DOCUMENT RESUME

ED 250 405		UD 023 433

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TITLE	Barriers to Clinical Services among Chronically Mentally Ill Hispanics.
INSTITUTION	Fordham Univ., Bronx, N.Y. Hispanic Research Center.
SPONS AGENCY	National Inst. of Mental Health (DHHS), Rockville, MD. Center for Minority Group Mental Health Program.
PUB DATE	Oct 83
NOTE	16p.
PUB TYPE	Reports - Research/Technical (143) -- Collected Works - Serials (022)
JOURNAL CIT	Hispanic Research Center Research Bulletin; v6 n3-4 p1-15 Jul-Oct 1983.
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Acculturation; Age; Family Influence; *Hispanic Americans; *Individual Characteristics; *Mental Disorders; *Mental Health Clinics; *Psychiatric Services; *Psychological Services
IDENTIFIERS	New York (Bronx); *Services Utilization

ABSTRACT

Drawing from a conceptual framework which hypothesizes a temporal sequence for persons who are in psychological distress, this paper focuses on two problems faced by chronically mentally ill (CMI) Hispanics in need of clinical services: (1) barriers in seeking follow-up clinical services upon discharge from a psychiatric hospital; and (2) barriers to effective psychiatric treatment. The research upon which the report is based compared data collected in a survey of residents of the Fordham Tremont area of the Bronx, New York City (the community sample), with data from all persons receiving services in November 1982 at Continuing Care, a mental health clinic for CMI patients from the same neighborhood. It was found that most Hispanics who underutilize mental health services do so because they do not recognize or acknowledge symptoms, while a smaller number acknowledge emotional problems but cannot get the services they need. Some evidence also was found for the existence of cultural and institutional barriers to the use of mental health services among Hispanics. Comparison of the community survey and clinic patient data also indicated that different Hispanic subgroups (recent immigrants, less acculturated) are less likely to seek treatment than are younger, better educated Hispanics, but more likely to persist in treatment and to have successful outcomes. Finally, instability in living arrangements was found to have a greater effect on clinical experiences than on utilization of mental health services. Based on these findings, this report presents extensive recommendations for increasing the number of CMI Hispanics utilizing mental health services and for improving treatment for CMI Hispanics. (GC)

RESEARCH BULLETIN

HISPANIC RESEARCH CENTER
FORDHAM UNIVERSITY
BRONX, NEW YORK 10458

JULY - OCTOBER 1983 Vol. 6, Nos. 3-4

Consistent with the Hispanic Research Center's commitment to clinical service research aimed at developing innovative intervention strategies for use with Hispanic clients, this double issue of the *Research Bulletin* presents a report on the barriers which keep the Hispanic chronically mentally ill (CMI) from receiving effective treatment. The research was conducted by Orlando Rodriguez, Research Associate of the Hispanic Research Center (HRC), as part of a subcontractual arrangement with Fordham-Tremont Community Mental Health Center's Project COPA (Community Organization for Patient Access). Project COPA is one of five demonstration projects funded by New York State's Office of Mental Health to develop innovative mental health services for minorities. It was designed to increase the utilization of mental health services by CMI Hispanics in the Fordham-Tremont area of the South Bronx, and to improve the therapeutic treatment received by the Hispanic CMI patients admitted to Project COPA.

Project COPA's research and interventions take on added significance when it is noted that their setting is one of the most impoverished areas of the nation, where one out of three residents receives public assistance, one out of three households is headed by a female, and only one out of four high school students will graduate.

This research continues a long and fruitful collaboration between the HRC and the Fordham-Tremont Community Mental Health Center (CMHC) dating back to 1978. The HRC's director, Lloyd H. Rogler, acted as chief consultant and adviser to the newly created CMHC and joined with twelve social service agencies serving the South-Central Bronx to develop a multifaceted demonstration project which included advocacy and referral, interagency coordination, outreach and research. These activities culminated in the approval of funding of the Hispanic Access Grant Demonstration Project which the CMHC submitted to the Office of Human Development Services. Under a subcontractual arrangement the HRC undertook to conduct research on the utilization of services by Hispanics. This project was one of eight nationwide demonstration projects to develop innovative service delivery approaches to the problem of Hispanic utilization of social services. The research component of the study explored several facets of utilization: need for services, use of services, applying for services not received, reasons for not applying, problems in applying and receiving services, and referral sources. A report on this project ("A Profile of Services Utilization in the Fordham-Tremont Area: Preliminary Report," written by Orlando Rodriguez, *HRC Research Bulletin*, January-April 1983, vol. 6, nos. 1-2) described the need for and the use of services for the disabled, the elderly, female heads of household, the unemployed, and the emotionally distressed among Hispanic, black and white residents of the Fordham-Tremont area. The data collected for this study have been used to supplement the research conducted for Project COPA.

The author has used the findings of this study to make recommendations for specific interventions to be implemented by Project COPA to improve clinical services. The HRC is currently conducting evaluation research to monitor the effects of these interventions on the lives of CMI Hispanics in the Fordham-Tremont area. The recommendations contained in the report which follows may also be considered in the design of outreach strategies and treatment modalities for the CMI and other clinical Hispanic populations in other localities.

The author gratefully acknowledges the assistance of Ms. Anne Burgunder, Associate Director of Fordham Tremont's CMHC, and of Dr. James Wrotten, Director of Evaluation and Research at the Fordham-Tremont CMHC at the time data were gathered for this project, in supplying the investigators with a computer data file on that Center's clients. Steven Jacobs, MSW, Director of Fordham-Tremont CMHC's Continuing Care Clinic; Dr. Nilda Valentin, Director of Project COPA; and the staff of Continuing Care were also of invaluable assistance in facilitating access to additional client data needed for completion of the research. The author also expresses gratitude to the following persons who helped in the planning and implementation of Project COPA: Dr. Aida Burnett of Fordham-Tremont CMHC's Outpatient Division; Frances Lorenzi, Director of the Children and Family Division of FTCMHC; Alma Gomez, Director of the Access Project of FTCMHC; Dr. Miguel Torrado, Director of Research, Office of Human Development Services, Department of Health and Human Services; Donna Chiglesi, Director of Consultation and Education of FTCMHC; and Ruth Casey, in charge of community liaison at Consultation and Education of FTCMHC. Instrumental in drawing up this report were HRC research assistants, William Burger, who helped in analyzing the Fordham-Tremont Residents Survey data, and Yvonne Martinez Ward, who assisted in analyzing the Fordham-Tremont client data.

BARRIERS TO CLINICAL SERVICES AMONG CHRONICALLY MENTALLY ILL HISPANICS

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This report examines barriers faced by chronically mentally ill (CMI) Hispanics in receiving clinical services. Our examination of barriers to clinical services follows a conceptual framework developed by Fordham University's Hispanic Research Center to understand the mental health problems of Hispanics.[1] The conceptual framework hypothesizes a temporal sequence, applicable to the CMI as well as to people experiencing less severe psychological distress, which is divided into five phases. The first phase involves the emergence of mental health problems the second phase involves intricate help-seeking behaviors which may lead the person to contact official mental health service providers; the third phase deals with attempts by such help providers to evaluate the client's psychological condition; the fourth phase begins when official mental health providers attempt to deal with the problem through therapeutic interventions; and the fifth phase involves the termination of treatment and the client's attempted resumption of customary social roles, relieved of the original problem or not.

The literature indicates that Hispanics experience pronounced difficulties in each of the five phases: there is very little epidemiological data on the prevalence and incidence of psychological distress in the Hispanic population;[2] Hispanics underutilize mental health services in relation to their mental health needs;[3] they are prone to be misdiagnosed because of culturally insensitive diagnostic procedures;[4] the treatment they receive does not fit their culture and life circumstances;[5] and, finally, they experience difficulty in resuming their customary social roles after undergoing treatment.[6] The phases comprise successive barriers which keep Hispanics from moving effectively through the entire sequence. Our report focuses on two problems faced by CMI Hispanics in need of clinical services: barriers in seeking follow-up clinical services upon discharge from a psychiatric hospital, corresponding to the second phase of the temporal sequence; and barriers to effective therapeutic treatment, corresponding to the fourth phase of the sequence.

