IMPROVISED CARE: PUBLIC HEALTH WITH LATINOS IN NEW IMMIGRANT DESTINATIONS

BY

DEIRDRE LANESSKOG

DISSERTATION

Submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy in Social Work
in the Graduate College of the
University of Illinois at Urbana-Champaign, 2016

Urbana, Illinois

Doctoral Committee:

    Associate Professor Lissette M. Piedra, Chair
    Clinical Associate Professor Janet Carter-Black
    Associate Professor Stacy Anne Harwood
    Professor Sandra Kopels

ABSTRACT

As Latino immigrants continue to settle in new destinations across the U.S., human service institutions in these communities struggle to meet the intense needs of their increasingly diverse clients (Jiménez, 2007). Health care providers in particular are often ill-equipped to serve Latino newcomers who speak limited English, come from different cultures, and who are more likely than their peers in traditional destinations to be poor (Kandel et al., 2011), uninsured (Portes, et al., 2012), and undocumented (Passel & Cohn, 2009). The mismatch between Latino clients' needs and providers' capabilities raises doubts about the long-term prospects for these communities and their new residents. Moreover, providers' abilities to overcome such challenges are critical to ensuring the well being of the 17 million children of immigrants who are mostly American-born and yet are less likely than the children of American parents to receive human service supports (Perreira et al., 2012). This study examines how human service institutions in 18 new destinations respond to the needs of their growing Latinos populations.

This qualitative study used 28 in-depth interviews with 30 public health administrators and front-line staff to identify how agencies serve Latino clients in new destinations. I used a two-step process of purposeful and snowball sampling to recruit participants (Patton, 1990). First, I invited the administrators from 28 Illinois counties with fast-growing Latino populations to join the study. Second, I asked administrators to nominate Latino-serving employees to participate. I analyzed the data using open coding to identify themes in the data, axial coding to determine the ways themes related to one another, and theoretical coding to tell the story of how institutions respond to this demographic shift (Strauss & Corbin, 1990).

Findings from this study suggest that inadequate structures and resources for serving diverse clients prompted new destination public health agencies to improvise service delivery for

Latino residents. The lack of government oversight of human services work with immigrants led agency administrators and staff to use considerable discretion in their work. Further, the dearth of bilingual professionals in these communities led administrators to rely heavily on non-professional bilingual clerical and intake staff to address Latino clients' complex needs. Consequently, agencies adopted a plethora of unsystematic and untested practices to address the heightened linguistic, cultural, and contextual barriers their Latino clients experienced. Latino immigrants are likely to encounter different types of services, levels of access, and quality of care across these communities.

This study highlights the need for increased attention to human service delivery in new destinations where Latino clients' needs and providers' capabilities are often incongruent. It underscores the need for additional research to identify evidence-based interventions that simultaneously attend to clients' needs and agencies' limitations. This research also highlights the need for strategies to overcome a scarce bilingual workforce, including appropriate guidelines for the use and supervision of bilingual non-professionals. Finally, this study emphasizes the need for enhanced government planning, oversight, and resources for human services with immigrants in the many new destinations across the country.

TABLE OF CONTENTS

CHAPTER ONE:

INTRODUCTION

The United States is experiencing a tremendous shift in population as large numbers of

Latinos, including many immigrants, move to parts of the country unsettled by newcomers since

the turn of the 20th century (Lichter & Johnson, 2006, 2009). This demographic trend is driven

by economic, social, and political forces similar to those that brought waves of poor, and yet

resourceful immigrants to America's largest cities over 100 years ago. However, the cities,

suburbs, and small towns receiving so-called "new destination" migrants, are largely unprepared

for the diversity and intense human services needs new residents bring (Jiménez, 2007). These

newcomers and their families are often poor, with limited education, English proficiency, and

personal resources (Fry, 2008). Further, a disproportionate number are undocumented (Passel &

Cohn, 2009), rendering them ineligible for many social safety net programs, unable to participate

fully in civic life, and fearful of attracting the attention of authorities (Lichter, 2012). Human

service institutions in new destinations have the potential to provide supportive services and to

help immigrant families incorporate into their new communities (Lamphere, 1992; Skerry,

2003). However, the human service infrastructure in new destinations is often underdeveloped,

with scarce resources and few bilingual professionals who might facilitate service delivery

(Lichter & Johnson, 2009). The resulting gap between Latino residents' needs and human

service providers' capabilities raises doubts about the long-term prospects for new destination

residents and their broader communities.

This service mismatch is especially concerning in health care, where across new and

traditional destinations Latinos experience greater health risks, greater incidence of certain

diseases (Centers for Disease Control and Prevention (CDC), 2014; Livingston, Minushkin, &

Cohn, 2008), and greater barriers to care, especially for immigrants (Livingston, 2009; Portes, Fernández-Kelly, & Light, 2012). Across several health indicators, U.S. Latinos fare poorly compared to other groups, experiencing higher rates of diabetes (Schneiderman et al., 2014), teen pregnancy (Patten, 2014), and new HIV infections (CDC, 2014). Further, access to health care is severely limited for the nearly 30% of all citizen Latinos and half of all immigrant Latinos who have no health insurance (Brown & Patten, 2014). For new destination Latinos, these disparities and barriers are likely amplified by systems of care designed for clients who speak English, are familiar with U.S. institutions, and who possess insurance or the ability to pay for services (Portes, Light, & Fernández-Kelly, 2009). Furthermore, health services are delivered by a complex and disjointed network of private hospitals and clinics, non-profit and federally funded clinics, for profit and non-profit specialty providers (mental health centers, substance abuse treatment centers) and public health agencies, all of which may choose to respond to growing Latino immigrant populations in their own ways.

The responses of human service institutions to demographic change in new destinations have significant implications both for newcomers and the communities in which they settle. Yet, we know little about the responses they are adopting, who and what forces shape these responses, and the extent to which these efforts are supported by the staff responsible for service delivery. This study illuminates the ways human service institutions respond to growing Latino populations by examining the ways public health agencies in Illinois new destinations serve their growing numbers of Latino clients. The study identifies policies and practices agencies use, the factors that facilitate or constrain agency options, and the ways agency administrators and Latino-serving staff influence and perceive their agencies' efforts. In the following paragraphs, I present a brief overview of the study's significance, theoretical framework, gaps in knowledge

addressed, and methodological approach. I also provide a brief synopsis of subsequent chapters of this dissertation, in which I address these topics in greater detail.

Current Study

Significance

This study enhances our understanding of human service work with Latino immigrants in new destinations. The study's main goal is to identify potential practices institutions and workers can use to better serve Latino clients in this context. The study's secondary goals are to identify potential policy changes needed to facilitate service delivery and to lay the groundwork for future research on additional practices institutions might adopt. We already know a great deal about the challenges these communities, their human service providers, and, most importantly, their Latino residents face. This study contributes to the literature by highlighting strategies institutions can use to overcome these challenges.

Theoretical Framework

This study is informed by three theories about the ways in which institutions and their workers influence human services work: a) institutional theory, b) bureaucratic incorporation theory, and c) the theory of street level bureaucracy. These theories suggest that institutions' work with clients is shaped by both external and internal forces. Externally, laws and policies about immigrants and immigration circumscribe agency practices and policies. However, perhaps more importantly, internal forces such as the professional and personal ethics of employees who view serving immigrants as part of their mission, may drive institutions to respond more favorably and proactively to immigrants needs. Together, these theories suggest that institutions and their workers have considerable discretion in serving Latino immigrant clients, whether to the benefit or the detriment of clients.

Gaps in Knowledge

This study addresses several gaps in the knowledge about human services work with Latino immigrants. First, unlike the bulk of the research on human services policies and practices with Latino immigrants, this study focuses on institutions in new destinations rather than traditional urban destinations. Second, in contrast to prior research that has centered on the experiences of bilingual professionals, this study incorporates the perspectives of administrators, as well as para- and non-professional Latino-serving staff in serving Latino immigrant clients. Third, while many studies address hospital, clinic, and individual health care provider work with Latino immigrant clients, this study brings much needed attention to the role public health agencies play in meeting Latino immigrants' needs. Finally, this study is one of the first to assess whether public health administrators, like public school superintendents, police chiefs, and to a lesser extent other human services administrators, proactively respond to immigrants' needs in spite of little political pressure to do so.

Research Design

This study uses a qualitative approach, including semi-structured interviews and thematic analysis to investigate three research questions:

1) What factors influence how human service institutions respond to Latinos in new destinations?

2) What responses do human service institutions use to serve Latinos in this context?

3) How are these responses influenced and perceived by agency administrators and Latino-serving staff?

Institutional context. Social service agencies, hospitals, federally funded health clinics, mental health centers, schools, public health departments, and other private, public, and non-

profit providers generate the human service safety net for vulnerable residents. I conducted this study with public health agencies because their broad mission to protect the public's health authorizes, but does not necessarily require, agencies to work with all community residents, including immigrants and undocumented people. Public health's broad services domains include infectious disease, maternal and child health, health education and promotion, emergency response, and environment health (e.g. restaurant and septic system inspections), providing many opportunities for interaction with immigrant and minority populations. Additionally, public health agencies rely on funding from federal, state, and local governments and so are subject to the human services policies of all three levels of government, but they are locally governed and sensitive to the needs of local populations (Meyer & Weiselberg, 2009; National Association of County and City Health Officials (NACCHO), 2014). Finally, like many new destination institutions, public health agencies are dominated by a primarily white, non-Hispanic workforce (Jones-Correa, 2008), and are led by administrators of whom nationwide 93% are white and only 2% are Hispanic (NACCHO, 2013).

Dissertation Overview

In subsequent chapters of this dissertation I describe this study and its findings in greater detail. In chapter two, I examine the literature on new destinations, their human service challenges, theories about institutional and worker behavior, and the strategies used to overcome service barriers in new destinations. Chapter three details the study's qualitative methods, study sites, thematic analysis, and the steps to ensure trustworthiness. Chapter four examines the contextual factors that influence agencies' responses and administrators' efforts to serve Latino immigrants in new destinations. Chapter five describes the response individual agencies use, and the influence of Latino-serving staff presents the perspectives of administrators and frontline

workers who influence their agencies' work with Latino residents. Chapter six summarizes the

study's findings and identifies implications for research, practice, and policy.

CHAPTER TWO:

LITERATURE REVIEW

In this chapter, I review the literature that informs this study. First, I describe the impetus for new destination migration and detail Latino immigrants' experiences in this new context. Second, I explain why human services systems in new destinations are unprepared to meet Latino immigrants' needs. Third, I provide a theoretical framework for understanding the considerable flexibility human service institutions and their workers have in shaping human services delivery. Fourth, I detail the strategies new destination institutions use to overcome service delivery challenges with immigrants. Finally, I explain how the current study addresses the gaps in this literature.

