ACCESS TO MENTAL HEALTH CARE: CLIENTS PERCEPTION OF SERVICES PROVIDED BY AGAPE CLINIC AND COMMUNITY CARE

by

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ABSTRACT

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The purpose of this study was to identify whether there is a relationship between acculturation and utilization of mental health services among U.S. born and non-U.S. born Hispanics in the United States. Furthermore, the purpose of this study was to identify factors, which lead U.S. born and non-U.S. born Hispanics to seek and utilize mental health services. Findings suggest that there is no relationship between acculturation and the utilization of mental health services. A lack of resistance may be due to a need of education on mental health illnesses.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Rationale for the Study</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Purpose of the Study</td>
<td>3</td>
</tr>
<tr>
<td>1.3 Objectives</td>
<td>5</td>
</tr>
<tr>
<td>2. REVIEW OF THE LITERATURE</td>
<td>6</td>
</tr>
<tr>
<td>2.1 Introduction of the Literature</td>
<td>6</td>
</tr>
<tr>
<td>2.1.1 Bidimensional Acculturation Model</td>
<td>6</td>
</tr>
<tr>
<td>2.2 Impact of the Problem</td>
<td>9</td>
</tr>
<tr>
<td>2.2.1 Suicide and Depression</td>
<td>10</td>
</tr>
<tr>
<td>2.2.2 Substance Abuse</td>
<td>12</td>
</tr>
<tr>
<td>2.2.3 Intimate Partner Violence</td>
<td>14</td>
</tr>
<tr>
<td>2.3 Access and Utilization of Mental Health Services</td>
<td>15</td>
</tr>
<tr>
<td>2.4 Historical Strategies to Resolve the Issue</td>
<td>18</td>
</tr>
<tr>
<td>2.5 Current Attempts to Resolve the Issue</td>
<td>18</td>
</tr>
<tr>
<td>2.6 Proposed Solutions</td>
<td>19</td>
</tr>
<tr>
<td>3. DESCRIPTION OF METHODOLOGY</td>
<td>21</td>
</tr>
<tr>
<td>3.1 Methods</td>
<td>21</td>
</tr>
<tr>
<td>3.1.1 Sample</td>
<td>21</td>
</tr>
<tr>
<td>3.1.2 Description of Instruments</td>
<td>22</td>
</tr>
</tbody>
</table>
APPENDIX

A. AGAPE APPROVAL LETTER .................................................................................. 49
B. IRB APPROVAL .................................................................................................... 51
C. ENGLISH FLYER .................................................................................................. 54
D. SPANISH FLYER .................................................................................................. 56
E. ENGLISH QUESTIONNAIRE ..................................................................................... 58
F. SPANISH QUESTIONNAIRE .................................................................................... 62
G. ENGLISH BIDIMENSIONAL ACCULTURATION SCALE ....................................... 66
H. SPANISH BIDIMENSIONAL ACCULTURATION SCALE ......................................... 70
I. ENGLISH PATIENT HEALTH QUESTIONNAIRE 9 ................................................ 73
J. SPANISH PATIENT HEALTH QUESTIONNAIRE 9 ................................................ 75
K. ENGLISH MOOD QUESTIONNAIRE ..................................................................... 77
L. SPANISH MOOD QUESTIONNAIRE ..................................................................... 79
M. ENGLISH CONSENT FORM ..................................................................................... 81
N. SPANISH CONSENT FORM ..................................................................................... 85
O. ENGLISH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT FORM .......................................................................................... 90
P. SPANISH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT FORM .......................................................................................... 94
Q. ENGLISH MENTAL HEALTH FLYER ..................................................................... 98
R. SPANISH MENTAL HEALTH FLYER ..................................................................... 100
S. ENGLISH COMMUNITY RESOURCE BOOKLET .................................................. 102
T. SPANISH COMMUNITY RESOURCE BOOKLET ................................................... 113

REFERENCES .............................................................................................................. 124

BIOGRAPHICAL INFORMATION .................................................................................. 132
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Family Members Support</td>
<td>29</td>
</tr>
<tr>
<td>1.2</td>
<td>Barriers to Mental Health Services</td>
<td>30</td>
</tr>
<tr>
<td>1.3</td>
<td>Reasons for Returning to Agape</td>
<td>31</td>
</tr>
<tr>
<td>1.4</td>
<td>Predictor Variables</td>
<td>37</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION

1.1 Rationale for the Study

The United States Census Bureau estimated that by the year 2030, Hispanics will make up 20.1% of the total U.S. population (Ethnicity and Ancestry Branch Population Division U.S. Census Bureau, n.d.). As of 2006, Texas had the second largest population of Hispanics (8,385,139). With such a rapid increase of Hispanics in the U.S., disparities in access to mental health care have become an important concern. The Surgeon General's Report on mental health recognized the importance of mental health for the prosperity of American families and society as a whole (U.S. Department of Health and Human Services [DHHS], 1999).

It is easy to overlook the value of mental health until problems surface. Yet from early childhood until death, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem. These are the ingredients of each individual's successful contribution to community and society. Americans are inundated with messages about success—in school, in a profession, in parenting, in relationships—without appreciating that successful performance rests on a foundation of mental health (U.S. DHHS, 1999, paragraph 7).

Furthermore, a major finding in the supplement to the Surgeon General's first mental health report stated the following: “Minorities have less access to, and availability of, mental health services” (U.S. DHHS, Office of the Surgeon General (OSG), Substance Abuse and Mental Health Services Administration (SAMHSA), 2001a, paragraph 16). The report also stated that the lack of access to mental health services is often a result of being uninsured or not having the resources (e.g. transportation, medication, health insurance, and education on mental health conditions) to access treatment for mental health care. The percentage of Hispanics (37%) who are uninsured is a little more than double that for all Americans (16%). Furthermore, only 18% of Hispanics are covered by public health care programs such as Medicaid Mental health disparities are expected to continue without support from public health programs (ex. Medicaid, Medicare) (U.S. DHHS, OSG, SAMHSA, 2001b) and non-profit organizations to pay for their mental health treatment.
For these reasons, mental health care centers have reported a difficulty in serving this particular population. Treatments for the mental health needs of Hispanics are often not taken care of by mental health specialists. Vega, Kolody, Aguilar-Gaxiola, and Catalano (1999) used a sample of urban and rural Mexican Americans to investigate the utilization of mental health services. In order to be eligible for the study participants were asked if they had parents or grandparents of Mexican origin. Results indicated 18.4% received care for their mental health concern from a general health care provider, with only 8.8% of those receiving mental health treatments from a mental health specialist (Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). In particular for non-U.S. born Hispanics who visit a general health care provider for mental health services, this number is even lower (1 in 10) (U.S. DHHS, OSG, SAMHSA, 2001b). In addition, the supplement to the Surgeon General’s report on mental health also indicates that non-U.S. born Hispanics access mental health services with even less frequency, with only one out of every 20 accessing mental health services from a mental health specialist (U.S. DHHS, OSG, SAMHSA, 2001b).

Access to mental health services is complicated by a collective sphere of barriers encountered by both U.S. born and non-U.S. born Hispanics. One of the barriers that prevent Hispanics from accessing mental health services is language (U.S. DHHS, OSG, SAMHSA, 2001b). Hakimzadeh and Cohn (2007) found that only 23% of non-U.S. born Hispanics was able to hold a conversation in English well. Meaning that 77% of non-U.S. born Hispanics are not able to hold a conversation well in English. Hakimzadeh and Cohn (2007) also reported that it is only after the first generation in the United States, that the ability to speak English increases for first (88%) and second (94%) generations. Not being able to hold a conversation with a health care provider is a detrimental factor preventing Hispanics from trying to access services from their mental health concern. To further complicate the situation, there is a definite shortage in the number of Hispanic mental health care providers and mental health providers who are able to communicate in Spanish with their clients. William and Kohout (1999) collected information from
members of the American Association of Psychology, and found that only one percent of the random sample identified themselves as Hispanics. Regrettably, there are only 29 Hispanic mental health providers per 100,000 Hispanics (U.S. DHHS, OSG, SAMHSA, 2001b). This clearly indicates that there is a shortage in mental health specialist who share the specific characteristics requested by Hispanics with mental health concerns. The lack of available therapists that can communicate with Hispanics in Spanish is a key factor in failure to access the few existing services.

Consequently, a lack of availability of services which are culturally sensitive to the mental health needs of Hispanics can result in a misdiagnosis of a mental health problem, failure to diagnose a mental health problem, or lack of understanding of mental health issues within the Hispanic community. For example, Hispanics often assign non-clinical names to clinical mental health issues. Cultural Bound Syndrome is a term given to a combination of psychiatric and somatic symptoms recognized by a particular culture. Among Hispanics, ataque de nervios, nervios, and mal de ojo are common misnomers given to mental health illnesses (U.S. DHHS, OSG, SAMHSA, 2001b). A lack of understanding these terms or not speaking the language may lead to miscommunication between the mental health specialist and the patient, as well as lack of utilization of mental health services.

The concern for the mental health wellbeing of Hispanics living in the United States has been made with a discussion of the following: the difficulty in access mental health services, description of those Hispanics who actually seek mental health treatment, and need for mental health providers who are able to understand the Hispanic culture. This is the foundation for the importance to continue researching Hispanic mental health disparities. The subsequent is a description of the purpose of this particular study.

1.2 Purpose of the Study

The purpose of this study was to identify whether there was a relationship between acculturation and utilization of mental health services among U.S. born and non-U.S. born
Hispanics in the United States. Furthermore, the purpose of this study was to identify factors, which lead U.S. born and non-U.S. born Hispanics to seek and utilize mental health services.

Definition of Terms

Acculturation

Corsini (1987) stated the following: “Acculturation is a process whereby individuals learn about the rules for behavior characteristics of a certain group of people” (p. 7-8).

- **Hispanics**
  Persons of Hispanic origin, in particular, were those who indicated that their origin was Mexican, Puerto Rican, Cuban, Central or South American, or some other Hispanic origin. It should be noted that persons of Hispanic origin may be of any race (U.S. Census, 1993, paragraph 2.)

- **Access**
  “freedom or ability to obtain or make use of something” (Access, Merriam-Webster, 2008, paragraph 2).

- **Availability**
  “the quality or state of being available” (Availability, Merriam-Webster, 2008, paragraph 2).

- **Appropriate Services**
  Services which are culturally sensitive to the mental health needs of Hispanics.

- **U.S. born Hispanics**
  Individuals who are born inside the U.S. territory, who define themselves as Hispanics, as defined by the U.S. Census (1993).

- **Non-U.S. born Hispanics**
  Individuals who are born outside the U.S. territory who define themselves as Hispanics, as defined by the U.S. Census (1993).
1.3 Objectives

Now that the terms that are of particular importance to the study have been defined, the following is a list of the main objectives that have been achieved in this study:

- Describe the participants on the following variables:
  - Age
  - Sex
  - U.S. Born or Non U.S. Born
  - Resistance to mental health services
  - Family Support
  - Barriers to mental health services

- To assess the relationship between level of acculturation and the willingness of U.S. born and non U.S. born Hispanics to access mental health services. This objective was terminated because there was no U.S. born Hispanics participants.

- To identify the reasons why Hispanics access mental health services from Agape.

- To identify and compare the similarities and differences among U.S. born Hispanics and Hispanics born outside of the U.S. on their willingness to access mental health services. This objective was terminated because there was no U.S. born Hispanic participants.
CHAPTER 2
REVIEW OF THE LITERATURE

2.1 Introduction of the Literature

2.1.1 Bidimensional Acculturation Model

The bidimensional model is one of the models used to elucidate the cultural construct of acculturation. Cabassa (2003) uses Berry and Sam’s (1996) conceptualization of the bidimensional model to illustrate the different categories that a person can fall under. The four categories include: assimilation, separation, integration, and marginalization. Under assimilation, Cabassa (2003) explains that a person for whatever reason does not wish to partake in their culture of origin, therefore he or she absorbs the dominant culture and partakes intensively with the dominant culture. Cabassa (2003) then explains that unlike assimilation, the category of separation rejects the dominant culture and conserves their culture of origin. Individuals who fall in this category may choose to avoid interacting with the dominant culture, or simply reject it (Cabassa, 2003). The category of integration seems to act as a medium between assimilation and separation. An individual does not reject either the dominant culture or the culture of origin, and simply embraces both cultures. Lastly, under the marginalization category, a person may be cast off by the culture of origin as well as the dominant culture.

As explained earlier, there are four categories under which a person may fall, but it is also important to understand each person’s unique experience, which affects their acculturative process. After a review of the literature, Smart and Smart (1995) identified six factors conducive to the unique acculturative process Hispanics in the United States undergo. The six factors include: 1. Discrimination due to skin color; 2. emphasis on family and social support; 3. immigration status; 4. geographic closeness to country of origin; 5. involuntary minority; and 6. decline of physical labor in the United States. Immigration status in particular, helps explicate the different experience by someone who enters a foreign country. A distinction is made
between immigrants from Cuba, Central America, and Mexican Americans. Some Central American’s and Cubans escape their country due to political persecution and find asylum in the United States. Smart and Smart (1995) illustrate the differences by offering the example of the experience by people from Mexican origin. A great number of non-U.S. born Mexicans enter the U.S. illegally, and are faced with limitations in accessing employment, financial benefits, and live in fear of deportation (Smart & Smart, 1995). These factors help explain the differences among Hispanic subgroups, which are conducive upon their unique experiences they encounter when entering the U.S.

Now that a brief explanation of the cultural construct of acculturation has been given, it is important to note that Lara, Gamboa, Kharanaina, Morales, and Bautista (2005) made the observation that the vast majority of the literature has focused on the effects of acculturation on people who are originally from Mexico, which leaves other Hispanic subgroups unrepresented. There are substantial differences among Hispanic subgroups and it is important to take into account their sociopolitical differences which affect their experience in trying to access mental health care. At this point, a brief example will be given of one of the major differences which differentiate a person’s experience of accessing mental health service. Because of their social political status, Cubans often reap the benefits that are offered to U.S. born citizens. Unlike Cubans, Mexican Americans and Central American’s often do not have the same benefits offered because of their immigration status. Mexican Americans and Central Americans often enter the U.S. illegally; therefore they do not qualify for government assistance upon their arrival.

Despite a persons’ country of origin, a substantial amount of research exists on the negative effect of acculturation on both the mental and physical wellbeing of immigrants and in particular of Hispanics in the United States (Burnam, Hough, Karno, Escobar, & Telles, 1987; Escobar, Nervi, & Gara, 2000; Lara et al., 2005). Acculturation has also been associated with the increase of mental health obstacles amongst Hispanics. Research has been conducted since the mid 1980’s to document the impact as well as the seriousness of the problem. It is important
reiterate that most of the studies regarding mental health amongst Hispanics have mainly focused on Mexican Americans (Lara et al., 2005).

Escobar, Nervi, and Gara (2001) reviewed the literature pertaining to the prevalence of mental health disorders amongst US born Hispanics non-US born Hispanics. Their intent was to critically review the literature pertaining to the psychopathology of Mexican Americans and assess its relationship to immigration. Five major large scale epidemiological studies were reviewed including: The Epidemiological Catchment Area Study (Burnam et al., 1987), National Comorbidity Study (Kessler, et al., 1994), Mexican American Prevalence and Services Survey (Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano, & Caraveo-Anduaga, 1998), U.S. Border Study of Adolescents (Pumariega, Swanson, Holzer, Linskey, & Quintero-Salinas, 1988; Swanson, Linskey, Quintero-Salinas, Pumariega, & Holzer, 1992), and the University of California – Irvine Study of Mexican Disorder and Primary Care (Escobar, Waitzkin, Silver, Gara, & Holman, 1998).

The succeeding fragment is a brief synopsis of important findings in two of the previously mentioned studies. Burnam et al. (1987) compared those individuals born in the United States to those born in Mexico, and found that individuals who were born in the United States had higher prevalence of depression, dysthymia, phobias, substance abuse and dependence. The prevalence of lifetime disorders was found to be lower in Mexicans born outside of the United States. Burnam and colleagues (1987) explained that those who were U.S. born participants tended to have high acculturation levels. Although Vega et al. (1998) did not study place of birth, his findings from the Mexican American Prevalence and Services Survey found that the number of years a person lives in the United States increases the probability of the person developing a mental health disorder. Individuals who spent more than 13 years in the United States had a higher prevalence rate of mental health disorders (Vega et al. 1998). Essentially, place of birth and the number of years a person lives in the U.S. server as indicators that a person has a higher likelihood of suffering from a mental health illness.

Comparisons made between U.S. born Hispanics and non U.S. born Hispanics have not been limited to the prevalence of mental health disorders amongst each group. Studies have also
been conducted to compare the prevalence of substance abuse and level of depression and distress, between U.S. born and non-U.S. born adolescents. For example, U.S. Border Study of Adolescents (Pumiariogea et al., 1988; Swanson et al., 1992) as reviewed by Escobar and colleagues (2000), explored prevalence of substance use, risk factors associated with substance abuse, and level of depression and distress. Adolescents living on either side of the Texas and Mexico border were compared and it was concluded that U.S. born teenagers of Mexican descent had a higher prevalence of drug use. In addition, National studies like the Youth Risk Behavior Surveillance (YRBS) (Center for Disease Control, 2005, 2007) are conducted biannually and assess suicide prevalence, suicide ideation, depression, and substance use among all ethnicities in the U.S.

To give a recapitulation, mental health illness affects Hispanic children, youth, and adults; with acculturation having a substantial impact on the mental health well being of this specific population. As stated earlier, place of birth, the number of years a person lives in the U.S., affect the prevalence of depression, distress, and substance abuse. Without profoundly reviewing the literature at this point, it is clear that some relationship exists between acculturation and the need for mental health services amongst Hispanics.

2.2 Impact of the Problem

As stated earlier, the literature clearly supports the impact acculturation has on the mental health stability of Hispanics. Research is able to depict what happens when people do not receive appropriate treatment for their mental health needs. The literature also mentions a number of issues that are faced by Hispanics, which causes them to have a difficult time accessing and utilize mental health services (eg. Lack of Spanish speaking mental health providers, lack of health care insurance, and mental health education). Consequently, this has been the case within the Hispanic community. Repercussions due to a lack of mental health care as identified by the National Council of La Raza (2005) include: suicide, depression, chemical dependency, limitations in seeking help for mental health services due to intimate partner violence, which translates to Hispanics not being able to function at their preeminent capacity.
2.2.1 Suicide and Depression

Documentation also exists of the adverse physical, social, and mental effects that occur when mental health needs are not met. It is estimated that approximately 90% of those who died from suicide in the United States also had a mental health concern (Goldsmith, 2002). According to the Center for Disease Control (CDC) (2004), Hispanics who died from suicide between 1999 and 2001, accounted for 5,332 deaths. Of those who died from suicide, 85% were men, translating to 4,531 deaths. In 2005 alone, 2,188 Hispanics died from suicide (McIntosh, 2007). Suicide is an adverse effect of mental illness that threatens the lives of Hispanic adults and youth when mental health needs are not met. Between the year 1999 and 2004, suicide among Hispanics in Texas as reported by the CDC and the Texas Department of Health Services, is about half (5.6 per 100,000) of the overall suicide rate for Texas (10.7 per 100,000) (Mental Health America of Texas, 2008). The highest percentage of suicides in the United States was among Hispanic adults who were older than 85 years of age. Hispanic adults ages 85 years of age and older also had the highest percentage of suicides in Texas (Mental Health America of Texas, 2008). Although the suicide rate for Hispanics was below the national average for the year 2001, suicide among young Hispanics ages 10-24 is the 3rd leading cause of death (CDC, 2004). According to the 2005 YRBS conducted by the CDC, Hispanic youth have a higher prevalence of attempting suicide, feeling sad or hopeless, and having a suicide plan. The YRBS reported that among high school students, 11.3% of Hispanic Americans reported that they had attempted suicide, which is 2.7% higher than the national average (CDC, 2004). More specifically, Hispanic females reported as having higher rates of suicide ideation and behavior than non-Hispanic White and Black females. The 2005 YRBS also stated that twenty eight percent of America’s youth felt sad or felt hopeless thus interrupting their normal activities for more than two weeks. In particular, Hispanic females have the highest prevalence rate of this sadness or hopelessness when compared with their Black and White female counterparts, with 46.7% having felt sad or hopeless for more than two weeks. (Twenty-six percent of Hispanic males indicated feeling sad
or hopeless.) Furthermore, Hispanic females also had the highest prevalence rate of having a suicide plan among their White and Black counterparts, with 13% of Hispanic females actually stating that they had suicide plans. With particular attention placed on the high prevalence of Hispanics females, 14.9% in fact attempted suicide.

