

**Final Evaluation of *Mente Sana, Vida Sana***  
**A Project Serving the Mental Health Needs of Latinos**  
**May 2022 – September 2025**

**Latino Priority Population**

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### Acronyms

**CDEP** – Community-defined Evidence Based Practices

**CDPH** – California Department of Public Health

**CBPR** – Community Based Participatory Research

**CRDP** – California Reducing Disparities Project

**HEC** – Health Education Council

**MHSA** – Mental Health Services Act

**VDS** – Ventanilla de Salud

### Keywords

**Hispanic/Latinx/Latino/Latino/a/x** – 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”, “Latinx”, and “Latino/a/x”. 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 MSVS activities.

## Executive Summary

The realities facing the Latino community in its struggle for access to culturally and linguistically appropriate mental health services are well documented:

- The 2022–2023 National Survey on Drug Use and Health (NSDUH) reported that approximately 23% of Latino adults with a mental illness received any form of mental health service in the prior year (SAMHSA, 2024).
- According to the Office of Minority Health (2024), Latino adults received mental health treatment at rates 28% lower than the general U.S. adult population, despite experiencing comparable or higher rates of anxiety and depressive symptoms.
- Between 2014 and 2019, the number of facilities offering services in Spanish decreased by nearly 18% (Pro et al., 2022),
- For Latino immigrants, the absence of linguistically and culturally competent providers perpetuates mistrust, reduces engagement, and increases the likelihood of early treatment termination (CPEHN, 2023).

Wanting to effect change, the Health Education Council (HEC), a Sacramento, California-based nonprofit organization, designed and implemented an innovative initiative called *Mente Sana, Vida Sana* (MSVS) [Healthy Mind, Healthy Life] to address the mental health needs of Latino immigrants. MSVS integrated mental health screenings into preventative, physical health screenings within the Consulate General of Mexico in Sacramento, California, a safe space for the Latino community. All MSVS interventions were dedicated to the realization of five intended outcomes:

- Increased knowledge about depression and treatment resources
- Improved detection of depression symptoms
- Reduced wait times for accessing mental health services

- Increased availability of culturally and linguistically appropriate mental health services
- Increased enrollment and retention in mental health services

MSVS pursued its intended outcomes through four interventions:

- Outreach and Education
- Integration of Depression Screening into Preventive Health Screenings
- Referral and Follow-up Support
- In-house Crisis Counseling

The Solomon Group was charged with evaluating the extent to which the MSVS project achieved its intended outcomes. Six evaluation questions guided the evaluation. After a thorough examination of data collected from key stakeholders, and analysis of relevant programmatic data, the evaluation team reports the following findings:

***Evaluation Question 1: To what extent did the MSVS project serve the population it was intended to serve?***

Results showed that MSVS served the population it was intended to serve and delivered services that were aligned with the project's design. During the project period, MSVS served 751 individuals, all of whom were Latinos. Ninety-six percent (n = 721) were born in Mexico while 4% (n = 30) were born in other Latin American countries (El Salvador, Guatemala, Chile, Colombia, and Honduras) and the United States.

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

A paired, two sample t-test was performed on subjects' pre and post knowledge scores to test whether there was a statistically significant difference between the pre and post means. The results showed a statistically significant increase in correct answers after subjects

participated in the educational intervention from pre-test ( $M = 1.84$ ,  $SD = .817$ ) to post-test ( $M = 1.92$ ,  $SD = 0.27$ );  $t(499) = 1.992$ ,  $p = .046$ . The evaluation team tested the validity of the result by administering the same 1-question knowledge test that MSVS used to gauge knowledge during the project period. The results showed that 100% ( $n = 9$ ) correctly answered the question. The results supported the conclusion that MSVS improved project participants' knowledge about depression/mental health.

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

The evaluation team's analysis found that the integration of the PHQ-9 depression screening tool as part of preventative health screenings had a significant impact on the detection of depression in MSVS participants. In the absence of the screenings, 367 Latinos who were experiencing different levels of depression would not have been identified and given the opportunity to be linked to culturally and linguistically appropriate mental health services.

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

The evaluation team found that MSVS significantly decreased wait times between the time project participants were classified as needing counseling services and the time they received a referral to MSVS' internal, crisis counseling services. The evaluation team also found that the project should work to reduce the amount of time between referrals and the delivery of internal, crisis 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?**

The evaluation team found that there was a stark difference in the referral completion rates between MSVS and Sacramento County. The finding suggests that the project had a positive impact on treatment enrollment for those who were referred to the project's internal counseling services, while there was less of an impact for those who were referred to external services. The difference between the enrollment completion rates between internal services and external services may suggest that many of the barriers that blocked or severely restricted Latinos from accessing external mental health services (enrollment restrictions, inadequate supply of Spanish-speaking mental health professionals, stigma, etc.) were still present.

***Evaluation Question 6: To what extent did the provision of in-house crisis counseling sessions impact project participants' mental health?***

The evaluation team concluded that MSVS' provision of in-house crisis counseling sessions helped to improve the mental health of those who received the project's crisis counseling services. The finding was supported by the results of a paired t-test as well as participant testimonials.

***Conclusion***

MSVS performance during the period under review showed that its interventions had the capacity to remove formidable barriers that blocked or limited the Latino community's access to culturally and linguistically appropriate mental health services. From the point of first contact, project staff initiated key components of the intervention within 5 minutes. The project's knowledge intervention achieved increased project participant knowledge about depression; its depression screenings led to the identification of 367 project participants who had been living with different levels of depression; staff members' quick follow-up and support services

encouraged 110 individuals to enter mental health counseling services; and, 83 individuals were empowered with strategies that alleviated their levels of depression, pain and trauma.

The evaluation team's analysis showed that MSVS' mental health interventions were effective in achieving the results they were intended to achieve using Community-defined Evidence Based Practices that safeguarded the Latino community's mental health and wellbeing.

### **Final Evaluation of the Mente Sana, Vida Sana Project – Phase 2 Extension**

This report presents the final evaluation results of the project, *Mente Sana, Vida Sana (MSVS) [Healthy Mind, Healthy Live]*, Phase II Extension. MSVS was designed to support the Latino community's health and wellbeing by removing barriers that block or limit access to culturally and linguistically appropriate mental health services. MSVS' design and intervention model were anchored in Community-defined Evidence Based Practices (CDEP). CDEPs are practices that communities have developed and refined over time with significant community input and there exists consensus within the community that the practices yield positive results (Martinez et al., 2010).

MSVS co-located mental health services within the Mexican Consulate in Sacramento, California, where it integrated mental health screenings into preventative, physical health screenings. MSVS' population of focus was adult Latinos living in Sacramento County, California and other surrounding counties.

MSVS is a project of the nonprofit organization, Health Education Council (HEC). The project was made possible through a grant funded by the California Department of Public Health, Office of Health Equity, California Reducing Disparities Project – Phase 2 Extension.

The challenges facing the Latino community in its struggle for access to culturally and linguistically appropriate mental health services are well documented by research that underscores a widening gap in mental healthcare utilization for Latinos.

#### **Prevalence and Unmet Mental Health Needs**

- The 2022–2023 National Survey on Drug Use and Health (NSDUH) reported that approximately 23% of Latino adults with a mental illness received any form of mental health service in the prior year (SAMHSA, 2024).

- According to the Office of Minority Health (2024), Latino adults received mental health treatment at rates 28% lower than the general U.S. adult population, despite experiencing comparable or higher rates of anxiety and depressive symptoms.

### **Impact of COVID-19**

- The COVID-19 pandemic significantly amplified preexisting inequities. Latino adults experienced higher rates of psychological distress, grief, and unmet mental health needs compared with other racial and ethnic groups (Ormiston et al., 2023).
- Studies show that pandemic-related stressors increased depressive and anxiety symptoms within Latino immigrant communities, while technological and linguistic barriers limited the potential benefits of virtual mental health care (Galletly et al., 2022).