New Destinations

Latino immigrants move to new destinations in search of low-skill jobs, lower costs of living, and a higher quality of life than they can expect to find in traditional urban centers (Leach & Bean, 2008; Kandel & Parrado, 2005). Before the arrival of Latino residents, many new destinations suffered from losses in population that contributed to economic downturns. Especially in more rural areas, the arrival of Latino residents offsets these decreases in population and provides much-needed customers for local housing markets, stores, and public schools (Donato, Tolbert, Nucci, & Kawano, 2008). For workers with limited education, skills, and knowledge of English, these communities offer opportunities, including ample work in fields such as agriculture, manufacturing, food processing, and hospitality. However, these positions offer low wages and do not typically include health insurance or other benefits. They also tend to attract a disproportionate number of undocumented workers (Passel & Cohn, 2009), who are ineligible for Medicaid and most other social safety net programs. Consequently, in spite of their

hopes for a better life, new destination Latinos are more likely than their urban peers to live in poverty (Kandel, Henderson, Coball, & Capps, 2011) and to be uninsured or underinsured (Portes, et al., 2012). As a result, they rely more heavily on emergency rooms, incur more hospitalizations, and generate greater medical bills than their traditional destination peers (Gresenz, Derose, Ruder, & Escarce, 2012). Thus, for these newcomers, life in new destinations brings a mixed bag of opportunities and potential pitfalls, especially in health care.

Latinos also encounter other challenges that can make life in new destinations more challenging than in traditional destinations. New destination residents are more likely than their urban counterparts to report feelings of isolation and fear (Harari, Davis, & Heisler, 2008). These feelings may stem from experiences of loss associated with migration or from the absence of supportive co-ethnic communities to help navigate an unfamiliar landscape. They may also arise from fears of deportation, or from more frequent experiences of discrimination and exclusion in new destinations (Jiménez, 2010; Marrow, 2011; Massey, 2008; Menéndez Alarçon & Novak, 2010; Zúñiga & Hernández-León, 2005). The accumulation of these negative experiences is certainly worrisome for the health and well being of immigrant adults. However, it is particularly concerning for the 17 million children of immigrants (Perreira et al., 2012). Although mostly American citizens, these children's life chances are greatly impacted by their families' abilities to meet basic needs and yet, they are less likely than the children of American parents to receive human services supports. In short, the arrival of Latino immigrants often invigorates new destinations, but the long-term outcomes for these communities may hinge on how well they support their new Latino neighbors.

Why are human service providers unprepared?

Local providers are ill prepared to meet immigrants' needs and part of this problem stems from the historical development of our country's human services system. When the largest waves of immigrants arrived in the U.S. at the turn of the 20th century, the founders of the field of social work claimed responsibility for their protection and incorporation into society (Abbott, 1995; Ehrenreich, 1985; Park, 2006; Park & Kemp, 2006). Social workers in urban immigrant communities initiated practices that later developed into human services programs for immigrants and established residents across the country. They served clients in community centers and in clients' homes, providing food and income assistance, health and sanitation instruction, home management, job training, English classes, probation supervision, child care, and early childhood education (Ehrenreich, 1985; Specht & Courtney, 1994). They also mediated tensions between immigrants and their neighbors, landlords, employers, and new communities (Ehrenreich, 1985). These early practices with immigrants and other vulnerable populations were later formalized into a variety of federal (e.g. Medicaid, food stamps), state (e.g. preschool, child welfare), and local (e.g. health inspection, primary education) initiatives to address a plethora of social issues. These programs are delivered by a complex web of institutions including social service agencies, hospitals, clinics, mental health centers, schools, and religious organizations.

This broad system of federal, state, and local human service bureaucracies was built between the 1920's and the 1960's, during a period of very low immigration (Engstrom & Okamura, 2008). Consequently, contemporary human services institutions were not designed for immigrant clients. Rather, they were created for clients who speak English, know how and where to access services, understand eligibility guidelines (Engstrom & Okamura, 2008), and possess private or public health insurance or other means to pay for services (Portes et al., 2009). In the

later decades of the 20th century when immigration to the U.S. increased dramatically, the federal government restricted access to federally funded safety net programs for most immigrant residents (Fix & Passel, 2002). States and localities followed suit, establishing their own programs and eligibility rules; some tightened restrictions on immigrants' access to services, while others tried to bridge service gaps for immigrant residents (Fortuny & Chaudry, 2011). As a result, immigrants' eligibility for human services varies greatly across different states, communities, institutions, and types of programs (Perreira et al., 2012). For example, legal immigrants are eligible for most public benefits only after they have resided in the U.S. for five years. Undocumented immigrants are ineligible for most public benefit programs; however, their American citizen children are eligible for programs such as food stamps and Medicaid.

Across human service institutions, public health agencies are among those with the most flexibility to serve immigrant clients. The American public health profession, much like the social work profession, is rooted in the urban immigrant centers generated by industrialization. Early public health professionals initially focused on sanitation and infectious disease prevention in densely populated cities (Fee, 2015; Rosen, 2015). Yet, over time, public health services evolved to include many of the functions addressed by early social workers, including maternal and child health, health promotion and prevention, nutrition, case management of medically fragile children, as well as the environmental conditions in homes, workplaces, and communities that impact health (Duffy, 1990). Public health agencies are located in nearly every county across the U.S., employ a variety of human service professionals, and are driven by their charge "to recognize community and individual health problems, and find a way to solve them" (Duffy, 1990, p. 128). The programs these agencies administer often have more lenient eligibility requirements than other social safety net programs. For example, most public health agencies

participate the federal WIC (Women, Infants, and Children) program that provides pre- and post-natal care and nutrition for women and young children regardless of citizenship status. Similarly, public health programs to address environmental hazards (e.g. lead paint, contaminated water) and infectious disease (e.g. Tuberculosis, Whooping Cough) serve both citizen and immigrant residents as a means of protecting and promoting the health of entire communities, whether in urban centers or in more recent new destinations.

Yet, human services work with immigrants can be complex and challenging regardless of location (Crosnoe et al., 2011; Pereira, et al., 2012). Language, cultural, and administrative barriers combine to hinder immigrants' access to care. Agencies are required by federal, as well as a myriad of state laws, to provide interpretation services to clients with limited English proficiency (Chen, Youdelman, and Brooks, 2007). However, assessment, reimbursement, and enforcement of agencies' efforts are often inconsistent. As a result, many agencies are either unaware of their obligations (Chen et al., 2007) or rely on untrained, unreliable interpretation methods, including clients' family and friends (Partida, 2007, Perreira et al., 2012). Often agencies rely heavily on bilingual employees, who, in addition to their official job duties, assume responsibility for assessing their own language skills (Piedra, Andrade, & Larrison, 2011) and for helping immigrant clients navigate linguistic, cultural, and administrative barriers (Engstrom & Min, 2004; Engstrom, Piedra, & Min, 2009; Lanesskog, Piedra, & Maldonado, 2015). These cultural barriers may include differing beliefs about the causes and appropriate treatment of mental health problems (Ruiz, Aguirre, & Mitschke, 2013), the role of the man in providing for the family (Pereira et al., 2012), or the use of folk remedies in treatment (Portes et al., 2009, 2012). Further, immigrant clients often require extra help from bilingual staff to navigate

eligibility and referrals (Jones, 2012), as well as outside tasks such as interpreting with other institutions in the community (Engstrom et al., 2009).

This confluence of historical and contemporary factors shifts the burden of human service work with immigrants to local institutions and their workers (Perreira et al., 2012). Although this system is largely designed, regulated, and funded by federal and state governments, service delivery takes place locally at the hands of local institutions and their workers. In new destinations, these institutions are serving immigrant clients without the benefit of sufficient resources, bilingual staff, and experience serving diverse clients (Fry, 2008; Perreira et al., 2012). Therefore, understanding the ways new destination human services institutions and their employees respond to this demographic change is a critical step for improving human services in this context.

Theoretical Approach to Human Services Institutions and Their Workers

This research draws on three theories, a) institutional theory, b) bureaucratic incorporation theory, and c) street level bureaucracy theory to frame the roles of human service institutions and their workers in new destinations. These theories describe the forces that shape institutions' work with clients, the ways institutions and workers influence immigrant incorporation in new destinations, and the discretion front-line staff use in delivering benefits and sanctions to clients.

Institutional theory. Institutional theory suggests that external forces such as public opinion and laws concerning immigrants, as well as internal forces such as the professional norms and personal beliefs of employees, influence the approaches human service agencies use to serve clients (Garrow & Hasenfeld, 2010). Local human service agencies are, at least to some extent, bound by the myriad of federal, state, and local laws and policies governing the types of

services agencies can provide to which immigrants and under which conditions. Similarly, these institutions are subject to political pressures from elected officials who wield considerable power over budget allocations, as well as from taxpayers who alternately fund and consume agencies' services. Finally, institutional theory suggests that human services agencies adapt the practices and characteristics of successful peer institutions.

All of these powerful external forces have the potential to shape how human service institutions operate. Yet, they are countered by the internal forces of the institution's employees, whose professional norms, personal beliefs, and ability to innovate impact the practices and climate of the institutions in which they work (Garrow & Hasenfeld, 2010). Particularly in human services, where workers come from a variety of fields with strong professional affiliations and ethical codes, workers seem likely to encounter inconsistencies between agency norms and professional standards. In this study, institutional theory provides a structure for exploring the external and internal forces and the ways they interact to influence institutions' work with immigrant clients.

Bureaucratic incorporation. Traditional theories of immigrant incorporation suggest that agencies respond to immigrants' needs only when immigrants hold sufficient political power to demand their attention. In contrast, bureaucratic incorporation theory suggests that in new destinations, some administrators are responding to immigrants' needs long before political leaders direct them to do so (Jones-Correa, 2008; Lewis & Ramakrishnan, 2007). This theory suggests that professional values may cause administrators to view serving immigrants as a professional responsibility. Administrators who hold this point of view may allocate resources or adapt programs to meet immigrants' needs, or resist pressure to treat immigrants differently from citizen clients. In this study, I use bureaucratic incorporation theory to examine the extent

to which public health administrators, whose professional affiliations often include the ties to "helping" professions (e.g. nursing, health education, social work), incorporate immigrants' needs into their agencies' work.

      Street-level bureaucracy. Although human services workers often have limited control over the content, eligibility rules, or benefit levels of the programs they administer, agency staff possess considerable flexibility in *how* they do their jobs. Street –level bureaucracy theory suggests that front-line staff effectively make policy "on the ground" by using their discretion to facilitate service access for some clients while heightening barriers for others (Lipsky, 1980). Human service workers often operate without the adequate time and resources they need to meet all clients' needs, following all agency protocols. Consequently, they prioritize some clients and some rules over others (Hasenfeld, 2010). Workers may determine these priorities based on any number of personal or professional factors, but the aggregate impact of their decisions generates preferential treatment for some and, more frequently, discriminatory treatment for other groups of clients (Lipsky, 1980). Street-level bureaucracy theory is used in this study to explore whether workers use their considerable discretion to help or to hinder Latino immigrant clients.