Hovey and King (1996) studied the influence of acculturation on suicide. Hovey and King (1996) examined the relationship between acculturation, depression, and suicidal ideation amongst Hispanic adolescents. High percentages of suicidal ideation and depression symptoms were found among participants. Hovey and King (1996) reported that a quarter of participants self-reported experiencing critical levels of suicidal ideation, and 23% or respondents self-reported critical levels of depression. A relationship was found between acculturative stress, depression, and suicidal ideation. Family functioning was a strong predictor of acculturative stress, thus having a family who is low functioning is relational to higher acculturative stress. Another predictor of acculturative stress is a person’s feelings about the future. Having positive expectations of the future serves as a protective factor against acculturative stress. As a final point, it was also recommended that adolescents suffering from acculturative stress should be treated with a cultural context in mind, since adolescents may be trapped between two cultures (e.g. Mexican culture and U.S. culture). As a consequence, being caught between two cultures may be a possible source for depression and suicide ideation.

Acculturation has also been examined by many researchers as a possible factor contributing to suicidal behavior amongst Hispanic adults (Fortuna, Perez, Canino, Sribney, & Alegria, 2007; Hovey, 2000). To continue, Hovey (2000) explains the intricate role acculturation plays in the lives of foreign born Hispanics suggesting that these individuals may be struggling between their culture of origin and their encounter with the new culture’s norms, values, and traditions. Hovey (2000) continues by explaining that immigrants’ mental health and wellbeing is also affected by their introduction to new factors (e.g. New language, lack of community and social support, discrimination).
Similar to findings in previous studies with Mexican Americans, Hovey's (2000) study on Central American immigrants supports the existence of a relationship between acculturation and the mental health wellbeing of Hispanics. Elevated levels of stress seems to serve as a predictor for being at risk for depression and suicide ideation. Hovey (2000) found a correlation between having a high level of depression and the following variables: stress ($r=.42$, $p<.0001$), low levels of education ($r=-.39$, $p<.001$), low levels of income ($r=-.28$, $p<.02$), family dysfunction ($r=.31$, $p<.005$), and ineffective social support ($r=-.31$, $p<.001$). Some of these factors were mentioned earlier as affecting the mental health stability of Hispanics. In essence, Hispanics who have elevated levels of acculturation are at a higher risk for both depression and suicide ideation.

It is important to reiterate that in the U.S., 90% of those who died from suicide, also suffered from a mental health illness (Goldsmith, 2002). With 5,332 Hispanics who died from suicide between 1999 and 2001 (CDC, 2004), it is essential that efforts are made to find possible factors that contribute to this number and to help reduce it as well. Hovey (2000) has done an exceptional effort in investigating the role of acculturation, suicide, and the mental well being of Hispanics. Now that a review of the association between suicide and acculturation has been completed, a review of the literature pertaining to association between acculturation and use of illicit substances will be reviewed.

### 2.2.2 Substance Abuse

The relationship between acculturation and the use of illicit substances amongst minorities has been documented since the early eighties. In their report on Mental Health, the National Council of La Raza (2005) made the following statement:

One of the most harmful consequences of poor mental health occurs when individuals are prone to excessive alcohol and illicit drug use. Cultural dissonance and acculturative stress, discrimination, socioeconomic pressure, loss of social support, mechanism upon immigration, and exposure to drugs and alcohol often lead to chemical use and dependency. (pg.11)
Chemical use and dependency among Hispanics born in the U.S. and outside the U.S. differ substantially. As Hispanics become more acculturated into western culture, they are more likely to consume alcohol and illicit drugs. Data from the 2002 National Survey on Drug Use was drawn by Ojeda, Patterson, and Strathdee (2008) to determine whether there was an association between “immigration characteristics” and the perception of participants on the effect that illicit substances have on health. Ojeda and colleagues (2008) reported that participants who answered that substance abuse posed a “great” or “moderate” threat to a person’s health, resulted in them being less likely to use “most substances” throughout their life. To continue, when comparing non-US born Hispanic to U.S. born Whites, non-US born were found to be more likely to perceive marijuana and LSD as a significant risk to health. Hispanic immigrants were also found to be less likely to use marijuana, cigarettes, and LSD. Ojeda et al. reported an interesting finding, when comparing the perception of marijuana and heroin, non-U.S. born Hispanics were more likely to perceive LSD as harmful but, less likely to view heroin as a harmful than U.S. born Hispanics.

Vega, Alderete, Kolody and Aguilar-Gaxiola (1998) studied the effects of gender and acculturation on the life time prevalence of drug use among U.S. born Hispanics and non-U.S. born Hispanics. A multi-stage clustered sample was gathered from Fresno, California. Vega et al. (1998) concluded that acculturation and nativity served as a stronger risk factor for women versus men. Findings illustrate the effect acculturation has on inhalant and other illicit drug use. Acculturated women (U.S. born and non-U.S. born) who were described as having and acculturation level 1 standard deviation above the mean, their odds of using inhalants and other illicit substances increased by four times. Although the effect of acculturation was not as strong as their female counterpart, males who had an acculturated level 1 standard deviation above the mean increased their odds of using inhalants and other illicit substances by three times. In essence, acculturation, participants’ residence (urban vs. rural), and gender are three factors which determine the likelihood of a person engaging in the use illicit substances and inhalants.
Similar to Ojeda et al.’s (1998) findings, Warner, Kerbs, and Fishbein (2008) conducted a study on the perception of substance use as a risk factor among children also concluded that non-US born Hispanic children viewed substances as more risky than U.S. born Hispanic children (73% greater than U.S. born respondents). Language used by the child to speak with his or her parents was also a factor in the study. Children who spoke English primarily with their parents were found to be 34% less likely when compared to those children who spoke Spanish with their parents to view using illicit substances as a great risk.

To recapitulate, the abuse of alcohol and illicit substance is associated with poor mental health, and the fusion of acculturative stressors. As the National Council of La Raza mentioned (2005), factors such as acculturative stress, lack of social support, socioeconomic pressure, are factors which often lead Hispanics to abuse of alcohol and use of illicit substances. It is important to keep in mind repercussion of substance abuse and the use of illicit substances due to poor mental health, especially when assessing the needs of Hispanics. In the subsequent section, a discussion will be made of the critical disparities Hispanic women face when seeking mental health care due to intimate partner violence.

2.2.3 Intimate Partner Violence

People of all racial, cultural and ethnic backgrounds are described as being equally susceptible to being abused by an intimate partner (Denham, Fraiser, Hooten, Belton, Newton, Gonzalez, et al. 2007; Grossman & Lundy, 2007; U.S. Department of Agriculture, Safety, Health, and Employee Welfare, n.d.) and most often affects women (Grossman & Lundy, 2007). Intimate partner violence leaves women vulnerable and with a need to access services for their mental health wellbeing. Emotional abuse and verbal abuse, especially in the form of intimidation, are tactics used by intimate partners to retain control over an intimate partner. Grossman and Lundy (2007) used data from the Illinois Coalition Against Domestic Violence and found that the majority (95.7%) of the women from the Hispanic subgroup had been verbally abused, 89.9% had been physically abused, and 17.2% sexually abused. An increase of 400% of Hispanic women who are victims of intimate partner violence in the United States
has occurred between 1990 and 2000 (Denham et al., 2000). Denham et al. (2000) found it necessary to identify descriptive characteristics of Hispanics who are victims of intimate partner violence in order to aid service providers in developing and implementing culturally sensitive treatment. The sample included: Hispanics, non-Hispanic Whites, and non-Latina African Americans, which allowed for a comparison of the prevalence differences amongst the three groups. Hispanic were characterized as being younger, having a lower education level than their counterparts, having children at home, and being less likely to report having health care insurance (Denham et al., 2000).

Brabeck and Guzman (2008) recruited and interviewed seventy-five participants who were born in Mexico or were of Mexican descent and had been victims of intimate partner violence. The researchers inquired about the barriers as well as their strengths, which facilitated or added to their impediment in seeking services. Participants were also given the opportunity to inform the researchers of their needs, and how services could be improved. The Hispanic respondents indicated that they would like more counseling services that focused on issues like self-esteem, decreasing fear and isolation, as well as parenting skills that would help them explain domestic violence issues to their children (Brabeck & Guzman, 2008). Participants stated that although counseling was available, limited movement within the shelter was a barriers preventing them from seeking counseling services. Brabeck and Guzman (2008) stated that even though women escape an abusive relationship, there is a need for mental health services in order to help battered women overcome the oppressive state of mind.

2.3 Access and Utilization of Mental Health Services

The need for mental health services has been documented with a discussion of the high prevalence substance use, suicide ideation, and intimate partner violence. However, the underutilization of mental health services by Hispanics in the United States has been well documented, especially after the 1999 mental health report by the Surgeon General. Vega, et al. (1999) studied the extent to which Mexican Americans underutilize mental health services. The researchers note that the appropriateness, accessibility, and cost-effectiveness of mental
health care are key variables in the underutilization of mental health services. Furthermore, Vega and colleagues (1999) note that in extreme cases in which mental health problems caused a high level of impairment, the level of utilization of mental health service by immigrant participants did not increase. Several theories were offered, including the idea that Mexican Americans substitute mental health treatment from mental health providers with emotional support systems (e.g. emotional support from family support systems). Advocacy for future research is also mentioned to address five key areas that revolve around reason for which Mexican Americans access mental health care for their mental health concern. These key issues include, but are not limited to: 1.) cultural beliefs regarding mental health, 2.) appropriateness of mental health services, 3.) need for Spanish speaking mental health providers.

A study included patients at San Diego's County Mental Health Department, a mental health department located in a county which was mentioned as being ranked number six in terms of its ethnic diversity (Barrio, Yamada, Hough, Hawthorne, Garcia, & Jeste, 2003). Barrio et al. compared the use of case management services by patients diagnosed with schizophrenia or schizoaffective disorder by European Americans, African Americans, and Hispanic’s. A significant difference was found among the utilization of case management, with 30.2% European Americans utilizing case management services at a disproportionate rate versus 19.3% for Hispanic patients, and 17.4% for African Americans. Hispanics were described as being more likely to be younger and living with family. Findings suggested that those who were living with family members were less likely to utilize case management services. Research findings supported Barrio et al.’s hypothesis that Spanish speaking Hispanics would utilize mental health case management at a lower rate. Never the less, findings were not anticipated; Barrio and colleagues, the underuse of case management services was less than expected when compared to the findings in other research studies. Barrio and colleagues explained that the difference may be due to the fact that San Diego has three bilingual centers which cater to the needs of non English speaking Hispanics.
Aguilera and Lopez (2008) attempted to identify barriers to accessing mental health services. The proportion of non-US born citizens in a community served as a predictor of the utilization of mental health services. Communities composed of a higher proportion of foreign-born non-citizens were less likely to utilize mental health services. Furthermore, it was also determined that foreign-born non-citizens with higher income were more likely to utilize mental health services, despite the fact that services were provided to all residents not considering their ability to pay for mental health services in the Los Angeles Community Department of Mental Health. Aguilar and Lopez (2008) recognize that the lack of utilization of mental health services by foreign born Hispanics may be related to the lower need of services. There are a number of studies that suggest that foreign born Hispanics have a lower prevalence of substance abuse, depression, and suicide. Rawal, Romansky, Jenuwine, and Lyons (2004) attempted to study mental health needs and utilization of mental health services among minorities in the juvenile detention system. Similar to the findings in other mental health disparities studies in which ethnicities are compared, White youth were reported as having higher rates of mental health service use, including prior to juvenile detention. Hispanics had the lowest percentage (19.4) of reporting having ever been in treatment (White-18.9%, and African American- 36.5%). Rawal and colleagues note that despite the evidence of mental health needs amongst the three groups compared, the evidence clearly states the needs and disparities amongst ethnicities. The report clearly highlighted the needs of Hispanic youth in the detention system due to the fact that Hispanic youth are less likely to currently be receiving treatment and having prior treatment. Having health care does not guaranty that Hispanics will utilize their mental health benefits. A clear example is set by Lagomasino’s et al. (2005) study on mental health disparities by Hispanics who suffer from depression and have health care benefits. Lagomasino and colleagues (2005) found that amongst Hispanics who have managed care they are: 1) less likely to receive any form of depression care, 2.) less likely than Whites to receive depression medication or counseling services (Whites =50% and Hispanics = 30%), and 3) only 19% receive depression treatment or counseling when compared to 36% of Whites.
2.4 Historical Strategies to Resolve the Issue

In the past, there have been three significant steps taken by the U.S. government to decrease mental health gaps for Hispanics. The first came in 1996 by Donna Shalala, then Secretary of the U.S. Department of Health and Human Services, when she initiated the Health and Human Services Hispanic Agenda for Action: Improving Services to Hispanic Americans. The aim of this initiative was to improve health care delivery for Hispanic in the United States. A second initiative was made in 1998 by President Clinton titled Racial and Ethnic Health Disparities Initiative, a challenge which involved an elimination of racial and ethnic health care disparities by the year 2010. After President Clinton's announcement, the White House hosted the first conference dedicated to Mental Health. The third initiative was made by the U.S. Surgeon General in 1999 as he reported on mental health issues. Followed by the supplemental report titled Mental Health: Culture, Race and Ethnicity, a report that included the needs of racial and ethnic minorities and the difficulties they encountered in terms of access and availability.

2.5 Current Attempt to Address the Issue

Since the 1999 Surgeon General's report on mental health, a number of initiatives were taken in order to meet mental health care needs of Hispanics. The Center for Mental Health Services (CMHS) has taken measures to decrease the disparities in mental health services provided to Hispanics. Such measures include a partnership with the Center for Substance Abuse Prevention and the Center for Substance Abuse Treatment. Through this partnership 17 Community Action Grants were funded with the purpose of applying exceptional mental health treatment modules and offering substance abuse prevention programs for Hispanics (U.S. DHHS, n.d).

According to the National Congress of Hispanics Mental Health, in 2000 SAMSHA will continue to support the needs of Hispanic adults and children with emotional disturbances, by continuing to sustain the community action programs. Mental health services for Hispanic children and their families have also been aided through 65 five-year grants offered though the Comprehensive Community Mental Health Services Program for children and their families. More
than 10,000 Hispanic children with severe emotional disturbances have been helped since it first began in 1993 (U.S. DHHS, OSG, n.d., a).

An additional initiative by SAMHSA included a Community Disparities Program whose central concern was to decrease health care disparities for ethnic minorities (U.S. DHHS, OSG, n.d., a). The goal of the program was to increase access to mental health services and substance abuse prevention programs. Hispanic women and adolescents living in the U.S. and Mexico were included in the program. Mental health services and substance abuse services were provided using culturally appropriate, gender specific service providers.

Furthermore, the goals of the President’s New Freedom Commission (2003) included the elimination of barriers that prevented minorities such as Hispanics from access mental health services. This goal would be accomplished by incorporating professionals in the mental health field that were diverse in terms of ethnicity, culture, and language. Therefore, meeting the needs of patients who have a distinct cultural background, including Hispanics. Other initiatives include the efforts from American Psychiatric Association (2005) and the National Alliance on Mental Health (2009) whose initiatives are aimed at reducing the barriers which prevent them from reviewing the mental health care they need. In efforts to eliminated barriers to mental health for minority communities (including Hispanics), NAMI created NAMI’S Multicultural Action Center. As for the American Psychiatric Association (2005) celebrated “Hispanic Heritage Month” by developing a new initiative which focused on educating Hispanics about mental health. This was done by providing resources and information about common mental health concerns. Even so, researchers have also offered suggestions that may be beneficial in the fight to reduce mental health disparities among Hispanics.

2.6 Proposed Solutions

Researchers like Ruiz (2002) and Logomasimo et al. (2005) have suggested tactics to improve access and utilization of mental health services by Hispanics. Some possible ways in which disparities could be improved include: providing patients with education that is culturally appropriate, allowing adequately diagnosing Hispanics with depression (Lagomasino et al.,
Ruiz (2002) offers an extensive list of recommendations that may aid in the effort to help Hispanics have an opportunity to seek mental health services. The following are a few solutions to the health/mental health disparities among Hispanics offered by Ruiz include, but are not limited to (2002):

1. Encouragement of equal professional representation of the different cultural, racial, and ethnic clients served and who represent the population composure of the United States
2. Encouragement of bilingualism amongst providers of mental health services
3. Advocate for governmental financial support of mental health research that includes Hispanics and other minorities in the United States

Ruiz (2002) recognizes the need and also encourages the representation of Hispanic mental health professionals in the mental health arena. In addition, having mental health providers who speak the client’s primary language prevents misdiagnosis of a health or mental health problem and the underutilization.
CHAPTER 3
DESCRIPTION OF METHODOLOGY

3.1 Methods

The purpose of this study was to identify whether there is a relationship between acculturation and utilization of mental health services among U.S. born and non-U.S. born Hispanics in the United States. Furthermore, the purpose of this study was to identify factors which lead U.S. born and non–U.S. born Hispanics to seek and utilize mental health services. Support to collect data from the Agape clinic was provided by Leslie Kemp, the executive director of the clinic. (See Appendix A for a copy of the letter of support from Agape.) The study was approved by the University of Texas at Arlington’s Institutional Review Board (IRB approval #: 2008-658f, Appendix B).

3.1.1 Sample

The necessary sample size (n = 34) was determined a priori based on a desired power level of .80, desired effect size of .50 (medium), and an alpha of .05 (Hinkle, Oliver, & Hinkle, 1985). However, as this was an exploratory study, although it is customary in social work to use an alpha of .05, an alpha of .10 was used as it is deemed more appropriate to detect differences in an exploratory study (Black, 1999).

The sample used for this study was gathered from the Agape Clinic and Community Care. Sixty-five participants were selected who met the following criteria: 1.) 18 years or older; 2.) had been referred to or were currently being seen by the Agape psychiatrist, or 3.) were being treated for a mental health disorder by the clinic’s physician. The sample was not a random sample because participants had to meet the criteria mentioned above, and the investigator was only at the clinic four days out of the week, limiting the opportunity for every person treated at Agape for mental health services to participate in the study. For those who visited the clinic on
days the researcher was not present, English and Spanish flyers were posted with contact information inviting participants to join the study (Appendices C and D).

3.1.2 Description of Instruments

Questionnaire

A questionnaire was created to inquire about participants’ willingness to access mental health services, the barriers they encountered, and about family support in accessing mental health services. The questionnaire is available in English and Spanish (Appendices E and F).

Bidimensional Acculturation Scale for Hispanics

In order to measure the level of acculturation, an instrument created by Marin and Gamba (1996) was chosen. The Bidimensional Acculturation Scale for Hispanics (BAS) was used to measure the construct of acculturation for those who participated in the study. The BAS is a 24-item questionnaire composed of three sections: linguistic proficiency, language use, and electronic media. The BAS was available in English and Spanish for participants to chose, depending on their language preference. (See Appendices G and H). The BAS was created in order to correct the assumption made by previous measurements of acculturation—that acculturation was a unidimensional construct. This instrument has been found to measure acculturation well in both Mexican Americans and Central Americans (Fisher & Corcoran, 2007).

The BAS was appropriate because, as stated before, it is available in both English and Spanish. Many immigrants from Mexico, Central, and South America may be unfamiliar with the English language (Fisher & Corcoran, 2007). In order to be culturally sensitive, it was important to find an instrument that had good validity, reliability, and was available in Spanish and English. Cabassa (2003) explained that the BAS has corrected the zero-sum assumptions made by previous measurements of acculturation. Gordon (1995) stated that unidimensional proponents believed that acculturation could be measured along a continuum, which ranged from complete immersion to one’s culture of origin to complete emersion into the host culture (as cited by Cabassa, 2003). Furthermore, Cabassa continues by explaining that the BAS scale provides independent measures for preservation of the culture of origin and the observance to the
dominant culture (Fisher & Corcoran, 2007). The BAS measures acculturation levels for the Hispanic population, which is the construct and population being studied. As stated before, a large portion of the Hispanic population does not speak English, thus the researcher had to be sensitive to the participants’ needs. Finally, due to the fact that the Hispanic population is quite diverse, an instrument that has good validity and reliability with a number of Hispanic subgroups was chosen.