Background

Data on inpatient admissions published by New York State underscore the dimensions of the problems faced by CMI Hispanics. According to a one-week survey of patient characteristics conducted by New York State's Office of Mental Health,[7] it is estimated that in 1981, 10,150 New York City residents were treated in inpatient and 33,270 in outpatient facilities. Among adult inpatients, which include the CMI, 14 percent were Hispanic, 32 percent were black, 52 percent were white, and 1 percent were Native Americans or Asian Americans. Expressed as rates, 170 out of every 100,000 Hispanics were treated in inpatient facilities, while the rates for blacks, whites, and Native Americans and Asian Americans were, 324, 231, and 50, respectively. Among Bronx residents, the inpatient rate for Hispanics was 182 per 100,000, while the rates for blacks, whites and the other ethnic groups were 271, 356, and 42, respectively. Outpatient treatment rates were higher for all ethnic groups, and Hispanics' rates were closer to blacks' (in some boroughs, slightly higher), while whites had the highest outpatient rates of all ethnic groups. The New York State data thus provide evidence that, with the exception of Native Americans and Asian Americans, Hispanics with chronic and other severe mental illnesses have the lowest inpatient facility utilization rates among New York City's ethnic groups.

A well-known deficiency of mental health facility treatment data is their failure to count those in need of services who do not make use of mental health services. To obtain more accurate utilization data, studies must take into account epidemiological estimates of the number of people in the population with varying degrees of clinical pathology. Since most ethnically comparative epidemiological studies show that Hispanics have mental illness rates greater than whites, and at least equal to blacks,[8] the New York State data suggest that CMI Hispanics underutilize mental health services even more than the utilization rates indicate. Hence the relevance of the data reported here which focus on barriers faced by chronically mentally ill Hispanics of the Fordham-Tremont area of the Bronx in using mental health services and in receiving therapeutic treatment.

The research addresses questions relevant to the use of mental health facilities by CMI Hispanics and to patterns of treatment among CMI Hispanics who received treatment at the Fordham-Tremont Community Mental Health Center (CMHC) before the establishment of Project COPA.

With respect to the utilization of services, we address the following issues:

- What are the patterns of use of mental health facilities by CMI Hispanics?
- What factors account for those patterns of use?
- What kinds of interventions are likely to increase Hispanic utilization of services for the CMI?

With respect to treatment, we focus on the following questions:

- What are the patterns of treatment experienced by CMI Hispanics?
- What factors account for these patterns?
- What kinds of interventions are likely to result in improved services for CMI Hispanics?

In this report, we summarize our analyses of two data files: a survey of residents of the Fordham-Tremont area,[9] referred to as the community sample, and a file on all patients receiving services in November 1982 at Continuing Care (CC), Fordham-Tremont CMHC's clinic for CMI patients, and referred to in this report as the CC sample. The survey of community residents provides information about background characteristics of mental health service underutilizers and factors related to underutilization. The sample of CC patients allows us to compare characteristics of CMI Hispanics who utilize a mental health service with characteristics of mental health service underutilizers in the community. We also use the CC data to compare Hispanic, black, and white patients on clinical and demographic characteristics related to (1) delays in admission to CC after discharge from the last psychiatric service, a factor related to utilization of mental health services; (2) the length of time in treatment; and (3) the attendance rate at CC, the last two being factors related to treatment. We first examine barriers faced by CMI Hispanics in seeking and being admitted to mental health services. We then examine barriers to treatment among Hispanics and other patients receiving services at CC.

In this report, group differences found to be statistically significant at the .05 level or lower are identified by using the term "significant" in describing them. When the term "significant" is not used, the reader could interpret the findings only as suggestive of group differences; or the wording will clearly show that no group differences were found. Statistical significance at the .05 level means that there is a five in 100 probability that the findings are spurious due to sampling error. By convention, sample group differences found significant at the .05 level or lower are considered reliable descriptions of group differences in the population.

Barriers to Utilization of Mental Health Services

The data reported here are based on a survey of a sample of residents of the catchment area of the Fordham-Tremont Community Mental Health Center. The area includes a major sector of the South Bronx, and less poor areas in the northwest Bronx. Respondents were selected through a multistage sampling procedure. In the first stage, 25 blocks were randomly selected, with probability proportionate to size of the Hispanic population in blocks. A team of bilingual interviewers was then sent out to systematically canvass every third household in the selected blocks, starting with a randomly pre-determined dwelling unit in each block. Through this procedure, the interviewing team gathered information on 673 households willing to participate in the study. This number represents 76 percent of all households contacted (885) and 58 percent of all households selected for contact (1160). In the final sampling stage, we selected two out of three Hispanic households, one out of two black households, and all white households. Because of some refusals by individuals originally willing to participate in the study, and many willing to participate but who could not be located at home after repeated contacts, we were able to interview 381 out of the 500 selected for interviewing. The sample includes 217 Hispanics, 90 percent of whom are Puerto Ricans, 87 blacks, and 77 whites. The sample's ethnic distribution slightly underrepresents blacks and slightly overrepresents Hispanics on the basis of 1980 census population estimates for the sampling area.

We identified people with emotional problems through two questions: a household report, which asked if any household member had an emotional problem in the last 12 months, and a 27-item mental health scale — the Demoralization Scale — administered to the respondent. The Demoralization Scale, a short version of which we used in the survey, was developed by Bruce Dohrenwend and associates out of the Psychiatric Epidemiology Research Instrument (PERI).[10] The Demoralization Scale measures eight clusters of symptoms related to J.D. Frank's definition of demoralization:[11] **dread,** the fear of being unable to control one's own feelings; **self-esteem,** f [illegible] of low self worth; **hopelessness-helplessness,** the feeling that little in life is positive; **anxiety,** worry, restlessness, and tension; **confused thinking,** trouble in thinking or concentrating; **sadness,** feelings of depression and loneliness; **psychophysiological symptoms,** somatic manifestations of negative emotions; and **poor physical health.** As such, the scale measures general feelings of psychological distress often associated with mental illness, rather than specific clinical pathologies. Hispanics in the Fordham-Tremont area have a significantly higher number of symptomatic responses with a mean score of six symptoms, approximately two symptoms more than blacks and whites.

In our analysis of the Demoralization Scale, we considered two different sources of response bias: respondent error, e.g., answering positively and negatively worded versions of the same items in the same direction; and acquiescense, yea-saying or nay-saying in answering questions. With respect to the first source of bias, we found the instrument to be reliable, with reliability coefficients higher than .8. Acquiescence, the second source of bias, is often measured by comparing the average of correlations among those scale items physically next to each other with the average of correlations among items measuring the same scale dimension.[12] Acquiescence is said to exist when the average of correlations among contiguous items is higher than the average of correlations among items measuring the same dimension. Because the Demoralization Scale was administered with same-dimension clusters contiguous to each other, we compared the average of correlations of items within clusters with the average of correlations of the last item in one cluster with the contiguous item in the next cluster. Using this method, we found slight acquiescence among each of the ethnic groups, particularly among white respondents. However, with the exception of whites, the differences between the average of intra-cluster and contiguous item correlations were less than .03, suggesting that acquiescence is not a major source of response bias in our scale.

Since the Demoralization Scale measures symptoms associated with mental illness, rather than specific dimensions of clinical pathology, we are unable to equate a given number of symptoms with a specific degree of pathology. Some studies hypothesize that Hispanic cultural norms permit freer expression of mental illness symptoms, while Americans may be more reticent about revealing such symptoms.[13] Thus, the differences in symptoms between Hispanics and the other ethnic groups in our sample may reflect the effects of cultural influences. Research now under way by Dohrenwend and associates is addressing the question of the number of symptoms in the Demoralization Scale which differentiates mentally ill and healthy individuals, and the extent to which ethnic differences in symptom scores reflect cultural influences. As an interim measure, we use a score of nine or more symptoms to denote demoralized individuals. This score corresponds to the average number of symptoms among those respondents who reported having emotional problems. One-fourth of Hispanics and fewer than one-fifth of blacks and whites reported nine or more symptoms. These proportions are slightly lower than those reported for demoralized individuals in other studies using the Demoralization Scale.[14] Thus, while comparison of the community sample's responses with those of a clinical population may result in downward or upward adjustment of the cutoff point for demoralization, we believe that the interim cutoff point of nine or more symptoms approximates demoralization.