      Taken together, these three theories provide a framework for examining the roles of institutions and their employees in new destination human service delivery. Ultimately, the responses of these agencies and their workers shape the relationships between immigrants and their new communities. These interactions, between agencies typically run by established residents with considerably more power than immigrant clients, set the tone for how immigrants are to be treated in the community, as well as how immigrants are likely to perceive their new governments (Lamphere, 1992). Thus, human service institutions and workers play powerful roles in negotiating tensions in new destinations (Lamphere, 1992), and in signaling the extent to

which immigrants deserve access to supportive human services (Brodkin, 2010; Hasenfeld, 2010).

<div align="center">**Role of Human Services Staff**</div>

Human service institutions' efforts to serve Latino immigrants hinge on the work of the employees who deliver those services. Consequently, one factor that warrants further attention is these workers' perspectives on their immigrant clients and their individual and institutional obligations to serve those clients. The literature on workers' perceptions and experiences serving immigrant clients focuses on bilingual professionals in traditional and new destinations. However, a smaller, more recent body of literature highlights the unexpected roles of administrators in new destinations.

Front-line Staff. Human service practitioners report a range of experiences and attitudes about their work with Latino immigrants. Bilingual professionals tend to view their work as especially meaningful and important, yet often overwhelming (Castaño, Biever, González, & Anderson, 2007; Engstrom & Min, 2004; Engstrom, Piedra, & Min, 2009; Jones, 2012; Verdinelli & Biever, 2009a, 2009b). These workers point to the increased complexity of immigrant clients' cases and the extra time workers need, but don't always receive, to help clients navigate the agency and the community (Castaño et al., 2007; Engstrom & Min, 2004; Jones, 2012; Verdinelli & Biever, 2009b). Additionally, workers felt obliged to interpret for clients and monolingual peers (Engstrom et al., 2009), all the while, expressing doubts about the adequacy of their own preparation and language skills (Moreno, Otero-Sabogal, & Newman, 2007; Verdinelli & Biever, 2009a). Consequently, many bilingual workers reported feeling fatigued by the stress of working in two languages (Castaño et al., 2007; Engstrom & Min,

2004), as well as overloaded by heavy caseloads and unrealistic expectations (Engstrom et al., 2009; Verdinelli & Biever, 2009b).

Perhaps more discouraging, bilingual professionals reported receiving inadequate support from their colleagues, supervisors, and institutions (Castaño, et. al, 2007; Engstrom & Min, 2004; Engstrom, et al., 2009; Lanesskog et al., 2015; Jones, 2012; Verdinelli & Biever, 2009a, 2009b). Many workers relayed that their monolingual colleagues and supervisors failed to recognize the difficulty of their work, leaving workers feeling undervalued and isolated (Castaño et al., 2007; Verdinelli & Biever, 2009a, 2009b). Further, in an earlier study, I found that bilingual workers in new destinations perceived their co-workers and institutions as highly resistant to improving services for Latinos, for whom they felt little responsibility (Lanesskog et al., 2015). In addition, the dearth of bilingual workers in new destinations generated opportunities for unethical workers to mistreat immigrant clients who were unlikely to complain and to go undetected by monolingual supervisors.

Divergent worker attitudes towards immigrants may be rooted in beliefs about the extent to which immigrants, especially undocumented immigrants, deserve access to human services. A nationwide study of social worker attitudes towards immigrants underscored this point by revealing that social workers held generally positive views of legal immigrants, but considerable ambivalence towards undocumented immigrants (Park, Bhuyan, Richards, & Rundle, 2011; Park & Bhuyan, 2012). Therefore, in new destinations, where undocumented immigrants are overrepresented, workers' may be more likely to express ambivalence about meeting Latino clients' needs.

Administrators. Little research directly examines the role of human service administrators in serving Latino immigrant clients. However, an emerging literature suggests

that administrators in related human service fields including public schools, police departments, and libraries are proactively incorporating immigrants' needs into their institutions' services (Jones-Correa, 2008; Lewis and Ramakrishnan, 2007). Administrators, driven by their professional missions and ethics, use their managerial authority to allocate resources, expand programming, and adapt services to reflect immigrants' needs, generating the so-called "bureaucratic incorporation" of immigrants.

Jones-Correa (2008) examined public schools and libraries in two new destination suburbs of Washington, D.C. and found that administrators in both types of institutions proactively addressed immigrants' needs. School superintendents channeled funding towards and expanded programming for Latino students. They instituted bilingual classrooms and expanded specialty programs to allow for more Latino student attendees, in spite of significant resistance from teachers and parents. Although these administrators were careful to publicly couch these programs as beneficial to all students, they privately acknowledged their professional motivations to ensure that immigrant students received a high quality education – one that addressed their unique needs. Jones-Correa noted budget constraints might limit institutions' abilities to expand programs in order to serve immigrants. However, he noted that library administrators in his study's communities effectively increased funding for books in Spanish, in spite of overall budget decreases for books in English (Jones-Correa, 2005).

Lewis and Ramakrishnan (2007) surveyed police chiefs in California counties and determined that they were often more knowledgeable and responsive to immigrants' needs than were elected officials. Police chiefs emphasized the necessity of building relationships with immigrants in order to prevent and solve crime. Sustaining these relationships led police chiefs

to resist external pressures to participate in immigration enforcement activities that would have jeopardized police credibility and eroded immigrants' goodwill.

Only two studies explore bureaucratic incorporation in typical human service institutions and the results of these studies are inconclusive. Cabell (2007) examined healthcare agencies in Owensboro, Kentucky and found that providers resented caring for immigrant clients they viewed as a strain on limited community resources. Conversely, Marrow (2011) found that many, but not all human service agencies in rural North Carolina responded positively to new immigrants' needs. She found that school health clinics and some healthcare agencies went to great lengths to serve immigrants, while other healthcare providers and social service agencies were unwilling to address immigrants' needs. In fact, Latino immigrants in these communities reported some of their most troubling interactions with social service workers they characterized as callous, discriminatory, and dismissive. Marrow suggests that the rigid eligibility requirements and rationing of benefits emphasized in many human services programs may restrict institution and worker responsiveness. Thus, two alternative hypotheses suggest that the presence of helping professionals could facilitate bureaucratic incorporation in new destination institutions, but the rigid rules of human services programs might constrain its development.

Taken together, the literature suggests complex relationships between new destinations human services institutions, their employees, and their Latino clients. On the one hand, some administrators and many bilingual staff seem remarkably committed to serving immigrant clients. On the other hand, other human service workers appear to view immigrants, especially those who are undocumented, with antipathy. The literature is unclear as to which perspective is more common or wields more influence in new destination institutions.

Addressing Human Services Delivery in New Destinations

A variety of stakeholders, including governments, human service providers, researchers, and advocates have attempted to improve human service access for Latino immigrants in new destinations. Many of these efforts focus on addressing language and cultural barriers as well as those stemming from a lack of citizenship status among many new destination migrants. In the following pages, I summarize these strategies, some of which were initially designed in traditional destinations or with other populations, and provide examples of their use in new destinations.

Interpreters

The majority of efforts to improve service access for Latino immigrants, across new and traditional destinations, center on the use of interpreters. An extensive body of research attests to the negative consequences of ineffective communication between patients and providers, especially in health and mental health care (Diamond & Rueland, 2009; Flores, 2006; Gregg & Saha, 2007; Piedra et al., 2011). Immigrants with limited English proficiency (LEP) are particularly at risk for poor outcomes in these service areas where language and cultural differences often combine with patients' low health literacy to impede access to and effectiveness of care (Schyve, 2007). Consequently, a bevy of federal and state laws and policies require health and mental health providers to provide language assistance to LEP clients.

At the federal level, Title VI of the Civil Rights Act of 1964 and U.S. Department of Health and Human Services guidelines outline providers' responsibilities to furnish free, linguistically and culturally appropriate interpretation for all LEP clients receiving federally funded services (Chen et al., 2007; U.S. Department of Health and Human Services (HHS), 2001). All fifty states have subsequently passed laws regulating language assistance for their

LEP residents (Perkins & Youdelman, 2008). The State of Illinois, site of this research study, has passed over 90 such laws detailing providers' responsibilities to LEP clients (Illinois Advisory Committee to the U.S. Commission on Civil Rights (IL Advisory Committee), 2011). However, the overall impact of these laws is limited by: insufficient funding, ineffective enforcement, providers' lack of awareness, and the absence of standardized methods to train and to assess interpreters' language skills (Chen et al., 2007; IL Advisory Committee, 2011; Partida, 2007; Perreira et al., 2012).

Downing and Roat (2002) examine the models of interpretation human service institutions use to serve LEP clients. Many use ad hoc or untrained interpreters including clients' family and friends, community volunteers, and bilingual employees. Institutions rely heavily on ad hoc interpreters because they are easy to find, are inexpensive, and often already have or are able to gain clients' trust. However, the quality of interpretation provided by these untrained interpreters is always in question, and research suggests it is often inaccurate and inferior to that of trained interpreters (Flores et al., 2012; Giordano, 2007; IL Advisory Committee, 2011; Rosenberg, Seller, & Leanza, 2007). Furthermore, institutions that receive federal health funding violate federal law by encouraging or requiring patients to use family or friends to interpret (Downing & Roat, 2002). Other institutions use trained interpreters such as dedicated interpreters on staff or contract interpreters, available in-person or over telephone or video conferencing. Although the professional interpreters typically provide higher quality interpretation than ad hoc interpreters (Karliner et al., 2007), they are more expensive, require greater effort to schedule, and are less able to develop trusting relationships with clients (Downing & Roat, 2002; Kirmayer et al., 2011). Telephone interpretation, which consists of handing a receiver back and forth in order to maintain privacy in open spaces, is viewed as

awkward and as less desirable than in-person interpretation by many administrators and staff (Crosnoe, et al., 2012; Perreira et al., 2012).

New destination institutions are developing a range of strategies that address clients' needs for efficacy and institutions' needs for expediency and efficiency in interpretation. Kaiser Permanente, a large managed healthcare organization operating in traditional and new destinations, has designed a process to assess the language skills and cultural knowledge of bilingual employees and to limit their interpretation to situations commensurate with their skills (Kaiser Permanente Institute for Health Policy, 2014, Robert Wood Johnson Foundation, 2008). Bilingual staff receive one of three interpreter designations: Level 1 interpreters can provide conversation and directions, Level 2 interpreters can provide simple medical instructions, and Level 3 interpreters can interpret clinical encounters. Similarly, the *Hablamos Juntos* initiative of the Robert Wood Johnson Foundation funded health care providers' initiatives to improve language access for fast-growing Latino populations in ten communities across the U.S. (Wu et al., 2007). Participating institutions used strategies such as offering financial incentives for bilingual staff to build their interpretation skills through assessment and training, allowing interpreters to accompany patients through all aspects of their hospital visits to build relationships, providing a 24-hour telephone access to a bilingual nurse, and providing video interpretation to rural hospitals to facilitate patient access to interpreters. This project encouraged institutional innovation, but did not attempt to evaluate the effectiveness of these initiatives.