The reliability for the BAS subscales ranges from an alpha of .81 to .97. The non-Hispanic domain had an alpha of .96 and the domain for Hispanic had an alpha of .90, after all the scores for the subscales had been combined. Overall, the BAS’s internal consistency ranges from good to excellent. The BAS has been shown to have good concurrent validity. It also has good validity with Mexican Americans and Central Americans. The scale was validated by correlation of the subscales of the BAS with other measurements that are used to measure acculturation (Fisher & Corcoran, 2007).

The Patient Health Questionnaire 9

The Patient Health Questionnaire 9 (PHQ-9) is a 10-item questionnaire used to assess depression in patients. The instrument inquires about whether a patient has experienced a number of symptoms associated with the DSM-IV criteria for depression. Scores include 0-4 (minimal), 5-9 (mild), 10-14 (moderate), 15-20 (moderately severe), 21-27 (severe). Kroenke, Spitzer, and Williams (2001) reported that the PHQ-9 had an excellent internal and test re-test reliability, a Cronbach’s alpha of 0.89 (Primary Care Study) and 0.86 (Obstetrics and Gynecology study). Kroenke and colleagues also reported that the PHQ-9 has a sensitivity of 84% and specificity of 72% when compared to nine other instruments (Appendices I and J).

Mood Questionnaire

The Mood Questionnaire is a questionnaire available in Spanish and English, used to assess Bipolar disorder. It is composed of 13 questions which inquire whether a patient experiences symptoms associated with Bipolar I and Bipolar II. Hirchfield et al. (2003) found a sensitivity and specificity of .281 and .972. (Appendices K and L).
3.1.3 Data Collection

The principal investigator collected data weekly, Wednesday through Saturday, during clinic hours for ten weeks. The principal investigator informed Agape’s personnel of the study and the eligibility requirements. Recruitment was conducted by posting flyers with information about the study. Health care providers were also given information about the study and they informed patients who qualified. Participants contacted the principal investigator if they were interested in the study. If participants were interested, they were asked about their preference in language. Participants were given a consent form (Appendices M and N), which contained information about the study and their rights as participants in the study. Consent forms were available in English and Spanish. At the time of the consenting process, participants were also given the Health Insurance Portability and Accountability Act (HIPAA) authorization form to read and sign (Appendices O and P). HIPAA forms were given so that the principal investigator could have access to the participants’ medical records to: 1. Verify that they were receiving treatment, and 2. Place a copy of the Mood and PHQ-9 questionnaire in their charts. Once the informed consent and HIPPA authorization processes had been completed, the investigator conducted the demographic questionnaire, BAS, PHQ-9, and Mood questionnaires in the participants preferred language, in an interview format. After the interview was concluded, the participant received a copy of the consent form, HIPPA authorization form, and a packet with a list of relevant resources (Appendices Q, R, S, and T).

3.1.4 Recording Scheme

The researcher personally administered the demographic questionnaire, BAS acculturation scale, the PHQ-9, and the Mood questionnaire to the participants. As the participant answered the questions, the researcher documented the participant’s answers. The data was then entered into SPSS for analysis.
3.1.5 Threats to Internal Validity

There are a number of factors that question whether the findings of this study are true. Contemporary history or events that may have an impact on this particular population (Rubin & Babbie, 2007) include: immigrant raids, passage of legislation which may affect their legal status in the United States, and legislation that demands obligatory deportation of immigrants. The investigator will attempt to control this threat by collecting data for a period of four months, and only interviewing the participant one time for an hour. An additional threat to the internal validity of this study is the factor of maturation. With time, people may increase their level of acculturation. In order to control this threat, data will be collected for a period of four months so that the threat of maturation is decreased. Instrumentation also affects whether the findings of this study are true. If the investigator chooses to change the measurement instrument in the middle of the study, or if there is a change in observers or a change in scorers, this may affect the interpretation of the outcomes (Rubin & Babbie, 2007). The plan is to use the one observer, rater, and the same measurements throughout the study in order to eliminate instrumentation as a risk to the internal validity of this study. Attrition and mortality may come into play if participants decide to not continue with the interviewing process once it has begun. This can be reduced by reporting any participant mortality that occurs. Statistical regression may affect the interpretation of the outcomes if there are scores at either extreme (high above the mean, or far below the mean) (Rubin & Babbie, 2007). This threat is difficult to control without the use of a random sample.

Selection is another possible threat, due to the fact that services are being provided in a faith-based institution, this may create a biased sample that may feel more comfortable receiving services from a religious institution than another facility. Selection as a threat is also difficult to control without the use of a random sample.

3.1.6 Threats to External Validity

There are also a number of factors that threaten the extent to which the findings in this study can be generalized to the entire Hispanic population. The external validity of the study may be affected by the reactive effects of the experimental arrangements. Participants in the study
may be affected by the Hawthorn Effect: the mere fact that they are participating in a study may cause them to act in a different manner from their normal behavior (Campbell & Stanley, 1963). This threat is difficult to control or reduce due to the necessity of informed consent. Another possible reactive effect of the experimental arrangement is that participants may feel compelled to participate in the study so that they will continue to receive services. This threat will be controlled with the use of the informed consent letter, which will explain to participant that they have no obligation of participating in the study, that they may refuse to participate in the study, and that they will continue to receive the services at Agape Clinic and Community Care they are entitled to even if they do not agree to participate in the study. Another threat to the external validity of the study is the Experimenter Effect, which is caused by cues or signals offered by the investigator, possibly altering the responses provided by the participants (Campbell & Stanley, 1963). This threat will be controlled by monitoring and reporting observations of the experimenter effect.

3.1.7 Data Analysis

Each objective was measured with an appropriate statistical measure, depending on the level of measurement of each objective. Since this is an exploratory study, an alpha of .10 will be used to interpret the findings as this is considered acceptable (Black, 1999). The following is a list of the main objectives in this study:

- To describe the participants on the following variables:
  - Age
  - Sex
  - U.S. Born or Non U.S. Born
  - Resistance to mental health services
  - Family Support
  - Barriers to mental health services
- To assess the relationship between level of acculturation and the willingness of U.S. born and non U.S. born Hispanics to access mental health services.
- To identify the reasons why Hispanics access mental health services from Agape.
To identify and compare the similarities and differences among U.S. born Hispanics and Hispanics born outside of the U.S. on their willingness to access mental health services.

Objective one is a demographic description of the study participants which includes: age, sex, country of birth, U.S. born non-U.S born, marital status, and frequency of speaking English and or Spanish. Frequency was the statistical procedure to measure sex, country of birth, U.S. born or foreign born, and frequency of speaking Spanish or English. The variable of age is an interval ratio variable, and was calculated by using the mean and standard deviation. Point-biserial correlation was to be used to determine objective two, which was to assess whether there is a relationship between acculturation and the utilization of mental health services among Hispanic immigrants and U.S. born immigrants. Objective three, “Why Hispanics access mental health services from Agape?” was measured by using qualitative analysis. Objective four, to identify and compare the similarities and differences among U.S. born Hispanics and Hispanics born outside of the U.S. on their willingness to access mental health services, was to be completed using a chi-square test of independence. Objectives two and four were aborted since there were no U.S. born immigrants in the study.
4.1 Results and Findings

There were two main purposes why this study was conducted: to identify whether there was a relationship between acculturation and utilization of mental health services among U.S. born and non-U.S. born Hispanics in the United States; and to identify factors, which lead U.S. born and non-U.S. born Hispanics to seek and utilize mental health services. Before initiating a discussion of the results, it is important to note that objectives 2 and 4 were aborted due to the fact that there were no U.S. born participants in the study. Additional objectives were added to make up for the deletions.

4.1.1 Objective 1

Objective one was to describe the participants on the following variables:

- Age;
- Gender;
- Place of Birth;
- Resistance to mental health services;
- Family Support; and
- Barriers to mental health services.

Age

The first variable used to describe the participants in the study was the variable age as reported by respondents. The mean age of those who participated in the study was 40.6 (SD = 10.6) with a range from 23 to 67 years of age.

Gender
The second variable used to describe those who participated in the study was gender. The majority of the participants in the study were females (n= 41, 63.1%). According to the data collected, males accounted for 36.9% (n= 24).

Place of Birth

The third variable used to describe those who participated was their place of birth. All of the participants were born outside of the United States. The majority of the participants in the study were born in Mexico (n= 47, 72.3%), followed by participants from Honduras (n=8, 12.3%), and El Salvador (n=1, 1.5%). Some participants did not disclose their nationality (13.8%).

Resistance to Mental Health Services

The fourth variable to describe the participants was their resistance to mental health treatment. The majority of the participants indicated that they were not resistant to mental health services (n= 49, 75.4%). Twenty-four percent of the participants indicated that they were resistant to mental health services (n= 16, 24.6%)

Family Support

The fifth variable used to describe participants was their families support in accessing mental health assistance. Half of the participants indicated that their family members were supportive in finding mental health assistance (n= 33, 50.8%). Table 1.1 illustrates the range of responses.

<table>
<thead>
<tr>
<th>Family Members Support</th>
<th>Frequency (n = )</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, my family members were supportive</td>
<td>33</td>
<td>50.8</td>
</tr>
<tr>
<td>Not at all</td>
<td>20</td>
<td>30.8</td>
</tr>
<tr>
<td>Some of my family members were supportive</td>
<td>9</td>
<td>13.8</td>
</tr>
<tr>
<td>At the beginning</td>
<td>3</td>
<td>4.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
**Barriers to Mental Health Services**

The final variable used to describe the participants in the study was the barriers they encountered in finding mental health services. The majority of participants (n=32, 49.2%) indicated “Other” as their response when asked “What are the barriers you encountered when searching for mental health services?” Table 1.2 illustrates the range of responses.

Table 1.2 Barriers to Mental Health Services

<table>
<thead>
<tr>
<th></th>
<th>Frequency (n=)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaware of Mental Health Concern*</td>
<td>23</td>
<td>35.4</td>
</tr>
<tr>
<td>Unaware of where to access mental health services</td>
<td>21</td>
<td>32.3</td>
</tr>
<tr>
<td>No health insurance</td>
<td>12</td>
<td>18.5</td>
</tr>
<tr>
<td>No health insurance and unaware of where to access mental health services*</td>
<td>4</td>
<td>6.2</td>
</tr>
<tr>
<td>No Problem Accessing Mental Health*</td>
<td>3</td>
<td>4.6</td>
</tr>
<tr>
<td>Transportation*</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Language*</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
<td>100</td>
</tr>
</tbody>
</table>

*Results of “Other” category

**4.1.2 Objective 2**

This objective was to assess the relationship between level of acculturation and the willingness of U.S. born and non U.S. born Hispanics to access mental health services. Objective 2 was aborted due to the fact that no U.S. born Hispanics participated in the study.
4.1.3 Objective 3

Objective three was to identify the reasons why Hispanics access mental health services from Agape. To answer this objective, the variable “reasons for visiting Agape” was used to identify the reasons why Hispanics accessed mental health services from Agape. When asked, “What about Agape has made you return for mental health services?”, the majority (n=34, 52.3%) of participants chose “other” as their response. Table 1.3 illustrates the range of responses.

Table 1.3 Reasons for Returning to Agape

<table>
<thead>
<tr>
<th>Frequency (n=)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>13</td>
</tr>
<tr>
<td>Doctors</td>
<td>12</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>3</td>
</tr>
<tr>
<td>No Charge for Services</td>
<td>3</td>
</tr>
<tr>
<td>Felt Better</td>
<td>12</td>
</tr>
<tr>
<td>All of the Above</td>
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<tr>
<td>First Time at Agape</td>
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<tr>
<td>Medication</td>
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<tr>
<td>Inexpensive</td>
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<td>Hope of Feeling Better</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
</tr>
</tbody>
</table>

Table 1.3 Reasons for Returning to Agape

*a Results of “Other” category
*b Includes doctors, psychiatrists, inexpensive, and staff

4.1.4 Objective 4

Objective four was to identify and compare the similarities and differences among U.S. born Hispanics and Hispanics born outside of the U.S. on their willingness to access mental
health services. This objective was aborted due to the fact that no U.S. born Hispanics participated in the study.

The following are the additional objective chosen to replace those that were aborted:

4.1.5 Objective 5

Objective five was to assess whether a relationship exists between resistance to mental health services and the following variables:

- Patient Health Questionnaire 9 (PHQ-9) Scores
- Suicidal Ideation
- Self-worth
- Gender
- Number of Years in the U.S.

**Patient Health Questionnaire 9 (PHQ-9) Scores**

The first variables examined under objective 5 included Patient Health Questionnaire 9 (PHQ-9) scores and resistance. In order to assess the relationship between scores on the PHQ-9 and patient’s resistance to mental health services, Pearson’s Correlation was used. Originally, a point-biserial had been assigned to assess this relationship between the continuous PHQ-9 score and the dichotomous variable of resistance. However, SPSS lacks the capability of assessing the strength of a relationship between variables using a point-biserial correlation. Therefore, Pearson’s Correlation coefficient was used. At the .10 level of significance, there was not a statistically significant relationship between PHQ-9 scores and resistance to mental health services ($r = .180, p = .152$).

**Suicidal Ideation**

Suicidal ideation and resistance to mental health services was the second pair of variables under objective 5. The statistical procedure Cramer’s V was used to assess the strength of the relationship between the ordinal variable of suicidal ideation and the nominal variable of patient’s resistance to mental health services. Both variables were treated as nominal because SPSS does not support a rank biserial correlation, which is used to assess the
strength of a relationship between a nominal dichotomous and an ordinal variable. At the .10 level of significance there was not a statistically significant relationship between suicide ideation and resistance ($V=0.221$, $p=0.365$).

**Self-worth**

The third pair of variables under objective 5 was resistance to mental health services and self-worth. Cramer’s $V$ was used to assess the relationship between self-worth and the patients resistance to mental health services. Again, both variables were treated as nominal because SPSS does not support a rank biserial correlation, which is used to assess the strength of a relationship between a nominal dichotomous and an ordinal variable. At the .10 level of significance there was not a statistically significant relationship between self-worth and resistance ($V=0.235$, $p=0.308$).

**Gender**

The fourth pair of variables under objective 5 was resistance and gender. To assess the relationship between gender and resistance, the Phi correlation coefficient was used because both variables are nominal dichotomous. There was not a statistically significant relationship between gender and resistance to mental health services at the .10 level of significance ($\phi = 0.141$, $p=0.255$).

**Number of Years in the U.S.**

The fifth and final pair of variables under objective 5 was the number of years a person has lived in the U.S. and a person’s resistance to mental health services. Pearson’s Correlation was used to estimate the strength between the number of years a person lives in the U.S. and resistance to mental health services. Originally, a point-biserial had been the assigned statistic to assess this relationship between the continuous score and the dichotomous variable of resistance. However, SPSS lacks the capability of assessing the strength of a relationship between variables using a point-biserial correlation. Therefore, Pearson’s Correlation was used. There was not a statistically significant relationship between the number of years a person lived
in the U.S. and resistance to mental health services at the .10 level of significance (r = .124, p = .325).

4.1.6 Objective 6

Objective six was to assess the relationship between PHQ-9 scores and the following variables:

- Family Level of Support
- Hispanic Dimension of the BAS
- Non-Hispanic Dimension of the BAS

Family Level of Support

The first pair of variables used under objective 6 was PHQ-9 scores and Family’s Level of Support. Kendall’s Tau was used to assess the relationship between scores and the level of support by family members because both variables are ordinal with tied ranks. Scores on the PHQ-9 were converted into ordinal categories as follows: 0-4 None, 5-9 Mild, 10-14 Moderate, 15-19 Moderately Severe, 20-27 (Kroenke, Spitzer, & Williams, 2001). There was not a statistically significant relationship between families level of support and PHQ-9 scores (τ = -.168, p = .111). However, it should be noted that this weak relationship approaches the .10 level of significance which is acceptable for exploratory studies (Black, 1999).

Hispanic Dimension of the BAS

The second pair of variables under objective 6 used was the PHQ-9 scores and the Hispanic Dimension scores on the BAS. Pearson’s Correlation was used to assess the relationship between scores. There was not a significant relationship between BAS scores on the Hispanic dimension and PHQ-9 scores (r = -.142, p = .258).

Non-Hispanic Dimension of the BAS

The third pair of variables under objective 7 used was the PHQ-9 scores and the Non-Hispanic Dimension scores on the BAS. Pearson’s Correlation was used to estimate the strength of the relationship between scores. There was not a significant relationship between BAS scores on the Non-Hispanic dimension and PHQ-9 scores (r = .007, p = .541).
4.1.7 Objective 7

Objective seven was to assess gender differences on the following variables:

- Level of Family Support
- Hispanic Dimension on the BAS
- Non-Hispanic Dimension on the BAS
- PHQ-9 Scores

Level of family support

The first pair of variables compared under objective 7 was gender and level of family support. Assessing the relationship between these variables required a rank biserial correlation coefficient since gender was measured as nominal dichotomous and family support was ordinally measured. However, SPSS does not support this function. Both variables were treated as nominal, using Cramer’s V correlation coefficient. There was not a statistically significant relationship between gender and level of family supportiveness (Cramer’s V=.521, p=.223).

Hispanic Dimension of the BAS

The second pair of variables under objective 7 was gender and BAS scores on the Hispanic Dimension. To assess if there were differences in the BAS scores on the Hispanic Dimension due to gender, a t-test was conducted. At the .10 level of significance, there was not a statistically significant difference in Hispanic dimension scores on the BAS between male and female participants (t=1.198, p=.238).

Non-Hispanic Dimension of the BAS

The third pair of variables compared under objective 7 was gender and BAS scores on the Non-Hispanic Dimension. To assess if gender differences existed in the BAS scores on the Non-Hispanic dimension, a t-test was conducted. At the .10 level of significance, there was not a statistically significant difference in the non-Hispanic dimension scores on the BAS between male and female participants (t=-1.192, p=.239).
4.1.8 Objective 8

Objective 8 was to determine if a model exists to predict the likelihood of a person being resistant to mental health services depending on the following variables:

- English Dimension of the BAS
- Spanish Dimension of the BAS
- PHQ-9 Scores
- Gender

The four variables under objective 8 were assessed using a Binary Logistic Regression analysis. The constant only module indicated that the dependent variable was statistically significant (Wald = 15.109, p<.001). Therefore, it was appropriate to run a regression with the four predictor variables. The Omnibus test of the model coefficients was significant at the .10 level ($\chi^2 = 8.056, p = .090$) indicating that inclusion of the four predictor variables is appropriate. The inclusion of the four variables explains 17.3% of the variance (Nagelkerke $R^2 = .173$). However, the Hosmer and Lemeshow Goodness-of-fit Test ($\chi^2 = 17.039, p = .017$) indicates that the model is not a good fit at the .10 significance level. Looking at each of the four variables, none are good predictors of resistance, either by themselves or together. Tables 1.4 shows the significance of each variable.

PHQ-9 Scores

The fourth pair of variables compared under objective 7 was gender and PHQ-9 scores. To assess gender differences among PHQ-9 scores, a t-test was conducted. At the .10 level of significance, there is not a statistically significant difference in PHQ-9 scores between male and female participants ($t = -.154, p = .878$).
Table 1.4 Predictor Variables

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</tbody>
</table>

4.1.9 Objective 9

Objective nine was to qualitatively assess patients on the following variables:

- Barriers to Mental Health Care
- Perceived Causes of Mental Health Dilemma
- Reasons for Accessing Mental Health Services from Agape

The participants in the study shared a fraction of their lives with the principal investigator, thus offering insight to the complex collective sphere of mental health issues amongst non-U.S. born Hispanics. The following are the qualitative analysis results gathered from the information participants shared with the principal investigator. Participants shared about the barriers they encounter when attempting to access mental health services, the reasons which led participants to seek out mental health services, and their perception of the source of their mental health problems. The principal investigator also will share her observations of Agape Clinic and Community Care, and their role in providing a safe environment in which patients are able to disclose their personal stories.

*Barriers to Mental Health Care*

Apart from the barriers identified in the 18 item questionnaire, a large percentage of participants indicated that the leading barrier to accessing mental health services was lack of knowledge on issues like anxiety and depression. Participants stated that the only reason they were taking medication to keep their mental health issue under control was due to the fact that
Agape personnel administered a PHQ-9 questionnaire or the doctor asked about depression and anxiety symptoms.

