era tonta porque no entendía el idioma. Pero no es así. Yo no entendía el idioma, pero yo sé expresarme en mi idioma bien y correcto./…the most difficult part of being an immigrant is…the language. Because many times you can know the language, you can study it in your country, but when you come here it's not like how you learned it. It's completely different. So it is very, very difficult to communicate. I have felt less valued in this country, because I think

> people thought that I was stupid because I didn't understand the language. But that's not the case. I didn't understand the language, but I know how to express myself well and correctly in my language. (Interviewee 10)

Service participants recounted multiple examples of discrimination and exploitation within mainstream U.S. society. Some of these instances of discrimination were related to language preference. One individual described a situation where they asked an employee at a store if they spoke Spanish, and were told in response that it was not the responsibility of the employee to speak to them in Spanish, because they should learn English. Service participants additionally recounted that in service settings, such as hospital waiting rooms, they were attended to after English-speaking consumers, even when they arrived first or when their needs were urgent. Individuals described situations where they trusted in immigration lawyers that later went on to charge them large sums of money without attending to their case, and other situations in their daily lives where they were taken advantage of because they were not aware of U.S. laws and social norms. Interviewee 11 stated that these experiences of discrimination and exploitation represented "un pleito de adaptación y aceptación/a battle for adaptation and acceptance" in which individuals ultimately were not accepted within mainstream U.S. society. In turn, as individuals internalized situations where they were made to feel of less worth and value, their emotional well-being was negatively impacted: "Uno sufre si no está aceptado/One suffers if they are not accepted" (Interviewee 11). Another service participant further described how their daily experiences of discrimination and exploitation led them to view themselves in a negative light:

> …aquí pasaban tantas cosas que llegó un punto a cuál yo nada más sentía ser víctima de muchas cosas. So entonces…ya no podía hablar y decir nada porque sentía que cualquier cosa, aunque tuviera yo la razón, me hacía sentir culpable. La gente me hacía sentir culpable. So entonces siempre la gente trataba de humillarme, siempre la gente trataba de hacerme menos./ So many things happened here that it reached a point where I felt like nothing more than a victim of many things. So then…I couldn't talk and I couldn't say

> anything because I felt like whatever happened, although I could have been correct, I was made to feel like it was my fault. People made me feel guilty. So people always tried to humiliate me, people always tried to make me feel less than them. (Interviewee 18)

Service participants additionally described that individuals of all racial and ethnic backgrounds, including individuals from their own countries of origin, perpetrated daily acts of discrimination and exploitation:

> …lo principal que te duele es de que sigue habiendo estas diferencias raciales. Esto es algo muy, muy difícil, que a pesar de que hay muchas culturas viviendo en este país, sigue habiendo esta discriminación, esa división racial. Eso es muy, muy triste. Muy triste. Otra de la situación es de que…de que aquí tu cultura, tu gente se vuelve a veces hasta contra ti porque piensan que les vas a quitar algo, que les vas a querer algo, entonces tienen como mucho recelo de apoyarte y ayudarte./…what pains you the most is that there continue to be these racial differences. This is very, very difficult, that although there are many cultures living in this country, there continues to be this discrimination, this racial division. That is very, very sad. Very sad. Another situation is that…that here your culture, your people sometimes turn against you because they think you're going to take something from them, that you want something from them, so they are suspicious to support you and help you. (Interviewee 10)

Service participants further discussed examples of fellow immigrants improperly training them when they began a new job because they were concerned that their new co-worker posed a threat to their job security. As Interviewee 11 stated: "Los hispanos vamos dividiendo./We Hispanics are becoming divided." Service participants discussed that observing their compatriots behaving in this manner rather than providing support was a disappointing and saddening experience.

The accumulation of these daily experiences of uncertainty, discrimination, and exploitation were also associated with a pervasive sense of fear. Coinciding with service participants' descriptions, one service provider stated that a constant fear of deportation was common among community members seeking services at the CWP:

> …making a life here is hard, too, because the conditions are being like they have fear in many ways to be discovered or to be…sent to their country…They are afraid all the time of applying to jobs with a false social security or they are afraid of getting sick and not having access to services. It's a difficult life. It's a very difficult life. (Interviewee 6)

Service providers and service participants additionally discussed that when community members do not have their documents, they are hesitant to access services and put their trust in service providers due to fear that their immigration status will be discovered. As a result of this fear, community members may be hesitant to apply for benefits for which they or their family members are eligible. One service participant further described how even when individuals have their documents, they continue to live in fear for which they cannot pinpoint the direct cause:

> Otra cosa como inmigrante que tienes miedo, tienes mucho, mucho miedo de todo. Tienes miedo, no sabes por qué, pero tienes miedo de todo. Aún cuando tienes el permiso de poder estar aquí, pero tienes miedo todo. Todo, y te hace inseguro, a mi me produjó mucha ansiedad, mucha inseguridad, mucha baja autoestima./ Another thing about being an immigrant is that you're afraid, you're very, very afraid of everything. You're afraid, you don't know why, but you're afraid of everything. Even when you have permission to be here, you're still afraid of everything. Everything, and it makes you insecure, it caused me a lot of anxiety, a lot of insecurity, very low self-esteem. (Interviewee 10)

As illustrated through this quote and the descriptions above, daily experiences of discrimination and exploitation are often internalized, leading individuals to feel afraid and uncertain and to question their personal value and worth.

Not only did individuals internalize personal experiences of discrimination and exploitation, but they also reported that they internalized mainstream narratives about immigrants in society at large. Several service participants spoke about prevalent stereotypes to which they have been exposed and spoke about their desire to change these stereotypes:

> Yo no puedo decir que mi cultura sea lamentablemente una cultura sin estudios, sin preparación, y sin metas al futuro, porque realmente no es así…hay doctores, hay maestros, hay abogados, hay un sin fin de latinos trabajando con la comunidad y afuera de la comunidad…o sea yo no te puedo decir que los latinos solamente somos borrachos, mujeriegos, y analfabetos y incultos, o somos narcotraficantes, o somos mujeriegos, o somos machistas. Hay un sin fin de personas. Y para decir que los latinos somos una, pues, no es así. Piensan que los latinos no leemos cuando realmente sí leemos. Pero pues lamentablemente nuestros gobiernos a veces no nos dan las oportunidades de sobresalir, de seguir estudiando, tener nuestras propias carreras, y por eso también muchas personas se vienen, lamentablemente, como inmigrante, a veces legal, a veces ilegal, a veces con una carrera de por medio vienen a los Estados Unidos a buscar y dejan muchas cosas

> atrás, como una familia, unos hijos, unos cargos, entonces muchas cosas. Entonces, nosotros no venimos ni a robar, ni a quitar el trabajo a otras personas, porque realmente creo que todos tenemos derecho a vivir, a trabajar, y pues tener las mismas oportunidades que todos./ I can't say that my culture lamentably is a culture without education, without preparation, and without goals for the future, because really that's not the case…there are doctors, there are teachers, there are lawyers, there are a countless number of Latinos working in and outside of the community…I can't say that we Latinos only are drunkards, womanizers, and illiterate and uncultivated, or that we're drug traffickers, or womanizers, or machos. There are an endless number of people. And to say that Latinos are of one kind, that's not the case. They think that we Latinos can't read when in reality we can read. But lamentably sometimes our governments don't give us the opportunity to move forward, to continue studying, to have our own professions, and for that reason there are also many people who come, lamentably, as immigrants, sometimes legally, sometimes illegally, sometimes seeking an opportunity in the United States to practice their profession, and they leave many things behind, their family, their children, many responsibilities, so many things. So we don't come to rob or to take away work from other people, because really I think that we all have the right to live, to work, and to have the same opportunities as everyone else. (Interviewee 13)

This quote suggests that Latino immigrants in the U.S. must constantly defend themselves from the stereotypical portrayals of themselves that are prevalent in U.S. society.

Service participants additionally described how they have been denied access to opportunities and services within U.S. society as a result of their immigration status. Individuals stated, for example, that they were unable to obtain identification documents or apply for financial aid so that they could attend college, which in turn limited the employment opportunities that they could pursue:

> Yo me gradué de la high school… La escuela, la college, no pude entrar y poder tomar algo porque no podía tener financial aid, so tendría que pagar todo. Entonces yo no podía entrar mi profesión, tomar mi profesión, pues entonces dije, no hay modo llegar a la escuela./ I graduated from high school…I couldn't enter college and major in something because I couldn't have financial aid, so I would have had to pay for it all. So I couldn't enter my profession, have a profession, so I said, there's no way to go to school. (Interviewee 17)

In addition to being denied access to educational and career opportunities, service participants discussed that their immigration status often denies them opportunities to generally participate in civic life or have their voices heard within U.S. society. Interviewee 11 noted, for example, that

local politicians typically do not respond when undocumented community members voice concerns about their community, because politicians know that as a result of their immigration status, they will not have a say in whether or not they are reelected. Service participants also identified the challenges associated with accessing health and social services that require a social security number. While several service participants stated that they were able to access services by investigating resources for which they qualified, several service participants stated that although they may be able to access health and social services if they pay for the services, the cost is often prohibitive and limits their access. One service participant described how the inability to access health services is another factor that leads them to believe that immigrants, particularly undocumented immigrants, are perceived to be of less value and worth within mainstream U.S. society:

> A veces no te dan…no tienes acceso al servicio médico, puedes estar enferma. Entonces, los inmigrantes indocumentados lamentablemente aquí no tienen nada. No son de las importadas personas que tienen eso, o si estás enferma y necesitas algo, si no tienes dinero, te mueres. Entonces es muy duro, es muy triste mirar todo eso./Sometimes they don't give you…you don't have access to medical services, although you could be sick. So undocumented immigrants lamentably don't have anything here. They are not among the valued people who have that, or if you're sick and you need something, if you don't have money, you die. So it's very difficult, it's very sad to see all of that. (Interviewee 18)

Although service participants taking part in individual interviews recognized that the mainstream narrative about Latino immigrants did not accurately represent who they are, many discussed that in the context of the challenges and poor treatment that they experienced, it became difficult not to internalize these messages and to question their own value and worth. Service participants thus described that experiences of discrimination, exploitation, and marginalization negatively impacted their mental health, leading them to question their own worth and to feel afraid and insecure.

**2. <u>Structural Context of Receiving Community</u>**

Not only did service participants describe experiences of discrimination, exploitation, and marginalization during the process of navigating the mainstream U.S. cultural context, but both service providers and service participants also discussed individuals' experiences of settling in communities marked by structural inequities. Often leaving situations of extreme poverty in their country of origin, individuals find that upon their arrival in the U.S., the type of employment opportunities to which they have access lead to continued experiences of poverty. Service providers and service participants noted that experiences of poverty within Chicago's urban context, and particularly within the Little Village community, are often accompanied by community violence. Several service providers noted that service participants may fear leaving their homes and walking in the neighborhood due to concerns about gang violence. One service participant described that when youth grow up in communities with limited resources where they perceive limited opportunities to pursue educational and career aspirations, they are susceptible to gang involvement, substance abuse, and teen pregnancy. This service participant described that structural inequities contribute to these social problems, and addressing these social problems in turn becomes difficult when limited resources are invested in the community:

> Y realmente creo que podemos evitar todas estas muertes tanto en las pandillas allá afuera…tantas mujeres golpeadas, tantos niños golpeados, tantas niñas golpeadas, tantas cosas que están pasando que si estuviera estos pequeños recursos, podríamos hacer este gran cambio. Porque realmente, imagínate, realmente podrían ser papás, mamás, abuelos, hijas que podrían ser grandes maestras. Hijos que podrían ser buenos doctores, papás que querrían ver a sus hijos van a la universidad, graduarse, abuelos que querrían ver a su primer nieto, nieta. Estamos… queremos hacer cambios, ¿pero en qué manera? Están cerrando escuelas, están cerrando muchos centros de apoyo./ And really I think we could avoid all these gang deaths happening out there…so many women beaten, so many boys beaten, so many girls beaten, so many things are happening that if we had these few resources, we could make this large change. Because really, imagine, really they could be fathers, mothers, grandparents, daughters that could be great teachers. Sons that could be good doctors, parents that would want to see their children go to college, graduate, grandparents that would want to see their first grandson, granddaughter. We want to

> make changes, but how? They're closing schools, they're closing many centers of support. (Interviewee 13)

This quote suggests that when individuals' daily experiences already lead them to question their value and worth, living in communities where limited resources are invested in their children and their futures may serve to reinforce their internalization of mainstream narratives.

The data presented in this section thus indicate that as Latino immigrant community members face the task of navigating a new cultural context, a task that is challenging even in the best of circumstances, this task is further complicated by poor treatment, denied access to services and opportunities, and exposure to mainstream narratives that portray Latino immigrants in a negative light. Experiences of structural oppression thus have the potential to negatively impact mental health, leading individuals to question their value and worth and to feel fearful and insecure. These mental health challenges may be accentuated in communities with limited resources to invest in services for community members.

### 3. Anti-Oppressive Practice at the Organizational Level

Informed by an understanding of community members' lived experiences of structural oppression, practice at the CWP intentionally aims to address the oppressive environmental contexts in which community members are situated. First, at the organizational level, the CWP has developed the infrastructure to deliver mental health services that provide an alternative to the traditional medical model of mental health treatment that is dominant in mainstream U.S. society. This alternative model of mental health treatment is reflected in the program's intentionality to not follow the "assess and diagnose" model of service delivery. While the medical model of mental health treatment requires that individuals be assigned a diagnosis through the DSM after an initial assessment, the goal of assessment at the CWP is to learn about individuals' experiences and to understand how the environment in which they are situated

impacts their current functioning, without assigning a diagnostic label. Mental health service providers discussed that in other experiences at community mental health agencies, the "assess and diagnose" treatment model posed a barrier to Latino immigrant clients accessing and engaging with services:

> …this is how it typically operates within these community mental agencies, right, that you come in, you interview with the intake worker, they assess you…which is very intrusive. And you're expected to open up on all these things and then talk to that person for an hour and then never see them again and then get referred to a clinician who may or may not be a fit. And then maybe also get seen by a psychiatrist, right? So it's a very rigid format. (Interviewee 5)

In contrast, at the CWP, the initial and subsequent meetings between service providers and service participants are centered around hearing and understanding the individual's experience:

> It was more so you were there to – again, meet people where they're at, right? You were there to just learn from their experiences, and go as far as you could in understanding people's experience, right? It wasn't a case to assess, diagnose and treat in that way. (Interviewee 5)

In the context of this alternative treatment model, service providers conceptualize mental health as being impacted by environmental influences rather than stemming from individual pathology: "…we stray as far away from the diagnostic end of mental health as we possibly can. We see people as people in an environment…We are products of our environments, not just products of our pathology" (Interviewee 7). This decision not to assign diagnostic labels to mental health service participants is informed by the program's intentionality to challenge the structural oppression that Latino immigrant community members experience:

> When you're dealing with communities that have been oppressed, marginalized, a lot of this internalized oppression, you know, going to a clinical setting that then reinforces that by giving them diagnoses and reinforcing that yes, they need to be treated for whatever they're dealing with is very, very reinforcing of this oppressive nature. (Interviewee 5)

At the CWP, mental health assessments are thus based on developing an understanding of individuals' experiences and the environmental context informing these experiences rather than being based upon evaluating whether individual symptomology meets specified diagnostic criteria.

Service providers' descriptions of their intentionality not to follow a traditional "diagnose and assess" model of mental health treatment coincide with service participants' descriptions. Service participants discussed that upon initiating mental health services at the CWP, they felt comfortable because they were not immediately asked to discuss their mental health symptoms at length. One service participant who had received mental health services at other organizations reported that at other organizations, they were made to feel as if they were crazy or that there was something wrong with them when they disclosed their mental health symptoms. In contrast, at the CWP they did not feel as if they were being judged or labeled. They largely attributed this difference to the fact that during the first session, they were given the freedom to set the therapeutic agenda and discuss an experience of their choice rather than being asked to answer a series of questions about their mental health symptoms:

> Entonces mi experiencia aquí en el programa que primero entré y no fue como todos los demás. Dejaron que hablara o que era lo que yo estaba buscando. Entonces eso me llamó la atención, no es como los otros que dicen, ¿y a qué vienes? No, ellos me escucharon, me dijeron, bueno, ¿qué podemos hablar? O sea ellos no me exigieron, de que hablara, o de que me deprimía, o algo así. No ellos, ¿qué quieres comenzar a hablar?/So my experience here in the program is that I first entered and it wasn't like the others. They let me talk, or it was what I was looking for. So that caught my attention, it wasn't like the others where they say, and why did you come? No, they listened to me, they said, well, what can we talk about? Or rather they didn't demand that I talk about certain things, or about why I'm depressed, or something like that. No, with them, what do you want to begin talking about? (Interviewee 11)

Another service participant who had not received prior mental health services expressed feeling similarly about the first mental health therapy session that they attended. In particular,

they reported that they appreciated the fact that they were not asked intrusive questions about difficult subject matter during their first session:

> …fue muy bien porque me parecía bien lo que haga la consejera, o sea no fue directamente al punto de que me llega, sino buscó la manera de una de otra de irme…o sea involuncrando a lo que fue pasado y no fue directamente…o sea como un paso a otro paso./…it was very good because I liked what the counselor did, they didn't go directly to the point that brought me in, but instead looked for a way to get me there bit by bit…or rather, getting to what happened and not going there directly…or rather step by step. (Interviewee 12)

In addition to allowing service participants to set the therapeutic agenda and slowly ease their way into discussing their reasons for initiating mental health services, another service participant identified the CWP's model as being different from the traditional medical model because medication was not immediately suggested as an option for treating mental health symptoms. This service participant stated that while friends and family members have recounted experiences with mental health treatment in which "lo primero que buscaban fue medicina/the first thing that they sought out was medicine," at the CWP "nunca me han hablado, nunca me habían dicho, tú necesitas medicina. Una de eso me ha ayudado natural/they have never talked to me about, they have never said, you need medicine. They have helped me naturally" (Interviewee 20). Service participants thus identified that the CWP's alternative mental health treatment model creates a therapeutic environment in which they feel neither judged nor labeled. In the context of this model, service participants are able to slowly discuss their reasons for seeking treatment without immediately answering intrusive questions about their mental health symptoms.

Mental health services at the CWP also stand in contrast to the traditional medical model in the sense that they are not time-limited. Service providers acknowledged that when mental health programs bill insurance for their services, the number of sessions that can be offered typically depends on insurance authorization. They noted that since the passage of the Patient Protection

and Affordable Care Act, the focus on providing short-term behavioral health services has increased. In this context, mental health therapists and clients establish a treatment plan that outlines short-term goals, and treatment is completed when these goals have been addressed. Service providers at the CWP noted that for the population they serve, who have commonly experienced multiple traumas both in their country of origin and in the U.S., treatment planning and time-limited services are not sufficient to support individuals in healing from trauma, which is a long-term process. Because the CWP serves only individuals who are uninsured or underinsured, and therefore does not rely on insurance as a source of funding, they do not face restrictions on the number and type of services that they are authorized to provide. In addition, because the CWP offers all services free of charge, service participants may engage in long-term services free of the concern that cost will make long-term participation prohibitive.

Service providers acknowledged that because they operate outside of the context of insurance regulations and authorizations, they have "a large amount of freedom for creativity" (Interviewee 1). In particular, service providers may devote increased time to developing relationships with service participants rather than focusing on identifying and working toward short-term goals. Within the context of this model, the relationship between the service provider and the service participant is a vehicle that facilitates the process of healing from traumatic experiences:

> We have the absolutely luxury of being funded through a Catholic hospital and being part of their charitable benefits funding stream. We can meet our clients as we see absolutely fit. That means absolutely minimal paperwork. It's just a true devotion to the work being almost entirely relational, not planned out and boxed in and meeting milestones and meeting have you met your goals yet. No. That to me stands out. (Interviewee 7)

One service participant similarly noted that the CWP's time-unlimited model has allowed them the opportunity to process and heal from past trauma at a level of depth that they had been unable to attain with prior mental health services:

> …le ayudan a uno a descubrir más cosas que ha pasado uno, más experiencias que ha tenido uno en tiempo de atrás, de niñez, y todo eso…Y te apoyan. Si ven que tu estás sufriendo, recibes apoyo de ellos con un aprecio, con cariño, eso. Que te escuchan con una paciencia y un cariño…no, olvides. Una cosa muy hermosa. Estoy encantada, encantada./…they help one to discover more things that have happened to them, more experiences that they had in an earlier time, in their childhood, and everything…And they support you. If they see that you're suffering, you receive their support with respect, with affection. They listen to you with patience and affection…no, forget it. A beautiful thing. I am so pleased, so pleased. (Interviewee 14)

Service providers also identified that their model of service delivery is different from the traditional medical model in the sense that service participants have more flexibility to start, stop, and reinitiate services without losing their therapy slot or having to return to the waiting list. The traditional medical model of mental health treatment tends to operate through "episodes of care" in which individuals officially initiate services through a diagnostic assessment, participate in therapy sessions until they have achieved short-term goals, and then officially end services after goal achievement when mental health providers complete paperwork to "close out" their case. In accordance with this "episodes of care" model, mental health service providers may also be mandated to "close out" individuals' cases after a specified number of "no shows," or instances when individuals miss appointments without providing 24-hour notice. Service providers at the CWP, however, noted that with long-term services focused on providing support in coping with trauma, treatment progression does not always fit this linear pattern. In cases where individuals do not feel ready to process specific components of traumatic experiences, there may be a period in which they stop attending services until they reach the point where they are ready to process these experiences in greater depth. Service providers thus allow service participants the

flexibility and space to stop and reinitiate services in accordance with their readiness to discuss difficult subject matter. This model of service delivery is reflective of the accompaniment approach. Service providers recognize that community members' healing journeys are not necessarily linear, and the CWP's treatment philosophy is grounded in the idea that service providers are still an available resource even when service participants are not actively engaging in services. Even when service participants "complete" treatment, there is the understanding that they may contact the program for support in the future if the need arises. The CWP thus becomes an additional resource within community members' social support networks.

Several service participants similarly described how the CWP's model of service delivery provides an alternative to the medical model's "episodes of care" approach. In particular, they stated that there were periods when they stopped services for reasons including travel to their country of origin, an increase in symptoms, or feeling unready to discuss difficult subject matter. One service participant described how they would sometimes miss a session if they needed additional time to reflect on content discussed during the previous week's session:

> Entonces como que los veo cada semana, la semana me pasa, ya lo pensé todo que me dijo, y regreso. Y no me preguntan de lo que pasó la semana pasada. Entonces, ¿cómo se siente hoy? ¿Qué quiere hablar? ¿Quiere que sigamos en la plática, o…? A veces digo con la plática y a veces ya lo pongo por más adelante y vuelvo traerlo en la mesa./So since I see them every week, I'll let a week pass, and then I'll think about everything that they said to me and return. And they don't ask me about what happened the week before. So it's, how are you feeling today? What do you want to talk about? Do you want to continue with our conversation, or…? Sometimes I say to continue with the conversation and sometimes I leave it and return to it later. (Interviewee 11)

This service participant thus describes that rather than being asked to explain why they did not attend a session or having their absence threaten their ability to continue with services, they are given the space to reflect on difficult subject matter and return to discuss it when they feel ready to do so.

Operating as an alternative to the traditional medical model of mental health treatment does not signify that service providers do not assess treatment progress. Service providers recognized the importance of collecting data to monitor progress and assess outcomes during the therapeutic process, but they also recognized the importance of conducting these assessments in ways that are culturally appropriate and that view mental health as more than simply the absence of a set of symptoms:

> And so we've been, in a responsible way, trying to find ways of integrating assessments that are not too intrusive, not too long, very culturally appropriate and can reflect people's understanding of wellness as they see mental health, not using very much a medical assessment method but more of a personal wellness method of assessment. (Interviewee 5)

While service providers do use the PHQ-9, a standard nine-item depression measure, to assess treatment progress, mental health service providers have also developed their own Empowerment Scale, a 16-item scale that measures constructs including level of self-awareness, self-expression, sense of self worth, and problem solving abilities. Both the PHQ-9 and Empowerment Scale are administered to service participants in Spanish. Mental health service providers typically administer the PHQ-9 to service participants during their first session and then administer it every six weeks until week 30 of treatment. Service providers begin administering the Empowerment Scale during the sixth week of treatment, and then administer the measure every six weeks until approximately week 36. These assessment practices thus suggest that while mental health providers do not ignore symptomology, their assessments extend beyond simply measuring the presence or absence of mental health symptoms and encompass constructs related to how individuals relate to themselves, how they relate to others in their interpersonal interactions, and how they navigate the challenges that they encounter in their daily lives.

The data presented above suggest that the CWP has developed an anti-oppressive practice model. In particular, the decision to provide an alternative to the traditional “assess and

diagnose" model of mental health treatment was intentionally made so as to avoid further stigmatizing individuals who are already discriminated against and stigmatized through stereotypical mainstream narratives about Latino immigrants. In addition, recognizing that community members are often denied access to long-term services that allow them to process past traumatic experiences, the program is intentionally designed to offer free, time-unlimited services that provide individuals with the support, space, and flexibility necessary to heal from past trauma.

### 4. Anti-Oppressive Practice at the Level of Individual Providers

At the level of individual providers, service providers described that their daily practice is informed by this same understanding of community members' lived experiences of structural oppression as is reflected in the program's organizational infrastructure. In particular, their practice is informed by this understanding of the sociopolitical elements of culture and the ways in which the process of interacting with oppressive social structures impacts community members' well-being. Service providers made explicit reference to aspects of community members' experiences and stated that their practice aims to challenge the oppressive social structures with which community members interact. As one service provider stated:

> How much are immigrants in this country scapegoated. How much are they blamed? I guess those two words really scapegoated and blamed for a lot of problems. That is internalized. How can they even push back against that narrative, right? What sociopolitical context can we look at and international context can we look at that are setting the stage that aren't actually their fault? (Interviewee 7)

Recognizing that service providers' practice is informed by this understanding, I will go on to discuss specific examples of practice strategies that service providers use to challenge oppressive social structures, highlighting how each strategy is informed by service providers' understanding of the lived experiences of community members.

**a. <u>Dismantling Power Differentials</u>**

One practice strategy that service providers utilize to challenge structural oppression is the practice of attempting to dismantle the power differential between themselves and service participants. Service providers discussed that because of community members' lived experiences in both their countries of origin and the U.S., they may feel powerless in many aspects of their daily lives and thus enter the therapeutic encounter with the belief that the mental health therapist is an expert to whom they should defer. One service provider described how the class system in Mexico, which is the country of origin for the majority of service participants, influences community members' tendencies to treat mental health therapists with deference:

> I always say that in Mexico class is what race is here in the U.S. It is very much that third rail in which people are discriminated against. And so we're dealing with people who migrated here because of – more often than – not always the case, right, but because of poverty, who were oppressed. And so they come into clinical space with seeing my diplomas on the wall, there is always a power and a class differential. (Interviewee 5)

In addition to this pre-migration experience, service providers noted that upon migrating to the U.S., exposure to mainstream narratives about Mexican immigrants, coupled with personal experiences of discrimination, tend to reinforce community members' "subordinate" status. The aim of service providers in therapeutic encounters is thus to dismantle the idea that service providers are "experts" and service participants are "subordinates," and to instead create a collaborative partnership in which both service providers and service participants contribute a unique set of expertise to the therapeutic encounter. Service providers described how they engage service participants in discussing subjects around which they have a set of expertise in an attempt to dismantle this power differential:

> …at the beginning, they expect to have this power difference between the therapist and the person. When they find that it is not like that, that they have power in here, they are like what I am doing here…Yeah, and then they trust you when for example, I feel like it's very useful when I tell them like how do you do? You cook that? How do you cook that? They

> answer. They end up telling me their recipe or something. They feel like they have power about something that I don't. It feels more equal. (Interviewee 6)

Service providers also identified that an aspect of dismantling the power differential between therapists and service participants is acknowledging that service participants are experts in their own life experiences. Coinciding with the program description outlined across agency documents, service providers described their practice as being firmly grounded in the strengths perspective. One service provider described the strengths perspective as a practice framework that actively challenges oppression by exploring how individuals have used their strengths and resilience to overcome difficult life circumstances:

> I think that oppression, I think that the power of it is how internalized it can become. When people have been living—it's like the fish out of water. It's sort of like a fish doesn't know it's swimming in water, right. So I think a lot of our clients, especially our female clients have been living in worlds of sort of just like systematized oppression both culturally and societally and politically. That it is their context. Then much like everyone else, you kind of internalize your context and it forms your idea of who you are. It forms your narratives of who you are in the world. The strengths perspective really challenges that. (Interviewee 7)

Service providers further discussed that a strengths-based practice framework does not dismiss the fact that individuals have experienced trauma, but instead leaves room to explore how individuals have been able to cope with that trauma:

> …of course you're not dismissing the real-life situations…but in your assessment…the way I've seen it myself is my assessment has more to do early on with understanding their experience, and at the same time from there pointing out where resilience, where people's possibilities hold – their strengths, right, their competencies. Where can we start assessing that early on? (Interviewee 5)

Another service provider reiterated that they assess strengths from the very start of service delivery: “From the beginning, talking about strengths. They started building some ideas about themselves. It takes time, but at the end they get it. They get that they are doing amazing things with life” (Interviewee 6). One service participant described how this process of assessing her

strengths and expertise early on in the therapeutic process helped her to reframe how she views herself:

> …como ellos ya habían conocido una parte de mi, que yo soy positiva, entonces que ellos me empezaron a animar, ¿verdad? De todo lo mal que me ha pasado, dicen, tú no estás mala porque tú has vivido cosas buenas./…they had gotten to know a part of me, that I am a positive person, so then they began to encourage me, right? With all of the bad that has happened to me, they said, you are not bad, because you have also lived good things. (Interviewee 11)

Operating from an understanding of how individuals internalize oppressive contexts and subsequently come to view themselves as being of less value and worth, service providers thus challenge oppressive social structures in their daily practice by dismantling the traditional service provider-service participant relationship and acknowledging individuals' strengths and expertise. By engaging service participants as equal partners in the therapeutic process, service participants begin to reframe their understanding of themselves as individuals who have a set of expertise.