### **Language Access and Workforce Capacity**

- Between 2014 and 2019, the number of facilities offering services in Spanish decreased by nearly 18% (Pro et al., 2022),
- By 2024, only about 5% of U.S. mental health providers reported Spanish language proficiency (Martinez & Sanchez, 2024).
- For Latino immigrants, the absence of linguistically and culturally competent providers perpetuates mistrust, reduces engagement, and increases the likelihood of early treatment termination (CPEHN, 2023).

### **Policy Environment and Immigration-Related Barriers**

- The 2019 expansion of the federal “public charge” rule generated a well-documented chilling effect, discouraging many immigrant families from seeking eligible health and social services due to fears of jeopardizing future immigration status (Kaiser Family Foundation, 2022). Although the rule was reversed in 2022, the residual fear and

misinformation have persisted, continuing to influence help-seeking behaviors among mixed-status families (Galletly et al., 2022).

The findings highlight the need for CDEPs that can remove the systemic barriers that have limited the Latino community's access to culturally and linguistically appropriate mental health services.

### **CDEP Purpose and Description**

MSVS was designed to address the unmet mental health needs of Latino immigrants, with a focus on adult Mexican immigrants living in Sacramento County, California and other surrounding counties. However, all individuals were offered services regardless of nationality and language spoken. MSVS' activities, outputs, and results were collectively intended to achieve the following outcomes:

- Increased knowledge about depression and treatment resources
- Improved detection of depression symptoms
- Reduced wait times for accessing mental health services
- Increased availability of culturally and linguistically appropriate mental health services
- Increased enrollment and retention in mental health services

### **MSVS Project Components**

#### **1. Outreach and Education**

The outreach and education component focused on raising awareness about depression and disseminating information about available MSVS services. The majority of outreach and education activities took place at MSVS' project site, the Consulate General of Mexico in Sacramento, California. On average, 150 individuals visited the consulate each day to access consular services and support. As individuals waited in the consulate's waiting area, project staff delivered presentations that de-stigmatized depression and other mental health conditions,

linked mental health to physical health, and encouraged individuals to participate in free health screenings.

Individuals who agreed to participate in the screenings were led to a private area where staff engaged them in conversation about physical and mental health. The MSVS project design and implementation strategy was challenging because it required on-the-spot recruitment of prospective project participants while they were waiting to be served by consular officials. MSVS staff had to exercise much skill when recruiting participants since individuals were more focused on their consular appointments than being engaged about depression and mental health, topics that have been shown to be associated with high rates of stigma within the Latino community (Jimenez et al., 2013). Additionally, when individuals agreed to the health screenings, project staff worked to deliver core elements of the intervention within 30 minutes. In response, project staff developed a 1-topic educational intervention that focused on dispelling mental illness stigma. The 1-topic educational intervention informed the development of a 1-question knowledge test, which asked, “¿Usted cree que la gente con depresión se puede mejorar solo teniendo la fuerza de voluntad para hacerlo?” [Do you believe that people with depression can get better only by having the willpower to do so?]. Respondents had three answer options, “Yes”, “No”, and “I don’t know”. The question was administered before and after each educational intervention.

## **2. Integration of Depression Screening into Preventive Health Screenings**

The second component worked to increase individuals’ willingness to participate in depression screenings by seamlessly integrating them into physical health screenings. Without the topic’s seamless integration, project designers believed that most project participants would not have agreed to the depression screenings. The Patient Health Questionnaire-9 (PHQ-9) was the tool used to screen depression symptoms. The PHQ-9 is a nine-item tool that scores each of the nine items from 0 to 3, resulting in a 0–27 depression severity score (Kroenke and

Spitzer, 2002). After the screenings were administered, staff members discussed the results with participants along with counseling or treatment options. Individuals who scored 10 (moderate) or higher were referred either to MSVS' in-house crisis counseling or to external treatment services. Individuals whose scores were below the mild range, but requested counseling, were also referred to counseling.

### **3. Referral and Follow-up Support**

The focus of the third component was to provide project participants with information, guidance, and support necessary for them to enroll in mental health counseling/treatment or access social services. Individuals who scored 5–9 (mild) were offered educational handouts on self-care, stress management, and information about MSVS' services. Project participants who received a score of 10–14 (moderate) were referred to experienced Master of Social Work students, those who scored 15–19 (moderately-severe) were referred to telehealth services offered by psychologists at the Autonomous University of Mexico, and those who scored 20–27 (severe) were referred to Spanish-speaking therapists contracted by MSVS.

The basis of the referral process was a good understanding and appreciation of each project participants' mental health needs. Staff were trained to use motivational communication that was strengths-based and person-centric. Before referrals were made, staff assessed the type of crisis each project participant was experiencing, the level of counseling required, and which therapist within MSVS' network was most equipped for the case. Project staff remained in regular contact with project participants, all the while providing support, identifying available resources, and encouraging project participants to enroll into counseling or treatment.

### **4. In-house Crisis Counseling**

During the piloting of the MSVS project, staff discovered it was difficult to enroll project participants into external mental health counseling programs. In response, MSVS formalized its own crisis counseling program. The in-house, crisis counseling sessions eliminated barriers

(enrollment restrictions, inadequate supply of Spanish-speaking mental health professionals, stigma, etc.) that previously challenged Latinos when accessing mental health services. The sessions were led by trained MSVS staff, social workers and clinical therapists. Crisis counseling sessions took place once a week and were usually completed within five weeks. If participants required more sessions, they were given more or referred to external agencies for long-term mental health care.

### **Modifications to the Project's Design/Implementation Strategy**

During the period under review, the MSVS project executed two modifications, which were in response to project participants' changing mental health needs:

- The PHQ-9 was increasingly administered over the phone, allowing staff to serve more people.
- Increased emphasis was placed on identifying and responding to more acute depression cases. Staff prioritized PHQ-9 screenings for those who were deemed to be more vulnerable to depression/mental illness, chronic illness, or were experiencing mental health challenges.

### **Infusion of Latino Cultural Values and Preferences**

The delivery of each project component integrated Latino cultural values and preferences. Research suggests that Latinos use culturally determined, common labels, perceptions, and terms to characterize mental illness (Cabassa et al., 2007). MSVS staff therefore avoided technical language when discussing depression and other mental health conditions. They instead used words that Mexican and other Latinos commonly used to talk about feeling unwell—such as “estrés” (stress), “desanimado” (down/discouraged), “triste” (sad), and “nervioso” (on edge)—and integrated familiar “dichos” (expressions) and narratives into counseling and psychoeducational interventions. Interventions focused on the individual, family—in line with the Latino community's strong family-centric (Familismo) values— and the

community. Staff acknowledged each project participant's mental health challenges, reminded them that they were not alone and that asking for mental health support was a sign of strength. There was also an emphasis on showing appreciation for project participants' efforts to educate their family members about depression and other mental health topics. All interventions focused on highlighting mental health resources that were provided by nonprofit organizations, public agencies, and religious institutions within each project participants' community.

The staff who delivered the education, depression screening, and referral support services were bilingual (Spanish and English) and bicultural (Mexican and American). Each staff member had previous experience with mental health, and experience supporting Latinos to access mental health services, and was committed to eliminating access barriers.

The project also established a network consisting of external service providers that had experience providing culturally and linguistically appropriate mental health services to Latinos. During the period under review, that network included The Autonomous University of Mexico, California State University – Sacramento, and Spanish-speaking therapists contracted by MSVS.

MSVS' focus on integrating culturally and linguistically appropriate terms and Latino cultural perspectives extended to MSVS's internal crisis counseling sessions. All counselors were bilingual (Spanish and English) and bicultural (Mexican and American). They also used Spanish expressions [dichos] during counseling sessions rather than technical terms. Counselors took note of participants' expressed religious beliefs—often beliefs associated with Catholicism—and infused those beliefs into counseling sessions to comfort and reassure participants. Additionally, counselors made sure to recommend depression and mental health coping strategies that were culturally acceptable to Latinos, including talking with close family/friends, engaging in a hobby, or going for a walk.