Perceived Causes of Mental Health Dilemma

One of the primary factors which participants associated with their mental health concern was disputes within the nuclear and extended family. A number of patients spoke about marriage disputes, arguments due to the inability to provide for the family, and family members not speaking to each other. Another cause was their financial crisis due to the freeze in construction projects, in which participants were employed. Participants stated the difficulty they had in finding employment and the stress it has caused them as they struggle to make ends meet. Not being able to provide for their families caused a number of men to lose their identity as the main provider of the household, resulting in depression. Other causes of mental health concerns included their diagnosis with high blood pressure and diabetes. Both males and females stated that after these diagnoses, their self-worth decreased.

Reasons for Accessing Mental Health Services from Agape

Agape is composed of, in the primary investigator’s opinion, a culturally sensitive environment which properly attends to the mental health and physical needs of Hispanics who seek their services. The clinic is well aware of the needs of the population they serve and accommodates the needs of predominantly Spanish speakers. Patients at the clinic are greeted by a Spanish speaking intake specialist who conducts the initial assessment in Spanish. Questionnaires, medication directions, and health information are available in Spanish and English, depending on the patient’s language preference. A translator is paired with health care providers who do not speak Spanish. Although not fluent, most health care providers are able to speak some Spanish with the patients. Especially during this economic crisis, some patients are unable to contribute a donation, despite this fact; Agape does not turn patients away.
CHAPTER 5
SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Summary of Purpose and Objectives

There were two main purposes why this study was conducted: to identify whether there was a relationship between acculturation and utilization of mental health services among U.S. born and non-U.S. born Hispanics in the United States; and to identify factors, which lead U.S. born and non-U.S. born Hispanics to seek and utilize mental health services. Before initiating a discussion of the results, it is important to note that objectives 2 and 4 were aborted due to the fact that there was no U.S. born participants in the study. Additional objectives were added to make up for the deletions.

5.1.1 Summary of Objective 1

The majority of the participants were females (n= 41, 63.1%). The mean age of participants was 40.6 years (SD= 10.6 years) and ages ranged from 23 to 67. All participants were non-U.S. born Hispanics with the greater part indicating that they were born in Mexico. The preponderance of the participants indicated that they were not resistant to mental health services (n= 49, 75.4%). Half of participants also indicated that their family members were supportive in finding mental health assistance (n= 33, 50.8%). Figure 1.1 illustrates the range of responses.

Barriers to Mental Health Services

Under objective one, the barriers to mental health services were also assessed. When asked “What are the barriers you encountered when searching for mental health services?”, the majority of participants noted that the main barrier encountered was being unaware of a mental health concern (n=32, 72%). The second most common barrier was being unaware of where to access mental health services (n=21, 32.3%).
Other common barriers included: the combination response of no health insurance and did not know where to find mental health services (n=32, 13%); the need for transportation (n=32, 3%); and language difficulties (n=32, 3%). Figure 1.2 illustrates the full range of responses.

*Implication*

Women continue to access mental health services at a greater rate than males. Unfortunately, males are four times more likely to die from suicide and less likely to seek help for depression (National Alliance on Mental Health Illness, 2003). Research has indicated that males are less likely to seek mental health services for their mental health problem (Grant & Potenza, 2006). Similar to the literature, the results support that Hispanics lack information about mental health concerns; do not have health insurance to cover the cost; and do not know where to find mental health services. Bierman, Magari, Jette, Splain, and Watson (1998) have written about how the lack of health care insurance prevents Hispanics from seeking health care service, but when a person does not know that he or she is suffering from a mental health concern, this becomes yet another barrier (As cited by the National Council of La Raza). Even though it is commonly thought that Hispanics are resistant to mental health services, the findings of this study do not support it. The lack of resistance may be attributed to the lack of understanding that he or she has a mental health problem.

*Recommendation*

Amongst Latino males, it is recommended that the health care provider build a trusting relationship with the male patients before discussing mental health services to prevent resistance to mental health treatment. Agape uses a collocation model of integrated health care, in which both general health care providers and mental health providers are located at the same premises (Hogg Foundation, 2007). With this kind of model the trusting relationship between the health care provider and the patient has already been established. Therefore, this makes it much easier for patients to access mental health services, without having to be referred somewhere else. It is also recommended that male patients be asked whether they would prefer
to see a female or male mental health provider. To guide this process, Kilmartin (2005) offers some pointers on how to communicate with males about depression, without being intrusive with their sense of masculinity. Kilmartin (2005) suggests using terms like: courage, assertiveness, facing a challenge to describe the actions taken by the patient to seek help for their mental health problem. It is also advised to steer away from “feminine-defined” terms and use language that males would associate better with. Clinics like Agape could design classes in which information about depression, suicide, and anxiety could be discussed by health care providers, social workers, or psychiatrists. Education about mental health illnesses is necessary for this particular population. General information such as: what is depression, what types of depression exist, symptoms of depression, treatment options, and specific community resources with eligibility requirements will help them understand what changes are taking place in their bodies and how to address those. NIMH (2009) has created pamphlets with this information catered to women. Although the information is beneficial, it is recommended that more information is provided aside from offering pamphlets. Education about mental health services could also be broadcasted on public service announcements on Spanish radio stations and Spanish television channels. This is of particular importance, since all participants chose to be interviewed in Spanish.

5.1.2 Summary of Objective 3

When participants were asked why they returned for mental health services, slightly more than half (n=34, 52.3%) of participants chose “Other” as their response. Responses for “Other” included: All of the above (n=34,17.6%,) (includes: doctors, psychiatrist, inexpensive fee for services, and staff), felt better (n=34, 35.3%) inexpensive (n=34,11.76%), first time at Agape (n=34,14.7%), medication included with services (n=34, 8.8%), and having hope of feeling better (n=34, 11.7%). Figure 1.4 illustrates the range of responses.

Implications

It seems that patients seek services from Agape because of its diverse range of services provided, which meet their unique and individual needs. A third seem to indicate that they return to
Agape because they felt better. This implies that the patient is taking the medication and feels better and continues coming back for services. Responses also imply that respondents (n=34, 17.6%) benefit from all the services provided by Agape personnel (doctors, psychiatrist, inexpensive fee for services, and staff) and the affordability of services. It is important to take this information into account since Aguilar-Gaxiola (2005) noted the issue of recidivism, with 70% of Hispanic patients who seek mental health services not continuing treatment after their initial visit (As cited by the National Council of La Raza, 2005). Unfortunately, there is little information on why there is such a high recidivism among Hispanics. The reasons participants gave may offer insight to finding strategies to reduce the high percentage of recidivism.

Recommendations

One of the goals that the National Congress for Hispanic Mental Health expressed in their national agenda in 2000, was the development of an information and referral system which included the core values known as FUERSA which stand for: focus on cultural competence, utilizing the community, every domain specific, reinforce cultural values, strength-based, across ages (U.S. DHHS, n.d., b). FUERSA is an acronym used to summarize the core values of the (NCHMH); this translates to “strength” in English. Social Workers, psychiatrists, and general health care providers should be aware of the community resources available in their area. This is especially important for areas with a high proportion of Hispanics who are often living in poverty, undocumented, and/or uninsured. This study found that over 95% of the participants were not insured and were not offered insurance by their employer. Agencies like Agape which are affordable and provide a wide range of services (e.g. General health care, psychiatry, dermatology) should be kept in mind. It also important for social workers and other health and mental health care providers to know eligibility criteria of existing community services for non-U.S. born residents.
5.1.3 Summary of Objective 5

There was not a statistically significant relationship found between resistance to mental health services and the following variables: PHQ-9 scores ($r = .180, p = .152$), suicidal ideation ($V = .221, p = .365$), self-worth ($V = .235, p = .308$), gender ($\varphi = .141, p = .255$) and number of years a person lived in the U.S. ($r = .124, p = .325$).

Implications

The following implications are made from the findings: 1.) high scores on the PHQ-9 do not increase or decrease the likelihood of being resistant to mental health services; 2.) having suicidal ideation does not increase or decrease the likelihood of being resistant to mental health services; 3.) a having low self-worth does not increase or decrease the likelihood of a person being resistant to mental health services; 4.) there are no gender differences in resistance to mental health services.; and 5.) the number of years a person lives in the U.S. does not increase or decrease the likelihood of being resistant to mental health services.

Recommendations

The results imply that mental health providers should not put emphasis on depression scores, suicide ideation, self-worth, gender, and the number of years a person lives in the U.S., as factors that contribute to the likelihood of a patient being resistant to mental health services. One of the factors contributing to the lack of resistance to mental health services may be due to the strong relationship that is formed between the patient and the health care provider at the Agape clinic. This relationship is built on the trust gained from the health care provider’s actions. The actions include: following through, seeking the most affordable follow-up services, accommodating to the patient’s native language, and continuity of care (i.e. receiving services from the same health care provider). The Agape health care providers are concerned about the physical, mental, and financial wellbeing of the client. Resistance to mental health services may be combated with building a trusting relationship with the patient.
5.1.4 Summary of Objective 6

There was not a statistically significant relationship between PHQ-9 scores and BAS scores on the Hispanic dimension ($r=-.142$, $p=.258$), and the Non-Hispanic dimension ($r=.007$, $p=.541$). However, the weak inverse relationship between PHQ-9 scores and family support ($τ=-.168$, $p=.111$) are nearly significant at the .10 level appropriate for exploratory studies (Black, 1999).

Implication

The literature in the past has cited the negative effects of acculturation on the mental health wellbeing of Hispanics (Hovey, 2000; Smart & Smart 1995; Vega et al., 1998). With that being said, a relationship between acculturation and depression was expected. However, surprisingly, the findings showed no significant relationship between high score of depression and acculturation. Interestingly, though the findings imply that there is a weak inverse relationship between family support and having high scores of depression on the PHQ-9 meaning that as depression increases, family support may decrease.

Recommendations

The findings indicate that there needs to be a re-evaluation of acculturation as a contributing factor to negative mental health repercussions. It should be noted that being highly acculturated with the host country does not necessarily indicate higher levels of depression. Researchers should continue conducting studies on the relationship between acculturation and mental health amongst the Hispanic population to identify whether there has been a change in the nature of this population, and whether acculturation continues to have negative mental health effects. It is recommended that this study be replicated with a larger sample size.

5.1.5 Summary of Objective 7

There was not a statistically significant relationship between gender and level of family supportiveness (Cramer’s $V=.521$, $p=.223$). Additionally, there was no difference between
males and females on their scores on the Hispanic (t= 1.198, p=.238) and non-Hispanic (t= -1.192, p=.239) dimensions of the BAS nor on their scores on the PHQ-9 (t= -.154, p=.878).

**Implication**

The findings suggest that acculturation and PHQ-9 scores do not differ between males and females. Therefore, this implies that males and females have similar levels of family support and acculturation levels. Being a male or a female does not imply that a person will have more or less support from family members. As well, being a male or a female has no implication on whether a person will be more or less acculturated.

**Recommendation**

The findings are different from expected based on the literature. It was expected that there would be a gender difference on the levels of family support, acculturation and depression. More research should be conducted on this emerging phenomenon in which gender differences in the sufferance of certain mental health issues seem to be disappearing. In the past women were more likely to suffer from depression and males were more likely to die from suicide, this may no longer be the case. Research on suicidality among youth is following a similar trend: the gender gap seems to be closing amongst youth, with females and males being equally susceptible to suicidality, especially among Hispanic youth(YRBS,2007). Researchers should re-assess the relationship between gender and mental health illnesses.

5.1.6 **Summary of Objective 8**

Objective 8 was to determine if a model exists to predict the likelihood of a person being resistant to mental health services depending on the following variables: English Dimension of the BAS, Spanish Dimension of the BAS, PHQ-9 Scores, and Gender. A Binary Logistic Regression analysis was conducted and indicated that the model was not a good fit based on the Hosmer and Lemeshow Goodness-of-fit Test ($\chi^2 = 17.039, p= .017$). Focusing on each of the four variables, none were good predictors of resistance, either by themselves or together. Table 1.4 shows the significance of each variable.
**Implications**

The results indicate that, contrary to previous studies, acculturation, depression, and gender were not good predictors of resistance to mental health services.

**Recommendations**

Mental health providers should be aware that acculturation, depression levels, and gender were not found to be predictors of resistance to mental health services. It is important to reiterate that a high percentage of participants were not aware that they were suffering from a mental health problem. Before focusing on the issue of resistance, it is important to educate the Hispanic population about their mental health well being.

5.1.7 **Summary of Objective 9**

Objective nine was to qualitatively assess patients on the following variables:

- Barriers faced when attempting to access mental health service
- Patient’s perception of the causation of their mental health problem
- Reasons for accessing mental health services from Agape

The participants in the study shared a fraction of their lives with the principal investigator, thus offering insight to the complex collective sphere of mental health issues amongst non-U.S. born Hispanics. Participants shared about the barriers they encounter when attempting to access mental health services, the reasons which led participants to seek out mental health services, and their perception of the source of their mental health problems. The following is a summary of the findings:

- The leading barrier to mental health service is lack of understanding of mental health problems
- The major perceived causes of mental health issues by Hispanics include: disputes with nuclear and extended families, inability to financially provide for family.
• The main reason Hispanics access mental health services from Agape include: 1.) Provides a culturally sensitive environment, 2.) Agape’s staff being aware of the needs of Hispanics and accommodating to those needs.

• Diagnosis of high blood pressure and diabetes seemed to have an intense impact on a small number of participants.

Recommendations

Due to the fact that a number of patients indicated that they were unaware of the symptoms associated with depression, it is important to educate mental health professionals of this fact. It is also important to educate patients of the symptoms associated with depression and anxiety so that patients do not have to suffer in silence. Administration of instruments like the PHQ-9 should continue to form part of the initial intake process for all Hispanic patients. With Hispanics having such a high rate of high blood pressure, heart disease (Rugulies, 2002) and diabetes (DeGoot, Anderson, Freedland, Clouse, & Lustman, 2001), it is important to monitor their depression once diagnosed.

Conclusions

In view of the fact that there is a shortage of mental health providers who speak Spanish (Williams & Kohout, 1999), Agape has demonstrated a number of strategies which could be implemented in clinics as well as mental health settings which allow patients to feel comfortable asking for and receiving help. Strategies mentioned included:

• Providing patients with questionnaires, medication directions, and health information in Spanish and English, depending on the patient’s language preference.

• Having an interpreter paired with health care providers who do not speak Spanish is also beneficial to patients being able to receive appropriate treatment regardless of there being a mental health provider who speaks the patient’s native language.

• Nature and tolerance of the staff is another key factor which contributes to patients feeling comfortable in asking for help. Staffs at Agape assess the physical, mental, and
financial wellbeing of patients. Staff is well informed of the available resources that patients are eligible for (e.g. Free eye clinic, dentist, community health programs, and food pantries).

- Agape provides services to patients at an affordable price. Patients are asked for a donation, which is then used to buy medications for the clinic. With the donation provided, a patient is able to see a health care provider and receive the medications prescribed.

- It is also important to reiterate the model used by Agape (integrated model) (Hogg Foundation, 2007), in which both general health care providers and mental health providers are located under the same premises. This is crucial to reduce resistance to mental health services, recommended by a trusted health care provider.
APPENDIX A

AGAPE APPROVAL LETTER
July 27, 2008

Institutional Review Board
University of Texas at Arlington
202 E. Border, Suite 201 Box 19188
Arlington, TX 76019

Dear Review Committee:

I am writing to express my support for the research study that Erika Ruiz, BSW (University of Texas at Arlington) is submitting to the Institutional Review Board Committee for review. The Agape Clinic has a continuing interest in understanding if there is a relationship between level of acculturation and the willingness of U.S. born and non U.S. born Hispanics to access mental health services which Erika Ruiz focuses upon in this proposed research.

I look forward to hearing that they have been successful in obtaining support from the IRB for this endeavor.

Sincerely,

Leslie Kemp
Executive Director
APPENDIX B

IRB APPROVAL LETTER
Erika Ruiz  
Dr. Regina Praetorius  
Dr. Doreen Elliott  
Dr. Diane Mitschke  
University of Texas at Arlington  
Social Work  
Box 19129

RE: Full Board Review Approval Letter  

Title: Access to Mental Health Care: Hispanic Client Perception of Services Provided by Agape Clinic and Community Service

IRB No.: 2008-658f

The University of Texas at Arlington IRB has approved the above-referenced study effective December 9, 2008. IRB approval for the research shall continue until December 8, 2009. In order for the research to continue, Continuing Review must be completed within the month preceding the date of expiration indicated above. A reminder notice will be forwarded to the attention of the Principal Investigator (PI) at that time.

The following revisions requested by the Full Board have been received and approved:

- The consent form has been updated to the correct reading level in both Spanish and English versions
- The addition of a HIPAA authorization was implemented
- The risks of a participant expressing suicidal ideation while undergoing study procedures have been addressed and controls have been applied

The approved subject sample size is 85 subjects.

Important Note: The IRB approved informed consent documents (ICD) and the Authorization to Use and Disclose Protected Health Information for Research Purposes (HIPAA), showing the stamped approval and expiration date of the article must be used when prospectively enrolling volunteer participants into the study. The use of a copy of any consent form on which the IRB-stamped approval and expiration dates are not visible, or are replaced by typescript or handwriting, is prohibited. The signed consent forms must be securely maintained on the UTA campus for the duration of the study plus three years. The complete study record is subject to inspection and/or audit during this time period by entities including
but not limited to the UT Arlington IRB, Regulatory Services staff, OHRP and by study sponsors (if the study is funded).

Please be advised that as the principal investigator, you are required to report local adverse (unanticipated) events to this office within 24 hours. In addition, pursuant to Title 45 CFR 46.103(b)(4)(ii), investigators are required to, “promptly report to the IRB any proposed changes in the research activity, and to ensure that such changes in approved research, during the period for which IRB approval has already been given, are not initiated without prior IRB review and approval except when necessary to eliminate apparent immediate hazards to the subject.”

All investigators and key personnel identified in the protocol must have filed a Conflict of Interest Disclosure and have documented CITI or Responsibility in Human Subjects Research – IRB 101 Training on file with this office prior to protocol submission.

If applicable, approval by the appropriate authority at a collaborating facility is required prior to subject enrollment. If the collaborating facility is engaged in the research, an OHRP approved Federalwide Assurance (FWA) may be required. To determine whether the collaborating facility is engaged in research, go to: www.hhs.gov/ohrp/assurances.

The UT Arlington Office of Research Administration appreciates your continuing commitment to the protection of human research subjects. Should you have questions or require further assistance, please contact Robin Dickey by calling (817) 272-9529.

Sincerely,

Patricia Turpin

Patricia Turpin, Ph.D., RN, CNAA, BC
Associate Clinical Professor
UT Arlington IRB Chair

53
Hispanic Mental Health Care

I am conducting a study to assist Agape in improving access to mental health services for Hispanic patients. If you would like to participate in this study, please take one of the tabs with you and give me a call. I will be in the clinic on Wednesday and Fridays.

THANK YOU!!!

Researcher
Phone: 214.228.0506 email: erika.ruiz@mavs.uta.edu
Cuidado de Salud Mental para los Hispanos

Estoy realizando un estudio para ayudar a la clínica de Ágape a mejorar acceso a servicios de salud mental para pacientes Hispanos. Si usted quiere tomar parte en este estudio, llévese por favor uno de las etiquetas con usted y déme una llamada. Estaré en la clínica los miércoles y los viernes.

¡GRACIAS!
APPENDIX E

ENGLISH QUESTIONNAIRE
English Version

1. Sex
   A. Female
   B. Male

2. Age
   _____

3. Where were you born?
   A. In the U.S. Of America
   B. Outside the United States of America

4. How many years have you been in the USA?
   _____ Years
   _____ Months

5. Were you resistant to getting mental health services?
   A. Yes
   B. No

6. If you answered “Yes” on # 5, when did you feel resistant?
   A. Before the session
   B. At the beginning
   C. In the middle of session
   D. Other

7. How did you hear about mental health services at Agape?
   A. Friend(s)
   B. Family member(s)
   C. Doctor Referral
   D. Television
   E. Radio
   F. Other

8. Did you come to Agape for physical or mental health care services?
   A. Mental health care
   B. Physical health care
   C. Other

9. Have you received mental health care at other places?
   A. Yes
   B. No
10. If you answered “Yes” on # 9, where did you receive mental health care?