**b. <u>Affirming and Validating Individuals' Experiences</u>**

In addition to their efforts to dismantle power differentials and recognize service participants' strengths and expertise, service providers additionally are intentional in their efforts to affirm and validate individuals and their experiences. First, service providers offer a space for service participants to freely express themselves and share their stories and experiences. As one service participant stated: "Ellos me dieron el espacio, me dieron la confianza/They gave me the space, they gave me the trust" (Interviewee 11). Offering this space is of particular significance when considering that within mainstream U.S. society, Latino immigrants are traditionally denied the space to share their stories and experiences. Not only are Latino immigrants often denied access to social service spaces as a result of their immigration status, but mainstream narratives about Latino immigrants also perpetuate stereotypes without documenting the voices and experiences of Latino immigrants themselves. Service providers recognized that community

members typically do not have the space to freely express themselves: “You have the experience. You have these answers. You just don't have the space. You haven't had the space to find them, right?” (Interviewee 8). This intentionality to offer a space is again closely connected to service providers’ use of a strengths-based framework. In particular, as service participants begin to share their stories and experiences within a therapeutic space that is uniquely their own, service providers affirm and validate individuals and their experiences and affirm that individuals have the answers within themselves to cope with the challenges that they are experiencing:

> I am like the mirror. I'm just reflecting back to you what – who you are, and sometimes I might shift the mirror a little to the side, and have you see a different perspective of something, but it's still you, and that strength and that wisdom that you have within yourself that's coming through. (Interviewee 8)

Service participants similarly described that having this space that is uniquely their own empowers them to think about situations from different perspectives and to see answers to problems that previously seemed too big to solve. One service participant described how the opportunity to freely express themselves and explore different perspectives and options within the therapeutic space has enhanced their problem-solving abilities and allowed them to implement solutions that they did not realize they were capable of implementing:

> Yo misma veo muchas, muchas puertas, muchas opciones. Y yo misma a mí que me sorprendo a veces de mí misma. Porque yo muchas cosas que incluso yo hecho, ya nunca pensé poder hacer aquellos./I myself see many, many doors, many options. And sometimes I surprise myself. Because many of the things that I have done, I never thought that I would be able to do them. (Interviewee 19)

Acknowledging the sociopolitical context in which service participants are traditionally denied the space to freely express themselves and share their stories and experiences, service providers thus offer a space where they are validating and affirming of individuals’ experiences and their abilities to find answers to problems. As a result, service participants feel empowered to look at problems from different perspectives and implement new solutions.

### c. Reframing Understandings of Traumatic Experiences

Not only did service providers acknowledge that their anti-oppressive practice strategies are closely connected to their strengths-based perspective, but they also acknowledged the link between anti-oppressive and trauma-informed services. Considering that the community members whom they serve often have experienced multiple traumas, including childhood trauma in their countries of origin and trauma associated with their migration journey and adjustment to life in the U.S., a major component of the therapeutic process entails exploring service participants' narratives of past traumatic experiences. During this process, service providers listen to and support service participants as they discuss their narrative, and then collaboratively look for opportunities to reframe the narrative so as to recognize individuals' strengths and resilience in coping with and overcoming traumatic experiences. One service provider described this process as follows:

> For me, personally, trauma informed care is while not ignoring the debilitation that can happen after someone has experienced trauma or multiple traumas is also taking the perspective of survivorship and the ultimately the internal strength that it takes for someone to survive a trauma at all. Also looking at trauma responses as ultimately an attempt to adapt post traumatically, just adapt to the person's new perspectives or adapt to their newfound sense of life after a trauma or after multiple traumas. While some of those responses can appear to be maladaptive in the sense that they are not actually serving the person, looking at the way that those responses have actually been healthy, at the very least an attempt for the person to regain a sense of control of any kind after experiencing a trauma or multiple traumas…I use the word narrative a lot because I think narrative work is also very powerful work. It's the idea of looking at the narrative that already exists around the trauma or traumas. Then deciding which parts of the narrative you want to keep and which parts you kind of want to rewrite. In particular, rewriting the parts of the narrative where the person is blaming themselves, where the person feels at fault for their trauma, and that reinforces their strengths as a human being, as a person. (Interviewee 7)

Service providers directly connected this process to their understanding of individuals' interactions with oppressive social structures. In particular, they acknowledged that part of the

process of reframing individuals' narratives entails exploring and challenging instances in which service participants have blamed themselves for oppressive environmental conditions:

> What it looks like is…starting to slowly, respectfully, question those narratives with curiosity, not defiantly, but sort of really start to explore the validity of those narratives and see if there are spaces in it where rather than taking a sort of oppression bound take on things that you can sort of insert strengths instead and say well is it that you are truly just a useless person who can't take matters into her own hands. Is that really true? Or is it that that has been imposed on you over the course of your entire life? How much of a choice did you really have in that matter and how much of a choice do you have now to start pushing back? It's like the opposite of victim blaming as well. It's looking at the realities of people's lives and how much oppression really does kind of infiltrate and filter in. Then saying maybe then you didn't have a choice to push back, but maybe now you do. (Interviewee 7)

Service participants described that they associate this specific practice of reframing trauma narratives with the treatment outcome of enhanced self-worth. One service participant discussed that after arriving in the U.S., they experienced multiple instances in which they were exploited and taken advantage of in their daily life. While they blamed themselves for these experiences before initiating mental health therapy services, they described that as a result of the therapeutic process, they have come to view themselves in a different light and recognize that they are not to blame for experiences of exploitation:

> …me ha ayudado mucho, me está ayudando mucho, porque antes era yo, ¿por qué me pasan las cosas? Y no sabía por que. Pero estoy entendiendo, a ver, de que siempre había hecho la culpa de que a lo mejor algo estoy haciendo mal yo, o aquel cosa. Pero con el paso de tiempo…me están ayudando a entender que las cosas pasan por algo y que no siempre es mi culpa…Aprendía entender que todas las cosas de que a veces pasaban no era por mi culpa, sino por la ignorancia de la demás gente, y pues tenía yo que aceptar mi culpa si que sea mi culpa./…it has helped me a lot, it is helping me a lot, because before I was, why are these things happening to me? And I didn't know why. But now I am understanding, seeing, that I had always blamed myself, that it must be something that I am doing wrong, or something like that. But with the passage of time…they are helping me to understand that things happen for some reason and that it is not always my fault…I learned to understand that all the things that happen are not always my fault, but rather could be because of the ignorance of other people, and well that I have to accept responsibility if it is my fault. (Interviewee 18)

This quote thus illustrates that the process of reframing trauma narratives can have a positive impact on community members who have internalized negative messages about themselves after experiencing traumatic events. As this service participant described, the therapeutic process helped them to recognize that they are not to blame for everything that has happened to them. They further described that they have developed the confidence to take responsibility for their mistakes without viewing themselves as a bad person. Other service participants similarly described that as they grow to develop an enhanced sense of self worth and recognize that they are not to blame for past experiences, this enhanced sense of self worth is reflected in their interpersonal interactions. One service participant discussed that while in the past they felt that they must please others and could not express their own opinions and viewpoints because they feared others would view them in a negative light, they now feel more confident to express themselves without subsequently blaming themselves if others react negatively to their opinion:

> Entonces dije, ¿por qué tengo que sentirme mal si la que estuvieran mal fueran ellas? Y eso me ha ayudado a comprender y a ver a esta parte que no me tengo que estar preocupando de todo ni tengo que llevar bien con todos…No puedo decirles la opinión de ellos, ¿por qué entonces no tengo opinión propia?/So I said, why do I have to feel badly if they were the ones that were wrong? And that has helped me to understand and to see that I don't have to be worrying about everything nor do I have to get along with everyone…I can't tell them what their opinion is, so why can't I have my own opinion? (Interviewee 11)

As both service providers and service participants have illustrated in their descriptions, this practice of reframing narratives to assist individuals in letting go of self-blame and to see their own strengths and resilience is associated with enhanced senses of self-worth among service participants. As service providers and service participants engage in this practice of reframing trauma narratives and subsequently challenge oppressive social structures that led individuals to question their own value and worth, service participants feel confident and empowered to

express themselves more freely in interpersonal interactions without feeling constrained by how others will perceive them.

**d. Advocating for Service Participants in Social Service Systems**

Service providers additionally identified that they aim to challenge oppressive social structures in their daily practice by directly advocating for service participants who are discriminated against within other social service systems. Service providers discussed this theme at length during their member check interviews. They noted that service participants commonly have experiences where they feel powerless as they attempt to navigate unfamiliar social service systems in the U.S., including the public school system and the child welfare system. Community members may, for example, have experiences where professionals within the school system stop providing a needed early intervention or educational service to their child, or may have experiences within the child welfare system where they are not given the opportunity to provide information or clarification on reports that were made. Service providers discussed that service participants may be hesitant to question decisions that are made within these systems due to both language barriers and the fact that they are unfamiliar with how these systems function and are fearful that they will be reprimanded if they are perceived as being disrespectful. Service providers thus stated that advocacy is an important component of their practice. Service providers may write letters on behalf of service participants with open child welfare cases, or may accompany service participants to IEP meetings at their child's school. Service providers recognized, however, that their role is not to act on behalf of service participants, but instead to provide them with the support and information necessary so that they feel empowered to act on their own behalf. While service providers may speak directly with professionals in other systems, another important component of their role is to educate service participants about their rights

within different social service systems. Service providers discussed that when service participants learn that they have the right to ask questions and request services that they believe will be beneficial to themselves and their family members, they feel empowered to more actively engage with systems that previously felt intimidating and overwhelming to navigate.

One service participant similarly described service providers' efforts to inform them of their rights within different social service systems. This service participant discussed that their mental health therapist provided them with the information necessary to navigate situations at their children's school:

> …todo eso me ha ayudado a entender gracias al programa de que voy con [staff member]. Entonces no me han dicho el programa tú tienes que hacer esto, verdad, sino que de la misma forma de como que van orientándote, tú cuentas de lo que tú como padre y como miembro de la comunidad tienes derecho y en lo que no tienes derecho. Entonces he aprendido muchísimo. He aprendido muchísimo de todo, de que yo tengo derecho, hasta donde yo puedo llegar. Y hay muchos padres que no saben eso./…all of this I have learned thanks to the program that I attend with [staff member]. So the program hasn't told me you have to do this, right, but rather in the way that they go about orienting you, you realize as a parent and as a member of the community what rights you have and what rights you don't have. So I have learned so much. I have learned so much about everything, that I have rights, what I am able to do. And there are many parents that don't know that. (Interviewee 18)

Recognizing that community members have had experiences in which they feel powerless during the process of navigating unfamiliar social service systems in the U.S., service providers thus intentionally strive to advocate for service participants within these systems and educate them about their rights. Service participants described that as a result of receiving this information, they feel empowered to be active participants who freely engage in dialogue with professionals within these systems.

Mental health service providers additionally described that they view their practice of conducting mental health assessments and writing letters for individuals with upcoming immigration cases as another way in which they advocate for community members. For

community members applying for U Visas in particular, which provide immigration relief for individuals who are victims of a crime, a mental health assessment is required as part of the application process. Because it is difficult for community members to access these mental health assessments free of charge within the community, service providers at the CWP will conduct assessments and write letters for immigration cases as part of their practice. Individuals who are in need of these services will typically meet with a mental health service provider two to three times so that the mental health service provider can develop a comprehensive understanding of the individual's experience and in turn write a personalized letter. Individuals who are in need of these assessments and letters are not placed on the same waiting list as are community members who are interested in initiating long-term mental health therapy, but instead are placed on a separate, shorter waiting list comprised only of individuals requesting these assessments. One service participant who was in need of this service described that the CWP was accessible and responsive in comparison to other places where they sought out assistance:

> En muchos lugares me decían que tenían que hacer una lista de espera de seis meses o de más tiempo, o que te regreso la llamada y ya no regresa la llamada. Y aquí me gustó que…o sea, a la semana me regresaron la llamada dándome información y o sea, poder ayudarme en una forma que yo podía…sí tuve que esperar en una lista, pero no larga como de seis meses. O sea, como yo ya necesito mi carta, ellos dan una forma de poderme ayudar./In many places they told me that they had a wait list of six months or longer, or, I'll call you back and then they don't call you back. And here I liked that…or rather, that week they returned my call and gave me information, they were able to help me in a way that worked for me…yes I had to wait on a list, but not long like six months. Or rather, as I need my letter now, they offered a way of helping me. (Interviewee 12)

This quote suggests that this service participant perceived service providers at the CWP to view their needs as a priority, and recognized that the CWP provided a critical role in allowing them to move forward with their immigration case. Service providers described that their efforts to support community members with upcoming immigration cases, particularly U Visa cases in

which individuals have experienced violence and exploitation, are a means of advocating for individuals whose experiences of violence and exploitation often go unrecognized within U.S. society due to their immigration status.

**e. Critical Consciousness Among Service Participants**

All of the practice strategies that service providers and service participants described in this section require that service providers and service participants actively engage in discussions about ways in which oppressive environmental conditions have impacted service participants' well-being and ways in which individuals can challenge these conditions in their interpersonal interactions. One service participant discussed that they became more aware of the social inequities impacting their community as a result of participating in the therapeutic process, and in turn became motivated to engage in community organizing efforts to challenge these social inequities. In particular, this service participant became involved in efforts to connect community members to mental health resources. They described that they were committed to decreasing service access barriers because they had experienced the transformative impact of mental health services firsthand:

> …he visto un gran cambio radicalmente que ha hecho en mi vida, tan radical. Entonces a veces decía yo podía seguir con estos pasos y meterme digamos para ayudar a que la gente se acerque [los servicios], que vaya y poder solucionar sus problemas sin necesidad de un rompimiento o de que haya problemas más graves… si yo vi este cambio en mi, creo que mil personas van a hacer este cambio que tanto desea./…I have seen a radical change that has happened in my life, so radical. So I said that I could continue with these steps and involve myself with helping people so that they become acquainted with [these services], so that they go and can solve their problems without having a big disruption or having more serious problems…if I saw this change in myself, I think that a thousand people are going to make this change that they so desire. (Interviewee 13)

Service providers similarly observed situations where service participants expressed a desire to give back to their community after participating in mental health services. Service providers

noted, for example, instances where service participants began teaching exercise classes to other community members or became *promotoras de salud* (community health workers). As one service provider stated:

> The most amazing thing that I have been seeing and not all of my clients get to this point, but it is to socially share that with the community and become a *promotora de salud* or something like that because they feel comfortable. They have a different integration of the story of trauma. They can help people after that and help themselves and find a purpose of that what happened to them. (Interviewee 6)

Synthesizing the data throughout this section, it is evident that an understanding of service participants' lived experiences of structural oppression informs the CWP's anti-oppressive practices at the organizational level and at the level of individual providers. At the organizational level, the CWP's anti-oppressive practice model provides an alternative to the traditional medical model of mental health treatment. The CWP's alternative assessment methods and time-unlimited model decreases stigmatization and promotes healing from trauma without the restrictions that are often imposed under the traditional medical model of mental health treatment. At the level of individual providers, service providers challenge oppressive social structures in their daily practice through their efforts to dismantle power differentials and engage with individuals' strengths and expertise; create a validating and affirming therapeutic space; collaborate with service participants to reframe narratives of past trauma; and advocate for service participants and empower them to exercise their rights within unfamiliar social service systems. Service participants associated these practices with reframed understandings of themselves and an enhanced sense of self-worth. These reframed understandings of themselves in turn inform their interpersonal interactions, interactions with social service systems, and interactions with their community at large. As service participants express themselves with increased confidence in their interpersonal interactions, exercise their rights within social service

systems, and work to address structural inequities within their communities, they are pushing back against oppressive social structures in their daily lives.

## H. Overall Experiences of Service Delivery

With respect to individuals' experiences regarding the role of culture in service delivery, the previous sections have outlined how an understanding of community members' cultural values and lived experiences informs the CWP's organizational infrastructure and service providers' daily practice. Section C described how this understanding informed efforts to decrease barriers that traditionally impede community members from accessing mental health services. Section D highlighted efforts to facilitate community members' engagement in CWP services by dismantling myths about mental health treatment. Sections E, F, and G identified how an understanding of community members' holistic needs, acculturative experiences, and experiences of structural oppression informed practices that were associated with positive treatment outcomes at the level of the individual, family, and community at large. At the level of the individual, service participants described that services at the CWP facilitated their emotional expression, promoted their problem-solving abilities, promoted healing from past trauma, and enhanced their sense of self-worth. At the level of the family, couples therapy and parenting support and education were associated with conflict resolution and positive communication within the family system. At the level of the community, group therapy, referrals to other organizations, and community organizing efforts enhance individuals' support systems, facilitate connections to community resources, and increase the capacity of the community at large to address community members' needs. In addition, service participants further identified that positive individual level outcomes influence outcomes at other levels of their environments, as they navigate interpersonal interactions with increased confidence, exercise their rights within

other social service systems, and become involved in promoting social change within their communities.

Synthesizing all of these components of experiences of service delivery, this section will now provide an overview of service providers' and service participants' summative experiences. The first part of this section will describe service participants' cumulative experiences, highlighting both their descriptions of overall satisfaction with CWP services and challenges that they encountered during the service delivery process. The second part of this section will describe the overall experiences of service providers, considering both their descriptions of personal transformation and their descriptions of the challenges associated with service delivery.

**1. Service Participant Experiences with Service Delivery**

Service participants' descriptions of service delivery at the CWP and the associated treatment outcomes culminated with general descriptions of their overall satisfaction with program services. Service participants discussed that while they recognized that mental health therapy is a long-term process and that they could not expect immediate resolution of their symptoms, they generally noted positive changes resulting from program services. One service participant specifically noted how these positive outcomes were evident across multiple areas of her life:

> Digo, yo me siento bien. Porque me ayuda. Porque vienen cambios en mis hijos, en la vida, en mi persona, en el trabajo, en el día a día./I say, I feel good. Because it helps me. Because changes come with my children, in my life, in me as a person, in my work, in the day to day. (Interviewee 19)

This overall satisfaction with and engagement in program services is also reflected in service participants' anticipation of their weekly appointments. As one service participant stated, "no me quiero perderme ni una sesión/I don't want to miss a single session" (Interviewee 21). Service participants' general descriptions of their overall experiences with service delivery thus

culminated with descriptions of how services led to positive changes in multiple areas of their lives, as reflected in their relationships with themselves, their family members, and other systems with which they interact in their daily lives. These descriptions of treatment engagement and satisfaction also coincide with the CWP's most recent statistics on "show" rates. These statistics indicate that for all of the mental health appointments that were scheduled at their Little Village location between March 2016 and March 2017, service participants attended 78% of scheduled appointments (A. Carrillo, personal communication, March 20, 2017). This show rate is higher than show rates at other mental health clinics serving similar target populations, where the rate of "shows" has been documented at 70% (Horton, 2006) and 72% (Stein et al., 2014).

Not only did service participants express a general satisfaction with the overall quality of program services and the positive changes that resulted from these services, but they also expressed a deep appreciation and gratitude that these services exist. One service participant discussed that because of financial constraints, the CWP offered them the opportunity to receive long-term services that they would not have been able to otherwise afford. They described the program as being a blessing to them: "Es una bendición haber encontrado a ellos, porque pues para mi ha sido un apoyo muy grande/It's a blessing to have found them, because for me it's been a huge support" (Interviewee 16). Similarly, another service participant stated that they cannot imagine their life without the CWP:

> Yo aprecio mucho la verdad esta organización que está allí, porque a mi me está ayudando muchísimo. Si llegara pasar algo que cerrarlo, yo no sé que sería yo./I really appreciate so much this organization that is there, because it is helping me so much. If something happened that caused it to close, I don't know how I would be. (Interviewee 18)

Service participants' satisfaction with and appreciation for CWP services is further reflected in their efforts to refer other community members to the program. As noted in section

D, eight of the 11 service participants who took part in individual interviews reported that they recommended the program to community members who they believed could benefit from supportive services. Satisfaction with program services is thus evident in the number of community members who continue to access services as a result of word-of-mouth referrals. As one service participant stated:

> …yo pienso que si como ejemplo, si yo tuviera una mala experiencia, ya no vuelvo allí. O sea, asi más que me dijera, oh como es este lugar, o me decía, no, no pues no vayas allí porque tratan mal a la gente, por eso./…I think that as an example, if I were to have a bad experience, I wouldn't return there. Or rather, if someone were to say to me, oh how is this place, or if they said to me, well you shouldn't go there because they treat people badly, for that reason. (Interviewee 12)

Conversely, because community members are satisfied with CWP services, they speak highly of the program to other community members. As a result, the number of individuals who seek program services continues to grow.

When I asked service participants what they would like to be different about the program, the only change that they commonly identified was that they would like to see increased resources invested in the program so that more people can be served. Two service participants stated that they would like to have longer therapy sessions, as they find it difficult to recount all of the week's events and express everything that they wish to express during an hour-long session. One service participant stated that although they ideally would like to have longer therapy sessions, they realize that resource challenges likely would make it difficult to offer longer sessions for all of the individuals whom the program serves:

> …las citas de una vez a la semana sí están un pocito pues….muy cortas o también el tiempo…pero pues claro, I mean es algo que uno debe trabajar con eso. Y entiendo que pues a veces no hay fondos o así, pero pues sí es…una vez a la semana, entonces…bueno, toda la semana es más dificil regresar y regresar tanto y todo eso. Pero sí. I mean, es lo único que yo pienso a veces es muy corto el tiempo, pero pues sí./…the weekly appointments are a bit…the time is very short…but I mean it's something that one should get used to. And I understand that sometimes there aren't funds, but it is…it's

> once a week, so…it's very difficult to return to everything from the week and all of that. But yes. I mean, that's the only thing that I think sometimes the time is very short, but yes. (Interviewee 17)

The resource challenge that service participants most commonly mentioned was the length of time for which individuals must wait to initiate mental health services. Almost all service participants mentioned that the mental health program currently has a waiting list. Coinciding with service participants' descriptions, service providers also identified the program's waiting list as posing the primary barrier for community members seeking to access mental health services. Even with the expansion of program services and the addition of staff members since the program's restructuring in 2009, service providers reported that community members who are interested in initiating services are currently put on a waiting list of approximately six to eight months. Of the six service participants who made reference to the amount of time that they personally waited to initiate services, the length of time ranged from one month to one year. In particular, three service participants reported that they were on the program's waiting list for approximately one month, one reported that they waited for approximately five months, and two reported that they waited for approximately one year. One of the service participants who was on the waiting list for one year reported that they were offered an ongoing appointment slot sooner, but had to extend their wait because they were unable to attend sessions during the time slot that was offered to them.

Service providers attributed the length of the current waiting list to limited space at their Little Village location and the limited number of mental health staff members. Service providers identified that as the CWP has expanded its reach and opened sites in other Chicago locations, staff resources are diverted from the Little Village location. While service providers noted that they view the expansion of their program in a positive light, as their sites in North Lawndale and

Brighton Park allow them to extend their reach to other communities who traditionally have had limited access to mental health services, expansion does require that staffing resources be invested in these sites. The number of service providers who offer mental health therapy at the Little Village site has increased from one full-time staff member in 2009 to three full-time mental health clinicians that carry caseloads at the present time; two of these three clinicians, however, split their time between other CWP sites. One service provider described these resource challenges as follows:

> I think that if we had four more full time clinicians, it would be really easy. They could call and they could be seen that week. I think that we have addressed every barrier to services. That known barrier to services, studied barrier to services, but we have limited clinicians. We have limited space. If we had the space, we wouldn't have the clinicians. (Interviewee 7)

Service providers also discussed that the growth of the program cannot keep pace with the level of need in the community. The mental health program's fiscal year 2015 work plan, for example, noted that "demand for mental health services exceeds current staffing levels " (Document 14). As one service provider stated:

> I definitely find right now we're going through a time where we're growing in terms of the need. The need is always growing. And our team grew. But it feels like with the team growing, the need also continues to grow. And it doesn't seem like we're kind of getting ahead of the need in the community. So it's challenging sometimes to find the time to provide all the services you see that are needed. So right now our wait list is very long. (Interviewee 8)

The length of the CWP's waiting list is a concern that was discussed in several of the staff meetings that I observed. Service providers recognized that the wait for services is a deterrent for individuals seeking mental health treatment, and staff members frequently discussed strategies for minimizing individuals' wait. For example, service providers offer group therapy for appropriate candidates while they are waiting for an individual appointment slot to become available. Service providers additionally offer an initial intake appointment when individuals call

to initiate services, so that prospective service participants have the opportunity to meet service providers and develop a connection while they are waiting for ongoing services. This initial intake also provides an opportunity to connect individuals with interim resources and supports until a slot becomes available at the CWP. Connecting individuals to interim services was a topic of discussion at a staff meeting that I observed in April of 2016. Service providers discussed making use of the referral network that they have developed through Roots to Wellness to connect individuals to interim services with local partner organizations. While service providers recognized that other programs that offer culturally appropriate mental health services for uninsured adults may be time-limited or charge for services, they agreed that it was important to offer options for interim support. Service providers recognized, however, that despite their efforts, the current wait to initiate ongoing individual mental health therapy poses a continued barrier to service access.

