The experiences of a mental health team in dealing with problems of an urban Hispanic population over a two-year period are presented. Successful and unsuccessful approaches are analyzed, and the insights obtained are evaluated for more general application in similar contexts.

SUCCESSFUL AND UNSUCCESSFUL APPROACHES TO MENTAL HEALTH SERVICES FOR AN URBAN HISPANO AMERICAN POPULATION

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THE content of this paper reflects the experiences, over a two-year period, of a Mental Health Team placed in an area of the city of Denver, Colorado, composed of large segments of a Hispano population.

In terms of clarification, the words successful and unsuccessful used above refer, by our criterion, the extent to which the Hispano population makes use of the mental health services. This is judged by simply counting the percentages of new patients and percentages of monthly patient encounters of Spanish-surnamed individuals. These percentages were then compared proportionately to numbers of non-Spanish-surnamed individuals.

Probably the best numerical description of the composition served by this Mental Health Team is found in the ethnic proportions registered in the Westside Neighborhood Health Center of which this team is a part. The present over-all registrations at the center comprise 68 per cent Hispano-surnamed, 27 per cent Anglo, and 5 per cent black and other groups. The "other" category includes a few individuals of Indian and Oriental descent. These percentages are taken from a total registration, to date, of slightly over 26,000 patients for the Westside Neighborhood Health Center.

The above figures include registrants for the Mental Health Team, and are presented for comparison with team registration figures in the material that follows.

Composition of the Mental Health Team and Early Experiences

Mental Health Team V is one of six Mental Health Teams of the Division of Psychiatric Services, Department of Health and Hospitals. Four of the teams have been decentralized from the main site at Denver General Hospital. Two of the teams, including Team V, are now parts of the two Neighborhood Health Centers.

Mental Health Team V consists of a psychiatrist, two psychologists, one psychiatric nurse, two social workers, and two mental health aides recruited from the neighborhood. The composition of the team has varied somewhat from time to time depending upon personnel

changes and shifts, but essentially reflects the discipline described above. At times the team leader has been a psychiatrist, at times a psychologist with consulting psychiatrists. Of the senior (or professional) team members, one psychologist is Spanish-speaking (the author of this paper, though not of Hispano descent) and the mental health aides are Spanish-speaking.

In September of 1967, Mental Health Team V was placed in two units of a housing project not far from the proposed site of the anticipated Neighborhood Health Center. That is, the Mental Health Team preceded the Health Center into the community. Actually the Health Center was not to be in existence for another year. (It should be noted here that the Neighborhood Health Centers are OEO projects that function under contractual agreements with the Denver Department of Health and Hospitals.)

With the placement of Team V in the two units of the housing project, it was now ready to receive patients at the community level. Actually we had some carry-over of patients whom we had collected at Denver General Hospital while the team was being organized. These were patients who lived in the catchment area defined for our team and were now seen at the housing project site. The housing project in which we were now located was very densely populated by Hispano families.

The physical make-up of the housing units in which we were located was an extremely important feature in our functioning. This was not obvious at first but, we were to learn later, a crucial factor in our contacts with the Hispano population.

The structure of the housing units is such that, upon opening the front door, one steps immediately into the "living room." Consequently, a patient, upon entering, was immediately in contact with a receptionist (who was Spanish-speaking), and also in contact with one of our aides. Since we were not a part of a larger unit at that time, we registered the new patients ourselves; as a patient entered our living room-reception room, he was assisted in his registration by the aides on duty and the receptionist. He was then sent on to whatever professional staff member was available, or to a specific staff member with whom an appointment might have been made. The living room-reception room (we were to find out later) was a critical "geographical feature" because it allowed the individual to enter our system immediately. That is, we were "immediately accessible" to him. (If the words immediate and accessible appear repetitious, please bear with them; their significance will become apparent shortly.)