### MSVS Participant Attrition

MSVS' target population, project design, and implementation site had significant implications for participant attrition. The population of focus was individuals who were highly mobile and difficult to track for the purpose of follow-up. The project design also presented significant challenges because it required on-the-spot recruitment of prospective project participants at the Consulate General of Mexico in Sacramento, California. Much effort and skill had to go into the recruitment effort since most of those being recruited were focused on their consular appointments and not keen on participating in health interventions. In addition to project-specific challenges, the traditional barriers (inadequate supply of experienced, bi-lingual/bicultural licensed therapists, enrollment restrictions, stigma, and lack of space for new patients), also influenced participant attrition. Project records highlighted three clear attrition points: depression screening, counseling and treatment enrollment, and treatment completion.

As explained previously, MSVS recruited project participants while they were waiting to be served by consular staff. That meant that project staff had approximately 30 minutes to deliver some of the core intervention components (education, depression screening, and referral to counseling/treatment services). The first attrition point was between the educational intervention and depression screenings. Records showed that 751 individuals were successfully recruited for one-on-one educational interventions. Of that number, 585 chose to participate in the depression screenings, resulting in a 78% success rate and a 22% (n = 164) refusal rate. Of those who chose not to participate in the depression screening, 67% indicated they did not have sufficient time.

The second attrition point was entry into counseling/treatment services. Depression screening results showed that 367 individuals received scores that warranted follow-up or referral to counseling or treatment services. Of the 367 individuals who were referred, 110

enrolled in the services they were referred to. This represented a combined 30% referral completion rate, and a 70% participant attrition rate for entry into counseling services.

The final attrition point was counseling completion. Of the 110 individuals who were enrolled into counseling services, 97 (88%) were enrolled into MSVS' internal, crisis counseling sessions. Of that number, 83 completed the assigned five crisis counseling sessions. This represents an 86% completion rate, and a 14% attrition rate. No data was made available on the completion rate for external counseling services.

### **Evaluation Questions**

Six overarching evaluation questions informed all activities and analysis undertaken as part of the final evaluation:

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

***Evaluation Question 2:*** *To what extent did the MSVS project impact participants' knowledge regarding mental health, depression, 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 detection of depression in MSVS participants?*

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

***Evaluation Question 5:*** *To what extent did the provision of direct referrals and follow-up support to referred individuals impact enrollment and retention?*

***Evaluation Question 6:*** *To what extent did the provision of in-house crisis counseling sessions impact project participants' mental health?*

### Performance and Outcome Indicators

While the six evaluation questions guided the evaluation, the project's performance and outcome indicators provided greater precision to the evaluation activities:

- # of individuals targeted during outreach efforts to participate in MSVS services, disaggregated by recruitment site.
- Total number and demographic characteristics of individuals successfully recruited to participate in at least one MSVS intervention element, disaggregated by age, gender, number of years in the USA, and English language ability.
- # of Level 1 depression/MH educational presentations delivered to large groups
- # of Level 2 depression/MH educational presentations delivered to large groups
- # of project participants who receive 1-on-1, MSVS educational interventions
- % of project participants who demonstrate increased depression/MH knowledge after participating in one-on-one educational interventions.
- # of PHQ 9 screenings administered, disaggregated by site.
- Distribution of PHQ 9 results, disaggregated by severity and project participants' demographic characteristics.
- Distribution of reasons for nonparticipation in depression screening (Limited Time, Lack of Interest in Topic, Already Screened for Depression)
- Average wait time for accessing internal MSVS counseling services
- Average wait time for accessing external MH services (for profit and nonprofit)
- Average wait time for accessing County mental health services.
- # of follow-up contacts (by phone, email, in-person, etc.) executed in support of the referral process or to promote retention.
- # of project participants who received follow-up contacts and support.
- % of project participants referred to follow-up mental health services, disaggregated by internal and external referral services.
- % of referred project participants that accessed the services they were referred to within 60 days, disaggregated by internal and external referral services.
- Distribution of factors cited by project participants for not accessing the services they were referred to (distance from service site, lack of transportation, work schedule, family responsibilities, lack of interest).

- # of project participants referred to in-house crisis counseling.
- % of project participants who were successfully enrolled into internal crisis counseling sessions.
- % of project participants who completed crisis counseling sessions.
- Pre/Post PHQ-9 screening results, disaggregated by age, gender, years in USA, and English ability.
- % of project participants who completed crisis counseling and achieved a reduction in their PHQ-9 score.
- % of individuals who completed internal crisis counseling sessions and self-reported increased capacity to manage depression symptoms utilizing strategies acquired during crisis counseling sessions.

### **Evaluation Approach, Design, and Methods**

In line with Community-based Participatory Research principles, the evaluation team held preliminary consultations with MSVS' key stakeholders (project staff, project participants, and implementation partners) to better understand the types of information each stakeholder group thought would be useful.

Based on stakeholder feedback, the final evaluation employed a Utilization-focused Approach. The approach's central tenet is that evaluations should be useful to end users. The approach stresses that evaluations must be planned, implemented, and the results disseminated in ways that maximize the likelihood that end users will act upon the results (Patton & Campbell-Patton, 2022). The approach was operationalized through a mixed methods design wherein both qualitative and quantitative data collection, analysis, and results triangulation were employed to deliver a more precise assessment of MSVS' effectiveness.

### **Sampling Methods**

Convenience sampling, a nonprobability sampling technique, was employed in support of qualitative 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 techniques 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 and led the evaluators to use descriptive analysis and graphs to present results. 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). A total of 18 subjects participated in qualitative data collection activities: 5 personal narratives; 6 semi-structured interviews with project participants; 3 semi-structured interviews with project staff; and 4 semi-structured interviews with implementing partners.

The evaluation team performed paired t-tests to determine whether there was a statistically significant difference between subjects' pre and post knowledge scores, and between their pre and post depression screening scores. T-tests were performed on all records within the sample frame, rather than on a sample of the records.

### **Quantitative Methods**

#### **Pre and Post Depression Knowledge Assessment**

A 1-question knowledge assessment was administered to gauge how well project participants acquired and retained knowledge shared during educational interventions. The evaluation team attempted to validate the results by administering the same 1-question test during interviews with project participants.

#### **Pre and Post Depression Screening**

The evaluation team reviewed data on counseling recipients' PHQ-9 scores before and after they received crisis counseling.

## **Quantitative Analysis**

The evaluation team performed paired t-tests to determine whether there was a statistically significant difference between subjects' knowledge scores before and after they received the educational intervention. The same was performed on PHQ-9 scores recorded before and after subjects participated in crisis counseling. The education and PHQ-9 t-test results were generalizable only to MSVS' project participants.

## **Qualitative Methods**

### **Desk Review**

Desk reviews of recent studies on the mental health of Latinos were performed along with a review of key project records, including semesterly reports, indicator performance databases, and performance evaluations executed during the period under review.

### **Semi-structured Interviews**

Semi-structured interviews were administered with project participants, staff, and implementation partners.

### **Personal Narratives**

Project participants recorded audio testimonials that documented their stories, the reasons why they chose to access MSVS' services, and the impact of those services on their mental health.

### **Qualitative Analysis**

After reviewing handwritten notes and audio recordings, key themes were identified manually by the evaluator. The evaluation team followed Creswell's (2014) six-step procedure for qualitative data coding and analysis:

1. Sort and arrange data into different data types.
2. Review and reflect on the complete body of data.
3. Develop applicable codes based on the data emerging from recorded interviews.

4. Assign codes based on the varying identified themes, categories, and sub-categories.
5. Identify relationships and connections between the different identified themes, categories and subcategories.
6. Interpret key findings in relation to evaluation questions.