Service participants' attributions of the reasons for the program's current waiting list mirrored those of service providers. They recognized that there is a high demand for the services that the CWP provides and that the small number of mental health therapists cannot keep up with this demand. Several service participants stated that although they understand why there is a waiting list, they also know that sometimes the wait can deter community members from seeking services. As one service participant stated:

> Obviamente que realmente como los terapistas son muy pocos, ellos ya cobraron todos sus horarios, entonces hay que esperar. Y lo malo, y aquí es un poco lamentable, porque mucha gente se desespera, se cansa, y pues no va./Obviously that really since the therapists are so few, their schedules fill up, so you have to wait. And the bad thing, and this is a bit unfortunate, because many people lose hope, they get tired, and so they don't go. (Interviewee 13)

One of the service participants who waited for an extended period before initiating services similarly acknowledged that while they were willing to wait, circumstances can change

considerably over time. Individuals who had an urgent need for services therefore may no longer feel this same sense of urgency when an ongoing therapy slot becomes available:

> Entonces sé que tienen short staffed, por eso tienen tanta espera. Pero pues sí, a veces cuando uno necesita los servicios allí, un año pues ya cambian las cosas./So I know that they're short staffed, for that reason there's such a long wait. But yes, sometimes when one needs services, in a year well things change. (Interviewee 17)

While service participants thus recognized that the waiting list can pose a barrier and deterrent to accessing mental health services, several service participants additionally stated that it is worth waiting because of the positive changes that result. One service participant stated that they would give the following recommendation to community members on the mental health program waiting list:

> …para los servicios que te dan…yo honestamente, sí lo esperaría… Si otras personas dijeran es que están tardando mucho, yo les diría, realmente espérate, porque realmente lo que vas a esperar y lo que vas a recibir al cambio, creo que la espera lo va a valer./…for the services that they give…I honestly would wait…If other people say that it's very delayed, I would say to them, really wait, because really what you are going to wait for and what you are going to receive in return, I think that the wait is going to be worth it. (Interviewee 13)

Service participants additionally described that they would like to see the CWP expand to other communities:

> Tal vez sería buena idea abrir otro lugar en otra area, sería bien. Porque le digo hay muchas personas que también necesitan ayuda, pero no hay lugares./Perhaps it would be a good idea to open another program in another area, that would be good. Because I tell you that there are many people who need help, but there aren't places. (Interviewee 20)

Another service participant similarly stated that they think the program would be able to help more community members if it were to expand to other communities:

> …a lo mejor que tuviera más espacio, ¿verdad? …que lo extendería a otras partes de la ciudad. Tuvieran más localidades, eso sería muy bueno, ¿no? Tal vez más localidades, más gente para ir a este programa. Para que tuviera más oportunidad ayudar a más personas./…perhaps if they had more space, right?...that they would extend to other parts of the city. If they had more locations this would be very good, wouldn't it? Perhaps

> more locations, more people that can go to this program. So that they have more of an opportunity to help more people. (Interviewee 10)

Service participants recognized that program expansion in turn requires that more resources be invested in the CWP and that society at large must recognize the value of investing in this program. Several service participants additionally noted that they have a responsibility as citizens and program participants to use services in a way that will promote the program's sustainability. One service participant discussed, for example, that if community members commit to participating in services, they have a responsibility to regularly attend their appointments so that they are not wasting staff time and resources, and are not taking away appointment slots from others who are in need of services. Another service participant acknowledged that community members can play a role in ensuring that the CWP receives the necessary financial support to continue its work of promoting wellness among individuals, families, and communities:

> … agradezco a Saint Anthony, a mi terapeuta, mi social worker, que están todo el tiempo pendiente de mi. Pues ojalá que haya más apoyo para ellos y para estos programas… porque yo sé que una gran parte de que haga funcione, de que un programa funcione, es lo económico. Entonces para eso debe haber mucho apoyo por parte de gobierno, por parte de la sociedad, para extender estos programas… Y que uno como ciudadano también ayude a que estos programas crezcan para una sociedad más sana. Este es lo principal./I thank Saint Anthony, my therapist, my social worker, for being there for me all the time. I hope that there is more support for them and for these programs…because I know that a large part of what makes them function, of what makes a program function, is economics. So there ought to be a lot of support from the government, from society, to extend these programs…and one as a citizen as well can help these programs grow for a healthier society. That is the primary thing. (Interviewee 10)

This quote illustrates that in order for the CWP to receive the necessary support to continue expanding its reach within Chicago and to continue serving community members, there must be a commitment within the community and within society at large to investing in the well-being of underserved individuals, families, and communities.

**2. <u>Service Provider Experiences with Service Delivery</u>**

Service providers described being part of the process of promoting individual, family, and community wellness as personally transformative. Mental health service providers described their transformative experience as beginning during their MSW internship placements. All of the mental health service providers at the CWP's Little Village location were initially placed at the CWP as MSW interns, and then were later hired as full-time employees. They discussed that their internship experiences defined how they came to conceptualize mental health therapy. As one service provider stated:

> …being given the opportunity to come here and learn the practice in an incredibly heartfelt way was so formative for my experience. I think because I was really taught from day one how to kind of push the boundaries and challenge the boundaries of what community mental health practice really is. I was given such liberty and such freedom to create such strong, heartfelt connections with my clients…So it set the stage, I think, for my own idea of what it would mean to be a therapist. It really set a really beautiful stage. It set a tone for what I wanted my career to be as a mental health professional. (Interviewee 7)

Mental health service providers described that based on their internship experiences, they knew that they wanted to work at the CWP upon receiving their degree. In cases where positions were not immediately available upon the conclusion of individuals' internships, service providers stated that they waited for available positions so that they could return to the CWP. Service providers additionally described that their work in other community mental health settings between the time of their internship placements and the time of their hire at the CWP reinforced their dedication to providing services in accordance with the CWP's model.

Service providers across CWP departments reported enjoying their jobs on a daily basis. As one service provider stated: "I can't tell you exactly what part of my job is the most rewarding because I think all of it is, and I'm just really happy here. I really love my job" (Interviewee 2).

Service providers additionally noted that observing positive individual, family, and community outcomes resulting from their work is particularly rewarding:

> …there is so much rewarding about my work…I think that serving as a part of someone's process towards healing and transformation and empowerment and creating a life that they truly want to be living is so rewarding. I'm being able to play a role in that. Watching people change and make healthy decisions…and helping them lead a healthier, happier life is incredibly rewarding. (Interviewee 7)

While service providers were overwhelmingly positive about their experience with service delivery at the CWP, this is not to say that their experience is free of challenges. Service providers noted that, as is typical in their line of work, taking in the pain that individuals, families, and communities experience can be stressful and emotionally draining:

> In general, I think working in communities that struggle with lots of trauma generationally, systemically, structurally, interpersonally; it can wear on you a little bit. The strengths perspective actually serves to minimize that wear and tear on your soul because you are constantly reinforcing with your clients back to their strengths and capacities rather than recognizing how terrible and horrible everything is and was. It is actually I think one of the best life jackets to get you afloat. But still in the same holding space for people who carry a lot of trauma with them can be a little tiring. (Interviewee 7)

> Seeing patterns within the community. That's difficult, too, to see certain issues that happen, and see them repeated over and over again in different people's lives. Which kind of points to more systematic issues, right? Issues of poverty and need, and specifically for the immigrant community, the immigration system, and just the stress that kind of puts on people. All these reoccurring topics. And as a clinician it can just get overwhelming, because you say, well, there's a lot of people who are being harmed by the same thing, and it's frustrating and discouraging, you know? So that's something that I know is a challenge. (Interviewee 8)

In addition to the challenge of coping with personal emotions around the traumatic experiences that individuals share with them, service providers also discussed the challenge of being unable to keep pace with the high level of need that exists within the community. In particular, service providers noted the frustration that they experience when community resources are not available to address individuals' needs. One specific challenge that service providers confront is a lack of services for uninsured, Spanish-speaking adults with severe and

persistent mental illness. The CWP is not designed to provide services to this population and does not provide psychiatry or medication management services. Service providers noted that while there are some limited options for obtaining medication and receiving outpatient medication management services, it is almost impossible for uninsured Latino immigrants with severe and persistent mental illness to access services that are aligned with their level of need. As one service provider stated:

> …finding long term intensive psychiatric services for people with severe and persistent mental illness who are Spanish speaking and unfunded, undocumented, uninsured, whatever you want to call it, is close to impossible. You can find outpatient psychiatric services for them, but ongoing intensive services like that wrap around service that is someone with severe and persistent mental illness would really need doesn't exist. (Interviewee 7)

Intensive outpatient programs are also largely unavailable for uninsured community members:

> Sometimes we have these clients like it's not a lot, but we have some clients that are very, very, I think they might need an IOP program, but they don't have insurance so they don't have access to that. The options are either hospitalization or this kind of therapy. They do not have any other option. For those clients, we struggle, because sometimes they are in crisis. You don't have any other option than your own and say call me if you feel desperate. So I do manage. That is very heavy. (Interviewee 6)

In addition to limited resources to serve individuals with more intensive mental health needs, service providers also expressed frustration with the systemic barriers that undocumented Latino immigrants generally face to accessing resources outside of the CWP:

> The other thing that is very hard is not finding resources for the people…That's very frustrating because you know what they need and you have to say, "No, you don't have access to that." That's terrible. (Interviewee 6)

> I would say the number one most challenging part of the work is feeling like there are so many barriers to getting people the support they need. The systems that are set up to work against this particular community are so powerful that it can feel a little bit like a David and Goliath feeling…It can always feel like an uphill battle working, trying to circumvent these systems that are just these whirling vortexes of oppression against our clients. (Interviewee 7)

As discussed in section F, service providers identified the CWP's family-oriented organizational culture as helping them to cope with the challenges associated with their work. In particular, service providers feel supported by their coworkers and draw energy and inspiration from their shared commitment to promoting the well-being of the Latino immigrant community. Mental health service providers also acknowledged that components of the CWP's model of service delivery are useful in promoting self care. As noted earlier in this section, Interviewee 7 identified that the strengths-based perspective serves to help practitioners focus on community members' resilience and minimizes the extent to which they become overwhelmed by the pain of individuals' traumatic experiences. Another service provider similarly stated that although it is overwhelming to hear the extent of others' pain, it is also hopeful to "see the strength of the people going through that stuff and surviving and doing better. I really get very amazed at the capacity of humans" (Interviewee 6).

Both service providers and service participants thus described their experiences of service delivery at the CWP as being marked by personal growth and transformation. Service participants reported overall satisfaction with program services, describing positive outcomes across multiple areas of their lives. Service providers described that accompanying service participants throughout the healing process is transformative, and further described that their model of service delivery has shaped them professionally. The challenges that service participants and service providers encountered during the service delivery process were primarily related to resource challenges. Service providers and service participants discussed that the CWP encounters challenges in keeping pace with the level of community need, thus leading to a waiting list for individual therapy of approximately six to eight months. Service providers additionally described that limited community resources pose a challenge to addressing the

holistic wellness of uninsured Latino immigrant community members, particularly individuals with more intensive mental health needs.

# V. DISCUSSION

The aim of this study was to understand how service providers and service participants described and experienced service delivery at the CWP, as well as to identify the mental health needs of community members and how the program addresses these needs. This case study used multiple methods of data collection, including 21 open-ended individual interviews with service providers and service participants, observations of routine program activities, and analysis of agency documents to answer the following three research questions: (1) How do service providers and service participants describe the services that are delivered at the Little Village location of Saint Anthony Hospital's CWP? (2) How do service providers and service participants experience service delivery within this organizational context? What is their experience with regard to the role of culture in service delivery, the accessibility of services, service engagement, and treatment outcomes? (3) From the perspectives of both service providers and service participants, what are the mental health needs of community members receiving services, and how does the program address these needs?

Central to this study's findings was the way in which an understanding of community members' lived experiences informed all aspects of service delivery at the CWP, both at the organizational level and at the level of individual providers. The first section of this chapter will summarize the findings as they pertain to each research question and will consider how these findings relate to the current literature reviewed in Chapter II. The next section will apply the study's findings in the context of LatCrit, paying particular attention to how service delivery at the CWP challenges mainstream narratives and creates counternarratives both about Latino immigrants and about the conceptualization of mental health and mental health treatment. The third section of this chapter will consider this study's implications for social work practice,

policy, education, and future research, while the fourth section will consider the study's limitations. Lastly, this chapter will end with service participant recommendations for promoting social change in the current sociopolitical context.

## A. Research Questions

### 1. How Service Providers and Service Participants Describe CWP Services

Central to service providers' and service participants' descriptions of service delivery at the CWP were their conceptualizations of services as being community-centered and culturally appropriate. In particular, services at the CWP are community-centered in the sense that they were developed specifically in response to community needs. Since the time of the program's inception, services were informed by staff members' observations of the most pressing needs of community members. In the present day, services are largely driven by the results of formal community health assessments. As service providers described, the CWP thus adapts its programming based on community members' needs rather than asking community members to adapt to a prescribed model of service delivery. In accordance with this community-centered focus, programming at the CWP is flexible and may change over time in accordance with the service needs of community members.

The CWP's community-centered focus is also closely related to interviewees' descriptions of program services as being culturally appropriate. Service providers at the CWP do not only articulate an understanding of community members' cultural values and beliefs, but they also recognize the sociopolitical elements of culture and community members' lived experiences within the sociopolitical context in which they are situated. An important component of the CWP's community-centered focus is thus understanding how service needs emerge in the context of community members' lived experiences. In turn, it is this understanding of

individuals' lived experiences that informs the development and implementation of services tailored to community members' needs. The development and implementation of holistic services, anti-oppressive practices, and services that integrate understandings of community members' acculturative experiences stem from the program's community-centered and culturally appropriate model of service delivery.

Contextualizing these findings in the body of literature on culturally competent practice, it is clear that the CWP embodies an example of culturally competent mental health practice at both the organizational level and the level of individual providers. Coinciding with current definitions regarding what organizational level culturally competent practice entails, the development of organizational infrastructure at the CWP is informed by an understanding of community members' cultural values, lived experiences, and service needs (Cherner et al., 2014; Chun-Chung Chow & Austin, 2008; Delphin-Rittmon et al., 2013a; Hernandez et al., 2009; Horevitz et al., 2013; Olavarria et al., 2009; Sue, 2001; Whealin & Ruzek, 2008). In addition, at the level of individual providers, CWP service providers' understanding of community members' values and experiences translates into concrete practice behaviors (Davis, 2007; Horevitz et al., 2013; Sperry, 2012; Sue, 2001). Although service providers tended to describe their model as being culturally attuned rather than as being culturally competent, contextualizing their descriptions in the current literature suggests that their model does in fact coincide with posited definitions of culturally competent practice. Furthermore, from an ecological perspective, the CWP's model of service delivery coincides with Metzl and Hansen's (2014) and Prilleltensky's (2008) assertions that there is increased potential to affect positive treatment outcomes when practitioners and organizations recognize and address the community and sociopolitical context in which individuals are situated.

The findings that emerged in relation to this research question also coincide with Figure 1 presented in Chapter II, which portrays the increased potential for services to be impactful across multiple environmental levels when they are culturally competent both at the level of individual providers and at the level of the organization as a whole (Delphin-Rittmon et al., 2013a; Hernandez et al., 2009; Metzl & Hansen, 2014; Sue, 2001). Findings suggest that the organizational context of the CWP supports service providers in carrying out culturally appropriate interventions. First, as will be discussed in greater depth in relation to the third research question, the program's design facilitates service providers' abilities to deliver services that promote holistic wellness, affirm individuals' cultural heritage, support the development and expression of service participants' bicultural identities, and challenge oppressive environmental conditions. Second, the program intentionally hires staff who are committed to serving the Latino immigrant community and who have an understanding of their cultural values and lived experiences. At the same time that the program is intentional in its hiring practices, it is also intentional in the training that it provides. Mental health service providers in particular described that their training was grounded in an understanding that culture is at the very core of service delivery. These hiring and training practices converge to create an organizational culture characterized by a dedication to serving the Latino immigrant community and a commitment to delivering services informed by an understanding of community members' needs. In this organizational context where cultural understanding and community engagement are the norm, service providers are supported in implementing interventions that promote wellness at the level of the individual, family, and community as a whole.

The current literature on culturally competent practice also coincides with the fact that cultural understanding at the CWP does not only encompass an understanding of cultural values

and belief systems, but rather encompasses a more expansive understanding of the sociopolitical elements of culture and individuals' experiences within the environmental contexts in which they are situated. Falicov (2007) identifies, for example, that culturally competent mental health practice with Latino immigrants requires an understanding of how community and broader societal contexts impact the acculturation process. Similarly, at the CWP service providers' cultural understanding is informed by an understanding of societal factors driving migration from individuals' countries of origin, the structural inequities that individuals commonly encounter in receiving communities, and experiences interacting with oppressive social structures. As identified in the literature and in the present study, understanding the sociopolitical context informing individuals' experiences and service needs is critical to culturally competent mental health practice.

Lastly, it is important to note that although the CWP's model of service delivery is illustrative of culturally competent practice as defined in the literature, service providers primarily referred to their services as being culturally attuned. One service provider stated that they see their model of service delivery as being culturally attuned rather than as being culturally competent because they are constantly learning from community members' experiences and do not believe practitioners can ever attain true mastery of cultural knowledge and understanding. This description of culturally attuned service delivery as reflecting a process of constant learning coincides with Jackson and Samuels' (2011) definition of culturally attuned social work practice. Jackson and Samuels (2011) define cultural attunement as "the process of joining with another as a learner and mutually valuing both indigenous and practitioner insights…being culturally attuned is not a fixed status to which one arrives. Rather, it requires ongoing learning, listening, and critical self-reflection" (p. 237). Service providers' description of their model as being

culturally attuned rather than culturally competent also aligns with the common critiques of cultural competence outlined in Chapter II (Carpenter-Song et al., 2007; Fisher-Borne et al., 2015; Furlong & Wright, 2011; Jani et al., 2016). As I discussed in Chapter II, however, scholars who were seminal in their conceptualizations of cultural competence describe it as a process of learning, growth, and evolving understanding rather than as a finite mastery of knowledge (Sue, 2001). Critical analysis of the debate surrounding cultural competence thus suggests that its shortcomings are related to the term's interpretation and application rather than to inherent problems with the definition itself. While Jani et al.'s (2016) focus group research with social work students and faculty indicated that the meaning of the term cultural competence is ambiguous and variable in the social work community, the authors also suggested that because of the prevalent use of the term and the similar ambiguity of "popular alternative terms," efforts should be invested in more clearly articulating what is meant by culturally competent practice rather than in debating semantics (p. 321). In keeping with Jani et al.'s (2016) recommendation, the CWP's model of service delivery can be used to offer a concrete example of what culturally competent practice looks like. In so doing, we can challenge the interpretations of cultural competence that frame the term as glossing over the impact of power and oppression and assuming that culture is a static construct that can be fully understood and "mastered" (Carpenter-Song et al., 2007; Fisher-Borne et al., 2015; Furlong & Wright, 2011; Jani et al., 2016). Instead, identifying the CWP as an example of culturally competent practice serves to promote a more expansive interpretation and application of the term. This expanded interpretation and application recognizes cultural understanding as an ongoing process of learning and reflection and conceptualizes culture as a dynamic construct that encompasses not

only cultural values and belief systems, but also the sociopolitical context that informs individuals' lived experiences.

**2. Service Provider and Service Participant Experiences with Service Delivery**

As discussed in regard to the previous research question, service providers and service participants described culture as being at the core of their experiences with service delivery at the CWP. An understanding of community members' cultural values and lived experiences informs CWP efforts to address service access barriers, facilitate service engagement, and develop and implement practices that promote positive mental health outcomes across multiple levels of individuals' environments. Service providers and service participants identified that the CWP addresses geographical, psychological, operational, and cultural factors that influence service accessibility. For example, the CWP is accessible via public transportation and is located outside of Saint Anthony Hospital in a community setting that feels comfortable and familiar to service participants. In addition, the program addresses barriers related to cost, hours of operation, child care, and transportation, and has established a culturally and linguistically affirming service environment. The primary barrier that community members experience in accessing mental health services through the CWP is the length of the program's waiting list, as there was a wait of approximately six to eight months to initiate ongoing individual mental health therapy at the time of data collection. Service providers reported that group therapy and initial intake appointments are strategies to facilitate prospective service participants' engagement in services while they are waiting to initiate ongoing individual therapy. In addition, service providers and service participants noted that the CWP's community-based, relationally focused, and accompaniment approaches facilitated service engagement.

While I will synthesize the strategies used to address mental health needs and their associated outcomes when discussing the third research question, it is important to note that service providers and service participants described CWP services as generally promoting positive mental health outcomes at the level of the individual, family, and community as a whole. Service participants discussed that these positive outcomes culminated in an overall satisfaction with program services. Service participants commonly referred other community members to the CWP and expressed a desire for program expansion to other communities throughout Chicago. Service providers similarly described their own experiences with service delivery to be personally transformative. While service providers generally reported their jobs to be rewarding, they also noted the challenges associated with working in a sociopolitical context where there are limited community resources for undocumented immigrant community members, particularly those with more intensive mental health needs.

The CWP's efforts to simultaneously address geographical, psychological, operational, and cultural factors influencing service access coincide perfectly with the access barriers that are frequently identified in the empirical literature (Aguilar-Gaxiola et al., 2012; Bridges et al., 2012; Cabassa et al., 2007; Martinez-Tyson et al., 2016; Santiago-Rivera et al., 2011; Shattell et al., 2008; Wells et al., 2013). It is noteworthy, however, that literature does not typically identify examples of how programs have developed the organizational infrastructure to address these multiple barriers. While Uttal's (2006) case study of a child care worker certification program outlined how the program addressed operational barriers related to scheduling, transportation, and child care, to my knowledge there are not any empirical examples of mental health programs that implement measures to address all four of Delgado's (2007) categories of factors influencing

service access. The CWP thus appears to be innovative in its efforts to simultaneously address these multiple factors.

Reflecting on the access barrier posed by the length of the CWP's current mental health program waiting list, both service providers' and service participants' descriptions delineate a connection between the length of the waiting list and the sociopolitical context in which the program is situated. In particular, service providers and service participants stated that the CWP is virtually the only program of its kind in Chicago in the sense that mental health services are long-term, free of cost, and targeted specifically for uninsured and primarily undocumented community members. As several service providers and service participants noted, a single program cannot keep pace with the needs of the community. While the Roots to Wellness collaborative enhanced the network of supportive services to which community members may be connected, the length of the program's waiting list still points to the structural inequities that result when access to affordable mental health services is largely related to individuals' immigration and insurance statuses. Connecting these findings to the current literature, it is again evident that while there is a body of literature identifying immigration and insurance statuses as barriers to service access (Aguilar-Gaxiola et al., 2012; Ayón, 2014; Bridges et al., 2012; Martinez-Tyson et al., 2016; Perez et al., 2016; Raymond-Flesch et al., 2014; Santiago-Rivera et al., 2011; Shattell et al., 2008; Wells et al., 2013), literature does not provide examples of mental health programs specifically and intentionally designed to reduce these barriers. Not only does the CWP's focus on service provision to uninsured and undocumented immigrant community members thus appear to be unique within the local context of Chicago, but it also appears to be unique within the larger national context of mental health services.

Service participants' general experiences of satisfaction with CWP services adds to the current body of literature suggesting that both organizational and individual level factors play a role in service satisfaction (Clossey & Rheinheimer, 2014; Delphin-Rittmon et al., 2013b; Ishikawa et al., 2010; Kaltman et al., 2016; Meyer & Zane, 2013; Piedra & Byoun, 2012; Valdez et al., 2013). At the organizational level, service participants identified the CWP's program model, physical environment, and organizational culture as leading them to feel comfortable, welcome, and valued during the process of service delivery. Service participants additionally reported that at the level of individual providers, providers delivered interventions in a manner that reflected an understanding of their cultural heritage and demonstrated a genuine concern for their well-being. These organizational and individual provider level factors converged to promote positive mental health outcomes across multiple environmental contexts, and culminated in an overall satisfaction with services. Data from service participant interviews also coincide with past findings indicating that it is not necessarily the ethnic background of mental health providers that is associated with service satisfaction, but rather that it is the extent to which providers demonstrate cultural understanding, an openness to learning from service participants, and a genuine interest in developing a warm, caring interpersonal relationship that extends beyond a mere business transaction (Delphin-Rittmon et al., 2013b; Ishikawa et al., 2010).

### 3. Mental Health Needs of Community Members and Strategies for Addressing Mental Health Needs

Service providers and service participants described community members' mental health needs as stemming from environmental factors. In particular, community members experience anxiety, depression, relational difficulties, difficult life adjustments, and substance

abuse. Underlying these mental health conditions are traumatic experiences stemming from individuals' childhoods in their countries of origin, the migration journey, and the challenges of adjusting to life in the U.S. Not only do individuals navigate an unfamiliar cultural context in the U.S. with limited social support, but they also encounter societal level acculturative stressors that impact their well-being. Service participants frequently recounted experiences of discrimination, exploitation, exposure to negative mainstream narratives about immigrants, limited access to services and opportunities, and structural inequities in their receiving communities. Service providers and service participants described all of these experiences as negatively impacting community members' mental health.

The CWP addresses community members' mental health needs through the delivery of holistic services, services that integrate an understanding of community members' acculturative experiences, and services that challenge the oppressive social structures with which community members interact. With regard to holistic service delivery, mental health services at the CWP are embedded within the context of a program that offers a range of on-site supportive services and within the broader context of Saint Anthony Hospital. This organizational context allows service providers to address mental health needs while simultaneously addressing a range of psychosocial needs for individuals across the lifespan. At the level of individual providers, service providers deliver individual therapy to promote individual healing; deliver couples therapy and family support services to promote wellness within the family system; and deliver group therapy, connect individuals to community resources, and engage in community organizing to enhance social support systems and increase community capacity to promote wellness within the Little Village community as a whole.

With regard to services that integrate an understanding of community members' acculturative experiences, the CWP has established an organizational culture that is affirming of individuals' values from their countries of origin, particularly the values of *respeto* and *familismo*. At the level of individual providers, service providers affirm individuals' cultural values and form relationships that extend beyond businesslike transactions. These relationships are reflective of service providers' adherence to an accompaniment approach, in which they conceptualize their role as that of walking alongside service participants as fellow human beings throughout their healing process. Service participants described this approach as facilitating their emotional expression and enhancing their problem solving abilities. Service providers additionally support service participants in navigating U.S. social systems and developing and expressing bicultural identities.

With regard to services that challenge oppressive social structures, the CWP's anti-oppressive practice model provides an alternative to the traditional medical model of mental health treatment. In accordance with their alternative model, the CWP does not assign diagnoses and does not follow a time-limited "episode of care" model. This alternative model is again reflective of the accompaniment approach to service delivery, as it encourages long-term connections between the CWP and community members in which the CWP remains a constant supportive resource even during periods when community members are not actively participating in services. At the level of individual providers, mental health service providers use strengths-based and trauma-informed approaches to identify service participants' expertise and dismantle power differentials; affirm individuals and their experiences; support individuals in reframing narratives of past trauma; and advocate for service participants and inform them of their rights within other social service systems. Service participants associated these practices with an

enhanced sense of self-worth, which in turn increased their confidence to express themselves in interpersonal interactions, exercise their rights within social service systems, and become involved in promoting social change within their communities.

One of the main findings that emerges with respect to this research question is the conceptualization of mental health challenges in the context of the lived experiences of community members. These findings support the literature acknowledging that acculturative stressors impact mental health (Aguilar-Gaxiola et al., 2012; Arbona et al., 2010; Ayón, 2014; Caplan, 2007; Cook et al., 2009; Falicov, 2007; Flores et al., 2008; Garcini et al., 2016; Horevitz & Organista, 2012; Hovey & Magaña, 2000; Raymond-Flesch et al., 2014; Salas et al., 2013; Stacciarini et al., 2015). These findings also take the discussion one step further in contextualizing community members' experiences within a LatCrit theoretical framework. While Salas et al. (2013) used what they defined as a critical framework to explore the impact of anti-immigrant legislation on Mexican immigrants' mental health, this study appears to be the only of its kind to explicitly equate societal level acculturative stressors with structural oppression. This study thus adds to the current body of literature by explicitly identifying how structural oppression impacts Latino immigrant community members' mental health.

To some extent, the CWP's emphasis on addressing mental health in the context of other psychosocial needs coincides with the literature on mental health practice with Latino immigrants. In Horton's (2006) ethnographic case study, she found that although service providers were located in a clinic that exclusively provided mental health services, a large component of service providers' work focused on addressing individuals' material resource needs and advocating for individuals within social service and legal systems. While the organizational context in which these service providers worked, however, imposed limitations on

the extent to which they could promote holistic wellness (Horton, 2006), the CWP's model of service delivery is intentionally designed to address a range of needs across multiple environmental contexts. In some ways, the CWP's provision of holistic services resembles the neighborhood center model. Neighborhood centers have their roots in the settlement house movement, a nineteenth century movement from which the social work profession was born (Koerin, 2003; Silbert & Timme, 2012; Yan & Sin, 2011). Just as settlement houses of the nineteenth century were intended to provide a range of direct services to newly arrived immigrants and address the structural inequities that they experienced within their communities and within society at large, modern day neighborhood centers offer a range of supportive services in the areas of physical and mental health, family support, material resource assistance, and recreation and personal development opportunities to underserved community members (Koerin, 2003; Silbert & Timme, 2012; Yan & Sin, 2011). Similar to the model of service delivery at the CWP, neighborhood centers both aim to promote holistic wellness among the individuals and families whom they serve and among the community as a whole through community organizing and development efforts (Koerin, 2003; Silbert & Timme, 2012; Yan & Sin, 2011). While the CWP is part of a larger hospital and is not by definition a neighborhood center, the theoretical alignment of these models is noteworthy.

