Final Evaluation of the Pilot Project, Mente Sana, Vida Sana Project,

a Project Serving the Mental Health Needs of Mexican Immigrants in Northern California

2017 - 2021

Latino Priority Population

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Acronyms

CDEP – Community Defined Evidence Project

CDPH – California Department of Public Health

CBPR – Community Based Participatory Research

CRDP – California Reducing Disparities Project

CMHDA – California Mental Health Directors Association

CMHPC – California Mental Health Planning Council

HEC – Health Education Council

MHSA – Mental Health Services Act

MHSOAC – Mental Health Services Oversight and Accountability Commission

OHE – Office of Health Equity

OSHPD – Office of Statewide Health Planning and Development

PARC – Psychology Applied Research Center at Loyola Marymount University

VDS – Ventanilla de Salud

Keywords

Hispanic/Latinx/Latino – The report uses the term “Latino” to describe the population served by the Mente Sana, Vida Sana (MSVS) project, although it references research that uses the terms “Hispanic” and “Latinx.” This was done for consistency with past MSVS evaluation reports.

Project Participant – A direct recipient of MSVS services.

Project Partner – An entity that provided direct or indirect support to the MSVS project.

Project Staff – Employees of the Health Education Council (HEC) who managed the MSVS activities.

Executive Summary

The Latino community continues to demand affordable, accessible, and culturally and linguistically appropriate mental health services. This demand has gone unmet for decades upon decades. In 2020, the Substance Abuse and Mental Health Services Administration reported that "major depressive episodes increased significantly in Hispanics aged 12-17 and Hispanics aged 18-49 during 2015-2018" (SAMHSA, 2020, p. 56).

The pilot project *Menta Sana, Vida Sana (MSVS)* was designed to eliminate barriers that restrict Mexican immigrants' access to mental health services in four northern California counties (Sacramento, San Joaquin, Stanislaus, and Yolo). The project site was the Consulate General of Mexico in Sacramento, California. The project's key components were 1) mental health/illness education; 2) depression screening using the Patient Health Questionnaire-9; 3) referral and post-referral support; 4) short-term crisis intervention counseling; 5) capacity development for entities that provide health services and mental health professionals; and 6) mental health education for the wider Latino community. Key challenges to the project included prospective beneficiaries' reluctance to access project services, the high mobility of project participants, and lack of long-term mental health service providers willing to accept MSVS participants.

Evaluation Design

The evaluation team employed a pre-test and post-test with no comparison group design along with a mixed-methods data collection and analysis approach. The team encountered some challenges when implementing the design because of MSVS's unique implementation strategy and the characteristics of its target population. Quantitative data was

collected through the project's service intake form and a mental health/depression knowledge survey. Qualitative data was collected through semi-structured interviews and focus groups. All data was triangulated to corroborate findings across the different data collection methods. Challenges in data collection were directly linked to the project's unique implementation strategy and the challenge of collecting data during the COVID-19 pandemic.

Results

Evaluation Question 1: To what extent did the MSVS project serve the populations/sub-populations it was intended to serve?

MSVS was designed to address the unmet mental health needs of Mexican immigrants, 18 years of age and older, who resided in four northern California counties (Sacramento, San Joaquin, Stanislaus, and Yolo). Findings suggested that MSVS served the population it was intended to serve. Of the 536 individuals who received project services, 96.6 percent (n = 518) reported they were born in Mexico and immigrated to the United States. The average reported length of stay in the United States was 20.5 years (SD = 9.9). The gender distribution was 67.2 percent (n = 360) female to 32.8 percent (n = 176) male. Participants' mean age was 43 (SD = 11.2). Of the 218 participants who provided information about their English-speaking ability, a combined 60 percent (n = 129) either reported their ability was "not good" or that they "do not speak English."

Evaluation Question 2: To what extent did the MSVS project impact participants' knowledge regarding mental health, mental illness, treatment resources, and the linkages between mental health and other health conditions?

The results suggested that the individuals who participated in the intervention had increased knowledge and more positive views about mental health/illness than individuals who did not participate in the intervention. For example, a higher percentage of individuals were able to define depression, identify its symptoms, and know where to look for information about

mental illness. There were also a few areas of concern, one of which was the increased percentage of individuals who reported they believed that people with mental illness could "snap out of it."

Evaluation Question 3: To what extent did integration of the PHQ-9 mental health screening tool as part of regular health checkup protocols impact the early detection of depression in MSVS participants?

Evidence suggests that the integration of the PHQ-9 mental health screening tool as part of regular health checkup protocol had a significant impact on the early detection of mental illness in MSVS participants. Data showed that from 2017 through 2020, when the highest number of screenings occurred, 46 percent (n = 137) of the results fell within the mild range, 27 percent (n = 80) fell within the moderate range, 16 percent (n = 48) fell within the moderately severe range, and 11 percent (n = 35) fell within the severe range. The finding that approximately half of the results fell within the mild range, which suggested that the individuals were experiencing the early symptoms of depression, was noteworthy.

Evaluation Question 4: To what extent did the provision of MSVS services at the Mexican Consulate and mobile consulate sites impact wait times for accessing mental health services?

Project data suggested that MSVS significantly impacted wait times for accessing mental health services. The project achieved a same-day wait time for service delivery for initial intake for depression screening with the PHQ-9 tool, and a 6-day wait time for first appointments with short-term crisis intervention counselors.

Evaluation Question 5: To what extent did the provision of direct referrals and follow-up contacts with referred individuals to promote successful completion of the referral process impact enrollment in mental health/illness services?

Evidence suggested that the project's direct referrals and follow-up contacts with referred individuals to promote successful service enrollment were more effective at securing enrollment in the project's in-house crisis intervention sessions than external mental health services. This may be because the traditional barriers that Latinos face when attempting to enroll into external mental health services still persisted.

Evaluation Question 6: To what extent did MSVS training and capacity development activities with entities that provide health services and mental health professionals impact the availability of quality, culturally and linguistically appropriate mental health services to Latinos residing in target counties (Sacramento, San Joaquin, Stanislaus, and Yolo)?

Findings suggested that the project's capacity development efforts had an impact on the availability of quality, culturally and linguistically appropriate mental health services for Latinos who accessed project services, although the impact could have been more pronounced had the project shown higher implementation fidelity to its planned capacity development efforts for entities that provided health services.

Evaluation Question 7: To what extent did MSVS interventions impact the broader Latino community's knowledge regarding mental health, mental illness, treatment resources, and the linkages between mental health and other health conditions?

While the evaluation team was unable to assess the impact MSVS's mental health/illness education had on the wider Latino community, project records suggested

educational efforts that targeted the wider Latino community achieved a wide reach and a high rate of interaction.

Conclusion

The results of the final evaluation of the pilot project, Mente Sana Vida Sana, suggest that the project model has merit. MSVS served the population it was intended to serve, and its interventions increased participants' mental health/illness knowledge, decreased waiting time for initial service intake and first appointments with counselors, and helped mental health professionals develop new capacity for serving the Latino community's mental health needs. The significant challenges that the project faced while attempting to enroll participants in external mental health services demonstrated that without a shift in federal and state laws, health policy, funding priorities and access restrictions, Latinos will continue to be blocked from meaningful access to external mental health services. Though it faced significant challenges, the MSVS model responded resoundingly with ¡*SÍ SE PUEDE! [It can be done!]* to the question of whether it was possible to guarantee the Latino community unfettered access to culturally and linguistically appropriate mental health services.

Final Evaluation of the Pilot Project, Mente Sana, Vida Sana

This report presents the results of the final evaluation of the pilot project, *Menta Sana, Vida Sana (MSVS).* MSVS was an innovative initiative that addressed the formidable barriers limiting Mexican immigrants' access to culturally and linguistically appropriate mental health/illness services in four counties in northern California (Sacramento, Yolo, San Joaquin, and Stanislaus). From December 2017 through July 2021, MSVS provided free mental health/illness education, depression screening, short-term crisis intervention counseling, and referral support.

The Latino community has been denied meaningful access to culturally and linguistically appropriate mental health services for decades. The consequences have been documented across a wide body of research.

Prevalence

- Research shows that in the Latinx/Hispanic population, older adults and youth are more susceptible to mental distress relating to immigration and acculturation (APA, 2017).
- According to SAMHSA's National Survey on Drug Use and Health, overall mental health issues are on the rise for Latinx/Hispanic people between the ages of 12 and 49 (SAMHSA, 2020).
- Major depressive episodes increased from 12.6 percent to 15.1 percent in Latinx/Hispanic youth ages 12–17, 8 percent to 12 percent in young adults 18–25, and 4.5 percent to 6 percent in the 26–49 age range between 2015 and 2018 (SAMHSA, 2020).