Following our placement in the housing projects, we began to structure our appointments with patients in the traditional way that most mental health clinics do to start with. Within a short time it became obvious that this would not work. The neighborhood people found that we were accessible on their first contact with us, and felt that we must therefore be accessible in other instances. Additionally, they found that we had services that were functionally useful to them: We had Spanish-speaking personnel; we had staff members who knew their way around the various other social agencies; they found out that a prescription was available to them without hours of waiting. Many of these factors were conveyed to the population through our aides and other patients. Actually what appeared to happen was that the Mental Health Team was willing to accept the single most descriptive characteristic of the neighborhood—"crisis"—and to adjust their thinking to it.

We were willing to accept the fact that a poverty-stricken population such as this is beset by endless intermittent

crises. Their average income is often $3,500 or less; they are culturally and educationally deprived; the existence of many father-absent families, of children on probation and adult males with prison records—all these factors contribute to an extremely precarious existence.

Consequently, a patient operating in this framework may be seen for the first time on a Monday and given an appointment for the following Monday. However, he may appear at your door on Friday, in an upset state because of a new crisis, and ask to be seen at that time. Interestingly enough, Mental Health Team V was apparently made up of individuals of sufficient flexibility to respond to this feature of the neighborhood and to act accordingly. Patients were seen when and where the need appeared greatest. Appointments were still made, but it was informally agreed upon that a patient appearing without an appointment would be seen by someone, either a professional staff member or an aide. This condition, of course, did away with the traditional 50-minute hour of psychotherapy, since the demand would not allow it. Patients could be seen for 5, 10, or 50 minutes, depending upon the need.

It might be well at this point to mention the relationship between the professional and nonprofessional members on the team. In time, we began to despise the word "professional" because it served only to create a gap between the professional and the indigenous aide. Consequently, this was discussed within team meetings with all the staff present, which resulted in an agreement that everyone would call everyone else by their first names and no titles were to be used. If the aides felt that titles should be used in the presence of a patient, that was left up to them. Additionally, if a distinction became necessary between professionals and nonprofessionals, the term "senior" staff member appeared acceptable. In any case, these adjustments appeared to help, and the crucial feature was, of course, the attitudes of those involved. A professional who perceives an aide as one in a lowly position will convey this whether he addresses the aide on a first name basis or not.

An additional adjustment was to extend the activities of the aides who assumed the work of co-therapists in group therapy as well as making home visits and initial intake interviews.

Along with these modifications, our new-patient load began to increase to an average of 90 new patients per month in addition to our continuing patient load. At that time, 70 per cent of both new patients and monthly patient contacts were Hispano-surnamed individuals. This figure closely approximated the proportion of Hispano registrations for the Neighborhood Health Center mentioned in the opening paragraphs of this paper.

Hispano Patient Visits Decline in the Team's New Location

While Team V was in operation in the housing project, the Westside Neighborhood Health Center was completed and all health departments were drawn together into one building. Team V was also moved into this building which was actually little more than a block from our original location.

In the new center, Mental Health was placed on the second floor; incoming patients were processed through an admissions procedure similar to the average hospital routine. Patients for Mental Health were no longer registered directly by mental health aides, but were processed by admissions personnel. Within the first month in this new location, the proportion of Hispano contacts fell from 70 to 50 per cent and continued to decrease for the next six months. This decrease was in terms of proportions, of course; our over-all numbers of new patients increased to an

average of over a hundred a month, but the proportion of Hispano visits continued to decrease to a low of 35 per cent of the total.

After considerable discussion as to the causes of this situation, a new procedure was developed. The team again registered new patients directly and a "drop-in room" procedure was instituted. The drop-in room consisted of a fairly large room which was open from 10 A.M. to 4:30 P.M. daily during the week. A senior staff member and an aide were assigned to the room during these hours. Here, any new patient was registered and seen by the assigned staff members. With this procedure, new patients calling in or referred by other health center departments were told to come in immediately should they desire. Interestingly enough, this process more or less reestablished the procedures that were employed by the team while operating in the housing project. Of course the drop-in system (like our housing project system) eliminated any waiting lists and again allowed new patients immediate access. Additionally, the drop-in room served patients already in the system as a place of respite—for a few moments, or hours if necessary—from some upsetting situation, or simply as a place to sit and talk and drink coffee with whichever staff members were available.