Our measure of mental health services utilization combines respondents' answers to the Demoralization Scale with their answers to the question on emotional problems among household members. We define as underutilizers those demoralized individuals who (1) acknowledge emotional problems but report receiving no services or fewer services than reported as needed, **or** (2) do not acknowledge emotional problems and consequently received no mental health services. Among demoralized blacks and Hispanics, over half did not receive mental health services because they did not acknowledge having emotional problems. One-fourth acknowledged emotional problems but reported not needing mental health services or reported receiving fewer services than needed. The number of demoralized whites was too small to report percentages. Less than 15 percent of nondemoralized respondents reported having emotional problems and among these, all but a few received services. Not all of the latter signify inconsistencies in measuring utilization, since some cases may represent successful treatment outcomes, that is, reduction of symptoms as a result of using mental health services.

Our data show that there are substantial numbers of psychologically distressed minority residents in the Fordham-Tremont area who have not made use of mental health services because they do not acknowledge symptoms as reflections of emotional problems. We consider it significant that most Hispanic underutilizers in the community are demoralized but unaware of having emotional problems. This suggests that outreach and treatment efforts need to consider the problems the CMI may have in acknowledging psychological distress symptoms.

We are aware that chronic mental

illness refers to more severe psychological distress than suggested by a score of nine or more symptoms in the Demoralization Scale. Our data include a small number of respondents with a number of symptoms high enough to suggest severe psychological distress, but the numbers are too small to support multivariate analysis. Thus, our analysis aims to uncover factors related to underutilization among demoralized Hispanics; demoralization here referring to psychological distress but not necessarily to clinical pathology. From this analysis we infer that the factors applicable to underutilization by demoralized Hispanics may be equally applicable to the smaller number of CMI Hispanics among the Fordham-Tremont population. Because the numbers of demoralized blacks and whites in our sample are too small, we restrict our analysis to Hispanics.

We conducted our analysis within the framework of two theories that explain Hispanic underutilization of mental health services: alternative resources theory and barrier theory.[15] According to alternative resources theory, Hispanics underutilize mental health facilities because they rely on helpers among friends, relatives, neighbors, and spiritualists.[16] The theory argues that the social organization of community life provides alternatives to the help formally provided by mental health service professionals. In contrast, barrier theory stresses obstacles to obtaining help among Hispanics who need mental health services. Barrier theory identifies two types of obstacles: Hispanic cultural beliefs and values about mental illness and treatment which predispose Hispanics against the use of impersonally administered professional services,[17] and organizational characteristics of service agencies,[18] such as the class and ethnic background of the professional staff, the staff's ability to speak Spanish, and impersonal treatment, which inhibit Hispanics from seeking and receiving services in mental health agencies.

The objective of our analysis was to determine the extent to which psychologically distressed Hispanics who underutilize services do so because they rely on informal resources alternative to professional mental health services, or because of cultural or institutional barriers. The two explanations of underutilization have important implications for mental health policy and programs. If Hispanics rely on the informal web of family and neighborhood life to solve emotional problems, mental health providers should encourage and help people in the community to carry out these health promotive functions. On the other hand, if Hispanics underutilize services because of cultural beliefs or because of institutional barriers, mental health programs would need to play a more active role in educating Hispanics about mental health, or in modifying the organizational structure of mental health agencies.

The Fordham-Tremont residents survey includes measures indicative of alternative resources, adherence to Hispanic values and norms, and institutional barriers. With respect to reliance on alternative resources, we asked respondents about their dependence on others for problems such as help with housework, companionship, and advice with personal problems. Their responses were classified according to the types of persons mentioned — household members, relatives, neighbors, friends, or associates. The last category includes persons such as building superintendents, grocers, landlords, workmates and work supervisors, and thus refers to members of the social network placed in formal social roles. Responses were also classified according to the total number of people mentioned, the total number of problems the respondent received help for, the total number of help instances by each type of helper, how frequently each person was seen, whether the person lived in the neighborhood or far away, and other background characteristics of these people. We found no differences among the ethnic groups in these social network characteristics, with the exception of a greater proportion among Hispanics of members of the social network who see each other on a daily basis. Our findings thus run counter to studies which assert that Hispanics are more likely than other ethnic groups to rely on friends, relatives and neighbors for help in solving problems.

With respect to adherence to Hispanic culture, respondents were administered a 23-item acculturation scale developed by Cuellar and associates.[19] The scale taps four dimensions of adherence to Hispanic culture: Spanish language use and preference, preference for the Hispanic cultural heritage (food, music, Spanish language media), cultural identification, and the ethnic groups the persons associate with. Mean scale scores range from 1 for completely unacculturated (responses indicating "only Spanish" or "mostly Spanish") to 5 for completely acculturated (responses indicating "only English" or "mostly English"). The mean score for respondents was 1.9, indicating that the majority of Hispanic residents in the Fordham-Tremont area are oriented to Hispanic culture.

Students of the migration and settlement process distinguish between acculturation, the psychological process of internalizing the norms and values of the host culture,[20] and structural integration, insertion into social roles typical of people born in the host society.[21] A migrant may be strongly integrated into the host society and yet be oriented to her/his native culture. From the viewpoint of structural integration, how the migrant fares in the society will be more strongly influenced by factors such as English-speaking ability or the groups one associates with, than by language or food preferences. To clarify this point, we divided the acculturation scale into two sub-scales: a cultural orientation scale consisting of items denoting cultural preferences (for example, the types of food preferred, the degree of identification with Hispanics), and a social integration scale tapping behavioral items (the language most used, the ethnic groups associated with). Scores in the two sub-scales are highly correlated and either sub-scale has the same degree of association with other variables in the data. Thus, in our analysis we used the acculturation scale consisting of both behavioral and psychological items.

In order to determine how organizational characteristics of mental health agencies may act as barriers to use of mental health facilities, it is necessary to directly measure those organizational characteristics among an adequate sample of mental health organizations. Since our survey focused on the behavior and opinions of residents, our approach precludes direct measures of the characteristics of organizations in the area. However, we asked respondents about the frequency with which they experienced 18 common problems in seeking or receiving services from local service agencies, for example, lack of attention by agency personnel, inability of personnel to speak Spanish, and having to make many appointments before being served. We divided these problems into three types: the kind of personal treatment given by agency staff, the language barrier, and difficulties in seeking or receiving service.

While most respondents reported few problems with agencies, Hispanics were the most likely to mention problems related to language, and whites were the most likely to mention problems in the personal treatment given by agency staff. There were no significant differences among the ethnic groups in reporting problems in seeking or receiving services.

Based on the Hispanic underutilization literature, we hypothesized that underutilizers are more likely to be found among those Hispanics who are unacculturated, among those who have a greater number of neighbors, friends, and relatives providing help with different types of problems, and among those who report more problems with service agencies. We analyzed the effect of these factors among psychologically distressed Hispanics, those in the sample scoring nine or more symptoms on the Demoralization Scale (N=54).

The data confirm our hypothesis that the unacculturated are more likely to underutilize mental health services. Four out of five with acculturation scores less than 1 — indicating a strong Hispanic orientation — underutilize mental health services, while one out of three with scores greater than 2.5 underutilize services. The data show no relationship between underutilization and perception of problems with agency personnel or perception of problems in seeking and receiving services. Among Hispanics, there is a slight but not significant relationship between utilization and perception of language problems with agencies.

The data show no relationship between underutilization and help by household members, neighbors, and friends. There is no relationship between having someone to talk to about personal problems, the help instance most closely related to mental health, and utilization of mental health services. The total number of people mentioned or the frequency with which these people see each other is likewise unrelated to utilization. Very few respondents (less than 2 percent) mentioned receiving help from spiritualists. Given such small numbers, we cannot test whether those receiving help from spiritualists are more likely to underutilize mental health services. The small number of respondents reporting help from spiritualists suggests that spiritualists are not a frequent recourse for distressed Hispanics.