### **Inclusion/Exclusion Criteria and Recruitment Strategy**

The inclusion criteria for participation in the evaluation process were limited to individuals who had direct experience either as project participants, project staff, or implementation partners.

#### **Project Participants**

Participation was limited to those who had received at least one project component. There were 751 (N = 751) former participants who qualified. Project staff first identified 25 who responded to their initial inquiries. All 25 were asked to be interviewed. Ten of them accepted the interview request but only 6 made themselves available at their scheduled interview time.

#### **Project Staff**

The inclusion criteria for project staff were limited to those staff who had played a role in the design, implementation, or documentation of project activities. Two project staff were interviewed.

#### **Project Partners**

The inclusion criteria for project partners were limited to those who provided direct or indirect mental health counseling or treatment services to project participants. Three mental health counselors/therapists were interviewed.

#### **Project Records**

All project records collected from May 2022 to September 2025 were included in the desk review.

## Measures and Data Collection Procedures

### Demographic, Performance, and Short-term Results

The project's participant intake database was one of the main sources of data for the evaluation. The database stored valuable demographic, service delivery, and short-term results data. The demographic data included participants' gender, age, place of birth, English ability, and health insurance coverage. Health data included glucose level, blood pressure, previous mental illness treatment, and depression screening results. The most significant short-term results data was data on post PHQ-9 scores and service satisfaction. Data was collected at every stage of the service delivery process, starting at first contact with project participants and ending with depression screenings that were administered after crisis counseling sessions were completed.

### Mental Health Knowledge Gain and Retention

Another source of data for the evaluation was mental health knowledge data that was collected throughout the project period and validated during the evaluation process. As explained earlier, the MSVS project faced unique challenges that required it to recruit, educate, screen, and refer project participants in the span of 30 minutes. To deliver an effective educational intervention in such a short time, project staff developed a one-topic educational intervention. The 1-topic educational intervention informed the development of a 1-question knowledge test, which asked, "¿Usted cree que la gente con depresión se puede mejorar SOLO teniendo la fuerza de voluntad para hacerlo?" [Do you believe that people with depression can get better ONLY by having the willpower to do so?]. Respondents had three answer options, "Yes", "No", and "I don't know". The question was administered at the start and end of each educational intervention. The evaluation team also incorporated the question into its interviews with past project participants. The question served two purposes, to validate the project's internal knowledge test results, and to test the level of knowledge retention.

## Stakeholder Experiences and Prospectives

Semi-structured interviews documented project staff, participants, and implementing partners' experiences and perspectives about the project's effectiveness. Interview guides provided structure and ensured that questions were aligned with the varying roles played by each of the stakeholders.

The MSVS direct service team consisted of three staff. Two were interviewed. Staff interviews consisted of 5 questions which focused on the original project design, changes made to the design and implementation strategy, key challenges, and staff members' opinions on the project's achievements. Project staff were interviewed by phone. Their responses were analyzed and key themes identified.

Project participant interviews consisted of six semi-structured questions. The questions allowed project participants to share their experiences and perspectives on how MSVS services impacted their mental health. The interviews were conducted by phone. When subjects agreed, the interviews were audio recorded. The details of each interview were reviewed individually, key themes identified and compared across all interviews.

The interviews with implementation partners centered on the therapies/strategies employed during counseling sessions and how partners measured each strategy's effectiveness. Responses were analyzed, key themes documented and compared across all interviews.

Project participants who received crisis counseling were given the opportunity to document their pre and post perspectives using audio recordings. The audio testimonials provided the clearest evidence of project participants' thoughts on the project's effectiveness.

All collected data was saved on encrypted, password protected folders that were only accessible to the evaluation team.

### **Institutional Review Board (IRB) Approval**

The MSVS evaluation protocol, data collection processes, and instruments received IRB approval from California's Office of Statewide Health Planning and Development (OSHPD), Committee for the Protection of Human Subjects. The original IRB approval was granted in December 2017, under Protocol ID 2017-043, with subsequent yearly extensions granted each year afterwards. The current IRB is scheduled to expire in October 2026.

### **Fidelity and Flexibility**

Nordén et al. (2017) suggests that, when intervention models do not achieve their intended outcomes, fidelity assessments provide a basis for evaluating whether the model was at fault or whether the model was implemented incorrectly. To gauge MSVS's fidelity to its original project design, the evaluation team assessed five elements that have traditionally 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). The evaluation team developed and applied a structured fidelity scoring system that utilized a 4-point Likert Scale anchored in specific descriptors and fidelity percentages like scales deemed reliable by Suhrheinrich et al. (2019):

- 4 – All planned activities executed (80 or more)
- 3 – Majority of planned activities implemented (60 – 79)
- 2 – Half of planned activities implemented (40 - 59)
- 1 – Limited implementation of planned activities (20 - 39)

After reviewing relevant reports and staff testimonials, the evaluation team assigned a fidelity score for each of the five elements. The scores were then averaged across all elements and project components, resulting in a fidelity score of 73. Table 1 details the scoring process and results:

<b>Table 1: Fidelity Assessment</b>				
<b>Overall Fidelity Score: 73</b>				
<b>Program Component: Mental Health Education</b>				
<b>Component Score: 19</b>				
<b><i>Adherence</i></b>	<b><i>Exposure</i></b>	<b><i>Quality of delivery</i></b>	<b><i>Participant Responsiveness</i></b>	<b><i>Program Differentiation</i></b>
During the project period, MSVS delivered culturally and linguistically appropriate educational interventions to Latinos at the designated project site in accordance with the project design.	Educational interventions were delivered within 5 minutes to ensure sufficient time for participant questions and the delivery of other intervention components.	Educational interventions were scripted, which ensured that the delivery quality was the same for each project participant. Post-knowledge tests showed increased participant knowledge.	Educational interventions sparked interest in other project components. The educational component secured the participation of 751 individuals. Though the figure seems large, the universe of possible participants was approximately 27,000.	The delivery of a culturally and linguistically appropriate mental health educational intervention in a non-clinical environment differentiated this project component from others.
<b>Score: 4</b>	<b>Score: 4</b>	<b>Score: 4</b>	<b>Score: 2</b>	<b>Score: 4</b>
<b>Program Component: Depression Screening</b>				
<b>Component Score: 20</b>				
<b><i>Adherence</i></b>	<b><i>Exposure</i></b>	<b><i>Quality of delivery</i></b>	<b><i>Participant Responsiveness</i></b>	<b><i>Program Differentiation</i></b>
Depression screenings were administered using the PHQ-9 instrument within private spaces at the Mexican consulate in Sacramento, California.	The depression screenings followed the same protocol for all participants. The testing method was introduced, the test was administered, the results were explained; and individuals were referred to appropriate services.	Depression screenings were administered by trained, bilingual/bicultural MSVS staff.	Project participants were engaged throughout the depression screening process. Records showed that participants asked many questions and were keen to understand the results.	The provision of free depression screening and guaranteed linkage to culturally and linguistically appropriate mental health services differentiated this intervention component from others.
<b>Score: 4</b>	<b>Score: 4</b>	<b>Score: 4</b>	<b>Score: 4</b>	<b>Score: 4</b>