Attitudes

- There is a perception in Latinx/Hispanic communities, especially among older people, that discussing problems with mental health professionals can create embarrassment and shame for the family, resulting in fewer people seeking treatment (Jimenez et al., 2013, pp. 1061–1068).

Treatment

- Latinx/Hispanic people are more likely to seek help for a mental health disorder from a primary care provider (10 percent) than a mental health specialist (5 percent) (APA, 2017).
- Poor communication with health care providers is often an issue. There is a shortage of bilingual or Spanish-speaking mental health professionals (APA, 2017).
- Mental health problems can be hard to identify, because Latinx/Hispanic people will often focus on physical symptoms and not psychiatric symptoms during doctor visits (APA, 2017).

Insurance

- Eighteen percent of Latinx/Hispanic people in the U.S. do not have health insurance, with those of Honduran and Guatemalan origin having the highest rates of being uninsured (35 percent and 33 percent, respectively) (Noe-Bustamante, 2019).

- In 2018, 56.8 percent of Latinx/Hispanic young adults 18–25 and 39.6 percent of adults 26–49 with serious mental illness did not receive treatment (SAMHSA, 2020).

Decades of activism by the Latino community and other underserved communities led the State of California to establish the California Reducing Disparities Project (CRDP) in 2009, with the goal of reducing health disparities within the African American, Latinx, Native American, Asian and Pacific Islander, and LGBTQ+ communities (CDPH, n.d.).

In Phase I (2012–2015), CRDP funded the development of population-specific strategic plans. The strategic plan for the Latino population was detailed in a report titled, *Community-Defined Solutions for Latino Mental Health Care: California Reducing Disparities Project Latino Strategic Planning.* Among other things, the Latino strategic plan documented the mental health status of Latinos, highlighted community-inspired strategies for improving mental health treatment, and proposed strategic directions and recommendations for reducing health disparities in Latino populations (Aguilar-Gaxiola et al., 2012). The Latino strategic plan and the plans for the four other underserved communities were compiled into an overarching, comprehensive strategic plan. The plan identified culturally appropriate strategies for improving access to mental health services, quality of care, and mental health outcomes for the five CRDP target populations (CDPH, 2014). The strategies were central to the development of special projects known as Community-Defined Evidence Projects (CDEP), which were designed around community members' cultural preferences and values, and could be evaluated using local measures of effectiveness and community impact.

In 2012, the Government of Mexico established the health program *Ventanilla de Salud (VDS)*. The program's goal is to improve the physical and mental health of Mexicans living in the United States. The VDS program operates at the Consulate General of Mexico in Sacramento, California, and is managed by the nonprofit Health Education Council (HEC). The HEC is an organization that serves communities made vulnerable by appalling health disparities through effective collaboration with diverse community partners. This includes a long history of collaboration with the Latino community, as the community strives to secure the key drivers of health: safety, access to services and healthy environments, family and social connections, education, and economic well-being.

In Phase II of the CRDP (2016–2021), HEC received funding to implement an innovative pilot project called *Mente Sana, Vida Sana (MSVS),* which was to fall under the broader VDS program. While VDS focused on physical health, MSVS expanded the program's purview to include mental health.

Project Description

MSVS was designed to address the unmet mental health needs of Mexican immigrants, 18 years of age and older, who resided in four northern California counties (Sacramento, San Joaquin, Stanislaus, and Yolo). The project's desired outcomes included:

- Increased Latino knowledge regarding mental health, mental illness, treatment resources, and comorbidities between mental illness and other health conditions.
- Improved rates of early detection of mental illness in Latino populations.
- Reduced wait times for Latinos who access mental health services.

- Increased availability of culturally and linguistically appropriate mental health services for Latinos.
- Increased Latino mental illness treatment enrollment and retention.

Project Components and Implementation Strategy

The project originally consisted of five components, all of which were delivered at the project site, the Consulate General of Mexico in Sacramento, California.

Mental Health and Mental Illness Outreach and Education

The education component focused on three goals: 1) defining mental health/illness and related symptoms; 2) highlighting the importance of mental health; and 3) identifying culturally and linguistically appropriate mental health resources for Latinos. The project delivered the component through presentations in the consulate's waiting area. As part of the presentations, members of the Latino community who had experienced mental illness often shared their experiences. The sharing of personal experiences was intended to normalize conversations about mental illness and decrease mental health-related stigma.

Depression Screening

The objective of the second component was to increase individuals' willingness to participate in mental illness screenings by incorporating them into physical health screenings. The Patient Health Questionnaire-9 (PHQ-9) was the screening tool used throughout the project period. The PHQ-9 is a nine-item depression screening tool that scores each of the nine items from 0 to 3, resulting in a 0-to-27 depression severity score (Kroenke and Spitzer, 2002). The physical health screenings, including blood pressure, blood glucose, and body mass, were administered by nursing students within the VDS office. After the health screenings were

completed, individuals were asked if they wanted to participate in the mental health screening, an opt-in approach (Walmsley, 2003). The PHQ-9 screenings were administered by trained HEC staff or mental health professionals in a private space reserved for the mental health screenings. After the screenings were administered, staff members discussed the results with participants. Individuals who scored 5–9 (mild) and higher were referred to in-house crisis counseling at the Consulate General of Mexico or to external mental health service agencies. Individuals whose scores were below the mild range, but who requested counseling, were also referred.

Referral Services and Follow-up Support

The focus of the third component was providing project participants the information, guidance, and support necessary for them to enroll in either in-house (at the Mexican consulate), short-term crisis intervention sessions or in external mental health services. Project staff regularly contacted referred individuals to provide advice and support. The project was also in regular contact with service providers to stay informed about their enrollment requirements, fees, and available space for new patients. The results of each contact, whether with referred individuals or service providers, were documented. Project staff continued to provide support to referred individuals until the individuals communicated that they no longer wanted support, faced a barrier that could not be overcome, or that they had successfully enrolled in a mental health program.

Media and Community Outreach

The focus of the fourth component was educating the broader Latino community about mental health/illness. The component consisted of public education messages disseminated

through Latino media, organizations that serve the Latino community, local community leaders, and religious institutions. The project worked closely with the Consulate General of Mexico in Sacramento, California to disseminate mental health/illness education messages through said entities and through social media platforms that serve the Latino community.

Health Provider and Mental Health Professional Capacity Development

The focus of the fifth component was increasing the capacity of entities that provide health services and mental health professionals' capacity to serve the Latino community's needs. Provider capacity was to be increased through training activities, which were to commence with a capacity assessment, followed by organization-specific capacity development support and periodic assessments to gauge changes in provider capacity. Health professional capacity was to be increased through an internship program for students enrolled in their second year of a Master of Social Work (MSW) program.

Modifications to the Project's Design and Implementation Strategy

During the period under review, MSVS modified some project components and processes in response to the observed needs of project participants. Each of the modifications was designed to improve service delivery to project participants.

Integration of Depression Screening into Existing Health Screening Programs

Early in the project, project staff changed the project strategy from an opt-in approach to an opt-out approach, wherein participants were advised about both the physical and mental components of the health screenings and consent was sought for the complete package of screenings, rather than differentiating between the physical health and mental health screenings. Incorporating the depression screening into a comprehensive health screening

regime, rather than treating the depression screening as a separate and unique activity, helped to reduce individuals' reluctance to participate in the mental health screenings.

Working Collaboratively with Consulate's Protection Department

The project began working collaboratively with the consulate's protection department to identify and refer individuals who could benefit from MSVS services. Individuals who visited the protection department were often facing difficult life situations that adversely affected their physical, emotional, and mental health, including the threat of deportation, criminal or civil legal proceedings, and domestic violence. The strategy ensured that individuals most in need of mental health services were referred to MSVS.

Providing Five Sessions of Short-Term Crisis Intervention Sessions

The project faced many challenges in its attempts to enroll individuals in external mental health counseling programs. In response, it offered individuals whose PHQ-9 score was at least 5–9 (mild), and those who requested it the opportunity to access free crisis intervention counseling sessions at the project site. The in-house sessions eliminated the barriers to culturally and linguistically appropriate mental health services for MSVS participants. The sessions were led by interns who were in their final year of a Master of Social Work program. The internship program was part of an effort to equip bilingual/cultural mental health professionals early in their careers with the knowledge and skills to serve the Latino community's mental health needs. The time between the initial services (education, PHQ-9 screening, and referral) and participants commencing the short-term crisis counseling sessions was six days on average. The sessions took place once a week and were usually completed within five weeks. If participants required more sessions, they were offered up to two

additional ones. After participants completed the in-house sessions, they were referred to external providers for long-term mental health services.