With this additional adjustment in our operation, the proportion of Hispano patient contacts began to change again. Whether the change was due directly to this alteration is naturally difficult to determine directly. Nonetheless, patient contacts with the Hispano population began to rise from the low of 35 per cent to 50 per cent within the next two months.

Subsequently to this, another alteration took place in Team V's activities. The team was moved out of the main building of the Health Center into a separate unit which is on the street level. This new unit offers more space for our activities and again we believe more "accessibility" to our patients. We are continuing to operate with the same drop-in room arrangement and, again, have noticed a further increase of Hispano patient encounters which, by the middle of January, 1970, have risen to 65 per cent. An increase in patient use of the drop-in room has also been apparent; on some days, as many as 45 individuals pass through the room.

Language and Cultural Considerations

So far, this paper has been concerned with topographical, geographical, and procedural features that appear to facilitate or hinder the uses of mental health services by the Hispano population. At this time we would like to move to a discussion of language and cultural features concerning this population.

As the only Spanish-speaking member of the senior staff of Mental Health Team V, the author is confronted with certain considerations that do not beset other team members. To expand these considerations, it becomes necessary to picture the Spanish-speaking population presently inhabiting the city of Denver. In terms of Hispanic culture and language, this group is extremely heterogeneous. Although the vast majority have a knowledge of both English and Spanish, there are great extremes in the frequency of language usage. It is possible to find Hispano people who claim not to speak any Spanish at all. In this group, the author usually finds that people understand the language even though they claim not to speak it. There is another somewhat small segment who speak only Spanish and have a small comprehension of English words. Still another group—comprised of Cuban refugees and immigrants from Mexico and other Latin American countries—seeks out mental health services, usually because of problems of adaptation to their

new environment. There are also Hispano people born and raised in the United States, who prefer when possible to speak in Spanish or to speak in a combination of English and Spanish. When these people wish to express themselves to a mental health worker, it is imperative that the worker have a knowledge of Spanish. Naturally, the more bilingual or monolingual in Spanish a community is, the more important it is for the professional mental health worker to speak the language.

However, even more important than the language itself, is the attitude of the mental health worker. To speak Spanish and yet have an unaccepting attitude toward the Hispano is worse than to have a positive attitude and not know the language.

Such attitudes have much to do with the acceptance of the folkloric and culturally different modes of thinking that seem to prevail in Hispano communities. It is quite possible that some of these differences are evident in other minority groups but perhaps in other forms. For instance, Hispano patients who report hearing voices do not (in this author's mind) represent the same qualitative type of aberration as would an Anglo patient with the same complaint.

The reason for this is that there are certain cultural factors that allow for and possibly encourage the hearing of voices. There is a famous fable called the "Llorona," which many Hispano people believe originated in sections of the United States but it is also known in old Mexico. This is the story of a woman who is believed to have caused the drowning of her baby. She is condemned to walk the face of the earth in search of the child into eternity. In the process she weeps, and she is said to be heard at night; hence the name Llorona, weeping woman.

An indication of the prevalence and acceptance of this story was recently demonstrated when a sixth grade class in a school not far from the health center was given an assignment in an English class to write a fairy tale. The next day, 75 per cent of the class presented the story of the Llorona. Furthermore, it has not been uncommon for teachers to call this writer to ask what to do with a child who tells them he has heard the Llorona. Often these teachers feel they should try to convince the student that he has not heard anything, which usually makes for a disruptive situation. We have known of student groups where it was actually the "in thing" to have heard the Llorona.

Another cultural factor along these lines has been manifested by certain teen-aged girls who have entered our clinic; they reported that they had heard voices telling them to become a nun. (This may not be so different from the idea existing in the Anglo society that one gets "the call" to follow a religious occupation.)