We found two aspects of social networks significantly and directly related to utilization: receiving help from associates, such as building superintendents and workmates, and having someone from whom to borrow money. Two out of five who mention associates as helpers with different problems underutilize mental health services while three out of four who do not mention associates among helpers underutilize mental health services. Among those who say they can borrow money from members of their social network, 70 percent underutilize mental health services while 58 percent of those who cannot borrow money from members of their social network underutilize mental health services. The logical connection between these aspects of social networks and underutilization is not readily apparent. We surmise that those who interact on a daily basis with workmates or supervisors may have access to information about mental health referrals and may become more conscious of psychological distress through the reactions of workmates. At the same time, psychological distress may become more readily apparent to others in environments away from the informal circle of friends and relatives, and this may lead to the psychologically distressed becoming more aware of their problems and acting upon them. It is harder to explain why those able to borrow money from members of their social network are less likely to utilize mental health services. The relationship is partly explained by the negative relationship between associates' help and being able to borrow money. Those who say they can borrow money from social network members are less likely to mention associates in their social network. Thus, the relationship between being able to borrow money and underutilization may be due to the fact that this group is less likely to have associates who react to the person's psychological distress and provide referral information and advice. We provide evidence for this explanation below, when we consider the combined effects of these social network factors and other types of factors related to utilization.

We determined which demographic subgroups among psychologically distressed Hispanics are most likely to underutilize mental health services. The data show that the type of income sources, family income, and the number of years in the United States are the only background characteristics related to utilization. Those on public assistance are more likely to underutilize mental health services; those receiving transfer benefits, in particular Supplemental Security Income (SSI), are more likely to utilize services, while receiving income from work is not related to utilization. Surprisingly, family income is positively associated with underutilization. An examination of the data shows that those in the middle and upper levels of the income distribution are the most likely to underutilize. Among those in the lower family-income tercile (under $3800), 53 percent underutilize mental health services. Among those in the middle tercile ($3800 to $5400), 80 percent underutilize services, while in the upper tercile, 65 percent underutilize services. We compared the mean demoralization scores among the three income groups and found no significant differences. Thus, we rule out the possibility that the lowest income group is more likely to utilize mental health services because of a greater need for them.

The differences in utilization among the income groups must be viewed in the context of income levels in the Fordham-Tremont area, where less than 10 percent of Hispanic families in our sample earn more than $10,000 yearly. Thus, the data indicate that the poorest among the poor utilize mental health services more than those slightly better off. We believe that this may be explained by the relationship between income levels and Medicaid eligibility. It is possible that Medicaid-eligible residents are more likely to use mental health services because of referrals from one health facility to another, while those not eligible for Medicaid are less likely to seek needed mental health services or to be referred by medical services to mental health services. On the other hand, those on public assistance are Medicaid-eligible and yet they underutilize mental health services. Thus, we are not able to completely explain the positive relationship between family income and underutilization.

Ninety percent of Hispanic immigrants in the Fordham-Tremont area have been in the United States for more than 10 years. The data indicate that the most recently arrived are the most likely to underutilize mental health services. Three-fourths of those who have been in the United States for less than 30 years underutilize mental health services, while half of those who have been in the country for over 30 years underutilize services. This relationship may reflect the effects of knowledge of the social system which accumulates with settlement over time, or it may reflect increasing acceptance of American beliefs about how to recognize and deal with emotional problems. To sort out the interrelationships among background characteristics, acculturation, and social network characteristics, we conducted a multiple regression of combinations of these factors on mental health services utilization.

For readers not acquainted with the logic of multiple regression, a brief explanation may be useful. Correlation coefficients indicate the strength of the relationship between two variables, or the degree to which change in one variable influences change in the other variable. A positive correlation indicates that the greater the score or quantity of one variable, the greater the score in the other variable; while a negative correlation indicates that the lower the score of one variable, the greater the score in the other variable. Multiple regression indicates the strength of relationship between one variable and the dependent variable (in our case, utilization), controlling for the effects that other variables have on the dependent variable and on each other. Thus, multiple regression coefficients indicate the individual and joint influences of variables on the dependent variable. The greater the separate contributions of each variable, the greater the percentage of the variance in the dependent variable explained, and the more satisfactorily the variables explain changes in the dependent variable.

With the exception of age, which we found to be related to background characteristics and acculturation, we included in the multiple regression analyses only those variables that have the strongest correlations with utilization: family income, income sources, number of years in the United States, acculturation, help from associates, and being able to borrow money from members of the social network. The correlations between these variables and utilization are not very strong (between) .2 and .3) both because of the relatively small number of psychologically distressed Hispanics in the sample and because other unmeasured factors may also explain utilization. However, with the exception of age, which is only indirectly related to utilization, most of the correlations are statistically significant at the .05 level or lower, and two are significant at the .01 level.

The first regression examined the effects of acculturation and the two social network variables (help from associates and borrowing money from social network members) on underutilization. Help from associates had the greatest and most significant effect, while the effect of being able to borrow money from members of the social network was minimized by its association with the other two variables. Thus, the first regression identifies two separate groups of people who underutilize mental health facilities: the unacculturated and those who are not able to rely on associates for help in solving problems.

The second regression examined the effects on utilization of social network and background characteristics; the third regression examined the effects of acculturation and background characteristics. Controlling for family income, type of income sources, number of years in the United States, and age increases the amount of total variance explained to 31 percent, but the effects of help from associates remain the same. The third regression indicated that the effects of acculturation on utilization are partly explained by the relationships among background factors and acculturation. The unacculturated underutilize mental health services in great part because they are older and have been in the country for shorter periods of time than the acculturated, but relatively recent migrants are more likely to underutilize regardless of their degree of acculturation.

The fourth regression examined the combined effects of background factors, acculturation, and social network variables. Taking into account significance levels, family income and help from associates had the strongest effects on utilization, income being positively related and help from associates negatively related to underutilization. The data suggest that the effects of acculturation on utilization are explained in great part by the influence on acculturation of age and number of years in the United States, but these effects do not meet the criterion of statistical significance. The greatest effect on utilization is found among those receiving benefits, especially SSI. However, while having such benefits adds the greatest contribution to the total variance, the effects are not as statistically significant as family income and help from associates. In summary, having a relatively high family income within a low-income range and lacking help from associates are separate and important sources of underutilization. While less important, age, recency of immigration, and reliance on public assistance are also related to underutilization.

We began the analysis of factors in underutilization with considerations of two theories of underutilization: alternative resources theory and barrier theory. Our findings indicate that cultural and institutional barriers are more applicable than the use of alternative resources to the underutilization of mental health services by Hispanics in the Fordham-Tremont area. We have seen that the degree of integration of residents into a social network of friends, relatives and neighbors and, in particular, having someone to talk to about personal problems, are not related to utilization of mental health facilities, and that other social network characteristics such as the number of people in the network or the frequency of contacts are also unrelated to utilization. Furthermore, very few respondents mention seeing spiritualists for help with emotional problems. Thus, we have no evidence that members of the social network act as surrogates to professional mental health workers. While having work associates and neighborhood helpers increases the likelihood of utilizing mental health services, their function does not appear to be an alternative to professional mental health care. Whether or not they received all mental health services needed, all psychologically distressed persons who acknowledged emotional problems have associates. Among underutilizers, only those who did not acknowledge emotional problems lack associates. Thus, associates appear to help the demoralized person in acknowledging emotional problems rather than in providing advice and referral information in lieu of the work of professional mental health workers.

The data provide some evidence for the existence of cultural and institutional barriers to the utilization of mental health services. We find that the unacculturated are more likely to underutilize services, but this is partly explained by the older ages and the fewer number of years in the United States among the acculturated. However, older people and those more recently arrived in the country are more likely to underutilize services, regardless of their orientation to Hispanic culture. It is likely that these subgroups have less knowledge of the ways of service bureaucracies and are therefore less likely to seek services or less likely to be helped with referrals to mental health agencies. We asked a subset of respondents about their knowledge of different types of mental health services, but the number of demoralized respondents among this subset was too small to analyze the effects of knowledge on utilization. Thus, we can only conclude that other characteristics of the most recently arrived and older Hispanics, besides their orientation to Hispanic culture, are also related to their underutilization of mental health services.