In-person and Virtual Support Groups

MSVS established separate support groups for women, parents, and the virtual community. It used the support groups to deliver mental health education, including sessions on stress management, depression, anxiety, healthy relationships, effective communication, self-esteem, and goal setting. The support groups established a safe space where Latinos could gather in-person or virtually to share their experiences and learn from one another. The ultimate objective of the support groups was for their participants to eventually feel comfortable enrolling in MSVS's depression screening or in-house counseling services. Support group participants were recruited through flyers at the Mexican consulate and emails that targeted parent groups at local schools. To encourage group cohesion, no new participants were allowed to join the support groups after the second week. The support group sessions were facilitated by a mental health professional, with an MSVS staff member always present.

Infusion of Latino Cultural Values and Preferences

The delivery of each project component reflected Latino cultural values and preferences. Rather than using technical terms to describe depression and other mental illnesses, project staff relied on words that Latinos, and particularly Mexicans, often used, such as "estrés" [stress], "desanimado" [despondent], "triste" [sad], and "nervioso" [on edge]. When recruiting prospective participants, project staff appealed to Latinos' higher emphasis on the family unit (familismo) by encouraging individuals to learn more about depression so they could support family members and friends who might experience mental health issues. Rather than

relying on clinical terms, counselors who facilitated the short-term crisis intervention sessions used Spanish expressions [dichos] that Latinos often used around family and friends. Counselors were always cognizant of the religious beliefs expressed during the crisis intervention sessions—often beliefs associated with Catholicism—and infused those beliefs into the sessions to comfort and reassure participants. Additionally, since all counselors were bilingual and bicultural, they understood the culturally acceptable coping strategies they could recommend to participants, such as talking with close friend, engaging in a hobby, or going for a walk.

The three staff who delivered the education, depression screening, and referral support services were bilingual (Spanish and English) and bicultural (Mexican and American). Of the three, two held a master's degree, one in public health and the other in community development. Together, the three had a combined 30 years of experience in implementing health projects that served the Latino community.

Impact of Political and Social Developments

MSVS's implementation period, from 2017 to 2021, saw worrisome developments in the political and social history of the United States and a global pandemic that unified all humans in fear, uncertainly, and untold loss.

In 2017, the thin glass veneer of perceived racial and social progress that had been achieved by the election of the nation's first black president, Barrack Obama, was shattered unapologetically by the election of Donald Trump. During the campaign, one of Trump's most racist and telling statements about Mexicans was, "They're bringing drugs. They're bringing crime. They're rapists. And some, I assume, are good people" (Reilly, 2016). Canizales and Agius

Vallejo (2021) best summarized the Trump presidency and what it meant for the Latino community:

> Trump and his administration were not the origin of Latinos' experiences of racism, but his rise to power was, in part, derived from Latino racialization. Preexisting politics of Latino immigration, Whites' fear of loss of status due to demographic shifts, and historical and contemporary processes of racializing Latinos were seized by the Trump administration and made central features of his renegade presidential campaign and policy agenda. White nationalist racism became the defining feature of the Trump presidency, making Latinos' heightened experiences of racism, and the relegitimization of overt White nationalism, one of its lasting legacies.

For Latinos, particularly Mexican immigrants who were served by the MSVS project, the Trump presidency was a time of fear and constant anxiety. The enforcement of a public charge rule meant that immigrants who sought public assistance could have their residency applications rejected; Immigration and Customs Enforcement (ICE) agents regularly entered courthouses to arrest undocumented immigrants; and even MSVS project participants and project staff feared that the project site, the Consulate General of Mexico in Sacramento, California, would be attacked. On the social front, the period drew global attention to America's racist inequalities in criminal justice, healthcare, and policing, with numerous high-profile, police-involved murders of black, brown, and historically marginalized men, women, and youth. These injustices led over 20 million people to take to the streets to demand accountability and

change (Roberts, 2021). As if this was not enough, this period was also when the entire world began to experience the COVID-19 pandemic, which, as of August 2021, was responsible for 4,366,259 deaths globally, and 621,688 deaths in the United States (John Hopkins University of Medicine, 2021). According to the Centers for Disease Control and Prevention (CDC, 2021):

> *Data on race and ethnicity for more than 90% of people who died from COVID-19 reveal that the percent of Hispanic or Latino, non-Hispanic Black, and non-Hispanic American Indian or Alaska Native people who have died from COVID-19 is higher than the percent of these racial and ethnic groups among the total U.S. population.*

The COVID-19 pandemic had a significant impact on the number of Latinos served, which had been rising each year after the project commenced in 2017, and was at its highest level in 2019. Table 1 highlights the pandemic's drastic impact on participation.

Table 1 – Yearly Participation in MSVS Project

Year	**# of Project Participants**
2018	149
2019	332
2020	51
2021	4
Grand Total	**536**

The pandemic forced MSVS to cease operations for a period of 8 months. During that period, HEC, the organization that manages MSVS, supported COVID-19 education, testing, and

vaccination programs for Latinos at the Mexican consulate. It then reinitiated MSVS services, but only over the phone. From November 2020, all MSVS services, including mental health/depression education, depression screening, and crisis counseling were provided over the phone.

MSVS Participant Attrition

It is important to understand the context in which the project operated and the project's unique implementation strategy when assessing participant attrition, since the rate of attrition reflected the difficulties inherent in providing mental health services to a highly mobile population that for years had faced significant barriers when attempting to access mental health services. MSVS recruited individuals while they were waiting for services at the Mexican consulate. If the recruitment effort was successful, core service components (education, depression screening, and referral) were delivered within a period of 15–30 minutes. After participants received the three components, most left the consulate and did not interact with the project again. The evaluation team focused its participant retention assessment on the two most applicable project components, crisis intervention and referral support to external mental health services. Individuals who were eligible for—or who requested—crisis counseling were assigned five free sessions. The schedule for the sessions depended on participants' availability and that of the crisis counselors. Project participants were encouraged to participate in all five sessions, but they were free to access the number of sessions they wanted.

Completion Rates for In-house Crisis Intervention Sessions

The key factors that affected retention in the in-house crisis intervention sessions included project participants' high mobility, transportation issues, family commitments, and

work schedules. Table 2 details retention figures for the in-house crisis intervention sessions and related details.

Table 2 – **In-house Crisis Counseling Retention**

	Session 1	Session 2	Session 3	Session 4	Session 5
Assigned	70	59	47	38	30
Completed	59	47	38	30	20
% Retention	84%	80%	81%	79%	67.%
Key factors affecting retention	● High mobility of population ● Lack of reliable or affordable transportation to services (prior to COVID-19) ● Family commitments ● Work schedule				
Strategies employed to promote retention	● Reminder calls 1–2 days before the counseling appointment. ● Leniency in welcoming participants back to subsequent sessions even after they did not attend a previous session. ● Counseling services delivered in a trusted, safe space (the Mexican Consulate) or by phone.				

Completion Rates for Referrals to External Mental Health Services

MSVS's in-house crisis counseling sessions were designed to provide short-term crisis coping and management strategies, not long-term counseling that could address more profound trauma. After the five sessions, individuals who required long-term mental health

services were referred to local mental health services that had been pre-screened by MSVS staff members. While the challenge with in-house crisis intervention sessions was retention, the challenge for external mental health services was enrollment. Project reports showed that even pre-screened mental health providers exhibited the same barriers to enrollment. Table 3 highlights the barriers and related details.

Table 3 - **External Mental Health Services Referral Completion**	
Number of participants referred	99
Participants who completed the referral process and enrolled in external mental health services	23
% Completion rate	23%
Key factors affecting referral completion	● Exorbitant fees ● Lack of sufficient Spanish speaking/bicultural staff ● Long wait times ● Service not accessible because of distance ● Service limitations (agency does not serve undocumented individuals)
MSVS strategies implement to address barriers affecting external service enrollment	● MSVS staff investigated each of the referral sites' registration requirements and processes, and shared that information with referred participants. ● MSVS staff pre-notified referral sites that MSVS participants had been referred. ● MSVS staff followed up with referred individuals and with referral site to assist in the registration completion process.

Evaluation Framework

The MSVS final evaluation sought to assess the extent to which the project had achieved its desired outcomes. Seven overarching evaluation questions guided all evaluation activities:

Evaluation Question 1: To what extent did the MSVS project serve the populations/sub-populations it was intended to serve?

Evaluation Question 2: To what extent did the MSVS project impact participants' knowledge regarding mental health, mental illness, treatment resources, and the linkages between mental health and other health conditions?