However, these teen-aged Hispano girls did not continue hearing the voices; their report appeared to be a response to a variety of stress conditions within their families. Furthermore, the quality of their description of these voices did not appear to us to have the same significance to them as auditory hallucinations might have if experienced by an Anglo patient. In fact, in our experience, non-English-speaking Hispano patients, who have been temporarily incarcerated for what was reportedly bizarre-appearing behavior, never sound as bizarre when being interviewed in Spanish. One wonders if such people, when unable to communicate, might perhaps be given to episodic outbursts of peculiar-appearing behavior which may be only reaction to situational frustration, and not necessarily demonstrative of a psychotic process at all.

Interestingly enough, when the author tested non-English-speaking Hispano patients with standard psychological tests —patients who had been classified in a

variety of psychiatric categories by other criteria—they did not test out significantly different than their Anglo counterparts in similar categories. Only in one factor did the Hispano differ and that was in terms of lability.[1] He appeared more labile than his Anglo comparison group and consequently more prone to express emotion—a feature not always acceptable to a majority culture more dominated by controlled emotional displays.

Additional cultural factors, that have proved complicating and often confounding for Team V to deal with, are the extended family and the relationships between fathers and sons.

Extended Family

Within our experience, the Hispano families with which we are in contact are essentially patriarchal. In somewhat similar fashion to Italian families, children are always children to the parents. As the children grow up and marry, their families only become extensions of the original unit. This process has been described and discussed by a number of investigators.[2] Through this system, families who live in Denver have roots in the San Luis Valley of Southern Colorado, New Mexico, Texas, and Arizona. There is often considerable movement back and forth between these areas, usually through these familial channels.

On the positive side, such a system offers assistance from several quarters; in some cases, where families become too large, some of the children may be raised by grandparents or uncles and aunts with very successful results.

This process, which obviously developed under rural conditions, contains some negative features when transported to an urban setting, since nearly all members of the extended family living in the urban setting are under considerable economic and adjustmental strain. If a tragedy strikes some members of the family, instead of receiving help from the other members, they become an additional strain on them; instead of uniting the total unit, tragedy causes much stress and anger over who is or is not doing his part. This is especially evident in families where a retarded child is cared for by the mother over many years. When the mother dies, the family units become battlegrounds of confusion and guilt over what is to be done with the retarded person who by now may be in his late forties or older. Suggestions that such a person should be placed in an institution are met with rejection and further dissension and guilt.

When matters of separation and divorce occur, these extended families again become battlegrounds with various members aligning themselves with either husband or wife, becoming interfering rather than assisting agents.

Father and Son Relationships

The father and son relationship constellation has been a difficult situation when disruptions occur, and one that our team has not dealt with successfully. In certain instances it develops that, from our standpoint, a nine- or ten-year-old boy experiencing some role confusion might benefit from some activities involving closer contact with his father. However, we have seen that the father in these families has no techniques to relate to his son in this way. The raising of children is the mother's job; the father's role is to work and to form associations with his *compadres*. If he relates to his son closely, it is when they perform some work task together. Again, this was a functional system in a rural setting, but it breaks down when transported to an urban situation; there are very few work tasks that father and son can perform together in the industrial city. Oddly enough, we have seen this problem occur in families that have been removed from rural life for many

generations, but in which these earlier relationship patterns continue. Truly, old ways die hard. An interesting aside to this is the fairly large number of individuals born and raised in Denver—who have no doubt had little schooling and speak no English at all—who have presented themselves to the Health Center, or are referred to Mental Health by friends.