The CWP's practice of integrating an understanding of community members' acculturative experiences throughout service delivery also coincides with the current literature on culturally competent mental health practice with Latino immigrants. At the level of individual providers, service providers' affirmation of cultural values such as *respeto* and *familismo,* as well as the development of personal relationships extending beyond businesslike transactions, mirror past findings on ways in which mental health practitioners integrate cultural constructs during

the process of service delivery with Latino service participants (Gelman, 2004; Ishikawa et al., 2010). This study's findings also coincide with pilot evaluations and case study research identifying that when practitioners acknowledge individuals' acculturative experiences and assist them in navigating unfamiliar U.S. social service systems, positive mental health outcomes result (Benson-Flórez et al., 2017; Piedra & Byoun, 2012; Valdez et al., 2013). It should be noted, however, that the literature on culturally competent mental health practice with Latino immigrants does not conceptualize the process of relationship-building in the context of an accompaniment approach. The findings from this study are thus novel in the sense that they highlight the extent to which service providers' accompaniment practices cultivate trusting relationships in which service participants perceive a genuine concern for their well-being.

At the organizational level, the findings from this study are also supported by literature suggesting that when there is an organizational culture in which cultural affirmation and understanding are the norm, community members feel comfortable and welcome in the program space (Horton, 2006; Ortiz, 2012). It is noteworthy that service participants felt affirmed and valued upon entering the CWP simply because service providers smiled and greeted them in their native language. It is equally noteworthy that service participants reported this treatment to be different from their reception in other service settings. While this finding may seem to suggest a need for increased emphasis on customer service in settings serving Latino immigrants, further exploration suggests that the treatment individuals receive at the CWP is not simply a matter of good customer service. Instead, the way in which service providers treat community members is informed by an understanding of community members' cultural values, particularly the value of *respeto*. Their actions thus reflect an intentionality to create an environment that is affirming of community members' cultural heritage and that conveys respect and value for who they are as

people. Not only are service providers intentional in their cultural affirmation, but service participants also interpret service providers' actions as conveying cultural understanding.

The CWP's emphasis on anti-oppressive practice is novel and adds to the current body of literature on culturally competent mental health practice with Latino immigrants. Although there are a few practice examples of cases where mental health providers acknowledged the impact of discrimination and advocated for service participants within other social service systems (Benson-Flórez et al., 2017; Horton, 2006), I have not encountered any empirical literature in the field of mental health that identifies examples of services explicitly driven by the goal of challenging oppressive environmental conditions. The model that again appears most similar to the CWP in its emphasis on addressing structural inequities is the neighborhood center model. As previously noted, neighborhood centers do not only provide direct services to underserved community residents, but they also promote social action through their community organizing efforts (Koerin, 2003; Silbert & Timme, 2012; Yan & Sin, 2011). Considering that the neighborhood center model's emphasis on social action has its historic roots in the settlement house movement (Koerin, 2003; Silbert & Timme, 2012; Yan & Sin, 2011), mental health practice at the CWP coincides with the model of service delivery that the founders of the social work profession envisioned. Service participants associated the CWP's anti-oppressive practices with enhanced self-worth, increased confidence in their interpersonal interactions, increased confidence to exercise their rights within social service systems, and a commitment to promoting social change in their community. These findings thus indicate that when mental health services address the larger sociopolitical context that impacts well-being, a practice in which the social work profession is historically grounded, there is the potential to affect positive outcomes across multiple environmental levels.

Findings pertaining to the CWP's strategies for addressing mental health needs also point to the increased potential to promote positive mental health outcomes when organizational infrastructure is in place to support service providers in their daily practice. Service providers noted that the family-oriented organizational culture at the CWP promotes a culture of self care and supports service providers in sustaining themselves as human beings. With regard to the CWP's anti-oppressive practice model in particular, data suggest that this practice model supports service providers in carrying out their job responsibilities in accordance with their professional values. For example, the CWP's anti-oppressive practice model does not require that service providers assign diagnoses; does not require that service providers develop treatment plans and work toward short-term behaviorally focused treatment goals; and does not require that service providers "close out" cases after a prescribed number of "no shows." Within the context of this model, service providers report that they have the freedom to engage in services in a way that facilitates the development of trusting relationships, promotes healing from past trauma, and challenges oppressive environmental conditions. The congruence between the CWP's organizational infrastructure and service providers' daily practice stands in contrast to Horton's (2006) case study. In the context of the outpatient mental health clinic that was the focus of Horton's (2006) study, insurance billing requirements and rules surrounding clinician productivity created tension between organizational demands and service providers' ability to deliver services that they perceived as adequately addressing individuals' needs. Service providers at the CWP reported that they have worked in settings that had these tensions and constraints, and see this type of organizational context as facilitating clinician burnout. Green, Dishop, and Aarons (2016) similarly concluded that there is a high potential for staff turnover in mental health agencies where there is "role conflict" (p. 1106). Considering that practitioner

burnout and turnover are typically associated with negative treatment outcomes (Green et al., 2016), it is possible that there is increased potential to positively impact mental health outcomes within the organizational context of the CWP, where the professional values of both individual providers and the organization are aligned.

## B. Theoretical Framework

While the previous section contextualized this study's findings in relation to the literature on mental health practice with Latino immigrants, this section will contextualize the findings in relation to LatCrit theory. Central to LatCrit is the tenet that U.S. social structures and institutions create and maintain narratives about Latinos and Latino immigrants that perpetuate the oppression of this population (Delgado & Stefancic, 2012; Delgado Bernal, 2002; Garcia, 1995; Irizarry, 2011; Solórzano & Yosso, 2002). Findings from this study, particularly findings pertaining to the CWP's anti-oppressive practices, demonstrate that not only is service delivery at the CWP informed by an understanding of how these narratives impact the mental health of Latino immigrants, but that service providers also engage with and challenge these mainstream narratives throughout the process of service delivery. This section will discuss the counternarratives that have been established as a result of anti-oppressive service delivery at the CWP. I will first discuss the counternarrative that service providers and service participants have collaboratively created about Latino immigrants, and I will then discuss the organizational counternarrative that has been created about mental health and mental health treatment.

### 1. Counternarrative About Latino Immigrants

Service participants' descriptions of their experiences of structural oppression reference the mainstream narrative about Latino immigrants to which they are exposed. Several service participants noted that the Latino immigrant population is commonly conveyed as being

uneducated, as being comprised of criminals, as taking away jobs from U.S. citizens, and as generally being valued less within U.S. society. Service providers also noted that mainstream narratives scapegoat and blame immigrants for economic problems and social ills, which in turn impacts community members' mental health. The CWP's anti-oppressive practices directly challenge these narratives.

Efforts to challenge mainstream narratives are especially reflected in service providers' trauma-informed and strengths-based work. Service providers described their trauma-informed and strengths-based work as being grounded in narratives. In particular, service providers collaborate with service participants to reframe their narratives about past traumatic experiences. This reframing process entails supporting individuals in letting go of feelings of self-blame, acknowledging the role of oppressive environmental conditions in the traumatic experience, and recognizing their strength and resilience in overcoming oppressive circumstances. In the new narratives that service participants create about themselves, they are establishing counternarratives that redefine who Latino immigrants are in U.S. society. These narratives challenge the notion that Latino immigrants are to blame for the economic problems and social ills in the U.S. and instead highlight individuals' strength and courage in leaving behind their families and friends to seek out opportunities that were unavailable to them in their countries of origin. These narratives challenge the assertion that immigrants are criminals, uneducated, and of less value, and instead emphasize individuals' strengths and expertise as they take on the task of navigating an unfamiliar cultural context and work to promote wellness within their families and their communities. As service participants integrate this reframed understanding of who they are and the inherent value that they possess, this reframed understanding is reflected in their interpersonal interactions, their interactions with social service systems, and their interactions

with their community at large. Through these interactions, service participants push back against narratives that devalue Latino immigrants and advocate for the rights to which they and their fellow community members are entitled.

### 2. Organizational Counternarrative

The CWP also challenges mainstream narratives about mental health and mental health treatment and has created a counternarrative about mental health service delivery. This counternarrative is reflected in the cultural understanding underlying the CWP's anti-oppressive practice model. Service providers at the CWP identified that culture does not only encompass an understanding of language, customs, traditions, values, and beliefs, but rather encompasses a deeper understanding of the sociopolitical context that informs individuals' lived experiences. This understanding informs a model of service delivery that aims to push back against oppressive environmental conditions and "challenge the boundaries of what community mental health practice really is" (Interviewee 7). Mental health service providers described that their training in this alternative model was formative to their professional development, and those who found themselves in other mental health settings noted how the organizational context of these settings contrasted with their conceptualizations of what it meant to be a mental health therapist.

The CWP's articulated understanding of the sociopolitical elements of culture informs their counternarrative about mental health symptomology. While service providers identified specific mental health conditions such as depression and anxiety that lead community members to seek services, their conceptualization of mental health challenges was primarily grounded in an understanding of the sociopolitical context in which mental health symptoms emerged. To avoid further labeling and stigmatization in the context of a society that labels and stigmatizes immigrants, service providers intentionally do not assign diagnoses and focus their assessments

on an understanding of individuals' experiences rather than on symptoms and diagnostic criteria. The CWP has thus created a counternarrative about mental health that conceptualizes individuals' struggles as stemming from environmental conditions rather than as stemming from individual pathology.

The way in which mental health challenges are conceptualized at the CWP in turn informs the way in which services are delivered. In contrast with the medical model's emphasis on short-term behavioral health treatment, services at the CWP are time-unlimited and focused on developing trusting relationships, promoting healing from past trauma, and challenging oppressive environmental conditions. The CWP has thus created a counternarrative about what it means to provide mental health treatment. Service participants with prior experiences of mental health treatment observed the manifestation of the CWP's counternarrative from the time of their first appointment, when they were given the freedom to set the therapeutic agenda rather than being asked a series of intrusive questions about their symptoms. One service participant additionally noted that at the CWP, they had the opportunity to explore past traumatic experiences at a depth that they had not attained with prior services. The CWP's counternarrative about mental health and mental health treatment impacts both service providers and service participants alike. As previously noted, the CWP's counternarrative is formative to service providers' conceptualizations of what it means to be a mental health therapist. In addition, as service providers deliver services in accordance with this counternarrative, they challenge community members' preconceived ideas about what it means to receive mental health services. In a society where the medical model of mental health treatment is the norm, the CWP's organizational infrastructure and service providers' individual practice converge to challenge mainstream conceptualizations about mental health and mental health treatment.

## C. Implications

This section will discuss the study's implications for social work practice, policy, education, and research. Each of these topics will be discussed in turn below.

### 1. Implications for Social Work Practice

This study's findings inform the following recommendations for individual providers in their mental health practice with Latino immigrant service participants:

- **Consider the range of psychosocial needs in which mental health needs are embedded.** Findings indicate that rather than compartmentalizing mental health needs, service providers can promote holistic wellness by connecting individuals to resources and supports that address a range of psychosocial needs impacting mental health. By intervening across multiple levels of individuals' environments, service providers can promote the well-being of individuals, families, and communities at large.
- **Be open to developing relationships that extend beyond businesslike transactions.** Both service providers and service participants noted that the impact of CWP services largely stemmed from the depth of their interpersonal relationships. Service participants frequently discussed that service providers were not simply fulfilling their job responsibilities, but rather that they demonstrated a genuine concern for their well-being and truly valued them as human beings. Service providers linked the relationally-centered nature of their work with the accompaniment approach, an approach that frames service providers' role as one in which they are there to walk alongside service participants throughout their healing journey. Service participants perceived the level and constancy of support that they received through this approach as paralleling the level of support they might expect to receive from a friend or family member. While one might argue that this

comparison suggests that service providers are overstepping professional boundaries, there are several pieces of evidence indicating that this is not the case. First, it is important to make the distinction that service participants do not describe service providers as *being* family or friends, but rather that they relate to them with expressions of concern and support similar to *what they might expect* from family or friends. Second, it is important to consider the meaning of this relationship for service participants at the CWP in the context of their lived experiences. Several service participants explicitly stated that their relationships with service providers play a critical role in their healing journey because service providers offer emotional support that they cannot receive from friends and family members who reside outside of the U.S. Informed by an understanding of community members' lived experiences, service providers are thus responding in a culturally appropriate manner to community members' service needs. Considering that the professional relationship is an important vehicle for promoting positive mental health outcomes, mental health practitioners can benefit from exploring what community members are looking for in the context of this relationship and demonstrating an openness to relating to community members in a way that is responsive to their service needs.

- **Support individuals in developing bicultural identities and navigating unfamiliar social service systems.** As these findings demonstrate, service providers can support service participants during the acculturation process. Service providers can offer support by affirming individuals' cultural heritage and engaging in conversations that explore aspects of individuals' belief systems that they wish to maintain and that they wish to redefine as they develop a bicultural identity in the U.S. Considering that service

participants are often navigating an unfamiliar cultural context with limited social support, service providers can also play an instrumental role in ensuring that service participants have access to culturally and linguistically appropriate information about U.S. social service systems.

- **Conceptualize mental health in relation to the sociopolitical context in which community members are situated.** Even in settings where service providers are required to assign diagnoses for billing purposes, diagnoses can be presented in a manner that reduces stigmatization. For example, service providers can speak with individuals about the impact of environmental stressors on mental health and provide education on symptoms that emerge in the context of these stressors. By conceptualizing mental health symptoms in the context of oppressive environmental conditions, service providers can challenge the pathology associated with the diagnostic process.
- **Look for opportunities to push back against oppressive environmental conditions.** Service providers may push back against oppressive environmental conditions in their daily practice by dismantling the power differential between themselves and the individuals whom they serve; acknowledging individuals' strengths and expertise; explicitly discussing the impact of discrimination, exploitation, and marginalization on mental health; and advocating for service participants and informing them of their rights within other social service systems. Service providers may find strengths-based and trauma-informed practice approaches to be useful in implementing these strategies. As illustrated through this study's findings, these approaches work in concert to help individuals understand their responses to traumatic experiences and recognize their strength and resilience in overcoming difficult circumstances. While service providers

may question their power to change oppressive contexts, service participants have identified the above strategies as having the potential to impact the way they relate to themselves, others, and their communities, thus increasing their sense of agency to promote the change that they desire in their own lives and in the communities where they live.

While the above recommendations are intended to provide some general guidelines for practice, they are not intended to be applied formulaically. Instead, it is important to recognize how the practice strategies implemented at the CWP were informed by a deep understanding of community members' culture and lived experiences. The overarching recommendation for service providers is thus to consider how their conceptualizations of culture can inform their practice. By recognizing that culture encompasses not only language, traditions, values, and beliefs, but also individuals' lived experiences within the sociopolitical context in which they are situated, service providers may be able to use a more expansive understanding of culture to inform their practice. As these findings illustrate, service providers develop this expansive, evolving understanding through ongoing assessment of the experiences and service needs of both the community at large and the individuals who come in for services. This recommendation is relevant to service providers across settings and across populations.

While I have thus far identified recommendations for social work practice at the level of individual practitioners, it is important to emphasize the role of the larger organization in facilitating service access and supporting individuals in their practice. To begin, the CWP has developed the organizational infrastructure to address a range of geographical, psychological, operational, and cultural factors that impact mental health service access. As noted in section A, the CWP is unique in its efforts to address these multiple factors. Looking to the CWP as a

model, organizations could benefit from investing in efforts to assess common barriers impeding service access in the communities that they serve and developing the infrastructure to address these barriers.

The CWP has additionally developed the organizational infrastructure to support service providers in promoting holistic wellness and delivering interventions informed by an understanding of community members' acculturative experiences and experiences of structural oppression. At the organizational level, organizations therefore have the charge of developing the infrastructure to support practitioners in their implementation of culturally competent practice. While organizations may have the flexibility to develop some components of the organizational infrastructure necessary to support practitioners, there may be some infrastructural components that are more challenging to implement. Organizations may, for example, be able to work toward creating a culturally accessible physical environment and an organizational culture that is affirming of community members' cultural heritage. At the same time, however, in outpatient mental health settings where insurance is billed for services, modifying infrastructure related to diagnoses and length of treatment requires more substantive policy changes surrounding insurance billing and reimbursement. Programs that can fund mental health services without depending on insurance reimbursement thus provide promising opportunities for addressing the mental health needs of oppressed and underserved communities. Saint Anthony Hospital's program can serve as a model for other communities. Considering that charitable hospitals are incentivized for implementing programs that promote community wellness (Bourassa, 2013), other hospitals may consider developing and implementing similar types of community wellness programs that allow them to obtain or maintain their designation as a charitable hospital and that generally promote a positive reputation of their hospital within the community.

### 2. Policy Implications

The findings from this study have several policy implications. First, the fact that the CWP is unique in its efforts to provide free, long-term mental health services for uninsured and undocumented community members points to a general need for services specifically targeted toward this population. In a political climate that is marked by anti-immigrant rhetoric (Lee, 2016), the importance of advocating for funding for these services cannot be overstated. Second, this study's findings suggest that insurance requirements may impede the delivery of mental health services that promote healing and holistic wellness. Coinciding with Horton's (2006) analysis of the tensions between organizational demands and service providers' beliefs about best practices, there is a clear need to reexamine policies surrounding insurance billing and reimbursement that prioritize clinician productivity over service participants' well-being.

The findings from this study also point to the importance of policies that incentivize hospitals to develop and implement programs similar to that of Saint Anthony Hospital. Charitable hospitals can currently receive tax exempt status for a range of activities that are considered to be of benefit to the community, including the provision of charity care to individual hospital patients and programming that promotes health and wellness within the community at large (Rosenbaum, Byrnes, Rothenberg, & Gunsalus, 2016). Rosenbaum et al. (2016) assert, however, that the Internal Revenue Service's current definition of "community benefit" may lead charitable hospitals to prioritize activities that fall under the category of individual patient services rather than investing in broader community health promotion activities. Rosenbaum et al. (2016) thus recommend that the Internal Revenue Service provide "a more comprehensive definition of community benefit spending that emphasizes community-wide health improvement" (p. vi). The authors additionally recommend that the Internal Revenue

Service partner with other government agencies to issue guidance to hospitals on how to develop and implement these community initiatives (Rosenbaum et al., 2016). While to date the Trump administration has not proposed any legislation targeting the criteria through which hospitals obtain or maintain charitable hospital status, it is important that social workers stay informed of political developments in this area and advocate for policy that supports the expansion of hospital's charitable activities. Considering that 68% of surveyed hospitals identified mental health as a priority community concern in a national study of 300 charitable hospitals (Rosenbaum et al., 2016), there is reason to believe that programs modeled after Saint Anthony Hospital's CWP can play a critical role in bringing accessible mental health services to underserved communities across the country.

Service participants' descriptions of their experiences of structural oppression and its impact on their mental health also point to a clear need for comprehensive immigration reform in the U.S. Service participants' descriptions poignantly illustrate that U.S. immigration policies have a profound impact on individuals' well-being, as they exclude individuals from accessing services and opportunities and from fully participating in U.S. society. Not only do policies directly marginalize immigrant communities and lead them to live in constant fear of deportation, but immigrant community members also internalize the narratives that accompany these policies. Internalization of these narratives in turn leads individuals to question their value and worth. Considering the profound impact of policies and narratives on mental health, social workers can play a crucial role in advocating for policy reform.

Taking on an advocacy role is of increasing importance in the aftermath of the election of Donald Trump to the U.S. presidency. Not only was Trump's anti-immigrant rhetoric pervasive throughout his campaign (Collinson & Diamond, 2016), but Trump also specifically targeted

Latino immigrants in the first week of his presidency by signing executive orders to construct a wall at the U.S.-Mexico border and to withhold funding from sanctuary cities where local authorities do not disclose individuals' immigration status to federal immigration officials (Bennett & Bierman, 2017; Executive Order No. 13,767, 2017; Executive Order No. 13,768, 2017). The Trump administration has also called for increased resources to be invested in hiring officials to monitor the U.S.-Mexico border and expanding detention capabilities in the border region (Executive Order No. 13,767, 2017; Executive Order No. 13,768, 2017; Kelly, 2017a; Kelly, 2017b). Throughout these executive orders, language that characterizes Mexican immigrants as criminal "aliens" who pose a threat to public safety is pervasive (Executive Order No. 13,767, 2017; Executive Order No. 13,768, 2017). Faced with this hostile political climate, social workers can play an invaluable role in pushing back against harmful legislation and challenging the anti-immigrant rhetoric that pervades national dialogue. Social workers can also persist in their demands for comprehensive immigration reform and demonstrate that political obstacles will not deter their advocacy efforts. Additionally, social workers can play a crucial role in advocating for local and state level policy changes. Examples include advocating for the expansion of sanctuary cities in spite of the administration's threats and advocating for policies that remove immigration status as a criterion for accessing services and benefits.

### 3. Implications for Social Work Education

This study has implications for social work education, particularly for the way in which content on cultural competence is delivered to students. As Jani et al. (2016) found in their focus group research with social work students and faculty members, there is considerable confusion regarding how the concept of cultural competence should be interpreted and how content should be delivered to prepare students for practice with diverse populations. One service provider at the

CWP also discussed that there was a discrepancy between the presentation of content on cultural competence in their own educational experience and the conceptualization of culturally appropriate service delivery at the CWP. They described that having a week's worth of content on Latino cultural values and traditions in their educational program did not coincide with the CWP's practice model in which cultural understanding is at the core of service delivery. Findings thus suggest that social work educators can better prepare students for culturally competent practice when they present content on culture as a dynamic and multi-faceted construct. When students understand that culture encompasses a range of elements including language, traditions, values, belief systems, sociopolitical context, and lived experiences, they can integrate this knowledge to assess and understand the experiences and service needs of the diverse individuals, families, and communities whom they serve. Courses that offer case studies of specific communities may be beneficial in allowing students to gain an in-depth understanding of the multiple elements that encompass culture, so that they can in turn translate this knowledge to assess and better understand the experiences of individuals and families across a range of diverse communities. Students will also benefit from recognizing that culturally competent service delivery requires a commitment to ongoing learning.

This study also has implications for the way in which content on mental health is integrated into social work curricula. While the person-in-environment concept is central to social work education and practice, the findings from this study suggest that the impact of the sociopolitical context on mental health is a component of the person-in-environment conceptualization that warrants further attention. From a LatCrit perspective, helping students to identify, challenge, and deconstruct mainstream narratives about Latino immigrants and other oppressed communities is critical to challenging the notion that mental health symptoms stem

from individual pathology. Attention to sociopolitical context is also essential to preparing students to deliver mental health interventions that address factors impacting well-being across multiple levels of individuals' environments.

### 4. Implications for Future Research

The findings from this study point to several areas warranting future research attention. To begin, because this is a qualitative case study focused on exploring experiences of service delivery, it was not intended to assess the direct causal link between mental health interventions and therapeutic outcomes. While service providers and service participants associated specific practice strategies with positive outcomes, a quasi-experimental design could be used in the future to directly assess the link between mental health service delivery and treatment outcomes. Future research could benefit from comparing outcomes routinely assessed during the course of mental health service delivery at the CWP, including outcomes related to self-awareness, self-expression, self-worth, and problem-solving capabilities, among individuals on the program's waiting list and individuals participating in ongoing mental health services.

In my discussion of the study's implications for social work practice, I also noted that there were components of the CWP's organizational infrastructure that could be challenging to implement in outpatient mental health settings where insurance is billed for services. For example, organizations relying on insurance reimbursement are required to assign diagnoses and will likely face limits on the number of mental health therapy sessions that they may offer to service participants. Considering that the larger sociopolitical context impacts how organizations deliver services, it is critical to seek feedback from mental health practitioners and administrators regarding components of the CWP's model that can and cannot be feasibly implemented across organizational settings. Focus group research with mental health practitioners and administrators

at organizations throughout Chicago could therefore provide an important opportunity to identify specific components of the CWP's model that can be implemented across outpatient mental health settings. This focus group research could also provide an opportunity to discuss how organizations and practitioners can work collaboratively to implement these components of the model. In addition, feedback from practitioners and administrators regarding components of the model that cannot feasibly be transferred can inform future efforts to change policies that pose barriers to the model's transferability.

Lastly, findings from this study signal the need to further explore existing informal mental health supports within Latino immigrant communities. Service providers noted that considering the demand for mental health services within the Little Village community and the challenges that they encounter in meeting this demand, one of the aims of the Roots to Wellness collaborative is to connect individuals to informal supports. Service participants also noted their own role in supporting fellow community members by connecting them with existing resources. As discussed in Chapter IV, service participants commonly referred family, friends, and acquaintances for services at the CWP. Service participants discussed that because they understand the challenges of navigating an unfamiliar cultural context and finding resources for which they are eligible, they believe it is important that they support community members who are facing similar challenges. Based on this finding, future research efforts could conduct open-ended individual interviews with Latino immigrants throughout Chicago to learn more about the processes through which they provide and receive informal mental health support. Not only could this line of research provide insight into how community strengths and resources can be leveraged to promote positive mental health outcomes, but in keeping with a LatCrit perspective,

this line of research could also document a counternarrative about the experiences of Latino immigrants in mobilizing community assets.

**D. Limitations**

This study has several limitations that I will address in this section. First, as noted in my discussion on implications for future research, this study was not intended to assess the direct causal link between mental health service delivery and treatment outcomes. While this study provides important insight into service providers' and service participants' perspectives on the positive mental health outcomes associated with CWP practices, an experimental or quasi-experimental design is needed to establish causality.

Second, it should be noted that of the 11 service participants who took part in individual interviews, ten of the 11 interviewees (91%) were female. Males are thus underrepresented in my study sample in comparison to their representation among the CWP mental health service participant population, where they comprise approximately 34% of the individuals who receive mental health services at the CWP's Little Village location (A. Carrillo, personal communication, March 20, 2017). While I engaged in purposive efforts to recruit male service participants, I observed that males generally appeared to be more hesitant to speak with me about my study. The male service participant who did take part in an interview provided insight into why this might be the case. In particular, he stated that males may face added stigma surrounding participation in mental health treatment in comparison to females, due to cultural norms surrounding what it means to be a strong male. Based on this service participant's perspective, it is possible that perceived stigma influenced male service participants' decisions not to take part in interviews. It is also possible that my positionality as a White, Anglo American, U.S.-born female may have contributed to male service participants' hesitancy to take part in this study.

More specifically, it is possible that differences in gender, coupled with differences in ethnicity and nativity, may have led male service participants to feel hesitant to speak with me about experiences with mental health service delivery. Due to the unequal gender representation within this sample, readers should be cautious about generalizing service participants' experiences of service delivery to male service participants.

Lastly, there is the potential concern that the service participants who took part in individual interviews did so because of their engagement in and satisfaction with program services. I took several measures to address this concern. First, in addition to my face-to-face recruitment efforts, I also posted informational flyers in the program's waiting area. I posted information in the waiting area so that individuals who were not regularly attending appointments had the opportunity to learn about the study and contact me if they were interested in taking part in an interview. In addition, the $25 gift card that I offered as compensation for participation, while not enough to be coercive, was intended to provide an incentive for individuals to take part in an interview regardless of their level of satisfaction with services. It is important to note that service participants who took part in interviews had been receiving CWP services for a time span ranging from several sessions to several years, suggesting that willingness to take part in an interview was not dependent on the length of time in which individuals had been engaged in services. The measures that I implemented thus lead me to feel confident that it was not simply individuals who were satisfied with program services who chose to take part in interviews, but rather that the CWP has a strong record of community member satisfaction with services.