11. Do your family members know that you are receiving mental health care?
   A. All of my family knows
   B. Some of my family knows
   C. None of my family knows
   D. Other

12. Were your family members supportive of you getting mental health care?
   A. Not at all
   B. Some of my family members were supportive
   C. At first they were not supportive but were supportive later
   D. Yes, my family members were supportive
   E. Other

13. What are some barriers you encountered in accessing mental health care?
   A. No health care insurance
   B. Unaware of where to access mental health care
   C. Other

14. What about Agape services have kept you coming back for mental health services?
   A. The doctor
   B. The psychiatrist
   C. No charge for services
   D. The staff
   E. Other

15. Who was the first person you spoke with about your mental health problem?
   A. Family member
   B. Friend
   C. Doctor
   D. Other

16. Do you have health insurance?
   A. Yes
   B. No
   C. Other
17. Has your place of employment offered you health insurance?
   A. Yes
   B. No
   C. Other

18. If you answered “Yes” on question 15, Did you accept it?
   A. Yes
   B. No
   C. Other
APPENDIX F

SPANISH QUESTIONNAIRE
Spanish Version

1. Sexo
   A. Mujer
   B. Varón

2. Edad
   _______

3. ¿Donde nació?
   A. En Los Estados Unidos
   B. Fuera de Los Estados Unidos

4. ¿Cuántos años ha vivido Usted en Los Estados Unidos?
   _______ Años
   _______ Meses

5. ¿Se resistió Usted a recibir servicios de salud mental?
   A. Sí
   B. No

6. ¿Si usted respondió “Sí” en la pregunta #5, cuando se sintió resistente?
   A. Antes de la sesión
   B. Al principio de la sesión
   C. A la mitad de la sesión
   D. Algo más

7. ¿Cómo se enteró Usted de los servicios de salud mental en Ágape?
   A. Un Amigo
   B. Un miembro de su familia
   C. Referencia del médico
   D. Anuncio de televisión
   E. Radio
   F. Algo más

8. ¿Usted fue a Agape para servicio de salud física o salud mental?
   A. Salud mental
   B. Salud física
   C. Algo más

9. ¿Ha recibido usted servicio para la salud mental en otro lugar?
   A. Sí
   B. No
10. ¿Si usted respondió “Sí” en la pregunta #8, en donde recibió cuidado para su salud mental?

11. ¿Saben sus miembros de familia que usted recibe asistencia de salud mental?
A. Sí, todos saben
B. Algunos saben
C. Ningún miembro de la familia sabe
D. Algo más

12. ¿Su familia le apoyó en su decisión de buscar asistencia de salud mental?
A. Para nada
B. Algunos miembros de la familia me apoyan
C. Al principio no me apoyaron pero después sí me apoyaron
D. Sí, me apoyaron
E. Algo más

13. ¿Cuáles fueron las barreras con las que se encontró en búsqueda de asistencia de salud mental?
A. Falta de Seguro de Enfermedad
B. No sabía donde conseguir asistencia de salud mental
C. Algo más

13. ¿Qué de Ágape lo hizo regresar para los servicios de salud mental?
A. El médico (no el psiquiatra)
B. El psiquiatra
C. Los servicios son gratis
D. El personal
E. Algo más

15. ¿Quien fue la primera persona a quien Usted reveló sus problemas de salud mental?
A. Un miembro de la familia
B. Un amigo/a
C. El médico
D. Algo más

16. ¿Tiene usted seguro de enfermedad?
A. Sí
B. No
C. Algo más
17. ¿Le han ofrecido seguro de enfermedad en su empleo?
A. Sí
B. No
C. Algo más

18. ¿Si usted respondió “Sí” en la pregunta #15, Lo acepto?
A. Sí
B. No
C. Algo más
APPENDIX G

ENGLISH BIDIMENSIONAL ACCULTURATION SCALE
English Version
Circle a number between 4 and 1 that best applies for each item.

Language Use Subscale

<table>
<thead>
<tr>
<th>Almost Always</th>
<th>Often</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

1. How often do you speak English? 4 3 2 1
2. How often do you speak in English with your friends? 4 3 2 1
3. How often do you think in English? 4 3 2 1
4. How often do you speak in Spanish? 4 3 2 1
5. How often do you speak in Spanish with your friends? 4 3 2 1
6. How often do you think in Spanish? 4 3 2 1

Linguistic Proficiency Subscale

<table>
<thead>
<tr>
<th>Very Well</th>
<th>Well</th>
<th>Poorly</th>
<th>Very Poorly</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

7. How well do you speak English? 4 3 2 1
8. How well do you read in English? 4 3 2 1
9. How well do you understand television programs in English? 4 3 2 1
10. How well do you understand radio programs in English? 4 3 2 1

67
11. How well do you write in English? 4 3 2 1
12. How well do you understand music in English? 4 3 2 1
13. How well do you speak Spanish? 4 3 2 1
14. How well do you read in Spanish? 4 3 2 1
15. How well do you understand television programs in Spanish? 3 2 1
16. How well do you understand radio programs in Spanish? 4 3 2 1
17. How well do you write in Spanish? 4 3 2 1
18. How well do you understand music in Spanish? 4 3 2 1

Electronic Media Subscale

Almost        Often        Sometimes
Almost        Almost        Always
Always        Never
4 3 2 1

19. How often do you watch television programs in English? 4 3 2 1
20. How often do you listen to radio programs in English? 4 3 2 1
21. How often do you listen to music in English? 4 3 2 1
22. How often do you watch television programs in Spanish? 4 3 2 1
23. How often do you listen to radio programs in Spanish?  
   4 3 2 1

24. How often do you listen to music in Spanish?  
   4 3 2 1
APPENDIX H

SPANISH BIDIMENSIONAL ACCULTURATION SCALE
Spanish Version

Marque con un círculo el número entre 4 y 1 a la respuesta que sea más adecuada para usted.

Language Use Subscale

<table>
<thead>
<tr>
<th>Casi Siempre</th>
<th>Frecuentemente</th>
<th>Algunas</th>
<th>Casi Veces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nunca</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

1. ¿Con qué frecuencia habla usted inglés? 4 3 2 1

2. ¿Con qué frecuencia habla usted en inglés con sus amigos? 4 3 2 1

3. ¿Con qué frecuencia piensa usted en inglés? 4 3 2 1

4. ¿Con qué frecuencia habla usted español? 4 3 2 1

5. ¿Con qué frecuencia habla usted en español con sus amigos? 4 3 2 1

6. ¿Con qué frecuencia piensa usted en español? 4 3 2 1

Linguistic Proficiency Subscale

<table>
<thead>
<tr>
<th>Muy bien</th>
<th>Bien</th>
<th>No muy bien</th>
<th>Muy mal</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

7. ¿Qué tan bien habla usted inglés? 4 3 2 1

8. ¿Qué tan bien lee usted en inglés? 4 3 2 1

9. ¿Qué tan bien entiende usted los programas de televisión en inglés? 4 3 2 1

10. ¿Qué tan bien entiende usted los programas de radio en inglés? 4 3 2 1

11. ¿Qué tan bien escribe usted en inglés? 4 3 2 1
12. ¿Qué tan bien entiende usted música en inglés?  4 3 2 1
13. ¿Qué tan bien habla usted español?  4 3 2 1
14. ¿Qué tan bien lee usted español?  4 3 2 1
15. ¿Qué tan bien entiende usted los programas de televisión en español?  4 3 2 1
16. ¿Qué tan bien entiende usted los programas de radio en español?  4 3 2 1
17. ¿Qué tan bien escribe usted en español?  4 3 2 1
18. ¿Qué tan bien entiende usted música en español?  4 3 2 1

Electronic Media Subscale

<table>
<thead>
<tr>
<th>Casi Siempre</th>
<th>Frecuentemente</th>
<th>Algunas Veces</th>
<th>Casi Nunca</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

19. ¿Con qué frecuencia ve usted programas de televisión en inglés?  4 3 2 1
20. ¿Con qué frecuencia escucha usted programas de radio en inglés?  4 3 2 1
21. ¿Con qué frecuencia escucha usted música en inglés?  4 3 2 1
22. ¿Con qué frecuencia ve usted programas de televisión en español?  4 3 2 1
23. ¿Con qué frecuencia escucha usted programas de radio en español?  4 3 2 1
24. ¿Con qué frecuencia escucha usted música en español?  4 3 2 1
APPENDIX I

ENGLISH PATIENT HEALTH QUESTIONNAIRE 9
# The Patient Health Questionnaire

## Nine-symptom Checklist

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2) Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3) Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4) Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5) Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6) Feeling bad about yourself — that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7) Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8) Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9) Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office coding: Total Score

If you have experienced any of these problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

- [ ] Not difficult at all
- [ ] Somewhat difficult
- [ ] Very difficult
- [ ] Extremely difficult

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APPENDIX J

SPANISH PATIENT HEALTH QUESTIONNAIR 9
Cuestionario sobre la salud del paciente (PHQ-9)

# Lista de verificación de nueve síntomas

Nombre:_________________ Edad:___________ Fecha de hoy:___________

<table>
<thead>
<tr>
<th>Durante las últimas 2 semanas, ¿con qué frecuencia le han molestado los siguientes problemas? (Marque su respuesta con un &quot;check&quot;).</th>
<th>Nunca (Not at all)</th>
<th>Varios días (Several days)</th>
<th>Más de la mitad de los días (More than half the days)</th>
<th>Casi todos los días (Nearly every day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Tener poco interés o placer en hacer las cosas</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2) Sentirse desanimada, depresiva, o sin esperanza</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3) Experimentar problemas para conciliar el sueño, dormir o dormir demasiado</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4) Sentirse cansada o tener poca energía</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5) Tener poco apetito o comer en exceso</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6) Sentir falta de amor propio o que ha fracasado y se ha decepcionado a sí misma y a su familia</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7) Tener dificultad para concentrarse en cosas tales como leer el periódico o mirar la televisión</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8) Se mueve o habla tan lentamente que otra gente se podría dar cuenta—o de lo contrario, está tan agitado o inquieta que se mueve mucho más de lo acostumbrado</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9) Se le han ocurrido pensamientos de que sería mejor estar muerta o de que se haría daño de alguna manera</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Sumar columnas: ______________________ 

(For office coding: Total Score) ______________________

Si usted marcó en forma afirmativa cualquiera de los problemas en este cuestionario hasta aquí, ¿cuan difficile se le ha hecho cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas?

☐ Nada en absoluto (Not difficult at all) ☐ Bastante dificil (Somewhat difficult) ☐ Muy dificil (Very difficult) ☐ Sumamente dificil ( Extremely difficult)

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AstraZeneca

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APPENDIX K

ENGLISH MOOD QUESTIONNAIRE
Mood Questionnaire

Instructions for patients: Please check ONE BOX ONLY for each of the questions below.

1. Has there ever been a period of time when you were not your usual self and...
   - YES
   - NO
   - you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?
   - you were so irritable that you shouted at people or started fights or arguments?
   - you felt much more self-confident than usual?
   - you got much less sleep than usual and found you didn’t really miss it?
   - you were much more talkative and/or spoke much faster than usual?
   - thoughts raced through your head and/or you couldn’t slow your mind down?
   - you were so easily distracted by things around you that you had trouble concentrating or staying on track?
   - you had much more energy than usual?
   - you were much more active and/or did many more things than usual?
   - you were much more social or outgoing than usual—for example, you telephoned friends in the middle of the night?
   - you were much more interested in sex than usual?
   - you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
   - spending money got you or your family into trouble?

2. If you checked YES to more than one of the above, have you experienced several of these during the same period of time?
   - YES
   - NO

3. How much of a problem did any of these situations cause you (like being unable to work; having family, money, or legal problems; and/or getting into serious arguments or fights)?
   - No problem
   - Minor problem
   - Moderate problem
   - Serious problem

Please discuss the results of this questionnaire with your physician.
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APPENDIX L

SPANISH MOOD QUESTIONNAIRE
Cuestionario sobre su estado de ánimo
Mood Questionnaire

Instrucciones: este cuestionario es importante para que podamos proporcionarle la mejor atención de salud posible. Sus respuestas servirán de ayuda para entender los problemas que tenga. Por favor conteste cada pregunta en la mejor medida posible.

1. ¿Le sucedió alguna vez que por un cierto período de tiempo usted comenzó a sentirse o actuar diferente de como era, y...
   - se sintió tan bien o con el ánimo tan elevado, o tan "hiperactivo", que algunos pensaron que usted no era la misma persona normal de siempre; o estuvo tan animado o "hiperactivo", que se metió en problemas o dificultades?
   - estaba tan irritable, que le gritaba a la gente; o iniciaba peleas o discusiones?
   - se sentía mucho más seguro de sí mismo que otras veces?
   - dormía mucho menos que de costumbre, pero notaba que no sentía falta de sueño?
   - hablaba mucho más, o mucho más rápido que de costumbre?
   - le pasaban las ideas muy rápidamente por la cabeza, o no podía pensar más lentamente?
   - se distraía muy fácilmente por las cosas que sucedían a su alrededor, al punto de que necesitaba hacer un gran esfuerzo en concentrarse o en continuar lo que estaba haciendo?
   - tenía más energía que de costumbre?
   - estaba mucho más activo o hacía muchas más cosas que de costumbre?
   - era socialmente mucho más activo y comunicativo, al punto de que—por ejemplo—telefonaba a amistades en medio de la noche?
   - se interesaba en el sexo más que de costumbre?
   - hacía cosas que no eran comunes en usted, o que la gente podría haber considerado excesivas, tonteras o arriesgadas?
   - el gastar dinero le causó problemas a usted o su familia?

2. Si usted marcó SÍ más de una vez, ¿ocurrieron varias de esas situaciones todas juntas en un mismo período de tiempo? Por favor, marque sólo una de las siguientes respuestas con un círculo.

3. ¿Cuántas dificultades le causaron cualquiera de las situaciones mencionadas (por ejemplo, no poder trabajar; problemas familiares, de dinero o legales; enfrascarse en discusiones o peleas)?
   Por favor, marque sólo una de las siguientes respuestas con un círculo.

Este Cuestionario ha sido diseñado exclusivamente como medio de evaluación y no deberá utilizarse como instrumento de diagnóstico. Consulte las primeras páginas del cuaderno para obtener el algoritmo de puntuación.

GRACIAS POR COMPLETAR ESTE CUESTIONARIO. POR FAVOR DEVUELVA EL FORMULARIO A SU MÉDICO.
APPENDIX M

ENGLISH CONSENT FORM
INFORMED CONSENT

PRINCIPAL INVESTIGATOR NAME:
Erika Ruiz

TITLE OF PROJECT:
Access to Mental Health Care: Hispanic Client Perceptions of Services Provided by Agape Clinic and Community Service

INTRODUCTION:
You are asked to be in a research study. Being in the study is voluntary. Please ask questions if there is anything you do not understand.

PURPOSE:
This study is being conducted to discover how living in America influences:
1) Your traditions and culture, and
2) Your use of mental health care.

DURATION:
This study will take about 1 hour.

PROCEDURES:
You do not have to take part in this study if you don’t want to. If you choose to be in the study, then you must read and sign the HIPAA authorization form. This form allows you to be in the study and allows the researchers and mental health care providers to review the questionnaires used in the study. The researchers will be able to read the answers you give on the questionnaires, but they will not be able to identify the person that answered the questionnaire. Your mental health care provider will be able to read the answers you give the mood questionnaires and he/she will be able to identify that you were the one who has answered the questionnaire. Allowing your mental health care provider to identify your answers will allow him/her to help you should he/she need to.

You will be asked to answer a total of four questionnaires. First, a 24-item questionnaire will measure how living in America influences your traditions and culture. Second, an 18-item questionnaire will measure 1) your willingness to use mental health care, 2) the difficulties you have encountered, and 3) your family supports. Lastly, two mood questionnaires will measure your depression and anxiety.

POSSIBLE BENEFITS:
By being in the study:
1) You will receive a packet of information on community resources that may be able to help you and your family.
2) You may help your mental health care provider better serve you.
3) You will help Agape learn more about the needs of you and your community so that Agape can better provide for those needs.

DEC 9 2008
APPROVED BY THE UTA-IRB
The IRB approval for this consent
Document will expire on
COMPENSATION:
As compensation for being in the study, you will receive a packet of information on
community resources that may be able to help you and your family.

POSSIBLE RISKS/DISCOMFORTS:
During this interview you will discuss your mental health. This may make you
uncomfortable. If you feel too uncomfortable during the interview, then you may choose to
continue with the study or quit the study. Please remember that the health care providers at
Agape are here to serve you. During or after the interview, if you feel uncomfortable about
what you discussed, you may choose to contact Agape, or a crisis counselor at (214) 828-
1000. These crisis counselors are available 24 hours a day and in either Spanish or English.

ALTERNATIVE PROCEDURES/TREATMENTS:
Nothing bad will happen if you are not in this study. If you are not in this study, you may
still use the services at Agape.

WITHDRAWAL FROM THE STUDY:
You may quit the study at any time without losing the compensation that you are otherwise
entitled.

NUMBER OF PARTICIPANTS: We expect 85 people to enroll in this study.

CONFIDENTIALITY:
Signed consent forms, questionnaires, and other identifiable data will be maintained in
Dr. Aguirre’s locked office (Social Work Building A, Rm. 318). The principal
investigator, Dr. Aguirre, Dr. Mitschke and Dr. Elliott will be the only personnel with
access to these files. Each (principal investigator, Dr. Mitschke and Dr. Elliott) will have
to gain access to the files through Dr. Aguirre. The mood questionnaires will be stored in
your medical charts at Agape. Agape will have access to the results of the mood
questionnaires for follow up purposes.

Under Texas law, social workers and health care providers must inform the proper
authorities of suspected child abuse, elderly abuse, and suicide ideation. If during the
interview you talk about any recent or future incident of abuse, then the social workers
and/or health care providers must report the recent or future abuse to the proper
authorities. This is done to protect the health and safety of children and the elderly. If
during the interview you talk about any suicide ideation or thoughts of harming yourself
or others, then your mental health care provider will be notified. This is done to protect
your health and safety and those around you. Your mental health care provider can help
you.

If in the unlikely event it becomes necessary for the Institutional Review Board to review
your research records, then The University of Texas at Arlington will protect the
confidentiality of those records to the extent permitted by law. Your research records will
not be released without your consent unless required by law or a court order. The data
resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could associate you with it, or with your participation in any study. If the results of this research are published or presented at scientific meetings, your identity will not be disclosed.

CONTACT FOR QUESTIONS:
Questions about this research or your rights as a research subject may be directed to Erika Ruiz at (214) 228-0506. You may contact Dr. Aguirre at (682) 225-7180 in the event of a research-related injury to the subject.

CONSENT:

As a representative of this study, I, Erika Ruiz, have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:

_________________________________  Date
Erika Ruiz
Principal Investigator

By signing below, you confirm that you have read or had this document read to you. You have been informed about this study’s purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time.

You voluntarily agree to participate in this study. By signing this form, you are not waiving any of your legal rights. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled, and that you may discontinue participation at any time without penalty or loss of benefits, to which you are otherwise entitled.

_________________________________  DATE
SIGNATURE OF VOLUNTEER

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The IRB approval for this consent Document will expire on

84
APPENDIX N

SPANISH CONSENT FORM
CONSENSO INFORMADO

INVESTIGADOR PRINCIPAL: Erika Ruiz

Título del proyecto: Acceso a Servicios de Salud Mental: La Precepción de los Clientes Latinos sobre los Servicios Dados por La Clínica Agape y Servicio Comunal

Este documento de consentimiento informado explicará en qué consiste ser un sujeto en un proyecto de investigación. Es importante que usted lea este material cuidadosamente y que luego decida si desea participar como voluntario.

PROPOSITO:
Este estudio será realizado para descubrir cómo el vivir en América influye:
1) Sus tradiciones y cultura, y
2) El uso de servicios para la salud mental

DURACION:
Usted participará en el estudio por aproximadamente una hora.