Problems of Traditional Methods

Other traditional mental health approaches meet with difficulty and often with failure, because of the cultural and familial structures mentioned above. In the experience of our team, for example, it has proved difficult to keep Hispano patients in group therapy. This problem has occurred in all age groups, not only with older patients. Our groups are organized on demand and consequently cannot be structured on any particular basis. Therefore, the groups are usually composed of peoples from all the ethnic groups coming into the center. Most groups contain about equal numbers of Hispano and Anglo patients. Initially, a group may have a majority of Hispano patients but, within a short time, they will begin to drop out. In an effort to find out why, the author began a session by asking those present why the Hispano members of our groups would not continue in the meetings. The reply from the Hispanos was an follows:

"We are not used to talking in groups. Often we feel that if we want to say something it will not sound right—the words will not be the right ones. We do not always know the right English words."

It was then suggested that, when this occurred, they might use the Spanish words or phrases, and the author or any group member who wished could translate. It was agreed that this would be tried at that time. Soon it became apparent that we had two groups: one conducted in Spanish, one in English. Oddly enough, the Anglo members became agitated because they felt, "they did not know what was going on." They felt this way even though everything said was translated. Subsequently, after more discussion, it was agreed upon by the whole group that this was obviously not the way to develop cohesiveness. It was agreed that Spanish should be used but not to the extent of causing a division within the group.

As things are now, some Spanish is used—sometimes purposely by the clinician, thus leading the group to stimulate certain members. However, this has not solved the drop-out rate of the Hispano patients. One might argue here, that perhaps these groups should only be composed of Hispano individuals so that the language could be used at will. But this sounds too much like a segregated experience, something that we are all obviously attempting to avoid, and which does not sound very positive in terms of mental health.

Because of these experiences the author has concluded that, although group therapy may have certain uses for this population, it must also appear confusing to the Hispano. Essentially, to function in group therapy one must verbalize, which is a problem for the Hispanos, as already mentioned. Next, it is based upon the idea of a "group," or a "group activity." In his culture, the Anglo is always part of some group; indeed his political and economic life are based upon group memberships. But the Hispano does not operate this way—a fact that has been glaringly apparent in the course of the minority-group strivings which have emerged in recent years.

The Hispano tends to function individually, and it is our feeling that he sees groups more in terms of family groups or friendship groups (*compadres*); not in terms of forming a group to accomplish some specific task or to talk about one's feelings. As indicated earlier, there is some test evidence as well as observable evidence that the Hispano tends to demonstrate his emo-

tions more easily than his Anglo counterpart. It is *not unacceptable* for both males and females to weep in public in the Hispano community. Nor are outbursts of anger unacceptable. So when we set up group therapy and encourage individuals to verbalize and demonstrate their emotions, it must appear to the Hispano that we are saying, "here is a place that you may come once a week and cry for an hour and a half." This must sound strange, indeed, since this is not a real problem in Hispano circles. Additionally, to the Hispano, there is apparently a difference between showing one's emotions and talking about them. A peculiar paradox appears here. We assume that individuals suffer when they cannot talk about or demonstrate painful feelings. Yet the Hispano person, who is apt to demonstrate his feelings, still appears to have some of the same types of problems as do those patients whom we are encouraging to express themselves either verbally or nonverbally.

An additional feature that was presented by Hispano patients in group discussions was brought out by two male patients with rather long histories of paranoid episodes. These two men both claimed that they believed curses had been placed upon them by someone in the neighborhood, and they felt they could not openly discuss this because the group might ridicule them for such beliefs. Both of these individuals were men in their middle thirties who had been born and raised in large cities (Denver and Detroit). This is mentioned here because it is often thought that these beliefs are for the most part relegated to isolated rural populations. Individual patients have told us that, for a certain amount of money, a curse may be placed upon someone. Other patients indicated that they have visited a *bruja* for "medicines" or to have the cards read to them.