Other studies describe how new destination institutions address the pervasive lack of bilingual professionals that limit their ability to provide even non-clinical services in Spanish. Seth and colleagues (2014) found that Texas WIC (Special Supplemental Program for Women,

Infants, and Children) providers used financial incentives to encourage Spanish-speaking applicants, substituted Spanish-speaking para-professionals for English-speaking professionals in health education classes, and used native Spanish-speaking employees to screen language skills in bilingual applicants. To overcome a lack of bilingual mental health providers in North Carolina, Beeber and colleagues (2009) trained bilingual Head Start workers to interpret for monolingual mental health nurses delivering mental health care to Latina mothers. Both studies highlight the challenges, as well as the necessity, of finding and training bilingual non-professionals to deliver care, but neither study evaluated client outcomes.

Culturally Adapted Interventions

Immigrant clients across new and traditional destinations need human service providers to recognize and to adapt their services to meet clients' diverse cultures, traditions, and beliefs (Alvarez et al., 2014; Fong, 2004; Lanesskog, et al., 2015; Organista, 2009). They need providers to understand that their varied cultures and life experiences often generate different perceptions of health issues, willingness to seek care, and preferences for treatment (Kirmayer et al, 2011; Portes et al., 2009, 2012; Ruiz, et al., 2013). Institutions in traditional immigrant destinations sometimes engage in outreach and collaboration with immigrant communities to align institutional programs and processes with clients' unique needs, strengths, and preferences (Acevedo-Polakovich, Crider, Kassab, & Gerhart, 2011). However, new destination providers often lack the bilingual staff, the experience, and the relationships with immigrant communities needed to engage in such deep collaboration. Rather, cultural adaptations in new destinations tend to focus more narrowly on adapting individual programs, rather than broader institutions, to meet Latino residents' human services needs. The limited literature on culturally adapted

programs in new destinations focuses on strategies in health promotion and mental health treatment.

Rhodes and colleagues (2007) systematic review of *promotoras*, or lay health advisors, highlights the potential for community members trained in health promotion, education, or intervention to bridge linguistic and cultural gaps between health agencies and their Latino clients. Although the review does not specifically address new destinations, the authors note the many times and uses of promotoras, including to distribute health information, to make referrals, to encourage cancer screening, and to aid in diabetes management. Two more recent studies evaluate promotora interventions in new destinations. Tran and colleagues (2012) used a promotora intervention to reduce depression, to facilitate coping, and to counter feelings of isolation among immigrant Latinas in North Carolina. Sauaia and colleagues (2007) found that using promotoras to deliver health education in Catholic churches increased mammogram rates in Colorado Latinas with health insurance. Finally, Seth and colleagues (2015) found that WIC administrators in Texas perceived as successful their efforts to train bilingual Latina clients to educate their peers on healthy nutrition practices. These limited studies suggest promising uses for promotoras in new destinations and warrant further research into their implementation and effectiveness.

Cristancho, Peters, and Garcés (2010) enlisted community groups to develop and implement community mental health interventions in five Illinois new destinations. These researchers used $5,000 grants to help residents establish and implement sports leagues, social clubs, speaker series, newsletters, mental health workshops, and bilingual counseling services to address Latino residents' unmet needs and service delivery preferences. Piedra & Byoun (2012) modified an existing cognitive behavioral group therapy for immigrant Latina mothers and

piloted its use in a new destination city in Illinois. They found the program to be beneficial both for the participants who reported lower levels of depression, and for the bilingual practitioners who received valuable training in delivering services in Spanish. Similarly, Aisenberg and colleagues (2012) developed and piloted telephone cognitive behavioral therapy for Latinos diagnosed with depression in a rural new destination in Washington. In addition to noting the effectiveness of the intervention, the authors suggest that the program's success indicates the potential for telephone interventions to improve access to care for especially for rural Latinos (Aisenberg et al., 2012; Dwight-Johnson et al., 2011).

Undocumented Status

Undocumented immigrants regardless of their location often fear the consequences of accessing human service programs (Perreira et al., 2012; Portes et al., 2009, 2012). Especially in new destinations, where larger undocumented populations reside (Passel & Cohn, 2009), immigrants often avoid seeking care out of fear of deportation for themselves or undocumented family members. Additionally, many immigrants mistakenly believe that receiving public benefits renders themselves and their children ineligible for citizenship or obligated to repay the state (Perreira et al., 2012). Uninsured immigrants often delay preventive and routine health care visits out of concerns over costs, unintentionally increasing the likelihood of poor outcomes and costly emergency care (Gresenz et al., 2012; Liebert & Ameringer, 2013; Portes et al., 2009). Consequently, Gresenz and colleagues (2012) found that Mexican immigrants in new destinations had more emergency room visits, hospital admissions, and health care expenditures than their traditional destination peers. Similarly, Korinek and Smith (2011) found that undocumented women in new destinations were significantly less likely to receive prenatal care

than their documented peers. Fear may play a more substantial role in new destinations than in traditional destinations.

In addition to fear, immigrants often cannot afford to be treated by the network of hospitals, clinics, and private providers used by most citizens (Liebert & Ameringer, 2013; Portes et al., 2009, 2012). Instead, uninsured and underinsured immigrants are relegated to a secondary health safety net comprised of Federally Qualified Health Centers (FHQC) funded clinics, charitable providers, and in some cases, public health agencies. These types of facilities offer a mix of preventive and primary care often at low or no cost to patients. However, they too sometimes require proof of residency and income, a challenge for undocumented people who may be more transient, who work using false identification, or who are paid under the table. Further, these providers are not available in all areas and, especially in more rural areas, may require patients to travel great distances. Consequently, new destinations Latinos often experience multiple and heightened barriers to care stemming from the fear, lack of insurance, and ineligibility for public programs associated with undocumented status.

A few studies identify strategies some institutions have used to try to reduce barriers for undocumented clients. Crosnoe and colleagues (2012) found that some new destinations agencies enlisted the aid of community-based organizations (CBOs) to facilitate communication and outreach with immigrant clients. Similarly, other agencies partnered with Latino media outlets and Latino-owned businesses to provide information through trusted channels. Portes and colleagues (2012) found that providers in communities with very active immigration enforcement relocated their services near churches or stopped advertising mobile clinics in order to evade immigration authorities. Additionally, they noted that some charitable providers simply stopped inquiring about patients' citizenship status and instead relegated more funds to indigent

care. Further, they learned that administrators at some FQHCs, which are legally mandated to require proof of residency and income, simply bent these rules for undocumented patients. These studies suggest ways institutions in new destinations might overcome barriers generated by undocumented status. Additional research is needed into these efforts' effectiveness for patients, as well as implications for institutions.

Current Study

The current study makes several contributions to the literature on human service work with Latinos in new destinations. First, this study focuses on new destination contexts that are less frequently addressed in the literature on human services work with immigrants. Second, this study examines public health agencies, which are notably absent from this literature, but which comprise a key part of the health safety net for uninsured and underinsured immigrants in new destinations. Third, the study incorporates the perspectives of agency administrators and non-professional, Latino-serving staff, whose perspectives may differ from those of the bilingual human service professionals highlighted in the literature. Finally, while most new destination studies take place in one or a few locations, this study takes place in 18 new destinations and allows for greater exploration of differences in contexts.

CHAPTER THREE

METHODS

Research Questions

This study uses qualitative research methods to identify how public health departments in new destination counties respond to fast-growing Latino populations. The study centers on three research questions:

(1) What factors influence how human service institutions respond to Latinos in new destinations?

(2) What responses do human service institutions use to serve Latinos in this context?

(3) How are these responses influenced and perceived by agency administrators and Latino-serving staff?

Research Design & Approach

I interviewed 19 agency administrators and 11 front-line staff to identify the policies and practices they use to serve new Latino clients. Qualitative methods are appropriate for this study because I wanted to understand how administrators and front-line workers make sense of these changing demographics and the ways they and their institutions have responded (Taylor & Bogdan, 1998). This study uses a constructivist approach, which assumes that the participants' perceptions are influenced by their everyday experiences in their communities, in their work lives, and in their personal interactions with other social structures and conventions present in their everyday lives (Charmaz, 2009). Therefore, I situate these interviews in the context of the current policies, professional standards, and everyday interactions human services workers encounter working with immigrant clients.

Researcher Reflexivity

My interest in this topic is shaped by a number of professional and research experiences. First, working for federal, state, and local agencies helped me understand the complex system of programs, policies, and funding that generates our human services safety net. In my work as a planner for a new destination county human services agency, I analyzed data that highlighted the ways gaps in this safety net disproportionately and negatively impacted immigrant families. I witnessed firsthand the frustrations of providers who struggled to communicate with and to effectively serve immigrants, as well as the indifference of providers who did not view immigrants as legitimate clients. I learned that existing human services systems, policies, and practices are often ill suited to meet immigrants' needs, and that changing these entrenched systems is terribly difficult.

In addition to these experiences, I spent the past six years studying human services work with Latino residents in Champaign, Illinois. This mid-sized city is home to the state's flagship university and to a small Latino population that has increased by over 200% since 1990 (Pew Research Center, 2013). Latinos comprise only 6% of this new destination county's 208,000 residents (U.S. Census Bureau, 2014). I engaged in a yearlong university-community collaboration and three qualitative studies to better understand how human service providers in this community work with Latino residents. Consequently, I learned that effective work with immigrant clients hinges on workers' capabilities and efforts, but also on institutional structures that facilitate or hinder service delivery. I try to approach this research by balancing three perspectives: my appreciation for the daunting challenges workers face, my understanding of institutional limitations, and my belief in immigrants' rights to access the human services they need to ensure the well-being of their families.

Participant Recruitment

I used purposeful and snowball sampling methods to recruit 30 participants from 18 public health agencies in Illinois new destinations.

Purposeful sample. I used purposeful sampling to identify administrators whose agencies were most likely to have experience serving new destination Latinos: those in counties with fast growing Latino populations (Patton, 1990). I used the Pew Research Center's (2013) dataset, "*U.S. Hispanic Population by County, 1980-2011,*" to identify Illinois counties with fast-growing Latino populations (Pew Research Center, 2013). I selected counties with above average growth in Latinos from 1990-2011. I excluded counties: a) with fewer than 1,000 Latino residents (Pew Research Center, 2013); b) in which Hispanics comprised 25% or more of the population in 1990, rendering them established populations (Gresenz, 2012); and c) considered part of metropolitan Chicago, a traditional immigrant destination (U.S. Census Bureau, 2013). The resulting 28 counties are highlighted in the Illinois map presented in Figure 1. A table detailing the populations and rates of growth in these counties can be found in Appendix A.