<b>Program Component: Mental Health/Illness Referral and Support</b>				
<b>Component Score: 15</b>				
<b><i>Adherence</i></b>	<b><i>Exposure</i></b>	<b><i>Quality of delivery</i></b>	<b><i>Participant Responsiveness</i></b>	<b><i>Program Differentiation</i></b>
Project participants were contacted regularly and provided advice, encouragement, and assistance to remove the many barriers limiting access to services.	Project participants who received a PHQ-9 result of mild or greater were referred to in-house crisis counseling or external treatment services.	After being referred to in-house or external counseling, participants on average received three follow-up calls/contacts.	Records showed that 367 individuals were referred. Of that number, 110 enrolled in the services they were referred to, a 30% success rate. When disaggregated, the enrollment data is concerning. While the project achieved a 93% completion rate for internal referrals, the referral completion rate for external referrals was only 8%.	The provision of follow-up calls and support differentiated the intervention from others. During interviews, many former participants reported that the follow-up calls and support were key factors in their decision to enroll in mental health counseling.
<b>Score: 4</b>	<b>Score: 4</b>	<b>Score: 4</b>	<b>Score: 1</b>	<b>Score: 2</b>
<b>Program Component: Mental Health Crisis Counseling and Treatment Services</b>				
<b>Component Score: 20</b>				
<b><i>Adherence</i></b>	<b><i>Exposure</i></b>	<b><i>Quality of delivery</i></b>	<b><i>Participant Responsiveness</i></b>	<b><i>Program Differentiation</i></b>
The project provided free, culturally and linguistically appropriate crisis counseling services.	The number of sessions assigned was based on participants' PHQ-9 scores. The project delivered an average of 5 sessions.	The sessions were administered by licensed, bi-lingual/bi-cultural social workers who specialized in either crisis counseling or clinical counseling. Records showed that 78% of those who received crisis counseling received post depression scores that were lower than their pre scores.	Participant testimonials and analysis of pre and post depression scores suggested that counseling sessions had a positive impact on participants' mental health.	Differentiating factors included easy access to trained, culturally competent social workers and therapists.
<b>Score: 4</b>	<b>Score: 4</b>	<b>Score: 4</b>	<b>Score: 4</b>	<b>Score: 4</b>

### **Flexibility**

Project records and staff members' accounts suggested that MSVS achieved an appropriate balance between fidelity and flexibility. Testimonials pointed to two specific moments when the project exercised flexibility: 1) changing project design to better serve participants who required more acute mental health services. 2) implementation of new strategies aimed at increasing the rates of counseling enrollment, retention, and completion.

During the project period, project staff analyzed depression screening results and found that there was an increase in individuals who required more acute counseling and treatment services. They also found that the individuals who presented acute cases were often more vulnerable, were experiencing active mental health episodes, or lacked access to health services. To respond to more acute needs, the project conducted two training activities that further developed staff members' capacity to respond to acute mental health cases. One result of the training activities was that staff developed additional capacity to triage acute cases and more precisely link them to appropriate treatment services. The project also modified its service delivery protocols to be more aligned with project participants' individual mental health needs.

### **Results**

As previously established, six evaluation questions guided the final evaluation. They included:

**Evaluation Question 1:** To what extent did MSVS serve the populations it was intended to serve?

**Evaluation Question 2:** To what extent did the MSVS project impact participants' knowledge regarding mental health, depression, 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 detection of depression in MSVS participants?

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

**Evaluation Question 5:** To what extent did the provision of direct referrals and follow-up support to referred individuals impact enrollment and retention?

**Evaluation Question 6:** To what extent did the provision of in-house crisis counseling sessions impact project participants' mental health?

The Solomon Group was charged with evaluating the extent to which the MSVS project achieved its intended outcomes. Six evaluation questions guided the evaluation. After a thorough examination of data collected from key stakeholders, and analysis of relevant programmatic data, the evaluation team reports the following findings in response to the six evaluation questions:

***Evaluation Question 1: To what extent did the MSVS project serve the population it was intended to serve?***

To gauge the extent to which the project served its intended target population, the evaluation team examined service records from the period under review, May 2022 – September 2025. During that period, MSVS served 751 Latinos. Ninety-six percent (n = 721) reported they were born in Mexico, while 4% (n = 30) were born in other Latin American countries (El Salvador, Guatemala, Chile, Colombia, and Honduras) and the United States.

The average length of stay in the United States was 17.4 years (SD = 14.0). This figure is of note since research has suggested that mental health disorders are more prevalent in Mexican immigrants who have lived in the United States for 13 years and more (Vega et al.,

1998). The gender distribution was 77% female (n = 578) to 23% male (n = 173). Mean age was 46 (SD = 13). Ninety percent (n = 676) of project participants were aged thirty years or older. When disaggregated by age groups, 33% (n = 246) of project participants were between 40–49 years old; 23% (n = 174) were 50 – 59; 17% (n = 129) were 30 – 39, 16% (n = 123) were 60 or older, 9% (n = 68) were 20 – 29; and 1% (n = 10) were 18 – 19 years old. Seventy-one percent (n = 430) of project participants described their English-speaking ability as either “Not very good” (41%, n = 250) or “I don’t speak English” (30%, n = 180). See Table 2 for a summary of participants’ demographic characteristics.

<b>Table 2 – Demographic Characteristics</b>	
<b>Demographic Variable</b>	<b>Results</b>
Place of Birth	96% (Mexico) 4% (USA, El Salvador, Guatemala, Chile, Puerto Rico, Colombia, Honduras)
Length of Time in USA (Mean)	17.4 Years
Gender	77% (Female) 23% (Male)
Age	33% (n = 246), 40 – 49; 23% (n = 174), 50 – 59; 17% (n = 129), 30 – 39; 16% (n = 123), 60+; 9% (n = 68), 20 – 29; 1% (n = 10), 18 – 19
English Ability	41% - Not Very Good 30% - I don’t Speak English 17% - Good 12% - Very Good
Insurance Coverage	54% (Not insured) 46% (Insured)
Blood Pressure	65% (High) 35% (Normal)
Glucose	60% (High) 40% (Normal)

Records showed that the project executed activities and generated outputs that were in line with the project’s design and implementation strategy:

- Number of individuals targeted for recruitment - **27,000**
- One-on-one educational sessions delivered - **751**
- Number of depression screenings administered – **585**

- Number of unique referral support activities executed to encourage enrollment into mental health counseling services – **889**
- Number of unique crisis counseling sessions delivered: **327**
- Number of mental health training activities conducted – **28**

The results clearly showed that MSVS served the population it was intended to serve and delivered services that were aligned with the project's design. The variables that led to the different rates of male and female project participation should be investigated and the findings used to inform subsequent recruitment strategies.

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

As previously explained, MSVS faced unique challenges that required it to recruit, educate, screen, and link project participants to counseling or treatment services within a 30-minute window of opportunity. To deliver all intervention components within 30 minutes, the project's educational messaging had to be simple but effective. To achieve this, the project devised a 1-topic educational intervention that focused exclusively on countering depression-related stigma/misinformation that blamed depressed individuals for not having sufficient willpower to heal themselves. The 1-topic educational intervention spurred the development of a 1-question knowledge test. The test was administered before and after each educational intervention. Multiple research studies have suggested that 1-question tests are as effective as multi-question tests when used appropriately (Bush et al., 2010).

The knowledge test asked, "¿Usted cree que la gente con depresión se puede mejorar SOLO teniendo la fuerza de voluntad para hacerlo?" [Do you believe that people with depression can get better only by having the willpower to do so?]. Project participants were given three answer options, "Yes", "No", or "I don't know". The pre and post tests were administered to 500 project participants. The pre results showed that 42% (n = 212) of

respondents responded “Yes”, 31% (n = 154) responded “No”, and 27% (n = 134) responded, “I don’ know.” The percentage of respondents who either answered “Yes” or “I don’t know” was 69% (n = 346), which suggested that most respondents lacked knowledge about the topic.

The post test results were drastically different. Ninety-two percent (n = 460) responded, “Yes”, 8% (n = 40) responding, “No”, and no one responded, “I don’t know”.

A paired, two sample t-test was performed on the pre and post knowledge scores to test whether there was a statistically significant difference between the pre and post means. The results showed a statistically significant increase in correct answers after subjects participated in the educational intervention from pre-test (M = 1.84, SD = .817) to post-test (M = 1.92, SD = 0.27);  $t(499) = 1.992, p = .046$ .