Evaluation Question 3: To what extent did integration of the PHQ-9 mental health screening tool as part of regular health check-up protocols impact the early detection of depression in MSVS participants?

Evaluation Question 4: To what extent did the provision of MSVS services at the Mexican Consulate and mobile consulate sites impact wait times for accessing mental health services?

Evaluation Question 5: To what extent did the provision of direct referrals and follow-up contacts with referred individuals to promote successful completion of the referral process impact enrollment in mental health/illness services?

Evaluation Question 6: To what extent did MSVS training and capacity development activities with entities that provide health services and mental health service providers impact the availability of quality, culturally and linguistically appropriate mental health services to Latinos residing in target counties (Sacramento, San Joaquin, Stanislaus, and Yolo)?

Evaluation Question 7: To what extent did MSVS interventions impact the broader Latino community's knowledge regarding mental health, mental illness, treatment resources, and the linkages between mental health and other health conditions?

Institutional Review Board (IRB) Approval

The MSVS evaluation protocol and data collection instruments received IRB approval from California's Office of Statewide Health Planning and Development (OSHPD), Committee for the Protection of Human Subjects, in December 2017, under Protocol ID 2017-043. MSVS's IRB was reapproved each subsequent year, and the final reapproval request was submitted in August 2021. That request covered the years 2021 to 2022.

Evaluation Design, Approach, and Methods

The evaluation team employed a pre-test and post-test with no comparison group design along with a mixed-methods data collection and analysis approach. The team encountered some challenges when implementing the design because of MSVS's unique implementation strategy and the characteristics of its target population. The challenges included the short duration of interventions (15–30 minutes), the fact most participants accessed services only once, the fact project participants were highly mobile and difficult to track, and the lack of project implementation cycles. The challenges made it difficult for the evaluators to collect paired pre and post data. When it was not possible to collect paired pre and post-data, unpaired pre and post data was collected. Quantitative data was collected through a modified version of Connor and Casey's (2015) Mental Health Literacy Scale, and MSVS's service intake forms. Qualitative data was collected through semi-structured interviews and focus groups. All data was triangulated to corroborate findings across the different data collection methods. Challenges in data collection were directly linked to the project's unique implementation strategy (described earlier) and the COVID-19 pandemic, which necessitated the use of computer-assisted telephone and web interviews rather than in-person interviews.

During the formulation of the evaluation design, the evaluation team worked closely with project staff to ensure that data collection processes were in line with Latino cultural preference. The discussions inspired three actions that were in line with Community-based Participatory Research (CBPR) principles: 1) evaluators used MSVS's referral support staff to recruit participants for the evaluation, since there was already a high level of trust [confianza] between the staff and former participants; 2) although the COVID-19 pandemic necessitated the use of technology-based data collection, a bilingual/bicultural member of the evaluation team always served as an interface between the subjects and the data collection technologies; and 3) questions and discussion items related to family, friends, and culture were interspersed throughout the interview questions and data collection processes, in recognition of the Latino community's strong emphasis on family.

Sampling Methods and Size

Convenience sampling, a nonprobability sampling technique, was used across all data collection methods. Convenience sampling was the most feasible option based on the project design and the characteristics of the project's target population. The sampling technique was ideal for the situation presented by the MSVS project, wherein a sample frame was difficult to establish, subjects were highly mobile, and the use of strategies such as snowballing were impractical, since project participants were never in contact with one another. The use of convenience sampling introduced a high degree of potential bias, led the evaluators to use descriptive rather than inferential statistics, and limited the generalizability of results to the population at large. While there are many limitations to convenience sampling, the evaluators

saw value in its ability to collect useful data on attitudes and opinions that could one day inform more rigorous research (Galloway, 2005).

Inclusion/Exclusion Criteria and Recruitment Strategy

Former Project Participants

Former project participants were limited to those who had participated in at least two project components. There were 536 (N = 536) former participants who qualified. Project staff attempted to recruit 32 out of the 536 to participated in the evaluation. Out of the 32, four were reached but declined the invitation to participate, nine did not respond after staff members attempted to reach them three times, and 19 agreed to participate, but only 16 made themselves available for data collection. Community Based Participatory Research (CBPR) principles were not applied during the sample selection process because of the small number of potential subjects and the fact they were never in contact with one another. The demographic breakdown of the final sample for each data collection method is as follows: Mental Health Literacy Scale, 12 participants (11 women and one man between the ages of 39 and 55); focus group discussions (two sessions, with a total of eight women who were between the ages of 39 and 49); and semi-structured Interviews (four women and one man between the ages of 39 and 55).

Project Staff

Staff members who had managed or supported MSVS activities at the Consulate General of Mexico in Sacramento, California, were included in the evaluation. There were three such staff, a program manager and two program assistants.

Project Partners

Project partners who managed the contract on behalf of the State of California, provided technical support to the project, or provided direct services to MSVS participants, were included in the evaluation. The evaluation team interviewed one representative from the California Department of Public Health - Office of Health Equity; one representative from the UC Davis Center for Reducing Health Disparities, the technical assistance partner; one representative from the Sacramento County Department of Health Services; one representative from Loyola Marymount University - Psychology Applied Research Center, the statewide evaluator; and three representatives from El Hogar Community Services, Inc., the project's mental health services provider.

Project Records

The evaluation team also conducted a desk review of key project reports. This included seven statewide evaluation semi-annual reports from the period between November 2017 and October 2020; and 11 Office of Health Equity quarterly reports that covered the period between July 2018 and March 2021.

Measures and Data Collection Procedures

In 2019, a midterm evaluation of the MSVS project was executed to gauge whether the project was on track to achieve its desired outcomes. In line with CBPR principles, evaluators collected feedback from participants on how well the project addressed their needs and what factors evaluators should focus on when evaluating the project's effectiveness. The feedback that was received suggested the final evaluation's focus should be on how well the project responded to participants' mental health needs. The feedback is reflected in the final evaluation's

quantitative and qualitative data collection processes and instruments, which were designed to capture whether the project addressed participants' needs. Project staff were also asked to provide the evaluation team key project plans, reports, support documents, and data files. The evaluation team conducted a desk review of the records, the results of which also informed the final data collection processes and instruments.

Service Intake Data

After individuals agreed to participate in project activities, they were informed of their rights as project participants and asked to consent to providing demographic and service intake data. Project staff then collected participants' data. The data was subsequently deidentified and entered in a database. The evaluation team cleaned the data and developed a corresponding codebook to facilitate analysis.

Mental Health Literacy Scale (MHLS)

The MHLS questionnaire collected demographic and mental health/illness knowledge data through multiple choice and Likert Scale questions. Past MSVS participants were recruited as participants in the mental health survey through phone contacts by project staff and the evaluation team. Those who elected to participate were informed of the survey's purpose and their rights as subjects, after which they were asked to provide verbal consent. Verbal consent was recorded on a physical copy of the consent form and filed in a secure location. Due to COVID-19 precautions, the knowledge survey was conducted over the phone. All questions and answer options were read in Spanish. Further clarifications were provided as needed. Subjects' answers were entered into SurveyMonkey, a web-based survey platform.

Semi-Structured Interview Guide

Semi-structured interviews documented participants' opinions and experiences using open-ended questions. The measures and procedures for the semi-structured interviews were detailed in an interview guide. Past MSVS participants were recruited by project staff and the evaluation team, and were interviewed by phone. Those who accepted selected the date and hour of their interview. Before the interview began, they were informed of the purpose of the interview and their rights as subjects, and asked to provide verbal consent to be interviewed. When verbal consent was given, it was recorded on a physical copy of the consent form and filed. Interviewees were asked questions about their experience with each MSVS component. Responses were documented in a word processing program.

Focus Group Discussion Guide

Focus group discussions allowed participants to share their individual and collective experiences, thereby enabling the evaluators to gain more insight into project activities and outcomes. MSVS focus group questions and procedures were detailed in a focus group guide. Past MSVS participants were recruited by project staff and the evaluation team to take part in web and phone-based focus group discussion sessions. Before the focus groups commenced, participants were informed about the purpose of the activity and their rights as subjects, after which they were asked to provide verbal consent. Verbal consent was recorded on a physical copy of the consent and filed. Focus group participants were then asked to share their experiences.

Data Analysis Plan

Descriptive analysis was performed on the project's service and MHLS data, and the results were presented as percentages or mean and standard deviations. Given the relatively small number of focus group and semi-structured interview participants, audio files were transcribed, reviewed, coded, and categorized manually. The analysis was guided by Creswell's (2014) six-step procedure for qualitative data coding and analysis:

1. The material was sorted and arranged into different data types.
2. Evaluators reviewed and reflected on the complete body of material.
3. Codes were developed based on the themes that emerged.
4. Codes were assigned to specific elements of the recording based on the varying identified themes, categories, and subcategories.
5. Relationships and connections between the different codes were identified.
6. The evaluation team interpreted key findings in relation to each evaluation question.