I invited the administrators of the 28 public health agencies in these counties to participate in the study, yielding 18 participants.

Figure 1. 28 Illinois counties with fast-growing Hispanic populations.

Source: diymaps.net (c)
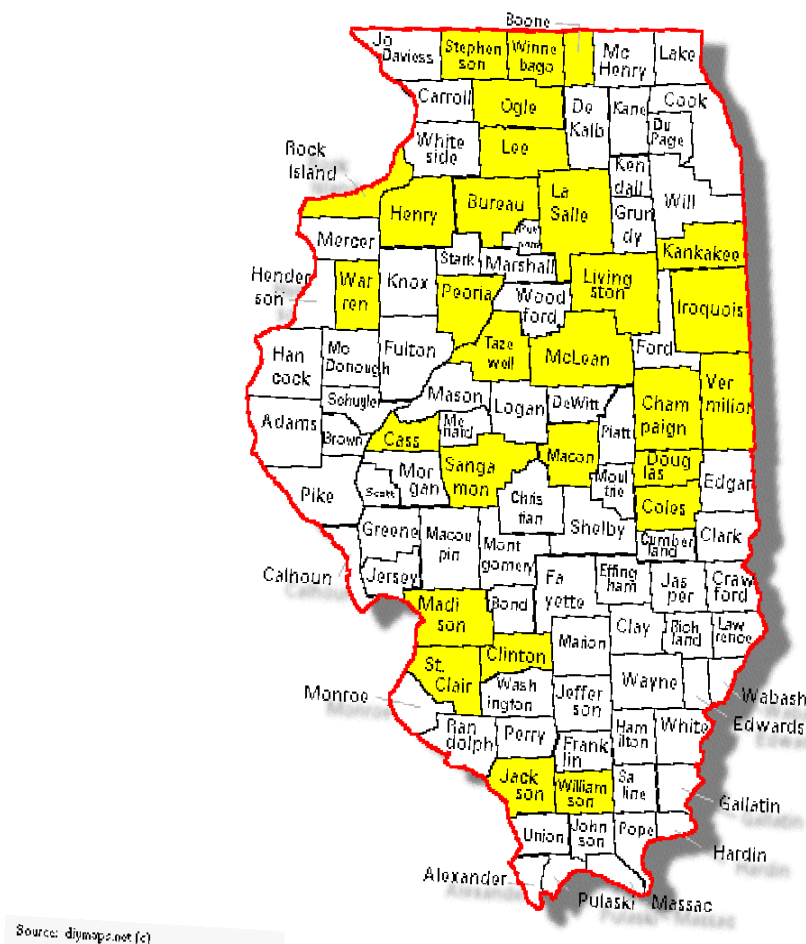
Snowball sample. I used a snowball approach to enable me to connect with informants

who knew much about the agencies' work with Latino residents, but whom I could not otherwise

identify (Patton, 1990). First, I asked administrators to nominate front-line, Latino-serving staff

from their agencies to participate in the study. They nominated 18 staff members, 11 of whom

participated in the study. Second, I also asked administrators to nominate knowledgeable peers

from other counties to participate in the study. Most of these nominees were already invited to

participate in the study; however, one administrator nominated a colleague with expertise serving

Latino clients in a neighboring county with a slow-growing Latino population. The combination of purposeful and snowball sampling yielded a total of 19 administrators and 11 Latino-serving staff from 18 counties.

Recruitment process. I recruited participants using email and telephone invitations, following up at least three times with non-responders. Many administrators hesitated to join the study claiming little expertise serving Latino clients, to which I responded with reassurance about the value of their contributions. Of the administrators who declined to participate, several gave no reason, one reported no increase in her county's Latino population, and several others replied with interest, but did not respond to follow-ups. The state budget crisis, which coincided with data collection, likely hindered recruitment as many participants repeatedly rescheduled their interviews due to pressing fiscal challenges.

Administrators nominated 18 Latino-serving staff; however, a few administrators could not identify any employees who specifically served Latino clients. Many of the staff seemed unfamiliar and inexperienced with this type of research study. Some presumed they must complete the interview on their own time; participation increased when I assured them the interview could be done during their work time. Of the 7 nominees who did not participate, one responded that she was unwilling to participate, another expressed interest but did not respond to follow up calls, and five did not respond. Workers' busy schedules, unfamiliarity with the research process, and unwillingness to share details about their work may have hindered participation.

Confidentiality

I maintained participants' confidentiality using three strategies. First, I followed IRB approved procedures for collecting, storing, and transferring study data. Second, I do not

identify the 18 counties represented in the study. Each of these counties has only one public health agency, one administrator, and, in some cases only one Latino-serving staff member, so revealing county names would likely divulge participants' identities. Third, I obscure participants' job titles, genders, educational background, and the names of the programs in which they work. For example, I use the generic titles of "administrator," and "outreach coordinator," in place of the participants' official job titles, which are often unique to their agencies.

Data Collection

I conducted 28 semi-structured, qualitative interviews with 30 participants via telephone at times that were convenient for interviewees. I intended to conduct all interviews individually, but conducted two joint interviews at the request of participants. Interviews lasted an average of one-hour in length and were audio-recorded. At the start of each interview, I reviewed the informed consent document with the participant and obtained verbal consent from the participant.

I conducted each interview in English using an interview guide (see Appendix B) that asked participants to describe their professional backgrounds, the communities they serve, and the policies and practices their agencies use to serve Latino clients. Questions included the following:

"How would you describe the Hispanic population in [insert name] County?"

"What public health programs or services do Hispanic residents use?"

"What policies or practices does the agency use in serving Hispanic residents?"

I used prompts such as, *"What happens if someone who speaks only Spanish walks into the agency?" and "What did you think of that?"* to encourage respondents to provide more detail on agency processes and to share their perspectives.

Interview audio files were transcribed by a paid transcriptionist usually within one week of the interview. I reviewed the transcripts for accuracy within a few days of receiving the completed transcript. As a result, most interviews were conducted, transcribed, and reviewed for accuracy within a 10-day period. Following the interview, I mailed each participant a thank you note and a $10 Amazon gift card as partial remuneration for their time. All data collection procedures were approved by the University's Institutional Review Board.

Data Analysis

I analyzed the interview data using a coding team, *a priori* codes, a transcript grouping scheme, and three phases of coding: open, axial, and theoretical (Strauss & Corbin, 1990; LaRossa, 2005).

Coding team. I analyzed the data with the help of two graduate Social Work students, both of whom are Latino and have experience in human services with Latino clients. Both students hail from large, urban, traditional immigrant destinations; however, only one student has experience working in traditional and new destinations.

***A priori* codes.** Before beginning data collection, I used the literature review and my previous research in this field to develop an a priori list of codes I anticipated encountering in the data (Strauss & Corbin, 1990). For example, from the literature as well as from personal experience, I learned that recruiting bilingual employees in new destinations was often a challenge. Thus, I created a code labeled, "barriers to serving Latino residents," and a sub-code labeled, "lack of bilingual employees" in anticipation of finding this topic in the data. I expected this list of a priori codes to require significant revision and expansion during the coding process, but nonetheless used this list as a starting point.

Transcript grouping. I grouped the transcripts in pairs or triads to maximize opportunities to compare data within a single agency, as well as to compare data across agencies. I grouped multiple transcripts (1 administrator, 1-2 front-line staff) from one agency/county together. I grouped single transcripts (1 administrator, no front-line staff) from one agency/county together in pairs or triads with similarly sized or geographically located counties.

Coding process. We used a five-step process to analyze the data. First, we independently read and analyzed one pair or triad of transcripts at a time. We coded the data using the a priori codes, but we also used open coding to identify data insufficiently addressed by the a priori codes (Ryan & Bernard, 2003). In open coding, we highlighted repetitive statements and patterns in the data and grouped these into themes with corresponding codes (Strauss & Corbin, 1990). Second, we discussed our codes, comparing and contrasting the patterns we noted in the transcripts, paying special attention to similarities and differences across participants and across agencies/counties (Ryan & Bernard, 2003). We explored areas in which our individual analysis of the data diverged, re-reading text and discussing our reactions, perceptions, and interpretations in an effort to reach consensus (Barbour, 2001). With each set of transcripts, we refined our codes and themes to reflect our developing understanding of the data. Third, we used axial coding to identify the ways themes related to one another (Strauss & Corbin, 1990). We repeated this process of separately reading and coding transcripts, then discussing and refining our codes as a group, until we analyzed all of the transcripts. Finally, I used theoretical coding, or the process of relating the overarching categories to one another, to tell the story or theory emerging from the data (La Rossa, 2005).

Strategies to Ensure Trustworthiness of the Study

This study relies upon the following five strategies to strengthen the study's credibility: triangulation, prolonged engagement, peer debriefing, member checking, and negative case analysis (Lincoln & Guba, 1985; Maxwell, 2005).

Triangulation. The study is strengthened by the triangulation of data from multiple sources: from administrators and front-line staff, and from multiple agencies across multiple communities (Corbin & Strauss, 2008). Collecting data from these different sources allowed me to analyze the data on many levels: comparing administrator and staff responses within and among agencies, examining responses to immigrants within and among agencies, and evaluating similarities and differences across counties of different size, makeup, and location.

Prolonged engagement. My prior work with public health agencies, immigrant advocacy groups, and human services providers in new destinations enhanced all aspects of this study. These experiences with providers, agencies, and communities helped me to build participants' trust, to learn the culture of agencies and communities, and to better understand the content and context of the data I collected and analyzed in this study (Lincoln & Guba, 1985).

Peer debriefing. I used peer debriefing to share interpretations of the data with peers who were willing to explore and to challenge my conclusions (Lincoln & Guba, 1985). I relied on four peers: two experienced qualitative researchers and two human services providers working in new and traditional destinations. We discussed topics including: participants' use of stereotypes, contextual variations between new and traditional destinations, and my own emotional reactions to the data. I used debriefing to examine my own biases and to clarify my interpretation of the data.

Member checking. During and after data collection, I used member checking to identify inaccuracies and to elaborate on concepts not adequately addressed in the data (Taylor & Bogdan, 1998; Lincoln & Guba, 1985). I asked participants to comment on data provided by other participants and to assess my own interpretations of the data. This process was especially useful in exploring topics that required special expertise, including public health finance, refugee resettlement, and historical background on public health in Illinois.