There is much being written these days about the *bruja* (witch), the *curador* (healer), and the *curandero* (medicine man or curing man), all of whom apparently practice types of folkloric medicine and folkloric psychiatry.[3,4] No doubt these practitioners represent natural care-givers who are sought out for a variety of emotional and physical reasons. Within our operation, we have only heard of the *bruja,* who apparently disperses certain herbs and reads futures in the cards as mentioned above. And, although we have indicated to our patients our willingness to meet and cooperate with these people, we have been unable to contact a single one in a two and a half year period. Probably we are viewed by these practitioners with considerable suspicion which hopefully will disappear in time. It is an interesting fact that those of our Hispano patients who are willing to admit it, will state that they will seek out these healers; yet they return for our services as well, without any apparent confusion as to the different approaches to problems employed by us and the healers.

In the above section, an attempt was made to describe the various cultural conditions of the Hispano population which our Mental Health Team encountered and with which we did not always deal successfully. However, we feel that we have made successful modifications which appear in the following section. The term successful, here, refers to numbers of patients who present themselves to us, seeking our services. And here we feel we are successful because these numbers average out to 102 new patients per month, with the average number of Hispano individuals again approaching 70 per cent. Additionally, we feel that our methods are successful, because 80 per cent of our patients come to us through some community contact other than the Westside Neighborhood Health Center: Schools, welfare workers, former patients, friends, action centers, and organizations resid-

ing directly in the community serve as referral sources for most of our patients. This, we feel, reflects the certain confidence which we have gained from the community.

Successful Approaches and Recommendations

1. *Accessibility*

Mental health services are made available in a variety of ways but, from our experience, we feel a team made up of several disciplines is the most effective. This team should be placed directly within the neighborhood which is to be served. Preferably, this team should occupy a building that is easily accessible to available transportation and team quarters should be on the ground floor. If the team is part of a medical unit, these suggestions should still be taken into consideration. Since there remain certain stigmas attached to mental health among all groups in society, the location of mental health facilities, simply by being hard to get to, can in itself support the unwillingness to come there for help.

2. *Mental Health Patients Registered by Mental Health Personnel*

For the Hispano individual, the first contact is of extreme importance, whether it is by phone or in person. Consequently, a bilingual receptionist is indispensable. Our Spanish-speaking receptionist is probably the most important member of the team in this respect, since she is usually the first contact.

3. *Crisis Orientation of Team Personnel*

Mental health patients should be registered by mental health personnel, preferably by Spanish-speaking mental health aides familiar with the neighborhood. No waiting lists should be established; a new patient should be seen as soon as he feels he wishes to come in. That is, this decision should be the patient's and not left up to a devised structure that excludes the needs of the neighborhood. Consequently, the team personnel should be rotated so that each member has a time when he sees only new incoming patients. Subsequently, the operation will take on the characteristic of an emergency room to a certain extent.

Again through our experience, the pattern of the Hispano patient has been that he comes to us during some crisis. He is seen for an average of five sessions which may occur once a week, or every day for five days, or within several days. As the patient begins to feel better, he begins to miss his sessions and will probably not be seen again until his next crisis.

Within this crisis framework medications become an important tool although our team has modified its uses of them. Since most of our patients come to us because of some critical incident, they are usually quite distressed and therefore psychotropic drugs are often employed. However, in an attempt to encourage the patient to return, he is seldom given more than a two-week supply of medicine and never given more than a month's supply. This method requires a patient to return soon for his medicine. It also prohibits certain patients from being disposed of by simply being given a prescription with several refills and, thus, not seen again for several months.

4. *Necessity for Having Spanish-Speaking Personnel*

If mental health services are to be offered to a population largely composed of Spanish-speaking people, the obvious conclusion is that the more Spanish-speaking mental health workers one has on the team the better. But Spanish-speaking professionals in this field are few and difficult to find. If such professionals cannot be found, then

a great deal of responsibility falls upon Spanish-speaking mental health aides. However, in our operation, with one Spanish-speaking professional and four Spanish-speaking aides, we have been able to maintain our non-English-speaking patients very well. Here, of course, the indigenous aide is an indispensable person who has demonstrated (on our team at least) the ability to assist and follow patients as competently as the professional.