The results obtained from the different data collection methods were triangulated to gauge whether the results converged, diverged, or were complementary, after which results were finalized.

Fidelity and Flexibility

An assessment of project implementation fidelity and flexibility was conducted across MSVS's five project components. Chen (2010) has suggested that when projects fail to achieve their expected outcomes, it is difficult to know without a fidelity assessment if the project

model was at fault or if the model was not implemented correctly. To gauge MSVS's fidelity to its original project design, the evaluation team assessed five elements that have typically been the focus of fidelity assessments: adherence, exposure, quality of delivery, participant responsiveness, and program differentiation (Dane & Schneider, 1998; Dusenbury et al., 2003; Mihalic, 2004). Through interviews with project staff and document reviews, the evaluation team was able to assign a fidelity score for each project component using a 4-point Likert Scale anchored in specific descriptors and fidelity percentages, similar to scales deemed reliable by Suhrheinrich et al. (2019):

- 4 – All project elements implemented (100%)
- 3 – Majority of project elements implemented (75%)
- 2 – Half of project elements implemented (50%)
- 1 – Project elements partially implemented (25%)

The individual percentage scores were then averaged to obtain an overall implementation fidelity percentage. The results of the assessment suggested that MSVS exercised a high level of implementation fidelity to the original project components, Mental Health/Illness Education, Depression Screening, and Public Outreach and Education. There was a moderate level of fidelity to the project components, Mental Health/Illness Referral and Support, and Health Provider and Mental Health Professional Capacity Development.

Mental Health/Depression Education

Adherence

MSVS adhered to its plan to reach the maximum number of Mexican immigrants with group presentations and one-on-one contacts at the Mexican consulate. The presentations and contacts educated Mexican immigrants about mental health/illness and depression.

Exposure

As planned, the project took advantage of the wait times for accessing consular services to deliver mental health/illness educational interventions to Mexican immigrants within a period of 5–15 minutes.

Quality of Delivery

The group and one-on-one presentations were guided by a script, which ensured the quality of the delivery to each project participant.

Participant Responsiveness

The presentations were interactive and elicited audience member participation. Participant involvement was evidenced by the fact that 97 percent (n = 519) of individuals who participated in MSVS services were recruited as a result of the presentations at the Mexican consulate.

Program Differentiation

The project delivered mental health and depression education at the Mexican consulate, a non-clinical setting that had previously not been associated with mental health services. The strategy of taking advantage of the wait times for consular services to provide free mental health services also set this component of the project apart.

Taken together, our findings suggest the project achieved 100 percent implementation fidelity to its planned mental health/illness education plans**.**

Depression Screening

Adherence

MSVS adhered to its plan to conduct depression screenings using the PHQ-9 instrument in a private space at the Mexican consulate in Sacramento, California.

Exposure

The screenings followed the same protocol for all participants. First, participants were educated about mental health and depression. Second, they were screened and their results were explained. Third, they were referred to in-house crisis counseling or external mental health services, if necessary.

Quality of Delivery

The depression screenings were administered by bilingual and bicultural MSVS staff who were trained extensively.

Participant Responsiveness

The effectiveness of the outreach and sensitization efforts was demonstrated by the wide range of comments and questions the project received after its presentations and social media sessions.

Program Differentiation

The use of the PHQ-9 depression screening tool in a non-clinical setting was not new; however, the fact that it was used as part of a free, culturally and linguistically appropriate health intervention that also provided in-house crisis counseling in a safe space for Latinos was

new, and differentiated the intervention from others. Our findings suggested the project achieved 100 percent implementation fidelity to its planned depression screening plans**.**

Referral Services and Follow-up Support

Adherence

The project adhered to its plan to refer and provide external mental health service enrollment support to project participants. This was done immediately after the PHQ-9 screening was administered and the results were shared with participants.

Exposure

Each project participant who received a PHQ-9 result of mild or greater was referred to in-house crisis counseling or external mental health counseling services. Individuals whose scores were below the mild range, but who requested counseling, were also referred.

Quality of Delivery

After being referred to in-house or external counseling, each participant was given an average of three follow-up calls, during which project staff provided advice and support to facilitate their enrollment in mental health services.

Participant and External Provider Responsiveness

When assessed by the number of individuals who were referred, supported, and enrolled in the external mental health services to which they were referred, participant response was only 23% (n = 23). The low rate of enrollment was due to the lack of affordable, culturally and linguistically appropriate, centrally located service providers with available space and enrollment requirements suitable to the needs of project participants. This lack of viable service

providers severely constrained project participants' enrollment in external mental health services.

Program Differentiation

This element of the project was differentiated by follow-up calls and the provision of support to all individuals who were referred, whether the referral was to in-house or external services. During interviews, many former participants communicated that the follow-up calls and support were key factors in their decision to continue seeking mental health services. Unfortunately, the follow-up calls and support provided could not change the lack of external mental health service providers able and willing to enroll project participants. As discussed earlier, the situation forced MSVS to establish its own in-house crisis intervention counseling sessions. Based on the project's inability to execute its plan to enroll participants in external services, the evaluation team assigned a 75% implementation fidelity score to the project's Referral Services and Follow-up Support activities.

Public Outreach and Education

Adherence

The project adhered to its plan to conduct outreach that educated the wider Latino community about mental health/illness and local resources available to that community.

Exposure

Public sensitization efforts were broad in nature and reached thousands of Latinos at the Mexican consulate through local organizations, community leaders, social media platforms, and religious institutions. The education effort focused primarily on addressing stigma associated with mental health/illness. The project did this by inviting Latinos to share their

personal experiences with mental health/illness, thereby helping to normalize and destigmatize the topic.

Quality of Delivery

The sensitization messages delivered to the wider Latino public focused on the same topics as the educational messages shared at the Mexican consulate; they defined mental health/illness and related symptoms, highlighted the importance of mental health, and identified culturally and linguistically appropriate mental health resources for Latinos.

Participant Responsiveness

The effectiveness of the outreach and sensitization efforts was demonstrated by the wide range of comments and questions project staff received after presentations and social media sessions.

Program Differentiation

This element was unique in that it sought to remove the stigma associated with mental health/illness through dialogue that educated Latinos, especially those who had never experienced mental health challenges.

Based on the aforementioned factors, the evaluation team assigned a 100 percent implementation fidelity score to the project's Public Outreach and Education activities**.**

Capacity Development Support

Adherence

This component was intended to increase the capacity of entities that provide health services and mental health professionals' capacity to serve the Latino community's mental health needs. Provider capacity was to be increased through training activities, and mental

health professional capacity was to be increased through an internship program for students in their final year of a Masters of Social Work program. The capacity development process for service providers was to commence with a capacity assessment, followed by targeted capacity development support and periodic assessments to gauge whether service providers had gained new capacity. While the project administered capacity assessments and some sensitization workshops, it did not engage in the level of activities that would develop new service provider capacity. Project staff suggested this was because the project prioritized the provision of direct services to project participants instead. MSVS did adhere to its plan to recruit and train Masters of Social Work students. The students had a profound impact on the project by serving as short-term crisis intervention counselors. During the period under review, three interns contributed 152 counseling hours to 43 project participants.

Exposure

The project was to work to increase service provider capacity. That work did not take place. The project did build mental health professionals' capacity through its internship program. Each intern who participated in the program was recruited and trained according to strict protocols established by MSVS and El Hogar Community Services, Inc., the project's mental health services provider.

Quality of Delivery

Interns were assessed throughout the training process to ensure they possessed the knowledge and skills to facilitate the short-term crisis intervention sessions. After the interns completed the training process, they were matched with project participants based on their

capabilities, and their work was planned and supervised by El Hogar's licensed clinical social worker.

Participant Responsiveness

Project participants reported they benefited immensely from the crisis management sessions because the sessions provided coping strategies to deal with stressful situations and symptoms associated with depression.

Program Differentiation

This component of the intervention differentiated itself from other interventions by building the capacity of mental health professionals to serve the Latino community. Through MSVS's internship program, 43 Latinos gained quick access to free, culturally and linguistically competent mental health counseling services.

The fact that the project only implemented one half of its planned capacity development activities led the evaluation team to assign an implementation fidelity score of 50 percent for that project component.