## E. Service Participant Recommendations for Promoting Social Change

In accordance with my LatCrit theoretical framework, I have chosen to conclude my dissertation with some synthesizing recommendations from a service participant regarding how individuals can promote social change in the current sociopolitical context. As I conducted member check interviews with service participants shortly after the election of Donald Trump to the U.S. presidency, I invited service participants to contribute to the final chapter of my dissertation by providing recommendations for how individuals can combat social injustice in the context of increasing anti-immigrant rhetoric. Of the two service participants who took part in individual member check interviews, one service participant provided me with recommendations. Below are their verbatim recommendations regarding how individuals can push back against oppressive social structures and anti-immigrant rhetoric:

> La injusticia a veces comienza entre nosotros mismos los hispanos. A veces los hispanos que tenemos un pocito deseo de…por ejemplo, a veces cuando los hispanos tienen un seguro social, como un manager, humillan a personas que no tienen un seguro social. Entonces es cuando empieza el mismo odio, racismo contra nosotros mismos. A veces humillamos las personas o criticarlas sin saberlas, sin saber su por qué. A veces los juzgamos por su color, su sexo. Y hay mucha injusticia con todo lo que nosotros mismos sembramos al juzgar otra persona sin conocerla. Debemos concientizarnos nosotros mismos antes de criticar o juzgar una persona. Todos somos iguales, todos fuimos criados por una sola persona. Todos somos humanos y debemos tratarnos como lo que somos.
>
> Injustice sometimes begins among Hispanics ourselves. Sometimes we as Hispanics have a bit of desire to…for example, sometimes when Hispanics have a social security number, like a manager, they humiliate people that don't have a social security number. And so this is when the same hatred, racism begins against ourselves. Sometimes we humiliate or criticize people without knowing them, without knowing their story. Sometimes we judge them for their color, for their gender. And there is much injustice with everything that we ourselves cultivate when we judge another person without knowing them. We ought to raise awareness among ourselves before we criticize or judge another person. We are all equal, we were all created by one person. We are all human beings and we ought to treat each other like what we are.

Although this service participant focuses their recommendations on increasing solidarity among Latinos and decreasing intragroup racism and hatred, their recommendations have critical

implications for individuals of all races and ethnicities. As this service participant states, pushing back against oppressive environmental conditions begins with how we relate to others in our interpersonal interactions. When we relate to others without judgment and embrace their humanity, we are in fact challenging oppressive mainstream narratives.

## CITED LITERATURE


Aguilar-Gaxiola, S., Loera, G., Méndez, L., Sala, M., Latino Mental Health Concilio, & Nakamoto, J. (2012). *Community-defined solutions for Latino mental health care disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup population report*. Sacramento, CA: UC Davis.

Alegría, M., Canino, G., Shrout, P. E., Woo, M., Duan, N., Vila, D…Meng, X. (2008). Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. *American Journal of Psychiatry*, *165*, 359-369.

Añez, L. M., Paris, M., Bedregal, L. E., Davidson, L., & Grilo, C. M. (2005). Application of cultural constructs in the care of first generation Latino clients in a community mental health setting. *Journal of Psychiatric Practice*, *11*(4), 221-230.

Antoniades, J., Mazza, D., & Brijnath, B. (2014). Efficacy of depression treatments for immigrant patients: Results from a systematic review. *BMC Psychiatry*, *14*, 176.

Arbona, C., Olvera, N., Rodriguez, N., Hagan, J., Linares, A., & Wiesner, M. (2010). Acculturative stress among documented and undocumented immigrants in the United States. *Hispanic Journal of Behavioral Sciences*, *32*(3), 362-384.

Ayón, C. (2014). Service needs among Latino immigrant families: Implications for social work practice. *Social Work*, *59*(1), 13-23.

Bachman, S. S., Tobias, C., Master, R. J., Scavron, J., & Tierney, K. (2008). A managed care model for Latino adults with chronic illness and disability: Results of the Brightwood Health Center intervention. *Journal of Disability Policy Studies*, *18*(4), 197-204.

Bennett, B., & Bierman, N. (2017, January 25). Trump orders moves on border wall and ‘sanctuary cities’ and is considering a refugee ban. *Los Angeles Times*. Retrieved from http://www.latimes.com/politics/la-na-pol-trump-immigration-20170125-story.html

Benson-Flórez, G., Santiago-Rivera, A., & Nagy, G. (2017). Culturally adapted behavioral activation: A treatment approach for a Latino family. *Clinical Case Studies*, *16*(1), 9-24.

Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology*, *46*(1), 5-68.

Berry, J. W. (2003). Conceptual approaches to acculturation. In K. M. Chun, P. B. Organista, & G. Marín (Eds.), *Acculturation: Advances in theory, measurement, and applied research* (pp. 17-37). Washington, DC: American Psychological Association.

Bledsoe, S. E. (2008). Barriers and promoters of mental health services utilization in a Latino context: A literature review and recommendations from an ecosystems perspective. *Journal of Human Behavior in the Social Environment*, *18*(2), 151-183.

Bourassa, B. (2013). Charitable hospitals: Roles and responsibilities. Retrieved from https://www.treasury.gov/connect/blog/Pages/Charitable-Hospitals-Roles-and-Responsibilities.aspx

Bridges, A. J., Andrews, A. R., & Deen, T. L. (2012). Mental health needs and service utilization by Hispanic immigrants residing in mid-Southern United States. *Journal of Transcultural Nursing*, *23*(4), 359-368.

Bronfenbrenner, U. (1994). Ecological models of human development. In *International Encyclopedia of Education* (2nd ed., Vol. 3). Oxford, UK: Elsevier. Reprinted in M. Gauvain & M. Cole (Eds.), *Readings on the development of children* (2nd ed.) (1993, pp. 37-43). New York, NY: Freeman. Retrieved from http://www.psy.cmu.edu/~siegler/35bronfebrenner94.pdf

Brown, A., & Patten, E. (2014). Statistical portrait of the foreign-born population in the United States, 2012. Retrieved from http://www.pewhispanic.org/2014/04/29/statistical-portrait-of-the-foreign-born-population-in-the-united-states-2012/

Bulut, E., & Gayman, M. D. (2016). Acculturation and self-rated mental health among Latino and Asian immigrants in the United States: A latent class analysis. *Journal of Immigrant and Minority Health*, *18*, 836-849.

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

Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(3), 316-330.

Caplan, S. (2007). Latinos, acculturation, and acculturative stress: A dimensional concept analysis. *Policy, Politics, & Nursing Practice*, *8*(2), 93-106.

Caplan, S., Paris, M., Whittemore, R., Desai, M., Dixon, J., Alvidrez, J…Scahill, L. (2011). Correlates of religious, supernatural and psychosocial causal beliefs about depression among Latino immigrants in primary care. *Mental Health, Religion & Culture*, *14*(6), 589-611.

Carpenter-Song, E. A., Schwallie, M. N., & Longhofer, J. (2007). Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services*, *58*(10), 1362-1365.

Casas, P., & Isarowong, N. (2015). Saint Anthony Hospital: Infusing developmental and family support services in community-based medical practice. *Zero to Three*, 29-37.

Cavazos-Rehg, P. A., Zayas, L. H., & Spitznagel, E. L. (2007). Legal status, emotional well-being and subjective health status of Latino immigrants. *Journal of the National Medical Association, 99*(10), 1126-1131.

Cherner, R., Olavarria, M., Young, M., Aubry, T., & Marchant, C. (2014). Evaluation of the organizational cultural competence of a community health center: A multimethod approach. *Health Promotion Practice*, *15*(5), 675-684.

Chicago Neighborhood Development Awards (n.d.). Blue Cross and Blue Shield of Illinois Healthy Community Award: Saint Anthony Hospital Mental Health Services. Retrieved from http://www.lisc-cnda.org/Past-winners/23rd-CNDA-Winners-2017-0/BLUE-CROSS-AND-BLUE-SHIELD-OF-ILLINOIS-HEALTHY-COMMUNITY-AWARD.html

Chun-Chung Chow, J., & Austin, M. J. (2008). The culturally responsive social service agency: The application of an evolving definition to a case study. *Administration in Social Work, 32*(4), 39-64.

Clossey, L., & Rheinheimer, D. (2014). Exploring the effect of organizational culture on consumer perceptions of agency support for mental health recovery. *Community Mental Health Journal, 50*, 427-434.

Collinson, S., & Diamond, J. (2016, September 1). Trump on immigration: No amnesty, no pivot. *CNN*. Retrieved from http://www.cnn.com/2016/08/31/politics/donald-trump-immigration-speech/

Cook, B., Alegría, M., Lin, J. Y., & Guo, J. (2009). Pathways and correlates connecting Latinos' mental health with exposure to the United States. *American Journal of Public Health, 99*, 2247-2254.

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Darnell, A. J., & Kuperminc, G. P. (2006). Organizational cultural competence in mental health service delivery: A multilevel analysis. *Journal of Multicultural Counseling and Development, 34*, 194-207.

Davis, T. S. (2007). Mapping patterns of perceptions: A community-based approach to cultural competence assessment. *Research on Social Work Practice*, *17*(3), 358-379.

Delgado, M. (2007). *Social work with Latinos: A cultural assets paradigm*. New York, NY: Oxford University Press.

Delgado, R., & Stefancic, J. (2012). *Critical race theory: An introduction* (2nd ed.). New York, NY: New York University Press.

Delgado Bernal, D. (2002). Critical race theory, Latino critical theory, and critical raced-gendered epistemologies: Recognizing students of color as holders and creators of knowledge. *Qualitative Inquiry, 8*(1), 105-126.

Delphin-Rittmon, M. E., Andres-Hyman, R., Flanagan, E. H., & Davidson, L. (2013a). Seven essential strategies for promoting and sustaining systemic cultural competence. *Psychiatric Quarterly, 84*, 53-64.

Delphin-Rittmon, M., Bellamy, C. D., Ridgway, P., Guy, K., Ortiz, J., Flanagan, E., & Davidson, L. (2013b). 'I never really discuss that with my clinician: US consumer perspectives on the place of culture in behavioural healthcare. *Diversity and Equality in Health and Care, 10*, 143-154.

Emden, C., & Sandelowski, M. (1998). The good, the bad and the relative, part one: Conceptions of goodness in qualitative research. *International Journal of Nursing Practice*, *4*, 206-212.

Enlace Chicago (2013). Little Village quality-of-life plan. Retrieved from http://enlacechicago.org/wp-content/uploads/2013/10/LV-QofL-Plan_Document.pdf

Executive Order No. 13,767, 82 Fed. Reg. 8793 (2017).

Executive Order No. 13,768, 82 Fed. Reg. 8799 (2017).

Executive Order No. 13,769 (2017). Retrieved from https://www.whitehouse.gov/the-press-office/2017/01/27/executive-order-protecting-nation-foreign-terrorist-entry-united-states

Executive Order No. 13,780 (2017). Retrieved from https://www.whitehouse.gov/the-press-office/2017/03/06/executive-order-protecting-nation-foreign-terrorist-entry-united-states

Falicov, C. J. (2007). Working with transnational immigrants: Expanding meanings of family, community, and culture. *Family Process*, *46*(2), 157-171.

Falicov, C. J. (2009). Commentary: On the wisdom and challenges of culturally attuned practices with Latinos. *Family Process, 48*(2), 292-309.

Feliciano, C. (2001). The benefits of biculturalism: Exposure to immigrant culture and dropping out of school among Asian and Latino youths. *Social Science Quarterly, 82*(4), 865-879.

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34*(2), 165-181.

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

Flores-Peña, Y., Ortiz-Félix, R. E., & Cárdenas-Villarreal, V. M. (2012). Maternal perceptions on well child care. *Revista Latino-Americana de Enfermagem*, *20*(2), 274-281.

Furlong, M., & Wight, J. (2011). Promoting "critical awareness" and critiquing "cultural competence": Towards disrupting received professional knowledges. *Australian Social Work*, *64*(1), 38-54.

Garcia, R. J. (1995). Critical race theory and Proposition 187: The racial politics of immigration law. *Chicano-Latino Law Review*, *17*(118), 1-28.

Garcini, L. M., Murray, K. E., Zhou, A., Klonoff, E. A., Myers, M. G., & Elder, J. P. (2016). Mental health of undocumented immigrant adults in the United States: A systematic review of methodology and findings. *Journal of Immigrant & Refugee Studies*, *14*(1), 1-25.

Gelman, C. R. (2004). Empirically-based principles for culturally competent practice with Latinos. *Journal of Ethnic & Cultural Diversity in Social Work*, *13*(1), 83-108.

Glisson, C., & James, L. R. (2002). The cross-level effects of culture and climate in human service teams. *Journal of Organizational Behavior*, *23*(6), 767-794.

Green, A. E., Dishop, C. R., & Aarons, G. A. (2016). Organizational stress as moderator of relationship between mental health provider adaptability and organizational commitment. *Psychiatric Services*, *67*, 1103-1108.

Green, L. W. (2014). Closing the chasm between research and practice: Evidence of and for change. *Health Promotion Journal of Australia*, *25*, 25-29.

Healey, P., Stager, M. L., Woodmass, K., Dettlaff, A. J., Vergara, A., Janke, R., & Wells, S. J. (2017). Cultural adaptations to augment health and mental health services: A systematic review. *BMC Health Services Research*, *17*, 8.

Hernandez, M., Nesman, T., Mowery, D., Acevedo-Polakovich, I. D., & Callejas, L. M. (2009). Cultural competence: A literature review and conceptual model for mental health services. *Psychiatric Services*, *60*(8), 1046-1050.

Ho, J., Yeh, M., McCabe, K., & Hough, R. L. (2007). Parental cultural affiliation and youth mental health service use. *Journal of Youth and Adolescence*, *36*(4), 529-542.

Horevitz, E., Lawson, J., & Chow, J. C. (2013). Examining cultural competence in health care: Implications for social workers. *Health & Social Work*, *38*(3), 135-145.

Horevitz, E., & Organista, K. C. (2012). The Mexican health paradox: Expanding the explanatory power of the acculturation construct. *Hispanic Journal of Behavioral Sciences*, *35*(1), 3-34.

Horton, S. (2006). The double burden on safety net providers: Placing health disparities in the context of the privatization of health care in the U.S. *Social Science & Medicine, 63,* 2702-2714.

Hovey, J. D., & Magaña, C. (2000). Acculturative stress, anxiety, and depression among Mexican immigrant farmworkers in the Midwest United States. *Journal of Immigrant Health, 2*(3), 119-131.

Irizarry, J. (2011). En la lucha: The struggles and triumphs of Latino/a preservice teachers. *Teachers College Record, 113*(12), 2804-2835.

Ishikawa, R. Z., Cardemil, R. V., & Falmagne, R. J. (2010). Help seeking and help receiving for emotional distress among Latino men and women. *Qualitative Health Research, 20*(11), 1558-1572.

Jackson, K. F., & Samuels, G. M. (2011). Multiracial competence in social work: Recommendations for culturally attuned work with multiracial people. *Social Work, 56*(3), 235-245.

Jani, J. S., Ortiz, L., & Aranda, M. P. (2009). Latino outcome studies in social work: A review of the literature. *Research on Social Work Practice, 19*(2), 179-194.

Jani, J. S., Osteen, P., & Shipe, S. (2016). Cultural competence and social work education: Moving toward assessment of practice behaviors. *Journal of Social Work Education, 52*(3), 311-324.

Johnson, A. (2017, March 15). Trump's second travel ban blocked by Hawaii judge Derrick Watson. *NBC News*. Retrieved from http://www.nbcnews.com/news/us-news/federal-judge-hawaii-blocks-trump-s-revised-travel-order-n734141

Kaltman, S., Hurtado de Mendoza, A., Serrano, A., & Gonzales, F. A. (2016). A mental health intervention strategy for low-income, trauma-exposed Latina immigrants in primary care: A preliminary study. *American Journal of Orthopsychiatry, 86*(3), 345-354.

Kawulich, B. B. (2005). Participant observation as a data collection method. *Forum: Qualitative Social Research, 6*(2), 1-28.

Kelly, J. (2017a). *Enforcement of the immigration laws to serve the national interest* [Memorandum]. Washington, DC: U.S. Department of Homeland Security.

Kelly, J. (2017b). *Implementing the President's border security and immigration enforcement improvement policies.* [Memorandum]. Washington, DC: U.S. Department of Homeland Security.

Keyes, K. M., Martins, S. S., Hatzenbuehler, M. L., Blanco, C., Bates, L. M., & Hasin, D. S. (2012). Mental health service utilization for psychiatric disorders among Latinos living in the United States: The role of ethnic subgroup, ethnic identity, and language/social preferences. *Social Psychiatry and Psychiatric Epidemiology*, *47*, 383-394.

Kiang, L., Grzywacz, J. G., Marín, A. J., Arcury, T. A., & Quandt, S. A. (2010). Mental health in immigrants from nontraditional receiving sites. *Cultural Diversity and Ethnic Minority Psychology*, *16*(3), 386-394.

Kim, G., Aguado Loi, C. X., Chiriboga, D. A., Jang, Y., Parmelee, P., & Allen, R. S. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research, 45*, 104-110.

Koerin. B. (2003). The settlement house tradition: Current trends and future concerns. *The Journal of Sociology & Social Welfare*, *30*(2), 53-68.

Kopan, T. (2017, February 22). Trump admin sets stage for mass deportations. *CNN*. Retrieved from http://www.cnn.com/2017/02/21/politics/dhs-immigration-guidance-detentions/

Lagomasino, I. T., Dwight-Johnson, M., Miranda, J., Zhang, L., Liao, D., Duan, N., & Wells, K. B. (2005). Disparities in depression treatment for Latinos and site of care. *Psychiatric Services*, 56, 1517-1523.

Lee, E. Y. (2016). Poll: Americans' anti-immigrant attitudes are fueled by racism. Retrieved from https://thinkprogress.org/poll-americans-anti-immigrant-attitudes-are-fueled-by-racism-30968b83a908#.fnruhf93u

Lee, S., & Matejkowski, J. (2012). Mental health service utilization among noncitizens in the United States: Findings from the National Latino and Asian American study. *Administration and Policy in Mental Health and Mental Health Services Research, 39*, 406-418.

Lopez, G. I., Figueroa, M., Connor, S. E., & Maliski, S. L. (2008). Translation barriers in conducting qualitative research with Spanish speakers. *Qualitative Health Research, 18*(12), 1729-1737.

Manoleas, P. (2008). Integrated primary care and behavioral health services for Latinos: A blueprint and research agenda. *Social Work in Health Care, 47*(4), 438-454.

Martinez-Tyson, D., Arriola, N. B., & Corvin, J. (2016). Perceptions of depression and access to mental health care among Latino immigrants: Looking beyond one size fits all. *Qualitative Health Research, 26*(9), 1289-1302.

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine, 103*, 126-133.

Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology, 41*(7), 884-901.

Moore, L., & Savage, J. (2002). Participant observation, informed consent and ethical approval. *Nurse Researcher, 9,* 58-69.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications, Inc.

Ojeda, V. D., & McGuire, T. G. (2006). Gender and racial/ethnic differences in use of outpatient mental health and substance use services by depressed adults. *Psychiatric Quarterly, 77,* 211-222.

Olavarria, M., Beaulac, J., Bélanger, A., Young, M., & Aubry, T. (2009). Organizational cultural competence in community health and social service organizations: How to conduct a self-assessment. *Journal of Cultural Diversity*, *16*(4), 140-150.

Organista, K. C. (2009). New practice model for Latinos in need of social work services. *Social Work, 54*(4), 297-305.

Orland-Barak, L. (2002). The theoretical sensitivity of the researcher: Reflections on a complex construct. *Reflective Practice, 3*(3), 263-278.

Ortiz, D. V. (2012). Structuring mental health within senior services: A case study of an outpatient mental health clinic serving Latinos. *Journal of Gerontological Social Work, 55*(6), 503-518.

Owen, J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). 'No-show': Therapist racial/ethnic disparities in client unilateral termination. *Journal of Counseling Psychology, 59*(2), 314-320.

Perez, G., Della Valle, P., Paraghamian, S., Page, R., Ochoa, J., Palomo, F…Corbie-Smith, G. (2016). A community-engaged research approach to improve mental health among Latina immigrants: ALMA photovoice. *Health Promotion Practice*, *17*(3), 429-439.

Phipps, R. M., & Degges-White, S. (2014). A new look at transgenerational trauma transmission: Second-generation Latino immigrant youth. *Journal of Multicultural Counseling & Development, 42*, 174-187.

Piedra, L. M., & Byoun, S. J. (2012). Vida Alegre: Preliminary findings of a depression intervention for immigrant Latino mothers. *Research on Social Work Practice*, *22*(2), 138-150.

Prilleltensky, I. (2008). The role of power in wellness, oppression, and liberation: The promise of psychopolitical validity. *Journal of Community Psychology, 36*(2), 116-136.

Ramirez Garcia, J. I. (2012). Mental health care for Latino immigrants in the U.S.A. and the quest for global health inequities. *Psychosocial Intervention, 21*(3), 305-318.

Raymond-Flesch, M., Siemons, R., Pourat, N., Jacobs, K., & Brindis, C. D. (2014). "There is no help out there, and if there is, it's really hard to find": A qualitative study of the health concerns and health care access of Latino "DREAMers". *Journal of Adolescent Health, 55*, 323-328.

Roots to Wellness (2014). Mental health needs assessment. Retrieved from http://rootstowellness.org/home/resources/little-village-mental-health-needs-assessment/

Rosenbaum, S., Byrnes, M., Rothenberg, S., & Gunsalus, R. (2016). *Improving community health through hospital community benefit spending: Charting a path to reform*. Washington, DC: The George Washington University Milken Institute School of Public Health.

Rosenberg, J. P., & Yates, P. M. (2007). Schematic representation of case study research designs. *Journal of Advanced Nursing, 60*(4), 447-452.

Saint Anthony Hospital (n.d.). Community outreach. Retrieved from http://wwww.sahchicago.org/index.php/community-outreach

Salas, L. M., Ayón, C., & Gurrola, M. (2013). Estamos traumados: The effect of anti-immigrant sentiment and policies on the mental health of Mexican immigrant families. *Journal of Community Psychology, 41*(8), 1005-1020.

Santiago-Irizarry, V. (1996). Culture as cure. *Cultural Anthropology, 11*(1), 3-24.

Santiago-Rivera, A. L., Kanter, J. W., Busch, A. M., Rusch, L. C., Reyes, W…Runge, M. (2011). Latino immigrants with depression: An initial examination of treatment issues at a community clinic. *Journal of Immigrant and Minority Health, 13*, 772-779.

Shattell, M. M., Hamilton, D., Starr, S. S., Jenkins, C. J., & Hinderliter, N. A. (2008). Mental health service needs of a Latino population: A community-based participatory research project. *Issues in Mental Health Nursing, 29*, 351-370.

Shear, M., & Preston, J. (2015, February 17). Dealt setback, Obama puts off immigrant plan. *New York Times*. Retrieved from http://www.nytimes.com/2015/02/18/us/obama-Immigration-policy-halted-by-federal-judge-in-texas.html?emc=eta1&_r=1

Shobe, M. A., Coffman, M. J., & Dmochowski, J. (2009). Achieving the American Dream: Facilitators and barriers to health and mental health for Latino immigrants. *Journal of Evidence-Based Social Work, 6*, 92-110.

Silbert, J. H., & Timme, L. (2012). Neighborhood Centers' road to building vibrant communities across southeast Texas. *AI Practitioner*, *14*(1), 41-45.

Solórzano, D. G., & Yosso, T. J. (2002). Critical race methodology: Counter-storytelling as an analytical framework for education research. *Qualitative Inquiry*, *8*(1), 23-44.

Sperry, L. (2012). Cultural competence: A primer. *The Journal of Individual Psychology*, *68*(4), 310-320.

Stacciarini, J. R., Smith, R. F., Wiens, B., Pérez, A., Locke, B., & LaFlam, M. (2015*). I didn't ask to come to this country…I was a child*: The mental health implications of growing up undocumented. *Journal of Immigrant and Minority Health*, *17*, 1225-1230.

Statistical Atlas (2015). National origin in South Lawndale, Chicago, Illinois. Retrieved from http://statisticalatlas.com/neighborhood/Illinois/Chicago/South-Lawndale/National-Origin

Stein, G. L., Lee, C. S. N., Shi, P., Cook, B. L., Papajorgji-Taylor, D., Carson, N. J., & Alegría, M. (2014). Characteristics of community mental health clinics associated with treatment engagement. *Psychiatric Services*, *65*(8), 1020-1025.

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, *29*(6), 790-821.

Sullivan, M. M., & Rehm, R. (2005). Mental health of undocumented Mexican immigrants: A review of the literature. *Advances in Nursing Science*, *28*(3), 240-251.

Uttal, L. (2006). Organizational cultural competency: Shifting programs for Latino immigrants from a client-centered to a community-based orientation. *American Journal of Community Psychology*, *38*, 251-262.

Valdez, C. R., Padilla, B., Moore, S. M., & Magaña, S. (2013). Feasibility, acceptability, and preliminary outcomes of the Fortalezas Familiares intervention for Latino families facing maternal depression. *Family Process*, *52*(3), 394-410.

Wells, A., Lagomasino, I. T., Palinkas, L. A., Green, J. M., & Gonzalez, D. (2013). Barriers to depression treatment among low-income, Latino emergency department patients. *Community Mental Health Journal*, *49*, 412-418.

Whealin, J. M., & Ruzek, J. (2008). Program evaluation for organizational cultural competence in mental health practices. *Professional Psychology: Research and Practice*, *39*(3), 320-328.

Yan, M. C., & Sin, R. (2011). The resilience of the settlement-house tradition in community development: A study of neighborhood centers in San Francisco. *Community Development*, *42*(1), 106-124.

Yin, R. K. (2003). *Case study research: Designs and methods* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Zong, J., & Batalova, J. (2016). Frequently requested statistics on immigrants and immigration in the United States. Retrieved from http://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states

Zuniga, M. E. (2002). Latino immigrants: Patterns of survival. *Journal of Human Behavior in the Social Environment, 5*(3/4), 137-155.

# APPENDICES

# APPENDIX A

## INDIVIDUAL INTERVIEW GUIDES

Interview Guide A

English-Language Interview Guide: Service Providers

Introduction: Thank you for taking the time to participate in this interview. Please remember that your participation is completely voluntary, and you are free to take a break or stop the interview at any time. The interview is expected to last for about an hour to an hour and a half. I will be asking questions about your experience working at this program. Do you have any questions for me before we get started?

1) Please describe your experience working at this program. (Probes: What does your position entail? What does a typical day look like for you?)
2) How would you describe the services that are delivered here at the Little Village location?
3) Do you think culture plays a role in service delivery?
    a) If so, how would you describe its role?
4) What is most rewarding about your work?
5) What is most challenging about your work?
6) What stands out to you about this program?
7) How long have you been working at this program?
8) Have you had any other jobs in your field?
    a) If yes, how does this program compare to other places where you have worked?
9) a) How would you describe the program's values?
    b) What program values do you see reflected in your practice?

**APPENDIX A (continued)**

10) a) What specific requirements did you need to meet in order to be hired for your position here?

b) What type of training did you have prior to your employment?

c) What type of training did you receive after being hired?

11) What do you think is the experience of service participants coming to this program?

12) a) How easy or difficult do you think it is for service participants to access services here?

b)What makes it easy or difficult?

13) a) When service participants come to this program, what issues do they come in with?

b) What strategies are used to address these issues?

c) In your opinion, how helpful are these strategies?

14) Is there anything else people should know about this program?

Demographic questions: I am asking a few questions to learn more about the people I am interviewing. It is completely up to you whether you would like to answer these questions.

1) What is your position at this organization?
2) What degree do you hold?
3) How many years of experience do you have in your field of training?

Closing: Thank you so much for speaking with me today. The information that you provided is valuable to my study. If I have any questions after reviewing the information in your interview, may I contact you to discuss my questions?

**APPENDIX A (continued)**

If yes: Thank you, I really appreciate it. What is the best phone number for me to reach you at? May I leave a message at this number?

To assess interest in participating in member check: After I finish all my interviews, I am planning to check back with anyone who is willing to speak with me again to make sure that what I came up with in my analysis matches what people shared with me. Choosing to speak with me about what I found is completely voluntary, and I wouldn't be providing a $25 gift card like I did for our interview today. Would you like me to contact you in a few months to speak about what I learned from the interviews?

If yes: Thank you so much for your willingness to help with this. Would you prefer to speak with me about my analysis individually or with a group of other employees who work here?

What is the best phone number for me to reach you at? May I leave a message at this number?

**APPENDIX A (continued)**

Interview Guide B

Spanish-Language Interview Guide: Service Providers

Introduction: Gracias por tomarse el tiempo para participar en esta entrevista. Por favor recuerde que su participación es completamente voluntaria, y usted es libre de tomar un descanso o parar la entrevista en cualquier momento. Se espera que la entrevista va a durar alrededor de una hora a una hora y media. Estaré haciendo preguntas acerca de su experiencia trabajar en este programa. ¿Usted tiene alguna pregunta para mí antes de empezar?