Again, to reiterate a crucial point, it has been our feeling that an attitude of acceptance of the Hispano patient, with all of his culturally different modes of behavior, is far more important than only speaking his language.

5. *Use of the Drop-In Room*

As described before, the drop-in room serves as ready entrance for new patients and a place to "drop in" for old patients. It offers the accessibility to our services which we are convinced is the key to serving the Hispano community.

In an expanded form, the drop-in room could approximate a neighborhood day care hospital. In many cases we have had patients come into this room daily and remain all day, as an alternative to hospitalization. This latter practice has been so successful that the state hospital installation in the Denver suburbs (Fort Logan) has discussed with us their possible intention of closing down the number of beds in their institution that are allotted to our catchment area. This is because they receive so few patients from us and, interestingly enough, have not received a single Hispano patient in the last year.

To recapitulate, the philosophy set forth in this paper holds that mental health services to the Hispano should be accessible, immediate, in response to anticipated recurring crises, and with short-term supportive goals mostly on an individual basis. Traditional long-term methods, aimed at the development of insight, do not appear appropriate with this population.

6. *Community Involvement*

As indicated earlier, the greater portion of new patients are referred to this Mental Health Team by agencies, organizations, and individuals located within the community—through their contacts with the Neighborhood Health Center Board of the Health Center. This board consists of representatives indigenous to the community and serves to reflect the health needs of the community. As part of this unit, a subcommittee for mental health was formed which concerned itself specifically with the problems of mental health. The existence of these two bodies brings to center staff the direct responses of the community concerning the adequacy of the services being offered. What is perhaps even more crucial, the board reflects the feelings of the community in terms of *how* services are being rendered.

Realistically it should be apparent that the success of a mental health unit, or indeed any health center unit, is necessarily related to being attuned to these representative groups. One does not have to look far in present-day health literature to find descriptions of insensitive, rejecting professionals delivering treatment to socially and economically deprived populations. The existence of the groups described here, and the necessity for health personnel to meet and cooperate with them, cannot be overemphasized.

7. *Relationships with Medical Services in the Health Center*

In keeping with the Health Center philosophy of offering comprehensive care to a poverty population, the Mental Health Team functions as an integral part of the total operation. Relative to the earlier discussion of "geographical"

placement of the Mental Health Team, it was not to be implied that the team should be separated from other units of the center, but only that it should be (and was) placed in a more accessible proximity to patients. At present the team is housed in a building adjacent to the main center, but this does not separate the services. Indeed, it is very necessary not to be separated from medical services, since many patients who are referred to mental health are often suffering from medical problems as well.

This is probably truer of our patient group since they tend to carry their crisis orientation into all aspects of behavior, and neglect physical problems that may be contributing to what they perceive as only "nervousness." Consequently, there is considerable interchange within all other sections of the Health Center. In several instances, treatment approaches are carried out on a cooperative basis. Some examples are a "weight watchers" group operating jointly under the Nutrition and Mental Health Sections. A drug addicts' group operates similarly. Individual patients from the Pediatric and Adult Medical Sections are referred to Mental Health for psychological and psycho-educational evaluations. There is, therefore, considerable interaction throughout the various services. Again, the recurring theme throughout this paper of "accessibility" applies to the availability of *all* health services in a poverty program.

It should be noted at this point that the procedures discussed here are extremely taxing to the staff of the team, and fatigue is chronic with all of its members. Whether this could be altered by a larger staff, or whether a larger staff would simply mean an even larger patient population, is difficult to say. In any case it is our hope that the material appearing here may be helpful to other mental health workers dealing with a similar population.[5]

Summary

This paper discusses the experiences of a mental health team composed of professionals and indigenous persons in an urban setting populated by an ethnic group of predominantly Hispanic descent. The experiences herein cover a two-year period and describe successful and unsuccessful approaches to this population. Some insights into the cultural responses to mental health are presented, along with an outline of methods that proved successful for this team, which hopefully might be similarly employed by other mental health workers operating within a similar framework.

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