The relationship between family income, types of income sources, and underutilization also suggests that some socioeconomic subgroups among low income residents of the Fordham-Tremont area face barriers to utilization of mental health services. The fact that among a low-income population, slightly higher income people are more likely to underutilize services suggests that eligibility for medical benefits provides access to services. Medicaid-eligible persons may come to acknowledge emotional problems through seeking other than mental health services. For example, among those who acknowledge emotional problems, two out of five received services from a medical doctor, while an additional one-fifth mention seeing a medical doctor before receiving a mental health service.

If Medicaid-eligibility promotes utilization of mental health services, it is only among those receiving SSI. People on public assistance, who qualify for Medicaid, are less likely to utilize mental health services than those receiving other types of benefits. While the number of respondents receiving other types of benefits is too small for detailed breakdowns of utilization by types of benefits, the data suggest that those on public assistance or receiving Social Security use mental health services less than those receiving SSI or private pensions.

In summary, those with relatively high income - - the working poor — may not seek mental health services because they are not placed in institutional positions where emotional problems may be recognized and acted upon. On the other hand, lower income people on public assistance relatively underutilize mental health services in spite of qualifying for free medical care, while those receiving SSI qualify for Medicaid and appear to be referred to mental health services. Since we find no significant age or income differences between those receiving public assistance and those receiving SSI, we surmise that the institutional process of being accepted for SSI leads to referrals to mental health facilities, in the process of which demoralized persons come to acknowledge having an emotional problem.

To gather additional information about those demographic characteristics of CMI Hispanics related to underutilization, we compared a group of utilizers, 136 Hispanic patients enrolled in November 1982 at Continuing Care (CC), Fordham-Tremont CMHC's clinic for the CMI, with mental health service utilizers and underutilizers in the community sample. We found that Hispanic CC patients and community underutilizers were similar in many background characteristics, but that they differed with respect to language use, age, and length of residence in the area. Ninety percent of the community underutilizers preferred to answer questions in Spanish, while only 30 percent of CC patients used Spanish when they came for treatment. While less significant, there was also a greater proportion of individuals aged 50 or older among the community underutilizers (64 percent compared to 42 percent among CC patients). Related to this is the greater proportion of second-generation Hispanics among CC patients (15 percent) compared to community underutilizers (5 percent), and the lower educational level of underutilizers (72 percent have less than nine years of education, while half of CC patients have a similar educational level). CC Hispanics have also been in the community less time than those sampled in the community. Thus, length of residence is not related to utilization of mental health services.

These background differences between the two groups suggest that CMI Hispanics sharing similar background characteristics with community underutilizers are less likely to use mental health services for the CMI. Thus, the findings suggest that concentrating outreach efforts among older, first-generation Hispanics, in particular those with difficulties in the use of English, will lead to greater utilization of the CC clinic by this group, and consequently, to an increase in the proportion of Hispanic clients in CC.

In addition to the importance of focusing on those characteristics of Hispanics which predict utilization, we stress non-recognition of symptoms as a locus of outreach efforts. We believe this finding is relevant to the situation of CMI Hispanics, in that the failure to seek follow-up mental health services after discharge from a psychiatric facility is in part due to the patient's inability to recognize feelings of distress as symptoms of a condition requiring care. In our conversations with Project COPA's outreach worker, and with personnel at the Bronx Psychiatric Center, the main inpatient source of referrals to CC, it was stressed that patients tend to equate discharge with cure, and that this is one of the major barriers to an effective transition from discharge to follow-up care. Thus, we believe that efforts to educate patients about the recognition of distress symptoms should be one of the main objectives of outreach and treatment for the CMI.

Another aspect of utilization of mental health services relevant to the situation of the CMI is the smoothness of the transition from hospital discharge to admission to follow-up care such as that offered at CC. We examined the clinical histories of CC patients to determine who is most likely to have delays in admission to CC after discharge from a psychiatric facility. Among Hispanic, black, and white patients enrolled at CC in November 1982 (N = 336), more than three out of four had been hospitalized prior to admission to CC, and one out of two had three or more psychiatric hospitalizations. One out of ten patients received only outpatient care prior to admission to CC, and 7 percent received no prior psychiatric service before admission to CC. There are no significant differences in previous clinical experiences among Hispanics, blacks, and whites. Thus, eight out of ten Hispanic patients were admitted to CC following a psychiatric hospitalization while an additional 10 percent entered after treatment at a Fordham-Tremont CMHC outpatient unit or some other outpatient facility. Hispanics with previous hospitalizations are more likely to enter CC within 30 days than those who previously received only outpatient care. Seventy-four percent of those with previous hospitalization entered CC within 30 days of discharge from the last psychiatric service, while 39 percent of those with only outpatient backgrounds entered CC within 30 days. While black and white patients have a pattern of delays in admissions similar to that of Hispanics, the data suggest that CMI Hispanics whose previous clinical experience is only in outpatient facilities should be a particular focus of outreach efforts.

We examined differences in clinical and demographic background characteristics among Hispanic, black, and white CC patients who entered CC 30 or more days after the last psychiatric service. We found that Hispanics under the age of 30 are the most likely to delay entry into CC. Forty-four percent of Hispanics under the age of 30 were admitted to CC 30 or more days after the last psychiatric service, while one-third of those aged 30-49 and one-fifth of those over 50 were admitted after the same time period. Among blacks, age had no effect on delays in admission, while among whites, the older, the more likely the delay in entry.

We also found that the longer Hispanics have been living in the area, the more likely they are to delay entry into CC. We have no explanation for this relationship, which is found to a lesser degree among blacks and which runs in the opposite direction among whites.

In the light of the community survey findings, it is interesting that we find no differences in delays in admission to CC between those Hispanics able and those unable to speak English, or between first- and second-generation Hispanics. Since the percentage of English-language speakers and second-generation Hispanics is much greater among CC patients than among the community underutilizers, comparison of the two data sets indicates that the immigration experience is more related to seeking services than to the specific aspect of utilization having to do with the transition from one psychiatric service to another.

In summary, an examination of clinical and demographic characteristics of Hispanic CC patients indicates that the characteristic most clearly related to delays in admission to CC is the type of previous psychiatric service received. Those whose only previous service was in an outpatient facility are the most likely to delay admission to CC, and among those with previous hospitalizations, the fewer the hospitalizations, the more likely the delay in admission. Thus, the patient's previous clinical experiences appear to prepare him or her for the process of follow-up care after an emotional crisis. As we show below, the patient's previous clinical experience and other background characteristics are also related to treatment experiences following admission to CC.

Barriers to Treatment of Hispanic CC Clients

Besides the first objective of increasing the utilization of mental health services by CMI Hispanics, Project COPA's second objective is to develop innovative services that will improve the treatment that Hispanic CMI receive once they overcome the initial barrier of admission to follow-up care.

To aid Project COPA in planning such services, we examined treatment-related characteristics of Hispanic, black, and white CC clients. Ideally, existing differences in clinical outcomes — for example, psychological adjustment — would provide the best criteria for planning specific services for Hispanics. Since treatment outcome data are not gathered at the Fordham-Tremont CMHC, we looked at two available treatment-related measures: the length of time in treatment and the attendance rate.