1) Por favor describa su experiencia trabajar en este programa. (Probes: ¿En qué consiste su posición? ¿ Cómo es un día típico para usted?)
2) ¿Cómo describiría los servicios que se entregan aquí en el sitio de la Villita?
3) ¿Usted cree que la cultura juega un papel en la prestación de servicios?
   a) En caso afirmativo, ¿cómo describiría su papel?
4) ¿Qué es lo más gratificante de su trabajo?
5) ¿Qué es lo más difícil de su trabajo?
6) ¿Qué se destaca a usted acerca de este programa?
7) ¿Por cuánto tiempo ha estado trabajando en este programa?
8) ¿Ha tenido otro trabajo en su campo?
   a) En caso afirmativo, ¿cómo se compara este programa a otros lugares en que ha trabajado?
9) a) ¿Cómo describiría los valores del programa?
   b) ¿Cuales valores están reflejados en su práctica?

**APPENDIX A (continued)**

10) a) ¿Qué requisitos específicos tuvo que cumplir para ser contratado para su posición?

b) ¿Qué tipo de entrenamiento tenía antes de su empleo?

c) ¿Qué tipo de entrenamiento recibió usted después de ser contratado?

11) ¿Que cree usted es la experiencia de los participantes de servicios que vienen a este programa?

12) a) ¿Qué tan fácil o difícil cree que es para los participantes de servicios acceder a los servicios aquí?

b) ¿Qué hace que sea fácil o difícil?

13) a) Cuando los participantes de servicios vienen a este programa, ¿cuáles son sus necesidades?

b) ¿Cuales estrategias se usan para hacer frente a estas necesidades?

c) En su opinión, ¿son útiles estas estrategias?

14) ¿Hay alguna otra cosa que la gente debe saber acerca de este programa?

Demographic questions: Estoy haciendo unas pocas preguntas para aprender un poco más acerca de las personas que estoy entrevistando. Es totalmente de usted si desea responder a estas preguntas.

1) ¿Cuál es su posición en esta organización?
2) ¿Qué es su título/grado?
3) ¿Cuántos años de experiencia tiene en su campo de entrenamiento?

**APPENDIX A (continued)**

Closing: Muchas gracias por hablar conmigo hoy. La información que ha proporcionado es valioso a mi estudio. Si tengo alguna pregunta después de revisar la información en su entrevista, ¿puedo contactarlo a usted para hablar sobre mis preguntas?

En caso afirmativo: Gracias, se lo agradezco mucho. ¿Cuál es el mejor número de teléfono para que lo contacte? ¿Puedo dejar un mensaje en este número?

To assess interest in participating in member check: Después de que termine mis entrevistas, estoy planeando chequear con los quienes están dispuestos a hablar conmigo de nuevo para asegurarse de que la información en mi análisis coincide con lo que las personas compartían conmigo. Escoger hablar conmigo sobre lo que encontré es completamente voluntaria, y para la segunda entrevista, yo no estaría proporcionando una tarjeta de regalo de $25 como lo hice para nuestra entrevista hoy. ¿Le gustaría que yo lo contacte a usted dentro de algunos meses para hablar de lo que aprendí de las entrevistas?

En caso afirmativo: Muchas gracias por su voluntad de ayudar con esto. ¿Prefiere hablar conmigo sobre mi análisis individualmente o con un grupo de otros empleados que trabajan aquí?

¿Cuál es el mejor número de teléfono para que lo contacte? ¿Puedo dejar un mensaje en este número?

**APPENDIX A (continued)**

Interview Guide C

English-Language Interview Guide: Service Participants

Introduction: Thank you for taking the time to participate in this interview. Please remember that your participation is completely voluntary, and you are free to take a break or stop the interview at any time. The interview is expected to last for about an hour to an hour and a half. I will be asking questions about your experience coming to this program. Do you have any questions for me before we get started?

1) Please describe your experience coming to this program. (Probes: Please note that I am not asking about your personal reasons for seeking services, but instead am asking what the place and people there are like. For example, how did you feel when you went there for the first time? What makes you keep going back?)
2) a) How easy or difficult is it to come to appointments at the program?

   b) What makes it easy or difficult?
3) How would you describe what the services are like to someone who has never been to the program?
4) What do you think are some of the reasons that people come to this program?
5) a) How have the services at the program been helpful?

   b) What hasn't been helpful about the services there?
6) I am asking this next question to learn more about how this program is similar to or different from other programs. Have you ever received mental health services with another agency?

   If no:

**APPENDIX A (continued)**

a) What did you expect when you came to this program?

b) How is the program similar to what you expected?

c) How is the program different from what you expected?

If yes:

a) How is your experience at this program similar to your past experiences at other agencies?

b) How is your experience at this program different from your past experiences at other agencies?

7) a) How would you describe your culture?

b) Does this program recognize your culture?

c) If yes, how?

8) What would you like to be different about the services at this program?

9) Is there anything else you think people should know about this program?

Demographic questions: I am asking a few questions to learn a bit more about the people I am interviewing and to make sure that I speak with people from many different backgrounds. This information is only to help me with my research, and it is completely up to you whether you would like to answer these questions.

1) Can you tell me about your experience as an immigrant? (Probe: Can you tell me how being an immigrant affects your experience when you want to access health or social services?)

2) What is your gender?

3) What is your age?

**APPENDIX A (continued)**

4) What country were you born in?
5) How long have you lived in the U.S?

Closing: Thank you so much for speaking with me today. The information that you provided is valuable to my study. If I have any questions after reviewing the information in your interview, may I contact you to discuss my questions?

If yes: Thank you, I really appreciate it. You may provide your real first name or you can make up a first name for me to use when I contact you. Can you provide me with the name you would like to be called by for all future correspondence?

Can you provide a telephone number where I can reach you? May I leave a message at this number?

To assess interest in participating in member check: After I finish my interviews, I am planning to check back with anyone who is willing to speak with me again to make sure that what I came up with in my analysis matches what people shared with me. Choosing to speak with me about what I found is completely voluntary, and I wouldn't be providing a $25 gift card like I did for our interview today. Would you like me to contact you in a few months to speak about what I learned from the interviews?

If yes: Thank you so much for your willingness to help with this. Would you prefer to speak with me about my analysis individually or with a group of other people who receive services at this organization?

What is the best phone number for me to reach you at? May I leave a message at this number?

**APPENDIX A (continued)**

Interview Guide D

Spanish-Language Interview Guide: Service Participants

Introduction: Gracias por tomarse el tiempo para participar en esta entrevista. Por favor recuerde que su participación es completamente voluntaria, y usted es libre de tomar un descanso o parar la entrevista en cualquier momento. Se espera que la entrevista va a durar alrededor de una hora a una hora y media. Estaré haciendo preguntas acerca de su experiencia venir a este programa. ¿Usted tiene alguna pregunta para mí antes de empezar?

1) Por favor describa su experiencia venir a este programa. (Probes: Por favor note que no estoy preguntando sobre sus razones personales para pedir los servicios, sino que estoy preguntando sobre el lugar y la gente allí. Por ejemplo, ¿cómo se sintió cuando fue allí por la primera vez? ¿Qué es lo que le hace seguir asistiendo?)

2) a) ¿Qué tan fácil o difícil es venir a citas en el programa?

b) ¿Qué hace que sea fácil o difícil?

3) ¿Cómo describiría usted los servicios a alguien quien nunca ha venido al programa?

4) ¿Qué piensa usted que son algunas de las razones por las que la gente viene a este programa?

5) a) ¿Cómo han sido útiles los servicios en el programa? (Probe: ¿Cómo le han servido los servicios en el programa?)

b) ¿Qué no ha sido útil sobre los servicios allí? (Probe: ¿Cómo no le han servido los servicios allí?)

6) Estoy haciendo esta siguiente pregunta para aprender más sobre cómo este programa es similar a o diferente de otros programas. ¿Alguna vez ha recibido servicios de salud mental con otra agencia?

**APPENDIX A (continued)**

Si no:

a) ¿Qué esperaba cuando vino a este programa?

b) ¿Cómo es el programa similar a lo que esperaba?

c) ¿Cómo es el programa diferente de lo que esperaba?

En caso afirmativo:

a) ¿Cómo es su experiencia en este programa similar a sus experiencias anteriores en otras agencias? (Probe: ¿Cómo es su experiencia en este programa parecida a sus experiencias anteriores en otras agencias?)

b) ¿Cómo es su experiencia en este programa diferente de sus experiencias anteriores en otras agencias?

7) a) ¿Cómo describiría su cultura?

b) ¿Este programa reconoce su cultura?

c) En caso afirmativo, ¿cómo?

8) ¿Qué le gustaría que sea diferente acerca de los servicios en este programa?

9) ¿Hay alguna otra cosa piensa usted que la gente debe saber acerca de este programa?

Demographic questions: Estoy haciendo unas pocas preguntas para aprender un poco más acerca de las personas que estoy entrevistando y para asegurarse de que hablo con muchas personas diferentes. Esta información es sólo para que me ayude con mi investigación, y es totalmente de usted si desea responder a estas preguntas.

1) ¿Me puede hablar sobre su experiencia como inmigrante? (Probe: ¿Puede usted decirme cómo ser un inmigrante afecta su experiencia cuando se quiere recibir servicios de salud o servicios sociales?)

**APPENDIX A (continued)**

2) ¿Cuál es su sexo?

3) ¿Cuál es su edad?

4) ¿En qué país nació usted?

5) ¿Por cuánto tiempo ha vivido usted en los Estados Unidos?

Closing: Muchas gracias por hablar conmigo hoy. La información que ha proporcionado es valioso a mi estudio. Si tengo alguna pregunta después de revisar la información en su entrevista, ¿puedo contactarlo a usted para hablar sobre mis preguntas?

En caso afirmativo: Gracias, se lo agradezco mucho. Usted puede proporcionar su nombre o usted puede inventar un nombre para mí usar cuando lo contacto a usted. ¿Me puede proporcionar el nombre que le gustaría ser llamado para toda la correspondencia futura? ¿Puede proporcionar un número de teléfono donde pueda contactarlo a usted? ¿Puedo dejar un mensaje en este número?

To assess interest in participating in member check: Después de que termine mis entrevistas, estoy planeando chequear con los quienes están dispuestos a hablar conmigo de nuevo para asegurarse de que la información en mi análisis coincide con lo que las personas compartían conmigo. Escoger hablar conmigo sobre lo que encontré es completamente voluntaria, y para la segunda entrevista, yo no estaría proporcionando una tarjeta de regalo de $25 como lo hice para nuestra entrevista hoy. ¿Le gustaría que yo lo contacte a usted dentro de algunos meses para hablar de lo que aprendí de las entrevistas?

**APPENDIX A (continued)**

En caso afirmativo: Muchas gracias por su voluntad de ayudar con esto. ¿Prefiere hablar conmigo sobre mi análisis individualmente o con un grupo de otras personas quienes reciben servicios en esta organización?

¿Cuál es el mejor número de teléfono para que lo contacte? ¿Puedo dejar un mensaje en este número?

# APPENDIX B

## MEMBER CHECK INTERVIEW GUIDES

Member Check Interview Guide A

English-Language Guide: Individual Member Check Interviews (to be used with both service providers and service participants)

Introduction: Thank you for taking the time to speak with me about my findings today. Your decision to speak with me is completely voluntary, and I won't be providing a $25 gift card like I did at our last interview. Do you have any questions for me before we get started?

1) Here are the themes that have come up during my analysis: _____ (the PI will provide a brief oral summary of her findings).
2) Do you have any questions about these themes?
3) Do these themes capture your experience at the agency?

   If yes:

   a) Is there any other feedback about my findings that you would like to share?

   If no:

   a) What aspects of your experience are missing from my findings?
   b) Is there any other feedback about my findings that you would like to share?

Closing: Thank you so much for speaking with me again today. The information that you provided is valuable to my research and has helped to ensure the accuracy of my analysis. I really appreciate all of the time that you have invested in this study.

**APPENDIX B (continued)**

Member Check Interview Guide B

Spanish-Language Guide: Individual Member Check Interviews (to be used with both service providers and service participants)

Introduction: Gracias por tomarse el tiempo para hablar conmigo sobre los resultados de mi investigación hoy. Su decisión de hablar conmigo es completamente voluntaria, y no estaré proporcionando una tarjeta de regalo de $25 como lo hice en nuestra última entrevista. ¿Tiene alguna pregunta para mí antes de empezar?

1) Aquí están los temas que han surgido durante mi análisis: _____ (la IP proporciona un breve resumen oral de sus resultados).

2) ¿Tiene alguna pregunta sobre estos temas?

3) ¿Estos temas capturan su experiencia en la agencia?

En caso afirmativo:

a) ¿Hay algún otro comentario acerca de mis resultados que le gustaría compartir?

Si no:

a) ¿Cuáles aspectos de su experiencia no están capturados en mis resultados?

b) ¿Hay algún otro comentario acerca de mis resultados que le gustaría compartir?

Closing: Muchas gracias por hablar conmigo de nuevo hoy. La información que proporcionó es valioso a mi investigación y ha ayudado a asegurar la exactitud de mi análisis. Realmente aprecio todo el tiempo que usted ha dedicado a este estudio.

**APPENDIX B (continued)**

Member Check Interview Guide C

English-Language Guide: Group Member Check Interviews (to be used with both service providers and service participants)

Introduction: Thank you for taking the time to speak with me about my findings today. Your decision to speak with me is completely voluntary, and I won't be providing a $25 gift card like I did at our last interview. I would also like to ask that everyone please respect the privacy of all who are here. To make sure that we respect each other's privacy, please do not discuss who is present today and the content of what is discussed outside of this meeting. Does anyone have any questions before we get started?

1) Here are the themes that have come up during my analysis: _____ (the PI will provide a brief oral summary of her findings).
2) Are there any questions about these themes?
3) Do these themes capture your experience at the agency?

   If yes:

   a) Is there any other feedback about my findings that you would like to share?

   If no:

   a) What aspects of your experience are missing from my findings?
   b) Is there any other feedback about my findings that you would like to share?

Closing: Thank you so much for speaking with me again today. The information that you provided is valuable to my research and has helped to ensure the accuracy of my analysis. I really appreciate all of the time that you have invested in this study.

**APPENDIX B (continued)**

Member Check Interview Guide D

Spanish-Language Guide: Group Member Check Interviews (to be used with both service providers and service participants)

Introduction: Gracias por tomarse el tiempo para hablar conmigo sobre los resultados de mi investigación hoy. Su decisión de hablar conmigo es completamente voluntaria, y no estaré proporcionando una tarjeta de regalo de $25 como lo hice en nuestra última entrevista. También me gustaría pedir que todo el mundo por favor respete la privacidad de todos quienes están aquí. Para asegurarse de que respetamos la privacidad de cada uno, por favor no hablen sobre quien está presente hoy y sobre el contenido de lo que se habla fuera de esta reunión. ¿Alguien tiene alguna pregunta antes de empezar?

1) Aquí están los temas que han surgido durante mi análisis: _____ (la IP proporciona un breve resumen oral de sus resultados).
2) ¿Hay alguna pregunta sobre estos temas?
3) ¿Estos temas capturan su experiencia en la agencia?

En caso afirmativo:

a) ¿Hay algún otro comentario acerca de mis resultados que les gustaría compartir?

Si no:

a) ¿Cuáles aspectos de su experiencia no están capturados en mis resultados?

b) ¿Hay algún otro comentario acerca de mis resultados que les gustaría compartir?

**APPENDIX B (continued)**

Closing: Muchas gracias por hablar conmigo de nuevo hoy. La información que proporcionaron es valioso a mi investigación y ha ayudado a asegurar la exactitud de mi análisis. Realmente aprecio todo el tiempo que ustedes han dedicado a este estudio.

Leave box empty - For office use only

## APPENDIX C

## SERVICE PROVIDER INFORMED CONSENT FORM

Informed Consent Form A: English-Language Form

**University of Illinois at Chicago**
**Research Information and Consent for Participation in Social Behavioral Research**
**Culturally Competent Mental Health Practice: A Case Study of an Organization Serving Latino Immigrants**

You are being asked to participate in a research study. Researchers are required to provide a consent form such as this one to tell you about the research, to explain that taking part is voluntary, to describe the risks and benefits of participation, and to help you to make an informed decision. You should feel free to ask the researchers any questions you may have.

Principal Investigator Name and Title: Caitlin O'Grady, PhD Candidate
Department and Institution: Jane Addams College of Social Work, University of Illinois at Chicago
Address and Contact Information: 1040 West Harrison St., Chicago, Il, 60607, 413-281-7517

**Why am I being asked?**

You are being asked to be a subject in a research study about service delivery at the Little Village location of Saint Anthony Hospital's Community Wellness Program. The aim of the study is to learn more about what program services are like and how they are carried out from the perspectives of both service providers and service participants.

You have been asked to participate in the research because you are a service provider at this program.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future dealings with the University of Illinois at Chicago, and it will not affect your relationship with your employer in any way. **If you decide to participate, you are free to withdraw at any time without affecting your relationship with the university or with your employer.**

**APPENDIX C (continued)**

Approximately 35 subjects may be involved in this research at UIC.

**What is the purpose of this research?**

The researcher is trying to learn more about how service providers and service participants describe services at the Community Wellness Program and how they experience service delivery. The researcher is also trying to learn more about the mental health needs of community members accessing services and how the program addresses these needs.

**What procedures are involved?**

This research will be performed at the Little Village location of the Community Wellness Program or at another community setting of your choice.

You will need to come to the study site once for an individual interview over the next nine months. If you are interested in helping the researcher check the accuracy of her findings, you will also be invited to come to the study site a second time for a member check interview.

The individual interview will take about one to one and a half hours. If you choose to take part in a member check, this member check interview will last no longer than one hour.

The study procedures are one individual interview expected to last between one and one and a half hours. During this individual interview, the researcher will be asking questions about your experience working at this program and how you would describe what services are like. The interview will be audio recorded. You may choose to conduct the interview either in your private office at the Little Village location of the Community Wellness Program or at another community setting of your preference, depending on where you feel most comfortable.

At the conclusion of the individual interview, you will be asked if you are interested in meeting with the researcher again after she has finished all of her interviews to make sure that what she came up with in her analysis matches your own experience. Choosing to speak with the researcher about her findings is completely voluntary. If you state that you are interested in participating in this member check interview, then she will contact you after she has finished all of her individual interviews to schedule a time to meet. You will be able to choose whether you would like to participate in this member check interview individually or in a group setting with others who work at this program.

**What are the potential risks and discomforts?**

To the best of the researcher's knowledge, your participation in this study has no more risk of harm than you would experience in everyday life. One possible risk of this research is a loss of privacy (revealing to others that you are taking part in this study), as it is possible that others may see you interacting with the researcher if you choose to take part in the individual interview at the Little Village location of the Community Wellness Program. It is also possible that other employees may learn that you participated in an interview if you choose to take part in a group

**APPENDIX C (continued)**

member check. For this reason, you have the option of participating in the member check interview individually in order to protect your privacy.
It is also possible that you may be concerned about being reprimanded if you say something negative about the program during your interview. In order to protect against this risk, the researcher will take measures to ensure that the findings presented in her published work cannot be linked to specific individuals. If the researcher presents a quote from your interview in her published work, she will ensure that your identity and position at the program cannot be discovered based on the content of the quote. In addition, the researcher will not disclose to others whether you chose to participate in the study, and your decision about whether to participate will not impact your job security in any way.

**Are there benefits to taking part in the research?**

This study is not designed to benefit you directly. This study is designed to learn more about mental health practice with Latino immigrants. The study results may be used to help other people in the future.

**What other options are there?**

You have the option to not participate in this study.

**What about privacy and confidentiality?**

The people who will know that you are a research subject are the principal investigator and her faculty advisor, and if you choose to speak with the researcher about her findings in a group setting after she has completed all individual interviews, other service providers present in the group setting will also learn that you participated in the study. It is also possible that your co-workers at the Community Wellness Program may learn that you are participating in this research if they see you interacting with the researcher. Otherwise information about you will only be disclosed to others with your written permission, or if necessary to protect your rights or welfare or if required by law.

Study information which identifies you and the consent form signed by you will be looked at and/or copied for checking up on the research by: The University of Illinois at Chicago's Office for the Protection of Research Subjects and/or state of Illinois auditors.

A possible risk of the research is that your participation in the research or information about you might become known to individuals outside the research. To protect against this risk, the researcher will take measures to securely store all information that is gathered. While your interview will be audio recorded, the audio file from the interview will be transferred from the audio recorder to a password-protected flash drive to which only the researcher has the password. The file on the audio recorder will then be deleted. In addition, while the researcher will use a transcription service to create a written transcript of your interview, your identifying information will not be shared with the transcription service. Furthermore, the audio file from your interview will be shared with the transcription service through a secure network server.

**APPENDIX C (continued)**

When the researcher receives the written transcript of your interview from the transcription service, she will save the document on the same password-protected flash drive as the audio file. You will not be identified by name in the written transcript. The researcher will assign a numeric code to your transcript and will create a master list that links your name and telephone number to your assigned numeric code. This master list will be saved on a separate password-protected flash drive to which only the researcher has the password. The researcher is only creating this link so that she can follow-up with you if she has any questions about the information you provided during your interview. Once the researcher has reviewed the information from your interview and has either contacted you or determined that no follow-up is necessary, the link will be destroyed.

When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity.

In addition, if you choose to take part in a group member check, please note that although we ask everyone in the group to respect everyone's privacy and confidentiality, and not to identify anyone in the group or repeat what is said during the group discussion, confidentiality in a group discussion cannot be guaranteed and other participants in the group may accidentally disclose what was said. If you would like to speak with the researcher about her findings and are concerned about doing so in a group setting, you will have the option of participating in an individual member check.

**What are the costs for participating in this research?**

There are no costs to you for participating in this research.

**Will I be reimbursed for any of my expenses or paid for my participation in this research?**

You will receive a $25 gift card to Pete's Fresh Market for your participation in the individual interview. If you do not finish the interview, you will still be compensated. You will receive your compensation immediately before starting your interview.

**Can I withdraw or be removed from the study?**

If you decide to participate, you are free to withdraw your consent and discontinue participation at any time. If you choose not to complete the individual interview, please notify the researcher during the interview when you wish to stop and the researcher will end the interview.

The Researchers also have the right to stop your participation in this study without your consent if: They believe it is in your best interests.

In the event you withdraw or are asked to leave the study, you will still be compensated as described above.

**APPENDIX C (continued)**

**Who should I contact if I have questions?**

Contact the researchers Caitlin O'Grady, PhD Candidate or Cassandra McKay-Jackson, Associate Professor at 413-281-7517 or 312-355-2280 or cograd5@uic.edu or cmckay@uic.edu:

- if you have any questions about this study or your part in it,
  if you have questions, concerns or complaints about the research.

**What are my rights as a research subject?**

If you feel you have not been treated according to the descriptions in this form, or if you have any questions about your rights as a research subject, including questions, concerns, complaints, or to offer input, you may call the Office for the Protection of Research Subjects (OPRS) at 312-996-1711 or 1-866-789-6215 (toll-free) or e-mail OPRS at uicirb@uic.edu.

**Remember**:

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

**Signature of Subject**

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research. I will be given a copy of this signed and dated form.

_____ _____

Signature Date

_____

Printed Name

_____ _____

Signature of Person Obtaining Consent Date (must be same as subject's)

_____

Printed Name of Person Obtaining Consent

Leave box empty - For office use only

**APPENDIX C (continued)**

Informed Consent Form B: Spanish-Language Form

**Universidad de Illinois en Chicago**
**Información y Consentimiento para Participación en el Estudio de Investigación de Conducta Social**
**Práctica Culturalmente Competente de La Salud Mental: Un Estudio de Caso de Una Organización Que Sirve Los Inmigrantes Latinos**

Se le ha pedido participar en un estudio de investigación. Los investigadores están obligados proveerle un formulario de consentimiento como este para explicarle lo que consiste el estudio de investigación, que participación es voluntaria, describir los riesgos y ventajas de participar, y ayudarle a tomar una decisión informada. Con confianza, consulte con las investigadores cualquier pregunta que tenga.

Nombre y Título de la Investigadora Principal: Caitlin O'Grady, Candidata al Doctorado
Departamento y Institución: Escuela de Trabajo Social Jane Addams, Universidad de Illinois en Chicago
Domicilio e Información de Contacto: 1040 West Harrison St., Chicago, Il, 60607, 413-281-7517

**¿Por qué se me pide participar?**

Se le está pidiendo ser un sujeto en un estudio de investigación sobre la prestación de servicios en la oficina de la Villita del Programa de Bienestar de la Comunidad de Saint Anthony Hospital. El objetivo del estudio es aprender más sobre cómo son los servicios del programa y cómo se llevan a cabo desde las perspectivas de ambos los proveedores de servicios y los participantes de servicios.

Se le ha pedido participar en la investigación porque usted es un proveedor de servicios en este programa.

Su participación en esta investigación es voluntaria. Su decisión de participar o no, no afectará sus relaciones actuales o futuras con la Universidad de Illinois en Chicago, ni afectará su relacion

**APPENDIX C (continued)**

con su empleador de ninguna manera. **Si usted decide participar, tiene opción de cancelar en cualquier momento sin afectar su relación con la universidad o con su empleador.**

Aproximadamente 35 sujetos pueden estar involucrados en esta investigación de la UIC.

**¿Cuál es el objetivo de esta investigación?**

La investigadora está tratando de aprender más sobre cómo los proveedores de servicios y los participantes de servicios describen los servicios en el Programa de Bienestar de la Comunidad y la forma en que experimentan la prestación de servicios.

La investigadora también está tratando de aprender más sobre las necesidades de salud mental de miembros de la comunidad quienes acceden a servicios y cómo el programa aborda estas necesidades.

**¿Qué procedimientos están involucrados?**

Esta investigación se llevará a cabo en la oficina de la Villita del Programa de Bienestar de la Comunidad o en otro entorno de la comunidad de su elección.

Usted tendrá que llegar al sitio de estudio una vez para una entrevista individual en los próximos nueve meses. Si usted está interesado en ayudar a la investigadora a comprobar la exactitud de sus resultados, también será invitado a venir al sitio de estudio por segunda vez para una entrevista de verificación de miembro.

La entrevista individual se prevee tendrá de una hora a hora y media de duración. Si decide participar en una verificación de miembro, esta entrevista no durará más de una hora.

Los procedimientos de este estudio incluyen una entrevista individual que se prevee tendrá de una hora a hora y media de duración. Durante esta entrevista individual, la investigadora estará haciendo preguntas sobre su experiencia trabajar en este programa y cómo describiría usted los servicios. La entrevista será audio grabada. Usted puede optar por hacer la entrevista en su oficina privada en el sitio de la Villita del Programa de Bienestar de la Comunidad o en otro entorno de la comunidad de su preferencia, según el lugar donde se siente más cómodo.

Al final de la entrevista individual, se le preguntará si usted está interesado en reunirse con la investigadora de nuevo después de que ella haya terminado con todas las entrevistas para asegurarse de que lo que ella aprendió de su investigación coincide con la propia experiencia de usted. Elegir hablar con la investigadora sobre los resultados de su investigación es completamente voluntario. Si usted indica que está interesado en hablar con la investigadora sobre los resultados de su investigación, ella se pondrá en contacto con usted después de que ella haya terminado con todas las entrevistas para programar una cita para reunirse. Usted podrá

**APPENDIX C (continued)**

elegir si desea hablar con la investigadora sobre sus resultados en forma individual o en un grupo con otros que trabajan en este programa.

**¿Cuáles son los riesgos y molestias potenciales?**

Al mejor del conocimiento de la investigadora, las cosas que va a hacer no tienen más riesgo de daño de lo que experiencia en la vida diaria. Un riesgo de esta investigación es la pérdida de la privacidad (revelando a otros que usted está tomando parte en este estudio), porque es posible que los demás puedan observar a usted interactuando con la investigadora si decide participar en la entrevista individual en la oficina de la Villita del Programa de Bienestar de la Comunidad. También es posible que otros empleados puedan aprender que usted participó en una entrevista si decide participar en una verificación de miembro de grupo. Por esta razón, usted tiene la opción de participar en la verificación de miembro de forma individual para proteger su privacidad.

También es posible que usted pueda estar preocupado por ser reprendido si usted dice algo negativo sobre el programa durante su entrevista. Para protegerse contra este riesgo, la investigadora tomará medidas para asegurar que los resultados presentados en su obra publicada no pueden estar vinculados a individuos específicos. Si la investigadora presenta una cita de su entrevista en su obra publicada, ella se asegurará que su identidad y posición en el programa no pueden ser descubiertas basado en el contenido de la cita. Además, la investigadora no revelará a otros si usted ha elegido participar en el estudio, y su decisión de participar no afectará su seguridad en el empleo de ninguna manera.