PROCEDIMIENTOS:
Usted no tiene que tomar parte en este estudio si no quiere. Si escoge participar en el estudio, tendrá que leer y firmar la forma de autorización de HIPAA. Esta forma le permite estar en el estudio y también le permitirá a los investigadores y a los proveedores de salud mental revisar los cuestionarios utilizados en el estudio. Los investigadores podrán leer las respuestas que usted dé en los cuestionarios, pero ellos no podrán identificar la persona que contestó el cuestionario. Su proveedor de salud mental podrá leer las respuestas que usted dé en los cuestionarios de humor y el/ella podrá identificar que fue usted quien ha contestado el cuestionario. Permitir a su proveedor de salud mental identificar sus respuestas le permitirá a el/ella ayudarle si el/ella necesita.

A usted se le pedirá contestar cuatro cuestionarios. Primero, un cuestionario de 24 preguntas que medirá cómo vivir en América influye sus tradiciones y cultura. El segundo, un cuestionario de 18 preguntas medirá 1) su voluntad para usar asistencia de salud mental, 2) las dificultades que usted ha encontrado, y 3) el apoyo de la familia. Por último, dos cuestionarios de humor medirán la depresión y la ansiedad.
POSIBLES RIESGOS O INCOMODIDADES:
Durante esta entrevista usted discutirá su salud mental. Esto le puede hacer sentir incómodo. Si usted se siente demasiado incómodo durante la entrevista, puede escoger continuar con el estudio o dejar el estudio. Recuerde por favor que los proveedores de asistencia médica en Agape están aquí para servirle. Durante o después de la entrevista, si usted se siente incómodo acerca de lo que usted discutió, puede escoger contactar a Agape, o un consejero de crisis al (214) 828-1000. Estos consejeros de la crisis están disponibles las 24 horas del día y hablan español o inglés.

POSIBLES BENEFICIOS:
Por participar en el estudio:
1) Usted recibirá un paquete de información de recursos en la comunidad que pueden ayudarle a usted y a su familia.
2) Usted puede ayudar a su proveedor de salud mental a servirle mejor.
3) Usted le ayudará a Agape aprender más acerca de sus necesidades y de su comunidad para que Agape pueda servir mejor a esas necesidades.

PROCEDIMIENTOS O TRATAMIENTOS ALTERNATIVOS:
No existe ningún peligro si usted decide no participar en este estudio. Usted seguirá recibiendo los servicios que usted califique en la clínica Agape.

CONFIDENCIALIDAD:

Bajo la ley de Tejas, los trabajadores sociales tienen el deber de informar el maltrato de niños y el abuso de las personas de edad avanzada a la autoridad apropiada. Si durante su entrevista usted revela cualquier incidente de abuso, estos serán informados a la autoridad apropiada. Este pasará para proteger la salud y bienestar de los niños y los viejos. Si durante la entrevista habla de el suicidio o pensamientos de maltratar a sí mismo o a otra persona, notifíquemos a su proveedor de salud mental. Esto pasará para proteger a su salud, bienestar, y a las personas acerca de usted.

Los hallazgos de este estudio podrán ser publicados o presentados en reuniones sin revelar su nombre o identidad. Se protegerá sus derechos y su privacidad, sin embargo, el Secretario del Departamento de Salud y Servicios Humanos, la Junta Evaluadora de la Universidad de Texas en Arlington, la Administración de Drogas y Alimentos (si fuese aplicable) y los trabajadores asociados con esta investigación podrán tener acceso a los documentos e información relacionados con este estudio. Su expediente (por ejemplo médico o estudiantil) será completamente confidencial según lo indica la ley. Este no será compartido con otras personas a menos que sea exigido por la ley o de acuerdo con las especificaciones mencionadas anteriormente.
Ultima revisión 11/23/2008

COSTO ECONOMICO:

Los posibles costos económicos asociados con su participación en este estudio son: su tiempo.

CON QUIEN HABLAR SI TIENE PREGUNTAS:

Usted podrá comunicarse con Erika Ruiz (214)228 - 0506 o la Dra. Aguirre (682)-225-7180 si tiene preguntas sobre esta investigación. Usted podrá comunicarse con el director de la Junta Evaluadora de la UTA llamando al teléfono (817) 272-3723 si usted tiene preguntas relacionadas con sus derechos como sujeto en un estudio de investigación.

PARTICIPACION VOLUNTARIA:

Su participación en este experimento de investigación es voluntaria. Usted puede rehusarse a participar o puede retirarse del estudio en cualquier momento que usted lo desee. Usted no perderá los beneficios o tratamientos a los que usted tiene derecho por el simple hecho de no participar en el estudio. Usted puede retirarse del estudio simplemente llamando a Erika Ruiz al siguiente número de teléfono (214)228 - 0506. Se le informará inmediatamente si cualquier hallazgo de este estudio podría hacerle cambiar de parecer.

DEC 09 2008
APPROVED BY THE UTA - IRB
The IRB approval for this consent Document will expire on
Ultima revisión 11/23/2008

INVESTIGADOR PRINCIPAL: Erika Ruiz

TITULO DEL PROYECTO: Acceso a Servicios de Salud Mental: La Precepción de los Clientes Sobre los Servicios Dados por Agape Clínica y Servicio Communal

Su firma a continuación confirma que usted ha leído este documento o que alguien se lo ha leído. Usted recibirá una copia firmada de este documento de consentimiento informado. A usted se le ha dado y se le continuará dando la oportunidad de hacer preguntas y de discutir su participación con el investigador.

Usted ha elegido participar en este proyecto de investigación libre y voluntariamente.

INVESTIGADOR PRINCIPAL

FIRMA DEL VOLUNTARIO

DEC 09 2008

APPROVED BY THE UTA-IRB
The IRB approval for this consent Document will expire on
APPENDIX O

ENGLISH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT FORM
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES

The University of Texas at Arlington

Name of Research Participant: ________________________________________________________

The privacy law, Health Insurance Portability & Accountability Act (HIPAA), protects my individually identifiable health information (protected health information). The privacy law requires me to sign an authorization (or agreement) in order for Erika Ruiz and her staff ("researchers") to be able to use or disclose my protected health information for research purposes in the study entitled Access to Mental Health: Hispanic Client Perceptions of Services Provided by Agape Clinic and Community Service

I authorize Erika Ruiz and her research staff to use and disclose my protected health information for the purposes described below. I also permit my doctors and other health care providers to disclose my protected health information for the purposes described below.

Service:

My protected health information that may be used and disclosed includes:

- Verification of treatment through chart review
- A copy of the PHQ9 and the Mood Assessment questionnaire will be placed in the patient's chart for his/her health care provider at Agape Clinic and Community Care to review and follow up.

The Investigator, Erika Ruiz may use and share my health information with:

- **The University of Texas at Arlington Institutional Review Board (IRB)**
  
  This is a group of people responsible for assuring that the rights of research participants are respected. Members and staff of the IRB at The University of Texas at Arlington, including the Office of Regulatory Services, may review the records regarding your participation in this research when the researcher or the research site is undergoing Quality Improvement Program (QIP) auditing or if you experience an "Adverse Event" (an unexpected unfavorable event) during the research procedures. If a representative of the IRB contacts you for information regarding your experience with this research you have the right to refuse to answer their questions.

- **Representatives of the Office of Human Research Protection (OHRP) or other government representatives, when required by law**
  
  [The OHRP may oversee the research project to confirm compliance with laws, regulations and ethical standards.]

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**APPROVED**

DEC 09 2008

Institutional Review Board

Page 1 of 3
Dr. Aguirre, Dr. Mitschke, and Dr. Elliott

[These people are members of the research team and may need access to your protected health information to assist the researcher in the research project.]

Once my health information has been disclosed to anyone outside of this study, the information may no longer be protected under this authorization.

Whenever possible, your health information will be kept confidential. The University of Texas at Arlington cannot guarantee the confidentiality of your health information after it has been shared with the recipients. Federal privacy laws may not apply to some institutions outside of The University of Texas at Arlington. There is a risk that the recipients could share your information with others without your permission.

The investigator(s) Erika Ruiz, Dr. Aguirre, Dr. Mitschke, and Dr. Elliott agree to protect my health information by using and disclosing it only as permitted by me in this Authorization and as directed by state and federal law.

The researchers may use your health information to create research data that does not identify you as a participant. This data may be used and shared by the researchers in a publication about the results of the research project or for other research purposes not related to the research project.

I do not have to sign this Authorization. If I decide not to sign the Authorization:

- It will not affect my treatment, payment or enrollment in any health plans nor affect my eligibility for benefits through Agape Clinic and Community Care.
- I will not be allowed to participate in this research study

After signing the Authorization, I can change my mind and:

- Not let the researcher disclose or use my protected health information (revoke the Authorization).
- If I revoke the Authorization, I will send a written letter to: The Agape Clinic and Community Care, Grace United Methodist Church, 4105 Junius St., Dallas, TX, 75246 to inform her of my decision.
- If I change my mind and withdraw the authorization, I will not be allowed to continue to participate in the study. It will not affect my treatment, payment or enrollment in any health plans nor affect my eligibility for benefits through Agape Clinic and Community Care.

It has been explained to me that I will not be allowed to review the information collected for the research until after the study is completed. When the study is over, I will have the right to access the information again.

This Authorization does not have an expiration date.

If I have not already received a copy of the Privacy Notice, I may request one by contacting the Privacy Officer. If I have any questions or concerns about my

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privacy rights, I should contact the Privacy Officer, Rusty Ward, at 423/272-3089 or the Office of Regulatory Services at 817/272-3723.

I am the subject or the authorized legal representative to act on behalf of the subject. I have read this information, and I will receive a copy of this form after it is signed.

________________________________________
Printed Name of Research Participant

________________________________________
Signature of Research Participant

__________________________
Date

Page 3 of 3

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APPENDIX P

SPANISH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT FORM
AUTORIZACION PARA UTILIZAR Y REVELAR INFORMACION PROTEGIDA DE SALUD PARA PROPOSITOS DE INVESTIGACION
La Universidad de Tejas en Arlington

Nombre del Participante: ________________________________________________

La ley del derecho a la intimidad, Acta de Portabilidad y Responsabilidad de Seguro Médico (HIPAA), protege mi información de salud individualmente identificable (información protegida de salud). La ley del derecho a la intimidad me requiere a firmar una autorización (o el acuerdo) para que Erika Ruiz y su personal ("investigadores") puedan utilizar o revelar mi información protegida de salud para propósitos de la investigación en el estudio titulado Acceso a Servicios de Salud Mental: La Precepción de los Clientes Hispanos Sobre los Servicios Datos por La Clínica Agape y Servicio Comunal

Yo Autorizo a Erika Ruiz y sus investigadores a utilizar y revelar mi información protegida de la salud para los propósitos descritos abajo. Yo también permito que mis médicos y otros proveedores de asistencia médica revelen mi información protegida de la salud para los fines descritos abajo.

Mi información protegida de salud que puede ser utilizada y revelada incluye:

- Verificación de tratamiento por examinación del expediente del paciente.
- Una copia del PHQ9 y el cuestionario de Evaluación de Humor será colocada en el expediente del paciente para que su proveedor de asistencia médica en la Clínica Agape y Servicio Comunal que lo revise y tome decisiones apropiadas.

La Investigadora, Erika Ruiz puede utilizar y puede compartir mi información de salud con:

- La Junta Evaluadora (IRB) de la Universidad de Tejas en Arlington

Este es un grupo de personas responsables de asegurarse de que los derechos de los participantes de investigación sean respetados. Los miembros y el personal de la Junta Evaluadora (IRB) en La Universidad de Tejas en Arlington, incluyendo la Oficina de Servicios Regulativos, pueden revisar los registros con respecto a su participación en esta investigación cuando el investigador o el sitio de investigación sea sometida a un auditó bajo el Programa del Mejoramiento de la Calidad (QIP) o si usted experimenta un “Evento Adverso” (un evento desfavorable e inesperado durante los procedimientos de la investigación). Si un representante de los representantes de IRB lo contacta a usted para información con respecto a su experiencia con esta investigación usted tiene el derecho de negarse a contestar sus preguntas.

Page 1 of 3

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Los representantes de la Oficina de Investigación de Protección Humana (OHRP) y otros representantes del gobierno, cuando sea necesario por ley

- La Dra. Aguirre, la Dra. Mitschke, y la Dra. Elliott pueden necesitar acceso a su información protegida de la salud para ayudar a la investigadora en el estudio.

Una vez que mi información de la salud haya sido revelada a cualquiera fuera de este estudio, pueda que la información ya no sea protegido bajo esta autorización. Siempre que sea posible, su información de la salud será mantenida en confidencial. La Universidad de Tejas en Arlington no puede garantizar la confidencialidad de su información de la salud después de que haya sido compartido con los destinatarios. Las leyes del derecho a la intimidad federales no pueden aplicar a algunas instituciones fuera de La Universidad de Tejas en Arlington. Hay un riesgo que los destinatarios puedan compartir su información con otros sin su permiso.

Las investigadoras Erika Ruiz, Dra. Aguirre, Dra. Mitschke, y Dra. Elliott están de acuerdo en proteger mi información de la salud utilizando y revelando sólo lo permitido por mí en esta Autorización y como es dirigido por el estado y la ley federal.

Los investigadores pueden utilizar su información de salud para crear los datos de investigación que no lo identifican a usted como un participante. Estos datos pueden ser utilizados y pueden ser compartidos por los investigadores en una publicación acerca de los resultados del proyecto de investigación o para otros propósitos de investigación no relacionados al proyecto de la investigación.

Yo no tengo que firmar esta Autorización. Si decidio no firmar la Autorización:

- No afectará el tratamiento, el pago ni la matriculación en cualquier planes de la salud ni afectará mi elegibilidad para beneficios por La Clínica Agape y Servicios Comunales.
- Yo no podré tomar parte en este estudio de investigación.

Después de que firme la Autorización, yo puedo cambiar de opinión y:

- No permitir que el investigador revele ni utilice mi información protegida de la salud (revoca la Autorización).
- Si revoco la Autorización, yo enviaré una carta escrita a: The Agape Clinic and Community Care, Grace United Methodist Church, 4105 Junius St., Dallas, TX, 75246 para informarles de mi decisión.
- Si cambio de opinión y retiro la autorización, yo no podre continuar en el estudio.

Se me ha sido explicado que yo no seré permitido revisar la información completa para la investigación hasta después de que el estudio sea completado. Cuándo el estudio

Page 2 of 3

APPROVED

Date 10-3-23

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termine, tendré el derecho de conseguir acceso a la información otra vez.

Esta Autorización no tiene una fecha de caducidad. Si ya no he recibido una copia de la Nota de Intimidad, yo puedo solicitar una por el Oficial de Intimidad. Si tengo cualquier pregunta o preocupación acerca de mis derechos de intimidad, yo debo contactar al Oficial de Intimidad, Rusty Ward, en 423/272-3089 o la Oficina de Servicios Regulativos en 817/272-3723.

Soy el sujeto o el representante legal autorizado a actuar a favor del sujeto.
He leído esta información, y yo recibiré una copia de esta forma después de que sea firmada.

______________________________
Nombre del Participante en el Estudio

______________________________
Firma del Participante en el Estudio

______________________________
Fecha

Page 3 of 3

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Dallas Mental Health Community Resources

ABC Behavioral Health
Location: 4600 Sammuelle Blvd.
Dallas, TX, 75228
Phone No.: 214) 275-8500
Services: Offers mental health services to people 14 yrs. and older. The services include coordination of medication and services, housing assistance, and employment assistance.
Hours: Monday-Friday 8 a.m. to 5 p.m. and Saturday 9 a.m.-3 p.m.
Eligibility: Must have ID or Driver's license, accepts North Star

Suicide and Crisis Center of North Texas
Location: 2808 Swiss Ave. Dallas, TX, 75204
Phone No.: (214) 828-1000
Services: Counselors are available to help people with mental health crisis who are contemplating suicide
Hours: 24 Hours a day
Eligibility: No ID requirement

Alcoholics Anonymous
Location: Mockingbird Ln. Suite 213, Dallas, TX 75244
Phone: 214) 887-6699
Services: Provides information about A.A. and locations of A.A. groups in Dallas
Hours: Monday through Friday 9 a.m. - 6 p.m., Every 3rd Saturday of a month 10 a.m. - 2:00 p.m.
Eligibility: No ID requirement

Children And Family Guidance Centers
Location: 8915 Harry Hines Blvd, Dallas, TX 75235
Phone: 214)351-3490
Services: Offers early intervention and counseling services for children, individuals, and families
Hours: Monday- Friday 9a.m until 5 p.m., Saturday by appointment
Eligibility: Proof of residency and income, North Star accepted

Dallas Metro Care MHMR Services
Location: 1389 River Bend Dr.,
Dallas, TX, 75247
Phone: 214)743-1200,
Services: Offers crisis intervention through telephone, rehabilitation for children, adolescents, and adults.
Hours: Monday- Sunday 24 hrs.
Eligibility: Must have proof of Dallas residency, health care, proof of guardianship

Children First Counseling Center
Location: 530 S. Carrier Pkwy, Suite 200
Phone: 972) 264-0604
Services: Provides Counseling services for individuals, couples, and family therapy
Hours: 9am. to 9pm. M-Th, Friday 9-12, Sat. by appt.
Eligibility: Accepts Medi-Cal and other health insurances, no identification required

Salesmanship Club Youth and Family Centers
Location: 1060 E. Tenth Street, Dallas, Texas, 75203
Phone: 214)915-1700
Services: Provides family therapy, infant and children evaluations, and an after school program
Hours: 9am. to 9pm. M-Th, Friday 9-12, Sat. by appt.
Eligibility: Accepts North Star and Chip, no identification required

Counseling Institute of Texas
Location: 705 W. Avenue B, Suite 306, Garland, TX 75040
Phone: 972) 494-0160
Services: Offers individual, marital, family therapy, including children and adolescents
Hours: 9 a.m. - 9 p.m., M-Th,
9 a.m. - 5 p.m-Friday, 9 a.m. - 4 p.m., Saturday
Eligibility: Only accepts North Star

99
APPENDIX R

SPANISH MENTAL HEALTH FLYER
Recursos de Salud Mental en Dallas

ABC Behavioral Health
Lugar: 4600 Samuell Blvd.
Dallas, TX 75228
No. De Teléfono: 214) 275-8500
Servicios: Ofrecen servicios de salud mental a personas de 14 años para arriba. Los servicios incluyen coordinación de medicamentos y servicios, apoyo de hogar, y trabajo.
Horas: Lunes - Viernes 9 a.m. - 5 p.m.
Elegibilidad: Necesita licencia de manejar o una identificación, Se acepta NorthStar

AL-ANON AND ALATEEN
Lugar: 5533 Dyer St, #103
Dallas, TX 75206
No. De Teléfono: (214) 363-0461
Servicios: Ayuda para la familia y para los amigos de personas que tienen un problema con el alcohol.
Horas: Lunes - Viernes 8 a.m. - 3 p.m.
Elegibilidad: No se requiere identificación

Alcohólicos Anónimos
Lugar: 5200 Mockingbird Ln, Suite 213, Dallas, TX 75244
No. De Teléfono: (214) 887-6699
Servicios: Ofrece información sobre A.A. y el lugar donde se reúnen los grupos de A.A.
Horas: Lunes - Viernes 9 a.m. - 6 p.m., Tres días 10 a.m. - 200 p.m.
Elegibilidad: No se requiere identificación

Children And Family Guidance Centers
Lugar: 891 S Harry Hines Blvd, Dallas, TX 75235
No. De Teléfono: (214) 351-3490
Horas: 8 a.m. - 8 p.m., lunes - viernes, 9 a.m. - 5 p.m., Sabado por apointment.
Servicios: Ofrece intervención temprana y servicios de consejería para niños, familias, e individuo.
Elegibilidad: Prueba de residencia y de ingreso. Se acepta NorthStar.

Metro Care Services
Lugar: 1351 Westmoreland, Cottage 5, Dallas, TX 75211
No. De Teléfono: (214) 330-7722
Servicios: Ofrecen consejería de crisis por teléfono, intervención de crisis móvil, y rehabilitación para los niños adolescentes e adultos.
Horas: 24 horas, Lunes - Domingo.
Elegibilidad: Debe tener prueba de residencia en Dallas, seguro de salud, y prueba de tutoría; no se requiere identificación.