We examined the effects on these

treatment-related variables of clinical and demographic patient characteristics. Among clinical characteristics, we looked at the effects of previous clinical treatment (no previous treatment, previous treatment only in outpatient clinics, one or two previous hospitalizations, or more than two hospitalizations), and the patient's diagnosis. Three-fourths of patients were previously hospitalized and 10 percent had received only outpatient services previously. There are no differences among the ethnic groups in the patterns of previous treatment. Over half of the CC patients are diagnosed as having some type of schizophrenia, and less than 20 percent are diagnosed as having either affective or neurotic disorders. Smaller numbers are diagnosed as having other types of chronic disorders. We found no differences among the ethnic groups in the types of diagnoses. This finding runs counter to some studies claiming that Hispanics are more likely than other groups to be diagnosed as having depressive/affective and other severe disorders.[22]

We also examined the effects on treatment-related variables of demographic characteristics of clients (sex, age at admission, years of education, number of years living at current residence, and who the patient lives with). Minority patients are younger than white patients. One-third of minority patients and less than one-fifth of white patients are under 30, while one-third of white patients and less than one-fifth of minority patients are over 50. Insofar as length of time at current residence indicates stability, white patients are more stable, with one-fourth having lived in the same residence for the last five years. The corresponding percentages among blacks and Hispanics are 14 percent and 13 percent, respectively. White patients also have a higher level of education while Hispanics have the lowest level. Two-fifths of white patients, 35 percent of black patients, and one-fifth of Hispanic patients have at least 12 years of education.

The data also indicate ethnic differences in living arrangements. One-fifth of white patients live with a spouse or partner, 12 percent live in female-headed households, 16 percent live alone, and over half live under other arrangements, for example, with parents, siblings, relatives, or friends. Among black patients, 16 percent live with a spouse or partner, 22 percent live in a female-headed household, one-fifth live alone, and over two-fifths live under other arrangements. Among Hispanics, 11 percent live with a spouse or partner, 19 percent live in a female-headed household, 26 percent live alone, and 44 percent live under other arrangements. Thus, while minority patients, especially Hispanics, are less likely than white patients to live with a spouse or partner, the patient population as a whole constrasts markedly with the community sample's pattern, where less than one-fifth of adults live with parents, siblings, or others.

We also examined the effects among Hispanics of immigration-related factors on treatment-related variables. The patient data provided information on the language of the admission interview, the patient's English-speaking ability (as rated at the admission interview), and the patient's birthplace. While more than three-fourths of Hispanic patients were born outside the United States (mainly in Puerto Rico), they appear to be relatively acculturated. Two-thirds of patients were rated to have fair or good English-speaking ability, and two-thirds spoke at the admission interview either in English or in a combination of English and Spanish.

At CC, as in most facilities offering follow-up care to the CMI, treatment relies on a combination of medication, psychological counseling aimed at reintegration of the patient into his or her family and community, and concrete services such as help in securing benefits or additional education. Given present knowledge about the treatment of chronic mental illness, the person is expected to remain a patient for a long term, although treatment for the successful patient may eventually consist of a minimum number of visits to obtain the next dose of medication. In this context, the longer the time in treatment, the more successful the patient. By this indicator, minority patients at CC are less successful than white patients. Among patients being treated at CC in November 1982, Hispanics had been in treatment for an average of 113 weeks, blacks for an average of 105 weeks, and whites for an average of 132. These differences are not significant, but they describe all patients in the active caseload at CC at the time of analysis. If we include those clients who left treatment before November 1982, Hispanic clients are in treatment for an average of 96 weeks, while the corresponding treatment periods for blacks and whites are 92 and 118, respectively. Thus, ethnic differences in treatment time among current clients are not distorted by ethnic differences in treatment times among clients who have left treatment. Consequently, differences in treatment time among current clients may be taken as probability statements of how long a given client is likely to remain in treatment.

We examined the average time in treatment among clinical and demographic subgroups. With respect to clinical variables, we found that among patients of all ethnic groups, those whose only previous clinical experience was in outpatient settings have significantly shorter periods in treatment — 84 weeks compared to 107 weeks among those without previous psychiatric treatment or those with one or two previous hospitalizations, and 128 weeks for those with two or more hospitalizations. Regardless of ethnicity, we found no significant differences in treatment time among patients with different diagnoses.

Factors related to the family's stability significantly affect the patient's time in treatment. For all ethnic groups, the longer a person has lived at the current residence, the longer the time in treatment. Those who have lived at the current residence for less than a year have an average treatment time of 65 weeks, while those who have lived at the current residence for more than four years have an average treatment time of 150 weeks. While not verifiable with current data, it is possible that patients living at the current residence for a short time may have received treatment in other clinics. However, a transfer to another clinic may represent a discontinuity in treatment which adversely affects the patient. Thus, regardless of the reasons behind the length of time in current residence, stable residents are also stable patients. The patient's living arrangements also affect treatment time. Those living with a spouse or partner have significantly longer treatment times (an average of 146 weeks) than those living under other arrangements. Patients living alone have an average of 124 weeks in treatment; those living in female-headed households average 117 weeks in treatment, while those living with parents, siblings, friends, or other relatives have an average treatment time of 103 weeks. These differences are less marked among minority patients and more marked among white patients, but the overall differences in treatment time among patients living under different arrangements are similar for each ethnic group. This is in line with Amin's finding that the extent of patients' social contacts with family and relatives was an important determinant of favorable post-hospital adjustment.[23]

We also found significant differences in treatment time among patients of different age and education subgroups. Regardless of ethnicity, older patients have longer treatment times than younger patients. Overall, patients under 30 have an average treatment time of 91 weeks; those between the ages of 30 and 39 have an average treatment time of 108 weeks; those 40 to 49 have an average treatment time of 127 weeks, while those over 50 have an average treatment time of 148 weeks. Patients with less education have significantly longer treatment times than the more educated. Those with less than 7 years of education have an average treatment time of 149 weeks; those with

7 to 9 years of education have an average treatment time of 114 weeks; those with 10 or 11 years of education have an average treatment time of 109 weeks; while those with 12 or more years of education have an average treatment time of 104 weeks. Within this general pattern, we found slight differences among the ethnic groups. White patients with 10 to 11 years of education have the longest treatment time while those with 7 to 9 years of education have the second longest. Among black patients, those with 7 to 9 years of education have the shortest treatment time while those with less than 7 years of education have the longest. Among Hispanics, those with less than 7 years of education have the longest treatment time, but those with 10 to 11 years of education have shorter treatment times than those with 12 or more years of education. Since younger patients are more educated, we examined the interrelation between age, education, and treatment-related variables in multivariate analysis given below.

We also examined the effects of immigration-related variables on treatment time among Hispanic patients. We found no significant differences in treatment time between those who are rated good English speakers and those rated poor English speakers. Nor did we find significant differences in treatment with respect to the language used in the admission interview or the patient's birthplace. While not significant, the foreign-born and those using only Spanish in the admission interview have longer treatment times than those born in the United States or those using English in the admission interview. We examine below the interrelation among these immigration-related variables and their effects on patients' clinical experiences.

The other treatment-related indicator available in the CC data is the patient's attendance rate, the ratio of actual to prescribed visits. We were able to compute this information only for the last month in treatment — November [illegible] — since information on the number of prescribed visits for other times was unreliable. We found no differences among the ethnic groups in attendance rates. Each group on the average kept four out of ten prescribed visits. We found significant differences among the three ethnic groups in the effects of clinical and demographic factors on attendance rates. We enumerate the differences here, and analyze them through multivariate analysis below.

Previous clinical experience only in an outpatient setting has a positive effect on attendance among black and white patients but has a negative effect on Hispanics. Hispanics with only previous outpatient experiences have the lowest attendance rates (30 percent of prescribed visits), while black and white patients with the same clinical experiences have the highest attendance rates (over 70 percent). Regardless of ethnicity, there are no significant differences in attendance rates according to the patients' diagnosis.

Stability in residence and in household living arrangements significantly affects attendance. White and black patients living at the current residence for less than one year have the lowest attendance rates (less than 30 percent). Those living at the current residence between 3 and 5 years have the highest attendance rates (over 50 percent) while those living at the current residence for over 5 years have almost as high attendance rates. Among Hispanics, there is no significant relationship between time at the current residence and attendance. Among minority patients, those living with a spouse or partner have significantly higher attendance rates (55 percent among blacks and 69 percent among Hispanics) than those living in female-headed households, or living with others. Those living alone have slightly higher attendance rates, but not significantly different from the latter groups. Among white patients, there are no significant differences in attendance among those living in different household arrangements.