**¿Hay beneficios de tomar parte en la investigación?**

Este estudio no está diseñado para beneficiar a usted directamente. Este estudio está diseñado para aprender más acerca de los servicios para los inmigrantes latinos. Los resultados del estudio pueden ser utilizados para ayudar a otras personas en el futuro.

**¿Qué otras opciones existen?**

Usted tiene la opción de no participar en este estudio.

**¿Qué pasa con la privacidad y la confidencialidad?**

Las personas que sabrán que usted es sujeto de investigación son la investigadora principal y su consejera de la facultad, y si usted decide hablar con la investigadora acerca de sus resultados en un ambiente de grupo después de que ella se haya completado todas las entrevistas individuales, otros proveedores de servicios presentes en el ambiente de grupo también aprenderán que usted participó en el estudio. También es posible que sus compañeros de trabajo en el Programa de Bienestar de la Comunidad puedan saber que usted está participando en esta investigación si observan a usted interactuando con la investigadora. Afuera de estos casos, la información sobre usted no será compartida con otros sin su autorización por escrito, o si necesario, para proteger sus derechos o el bienestar o si es requerido por la ley.

**APPENDIX C (continued)**

Información del estudio que le identificara individualmente y el formulario de consentimiento firmado por usted serán examinados o copiados para analizar la investigación por: la Oficina para la Protección los Sujetos de Investigación de la Universidad de Illinois en Chicago y/o los auditores del estado de Illinois.

Un posible riesgo de la investigación es que su participación en la investigación o información sobre usted podría ser conocida a personas ajenas a la investigación. Para protegerse contra este riesgo, la investigadora tomará medidas para almacenar de forma segura toda la información que se recopila. Mientras que su entrevista será grabada de audio, el archivo de audio de la entrevista será transferido de la grabadora de audio a una unidad flash protegida por contraseña de que sólo la investigadora tiene la contraseña. A continuación, se elimina el archivo de la grabadora de audio. Además, mientras que la investigadora va a utilizar un servicio de transcripción para crear una transcripción escrita de su entrevista, su información de identificación no será compartida con el servicio de transcripción. Además, el archivo de audio de la entrevista será compartida con el servicio de transcripción a través de un servidor de red seguro. Cuando la investigadora recibe la transcripción escrita de su entrevista del servicio de transcripción, ella se guardará el documento en la misma unidad flash protegida por contraseña en que está guardado el archivo de audio. Usted no será identificado por su nombre en la transcripción escrita. La investigadora asignará un código numérico para su transcripción y creará una lista principal que une su nombre y número de teléfono de su código numérico asignado. Esta lista maestra se guarda en una distinta unidad flash protegida por contraseña de que sólo la investigadora tiene la contraseña. La investigadora está haciendo este enlace solamente para que ella pueda ponerse en contacto con usted si ella tiene alguna pregunta sobre la información que proporcionó durante su entrevista. Cuando la investigadora ha revisado la información de su entrevista y ha puesto en contacto con usted o determinado que una llamada de seguida no es necesario, el enlace será destruido.

Cuando los resultados de la investigación sean publicados o discutidos en las conferencias, no se incluirá información que pueda revelar su identidad.

Además, si elige participar en una verificación de miembro de grupo, por favor se nota que aunque pedimos a todos en el grupo de respetar la privacidad y confidencialidad de todos, y no identificar a nadie en el grupo o repetir lo que se dijo durante la discusión del grupo, la confidencialidad en una discusión de grupo no se puede garantizar y otros participantes en el grupo pueden accidentalmente revelar lo que se dijo. Si a usted le gustaría hablar con la investigadora sobre sus resultados pero se preocupa por hacerlo en un ambiente de grupo, entonces usted tiene la opción de participar en una verificación de miembro de forma individual.

**¿Cuáles son los costos para participar en esta investigación?**

No hay costos para usted por participar en esta investigación.

**APPENDIX C (continued)**

**¿Me reembolsarán por cualquiera de mis gastos o me pagarán por mi participación en esta investigación?**

Usted recibirá una tarjeta de regalo de $25 de Pete's Fresh Market por su participación en la entrevista individual. Si usted no termina con la entrevista, usted igual será compensado. Usted recibirá su compensación inmediatamente antes de empezar su entrevista.

**¿Puedo retirarme o ser eliminado del estudio?**

Si usted decide participar, es libre de retirar su consentimiento y discontinuar participación en cualquier momento. Si decide no completar la entrevista individual, por favor notifique a la investigadora durante la entrevista cuando se desea parar y la investigadora va a terminar la entrevista.

Las investigadoras también tienen el derecho de cancelar su participación en este estudio sin su consentimiento si: ellas creen que es en su mejor interés.

En el caso de que usted se retire o se le pide dejar el estudio, usted todavía será compensado como se describió anteriormente.

**¿A quién debo contactar si tengo preguntas?**

Póngase en contacto con las investigadoras Caitlin O'Grady, Candidata al Doctorado o Cassandra McKay-Jackson, Profesora Asociada al 413-281-7517 o 312-355-2280 o por correo electrónico a cograd5@uic.edu o cmckay@uic.edu:

- si tiene alguna pregunta acerca de este estudio o su participación en él,
  si tiene preguntas, inquietudes o quejas sobre la investigación.

**¿Cuáles son mis derechos como sujeto de investigación?**

Si usted siente que no ha sido tratado de acuerdo con las descripciones en este formulario, o si tiene alguna pregunta sobre sus derechos como sujeto de investigación, incluyendo preguntas, preocupaciones, quejas, o para ofrecer de entrada, puede llamar a la Oficina para la Protección los Sujetos de Investigación (OPRS) al 312-996-1711 o 1-866-789-6215 OPRS (llamada gratis) o por correo electrónico al uicirb@uic.edu.

**Recuerde:**

Su participación en esta investigación es voluntaria. Su decisión sobre su participacion no afectará sus relaciones actuales o futuras con la Universidad. Si decide participar, usted es libre de retirarse en cualquier momento sin afectar dicha relación.

**APPENDIX C (continued)**

**Firma del Sujeto**

He leído (o alguien me ha leído) la información anterior. Se me ha dado la oportunidad de hacer preguntas y mis preguntas han sido contestadas a mi satisfacción. Estoy de acuerdo en participar en esta investigación. Se me dará una copia de este formulario firmado y fechado.

_____ _____

Firma Fecha

_____

Nombre—en Letra Impresa

_____ _____

Firma de la persona que obtiene el consentimiento Fecha (debe ser igual que del sujeto)

_____

Nombre de la persona que obtiene el consentimiento—en Letra Impresa

Leave box empty - For office use only

## APPENDIX D

## SUBJECT INFORMATION SHEET

Subject Information Sheet A: English-Language Form

### SUBJECT INFORMATION SHEET

University of Illinois at Chicago
Culturally Competent Mental Health Practice: A Case Study of an Organization Serving Latino Immigrants

**What is the purpose of this research?**
You are being asked to participate in a research study about the services provided at Saint Anthony Hospital's Community Wellness Program. Caitlin O'Grady, PhD Candidate at the Jane Addams College of Social Work at the University of Illinois at Chicago, is conducting this research to learn more about what services are like and how they are carried out from the perspectives of both those who provide services and those who receive program services.

**Why am I being asked?**
You are eligible to participate in this study because you receive services through the Community Wellness Program. Your participation in this research is voluntary. Your decision to participate will not affect your current or future relations with the University of Illinois at Chicago, and it will not affect your receipt of program services in any way.

**What procedures are involved?**
The procedures for this study include one individual interview expected to last between an hour and an hour and a half. During this individual interview, the researcher will be asking questions about what services at this program are like. The interview will be audio recorded.

At the end of the individual interview, you will be asked if you are interested in meeting with the researcher again after she has finished all of her interviews to make sure that what she learned from her research matches your own experience. Choosing to speak with the researcher about her findings is completely voluntary. If you state that you are interested in speaking with the researcher about her findings, then she will contact you after she has finished all of her

**APPENDIX D (continued)**

interviews to schedule a time to meet. You will be able to choose whether you would like to speak with the researcher about her findings individually or in a group setting with others who receive program services.

**What are the potential risks and discomforts and how will they be addressed?**

One question in the interview will ask you to discuss your experience as an immigrant. I am only asking about this information for research purposes. Please know that it is completely up to you whether you choose to answer this question, and you may provide as much or as little information as you feel comfortable sharing. If you choose to answer this question, the information that you share will be kept private from others. You will not be asked to provide your full name at any time during this study. While the researcher will be asking for a first name and telephone number that she will link to your interview in case she has any follow-up questions, you may choose to give the researcher an alias (a name other than your own) and a phone number different from your own where you can be contacted (for example, the phone number of a family member or friend). The researcher will destroy this link as soon as she follows up with you or determines that no follow-up is needed. In addition, when the results of the research are published or discussed in conferences, no information will be included that would reveal your identity.

It is also possible that you may be concerned that the services you receive will be affected if you say something negative about the program. To address this concern, the researcher will not reveal to anyone at the program whether you participated in an interview. Your decision to participate and the information that you share will not affect your services through the Community Wellness Program in any way.

Lastly, you will not be asked to share your own personal reasons for coming to the Community Wellness Program at any time during the interview. However, if you are uncomfortable with any of the questions or become upset as a result of information that you discuss during the interview, please know that you can skip a question or stop the interview at any time.

**Are there benefits to taking part in the research?**

This study is not designed to benefit you directly. This study is designed to learn more about services for Latino immigrants. The study results may be used to help other people in the future.

**What other options are there?**

You may choose not to participate in this research. Your choice of whether or not to participate will not affect your services at the Community Wellness Program in any way.

**What about privacy and confidentiality?**

Only the researcher and her faculty advisor will know whether you participated in this study, except in cases where you choose to speak with the researcher about her findings in a group setting after she has completed all individual interviews. In cases where you choose to speak with the researcher about her findings in a group setting, others in the group will learn that you participated in this study. In addition, please note that your privacy may be breached if you

**APPENDIX D (continued)**

become upset about information that you discuss during your individual interview and it is necessary for the researcher to refer you to speak with your mental health therapist at the Community Wellness Program. Otherwise, however, the researcher will not reveal to others whether or not you participated in the study. In addition, the researcher will store all study materials on a password-protected flash drive. If you choose to speak with the researcher about her findings in a group setting after she has completed all individual interviews, then others in the group will learn that you receive services at the Community Wellness Program and that you participated in an interview. While everyone in the group will be asked to respect each other's privacy, confidentiality in a group discussion cannot be guaranteed. If you would like to speak with the researcher about her findings but are concerned about doing so in a group setting, then you have the option of meeting with the researcher individually to discuss her findings.

**Will I be paid for my participation in this research?**

You will receive a $25 gift card to Pete's Fresh Market for your participation in the individual interview. If you do not finish the interview, you will still be compensated. You will receive your compensation immediately before starting your interview.

**Can I withdraw or be removed from the study?**

You can choose whether or not to participate in this study. If you decide to participate, you are free to stop your participation at any time. The researcher may also stop your participation in this study if she believes it is in your best interests.

**Who should I contact if I have questions?**

You may contact the principal investigator, Caitlin O'Grady, PhD Candidate at the University of Illinois at Chicago by telephone at 413-281-7517 or by email at cograd5@uic.edu. You may also contact the faculty advisor overseeing this study, Cassandra McKay-Jackson, Associate Professor, by telephone at 312-355-2280 or by email at cmckay@uic.edu.

**What are my rights as a research subject?**

If you feel you have not been treated according to the descriptions in this form, or if you have any questions about your rights as a research subject, including questions, concerns, complaints, or to offer input, you may call the Office for the Protection of Research Subjects (OPRS) at 312-996-1711 or 1-866-789-6215 (toll-free) or e-mail OPRS at uicirb@uic.edu.

**Remember**: Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University, nor will it affect your services through the Community Wellness Program. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research, as indicated by the "X" I am marking on the line below. I will be given a copy of this form to keep for my records.

**APPENDIX D (continued)**

_____ _____

Please mark with an "X" to indicate your agreement to participate Date

_____ _____

Signature of Person Obtaining Consent Date (must be same as subject's)

_____

Printed Name of Person Obtaining Consent

Leave box empty - For office use only

**APPENDIX D (continued)**

Subject Information Sheet B: Spanish-Language Form

**HOJA DE INFORMACIÓN PARA LOS SUJETOS DE LA INVESTIGACIÓN**
Universidad de Illinois en Chicago
Práctica Culturalmente Competente de La Salud Mental: Un Estudio de Caso de Una Organización Que Sirve Los Inmigrantes Latinos

**¿Cuál es el objetivo de esta investigación?**
Se le pide participar en un estudio de investigación sobre los servicios proveídos al Programa de Bienestar de la Comunidad de Saint Anthony Hospital. Caitlin O'Grady, Candidata al Doctorado en la Escuela de Trabajo Social Jane Addams en la Universidad de Illinois en Chicago, está haciendo esta investigación para aprender más sobre cómo son los servicios y cómo están llevados a cabo desde las perspectivas ambos de los que los proveen y de los que los reciben.

**¿Por qué se me pide?**
Se le pide participar en este estudio por recibir servicios a través del Programa de Bienestar de la Comunidad. Su participación en esta investigación es voluntaria. Su decisión de participar no afectará sus relaciones actuales o futuras con la Universidad de Illinois en Chicago, ni afectará los servicios que recibe en el programa de ninguna manera.

**¿Qué procedimientos están involucrados?**
Los procedimientos de este estudio incluyen una entrevista individual que se prevee tendrá de una hora a hora y media de duración. Durante esta entrevista individual, la investigadora estará haciendo preguntas sobre cómo son los servicios en este programa. La entrevista será audio grabada.

Al final de la entrevista individual, se le preguntará si usted está interesado en reunirse con la investigadora de nuevo después de que ella haya terminado con todas las entrevistas para asegurarse de que lo que ella aprendió de su investigación coincide con la propia experiencia de usted. Elegir hablar con la investigadora sobre los resultados de su investigación es completamente voluntario. Si usted indica que está interesado en hablar con la investigadora sobre los resultados de su investigación, ella se pondrá en contacto con usted después de que ella

**APPENDIX D (continued)**

haya terminado con todas las entrevistas para programar una cita para reunirse. Usted podrá elegir si desea hablar con la investigadora sobre sus resultados en forma individual o en un grupo con otros que reciben los servicios del programa.

**¿Cuáles son los riesgos y molestias potenciales y cómo van a ser abordados?**
Una pregunta en la entrevista le pedirá a usted a hablar sobre su experiencia como inmigrante. Esta información es solo para fines de investigación. Por favor sepa que es totalmente su decisión si elige responder a esta pregunta, y puede proporcionar tanta información como usted se siente cómodo compartiendo. Si elige responder a esta pregunta, la información que usted comparta se mantendrá privada de los demás. No se le pedirá que proporcione su nombre completo en ningún momento durante este estudio. Mientras que la investigadora estará pidiéndole un nombre y número de teléfono que ella va a vincular a su entrevista en caso de que ella tenga alguna pregunta de seguimiento, usted puede optar por dar a la investigadora un alias (un nombre que no sea el suyo propio) y un número de teléfono diferente de su propio donde pueda ser contactado (por ejemplo, el número de teléfono de un familiar o amigo). La investigadora destruirá este enlace tan pronto como ella haga una llamada subsiguiente a usted o determine que no se necesita de seguimiento. Además, cuando los resultados de la investigación se publican o son hablados en conferencias, ninguna información que revele su identidad será incluída.

También es posible que usted pueda estar preocupado de que los servicios que recibe sean afectados si usted dice algo negativo sobre el programa. Para hacer frente a esta preocupación, la investigadora no revelará a ninguna persona al programa si usted participó en una entrevista. Su decisión de participar y la información que usted comparta no afectarán sus servicios a través del Programa de Bienestar de la Comunidad de ninguna manera.

Finalmente, no se le pedirá que comparta sus razones personales para venir al Programa de Bienestar de la Comunidad en ningún momento durante la entrevista. Sin embargo, si no se siente cómodo con cualquiera de las preguntas o se siente incómodo como resultado de información que se maneja durante la entrevista, por favor sepa que puede saltarse una pregunta o dejar la entrevista en cualquier momento.

**¿Hay beneficios de tomar parte en la investigación?**
Este estudio no está diseñado para beneficiar a usted directamente. Este estudio está diseñado para aprender más acerca de los servicios para los inmigrantes latinos. Los resultados del estudio pueden ser utilizados para ayudar a otras personas en el futuro.

**¿Qué otras opciones existen?**
Usted tiene la opción de no participar en este estudio. Su elección de sí o no participar no afectará sus servicios al Programa de Bienestar de la Comunidad de ninguna manera.

**¿Qué pasa con la privacidad y la confidencialidad?**
Sólo la investigadora y su consejera de la facultad sabrán si usted participó en este estudio, excepto en los casos en que usted elige hablar con la investigadora sobre sus resultados en un

**APPENDIX D (continued)**

ambiente de grupo después de que la investigadora haya completado todas las entrevistas individuales. En los casos en que decida hablar con la investigadora sobre sus resultados en un ambiente de grupo, otros en el grupo sabrán que usted participó en este estudio. Además, por favor se nota que su privacidad puede ser violada si queda incómodo por la información que usted compartió durante su entrevista individual y es necesario que la investigadora lo refiera con su terapeuta del Programa de Bienestar de la Comunidad. Sin embargo, la investigadora no revelará a los demás si usted participó en el estudio en ningún otro caso. Además, la investigadora va a almacenar todos los materiales del estudio en una unidad flash protegida por contraseña. Si elige hablar con la investigadora sobre los resultados de su investigación en un grupo después de que ella haya terminado con todas las entrevistas individuales, otros en el grupo sabrán que usted recibe servicios en el Programa de Bienestar de la Comunidad y que participó en una entrevista. Si bien se le pedirá a cada persona en el grupo de respetar la privacidad de los demás, la confidencialidad en una discusión de grupo no se puede garantizar. Si a usted le gustaría hablar con la investigadora sobre sus resultados pero se preocupa por hacerlo en un ambiente de grupo, entonces usted tiene la opción de encontrarse con la investigadora individualmente para hablar sobre sus resultados.

**¿Me pagarán por mi participación en esta investigación?**
Usted recibirá una tarjeta de regalo de $25 de Pete's Fresh Market por su participación en la entrevista individual. Si usted no termina con la entrevista, usted igual será compensado. Usted recibirá su compensación inmediatamente antes de empezar su entrevista.

**¿Puedo retirarme o ser eliminado del estudio?**
Usted puede elegir si desea o no participar en este estudio. Si decide participar, usted es libre de retirar su consentimiento y discontinuar participación en cualquier momento. La investigadora también puede cancelar su participación en este estudio si ella cree que es en su mejor interés.

**¿A quién debo contactar si tengo preguntas?**
Puede comunicarse con la investigadora principal, Caitlin O'Grady, Candidata al Doctorado en la Universidad de Illinois en Chicago por teléfono al 413-281-7517 o por correo electrónico a cograd5@uic.edu. También puede ponerse en contacto con la consejera de la facultad que supervisa este estudio, Cassandra McKay-Jackson, Profesora Asociada, por teléfono al 312-355-2280 o por correo electrónico a cmckay@uic.edu.

**¿Cuáles son mis derechos como sujeto de investigación?**
Si usted siente que no ha sido tratado de acuerdo con las descripciones en este formulario, o si tiene alguna pregunta sobre sus derechos como sujeto de investigación, incluyendo preguntas, preocupaciones, quejas, o para ofrecer de entrada, puede llamar a la Oficina para la Protección los Sujetos de Investigación (OPRS) al 312-996-1711 o 1-866-789-6215 (llamada gratis) o por correo electrónico al uicirb@uic.edu.
**Recuerde:** Su participación en esta investigación es voluntaria. Su decisión sobre la misma no afectará sus relaciones actuales o futuras con la Universidad, ni va a afectar a sus servicios a través del Programa de Bienestar de la Comunidad. Si decide participar, usted es libre de retirarse en cualquier momento sin afectar esas relaciones.

**APPENDIX D (continued)**

He leído (o alguien me ha leído) la información anterior. Se me ha dado la oportunidad de hacer preguntas y mis preguntas han sido contestadas a mi satisfacción. Estoy de acuerdo en participar en esta investigación, como se indica con la "X" que estoy marcando en la línea de abajo. Se me dará una copia de este formulario para llevar para mis archivos.

_____ _____

Por favor, marque con una "X" para indicar su acuerdo a participar Fecha

_____ _____

Firma de la persona que obtiene el consentimiento Fecha (debe ser igual que del sujeto)

_____

Nombre de la persona que obtiene el consentimiento—en Letra Impresa

# APPENDIX E

## PARTICIPANT OBSERVATION GUIDE

Date:

Day of the Week:

Time:

Observation Activity:

Duration of Observation:

1) What is the physical environment like? (i.e. artwork, music playing, temperature)
2) Who is present? (Provide a brief description including gender, whether a service provider or service participant, type of dress; no personally identifiable information)
3) What is occurring?
4) What are the verbal behaviors of those present? (i.e. language they are speaking, content of conversation, flow of conversation [pauses, silences, interruptions])
5) What are the non-verbal behaviors of those present? (i.e. facial expressions, body language, activities)
6) What types of interactions are occurring among those who are present?

Researcher Positionality and Reflexivity

1) What are my verbal behaviors? Do I speak to anyone?
2) What are my non-verbal behaviors?
3) What are my thoughts and feelings as I am observing?
4) What do others do when they see me? Do they interact with me?

Leave box empty - For office use only

## APPENDIX F

## STAFF MEETING OBSERVATION PERMISSION FORM

### REQUEST FOR PERMISSION TO OBSERVE STAFF MEETING

University of Illinois at Chicago
Culturally Competent Mental Health Practice: A Case Study of an Organization Serving Latino Immigrants

**What is the purpose of this observation?**

Caitlin O'Grady, PhD Candidate at the Jane Addams College of Social Work at the University of Illinois at Chicago, is conducting a research study at the Community Wellness Program to learn more about what services are like and how they are carried out from the perspectives of both those who provide services and those who receive services through this program. As part of this study, the researcher will be observing different program activities to learn more about how the program functions and what services are like. One of the activities that the researcher hopes to observe is your upcoming staff meeting.

**What will this observation entail?**

The researcher is interested in generally learning more about what staff meetings are like. The researcher will be taking notes on general patterns of interaction and content covered during the meeting, but will not be recording any personal information about you or about any service participants discussed during the meeting.

**What is being asked of me?**

Nothing will be asked of you during the time that the researcher observes the staff meeting. The researcher is providing you with this form to ensure that you are comfortable with her plan to observe and to request your permission to conduct this observation. If you agree to this plan for the researcher to observe the upcoming staff meeting, please indicate your agreement by marking an "X" on the line at the bottom of this form. If you do not agree to this plan, then please do not mark an "X" on the line. You will be asked to return this permission form in a manila envelope. If the researcher receives any forms that are returned without an "X," then she will not observe the staff meeting.

**APPENDIX F (continued)**

I have read (or someone has read to me) the above information. I agree for Caitlin O'Grady to observe the upcoming staff meeting, as indicated by the "X" I am marking on the line below.

_____

Please mark with an "X" to indicate your agreement Date

Leave box empty - For office use only

## APPENDIX G

## PARENTING CLASS OBSERVATION PERMISSION FORM

Parenting Class Permission Form A: English-Language Form

### REQUEST FOR PERMISSION TO OBSERVE PARENTING CLASS

University of Illinois at Chicago
Culturally Competent Mental Health Practice: A Case Study of an Organization Serving Latino Immigrants

**What is the purpose of this observation?**

Caitlin O'Grady, PhD Candidate at the Jane Addams College of Social Work at the University of Illinois at Chicago, is conducting a research study at the Community Wellness Program to learn more about what services are like and how they are carried out from the perspectives of both those who provide services and those who receive services through this program. As part of this study, the researcher will be observing different program activities to learn more about how the program functions and what services are like. One of the activities that the researcher hopes to observe is your upcoming parenting class.

**What will this observation entail?**

The researcher is interested in generally learning more about what this parenting class is like. The researcher will be taking notes on the physical environment where the class takes place, general patterns of interaction, and content covered during the class. The researcher will not be recording any personal information about you or about anyone else attending the class.

**What is being asked of me?**

Nothing will be asked of you during the time that the researcher observes the class. The researcher is providing you with this form to ensure that you are comfortable with her plan to observe and to request your permission to conduct this observation. If you agree to this plan for the researcher to observe the next class, please indicate your agreement by marking an "X" on the line at the bottom of this form. If you do not agree to this plan, then please do not mark an "X" on the line. You will be asked to return this permission form in a manila envelope. If the researcher receives any forms that are returned without an "X," then she will not observe the class.

**APPENDIX G (continued)**

I have read (or someone has read to me) the above information. I agree for Caitlin O'Grady to observe the upcoming parenting class, as indicated by the "X" I am marking on the line below.

_____

Please mark with an "X" to indicate your agreement Date

Leave box empty - For office use only

**APPENDIX G (continued)**

Parenting Class Permission Form B: Spanish-Language Form

**SOLICITUD DE PERMISO PARA OBSERVAR EL TALLER PARA PADRES**
Universidad de Illinois en Chicago
Práctica Culturalmente Competente de La Salud Mental: Un Estudio de Caso de Una Organización Que Sirve Los Inmigrantes Latinos

**¿Cuál es el propósito de esta observación?**
Caitlin O'Grady, Candidata al Doctorado en la Escuela de Trabajo Social Jane Addams en la Universidad de Illinois en Chicago, está haciendo un estudio de investigación en el Programa de Bienestar de la Comunidad para aprender más sobre cómo son los servicios y cómo se están llevando a cabo desde las perspectivas de los que proveen los serviciois y los que los reciben a través de este programa. Como parte de este estudio, la investigadora estará observando diferentes actividades del programa para aprender más sobre cómo funciona el programa y cómo son los servicios. Una de las actividades que a la investigadora le gustaría observar, con su permiso, es el próximo taller para padres.

**¿Qué conllevará esta observación?**
La investigadora está interesada en aprender de una manera general sobre cómo es este taller para padres. La investigadora va a tomar apuntes sobre el ambiente físico donde la clase se lleva a cabo, los patrones generales de interacción, y el contenido que se trata durante la clase. La investigadora no anotará ninguna información personal sobre usted o sobre cualquier persona que asiste a la clase.

**¿Qué es lo que pide de mí?**
No se le pedirá nada a usted durante el tiempo que la investigadora observa el taller. La investigadora está dándole éste formulario para asegurarse de que usted está cómodo con su plan para observar y para solicitar su permiso para realizar esta observación. Si está de acuerdo con este plan para que la investigadora observe este taller, por favor indique que está de acuerdo marcando una "X" en la línea en la parte inferior de este formulario. Si usted no está de acuerdo con este plan, entonces por favor no marque con una "X" en la línea. Se le pedirá que devuelva este formulario de permiso en un sobre color manila. Si la investigadora recibe algún formulario que se devuelve sin una "X", entonces ella no observará el taller.

**APPENDIX G (continued)**

He leído (o alguien me ha leído) la información anterior. Estoy de acuerdo de que Caitlin O'Grady pueda observar el próximo taller para padres, como se indica con la "X" que estoy marcando en la línea de abajo.

_____

Por favor, marque con una "X" para indicar su acuerdo Fecha

# APPENDIX H

## FACE-TO-FACE AND TELEPHONE SCRIPTS

Face-to-Face Recruitment Script A
(for use with service providers at staff meeting)

Hi everyone, thanks so much for letting me speak with you today. My name is Caitlin O'Grady, and I am a PhD candidate at the Jane Addams College of Social Work at the University of Illinois at Chicago. I am conducting a research study here at the Little Village location of the Community Wellness Program to learn more about what services are like and how they are carried out from the perspectives of both service providers and service participants. As part of my research, I am hoping to conduct interviews with employees and interns at the Community Wellness Program to learn more about your experiences with service delivery. If you choose to participate in an individual interview, it will be audio recorded and will last for about an hour to an hour and a half. You will be compensated for your time with a $25 gift card to Pete's Fresh Market. The interview can be conducted here in your private office or at another community setting of your preference, depending on where you feel most comfortable. Your choice to take part in this interview is completely voluntary and will not affect your job here in any way.