The evaluation team tested the validity of the results by administering the same 1-question knowledge test during phone interviews with project participants. The results showed that 100% (n = 9) correctly answered the question. Taken together, the results provided sufficient evidence that MSVS improved project participants’ knowledge about depression/mental health.

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

The evaluation team analyzed service recruitment, depression screening, and PHQ-9 data to assess the extent to which integration of the PHQ-9 depression screening tool impacted detection.

Records showed that 585 individuals were successfully recruited to participate in depression screenings. These were individuals who were referred to or sought out MSVS services, received the depression/mental health educational intervention, and were then screened for depression within a preventive, mental and physical health screening protocol. Project staff suggested that

far less Latinos would have participated in the depression screenings, had it not been integrated into preventative health screenings. The claim is supported by a large body of research that suggests depression and other mental illnesses are topics associated with high rates of stigma within the Latino community, thereby affecting treatment enrollment rates (Jimenez et al., 2013). Evidence of that is apparent in the 88% (n = 210) of project participants who answered “No” to the question, “Have you previously received therapy/counseling?”

The integration of depression screenings led to the finding that most project participants—60% (n = 367)—exhibited depression symptoms that required follow-up or referral to treatment services. According to Kroenke, Spitzer, and Williams (2001), PHQ-9 scores of 5, 10, 15, 20 are cutoffs for mild, moderate, moderately severe, and severe depression. Recommended post-screening actions begin with follow-up starting at score 5 (mild), while scores from 10 (moderate), 15 (moderately severe), and 20 (severe) call for treatment. Disaggregated by severity, 22% (n = 130) of the baseline PHQ-9 results fell within the mild range, 17% (n = 97) within the moderate range, 11% (n = 67) within the moderately severe range, and 10% (n = 60) within the severe range.

Analysis of data collected through semi-structured interviews and audio narratives aligned with the depression screening results. When project participants were asked to describe the factors that influenced their decision to participate in the depression screening, three themes emerge from their responses:

- **Fear and Uncertainty Regarding U.S. Immigration Policies**

Subjects described feeling anxious, depressed, and uncertain about the future. They also described feeling hopeless and not wanting to venture outside. Multiple subjects described experiencing panic attacks and sometimes feeling as if they were drowning, unable to breathe.

- **Domestic Violence**

Female subjects in particular described serious physical, mental, and emotional abuse by their partners. They reported being afraid to report abuse, not knowing how their partners would respond and the possible repercussions for their family.

- **Death of Family Members**

At least four subjects spoke of depression caused by the loss of loved ones. One spoke of the loss of five loved ones in a single tragic incident. For the four subjects, the loss of family members was unbearable. They sought MSVS services to assist them to process their loss.

- **Past Traumatic Experiences**

Some subjects spoke of trauma they experienced during childhood, including physical and/or sexual abuse. All spoke of seeking MSVS services to help them cope with their past trauma and to learn new ways of responding to the issues that continue to challenge their mental health and wellbeing.

The evaluation team also analyzed five personal narratives that were recorded by project participants who received crisis counseling. The audio testimonials provided the clearest evidence that the PHQ-9 scores reflected the mental health challenges project participants faced. See Table 3 for excerpts from three of the testimonials.

<b>Table 3: Personal Narratives – Pre-Crisis Counseling</b>		
<b>Gender</b>	<b>Age</b>	<b>Reasons for Seeking MVSV Services and Hopes for the Future</b>
Male	36	<p><i>“Yo crecí en México, con una crianza muy diferente a la de aquí. En cierta manera pues fui abusado físicamente por mis padres, mis tíos, y este pues crece uno con odio, resentimiento, con coraje, con amargura, porque pues no tiene uno la capacidad a veces de sobresalir de estos problemas psicológicos.”</i></p> <p><i>[“I grew up in Mexico, with a very different upbringing than here. In a way, I was physically abused by my parents and my uncles, and I grew up with</i></p>

		<p><i>hatred, resentment, anger, and bitterness, because sometimes you don't have the ability to overcome these psychological problems.”]</i></p> <p><i>“Entonces pues espero que me sirva mucho de ayuda y que me acepten en el programa para yo poder tener tratamiento mental para sobrellevar de estos traumas que yo tengo. ... pues fueron muchas cosas las que pasé traumáticas en mi vida y quiero soltar, quiero soltar todo ese coraje, todo ese odio, todo ese rencor, todo ese sufrimiento que le da a uno vueltas día con día, que uno piensa, que uno se acuerda y le llega a uno el sentimiento, y quisiera uno gritar.”</i></p> <p><i>[So, I hope this will be a great help and that I'll be accepted into the program so I can receive mental health treatment to overcome these traumas I have... I went through many traumatic things in my life and I want to let go, I want to release all that anger, all that hatred, all that resentment, all that suffering that haunts you day after day, that you think about, that you remember and the feeling comes over you, and you just want to scream.]</i></p>
Female	46	<p><i>“...miré toda esa violencia en mi casa, yo pensando que eso era normal, que, pues tenía que aguantarme y vivir así porque pues yo lo miré en mi casa, con mi papá que golpeaba mi mamá. Mi hermano, cómo nos golpeaba, nos gritaba, nos decía muchas cosas feas. Y después me junto con este hombre y pues también, después fue también igual. Pero yo callaba, yo no decía nada porque también él me amenazaba. Decía que, si yo decía, me podía matar o matar a mis hijos, entonces pues no decía nada a nadie.”</i></p> <p><i>[...I saw all that violence in my house, thinking it was normal, that I just had to put up with it and live like that because I saw it at home, with my dad hitting my mom. My brother, how he hit us, yelled at us, and said so many awful things to us. And then I got together with this man, and it was the same. But I kept quiet, I didn't say anything because he threatened me too. He said that if I said anything, he could kill me or my children, so I didn't tell anyone.]</i></p> <p><i>“Pero yo escogí participar en este proyecto para buscar ayuda para mí, para poder sobrellevar día a día de cómo le afecta a uno mental, le afecta a uno en todas las formas de cómo ser, cómo ayudar a nuestros hijos. Por la tristeza, por la angustia, porque uno se siente con ese estrés, con esa desesperación, con esa tristeza grande.”</i></p> <p><i>[“But I chose to participate in this project to seek help for myself, to be able to overcome how it affects you mentally, how it affects you in every way, how you are, how you help your children. Because of the sadness, the anguish, because you feel that stress, that despair, that great sadness.”]</i></p>
Female	48	<p><i>“...he tomado la decisión de participar en el proyecto de Mente Sana, Vida Sana porque me siento con depresión y ansiedad y yo la verdad pues necesito ayuda verdad y me hablaron de este programa y me gustaría participar porque estoy pasando por un proceso de divorcio. También en</i></p>

	<p><i>febrero falleció mi papá y me siento muy mal y necesito el programa.”</i></p> <p><i>[“...I’ve decided to participate in the Healthy Mind, Healthy Life project because I’m experiencing depression and anxiety, and I really need help. I heard about this program, and I’d like to participate because I’m going through a divorce. Also, my father passed away in February, and I’m feeling very bad and I need the program.”]</i></p> <p><i>“Solamente yo lo que quiero es tener una vida normal como todos y sentirme bien conmigo misma y sentir esa felicidad de cuando de cuando yo era niña porque en mi niñez fui muy feliz y me gustaría que eso regresara a mi vida sentirme a gusto yo no sentir esta depresión y ansiedad.”</i></p> <p><i>[“All I want is to have a normal life like everyone else and feel good about myself and feel that happiness I had when I was a child because I was very happy in my childhood and I would like that to return to my life, to feel comfortable and not feel this depression and anxiety.”]</i></p>
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The evaluation team’s analysis found that the integration of the PHQ-9 mental health screening tool as part of preventative health screenings had a significant impact on the detection of depression in MSVS participants. In the absence of the screenings, 367 Latinos who were experiencing different levels of depression would not have been identified and given the opportunity to be linked to culturally and linguistically appropriate mental health services.