Children First Counseling Center
Lugar: 530 S. Carrol Place, Suite 200
No. De Teléfono: (972) 264-0604
Servicios: Ofrecen consejería individual, familiar, y de pareja.
Horas: Lunes - Viernes 9 a.m. - 9 p.m.
Elegibilidad: Se acepta Medicaid y otros seguros de salud; no se requiere identificación.

Salesmanship Club Youth and Family Centers
Lugar: 106 E. Tenth Street, Dallas, TX 75203
No. De Teléfono: (214) 915-1700
Servicios: Ofrecen servicios de terapia familiar, evaluación para niños y adolescentes, y un programa terapéutico extraescolar.
Horas: Lunes - Viernes 8:30 - 5:30 p.m.
Elegibilidad: Se acepta Northstar y CHIP; no se requiere identificación.

Counseling Institute of Texas
Lugar: 705 W. Avenue B, Suite 306, Garland, TX 75040
No. De Teléfono: (972) 494-0160
Servicios: Ofrecen consejeras individuales, familiares, y de pareja.
Horas: 9 a.m. - 9 p.m., lunes - viernes, 9 a.m. - 5 p.m., sabados.
Elegibilidad: Solo se acepta NorthStar.

GRACIAS POR SU TIEMPO!!
APPENDIX S

ENGLISH COMMUNITY RESOURCE BOOKLET
WHERE CAN I GO IF I NEED FOOD?

The following list may help you and your family if you need food.

WILKINSON CENTER
5200 BRYAN STREET
DALLAS, TX 75206
TELEPHONE: 214-821-6380
TOLL FREE: 1-800-880-4996
HOURS: MONDAY - FRIDAY 9:00 A.M. - 4:30 P.M.
FREE OF CHARGE
SERVES THE FOLLOWING ZIP CODES:
75204 75206 75214
75217 75223 75226
75227 75228 75246

CENTRAL DALLAS MINISTRIES
409 NORTH HASKELL
DALLAS, TX 75246
PHONE #: 214-822-0710 EX 111
HOURS: MONDAY - THURSDAY 9:00 A.M. - 3:00 P.M.
SATURDAY: 9:00 A.M. - 12:30 P.M.
CLOSED: FRIDAY AND SUNDAY
COST: FREE

AGAPE CLINIC:
WWW.AGAPEClinic.ORG
PHONE #: 214-824-2533
GRACE UNITED METHODIST CHURCH
4105 JUNIUS ST. @ HASKELL (DALLAS, TX)
WEDNESDAY: 8:00 - 12:00
(SEPT. - MAY)
THURSDAY: 7:30 - 4:00
FRIDAY: 7:30 - 12:00
MY CHILDREN NEED CLOTHES
AND I DO NOT HAVE MONEY TO BUY CLOTHES.
WHERE CAN I GO?

THE FOLLOWING ARE STORE RESOURCES
WHERE YOU CAN BUY CLOTHING AND HOUSEHOLD GOODS AT A
LOW PRICE:

NORTH DALLAS SHARED MINISTRIES
2875 MERRELL ROAD
DALLAS, TX 75229
PHONE #: 972-620-8696
HOURS: MONDAY – FRIDAY 9:30 A.M. –
2:00 P.M.
SATURDAY 9:00 A.M. – 11:30 A.M.
REQUIREMENT: PHOTO IDENTIFICATION (AMERICAN OR
MEXICAN)
THE FOLLOWING ZIP CODES ARE SERVED:
75001 75220 75234 75248
75204 75225 75235 75251
75205 75229 75240 75252
75209 75230 75243 75252
75219 75231 75247 75287

CATHOLIC CHARITIES
WORLD OF GOODS RESALE STORE
BRADY CENTER
1009 ELM STREET
DALLAS, TX 75226
PHONE #: 214-624-1105
HOURS: MONDAY – FRIDAY 8:30 A.M. –
5:00 P.M.
SERVICES: NEW CLOTHES OR GENTLY
USED CLOTHES, AND OTHER GOODS FOR
OUR HOME

THE FAMILY PLACE THRIFT SHOP
1463 WEBB CHAPEL EXT.
DALLAS, TX 75220
PHONE #: 214-358-0381
HOURS: MONDAY – SATURDAY 10:00 A.M. 5:30 P.M.
SUNDAY 1:00 P.M. – 5:00 P.M.

NORTH DALLAS SHARED MINISTRIES
2875 MERRELL ROAD
DALLAS, TX 75229
PHONE #: 972-620-8696
HOURS: MONDAY – FRIDAY 9:30 A.M. –
3:00 P.M.
SATURDAY 9:00 A.M. – 11:30 A.M.
THE FIRST AND THIRD MONDAY OF
EACH MONTH FROM 6PM TO 7:30 PM
FREE SERVING THE FOLLOWING ZIP CODES:
75001 75220 75234
75248 75294 75225
75238 75251 75285
75229 75240 75252
75209 75230 75245
75252 75219 75231
75247 75287

CATHOLIC CHARITIES
ASSISTANCE THE ELDERLY AND THEIR
FAMILY
BRADY CENTER
4009 ELM STREET
DALLAS, TX 75226
PHONE #: 214-626-9330
HOURS: MONDAY – FRIDAY 8:00 A.M. –
5:00 P.M.
CROSS FAMILY CENTER
4906 BONNIE VIEW
DALLAS, TX 75241
PHONE: 214-375-0133
HOURS: MONDAY – FRIDAY 8:00 A.M. – 5:00 P.M.

JEFFERSON FAMILY ASSISTANCE CENTER
1924 WEST JEFFERSON #102
DALLAS, TX 75241
PHONE: 214-941-8596
HOURS: MONDAY – FRIDAY 8:00 A.M. – 5:00 P.M.

THE FOLLOWING IS A LIST OF RESOURCES WHEN INDIVIDUALS AND THEIR FAMILIES DO NOT HAVE A PLACE TO LIVE.

I LOST MY HOUSE/ APARTMENT. WHERE CAN I GO?

DALLAS LIFE FOUNDATION (DALLAS FUNCIÓN DE VIVA)
100 CADIZ STREET
DALLAS, TX 75221
PHONE: 214-421-1360
HOURS: MONDAY – FRIDAY 8 A.M. – 4 P.M.
SERVICES: FOOD, HOUSING, MEDICAL CARE, TRAINING, AND PROGRAMS TO RETURN TO SCHOOL.
REQUIREMENTS: Requires a Photo Identification. The Dallas Life Foundation requires an appointment and an application. Applications accepted Monday through Friday from 6:00 – 7:00 P.M.

I LIVE IN A PLACE WHERE THERE IS VIOLENCE AND I NEED A PLACE TO LIVE. WHERE CAN I GO?

THE FAMILY PLACE
DOMESTIC VIOLENCE SERVICES
OFFICE HOURS: MONDAY – FRIDAY 9:00 A.M. – 5:00 P.M.
SERVICES: EMERGENCY REFUGE, SUPPORT, CHILD DEVELOPMENT CENTER, COUNSELING FOR CHILDREN, COUNSELING VISITATION UNDER SUPERVISION
REQUIREMENTS: DOCUMENTS ARE NOT REQUIRED
I AM PREGNANT OR I JUST HAD A BABY, I NEED SPECIAL TREATMENT. WHERE CAN I GO?

DALLAS PREGNANCY RESOURCE CENTER
12959 JUPITER, SUITE 140
DALLAS, TX 75238
PHONE: 214-343-9263
HOURS: MONDAY–THURSDAY 10:00 A.M.–6:45 P.M.
TUESDAY AND FRIDAY 10:00 A.M.–3:45 P.M.
REQUIREMENTS: Requires appointment, requires proof of identification, requires Mexican identification, requires services: counseling, pregnancy exam, services for ant-contraceptive classes on nutrition and labor, material assistance and support services after abortion.

I NEED HELP TO LEARN ENGLISH. WHERE CAN I GO?

WILKINSON CENTER
ENGLISH AS A SECOND LANGUAGE (ESL)
5200 BRYAN STREET
DALLAS, TX 75206
PHONE: 214-421-6380
TOLL FREE: 1-800-880-4968
HOURS: MONDAY–FRIDAY 9:00 A.M.–4:30 P.M.
REQUIRES IDENTIFICATION (MEXICAN OR AMERICAN).
My Children Need Their Shots. Where Can I Go?

North Dallas Shared Ministries
2875 Merrell Road
Dallas, TX 75229
Phone: 3-872-620-8696
Hours: Tuesday 10:30 A.M.
Tuesday and Thursday at 5:00 P.M.
The following ZIP codes are served:
75001 75220 75234
75248 75204 75225
75235 75251 75205
75229 75240 75252
75205 75230 75244
75252 75219 75231
75247 75287

Where Can I Go if I Need Help Finding Care for My Children?

Central Dallas Ministries
Roseland Community Center
3535 Munger Avenue
Dallas, TX 75204
Phone #: 214-825-9410
Hours: Monday - Friday 10:00 A.M. - 6:00 P.M.
Saturday 10:00 A.M. - 6:00 P.M.
Services: open to the public. Sport groups, gym open and community activities. Parenting classes for adults. Cooking, healthy ways to live, and mentors for children and adults. Includes resources for other resources in the community and assistance in finding employment.

¿Where Can I Go If I Need Help Finding Employment?

Different Employment Programs offered by the Wilkinson Center
CareerWorks is a 5 week course with classes on Monday - Friday from 12:30 p.m. CareerWorks has classes for career planning, helps in finding work, how to write a resume, how to dress for a job interview and interview preparation.

I Don't Have a Job or Medical Health Insurance, But I Need to See a Doctor. Where Can I Go?

Agape Clinic
Grace United Methodist Church
4105 Junius Street (Corner Junius & Haskell)
Dallas, TX 75246
CAREERWORKS ACTIVITIES

FIELD OF FASCINATION: Each student has an opportunity to determine his or her field of fascination. We then help students adapt and find employment in position within their field of interest. A key to the success of the program is due to finding employment in the individual's area of interest. Identification is made of strengths in the individual's previous employment and how these strengths can be utilized in the individual's resume and interview.

Mock Interviews:

Each student should prepare, practice and participate in mock interviews. Work is done with professional volunteers to improve a person's interviewing skills. The students must be able to share positive work experiences, learn constructive responses for potential employers, and have confidence in their skills.

JOB SEARCH: The assistance to find work is conducted. During the last two weeks of class with Interfaith Housing Coalition, the volunteers and employees are available to each student in order to investigate potential employers, make changes to cover letters, and other help that is necessary. At the end of CAREERWORKS the student will have a graduation celebration in the Wilkinson Center, where the organizations and volunteers of the church offer food. Students are given the opportunity to buy professional clothing.

GED Classes: Monday - Thursday
1:00 P.M. - 3:00 P.M.

NORTH DALLAS SHARED MINISTRIES
2875 MERRILL ROAD
DALLAS, TX 75229
PHONE #: 972-620-8696
HOURS: MONDAY - FRIDAY 9:30 A.M. - 3:00 P.M.
SERVICES: Counselors available to help find employment, write resume, and prepare for interviews.

The following zip codes are served:
75001 75220 75234 75248
75204 75225 75235 75251
75205 75229 75240 75252
75209 75230 75244 75252
75219 75231 75247 75267
WHERE CAN I GO TO GET LEGAL COUNSELING?

CATHOLIC CHARITIES OF DALLAS
IMMIGRATION COUNSELING SERVICES
5414 MAPLE AVENUE, SUITE 400
DALLAS, TX 75206
PHONE: 214-634-7182
HOURS: TUESDAY - SATURDAY (FIRST AND SECOND WEEK OF EACH MONTH), THE FOLLOWING WEEKS THE OFFICE IS OPEN MONDAY THROUGH FRIDAY. CONSULTATIONS BEGIN AT 1:00 P.M. MUST GET THERE AT 12 P.M. OR BEFORE IN ORDER TO GET A NUMBER.
SERVICES: FAMLIY PETITIONS, CITIZENSHIP, SERVICES TO ABUSED IMMIGRANT WOMEN, SERVICES TO IMMIGRANTS VICTIMS OF CRIME, DEPORTATION REMOVAL.
REQUIREMENTS: PHOTO ID (MEXICAN OR AMERICAN)

SOUTHEAST DALLAS COOPERATIVE PARISH SHALOM ZONE
URBAN PARK UMC
IMMIGRATION JUSTICE FOR OUR NEIGHBORS
5670 MILITARY PARKWAY
DALLAS, TX 75227
PHONE: 214-361-0901
REQUIREMENTS: PHOTO ID (MEXICAN OR AMERICAN), AND PROOF OF CHILDREN AT HOME WHO ARE UNDER 18
HOURS: MONDAY - THURSDAY 9:00 A.M. - 2:00 P.M.

TRANSPORTATION

AUSTIN STREET CENTRE
2329 HICKORY
DALLAS, TX 75226
PHONE: 214-428-4242
HOURS: OPEN 24 HOURS
REQUIREMENTS: A PHOTO IDENTIFICATION AND AN APPOINTMENT IDENTIFICATION FROM THE MEXICAN CONSULATE ARE ACCEPTED.
SERVICES: HOUSING, FOOD, SECURITY, MEDICAL HELP, PSYCHIATRIC, JOB TRAINING PROGRAM, DAY PROGRAM, REHABILITATION PROGRAM.
MUST LIVE IN THIS CENTER IN ORDER TO RECEIVE SERVICES
DART

AIKARD STATION
1401 PACIFIC
DALLAS, TX 75202
PHONE: 214-979-1111
DIFFERENT TYPES OF PROGRAMS OFFERED BY DART
LOCAL CHARGE - VALID ONLY FOR A TRIP IN THE DALLAS METROPOLITAN AREA. THIS PASS MAY BE USED TO USE THE BUS, DART RAIL, AND THE TRE FROM THE UNION STATION THROUGH THE W. IRVING STATION.
SUPERIOR CHARGE - VALID FROM THE METROPOLITAN AREA THROUGH FT. WORTH. THIS PASS MAY BE USED TO USE THE BUS AND DART RAIL, AND THE TRE TRAIN IN THE BUSES MARKED "T" IN FT. WORTH.
I DON'T HAVE A JOB OR MEDICAL INSURANCE, BUT I NEED TO SEE A DOCTOR. WHERE CAN I GO?

- SPECIALTY CLINICS
- FOOT CLINICS
  - HOURS: TUESDAY 5:00 P.M.
- DERMATOLOGIST CLINIC
  - HOURS: FIRST AND THIRD THURSDAY OF EACH MONTH AT 5:00 P.M.
- SECOND TUESDAY OF EACH MONTH AT 5:00 P.M.
- WOMEN'S CLINIC
  - FEMALE AND BREAST EXAM ONLY
  - HOURS: FIRST AND THIRD WEDNESDAY OF EACH MONTH AT 5:00 P.M.
- DENTAL CLINIC FOR ADULTS
  - FOR EXTRACTION AND INFECTIONS ONLY
  - HOURS: FIRST AND THIRD FRIDAY OF EACH MONTH AT 8:00 A.M.

WHERE CAN I GO IF I NEED HELP FINDING CARE FOR MY CHILDREN?

WILKINSON CENTER
5200 BRYAN STREET
DALLAS, TX 75206
214-621-6360
FREE CALL: 1-800-880-4988
HOURS: MONDAY–FRIDAY 9:00 A.M. – 4:30 P.M.
COST: FREE
THE FOLLOWING ZIP CODES ARE SERVED:
75204  75206  75214
75217  75223  75226
75227  75228  75246
DIFFERENT PROGRAMS OFFERED BY THE WILKINSON CENTER
C.L.E.M.B. (CHANGING LIVES, IMPROVING MINDS AND BODIES) IS A PROGRAM FOR CHILDREN AGES 5-14 WHO ARE AT RISK
HOME WORK AND TUTORING. HOME WORK IS THE PRIMARY PRIORITY OF THE CLIMB PROGRAM. OUR VOLUNTEERS PERMIT US TO MEET THE NEEDS OF OUR STUDENTS AND THE INDIVIDUAL OPPORTUNITIES OF THE COURSE
SMARTBODY IS A PROGRAM ABOUT HEALTH AND NUTRITION. SMARTBODY MAKES AN EFFORT TO INCLUDE HEALTHY EATING HABITS. THE GOAL IS TO REDUCE THE INCIDENCE OF OBESITY IN YOUTH AND CHILDREN.
ARTWORKS: UNDER THE DIRECTION OF A COMMUNITY ARTIST, THE STUDENTS HAVE ACCESS TO AN ART STUDIO WHERE THEY ARE ABLE TO CREATE, EXPRESS, AND STRENGTHEN THEIR FINE AND MOTOR SKILLS.

CAMP CLIMB. IS A FREE PROGRAM WHICH TAKES PLACE ALL YEAR AROUND IN THE CITY OF DALLAS. DURING THE SUMMER, THE CHILDREN CONTINUE TO RECEIVE EMOTIONAL AND EDUCATIONAL SUPPORT THEY NEED. DOES NOT STOP AT THE END OF THE SCHOOL YEAR.

SPECIAL EVENTS: THE CHILDREN LISTED IN THE CLIMB PROGRAM HAVE AN OPPORTUNITY TO PARTICIPATE IN EVENTS THROUGHOUT THE YEAR. SOME EVENTS INCLUDE OUR BACK TO SCHOOL SHOE GIFT, CHRISTMAS GIFTS, AND FAMILY FUN NIGHT.

PROGRAMS ARE AFTER SCHOOL FROM MONDAY—THURSDAY 3:30 P.M.—5:00 P.M.

CENTRAL DALLAS MINISTRIES
MEDICAL CLINIC AND PHARMACY
801 N. PEAK STREET
DALLAS, TX
PHONE #: 214-821-8644
HOURS: MONDAY 10:00 A.M.—5:00 P.M.
TUESDAY 9:00 A.M.—9:00 P.M.
WEDNESDAY 9:00 A.M.—5:00 P.M.
THURSDAY 9:00 A.M.—9:00 P.M.
FRIDAY 10:00 A.M.—2:00 P.M.
SATURDAY AND SUNDAY: CLOSED

DENTAL CLINIC
HOURS: MONDAY 8:30 A.M.—5:30 P.M.
TUESDAY 8:30 A.M.—5:30 P.M.
WEDNESDAY AND THURSDAY: CLOSED
SATURDAY AND SUNDAY: CLOSED
REQUIREMENTS: NEED TO MAKE AN APPOINTMENT TO RECEIVE MEDICAL AND DENTAL CARE. PHOTO ID REQUIRED. U.S. AND MEXICO ID ACCEPTED. MUST HAVE A PROOF OF RESIDENCE.

NORTH DALLAS SHARED MINISTRIES
2875 MERRELL ROAD
DALLAS, TX 75229
PHONE #: 972-620-8696
HOURS: MONDAY (ADULTS ONLY) 5:00 P.M.
TUESDAY AND THURSDAY (ADULTS AND CHILDREN) 5:00 P.M.
TUESDAY (CHILDREN ONLY) 10:30 A.M.
ZIP CODES SERVED:
75001 75201 75234 75248
75004 75204 75235 75251
75205 75229 75240 75252
75209 75230 75244 75252
75219 75231 75247 75287
ReCURSOS ESPAÑOLES
¿DONDE PUEDO IR SI NECESITO COMIDA?