I invite you to speak with me if you are interested in learning more about this study or would like to schedule an individual interview. I will be available after today's meeting, and will be on-site two days per week during the time that I am conducting my research here. Please feel free to speak with me today or whenever I am on-site, and I will be happy to answer any questions you may have or to schedule an interview whenever is convenient. In addition, if you prefer to speak with me in a more private setting, you will find my telephone number on the flyer that I am handing out. Please feel free to call me on that number.

Thank you so much again for allowing me to speak with you today. Do you have any questions for me at this time?

**APPENDIX H (continued)**

Face-to-Face Recruitment Script B
(for service providers speaking with the principal investigator on-site in response to the flyer)

Thank you for your interest in my research. Do you have any questions about my study?

Are you interested in scheduling an interview?

Where would you like to meet? We can conduct the interview in either your private office at the Community Wellness Program or at another community setting of your choice, whatever you would prefer. I am offering the option of conducting the interview at a location outside of the program in case you are concerned that your coworkers will see you speaking with me.

When would be convenient for you to meet? We can meet now if that is convenient for you.

If scheduling in advance:
I look forward to seeing you then. The interview will last for about an hour to an hour and a half and will be audio recorded. Before we start the interview, we will review a consent form that provides more details about the study and your rights as a research participant. I will also be providing a $25 gift card to Pete's Fresh Market as compensation for your time at the start of the interview. Please feel free to call me if anything comes up between now and the time of the interview and you need to reschedule.

Do you have any additional questions for me at this time?

**APPENDIX H (continued)**

Face-to-Face Recruitment Script C: English-Language Version
(for service participants speaking with the principal investigator on-site in response to the flyer)

Thank you for your interest in my research. Please allow me to provide further details about my study. I will be doing interviews with individuals who receive counseling services here at the Community Wellness Program so that I can learn more about what these services are like. Just so I can confirm that you're eligible to participate in this study, can you tell me who you meet with at the Community Wellness Program?

If individual does not give the name of a service provider who provides mental health services:
Thank you so much for coming to speak with me, but unfortunately you won't be able to take part in this study, since I am only doing interviews with individuals who receive counseling services here. Thanks again for speaking with me, and I hope that you have a good day.

If individual gives the name of a service provider who provides mental health services:
Thank you for providing that information. You are eligible to take part in this study. Do you have any questions regarding what this study is about?

Are you interested in scheduling an interview?

When would be convenient for you to meet? We can meet now if that is convenient for you.

If scheduling in advance:
I look forward to seeing you then. The interview will take place at [specify the exact location of the interview, either Saint Anthony Hospital's main campus or Taller de Jose], and will last for about an hour to an hour and a half. I will audio record the interview. Before we start the interview, we will review an information sheet that provides more details about the study and your rights as a research participant. I will also be providing a $25 gift card to Pete's Fresh Market as compensation for your time at the start of the interview. Please feel free to call me if anything comes up between now and the time of the interview and you need to reschedule.

Do you have any additional questions for me at this time?

**APPENDIX H (continued)**

Face-to-Face Recruitment Script C: Spanish-Language Version
(for service participants speaking with the principal investigator on-site in response to the flyer)

Gracias por su interés en mi investigación. Por favor permítame dar más detalles acerca de mi estudio. Estaré haciendo entrevistas con las personas que reciben servicios de terapia aquí en el Programa de Bienestar de la Comunidad para que pueda aprender más sobre cómo son estos servicios. Sólo para que pueda confirmar que usted es elegible para participar en este estudio, me puede decir con quién se reune en el Programa de Bienestar de la Comunidad?

If individual does not give the name of a service provider who provides mental health services:
Gracias por venir a hablar conmigo, pero desafortunadamente no va a poder tomar parte en este estudio, porque sólo estoy haciendo entrevistas con las personas que reciben servicios de terapia aquí. Gracias de nuevo por hablar conmigo, y espero que tenga un buen día.

If individual gives the name of a service provider who provides mental health services:
Gracias por esa información. Usted es elegible para participar en este estudio. ¿Tiene alguna pregunta con respecto a lo que se trata este estudio?

¿Está interesado en programar una entrevista?

¿Cuándo sería conveniente para reunirse? Podemos reunirnos ahora si es conveniente para usted.

If scheduling in advance:
Espero vernos a continuación. La entrevista tendrá lugar en [especificar la ubicación exacta de la entrevista, ya sea el campus principal de Saint Anthony Hospital o Taller de Jose], y tendrá una duración de aproximadamente una hora a una hora y media. La entrevista será de audio grabada. Antes de empezar la entrevista, vamos a revisar una hoja de información que provee más detalles sobre el estudio y sus derechos como participante en la investigación. También le voy a dar una tarjeta de regalo de $25 a Pete’s Fresh Market como compensación por su tiempo en el inicio de la entrevista. Por favor no dude en llamarme si surge algo entre ahora y el momento de la entrevista y necesita volver a programar.

¿Tiene alguna pregunta adicional para mí en este momento?

**APPENDIX H (continued)**

Telephone Script A
(for service providers who contact the principal investigator in response to flyer)

Thank you for your call. Can you tell me your name and your position at the Community Wellness Program?

Thank you for that information. Do you have any questions about my study?

Are you interested in scheduling an interview?

Where would you like to meet? We can conduct the interview in either your private office at the Community Wellness Program or at another community setting of your choice, whatever you would prefer. I am offering the option of conducting the interview at a location outside of the program in case you are concerned that your coworkers will see you speaking with me.

When would be convenient for you to meet?

I look forward to seeing you then. The interview will last for about an hour to an hour and a half and will be audio recorded. Before we start the interview, we will review a consent form that provides more details about the study and your rights as a research participant. I will also be providing a $25 gift card to Pete's Fresh Market as compensation for your time at the start of the interview. Please feel free to call me if anything comes up between now and the time of the interview and you need to reschedule.

Do you have any additional questions for me at this time?

**APPENDIX H (continued)**

Telephone Script B: English-Language Version
(for service participants who contact the principal investigator in response to flyer)

Thank you for your call. Please allow me to provide further details about my study. I will be doing interviews with individuals who receive counseling services at the Community Wellness Program so that I can learn more about what those services are like. Just so I can confirm that you're eligible to participate in this study, can you tell me who you meet with at the Community Wellness Program?

If individual does not give the name of a service provider who provides mental health services: Thank you so much for calling, but unfortunately you won't be able to take part in this study, since I am only doing interviews with individuals who receive counseling services. Thanks again for your call, and I hope that you have a good day.

If individual gives the name of a service provider who provides mental health services: Thank you for that information. You are eligible to take part in this study. Do you have any questions regarding what this study is about?

Are you interested in scheduling an interview?

When would be convenient for you to meet?

I look forward to seeing you then. The interview will take place at [specify the exact location of the interview, either Saint Anthony Hospital's main campus or Taller de Jose], and will last for about an hour to an hour and a half. I will audio record the interview. Before we start the interview, we will review an information sheet that provides more details about the study and your rights as a research participant. I will also be providing a $25 gift card to Pete's Fresh Market as compensation for your time at the start of the interview. Please feel free to call me if anything comes up between now and the time of the interview and you need to reschedule.

Do you have any additional questions for me at this time?

**APPENDIX H (continued)**

Telephone Script B: Spanish-Language Version
(for service participants who contact the principal investigator in response to flyer)

Gracias por su llamada. Por favor permítame dar más detalles acerca de mi estudio. Estaré haciendo entrevistas con las personas que reciben servicios de terapia en el Programa de Bienestar de la Comunidad para que pueda aprender más sobre cómo son esos servicios. Sólo para que pueda confirmar que usted es elegible para participar en este estudio, ¿me puede decir con quién se reune en el Programa de Bienestar de la Comunidad?

If individual does not give the name of a service provider who provides mental health services: Muchas gracias por llamar, pero desafortunadamente no va a poder tomar parte en este estudio, porque sólo estoy haciendo entrevistas con las personas que reciben servicios de terapia aquí. Gracias de nuevo por su llamada, y espero que tenga un buen día.

If individual gives the name of a service provider who provides mental health services: Gracias por esa información. Usted es elegible para participar en este estudio. ¿Tiene alguna pregunta con respecto a lo que se trata este estudio?

¿Está interesado en programar una entrevista?

¿Cuándo sería conveniente para reunirse?

Espero vernos a continuación. La entrevista tendrá lugar en [especificar la ubicación exacta de la entrevista, ya sea el campus principal de Saint Anthony Hospital o Taller de Jose], y tendrá una duración de aproximadamente una hora a una hora y media. La entrevista será de audio grabada. Antes de empezar la entrevista, vamos a revisar una hoja de información que provee más detalles sobre el estudio y sus derechos como participante en la investigación. También le voy a dar una tarjeta de regalo de $25 a Pete’s Fresh Market como compensación por su tiempo en el inicio de la entrevista. Por favor no dude en llamarme si surge algo entre ahora y el momento de la entrevista y necesita volver a programar.

¿Tiene alguna pregunta adicional para mí en este momento?

**APPENDIX H (continued)**

Telephone Script C: English-Language Version
(to contact service providers and service participants regarding participation in member check interviews)

This is Caitlin O'Grady calling from the University of Illinois at Chicago. Thank you so much again for speaking with me last _____ (specify time that has passed since completing the interview). The information that you provided was valuable to my research.

Last time that we spoke, you had mentioned that you might be interested in speaking with me again after I finished all of my interviews to help me make sure that what I came up with in my analysis matches what people shared with me. Choosing to speak with me about this is completely voluntary, and I wouldn't be providing a $25 gift card like I did for our last interview. Are you still interested in speaking with me about my findings?

If no: Not a problem at all. I really appreciate all of the time that you have invested in assisting me with my research.

If yes: Thank you so much for your willingness to help with this. Last time we spoke, you mentioned that you were interested in meeting _____ (specify whether they had indicated that they preferred to meet individually or in a group). Is this still your preference? For those requesting individual meetings: When would be a convenient time for you to meet? For those requesting group meetings: I am planning to hold a group meeting at either _____ or _____ (give two meeting time options). Which of these times would be most convenient for you?

**APPENDIX H (continued)**

Telephone Script C: Spanish-Language Version
(to contact service participants regarding participation in member check interviews)

Está hablando Caitlin O'Grady de la Universidad de Illinois en Chicago. Muchas gracias de nuevo por hablar conmigo el _____ (especifica cuando fue la entrevista). La información que proporcionó era valioso para mi investigación.

Cuando hablamos la vez pasada, se había mencionado que usted podría estar interesado en hablar conmigo de nuevo después de que yo haya terminado con todas mis entrevistas para ayudarme a asegurarse de que la información en mi análisis coincide con lo que las personas compartían conmigo. Elegir hablar conmigo sobre esto es completamente voluntaria, y yo no le daría una tarjeta de regalo de $25 como lo hice para la entrevista anterior. ¿Todavía está interesado en hablar conmigo sobre mis resultados?

En caso negativo: No es ningún problema. Realmente aprecio todo el tiempo que usted ha dedicado a ayudarme con mi investigación.

En caso afirmativo: Muchas gracias por su disposición para ayudar con esto. Cuando hablamos la vez pasada, usted mencionó que estaba interesado en reunirse _____ (especificar si había indicado que prefería reunirse individualmente o en grupo). ¿Todavía es su preferencia?
Para los que piden reuniones individuales: ¿Cuándo sería un momento conveniente para reunirse?

Para los que piden una reunión en grupo: Estoy planeando a tener una reunión en grupo a _____ o _____ (dar dos opciones de tiempo de reunión). ¿Cuál de estos tiempos sería más conveniente para usted?

**APPENDIX H (continued)**

Face-to-Face Script Requesting Permission to Observe Staff Meeting
(to be used with service providers at the start of the staff meeting prior to the meeting that the principal investigator plans to observe)

Hi everyone, thank you so much for allowing me to speak with you again today. I want to thank you all for your assistance with my research. I really appreciate all of the time that you are investing in this project, whether through participating in an interview or through distributing flyers to service participants. My research would not be possible without your support.

I also wanted to inform you of another component to my research. In addition to conducting interviews, I am also planning to observe different events and activities here at the Community Wellness Program so that I can learn even more about your services. I am hoping to observe one of your staff meetings if you all are comfortable with me doing so. In particular, I wanted to see if you all are comfortable with me observing your next staff meeting. I won't be collecting any personal information about you or any service participants that you discuss during the meeting. Instead, I am interested in learning more generally what staff meetings here are like.

I am distributing a permission form that provides details about my plan to observe. If you agree to my plan to observe the next meeting, please mark an "X" on the line at the bottom of this form. If you do not agree to this plan, then please do not mark an "X" on the line. Please return this permission form in the manila envelope that I am providing. If I receive any forms that are returned without an "X," then I will not observe the staff meeting.

Do you have any questions for me at this time?

**APPENDIX H (continued)**

Face-to-Face Script Requesting Permission to Observe Parenting Class: English Language Version
(to be used with service participants at the start of the parenting class prior to the class that the principal investigator plans to observe)

Good evening everyone, thank you so much for letting me speak with you today. My name is Caitlin O'Grady, and I am a PhD candidate at the Jane Addams College of Social Work at the University of Illinois at Chicago. I am conducting a research study to learn more about what services are like at the Community Wellness Program and how they are carried out. As part of my research, I am hoping to observe different program activities so that I can learn as much as possible about the program's services.

One of the activities that I am hoping to observe, with your permission, is this parenting class. In particular, I am asking for your permission to come observe your class the following week. I won't be asking for any of your names and won't identify you in the notes that I take about the class. I am just interested in generally learning more about what this class is like.

It is completely up to you whether you give me permission to observe, and your decision will not impact your services in any way. I will only observe if everybody in the class gives me permission. I am handing out a permission form that provides details about my plan to observe. If you are comfortable with me observing the class next week, please mark an "X" on the line at the bottom of the form. If you do not agree to this plan, then please do not mark an "X" on the line. Please return this permission form in the manila envelope that I am providing. If I receive any forms that are returned without an "X," then I will not observe the class next week.

Thank you again for your time. Do you have any questions?

I will be outside of the classroom during the entire class time tonight. If you think of any questions, please feel free to come speak with me.

**APPENDIX H (continued)**

Face-to-Face Script Requesting Permission to Observe Parenting Class: Spanish Language Version
(to be used with service participants at the start of the parenting class prior to the class that the principal investigator plans to observe)

Buenas noches a todos, muchas gracias por dejarme hablar con ustedes hoy. Mi nombre es Caitlin O'Grady, y soy una candidata al doctorado en la Escuela de Trabajo Social Jane Addams en la Universidad de Illinois en Chicago. Estoy haciendo un estudio de investigación para aprender más sobre como son los servicios en el Programa de Bienestar de la Comunidad y como están llevados a cabo. Como parte de mi investigación, estoy esperando a observar diferentes actividades del programa para que pueda aprender tanto como sea posible acerca de los servicios del programa.

Unas de las actividades que estoy esperando a observar, con su permiso, es este taller para padres. En particular, yo estoy pidiendo su permiso para que pueda venir a observar su clase de la semana siguiente. No les pediré que me den sus nombres y no les identificaré en los apuntes que tomo sobre la clase. Solamente quiero aprender más generalmente como es esta clase.

Es totalmente de ustedes si quieren darme permiso para observar, y su decisión no afectará sus servicios de ninguna manera. Solamente voy a observar si todos en la clase me dan permiso. Les doy ahora un formulario de autorización que provee los detalles sobre mi plan para observar. Si se siente cómodo conmigo observando la clase la próxima semana, por favor marque con una "X" en la línea en la parte inferior del formulario. Si usted no está de acuerdo con este plan, entonces por favor no marque con una "X" en la línea. Por favor entregue este formulario de autorización en el sobre color manila que estoy dándoles. Si recibo cualquier formulario que se devuelve sin una "X", entonces no voy a observar la clase de la próxima semana.

Gracias de nuevo por su tiempo. ¿Alguién tiene alguna pregunta?

Voy a estar afuera de la sala por todo el tiempo que dura la clase esta noche. Si piensan en alguna pregunta, por favor no duden en venir a hablar conmigo.

**APPENDIX I**
**SERVICE PROVIDER AND SERVICE PARTICIPANT INFORMATIONAL FLYERS**

# Seeking Paid Research Study Participants

## Interested in Sharing your Experience as a Service Provider at the Community Wellness Program?

You have the opportunity to participate in a paid research study. Caitlin O'Grady, PhD Candidate at the University of Illinois at Chicago, is seeking individuals to participate in an audio recorded interview to learn more about services at the Community Wellness Program. You will be compensated with a $25 gift card to Pete's Fresh Market.

Your choice to participate in this study is completely voluntary and will not impact your job security.

To learn more about this study or to schedule an individual interview, please contact Caitlin O'Grady at 413-281-7517.

**APPENDIX I (continued)**

# Seeking Paid Research Study Participants

## Interested in Sharing your Experience Receiving Services through the Community Wellness Program?

You have the opportunity to participate in a paid research study. Caitlin O'Grady, PhD Candidate at the University of Illinois at Chicago, is seeking individuals to participate in an audio recorded interview to learn more about services at the Community Wellness Program. You will be compensated with a $25 gift card to Pete's Fresh Market.

Your choice to participate in this study is completely voluntary and will not impact the services you receive in any way.

To learn more about this study or to schedule an individual interview, please contact Caitlin O'Grady at 413-281-7517. Caitlin speaks Spanish.

**APPENDIX I (continued)**

# Buscando Participantes Para El Estudio de Investigación Pagada

# ¿Está Interesado en Compartir Su Experiencia de Recibir Los Servicios en El Programa de Bienestar de La Comunidad?

Usted tiene la oportunidad de participar en un estudio de investigación pagada. Caitlin O'Grady, Candidata al Doctorado en la Universidad de Illinois en Chicago, está buscando personas para participar en una entrevista de audio grabada, para obtener más información sobre los servicios del Programa de Bienestar de la Comunidad. Usted será compensado con una tarjeta de regalo de $25 de Pete’s Fresh Market.

Su decisión de participar en este estudio es completamente voluntaria y no afectará los servicios que recibe de ninguna manera.

Para aprender más sobre este estudio o para programar una entrevista individual, por favor póngase en contacto con Caitlin O'Grady al 413-281-7517. Caitlin habla español.

# APPENDIX J

SAINT ANTHONY HOSPITAL

December 14, 2015

To Whom It May Concern:

Please accept this letter of support for Caitlin O'Grady, PhD Candidate at the Jane Addams College of Social Work at the University of Illinois at Chicago, to conduct her dissertation research at Saint Anthony Hospital's Community Wellness Program. In particular, Ms. O'Grady has my permission to carry out research activities including the recruitment of service providers and service participants, the conduction of individual interviews, and the conduction of observations of our waiting area and staff meetings. Ms. O'Grady additionally has my permission to observe one of our regularly offered parenting classes, which take place at St. Agnes of Bohemia Church at 2651 S. Central Park Avenue. I have offered Ms. O'Grady an office space on-site for two days per week at our Community Wellness Program location at 2826 W. Cermak Road during her data collection period to facilitate the conduction of her research activities.

While Ms. O'Grady will play a primary role in the recruitment of research participants, I am also willing to support her in her recruitment efforts. I am inviting her to attend a staff meeting to explain her research to program employees, and I will be supporting her in distributing informational flyers to employees that are not present at the staff meeting. Myself and other staff members under my supervision are also willing to distribute informational flyers to our service participants in order to assist Ms. O'Grady in her efforts to inform our service participant population about her research.

In closing, I would like to note that Saint Anthony Hospital does not have an Institutional Review Board, and I am therefore requesting that this letter serve as the necessary documentation for her to begin her research after receiving approval from the University of Illinois at Chicago's Institutional Review Board.

Thank you for your time and attention.

Sincerely,

Arturo Carrillo, Program Manager
Saint Anthony Hospital: Community Wellness Program
2826 W. Cermak Road
Chicago, IL 60623

## APPENDIX K

## IRB APPROVAL LETTER

UNIVERSITY OF ILLINOIS
AT CHICAGO

Office for the Protection of Research Subjects (OPRS)
Office of the Vice Chancellor for Research (MC 672)
203 Administrative Office Building
1737 West Polk Street
Chicago, Illinois 60612-7227

**Approval Notice**
**Initial Review (Response to Modifications)**

March 7, 2016

Caitlin O'Grady, MSW,BA
Jane Addams School of Social Work
1040 W. Harrison St
M/C 309
Chicago, IL 60612
Phone: (413) 281-7517

RE: **Protocol # 2015-1217**
**"Culturally Competent Mental Health Practice: A Case Study of an Organization Serving Latino Immigrants"**

Dear Ms. O'Grady:

Your Initial Review application (Response to Modifications) was reviewed and approved by the Expedited review process on February 18, 2016. You may now begin your research.

Please note the following information about your approved research protocol:

**Please remember to submit a copy of the transcription agreement when completed. The agreement must be accompanied by an Amendment form when submitted to the UIC IRB.**

**Please note that stamped and approved .pdfs of all recruitment and consent documents will be forwarded as an attachment to a separate email. OPRS/IRB no longer issues paper letters and stamped/approved documents, so it will be necessary to retain the emailed documents for your files for auditing purposes.**

| | |
|---|---|
| **Protocol Approval Period:** | February 18, 2016 - February 17, 2017 |
| **Approved Subject Enrollment #:** | 35 |

**APPENDIX K (continued)**

**Additional Determinations for Research Involving Minors:** These determinations have not been made for this study since it has not been approved for enrollment of minors.

**Performance Sites:** UIC, OSF Saint Anthony Hospital, St Agnes of Bohemia
**Sponsor:** Institute for Research on Race & Public Policy
**PAF#:** Not applicable
**Grant/Contract No:** Not applicable
**Grant/Contract Title:** Not applicable
**Research Protocol:**

a) Culturally Competent Mental Health Practice: A Case Study of an Organization Serving Latino Immigrants; Version 2; 01/19/2016

**Recruitment Materials:**

a) Service Provider Informational Flyer; Version 2; 01/19/2016
b) Recruitment Materials Face-to-Face and Telephone Scripts; Version 2; 01/19/2016
c) Service Participant Informational Flyer; Version 2; 01/19/2016

**Informed Consents:**

a) Request for Permission to Observe Staff Meeting; Version 2; 01/19/2016
b) Request for Permission to Observe Parenting Class; Version 2; 01/19/2016
c) Service Participant Information Sheet; Version 3; 02/15/2016
d) Service Provider Informed Consent Document; Version 3; 02/15/2016
e) A waiver of documentation (verbal consent/no written signature obtained) has been granted for all participant-based research activities including observations and interviews under 45 CFR 46.117(c)(1) (minimal risk; signed document would be only element linking subjects with research)
f) A waiver of documentation (verbal consent/no written signature obtained) has been granted for service providers for staff meetings and at parenting classes under 45 CFR 46.117(c)(2) (minimal risk; subjects will informed verbally and via flyers; no identifiable data otherwise collected)

Your research meets the criteria for expedited review as defined in 45 CFR 46.110(b)(1) under the following specific categories:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes., (7) Research on individual or group characteristics or behavior (including but not limited to research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

**APPENDIX K (continued)**

**Please note the Review History of this submission:**

| Receipt Date | Submission Type | Review Process | Review Date | Review Action |
|---|---|---|---|---|
| 11/23/2015 | Initial Review | Expedited | 11/30/2015 | Modifications Required |
| 01/20/2016 | Response To Modifications | Expedited | 01/28/2016 | Modifications Required |
| 02/15/2016 | Response To Modifications | Expedited | 02/18/2016 | Approved |

Please remember to:

→ Use your **research protocol number** (2015-1217) on any documents or correspondence with the IRB concerning your research protocol.

→ Review and comply with all requirements on the OPRS website under:
"**UIC Investigator Responsibilities, Protection of Human Research Subjects**"
*(http://tigger.uic.edu/depts/ovcr/research/protocolreview/irb/policies/0924.pdf)*

**Please note that the UIC IRB has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.**

**Please be aware that if the scope of work in the grant/project changes, the protocol must be amended and approved by the UIC IRB before the initiation of the change.**

We wish you the best as you conduct your research. If you have any questions or need further help, please contact OPRS at (312) 996-1711 or me at (312) 996-2014. Please send any correspondence about this protocol to OPRS at 203 AOB, M/C 672.

Sincerely,

Sandra Costello
Assistant Director, IRB # 2
Office for the Protection of Research Subjects

**Please note that stamped and approved .pdfs of all recruitment and consent documents will be forwarded as an attachment to a separate email. OPRS/IRB no longer issues paper letters and stamped/approved documents, so it will be necessary to retain the emailed documents for your files for auditing purposes.**

cc: Creasie Hairston, Jane Addams School of Social Work, M/C 309
Cassandra McKay-Jackson (faculty advisor), Jane Addams School of Social Work, M/C 309

# VITA

NAME: Caitlin L. O'Grady

EDUCATION: Bachelor of Arts in Pscyhology; Bachelor of Arts in Spanish, Kenyon College, 2007

Master of Social Work, University of Denver, 2009

Ph.D., Social Work, University of Illinois at Chicago, 2017

RESEARCH: Research Assistant to Dr. Cassandra McKay-Jackson, 2015-2016
Jane Addams College of Social Work, University of Illinois at Chicago

Research Assistant to Dr. Charles Hounmenou, 2015-2016
Jane Addams College of Social Work, University of Illinois at Chicago

Research Assistant to Dr. Alan Dettlaff, 2013-2015
Jane Addams College of Social Work, University of Illinois at Chicago

TEACHING: Adjunct Instructor, Jane Addams College of Social Work, University of Illinois at Chicago
Social Work Research, Fall 2016 and Spring 2017

PRACTICE: Mental Health Therapist
Mary's Center for Maternal and Child Care, Washington, DC, 2011-2013

Behavioral Health Provider (Split full time position)
Jefferson Center for Mental Health at Metro Community Provider Network, Lakeview, CO, 2010-2011

Family Services Outpatient Therapist (Full time position, 2009-2010; Split full time position, 2010-2011)
Jefferson Center for Mental Health, Lakeview, CO, 2009-2011

HONORS: Dissertation Research Grant, Institute for Research on Race and Public Policy, University of Illinois at Chicago, January-June 2016

University Fellowship, University of Illinois at Chicago, 2013-2017

PUBLICATIONS: **O'Grady, C.L.**, & Rocha, J.S. (2016). Social work practice with Latinos: A review of the literature. *TS Cuadernos de Trabajo Social*, *15*, 47-62.

**O'Grady, C.L.**, & Swartz, J.A. (2016). The effects of insurance status and medical need on community-based health care access among jail detainees with serious mental illnesses. *Criminal Justice and Behavior*, *43*(10), 1386-1405.

Dettlaff, A.J., Fong, R., & **O'Grady, C.** (2016). Introduction to culturally responsive practice with immigrant and refugee children and families. In A.J. Dettlaff & R. Fong (Eds.), *Immigrant and refugee children and families: Culturally responsive practice*. New York, NY: Columbia University Press.

PRESENTATIONS: **O'Grady, C.** (2016 October). *Anti-oppressive mental health practice with Latino immigrants: Preliminary findings from an organizational case analysis.* Presentation at the Latino Social Workers Organization Conference, University of Illinois at Chicago, Chicago, IL.

Carrillo, A., Rocha, J., **O'Grady, C.**, & Bocanegra, K. (2016 April). *Structural social work: A framework for understanding Latino issues.* Poster presentation at the Latino Social Workers Organization Conference, New York University, New York, NY.

**O'Grady, C.** (2016 January). *Religiosity, mental health, and substance use among Latino adults*. Presentation at the Society for Social Work and Research 20th Annual Conference, Washington, DC.

**O'Grady, C.**, & Swartz, J.A. (2016 January). *The effects of insurance status and medical need on community-based health care access among jail detainees with serious mental illnesses*. Presentation at the Society for Social Work and Research 20th Annual Conference, Washington, DC.

Dettlaff, A., Needell, B., **O'Grady, C.**, Deporto, S., & Lightbourne, W. (2015 January). *Emerging strategies to address the needs of Latino children in the child welfare system: Innovations and advances in California.* Presentation at the Society for Social Work and Research 19th Annual Conference, New Orleans, LA.

Rocha, J., & **O'Grady, C.** (2014 October). *Social work practice with Latinos: A review of best practices and directions for future research.* Presentation at the Latino Social Workers Organization Conference, University of Illinois at Chicago, Chicago, IL.

CERTIFICATIONS: Licensed Clinical Social Worker, Illinois