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

To assess the extent to which MSVS impacted wait times for accessing mental health services, the evaluation team reviewed project data that captured internal wait times for obtaining first appointment for education/screening services as well as wait times for the delivery of crisis counseling. The evaluation team then compared MSVS’ wait times against wait times recorded for Sacramento County.

Wait times for obtaining first appointments for education/screening services were documented on MSVS’s participant intake form. The records showed that the wait times between first contact and obtaining first appointment for education/screening services was 5

minutes. The 5-minute wait time was possible because MSVS services were based within the Consulate of Mexico. After the initial intake, project staff delivered core intervention components, including mental health/depression education and depression screening. Those whose depression screening results warranted a referral were referred to appropriate services. All this took place within approximately 30 minutes.

Records showed that wait times for obtaining first appointments for in-house crisis counseling was 3 days. It is important to clarify that obtaining an appointment was equivalent to open space being identified in MSVS' counseling services. That wait time was possible because MSVS' staff were also qualified and trained to provide crisis counseling services. Having in-house crisis counselors ensured that project participants were not hindered by the structural, social and economic barriers that traditionally blocked access to culturally and linguistically appropriate mental health services. That wait time was also possible because of the work MSVS had undertaken to increase its staff members' capacity to serve project participants' more acute mental health needs, and through the establishment of a network of partners that provided counseling services in close collaboration with MSVS staff. That network consisted of The Autonomous University of Mexico, California State University – Sacramento, and MSVS-contracted therapists.

Records showed that the average wait time for delivery of internal crisis counseling within MSVS' network of service providers was 17.5 days. For comparison, the evaluation team reviewed relevant wait times for accessing public mental health services. The State of California conducts periodic assessments of the 57 mental health plans that provide specialty mental health services to Californians. The most recent report titled, *FY 2023-24 Statewide Annual Technical External Quality Review Report, MEDI-CAL Specialty Mental Health*, found that in Sacramento, where MSVS is based, the average wait time for non-emergency appointments was 13.9 days, while the wait time for delivery of non-emergency services was 18.8 days.

The difference in wait times for initial intake (MSVS – 5 Minutes / Sacramento County – 13.9) and service delivery (MSVS – 17.5 days / Sacramento County – 18.8 days) between MSVS and Sacramento County provided clear evidence of MSVS' impact on wait times. While MSVS' wait time for service delivery was commendable, the project should work to reduce the wait time further.

The testimonials gathered through semi-structured interviews showed that project participants appreciated the speed with which space was identified for them in MSVS' crisis counseling (3 days); although on average it took 17.5 days for the actual services to be delivered. One interviewee stated, "Yo estoy totalmente satisfecha con el programa y este la rapidez simplemente de que me pudieron conectar con alguien [I am completely satisfied with the program and the speed with which they were able to connect me with someone]." Another stated, "Traté de buscar recursos por otra parte y realmente me tardaron como a dos meses en casi tres y pues eso nada más para una entrevista." [I tried to find resources elsewhere and it really took me about two months, almost three, and that was just for an interview.] The word "rápido" [fast] was used by more than one project participant to describe the rate with which they were linked to culturally and linguistically appropriate services.

The evaluation team found that MSVS significantly decreased wait times between the time project participants were classified as needing counseling services and the time they received a referral to MSVS' internal, crisis counseling services. The evaluation team also found that the project should work to reduce the amount of time between referrals and the delivery of internal, crisis 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 impacted mental illness treatment enrollment, the evaluation team analyzed data that captured service referrals, follow-up calls/contacts, and counseling enrollment.

Records showed that 367 project participants were referred to counseling services. Ninety-nine individuals chose not to follow through on their referral while 268 followed through by accepting referral support and attempting to enroll into counseling or treatment services. Of those who followed through, 61% (n = 164) were referred to external services, while 39% (n = 104) were referred to internal crisis counseling services. To encourage enrollment completion, project staff executed 889 unique follow-up contacts. Each contact provided staff with an opportunity to engage project participants about their mental health needs as they provided additional encouragement and support. Records showed that MSVS' contacts and follow-up support resulted in 110 individuals enrolling into counseling services—a 41% referral completion rate. Ninety-seven of them were successfully enrolled into MSVS' crisis counseling sessions while 13 were enrolled into external treatment services. Contact rates were nearly identical for those who completed their referral and those who did not complete their referral. The mean contact rate for individuals who completed the referral process was 2.9 (SD = 1.13), while the mean for those who did not complete their referrals was 2.6 (SD = 1.32). Even though the rates were close, they are in line with research that suggests a positive, direct relationship between follow-up contacts and service enrollment (Myerson et al., 2022).

MSVS' 41% referral completion rate is noteworthy and suggests that MSVS' referral and support model may be a promising practice. Past studies have reported varying enrollment rates: one study reported that 15% of Mexican immigrants with a psychiatric diagnosis used

services (Vega et al., 1999). Another study found that only 36.1% of Hispanics received mental health services (SAMHSA, 2022). A 2024 study reported that only 11.7% of Latinos who wished to access services successfully did so (Newberry et al., 2024).

The evaluation also analyzed the significant difference between the enrollment rates between MSVS' internal crisis counseling and external treatment services. Project records indicated that, of the 164 individuals who were referred to external services, only 13 (8%) successfully completed the referral process, while of the 104 who were referred to internal crisis counseling, 93% (n = 97) completed the referral and enrolled into services.

The stark difference in the referral completion rates suggests that the project had a positive impact on treatment enrollments for those who it referred to its own counseling services. The results also suggest that many of the barriers (enrollment restrictions, inadequate supply of Spanish-speaking therapists, space availability, affordability, stigma, etc.) that had historically blocked or severely limited Latinos' access to culturally and linguistically appropriate mental health services were still present when project participants attempted to access external services.

***Evaluation Question 6: To what extent did the provision of in-house crisis counseling sessions impact project participants' mental health?***

To assess the extent to which the project's in-house crisis counseling sessions impacted project participants' mental health, the evaluation team analyzed crisis counseling enrollment and completion data, pre and post-PHQ-9 results, and participant testimonials and perspectives.

Project records showed that during the period under review, 97 project participants were successfully enrolled into MSVS' internal, crisis counseling sessions. Of that number, 86% (n = 83) completed internal crisis counseling. The evaluation team received no data on external treatment completion therefore all subsequent analysis was conducted on data from the internal crisis counseling sessions. The 14% internal dropout rate recorded was significantly lower than

the rates reported by past studies. For example, one study reported a dropout rate of 58.33% (Escovar et al., 2023).

Of the 97 project participants who completed internal crisis counseling, the project recorded both pre and post-PHQ-9 results for 46. Seventy-eight percent ( $n = 36$ ) of those who completed crisis counseling recorded lower post-PHQ-9 scores. A paired sample t-test was conducted to determine whether there was a statistically significant difference between the pre and post-PHQ-9 means after project participants completed crisis counseling. The results showed a statistically significant difference between pre counseling, PHQ-9 scores ( $M=11.6$ ,  $SD=5.4$ ) and the post counseling PHQ-9 scores ( $M=8.35$ ,  $SD = 4.50$ )  $t(44) = 3.57$ ,  $P < .001$ . The results suggest that the crisis counseling sessions influenced participants' PHQ-9 scores.

The evaluation team also analyzed audio narratives that were recorded after individuals completed their assigned crisis counseling sessions to validate whether the t-test results aligned with the experiences and perspectives of those who completed crisis counseling. Key observations from the testimonials included:

- The strategies taught to those who received crisis counseling (breathing techniques, grounding, coping, safety skills, and psycho education) were very useful
- Anxiety was often mentioned alongside depression
- "I feel better" was a common phrase used to describe subjects' current mental health and wellbeing
- Gratitude expressed for the availability of MSVS' mental health services

Table 4 presents three post-crisis counseling testimonials. The testimonials are from the same subjects whose pre-counseling testimonials were shared in an earlier section of this report (see page 35). The testimonials were the clearest measure of the extent to which the provision of in-house crisis counseling impacted project participants' mental health.