Implementation Flexibility

MSVS was designed and implemented as a pilot project. The purpose of a pilot project is to test the viability of new approaches and intervention models, which can then be scaled up if they are shown to be effective. Pilot projects are expected to be flexible, as they face unexpected internal and external variables. While implementation fidelity is critical to well tested and validated interventions, pilot projects such as MSVS are expected to change as they discover the right mix of inputs, activities, and outputs to achieve their desired outcomes. Project records and staff members' accounts suggested that MSVS achieved an appropriate

balance between adherence and flexibility. The project was presented with three critical challenges, and modified its approach and project design to respond adequately to each challenge. To counter Latinos' resistance to participating in the mental health screenings, MSVS integrated the screenings into the physical health screenings and worked more closely with the consulate's protection department to identify individuals who needed mental health services. To address the lack of external mental health service providers willing to enroll project participants, MSVS established its own in-house crisis counseling sessions. MSVS also established an internship program so that future mental health professionals could gain valuable experience serving the Latino community. After the closures caused by the COVID-19 pandemic, MSVS offered its services over the phone and established virtual support groups so Latinos could share their experiences and learn from one another.

Results

Evaluation Question 1: To what extent did the MSVS project serve the populations/sub-populations it was intended to serve?

MSVS was designed to address the unmet mental health needs of Mexican immigrants, 18 years of age and older, who resided in four northern California counties (Sacramento, San Joaquin, Stanislaus, and Yolo). To assess whether the project served the population it was intended to serve, the evaluation team reviewed data collected from project participants during the service intake process. The data showed that MSVS served 536 Latinos. Table 4 provides a breakdown of the number of project participants who were served in each project component.

Table 4 – Number of individuals who participated in each project component

Project Component	Number of Individuals
1. Mental health/illness education;	**536**
2. Depression screening using the Patient Health Questionaire-9	**536**
3. Referrals and post-referral support to external mental health services.	**169**
4. Short-term crisis intervention counseling	**70**
5. In-person and virtual support groups	**24**

Of the 536 individuals who received project services, 96.6 percent (n = 518) reported they were born in Mexico and immigrated to the United States. The average reported length of stay in the United States was 20.5 years (SD = 9.9). This high percentage was expected, since the site for all project activities was the Consulate General of Mexico in Sacramento, California. The gender distribution was 67.2 percent (n = 360) female to 32.8 percent (n = 176) male.

Participants' mean age was 43 (SD = 11.2). Of the 536 participants, 1.7 percent (n = 9) were 18–19 years of age; 34 percent (n = 182) were 20–39 years of age, 38 percent (n=203) were 40–49 years of age, 18 percent (n = 98) were 50–59 years of age, and 8 percent (n = 44) were 60 years or older. Of the 218 participants who provided information about their English-speaking ability, a combined 60% (n = 129) either reported their ability was "not good" or that they "do not speak English." These findings supported the conclusion that MSVS served the population it was intended to serve.

Evaluation Question 2: To what extent did the MSVS project impact participants' knowledge regarding mental health, mental illness, treatment resources, and the linkages between mental health and other health conditions?

To measure the project's impact on participants' knowledge about mental health/illness, former participants were administered select elements (questions 16–35) of Connor and Casey's (2015) Mental Health Literacy Scale (MHLS). The MHLS was administered to Mexican immigrants who were visiting the Mexican Consulate in Sacramento, California in December 2017, when the project commenced. Convenience sampling was employed because it was difficult to recruit participants while they awaited their turn to access consular services. Thirty individuals, 99 percent (n = 29) of whom were Mexican immigrants to the United States, participated in the survey. The evaluation team used the results of this earlier exercise as a baseline and administered the same survey, plus three additional questions about depression, during the final evaluation to 12 former project participants, again using convenience sampling.

Although the use of a nonprobability sampling technique increased the chances of bias and made the results ungeneralizable to the population at large, the results did provide valuable insight into the project and findings that can be tested in the future through more rigorous techniques. The results suggested that the individuals who participated in the

intervention had increased knowledge and more positive views about mental health/illness than individuals who did not participate in the intervention. Although the overall results were positive, there were a few areas of concern. Tables 5A and 5B detail the differences between the baseline and endline results. See Annex 1A for the full results.

Table 5A – Mental Health Literacy Scale Results, Baseline Evaluation (2017) vs Endline Evaluation (2021)	
Positive Results	
Individuals who reported they knew where to look for information about mental illness.	Increased from 13.3% to 58.3%.
Individuals who reported they were confident attending face-to-face appointments to seek information about mental illness.	Increased from 40.0% to 66.7%.
Individuals who reported they totally disagreed with the statement that mental illness was a sign of personal weakness.	Increased from 6.7% To 16.7%.
Individuals who reported they would be willing to have someone with a mental illness work close to them.	Increased from 6.7% 50.0%.
Individuals who reported they did not believe mental illness was a real medical illness.	Decreased from 10.3% to 0%.
Individuals who reported they thought people with mental illness were dangerous.	Decreased from 33.3% to 0%.

Individuals who reported they believed that mental illness treatment that was provided by a mental health professional would not be effective.	Decreased from 40.0% to 33.3%.

Three additional questions were added to the endline MHLS that were not included in the baseline survey. The questions covered the following topics: the definition of depression, the relationship between mental health and physical health, and the importance of mental health. Results suggested that individuals who participated in the intervention were knowledgeable about the three topics. One hundred percent (N = 12) of endline knowledge survey respondents identified the symptoms associated with depression—"Sentimientos de tristeza, llanto, vacío o desesperanza" ["Feelings of sadness, crying, emptiness, or hopelessness"]. Eighty-three percent (n = 10) responded "false" to the statement, "La salud mental y la salud física NO están relacionadas, es decir, la salud física NO afecta la salud mental y la salud mental NO afecta la salud física" ["Mental health and physical health are NOT related, that is, physical health does NOT affect mental health and mental health does NOT affect physical health"]. Ninety-two percent (n = 11) responded "true" to the statement, "La salud mental es igual de importante que la salud física" ["Mental health is as important as physical health"].

Table 5B – Mental Health Literacy Scale Results, Baseline Evaluation (2017) vs Endline Evaluation (2021)	
Individuals who reported they believed that people with mental illness could "snap out of it."	Increased from 20.0% to 50.0%

Individuals who reported they totally disagreed with the statement “If I had a mental illness, I would not tell anyone.”	Decreased from 51.7% to 16.7%
Individuals who reported they would be willing to allow someone with a mental illness to marry their family member.	Decreased from 6.7% to 0%

The knowledge survey results suggested that mental illness-related stigma was still a significant factor. Opinions shared during the two focus groups also supported this idea.

- “Persona loca, o algo así bien despectivo.” [“Crazy person, or something like that very derogatory.”]
- “La gente dice ‘Ay no, yo no lo necesito (servicios de salud mental), yo no estoy loca.’” [“People say, 'oh no, I don't need it (mental health services), I'm not crazy.”]
- “Es una discapacidad.” [“It is a disability.”]

These results suggested that the project had an impact on participants’ knowledge regarding mental health, mental illness, treatment resources, and the linkages between mental health and other health conditions. They also suggested there is still much more to be done with respect to mental illness-related stigma reduction.

Evaluation Question 3: To what extent did integration of the PHQ-9 mental health screening tool as part of regular health check-up protocols impact the early detection of mental illness in MSVS participants?

Records showed that over the project period, 536 Latinos, 97 percent (n = 518) of whom reported they were Mexican immigrants, received a depression screening with the PHQ-9 tool. This contrasted with the two years prior to the project's full implementation, when 871 individuals received health screenings without the depression screening in 2016 and 491 received them in 2017, respectively. Project activities commenced in late December 2017; therefore, 2018 was the first full year of project activities. During 2018, 149 individuals were screened for depression. Of that number, 64 percent (n = 95) received scores that warranted follow-up or referral to treatment services. In 2019, 332 individuals were screened for depression—a 45 percent increase from the 2018 total. Of those 332, 51 percent (n = 169) received scores that warranted follow-up or referral to treatment services. In 2020, the number of individuals screened decreased significantly to 51 due to COVID-19 pandemic closures, a 154 percent drop from the previous year's total. Of the 51 screenings administered, 70 percent (n = 36) required follow-up or referral. The breakdown of the PHQ-9 results was analyzed and categorized by severity. The data showed that from 2017 through 2020, when the highest number of screenings occurred, 46 percent (n = 137) of the results fell within the mild range, 27 percent (n = 80) fell within the moderate range, 16 percent (n = 48) fell within the moderately severe range, and 11 percent (n = 35) fell within the severe range. It is worth noting that approximately half of the results fell within the mild range, which suggests that the individuals were experiencing the early symptoms of depression.