Negative case analysis. I used negative case analysis to challenge my interpretations by seeking data from the study that conflicted with my conclusions (Lincoln & Guba, 1985). For example, although a vast majority of the administrators reported a reluctance to use telephone translation services, one administrator indicated that her agency relied solely on telephone translation. This one negative case forced me to reconsider my conclusion that new destination providers rejected telephone interpretation, but rather that there existed a hierarchy of preferences around interpretation. In this instance, negative case analysis generated a more nuanced interpretation of the data.

Limitations

The study's most significant limitation stems from participant recruitment. Respondents who chose to participate in this study likely hold more favorable views on Latino immigrants than those who declined or were not recommended to participate. Certainly administrators who were disinterested in serving Latino populations may have been more likely to decline. Similarly, workers with more critical views of their agencies or their clients may not have been nominated by administrators who want to present their agencies in a positive light.

Additionally, participants may have been motivated to give more socially desirable answers about their views around and efforts to serve immigrants than those they actually held

(Rubin & Babbie, 2011). Similarly, respondents may not have shared their true feelings about employers, colleagues, and clients because they feared repercussions of the loss of their jobs. Further, front-line staff who were Latina, immigrant, or bilingual may have been less willing to share their perspectives with a researcher who is not Latina, not an immigrant, and not bilingual.

The study is also limited by its use of one data collection method at a single point in time. Collecting data using multiple methods at multiple points in time would likely have yielded richer data. Conducting participant observation would have allowed me to examine discrepancies between what participants say and what they do in their day-to-day work with clients. Observation might also have illuminated agency and worker activities that participants neglected to mention because they have become unremarkable or routine over time (Shaw & Gould, 2001). In addition, using in-person methods might have facilitated greater trust between the participants and the researcher. These methods might also have provided opportunities for interaction with a more diverse pool of workers, generating more diverse perspectives and insights.

Finally, the study's focus on public health agencies in one state limits its transferability to other new destinations and types of human services institutions. Especially in light of Illinois' dismal state finances, one might expect to find more diverse or robust responses to immigrants in states with better-funded human services systems. Similarly, other human services institutions (e.g. social service agencies, schools, health clinics) with different missions, funding streams, regulatory oversight, and types of professional and non-professional staff may respond differently to new immigrant clients.

CHAPTER FOUR

RESULTS: INADEQUATE STRUCTURES AND RESOURCES FOR SERVING

LATINO IMMIGRANTS

When I embarked on this research study, I expected my key findings to center on the strategies agencies used to serve new Latino populations. I anticipated that agencies used a small number of similar policies and practices across these destinations and that this dissertation would identify innovative approaches that could be used by institutions facing the same demographic shift in other communities.

Instead, I found that the public health agencies in this study were essentially left to their own devices in responding to new Latino populations. Inadequate structures and resources for serving diverse clients prompted agencies to improvise services for Latino residents. A lack of government oversight and support of human services work with immigrants led agency administrators to use considerable discretion in their work. Further, the dearth of bilingual professionals in these communities led administrators to rely heavily on non-professional bilingual staff to address Latino clients' complex needs. Consequently, individual agencies adopted a plethora of responses to address common service barriers that stemmed from language and cultural differences, as well as from the difficult circumstances their clients faced in new destinations.

The responses agencies used were certainly interesting and sometimes innovative. However, perhaps more importantly, they resulted from a unique service context in which administrators and Latino-serving staff had unparalleled responsibility for deciding whether and how their individual agencies served Latino clients. The most important forces in determining public health responses to Latino clients in new destinations turned out to be the agencies'

employees. I begin this chapter by describing the public health administrators and Latino-serving staff who participated in this study. Next, I identify the pervasive lack of structures and resources for human service work with diverse clients. I describe how these contextual factors spurred agency administrators to rely on their professional judgment and non-professional bilingual staff to overcome such limitations. In the following chapter, I explore the specific practices Latino-serving staff at individual agencies devised and implemented to serve Latino clients, as well as the tremendous burden these mostly untrained workers experienced as a result of their efforts.

Participant Demographics

Study participants (n=30) were overwhelmingly female (n=27). All administrators (n=19) were non-Latino and spoke only English. Most front-line staff (n=11) were Latino (n=8) and bilingual (English and Spanish) (n=10). Further, all administrators (n=19) possessed at least a 4-year college degree and nearly half (n=9) possessed a graduate degree. Almost half (n=5) of the staff participants had a high school diploma. The other six staff had an Associate's Degree (n=2) or Bachelor's Degree (n=4). A summary of participant demographics is displayed in Table 1.

Table 1. Participant Demographics

Characteristic	Administrators (n=19)		Front-line staff (n=11)	
	n	%	n	%[*]
Ethnicity				
Latino	0	0%	8	73%
Non-Latino	19	100%	3	27%
Language				
Bilingual	0	0%	10	91%
Monolingual	19	100%	1	9%
Gender				
Female	17	89%	10	91%
Male	2	11%	1	9%
Education[1]				
High School	0	0%	5	45%
Associate Degree (2 year)	0	0%	2	18%
College Degree (4 year)	10	53%	4	36%
Graduate Degree	9	47%	0	0%

[1] Reflects highest degree attained.
[*] Due to rounding, percentages may not total 100.

Nearly all administrators (n=18) held at least one degree in a health or human services related subject area. A few administrators held degrees in public health, although most held degrees from fields associated with health and human services work, including nursing, environmental health, social work, biology, earth science, psychology, sociology, or nutrition. A few administrators held degrees in fields not typically associated with health and human services professions, such as business, economics, philosophy, and finance. Nearly half of administrators held advanced professional degrees in health and human services fields or in business/health administration. Administrators' specific job titles and types of degree attained are obscured to protect participant confidentiality.

Staff participants often held dual positions at their agencies (n=5), often serving as interpreters in addition to their primary roles. The staff participants in this study include the case managers (n=2) and nurses (n=1) often referred to as front-line, para- or professional staff.

However, administrators were asked to recommend workers in any positions who directly served Latino clients. They also recommended bilingual administrative assistants (n=3) and intake specialists (n=3), roles often categorized as clerical or non-professional. The Hispanic outreach coordinator (n=2) positions are not so easily classified, as one position was filled by a participant with a college degree and the other was filled by a participant with a high school diploma. Overall, staff participants had markedly lower levels of education. Further, although four of the staff participants held Bachelor's degrees, only one staff participant possessed a Bachelor's Degree in a health or human services related subject.   Participants' job titles and levels of education are described in Table 2.

Table 2. Participants' Job Titles and Education/Training

ID #	Job Title(s)	Education/Training*
1	Hispanic Outreach Coordinator	BA in unrelated field
2	Administrator	BA & MA in related fields
3	Administrator	BA in related field
4	Administrative Assistant	HS Diploma
5	Administrator	BA in unrelated field, MS in related field
6	Administrator	BS & MS in related field
7	Administrator	BS in related field, MA in unrelated field
8	Administrator	BS & MS in related fields
9	Administrator	BS & MS in related fields
10	Peer Counselor/ Intake Specialist	HS Diploma, certificate in related field
11	Administrative Assistant/ Interpreter	Associate's Degree in unrelated field
12	Nurse	Associate's Degree in related field
13	Hispanic Outreach Coordinator/ Interpreter	HS Diploma
14	Administrator	BA in related field
15	Administrator	BA & MS in related field
16	Administrative Assistant	HS Diploma, certificate in related field
17	Intake Specialist	BA in unrelated field, certified medical translator
18	Administrator	MS in related field
19	Administrator	MS in unrelated field
20	Administrator	BS in related field
21	Administrator	BS in related field
22	Administrator	BS in related field
23	Intake Specialist/Interpreter	HS Diploma
24	Administrator	BS in related field
25	Administrator	BS in related field
26	Case Manager/ Supervisor	BA in unrelated field
27	Case Manager	BA in related field
28	Administrator	MS in unrelated field
29	Administrator	BS in related field
30	Administrator	BA in related field

* Related fields include physical and biological science, health professions, and social science,subject areas; unrelated fields include business, economics, & fine arts subject areas

Inadequate Structures and Resources

This study's findings suggest that the unique contextual factors in new destinations significantly limited public health agencies' responses to Latino immigrants. The lack of government oversight, support, and funding of human services work with diverse clients left agency administrators to rely on their own professional judgment in guiding their agencies through this demographic shift. The scarce bilingual workforce in new destinations prompted administrators to rely heavily on bilingual non- and para-professional staff. The ways these contextual forces impacted public health agencies, and in particular their administrators, are detailed below.

Absence of Government Oversight

Federal and state governments. Administrators highlighted their agencies' dependence on federal, state, and local governments for the authority and funding needed to conduct their work. Yet, many described their relationships with all three levels of government as frustrating and unsupportive. Administrators noted that much of their funding came from state and federal agencies (e.g. Medicaid and WIC) who mandated that services be provided in the client's language, but then failed to provide the resources agencies needed to do so. For example, most administrators reported using bilingual staff and contract interpreters to translate into Spanish the written materials they received from funders (e.g. the USDA for WIC, the CDC for immunizations and infectious disease). Although funders provided some materials in Spanish, they rarely provided all program materials in Spanish. Consequently, administrators expressed frustration at their agencies' inability to provide important materials to Spanish-speaking clients and the necessity of using scarce resources on translation. One administrator expressed her

considerable irritation with the lack of Spanish-language materials provided by the federal WIC program.

> What we do have in terms of translated materials do mostly come from the funders, but they don't share with us a full set [of materials]… There's an intake form and there's educational material [in Spanish]. Where's the breastfeeding stuff...where are the basic educational pieces of information [in Spanish] that we give to every client? Where are those? (Administrator, 9)

This administrator and several of her colleagues resented what they viewed as unreasonable mandates from federal and state agencies' that shifted the costs of providing linguistically accessible materials to local providers.

Administrators seemed either unaware of or unconcerned with federal and state policies that required them to provide free and appropriate interpreters for clients who did not speak English. Only a few administrators mentioned the existence of such regulations. In fact, when asked whether their agencies allowed children to interpret for their parents, many administrators responded that they "don't want to use children," or that doing so was not "good policy." However, only two administrators mentioned that using child interpreters was problematic; that doing so violated clients' civil rights and Medicaid rules. One administrator (7) insisted that using child interpreters, "isn't an acceptable form" of interpretation under Medicaid guidelines. She recognized her own agency's responsibility to provide interpreters, but noted with some irony that many private physicians in her community were often unwilling to provide interpreters even though they received Medicaid reimbursement and were subject to the same rules. Latino-serving staff confirmed that Spanish-speaking clients often used their children to interpret at private health clinics in the community, suggesting widespread inattention or lack of awareness

in these communities of all Medicaid providers' legal responsibilities to furnish interpreters.

These administrators and Latino-serving staff confirm what the literature on human service

providers' use of interpreters suggests: that providers are frequently unaware of, or are unable or

unwilling to adhere to these federal and state requirements (Chen et al., 2007; IL Advisory

Committee, 2011; Partida, 2007; Perreira, 2012). Yet, as only two of 19 administrators

acknowledged these policies at all, data from this study suggest a widespread lack of awareness

across new destinations.