Older patients have higher attendance rates than younger ones. Those under the age of 30 have an average attendance rate of 38 percent of prescribed visits while those over 50 have an attendance rate of 47 percent. While this holds for all the ethnic groups, the relationship is significant only among whites and Hispanics. The less educated have higher attendance rates than the more educated, but only significantly among white patients. Thus, we find the same pattern among education, age and attendance that we found with respect to treatment time.

Among Hispanic patients, we found no differences in attendance between those with poor English ability and those with good English ability, or between those using English and those using Spanish in the admission interview. However, the foreign-born have significantly higher attendance rates than those born in the United States (45 percent and 32 percent, respectively). Thus, as in the case of time in treatment, immigration-related variables have a weak effect on treatment-related variables, but the data suggest that the unacculturated have more positive clinical experiences than the unacculturated.

We examined three aspects of treatment experiences at CC: the time between discharge from the last psychiatric service (discussed in our analysis of utilization of mental health services by CMI Hispanics), time in treatment, and the attendance rate. We found that each variable is an independent measure of the client's experience at CC. There is no relationship between the time it took the patient to be admitted to CC after the last psychiatric service and the length of time in treatment, or the attendance rate; and there is no relation between time in treatment and attendance. Since each is an independent indicator of the patient's treatment experience, we computed an index summarizing the patient's experience across three indicators. The lowest score, zero, indicates that the client entered CC 30 or more days after the last psychiatric service, has been in treatment for less than 122 weeks — the mean for all patients at CC — and has an attendance rate below the clinic mean of 40 percent. The highest score, three, indicates scores above the mean for each of the three indicators. Clients without prior psychiatric services are excluded from the computations. We found no differences among the ethnic groups in treatment experience scores. Hispanics, blacks, and whites had the same mean score of 1.8. We are aware that time in treatment introduces an artificial element in the index, since some clients with a length of time in treatment below the mean may in the future still be in treatment, while some above the mean may drop out shortly. However, as indicated above, ethnic differences in treatment time still remain after we consider those clients who have left treatment.

Reviewing the relationships among clinical-, demographic-, and treatment-related variables, we find different configurations of relationships among specific treatment and background variables. Four main patterns, tested below through multivariate analysis, emerge from the data: (1) Previous clinical experience only in outpatient settings negatively affects treatment at CC. (2) Stability in living arrangements affects treatment. (3) Age and education jointly affect treatment. The older and less educated the patient, the more stable his/her treatment-related experiences at CC. (4) First-generation Hispanics are marginally more likely to have stable treatment experiences at CC. None of these patterns simultaneously apply to all treatment-related and background variables. To determine the interrelations among these variables in affecting treatment experiences, we conducted multiple regression analyses on the index of clinical experiences separately for each ethnic group.

The results of the multiple regression analyses point to previous clinical experience and residential stability as the key factors in determining the quality of clinical experiences at CC. Among Hispanics, previous clinical experience and residential stability explain 20 percent of the variance. Adding indicators of living arrangements increases the variance explained by four percentage points, while education, age, and immigration-related variables increase the variance explained by only three percentage points. When all variables are included in a multiple regression, previous experience in an outpatient setting or having fewer than three psychiatric hospitalizations; shorter lengths of time at the current residence, and being young and relatively educated are factors significantly and negatively related to successful clinical experiences at CC. Among these factors, previous clinical experience, especially previous treatment only at outpatient clinics, is the strongest predictor. After controlling for the effects of these variables on each other, the relationship between previous clinical experience and the index of clinical experiences at CC remains the same, while the relationships between the clinical experience index and residential stability, age, and education are attenuated. In other words, young, relatively educated, or residentially unstable Hispanics are less successful at CC in part because they tend to have previous clinical experiences only in outpatient settings or have fewer previous psychiatric hospitalizations than others, but regardless of the patient's age, education, or residential stability, those who are treated previously only in outpatient clinics or had relatively few hospitalizations tend to be less successful at CC. The other factors – the patient's household living arrangements, his/her English-speaking ability, and his/her immigrant generational status — have very weak explanatory power and are not significantly related to clinical experiences at CC. While young and relatively educated patients are more likely to be born in the United States, those who were born outside the country or have limited English-speaking ability also tend to have less successful clinical experiences.

White patients' clinical experiences are influenced by the same factors that affect Hispanics' experiences, but these factors have less of an effect among black patients. Among white patients, previous clinical experiences in outpatient clinics, residential stability, and age and education are the strongest predictors of successful clinical experiences at CC. Those living with a spouse or partner tend to be more successful, but only if they are residentially stable. Together, these factors explain 24 percent of the variance in the clinical experience index. Whites' previous clinical experiences, residential stability, and age and education act as independent factors, whereas those of Hispanics do not. In a multiple regression, the regression coefficients of these factors are virtually identical to their individual correlations with the clinical experience index. Among white patients, each factor has an accumulative effect. Patients sharing three of these characteristics are less successful than those sharing only two of them, and these persons in turn are less successful than those sharing only one.

Among black patients, only residential stability is significantly and strongly related to successful clinical experiences at CC. Older patients and those living with a spouse or partner are more likely to have successful clinical experiences, in part because they are more residentially stable; but residentially stable young patients living under other household arrangements, nevertheless, have successful clinical experiences at CC. Among black patients, previous clinical experiences have no effect on their experiences at CC. Together, these factors explain only 9 percent of the variance, indicating that other factors not available in the patient data must be taken into account.

Summary and Recommendations

Our findings suggest interventions to increase the utilization of mental health services and improve the services received by CMI Hispanics. The findings also identify specific Hispanic subgroups that should be focused on in outreach efforts to increase utilization and improve services. We shall review these findings and discuss recommendations first with respect to outreach, and then with respect to treatment-related interventions.

We have analyzed factors related to the utilization of mental health services by psychologically distressed Hispanics, and by inference applied these factors to the situation of CMI Hispanics in the Fordham-Tremont area. We found that most Hispanics who underutilize mental health services do so because they do not recognize or acknowledge symptoms, while a smaller number acknowledge emotional problems but are not able to get all the mental health services they need. Our data provide no evidence for the theory that Hispanics underutilize mental health services because of reliance on informal social networks providing social support in lieu of the professional care given by mental health agencies. We found some evidence for the existence of cultural and institutional barriers to the use of mental health services among Hispanics. With respect to cultural barriers, we found that recent immigrants and those more oriented to Hispanic culture are less likely to utilize mental health services. With respect to institutional barriers, we found that some Hispanic subgroups — those on public assistance, the elderly, the poor who are ineligible for Medicaid, and the non-English speaking — are less likely to utilize mental health services.

We analyzed clinical and demographic characteristics of CMI Hispanic, black, and white patients receiving services at Fordham-Tremont CMHC's Continuing Care clinic as of November 1982. We found that previous clinical experience is the characteristic most consistently related to Hispanic patients' success at CC. Those Hispanics whose only previous psychiatric experience is with an outpatient facility are the most likely to be delayed in entering CC after the last psychiatric service, have the shortest periods of time in treatment, and have the lowest attendance rates. Younger and relatively educated Hispanics and the residentially unstable are also less likely to have successful clinical experiences.

Comparisons between those factors found to affect utilization and those found to affect treatment-related experiences suggest interesting considerations about barriers to clinical services faced by Hispanics. The findings underscore the usefulness of viewing the mental health problems of Hispanics and other ethnic groups within a temporal perspective of successive stages. Our data suggest that Hispanics have more problems in seeking mental health care than other ethnic groups, but among the CMI, all ethnic groups face problems in making effective use of clinical services. Furthermore, success in seeking treatment may not be equal to success in receiving treatment. Mental health care for the CMI appears to be a learning process where each additional clinical service increases the patient's ability to make effective use of treatment. Thus, successful seeking of mental health care does not ensure successful treatment.