Data collected during focus group sessions and semi-structured interviews suggested that individuals who accessed MSVS services believed they needed mental health support. Interview participants spoke of experiencing mourning, interfamilial conflicts, broken relationships, and stressful life situations, among other things, at the time they accessed MSVS services. Focus group participants also communicated that the depression screenings led them to take their mental health more seriously. This was illustrated by the following comment:

> Antes, tomábamos las cosas [salud mental] muy a la ligera y conforme los tiempos van cambiando empezamos a ver que, si son cuestiones serias y les damos más importancia, tratar de ayudar también en lo que se pueda a las personas que uno ve que están pasando por tiempos difíciles. [Before, we took things (mental health) very lightly and as times change, we begin to see that yes, they are serious issues and we give them more importance, and try to also help the people you see who are going through difficult times as much as possible.]

Another former participant shared that she previously accessed limited, external mental health services, and would not have reengaged in such services had it not been for MSVS offering them for free. The evidence reviewed suggested that the integration of the PHQ-9 mental health screening tool as part of a regular health check-up protocol had a significant impact on the early detection of mental illness in MSVS participants.

Evaluation Question 4: To what extent did the provision of MSVS services at the Mexican Consulate and mobile consulate sites impact wait times for accessing mental health services?

To assess the extent to which MSVS affected its participants' wait times for accessing mental health services, the evaluation team first reviewed project records to identify wait times

for accessing core project components (mental health/illness education, depression screening, and short-term crisis intervention counseling). Since services were delivered to project participants individually and did not require a minimum number of participants, they commenced within five minutes from the time individuals agreed to participate. The project delivered the project components Mental Health/Illness Education, Depression Screening, and Referral Support, within 30 minutes. Wait time between referral and enrollment in the in-house, short-term crisis intervention sessions, was six days. The sessions took place once a week and were concluded within five weeks.

Under California state law, county governments are responsible for administering mental health services to low-income populations. Although undocumented immigrants cannot access county mental health services, except in the case of emergency, the fact that county mental health services are responsible for serving low-income individuals made them the most appropriate point of reference. In its report, *2019–2020 Medi-Cal Specialty Mental Health External Quality Review Report*, the firm Behavioral Health Concepts Incorporated (2021) found that the statewide average for wait times in counties the size of Sacramento County, where MSVS is based, were 7 days for initial intake and 25 days for first appointments for psychiatric care. Project data on service wait times showed that MSVS achieved same-day wait times for initial intake for depression screening with the PHQ-9 tool and wait times of 6 days for first appointments for the short-term crisis intervention sessions. Tables 6A and 6B highlight the difference in wait times.

Table 6A – Statewide Average for Wait Times for Initial Intake Appointment in Counties the Size of Sacramento County vs MSVS		
County Mental Health Services	**MSVS**	***Difference***
7 Days	Same Day	7 Days

Table 6B – Statewide Average for Wait Times for First Psychiatry Appointment in Counties the Size of Sacramento County vs MSVS		
County Mental Health Services	**MSVS**	***Difference***
25 Days	6 Days	19 Days

The stark difference in wait times for initial intake (7 days) and psychiatry appointments (19 days) between MSVS and California counties the size of Sacramento County suggested that MSVS had a significant impact on its participants' wait times when they were accessing counseling services.

Evaluation Question 5: To what extent did the provision of direct referrals and follow-up contacts with referred individuals to promote successful completion of the referral process impact mental illness treatment enrollment?

To assess the extent to which provision of direct referrals and follow-up contacts with referred individuals to promote successful completion of the referral process affected mental illness treatment enrollment, the evaluation team reviewed project records and interviewed former project participants. Project records showed that, of the 536 participants who received a depression screening, 169 were referred to either in-house crisis counseling or external mental health services, with 70 referred to in-house and 99 referred to external services. The

completion rate for in-house referrals was 84 percent (n = 59), while the completion rate for external referrals was 23% (n = 23). The stark difference in the referral completion rates suggests that many of the barriers that had historically blocked or severely restricted Latinos from accessing culturally and linguistically appropriate mental health services were still a factor in the counties served by the project. A closer look at the factors that affected project participants' enrollment revealed that the former were related to the service providers. See Table 7A.

Table 7A – Factors affecting external referral completion	
Key factors	● Exorbitant fees ● Lack of sufficient Spanish speaking/bicultural staff ● Long wait times ● Service not accessible because of distance ● Agency does not serve undocumented individuals
MSVS strategies implemented to address barriers blocking external service enrollment	● MSVS staff followed up with referred participants and with external service site to help bridge whatever issue was blocking enrollment. If the issue could not be resolved, MSVS worked to identify an alternate service provider.

The factors that affected project participants' enrollment in the in-house crisis intervention sessions were related to participants' personal challenges. See Table 7B.

Table 7B – Factors affecting external referral completion	
Key factors	● High mobility with respect to housing situations ● Lack of reliable or affordable transportation ● Family commitments ● Employment commitments
Strategies employed to promote retention	● Reminder calls made to individuals 1–2 days before the scheduled counseling appointments ● Transportation support (This support was provided prior to COVID pandemic. During the pandemic, counseling sessions took place over the phone.) ● Leniency in welcoming participants back to counseling sessions after they missed sessions. ● Ensuring that counseling sessions were useful to attendees. This was done by focusing each session on simple strategies that Latinos could implement daily to improve their mental health.

The referral support that was provided to project participants through periodic calls helped increase enrollment in the in-house crisis counseling sessions. One focus group participant best described the importance of the referral support and follow-up calls:

> *Creo que es importante que nos animen un poquito porque hay veces que uno pasa un mal día y dices mejor no voy, pero si alguien te llama te sientes como importante, hay alguien que se preocupa por uno, para que vayas al curso, te sientes muy bien y eso te anima a seguir."* ["I think it is important that they encouraged us a little because there are times when one has a bad day and you say, 'I better not go,' but if someone calls you, you feel important, there is someone who cares about you, so that you then go to the course, you feel very good and that encourages you to continue."]

In summary, evidence demonstrated that the project's direct referrals and follow-up contacts with referred individuals to promote enrollment were more effective at securing enrollment in the in-house crisis intervention sessions than in external mental health services. This may have been because the traditional barriers Latinos face when attempting to enroll in external mental health services still persisted.

Evaluation Question 6: To what extent did MSVS training and capacity development activities with entities that provide health services and mental health professionals impact the availability of quality, culturally and linguistically appropriate mental health services to Latinos residing in target counties (Sacramento, San Joaquin, Stanislaus, and Yolo)?

As discussed in the section on implementation fidelity, MSVS achieved an intermediate level of fidelity to its capacity development plans. The project was intended to develop the capacity of two separate groups: entities that provided health services and mental health professionals. Project activities focused on the latter; therefore, the evaluation team assessed the extent to which capacity development efforts for mental health professionals affected the availability of quality, culturally and linguistically appropriate mental health services. For more details about the project's planned capacity development activities for entities that provided health services, refer to the implementation fidelity section.

The project did not administer pre and post capacity assessments for mental health professionals; therefore, the evaluation team relied on project reports and semi-structured interviews with students in their final year of study in a Masters of Social Work program who participated in MSVS's internship program. Project records showed that three interns participated in the program from 2018 through 2020. Together, they provided 152 hours of free

crisis intervention counseling to 43 project participants. Another 27 project participants received counseling support from two already licensed mental health professionals.

During interviews, the three former interns, each disclosed that they gained important experience and new capacity during their internship. Their descriptions of the capacity they gained included: 1) they learned about the Latino community's mental health needs and the barriers members of that community face when attempting to access mental health services; 2) they had the opportunity to learn about and practice innovative counseling strategies under the supervision of a licensed clinical social worker; and 3) they felt better prepared to advocate on behalf of Latino patients during their careers. These findings suggested that the project's capacity development efforts had an impact on the availability of quality, culturally and linguistically appropriate mental health services for Latinos who accessed project services, although the impact could have been more pronounced had the project exercised a higher level of implementation fidelity to its planned capacity development efforts for entities that provided health services.

Evaluation Question 7: To what extent did MSVS impact the broader Latino community's knowledge regarding mental health, mental illness, treatment resources, and the linkages between mental health and other health conditions?