    Local governments. At the local level, administrators indicated that their agencies'

relationships with county government, especially with county boards to whom they reported,

were equally complex and often adversarial. Administrators knew and interacted regularly with

elected officials, as relationships between community leaders tend to be closer in these smaller

communities than they might be in traditional, urban destinations. Nonetheless, administrators

reported that local elected officials were often disinterested in public health and in agencies'

efforts to serve Latino residents. Consequently, administrators approached their county boards

very carefully, with some focused on engaging and educating board members in order to gain

their support, while others tried to keep board members at arms lengthy by revealing few details.

    Several administrators advocated sharing as little information as possible with county

boards they perceived as unsupportive. "I call them [some county board members] my own

personal party of no. Whatever I want they'll always vote against me, because I'm too big

government," explained one administrator matter-of-factly (Administrator, 15). Others echoed

this sentiment, including an administrator whose agency spent approximately $50,000 annually

on contract interpreters. "I don't know that they [county board] have put two and two together as

far as costs" the agency incurs for interpretation, suggesting that the less the county board knew

about these costs, the better (Administrator, 29).   Consequently, in some counties, administrators maintained secrecy about their agencies' work in order to avoid displeasing elected officials.

Conversely, other administrators took a different approach, pro-actively providing an abundance of scientific evidence and expert endorsements to garner the support or at least acquiescence of local officials. "I always try to explain things as far as 'this is evidence-based, or here's why we're doing this. I don't just do it without trying to explain the reasoning," clarified one administrator (Administrator, 2). Another reported lining up experts to validate her agency's work at any county board meetings in which public health issues might be discussed. She explained,

> We've got politicians and elected officials that don't have any sort of knowledge of
>
> public health. We need to be very attentive, deliberate in how we try to engage them in
>
> issues. It's not beyond us to stack the deck. If I know I've got a serious situation coming
>
> up, to make sure I have my experts available. (Administrator, 25)

Administrators used divergent approaches to manage their relationships with local officials; some provided as little information as possible, while others emphasized empirical support for their work. Administrators seemed keenly aware of the need to anticipate the likely reactions of elected officials and to tailor their approaches in ways that reduced the odds of generating unfavorable reactions. Regardless of the approaches they used, many administrators seemed to view elected leaders as adversaries, rather than partners in meeting the needs of new Latino residents. As one administrator wryly suggested, "sometimes you make them think they are" driving public health decisions, when in reality she tells government leaders what the agency should do (Administrator, 15). In general, administrators reported that their agencies

responded to Latino residents' needs in spite of rather than because of government leaders' priorities.

This portrayal of administrators and local institutions as more responsive to Latino residents' needs than are local politicians echoes the perspectives of new destinations school superintendents and police chiefs found in the literature on bureaucratic incorporation (Jones-Correa, 2008; Lewis & Ramakrishnan, 2007). This literature highlights the ways administrators advocate and improve services for immigrant clients by sidestepping local leaders' authority. However, though many administrators in this study stealthily expended resources and staff time for serving Latino clients, they seemed unlikely to advocate publicly or directly on Latino clients' behalf with their communities' elected leaders. In avoiding conflict with local leaders, new destination administrators may be missing opportunities to educate leaders on the implications of changing demographics.

Lack of Funding

Every administrator who participated in the study relayed deep concerns about funding. This is unsurprising given that at the time of the interviews the State of Illinois had been operating without a budget for many months. State funds to all public agencies, including local health departments, were delayed or altogether in jeopardy as a result of the lack of a budget. Agencies relied on a mix of user fees, state and federal grants, and local tax revenues, but the proportion of funding from each of these sources differed across counties. Consequently, agencies that depended heavily on state funds struggled to keep their doors open and to meet payroll in the wake of this crisis, let alone to expand or improve services. Their limited options for generating funds included increasing user fees for their mostly low-income clients, appealing to local governments, or applying for additional grants from federal agencies or non-

governmental sources. Administrators seemed pessimistic about the prospects of generating additional resources from these sources.

Further, administrators reported a complete dearth of funds to improve services for increasingly diverse client populations. None of the administrators were aware of funding sources they could access for help in serving new Latino populations. In fact, several administrators reported that sharp declines in funding from state and local governments severely limited their ability to conduct any outreach in their counties, let alone to Latino residents who might require more time and attention. One administrator explained that the state's prior budget crisis in 2010, had forced her agency to lay- off two-thirds of its staff. As a result, the agency was left with no bilingual employees and only enough staff to cover the most basic services and operating hours. This agency's administrator (22) explained that the agency "…can't do a lot of outreach. We can't offer those services outside of the building," and so the agency was unable to reach out to the county's Latino residents, many of whom were located in more rural communities in the far reaches of the county.

In dealing with financial constraints, administrators lamented that budget conscious local governments were unlikely to provide additional funds, that poor clients were unable to afford increases in user fees, and that grant funding was often not a good match for meeting Latino clients' needs. Several administrators explained that grant funders were increasingly interested in funding regional or collaborative projects that would reach larger numbers of clients, rather than small, local pockets of residents. Only a few of the agencies in this study reported having regular interactions with neighboring public health departments, let alone regional collaborations with multiple agencies through which to pursue funding. In addition, administrators from less populated counties reported that their small populations limited their competitiveness. Two

administrators explained their frustrations in trying to fund work with tiny, but vulnerable Latino communities.

> …when you're looking at …[a Latino population of] 1,400 people, it's hard to get any kind of funding…If you are a larger – such as a county that would have 100,000 [people]…now you're talking about dollars that a grantor would do. (Administrator, 19)

> …we did try to…see what we could do for low birth weights [in babies]…we do know that we do have some issues with low birth weight…[but] we didn't rank as far as the number of individuals that could be reached for that [grant] program, so we weren't eligible for that grant. (Administrator, 18)

Conversely, one administrator from a larger county whose Latino residents lived primarily in rural areas expressed frustration that her county's larger, predominately urban population rendered the agency ineligible for rural grants she might use to serve Latino residents in outlying communities.

Beyond the limited availability and changing requirements for grants, respondents revealed a more pervasive challenge in using grant funding to address Latino clients' needs. They reported that the grant funding to which public health agencies do have access is narrowly focused on specific health issues such as infectious disease (e.g. HIV/AIDS, Tuberculosis, and sexually transmitted diseases), on breast, cervical, and prostate cancer screenings, lead screening, and on pre- and post-natal care for women and their children. Thus, even when agencies could secure additional grant funds, the funds could only be used to fund initiatives related to these health concerns, which were seldom aligned with Latino clients' needs. In response, several agencies reported creative attempts to leverage available funding to serve Latino residents. For

example, one agency reported using funds from a breast and cervical cancer grant to host a women's health event for Latina women at a local Mexican restaurant. The administrator noted that,

> We did have the specific funding that we were able to use to provide the location and the food and things like that…[but that the clients] were educated not only about breast health, but also about our family planning services and different services that they might be able to use. (Administrator, 8)

Similarly, another agency reported using its lead screening funds to test pre-school aged children at a predominately Latino Head Start program. Although the agency did identify and treat a few children with elevated lead levels, the administrator relayed her excitement at the prospect of building on the agency's work at the school to develop relationships with Latino parents, who might not realize they were eligible for WIC or other services the public health agency could provide. She explained,

> I'm looking forward to this next year to see what other opportunities we might have in working with them…maybe a night event where… we could get them certified on WIC, ask about their nutritional habits and give that information - just have a night that we could dedicate to serving the family as a whole. (Administrator, 24)

The most striking example of using issue-specific grant funding to serve Latino residents came from a county with a large HIV/AIDS prevention grant. The county leveraged this funding to develop a Latino outreach center that provided English language classes, citizenship classes, homework and college planning support for youth, as well as health services. This agency's administrator explained that she and her management team wanted to do something impactful – particularly for the county's growing Latino community – with the money. "We have the big pot

of [HIV] money that we need to spend, and…I don't want to throw it away on things. I want something sustainable…[the management team and I thought] why don't we have a location where a lot of the Latino population feel comfortable?" (Administrator, 6). Although the agency could not directly use these grant funds for non-health related services, they could use the HIV funds to support the program's staff, facilities, and equipment, which the agency augmented with local tax dollars, in-kind donations, and services from volunteers.

The administrator whose county developed this outreach center added that the dearth of funds to meet Latino residents' needs led her to change her approach to seeking funds. Rather than using data on clients' needs to drive her funding applications, she instead worked to fit whatever funding was available to meet her clients' needs. She described this shift in approach as, "…instead of, hey, here's the true data. This is what we need…[It's], okay, here's funding. How can we make it go towards what we might need?" (Administrator, 6). Although the agency was clearly successful in using this approach to serve its growing Latino population with issue-specific, HIV grant funding, front-line staff at the agency noted, without irony, that the agency had "never found anyone [HIV] positive" in the local community (Hispanic Outreach Coordinator, 1). This approach is quite savvy in that it uses available resources in an area for which the agency's clients have little need (e.g. HIV) to provide other services that better address clients' needs (e.g. Latino outreach). The very limited literature on public health funding mechanisms does not address this practice. However, its existence highlights the mismatch between public health needs and available sources of funding, especially in new destinations. Further, it underscores the inefficiencies that can result from a lack of planning.

Only a handful of administrators reported success in leveraging issue-specific funding to facilitate work with Latino residents; most administrators seemed unaware of this potential

funding mechanism. One administrator with significant budget and finance expertise suggested that agencies engaged in this approach would be wise to avoid the appearance of improprieties by planning ahead and incorporating these activities into grant applications and "deliverables," or outcome reports, required by funders. For example, this administrator suggested that agencies highlight outreach efforts and justification for such activities into grant applications and budgets at the outset, perhaps stating, "that a portion of the grant will be used for outreach to the Hispanic community, which has been neglected for the last 10 or 12 years…" (Administrator, 28).

In spite of these innovative efforts to channel resources towards Latino clients, both administrators and front-line workers bemoaned the fact that often there simply were no funds available to meet Latino clients' needs. Especially for undocumented clients, who are ineligible for Medicaid, public housing, utility assistance, food stamps, and many other supportive services, participants indicated that they often found themselves unable to assist clients with either services or referrals. Bilingual front-line staff described many frustrating instances in which they simply could not find help for their clients, "We're back against the wall…it's not like we have funding available to help them [undocumented clients] out." (Bilingual Case Manager, 27). The administrator in one county explained that her agency relied upon a reserve of "hardship" funds –those the agency set aside to use for Medicaid ineligible, poor clients – but that these funds were used primarily for vaccines, not for other types of care. When asked what options were available for her undocumented clients who do not qualify for Medicaid, one administrator simply said, "Pray." (Administrator, 18).