Comparison of the community survey and patient data also suggests that subgroups successful in seeking treatment may not necessarily be successful in making effective use of treatment. For example, in our study area, the young and relatively educated are more likely than others to utilize mental health care, but once in treatment they are more likely to drop out and less likely to attend treatment sessions. Immigration-related factors — acculturation and the recency of immigration — are important factors in underutilization but have no effect on treatment-related clinical experiences. Immigration-related factors may have little effect on treatment-related factors because the patient population is more homogeneous with respect to acculturation. Thus, a selection process may occur whereby second-generation, unacculturated Hispanics are less able to seek mental health services and as a result acculturation has less importance in determining clinical experiences.

We also found that instability in residential and household living arrangements has a greater effect on clinical experiences than on utilization of mental health services. Hispanics in unstable living arrangements are less likely to utilize mental health services, but the relationship is weak. By contrast, residential stability emerges as a central factor in patients' treatment-related experiences. Differences in income and in sources of income — data which were not available in the patient file — may explain the effects of residential instability. Of particular note is the greater proportion of patients, compared to the community sample, living with friends, siblings, or relatives other than parents. This may reflect the family dislocations experienced by people hospitalized for mental illness. While the patient data have no information on the emotional supports provided by members of the social network, the greater influence of household living arrangements on clinical experiences compared to their influence on utilization suggests that integration into social networks may have a greater role in treatment experiences than in providing resources alternative to utilization of mental health services.

Our findings suggest specific interventions that mental health agencies may implement in order to overcome barriers faced by Hispanics in seeking and receiving clinical services. We first suggest recommendations for increasing the number of CMI Hispanics utilizing mental health services, continue with recommendations for improving the clinical treatment received by CMI Hispanics, and then suggest recommendations equally applicable to both utilization and improvement of mental health services. All the recommendations are keyed to the main findings of this study.

Recommendations to Increase the Number of CMI Hispanics Utilizing Mental Health Services

Because most recent immigrants, the unacculturated, and the elderly are the least likely to utilize mental health services, we recommend that:

1. Outreach efforts be instituted in inpatient facilities, community organizations and social service agencies to identify Hispanics with these characteristics. Priority in personal contact time should be accorded to members of these subgroups and their relatives to persuade them to enter follow-up care.

2. Personal contacts with older, first-generation Hispanics should be based on traditional Hispanic rules of interaction: respectful form of address, use of traditional sayings to prove a point, deference to authority, and respect for traditional notions of mental illness. The literature suggests that employment of these interaction styles among first-generation Hispanics will minimize distrust.[24]

Since for most Hispanics, underutilization is due to the inability to link symptoms with emotional problems, we recommend that:

3. Patients about to be discharged from psychiatric hospitals and their relatives should be given educational presentations stressing how follow-up care after discharge will help patients to recognize symptoms to prevent future crises. Presentations could take the form of videotapes to be shown in the hospital, followed by questions and answers and personal contacts with patients.

4. Presentations should be made to service providers in inpatient facilities focusing on the problems Hispanics face in seeking mental health care. The presentations should be followed up with arrangements to provide referrals to post-hospitalization care.

5. Group visits to post-hospitalization clinics should be arranged for patients about to be discharged. Transportation should be provided and a presentation of services should be given.

6. To smooth the transition to follow-up care, patients ready for discharge from inpatient facilities should be enrolled in post-hospitalization care prior to discharge.

7. Presentations should be made to service providers in non-mental health agencies, including clergy, about how to recognize Hispanics with emotional problems and properly refer them to mental health agencies.

8. Presentations should be made in the form of prepared talks or videotapes to Hispanics in community settings such as churches and senior centers. The presentations should stress the relation of symptoms and emotional problems and the availability of services for the chronically mentally ill.

Low-income Hispanics who are ineligible for Medicaid are less likely to utilize mental health services than the Medicaid-eligible. Therefore, we recommend that:

9. Waivers or reduction of fees for the Medicaid-ineligible should be stressed in outreach contacts with patients. In evaluations of mental health programs, provision of services regardless of ability to pay has been emphasized as one of the key factors in increasing Hispanic utilization of mental health services.[25]

Recommendations to Improve Treatment for CMI Hispanics

In our study area, Hispanic and black patients stay in treatment for less time than white patients. Attendance rates for patients of all ethnic groups are on average lower than 50 percent of all prescribed visits. Therefore, we recommend that:

10. In addition to the goal of psychosocial adjustment, treatment for the CMI should include efforts to improve attendance rates and duration of treatment as patient goals.

11. Symbolic rewards should be offered to patients who fulfill attendance and treatment goals. Examples of such rewards are inexpensive gifts or publicly exhibited recognition certificates.

Hispanics with previous clinical experience only as outpatients have longer time gaps between the last psychiatric service and admission to follow-up, have shorter durations in treatment, and have lower attendance rates. Those with one or two previous hospitalizations do better than those with only outpatient experiences, but they do worse than those with more than two previous hospitalizations. We therefore recommend that:

12. When there are more patients than treatment slots, and after consideration of each patient's clinical needs, priority in admission should be given to patients with only previous outpatient treatment or with only one previous hospitalization.

13. Among patients with only outpatient experiences, a major goal of treatment should be the avoidance of hospitalization. The treatment should stress the relations between attendance and the avoidance of hospitalization.

Since younger, more educated, second-generation patients have shorter durations in treatment and lower attendance rates than older, less educated, first-generation patients, we recommend that:

14. When there are more patients than treatment slots, and after consideration of each patient's clinical needs, younger, second-generation patients should have greater priority in admission than older, second-generation patients.

15. Therapists should develop specific counseling approaches for first- and second-generation patients. The approach for the first-generation patient should stress appeals to traditional beliefs, parental authority, discipline and family cohesion; the therapist should present her/himself in a polite, low-key fashion. The approach for the second-generation patient should emphasize individuality and personal autonomy, expression of feelings; the therapist should cast her/himself in a professional expert role. Inclan[26] provides therapeutic models to follow with these two subgroups.

Our finding that patients living under relatively stable family arrangements have more positive clinical experiences highlights the importance of family support in the patient's treatment. We therefore recommend that:

16. Mental health agencies should consider implementing family-oriented therapies such as the eco-structural[27] or other family approaches[28] in the treatment of CMI Hispanics.

17. Mental health agencies should develop surrogate family therapy approaches for patients lacking stable family supports. A model upon which to draw for this approach is Maldonado-Sierra's and Trent's surrogate family therapy for schizophrenics.[29]

Since the relationship between symptom recognition and underutilization may also be relevant to success in treatment, we recommend that:

18. A major treatment goal should be to help the patient recognize the link between symptoms of distress and emotional problems or possible crises.

19. Clinics for the CMI should provide pre-treatment orientation to patients. An example of this is Acosta's "Tell It Like It Is" videotape orientation for patients.[30] The orientation should stress what the therapist does, what is expected of the patient with respect to attendance and time in treatment, and the patient's goals in undergoing treatment. First- and second-generation patients should be given different orientations, each tailored to the personal approach most effective with each group.

Recommendations Equally Applicable to Utilization and Improvement of Mental Health Services

Our findings support often-repeated assertions about the shortage of Hispanic mental health professionals and the need for bilingual and bicultural personnel in providing therapeutic services to Hispanics.[31] Therefore, we recommend that:

20. Mental health agencies serving areas with substantial numbers of Hispanics should undertake efforts to increase the number of Hispanic therapists and support personnel.

21. Mental health agencies, in conjunction with government and educational institutions, should offer inducements to non-Hispanic therapists to undertake Spanish-language instruction and training in Hispanic culture

22. Mental health agencies and other concerned institutions should utilize Hispanic paraprofessionals more effectively. For example, it has been suggested that Hispanic paraprofessionals could be trained as bilingual/bicultural interpreters.[32] Hispanic paraprofessionals could also be offered special educational programs leading to certification as clinical psychologists.

Our review of the mental health literature indicates the need for research and evaluation to test the interventions that have been proposed here and elsewhere to reduce barriers to clinical service among Hispanics. This study has focused on barriers to clinical services among a CMI population in a majority Puerto Rican area of the South Bronx. Our findings and recommendations may be applicable to individuals beset with less severe emotional problems and to other Hispanic and non-Hispanic populations living in inner-city areas. We invite social scientists and practitioners in other areas to consider the applicability of our findings and recommendations.

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