The evaluation team was unable to measure the extent to which MSVS activities affected the broader Latino community since the project's public education efforts did not include pre and post knowledge assessments, nor was contact data collected from individuals targeted during the public educational efforts. Had it been, it would have been possible for the evaluation team to assess their knowledge. The evaluation team instead elected to measure

reach and level of interaction, two metrics that researchers have suggested are key to assessing the effectiveness of interventions delivered mainly over social media (Bennett & Glasgow, 2009; Preece & Shneiderman, 2009). With respect to reach, the project directed its mental health/illness messages at specific sectors: Spanish language radio, social media platforms popular with Latino audiences, social service organizations, community leaders and religious institutions. Project staff participated in three discussions on mental health/illness on Radio Lazer 94.3. The station is one of the largest Spanish-language stations. It serves multiple markets in California and Reno, Nevada, with a total market size of close to 3 million Latino listeners (apkcombo.com, n.d.). The organization disseminated mental health/illness educational messages through 36 local social service organizations and three respected community leaders. The project also worked with two religious institutions (Casa Verbum Dei of Sacramento, California, and Grace Presbyterian Church of Sacramento, California) to disseminate educational messages to their membership. The project had a strong presence on Facebook Live, where it hosted discussions on mental health for the Latino community. Project records that were based on an analysis of Facebook Live analytics showed that the project hosted 21 Facebook Live sessions, which reached 27,610 persons. While the evaluation team was unable to assess knowledge increase, the available evidence suggested that MSVS's public education efforts achieved a wide reach and a high rate of interaction.

Discussion and Recommendations

MSVS served the population it was intended to serve, Mexican immigrants to the United States. The project achieved this by placing the service site within the Consulate General of Mexico in Sacramento, California, which was a safe space for Mexican immigrants, and one in

which culturally and linguistically appropriate services were guaranteed. Although the project served its intended population, a closer examination of the data suggests that future iterations of the project should address challenges in recruiting young adults 18–19 years of age, men, and adults 60 and above. The lack of participation by older adults is of note, since past research has suggested that mental health disorders are more prevalent in Mexican immigrants living in the United States for 13 years and more (Vega et al., 1998). The list of possible reasons the project was not able to recruit higher numbers of young adults, men, and older adults is long. It includes the project site, the recruitment messages, and the differences in the demographic characteristics of MSVS recruiters and individuals they recruited. More data should be collected from these subpopulations to inform the development of targeted recruitment approaches and messages.

Data suggested that MSVS's educational efforts had some impact on the level of participant knowledge about mental health/illness. The educational messages that seem to have been less effective were those tied to mental illness-related stigma. The project should focus additional efforts on combating mental illness-related stigma through activities that humanize individuals living with mental illness, and on normalizing discussions about mental health/illness.

The fact that almost 60 percent of the project participants screened by the MSVS project received PHQ-9 scores that required follow-up or referral to mental health services drove home the need for more Latinos to have access to mental health screenings. It is equally important for those screenings to be linked to culturally and linguistically appropriate mental illness treatment services. This will require the project to look further into the psychological

barriers that influence Latinos' decision not to participate in the screenings. The project should also explore options for expanding the mediums through which the PHQ-9 screenings can be administered. The project's move away from in-person PHQ-9 screenings to telephone-based screenings in response to the COVID-19 pandemic suggest that viable options exist. Options that should be explored, particularly to counter the stigma associated with publicly accessing mental health services at the consulate, are self-administered, web- or phone-based PHQ-9 screenings. The critical factor will be how MSVS can deliver the same level of culturally and linguistically appropriate services through a website or phone application and link users to in-house crisis counseling or external mental health service providers.

The evaluation findings suggest that MSVS decreased wait times when compared to the reported wait times for counties the size of Sacramento County (BHCI, 2021). This was achieved with only three MSVS staff members, who managed all MSVS services as well as the physical health services. If the project had been called on to serve a significantly higher number of Latinos, with the same number of staff, wait times would have increased. It is critical that MSVS assess staffing needs against expected increases in project demand as more Latinos learn of its culturally and linguistically appropriate mental health services.

While the project should be recognized for achieving an 84 percent in-house crisis intervention enrollment completion rate, MSVS must work to identify more effective strategies for enrolling Latinos into the culturally and linguistically appropriate services that exist. MSVS does not have the resources to provide the type of long-term mental illness treatment services that Latinos who have experienced serious trauma need. What it does have is an effective model for how other entities that wish to better serve the mental health needs of the Latino

community can deliver culturally and linguistically appropriate services to that community. MSVS must continue to implement and refine its model while also leveraging its experience to advocate for key stakeholders to address the structural inequalities and deficiencies that block all but a small number of Latinos from accessing meaningful mental health services. It is also important to acknowledge that concerted action is needed from federal and state policy makers, local governments, and mental health service providers in order to address the inequalities. But as it waits for long-term solutions, MSVS must also advocate for more initiatives like MSVS that deliver mental illness prevention and early detection services in non-clinical, community settings or through peer-to-peer networks. The outcomes MSVS achieved suggests that interventions delivered in community settings can reach unserved and underserved populations, reduce wait times, and provide effective mental health and crisis intervention support. The HEC, the nonprofit that manages MSVS, has already began to expand its use of such community and peer-to-peer mental health interventions. In 2019, the HEC implemented the Peers Helping Peers project, which uses facilitadores comunitarios [community facilitators] to deliver mental health wellness interventions to underserved Latino communities. In 2021, the HEC also implemented the FEMA/CalHOPE project, which trains community members as crisis counselors to support the mental health of communities affected by disasters through active listening, sharing of coping strategies, and helping to identify next steps toward wellness. The HEC should continue to develop and expand the reach of such efforts.

The project's capacity development initiatives made an important contribution to the effort to provide more mental health professionals with the necessary knowledge and skills to

serve the Latino community. According to the Bureau of Labor Statistics (n.d), approximately 30 percent of psychologists were self-employed in 2020, which means the overwhelming majority provide their services as employees in academic, educational, healthcare, and public settings. For MSVS's capacity development efforts to achieve long-term impacts, the project must identify more effective strategies that build the capacity of entities which provide health services to the Latino community.

Conclusion

The results of the final evaluation of the pilot project, Mente Sana Vida Sana, suggest that the intervention model has merit. In particular, the project design and implementation strategy served the population it was intended to serve, Mexican immigrants to the United States. It helped increase participants' mental health/illness knowledge, decreased wait times for initial service intake and enrollment in in-house mental health services, and helped develop the capacity of mental health professionals to serve the Latino community. While the project was able to achieve said outcomes, its model and implantation strategy were not able to build the capacity of entities that provide health services to the Latino community, nor were they able to remove the barriers that project participants faced when attempting to access external mental health services. The significant challenges that the project faced while attempting to enroll participants in external mental health services demonstrates that without shifts in federal and state laws, health policy, funding priorities and access restrictions, Latinos will continue to be blocked from meaningful access to mental health services.

Although MSVS faced significant challenges, the MSVS approach secured unfettered access to culturally and linguistically appropriate mental health services for the Latinos who accessed its services, thereby demonstrating that ¡*SÍ SE PUEDE! [It can be done!].*

This final evaluation of the MSVS project had a number of limitations, including the research design, small sample size, and limited statistical analysis. The evaluation team attempted to employ a pre-test and post-test with no comparison group design, but it encountered challenges due to the project design and the characteristics of the project participants. The short duration of interventions (15–30 minutes) and the fact most participants accessed services only once and were highly mobile and difficult to track made it difficult for the evaluators to collect paired pre and post data. The difficult experience of recruiting former participants for the evaluation also led the team to employ convenience sampling, a nonprobability sampling technique, to ensure the largest number of subjects participated in the process. Even with this strategy, the team only secured the participation of 16 past participants. These two limitations influenced the evaluation's third notable limitation, its exclusive reliance on descriptive statistics rather than a mix of descriptive and inferential analysis to measure the extent to which the project achieved its desired outcomes. These limitations must be addressed in future studies with more rigorous evaluation designs, sampling techniques, and samples that permit inferential statistics and generalization of results to the population at large. There are notable opportunities for future studies on Latino access to mental health services, including the applicability of other mental health screening tools, the impact of gender- and age-specific recruitment strategies on mental health service enrollment, the effectiveness of strategies for increasing providers' willingness to accept documented and undocumented migrants as

patients, and exploration of the effectiveness of community and peer-to-peer mental health interventions. Each of these topics would broaden the knowledge base of effective strategies for removing barriers standing in the way of the Latino community's access to culturally and linguistically appropriate mental health services.

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Annexes

Annex 1A - MSVS Service Intake Form

Annex 1B - MSVS Service Intake Results

Annex 2A – MHLS

Annex 2B - MHLS Results

Annex 3 – MSVS Final Evaluation Protocol

Annex 4A - Focus Group Guide

Annex 4B - Focus Group Consent Form

Annex 5 - MSVS Implementation Fidelity Assessment Form

Annex 6 - MSVS IRB Continuing Review Approval