LA SIGUIENTE LISTA PUEDE AYUDARLE A USTED Y A SU FAMILIA SI NECESITA COMIDA:

WILKINSON CENTER (CENTRO DE WILKINSON)
5200 BRYAN STREET
DALLAS, TX 75206
TELÉFONO: 214-821-5980
LÍNEA CRÉDITA: 1-800-880-4988
HORARIO: LUNES - VIERNES 9:00 A.M - 4:30 P.M
COSTO: GRATIS
CÓDIGOS POSTALES EN LOS QUE SERVIRÁN:
75224, 75227, 75228, 75246

CENTRAL DALLAS MINISTRIES
(MINISTERIO DE DALLAS CENTRAL)
CENTRO DE RECURSOS
409 NORTH HASKELL
DALLAS, TX 75246
TELÉFONO: 214-823-710 EXT. 111
HORARIO: LUNES - JUEVES 9:00 A.M - 4:00 P.M
SÁBADO: 9:00 A.M - 12:30 P.M
CERRADO: VIERNES Y DOMINGO.
COSTO: GRATIS

AGAPE CLINIC
WWW.AGAPECLINIC.COM
TELÉFONO: 214-822-5686
GRACE UNITED METHODIST CHURCH
405 JUNIUS ST, DALLAS, TX 75216
MIÉRCOLES: 9:00 - 12:00
JUEVES: 9:30 - 4:00
VIERNES: 7:30 - 12:00
SÁBADO: 9:00 - 12:00

115
LOS SIGUIENTES RECURSOS SON T¡EN- DAS DONDE PUEDE COMPRAR ROPA Y CO- SAS PARA LA CASA A UN PRECIO BAJO:

NORTH DALLAS SHARED MINISTRIES
MINSITRIO
CLOTHES CLOSET (CLOSET DE ROPA)
2875 MERRELL ROAD
DALLAS, TX 75229
TELEFONO: 214-358-0381
HORARIO: LUNES 9:30 A.M. - 3:00 P.M.
SABADO 9:00 A.M. - 11:30 A.M.
REQUISITOS: SE REQUIERE UNA FOTO (AMERICAN A O MEXICANA)
CODIGOS POSTALES QUE SERVIMOS:
75001  75220  75224  75248
75224  75225  75228  75231
75201  75229  75236  75251
75203  75230  75243  75252
75219  75231  75247  75287

CATHOLIC CHARITIES (CARIDADES CATOLICAS)
WORLD OF GOODS RESALE STORE
BRADY CENTER
4009 EL M STREET
DALLAS, TX 75226
TELEFONO: 214-826-8390
HORARIO: LUNES A VIERNES 8:30 A.M. - 3:00 P.M.
SERVICIOS: ROPA NUEVA O RECICLADA, YA Y OTROS COSAS NECESARIAS PARA EL HOGAR

THE FAMILY PLACE THRIFT SHOP
TIENDA DE EL LUGAR DE FAMILIA
3463 WEBB CHAPEL EXT
DALLAS, TX 75220
TELEFONO: 214-358-0381
HORARIO: LUNES - SABADO 10:00 A.M. - 3:30 P.M.
DOMINGO 1:00 P.M. - 5:00 P.M.

NORTH DALLAS SHARED MINISTRIES
(MINISTE DE DALLAS NORTE)
CENTRO DE AYUDA DE EMERGENCIA
2875 MERRELL ROAD
DALLAS, TX 75229
TELEFONO: 214-358-0381
HORARIO: LUNES - VIERNES 9:30 A.M. - 3:00 P.M.
SABADO 9:00 A.M. - 11:30 A.M.
LUNES DE TARDE EL PRIMERO Y TERCER LUNES DEL MES DE 6PM A 7:30 PM)
COSTO GRATIS
CODIGOS POSTALES EN LOS QUE SERVIMOS:
75001  75220  75236  75284
75248  75204  75225
75251  75220  75231
75203  75230  75243  75252
75219  75231  75247  75287

CATHOLIC CHARITIES (CARIDAD CATOLICA)
ASISTENCIA PARA ANCIANOS Y FAMILIA
BRADY CENTER
4009 ELM STREET
DALLAS, TX 75226
TELEFONO: 214-826-8390
HORARIO: LUNES - VIERNES 8:00 A.M. - 5:00 P.M.
Cross Family Center
4906 Bonnie View
Dallas, TX 75241
Teléfono: 214-375-0133
Horario: Lunes - Viernes 8:00 a.m. - 5:00 p.m.

Jefferson Family Assistance Center
1924 West Jefferson #102
Dallas, TX 75241
Teléfono: 214-941-8596
Horario: Lunes - Viernes 8:00 a.m. - 5:00 p.m.

La siguiente es una lista de recursos donde ofrecen un lugar seguro para individuales y familias que no tienen donde vivir:

Dallas Life Foundation (Dallas Fun.

HE PERDIDO MI CASA/ APARTAMENTO Y NO Tengo DONDE VIVIR. ¿Donde puedo ir?

Dación de Viva
1100 Cadiz Street
Dallas, TX 75221
Teléfono: 214-421-1389
Horario: Lunes - Viernes 8 a.m. - 4 p.m.

Servicios: comida, techo, cuidado médico, entrenamiento, y programas para volver a la escuela.

Requisitos: Una identificación con foto es necesaria. Esta Fundación (Dallas Life Foundation) requiere cita y aplicación. Estas serán aceptadas de Lunes a Viernes de 6:00-9:00 p.m.

VIVO EN UN LUGAR DONDE HAY VIOLENCIA Y NECESITO OTRO LUGAR DONDE VIVIR. ¿DONDE PUEDO IR?

The Family Place (El Lugar de Familia)
Domestic Violence Services (Servicios de Violencia Doméstica)
Horario de Oficina: Lunes a Viernes 9:00 a.m. - 5:00 p.m.
Servicios: refugio de emergencia, apoyo, centro de desarrollo para niños, consejería, centro de Visitación bajo supervisión
Requisitos: no se requiere documentos.
¿A DONDE PUEDO IR PARA CONSULTAR AYUDA LEGAL Y CONSEJERIA?

CATHOLIC CHARITIES OF DALLAS
(CARIDAD CATOLICA DE DALLAS)
IMMIGRATION COUNSELING SERVICES
(SERVICIO DE CONSEJERA DE INMIGRA-
CION)
5414 MAPLE AVENUE, SUITE 400
DALLAS, TX 75235
TELEFONO: 214-634-7182
HORARIO: MARTES – SABADO (PRIMERO Y
SEGUNDO SABADO DE CADA MES) LAS DE
MAS SEMANAS LA OFICINA ESTA ABIERTA
DE LUNES A VIERNES. LAS CONSULTAS
EMPEZAN A LA 1:00 P.M. DEBE LLEGAR A
LAS 12:00 P.M. O ANTES PARA RECIBIR UN
NUMERO PARA LA CONSULTA.
SERVICIOS: PETICIONES FAMILIARES, CIU-
DADANIA, ABUSO A LA MUJER, INMIGRA-
TE, SERVICIOS A INMIGRANTES VICTIMAS
DE CRIMEN, DEPORTACION, REMOVIMEN-
TO.
REQUISITOS: SE REQUIERE IDENTIFI-
CACION CON FOTO (AMERICANA O MEXI-
CANA).

SOUTHEAST DALLAS COOPERATIVE PAR-
ISH SHALOM ZONE
URBAN PARK UMC
IMMIGRATION JUSTICE FOR OUR NEIGH-
BORS
6670 MILITARY PARKWAY
DALLAS, TX 75227
TELEFONO: 214-381-0901
REQUISITOS: SE REQUIERE IDENTIFI-
CACION CON FOTO (AMERICANA O MEXI-
CANA) Y PRUEBA DE NINOS EN SU CASA ME-
NORES DE 18.
HORARIO: LUNES A JUEVES 9:00 A.M. –
2:00 P.M.

TRANSPORTACION

AUSTIN STREET CENTRE (CENTRO DE LA
CALLE AUSTIN)
2929 HICKORY
DALLAS, TX 75226
TELEFONO: 214-428-4242
HORARIO: ABIERTO LAS 24 HORAS
REQUISITOS: SE REQUIERE UNA IDENTIFI-
CACION CON FOTO Y CITAS. IDENTIFICACION
DEL CONSULADO MEXICANO SON ACEPTA-
DAS EN ESTE CENTRO.
SERVICIOS: TECNOLOGIA, SEGURIDAD,
AYUDA MEDICA/PSIQUIATRICO, PROGRAMA
DE TERAPEUTICA, PROGRAMA DE TRABAJO,
PROGRAMA DE DIA, PROGRAMA DE REHABILITACION.

DEBES DE ESTAR VIVIENDO EN ESTE REFU-
GIO PARA RECIBIR LOS BENEFICIOS

DART

AKARD STATION (ESTACION AKARD)
1401 PACIFIC
DALLAS, TX 75202
TELEFONO: 214-979-1111
DIFERENTES TIPOS DE PROGRAMAS Y TARIFAS OFERTOS POR DART

TARIFA LOCAL - VALIDO EN VIAJE ENTRE
LA AREA METROPOLITANA DE DALLAS SO-
LAMENTE. ESTOS PASES PUEDEN SER UTO-
LIZADOS PARA EL AUTOBUS Y EL TREN DE
DART, Y EN EL TREN TIRE DESDE LA Esta-
CION UNION (UNION STATION) HASTA LA
ESTACION DE W. IRVIN.

TARIFA SUPERIOR - VALIDO EN VIAJE EN-
TRE LA AREA METROPOLITANA DE DALLAS
Y FORT WORTH. ESTOS PASES PUEDEN
SER UTILIZADOS EN LOS AUTOBUSES Y TRENES DE DART, EN DART A LLAMADA, EN
EL TREN TIRE EN LOS AUTOBUSES "T" EN FORT WORTH.
ESTOY EMBARAZADA Y/O APEGUE UN HIJO Y NECESITO SERVICIOS MÉDICOS ESPECIALES. ¿A DONDE PUEDO IR?

DALLAS PREGNANCY RESOURCE CENTER
(CENTRO DE RECURSOS DE EMBARAZO)
DALLAS
1259 JUPITER, SUITE 140
DALLAS, TX 75528
TELÉFONO: 214-349-2923
HORARIO: LUNES Y JUEVES 10:00 A.M. – 6:45 P.M.
MARTES Y VIERNES 10:00 A.M. – 3:45 P.M.
REQUISITOS: SE REQUIERE CITA. SE REQUIERE IDENTIFICACIÓN CON FOTO (SE ACEPTA IDENTIFICACIÓN MEXICANA).
SERVICIOS: CONSEJERÍA, EXAMEN DE EMBARAZO, CONSULTAS PARA ANIT CONCEPTIVOS, CLASES DE NUTRICIÓN Y DE PARTO, ASISTENCIAS DE MATERIAL Y SERVICIOS DE APOYO PARA POST-ABORTO

NECESITO AYUDA PARA APRENDER INGLÉS. ¿DONDE PUEDO IR?

WILKINSON CENTER (CENTRO DE WILKINSON)
ENGLISH AS A SECOND LANGUAGE (ESL) CLASES (CLASES DE INGLÉS)
5200 BRYAN STREET
DALLAS, TX 75206
TELÉFONO: 214-821-6380
LLAMADA GRATIS: 1-888-4988
HORARIO: LUNES – VIERNES 9:00 A.M. – 4:30 P.M.
REQUISITOS: IDENTIFICACIÓN REQUERIDA (AMERICANA O MEXICANA)
**Donde puedo ir si necesito ayuda para conseguir cuidado para mi hijo?**

- **Wilkinson Center (Centro de Wilkinson)**
  - 5200 Bryan Street
  - Dallas, TX 75206
  - 214-821-6380
  - Llamada gratis: 1-800-880-4988
  - Horario: Lunes-Viernes 9:00 a.m. - 4:30 p.m.
  - Costo: Gris
  - Códigos Postales en los que servimos: 75204, 75226, 75246

**Diferentes Programas de Cuidadera**
- C.L.I.M.B. (Changing Lives, Improving Minds and Bodies) (Cambiar Vidas, Mejorar Mentes y Cuerpos) es un programa para niños entre la edad de 5-14 que están en riesgo.
- Tarea y Tutoria: La tarea es la primera prioridad en el programa de CLIMB. Nuestro equipo de voluntarios dedicados permite que nos dirijamos las necesidades de los estudiantes y las oportunidades individuales del curso particular.

**Cuerpo Inteligente (SMARTBODY)** Es un programa de la salud y de la nutrición. SMARTBODY hace la esfuerza de incluir hábitos sanos de comer y de la aptitud para la vida con la meta de reducir la incidencia de la obesidad en niños y la juventud.

**Clinicas de Especialidades**
- **Clinicas de los Pies**
  - Horario: Martes 5:00 p.m.

**Clinica de Dermatologia**
- Horario: Primer y Tercer Jueves del mes a las 5:00 p.m.

**Clinica de Mujer**
- (Examen de mujer y de pecho solamente)
- Horario: Primer y Tercer Miércoles del mes a las 5:00 p.m.

**Clinica Dental para Adultos**
- (Para extracciones y infecciones solamente)
- Horario: Primer y Tercer Viernes del mes a las 8:00 a.m.
TRABAJOS DE ARTE (ART WORKS). BAJO DIRECCIÓN DE UN ARTISTA DE LA COMUNIDAD, LOS ESTUDIANTES TIENEN ACCESO A UN ESTUDIO DEL ARTE EN DONDE PUEDEN CREAR Y EXPRESARSE Y TAMBIÉN FORTALECER SUS HABILIDADES DE MOTOR FINAS.

CAMPAÑA CLIMB (CAMP CLIMB). ES UN PROGRAMA GRATIS POR TODO EL AÑO EN LA CIUDAD DE DALLAS. CAMPAÑA CLIMB ES UN PROGRAMA EN EL VERANO DONDE NIÑOS PUEDEN CONTINUAR A RECIBIR SOPORTE DE EDUCACIÓN, EMOCIONAL Y FÍSICA QUE NECESITAN NO PARA CON EL ANO ESCOLAR.

EVENTOS ESPECIALES: LOS NIÑOS ALISTADOS EN EL PROGRAMA CLIMB Tienen LA OPORTUNIDAD DE PARTICIPAR EN EVENTOS A TRAVÉS DEL AÑO COMO NUESTRA IMPULSO ANUAL DEL ZAPATO DE PARA TRAS A ESCUELA, RECIBIENDO LOS RECA VOS DE NAVIDAD Y NOCHE DE LA DIVERSIÓN DE LA FAMILIA.

PROGRAMAS SON DESPUÉS DE ESCUELA.
LUNES—JUEVES 3:30 P.M.—6:00 P.M.

CENTRAL DALLAS MINISTRIES (MENISTRO DE DALLAS CENTRAL)
MEDICAL CLINIC AND PHARMACY
801 N. PEAK STREET
DALLAS, TX.
TELEFONO: 214-821-8644
HORARIO: LUNES 10:00 A.M.—5:00 P.M.
MARTES 9:00 A.M.—9:00 P.M.
MIÉRCOLES 9:00 A.M.—5:00 P.M.
JUEVES 9:00 A.M.—9:00 P.M.
VIERNES 10:00 A.M.—2:00 P.M.
SÁBADO Y DOMINGO: CERRADO

CLINICA DENTAL
HORARIO: LUNES 8:30 A.M.—5:30 P.M.
MARTES 8:30 A.M.—5:30 P.M.
MIÉRCOLES Y JUEVES: CERRADO
SÁBADO Y DOMINGO: CERRADO
REQUISITOS: NECESITA HACER CITA PARA SERVICIOS MEDICO Y/O DENTAL. SE REQUIERE UNA IDENTIFICACIÓN CON FOTO DE LOS ESTADOS UNIDOS O DE MÉXICO Y PRUEBA DE DIRECCIÓN DONDE VIVE.

NORTH DALLAS SHARED MINISTRIES
(MINISTRO DE DALLAS NORTE)
2875, MERRELL ROAD
DALLAS, TX 75229
TELEFONO: 972-620-8690
HORARIO: LUNES (ADULTOS SOLO) 5:00 P.M.
MARTES Y JUEVES (ADULTOS Y NIÑOS) 5:00 P.M.
MARTES (NIÑOS SOLO) 10:30 A.M.
CODIGOS POSTAL QUE SERVIMOS:
75001 75220 75234 75248
75204 75225 75253 75251
75205 75226 75240 75252
75209 75230 75244 75252
75219 75231 75247 75287
**Mi niño(s) necesita sus vacunas. ¿Dónde puedo ir?**

**Agaape Clinic (Clínica Agaape)**
Grace United Methodist Church
4105 Junius Street (esquina de Junius y Haskell)
**Dallas, TX 75246**
Horario: Las vacunas son administradas solo los sábados de 8:00 a.m. a 12:00 p.m.

**North Dallas Shared Ministries (Ministerio de Dallas Norte)**
2875 Merrell Road
**Dallas, TX 75229**
Teléfono: 972-620-8696
Horario: Martes y Jueves a las 5:00 p.m.
Códigos Postales en los que sirven:
75001 75220 75234
75248 75254 75255
75239 75251 75205
75229 75240 75252
75203 75230 75244
75252 75219 75231
75247 75267

**Agaape Clinic (Clínica Agaape)**
Grace United Methodist Church
4105 Junius Street (esquina de Junius y Haskell)
**Dallas, TX 75246**

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**¿Donde puedo ir si necesito ayuda para conseguir cuidado para mi hijo(s)?**

**Central Dallas Ministries (Ministerio de Dallas Central)**
Roseland Community Center
3535 Munger Avenue
**Dallas, TX 75204**
Teléfono: 214-828-9410
Horario: Lunes-Viernes 10:00 a.m. a 8:00 p.m.
Sábado 10:00 a.m. a 6:00 p.m.
Servicios: Abierto al público para deportes de equipo, gimnasio abierto y actividades comunitarias. Clases educacionales para adultos y niños (incluye recursos para otras servicios y cuidado en la comunidad) y asistencia para encontrar trabajo.

**Diferentes Programas de Empleo**

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**Offerta por el Centro de Wilkinson**

**Carrera Trabaja (CareerWorks):** Es un curso de 5 semanas con clases los lunes a viernes de las 9:30 a.m. a 12:30 p.m. CareerWorks tiene clases de planes de carrera. Este programa es diseñado para adultos y ofrece entrenamiento para planear comercialización de usted. Ayuda en buscar trabajo, como escribir un currículum, cómo vestir para empleo y preparación para entrevistas.
Carrera Trabaja (CareerWorks) Actividades

Campo de la Fascinación (Field of Fascination): Cada estudiante tiene una oportunidad de determinar su campo personal de la fascinación. Entonces ayudamos a los estudiantes a adaptar y buscar el trabajo a las posiciones dentro de ese campo. El trabajo en la carrera de su opción es una de las llaves al éxito del programa. Identificando puntos de venta personales se enseñan a los estudiantes formas de identificar áreas de fuerza en sus últimos trabajos y cómo utilizar esas fuerzas como puntos de venta en sus resúmenes y las entrevistas.

Entrevistas Falsas (Mock Interviews): Cada estudiante debe prepararse y participar en sesiones falsas de la entrevista. Trabajan con los varios voluntarios profesionales para mejorar sus habilidades de entrevista. Los estudiantes deben poder compartir experiencias positivas profesionales, aprender resumir puestas constructivas a las barreras del empleo y tener confianza en la comodidad de usted.

Búsqueda del trabajo (Job Search):

La asistencia para buscar trabajo se conduce las últimas dos semanas de la clase con la Interfaith Housing Coalition. Los voluntarios y empleados están disponibles para cada estudiante para investigar compañías, hacernos cambios en las letreras de cubierta y cualquier otra ayuda necesitada. Sobre la terminación del programa de Carrera Trabaja (CareerWorks) y la celebración de la graduación en el centro de Wilkinson donde los grupos y las organizaciones voluntarias de la iglesia dan una comida. Ayuda de la comunidad y tener un guardarropa para los graduados en donde pueden comprar ropa profesional. Este programa de autorización provee la verificación de clientes un camino fuera de pobreza.

GED Classes (Diploma del Preparatorio) Lunes – Jueves 1:00 p.m. – 3:00 p.m.

North Dallas Shared Ministries (Ministro de Dallas Norte)
2875 Merrell Road
Dallas, TX 75229
Teléfono: 972-620-8696
Horario: Lunes – Viernes 9:30 a.m. – 3:00 p.m.
Servicios: Consejeros disponibles para ayudar a conseguir empleos, disponibles escribir su resumen y prepararse para entrevistas.
Códigos Postales en los que servimos: 75001 75220 75224 75248 75204 75225 75235 75251 75205 75229 75240 75252 75209 75230 75244 75252 75219 75231 75247 75287
REFERENCES


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President’s New Freedom Commission on Mental Health (2003). Achieving the promise:
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Health Needs and Service Utilization of Youth in the Juvenile Justice System. *Journal of
Behavioral Health Services & Research. 31*(3), 242-254.

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Rugulies, R. (2002). Depression as a predictor for coronary heart disease. A review and meta-

85-91.

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BIOGRAPHICAL INFORMATION

Erika Ruiz received her B.S.W from the University of Texas in Arlington in May of 2007. Upon successful defense of her thesis, she will receive her M.S.S.W, also from the University of Texas of Arlington. In the near future Erika hopes to pursue a doctoral degree in Social Work, after gaining field experience. Among her many interest, Erika is particularly interested in access to mental health care and health care for minorities. Erika plans to continue to work as an advocate for the Hispanic community.