Table 4: Personal Narratives – Post-Crisis Counseling		
Gender	Age	Reasons for Seeking MVSV Services and Hopes for the Future
Male	36	<p>“...me ha servido mucho algunas de las estrategias que aprendí...una de ellas es respirar profundamente en momentos de estrés o de ansiedad. Es una de las partes que me ayudaron a sobresalir de ciertas cosas de ciertas preocupaciones en las cuales yo paso. Me está ayudando...”</p> <p>[...some of the strategies I learned have been very helpful...one of them is taking deep breaths during moments of stress or anxiety. That's one of the things that has helped me overcome certain worries I go through. It's helping me...]</p>
Female	46	<p>“Tomé las clases y sesiones de consejería y allí aprendí varias estrategias y una de ellas fue la respiración profunda a cómo respirar cuando uno está en esa desesperación en esa tristeza o en ese enojo que le ayuda a uno la respiración lo calma. Y también aprendí la meditación para antes de dormir, oyendo consejería o videos de consejeros o también leyendo un libro. La otra estrategia era teniendo tiempo para mí misma como haciendo citas para mi chequeo físico, haciendo ejercicio y también yendo a mis grupos espirituales. Otra estrategia era organización de mi tiempo de cómo tener una agenda y apuntar a todos mis deberes que tenía que hacer durante el día.”</p> <p>[I took counseling classes and sessions, and there I learned several strategies. One of them was deep breathing—how to breathe when you're feeling desperate, sad, or angry. Breathing helps calm you. I also learned meditation before bed, listening to counseling sessions or videos of counselors, or reading a book. Another strategy was making time for myself, like scheduling appointments for physical checkups, exercising, and attending my spiritual groups. Another strategy was organizing my time, using a planner, and writing down all my daily tasks.]</p> <p>‘También aprendí a cómo no sentirme culpable de mi vida que viví con mis hijos cuando eran pequeños. No sentirme culpable de lo que pasé con mi pareja. Aprendí que no era mi culpa y yo hice lo que yo quería lo mejor para mis hijos e hice lo mejor posible para ellos.’</p> <p>[I also learned how not to feel guilty about the life I lived with my children when they were young. Not to feel guilty about what I went through with my partner. I learned that it wasn't my fault, and I did what I wanted, what was best for my children, and I did the best I could for them.]</p>
Female	48	<p>“Estuve pasando por una depresión, muy fuerte ansiedad ahora que falleció mi padre y también pasé por un divorcio. La verdad sí necesitaba la ayuda. Me sentía muy mal y agradezco mucho con los servicios que tenían ofrecido, me he sentido mejor, gracias. Me he sentido mejor y gracias a Dios porque ahí estoy. Bueno sí necesitamos este buen servicio. Tuve cuatro sesiones con el terapeuta. Me he sentido mucho mejor. Muchas gracias.”</p>

	<p>[I was going through a period of depression and very severe anxiety after my father passed away, and I also went through a divorce. I really needed help. I felt very bad, and I'm so grateful for the services you offered. I've felt much better, thank you. I've felt better, and thanks to God, I'm here now. We really needed this kind of service. I had four sessions with the therapist. I've felt so much better. Thank you so much.]</p>
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After analyzing crisis counseling enrollment and completion data, pre and post-PHQ-9 results, and participant testimonials and perspectives, the evaluation team concluded that MSVS' provision of in-house crisis counseling sessions helped to improve the mental health of those who received the project's crisis counseling services. The finding was supported by the results of a paired t-test as well as participant testimonials.

**Discussion and Recommendations**

The fact that males represented only 23% of those who were successfully recruited suggests that MSVS will need to further calibrate its recruitment strategies to attract male Latinos. At least one study suggested that the lifetime psychiatric disorder rates for male and females Latinos were close, 28.14% to 30.23%, respectively (Alegría et al., 2007). Another study suggested that the rates of receiving outpatient mental healthcare were lower for male Latinos than female Latinas, at a rate of 9.2% to 13.6%, respectively (Olfson et al., 2023). This suggests that a large percentage of Latino males who could have benefited from MSVS' mental health services remained out of the project's reach. This issue warrants further investigation by project staff. It also presents a unique opportunity for new research that can expand the knowledge base on gender-specific barriers to treatment enrollment for male Latinos. Such research would inform the development of more precise, gender-specific, recruitment strategies for male Latinos.

The analysis of pre and post knowledge scores demonstrated that MSVS increased project participants' knowledge relative to the project's 1-topic intervention. Testimonials recorded by project participants suggested that there may be need to expand the purview of

MSVS' mental health screenings. Other than depression, the mental health condition that project participants mentioned often was anxiety. Project participants spoke of regularly experiencing panic attacks during this current anti-immigrant climate, not being able to breathe, and only finding relief through the breathing exercises taught during MSVS' crisis counseling sessions. It is possible that both the need and opportunity exist for MSVS to expand its mental health screening and related services to include anxiety. MSVS has already established a strong screening and referral infrastructure that may be able to support an additional mental health condition. As with the PHQ-9 tool, there are abundant evidence-based screening tools for anxiety (e.g., Generalized Anxiety Disorder 7-item). The evaluation team encourages project staff to explore the feasibility of expanding MSVS' focus to include anxiety.

The evaluation findings showed that MSVS achieved lower wait times for first appointment and service delivery when compared to wait times reported for Sacramento County. In the case of wait times for service delivery, although MSVS' wait times were lower, they were not significantly lower (MSVS – 17.5 days / Sacramento County – 18.8 days). The evaluation team recommends that MSVS dedicate more resources to lowering wait times for the delivery of counseling services. If project staff see merit in the recommendation, they can start by first identifying the factors affecting the current 17.5-day wait time then taking appropriate action to lower that number.

### **Limitations of the Evaluation**

This final evaluation of the MSVS project had distinct limitations. It relied mostly on convenience sampling because of MSVS' design and the difficulty the evaluation team experienced when attempting to engage past participants. The evaluation team attempted to compensate for this reliance on convenience sampling by, when possible, performing t-tests on the project's quantitative data, but the results were only generalizable to project participants and not the larger population. The second limitation was that the evaluation team did not have

sufficient data with which to investigate three critical issues that limited the project's effectiveness, the first being factors limiting male Latino recruitment success, the second being the wait time (17.5 days) recorded for delivery of counseling services, and the third being the low rates of enrollment completion for external treatment services. The absence of clarity on the three issues is notable. The evaluation team will work to ensure more clarity on the three issues by collecting and analyzing new data with the intention of incorporating those findings into an updated version of this report.

### **Conclusion**

The MSVS project's performance during the period under review demonstrated that its interventions had the capacity to remove barriers that block or limit the Latino community's access to culturally and linguistically appropriate mental health services. Project records showed that MSVS served the population it was intended to serve and delivered services that were aligned with the project's design. Analysis revealed a statistically significant difference between pre and post knowledge scores after subjects participated in MSVS' educational intervention. MSVS' integration of the PHQ-9 mental health screening tool as part of preventative health screenings had a significant impact on the detection of depression in MSVS participants, resulting in the identification of 367 project participants who had been living with different levels of depression. MSVS significantly decreased wait times and positively impacted referral completion rates for Latinos that were linked to MSVS's internal counseling services while it faced challenges when attempting to reduce wait times for the delivery of crisis counseling services and enrollment in external services. MSVS' support services encouraged 110 project participants to enter mental health counseling services, and those services empowered 83 project participants with strategies that alleviated their levels of depression, pain and trauma.

In summary, the evidence analyzed by the evaluation team showed that MSVS' mental health interventions achieved the results they were intended to achieve using Community-defined Evidence Based Practices that safeguarded the Latino community's mental health and wellbeing.

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