Participants' descriptions of the challenges of adequately serving undocumented clients confirm what the literature suggests is a particularly difficult barrier to overcome in new destinations (Perreira, et al., 2012). The larger proportion of undocumented clients, who are

ineligible for most social safety net programs (Fix & Passel, 2002), generates a disproportionately greater burden on new destination institutions and their workers. Although the literature focuses on these restrictions' dire implications for clients (Portes et al., 2009), this study suggests that these restrictions also serve as a hardship and source of tremendous frustration for the agencies charged with protecting the public's health, but who have few resources with which to provide appropriate care to a significant portion of their caseload.

Professional Values Set the Tone

Administrators' motivations for serving Latino residents stemmed from their professional missions to ensure the health of everyone in their communities. As one administrator explained, the role of public health was to enable people to live healthy lives. "We want people to be healthy. It's our responsibility to help them do that. If there's barriers there, then what can we do on our end to remove those?" (Administrator, 5). These professional values spurred administrators to expend extra resources, particularly to hire bilingual staff, and set the tone for workers to improvise, including bending rules, to serve Latino clients. Several administrators emphasized that fulfilling this responsibility led them to channel "resources into [services] that we – extra resources – that we wouldn't with English-speaking clients" (Administrator, 7). For example, one administrator described feeling obliged to offer enhanced pay to attract the bilingual staff needed to serve her Latino residents, saying, "I have such a large [Latino] population that I thought it was important to pay for that [bilingual staff]" (Administrator, 3).

Additionally, some administrators described their efforts to set high standards for the treatment of clients, particularly Latinos. A few administrators pointed to their efforts to instill and to enforce high standards among agency staff. As one administrator described, "…our philosophy is taking care of our patients and we do whatever needs to be done...This is our

culture. If they [staff] don't do it, then they hear about it [from me] because that's what we're here for" (Administrator, 15). Another added that she did not hesitate to fire staff members who treated clients poorly, remarking, "if you are rude to our clients…I won't put up with that" (Administrator, 2). Still, other administrators went further, instructing their staff members to help clients in any way they could and advocating bending the rules, especially for undocumented clients. For example, one administrator described instructing her employees to accept fraudulent social security numbers from undocumented clients. This administrator explained that enforcing immigration law was "not my problem" and was certainly not the responsibility of her agency (Administrator, 15). Clients likely benefit from administrators' admonitions that workers treat them well and bend unjust policies to facilitate access to services. However, by encouraging staff to disregard some rules, administrators may inadvertently encourage staff to break other rules, including those that are in place to ensure clients receive appropriate care. Administrators seemed unaware of the potential for unscrupulous workers to show favoritism, or even to abuse Latino clients who are unlikely to report mistreatment (Lanesskog et al., 2015). Especially in agencies with few bilingual staff able to understand interactions in Spanish between workers and clients, inappropriate treatment of clients may go undetected.

Many staff participants confirmed that their administrators were significantly more concerned with Latino clients' needs than were the administrators of other local institutions such as social service agencies or hospitals. The Hispanic outreach coordinator (13) at one agency appreciated her administrator's attention to language barriers, saying, "I know that our administrator has seen such a need. She's been willing to accommodate that [interpretation] service. It's important to her…we're very fortunate." The nurse (12) at another agency

appreciated her administrator's willingness to stand up for the Latino community, saying, "She's very open about helping our people. She's not afraid. She's not one to sit back and say, 'Yeah, yeah. We need to do something.' She's pretty good about stepping up to the plate." However, this study suggests that administrators rely very heavily on Latino-serving staff, many of whom have limited human service education and training, to identify and to meet their clients' complex needs.

Over-reliance on Bilingual Staff

As a result of the lack of bilingual professionals, new destination administrators relied heavily on non-professional bilingual staff to guide their agencies' work with Latino clients. Some suggested because these staff interacted with Latino clients regularly, they were better able to assess and to respond to clients' needs. "It's not me…I have some ideas, but like I said, we have a great staff…[it's] their ideas. They're getting the information from clients too. They're seeing the clients' needs far more than I do" (Administrator, 6). Others echoed this sentiment, relaying a willingness to try nearly anything these employees suggested, saying, "if it's a good idea, we'll try it, even if it seems like it might not work" (Administrator, 2). Still, another indicated that she relied exclusively on bilingual staff to alert her to Latino clients' needs. Since staff had not recently suggested otherwise, this administrator (3) felt confident that the agency was meeting Latino clients' need, because her staff, "…are not usually shy about telling me what's going on. If there is something [needed], they just haven't told me yet." Staff confirmed administrators' accounts of their roles. A bilingual administrative assistant described how her agency's administrator regularly solicited her input.

She [administrator] came and asked me, "What did I think was their main problem to get health services?" or "What are the concerns that they always have?" Things like that.

>They [administrators] are always trying to improve the ways to help the community.
>
>(Bilingual Administrative Assistant/Interpreter, 11).

However, about half of the Latino-serving staff these administrators relied upon were non-professionals with a high school diploma and very limited or no human services training. Even among staff with college degrees, only a few studied human services related subjects. Yet, administrators presumed that these workers had the knowledge and experience needed to accurately assess clients' needs and to recommend appropriate interventions. Clerical and intake staff in particular reported that they worked independently with Latino clients, indicating that they could consult with more experienced staff, but were not supervised or included in teams of direct-service providers. Thus, this trial and error approach to serving Latino immigrants often took place in a vacuum of professional human service expertise.

 Further, administrators charged bilingual workers with doing whatever they could to aid Latino clients and to earn their trust, especially by speaking with them in Spanish and helping them navigate a new community. One administrator captured what her colleagues at other agencies suggested: that she counted on her agency's bilingual worker to be available to help Latino clients with whatever they needed, including non-health related issues.

>The clients actually seek her [Bilingual Intake Specialist] out. They'll come in with
>
>questions about other things that really have nothing to do with our health department,
>
>but they'll just come in to talk to her for assistance. She's real outgoing, real friendly,
>
>and it's essentially what she does. (Administrator, 20)

Bilingual staff reinforced this mandate to do whatever needed to be done for Latino clients. "Whatever they need, I try to connect them to services within our community or whatever else

needs to be done, whether it be food, shelter, medical, mental health – anything," affirmed one participant (Hispanic Outreach Coordinator, 13).

In short, the bilingual employees in this study, regardless of their job titles or levels of expertise, often served as the face of the agency and a jack-of-all trades for Latino clients. Prior research on bilingual human service workers suggests that administrators and institutions often expect bilingual staff to take on these critical roles for LEP clients (Castaño et al., 2007; Engstrom et al., 2009; Engstrom & Min, 2004; Jones, 2012; Verdinelli & Biever, 2009b). Yet the literature on bilingual workers recognizes professionals such as social workers and therapists, rather than clerical or intake staff who perform these roles in new destinations. For these institutions, using untrained bilingual staff seemed to be the best of few options – or even the only option - for serving growing Latino populations. However, using a largely untrained workforce to serve a particular group of clients has potential downsides for both workers and clients. Even highly trained professional bilingual staff expressed significant distress resulting from inadequate agency support, heavy caseloads, and isolation (Castaño et al., 2007; Engstrom et al., 2009; Lanesskog et al., 2015; Jones, 2012; Verdinelli & Biever, 2009a, 2009b), suggesting the potential for similar negative impact on untrained bilingual workers. For clients, using untrained workers inherently lowers the standard of care and the overall agency expectations for how this group of clients will be served. Similarly, as bilingual professionals in the literature noted that administrators seemed unaware of the difficulty they faced serving immigrant clients, the administrators in this study seemed not to recognize the potential for their use of untrained bilingual staff to generate stress on workers and lower quality care for Latino clients.

Unprecedented Staff Autonomy

As a result of administrators' directives that staff help Latino clients in any way possible, staff noted that administrators afforded them significant autonomy and flexibility, with little oversight, in serving Latino clients. One worker explained,

> I work at my own pace and do my own things. It's easier for me to help somebody if I'm needed to. I don't report everything of what I'm doing to them [administrators]…I'm not afraid to tell [them]. It's just helping our clients get through whatever they need to get through, I think they [administrators] would consider it part of the job. (Bilingual Administrative Assistant, 16)

Administrators and staff rationalized the unusual sway staff held over agency policies and practices as benefitting the clients. However, a few staff reported a startling level of influence. One bilingual administrative assistant (4) reported that, "Every single thing I've wanted, I've gotten, because she [the administrator] sees that I'm doing it for the community." Administrators confirmed giving bilingual staff unprecedented power over agencies' work with Latinos. One administrator (3) remarked that she "would never stop her [bilingual administrative assistant] from trying something out" to serve Latino clients. These statements highlight the unprecedented authority administrators ceded to bilingual staff who were hired into low-level, clerical positions, but who engaged in the kind of direct practice work that for other client populations was usually performed by professional staff.

Similar statements from the two Hispanic outreach coordinators, from different counties and with very different qualifications, underscored the pervasive influence Latino-serving staff held in spite of their limited expertise. One agency's outreach coordinator (13), who possessed only a high school diploma, seemed to acknowledge the inappropriate extent of her

independence, saying, "I pretty much – I know this is bad to say – but she [administrator] pretty much lets me do what we need to do." The Hispanic outreach coordinator (1) in another community described prevailing in a heated disagreement with her administrator about services for Latino clients. This worker insisted that, "I know the community and I know the people and I know what they need," even though her college degree was in a subject unrelated to health and human services and she had no formal human services training. Rather, this worker argued that working with Latino clients on a regular basis rendered her better qualified to make decisions about service delivery for Latinos than the agency's administrator, a human services professional with decades of experience and advanced public health training. Perhaps a more effective strategy would be to integrate the staff member's practical expertise with the administrator's professional knowledge; however, the administrator acknowledged deferring to the outreach coordinator on most issues.

Interestingly, professional staff seemed more likely than non-professional staff to characterize their influence with administrators in more moderate terms. These staff reported that their administrators were usually very receptive to their ideas, but that their suggestions were not always acted upon right away, if at all. The one nurse (12) who served Latino clients, but who was not bilingual explained that her administrator "listens to me." However, she added that, "maybe I won't always get my way all the time." The bilingual case manager (26) whose county spent $50,000 per year on interpretation described how she and her colleagues, "…finally convinced our administrators that there's a need here [for interpreters] and we will all benefit from this, despite the fact that it's costing us money."

Administrators seemed to be unconcerned that a small cadre of bilingual staff with limited human service experience bore so much responsibility for serving Latino clients. Rather,

administrators seemed grateful and appreciative to have these employees, and presumed that they effectively advocated for and served Latino clients, similar to administrators' perceptions of bilingual professionals' capabilities in traditional destinations (Engstrom, et al., 2009; Moreno et al., 2007; Verdinelli & Biever, 2009a, 2009b). Yet, one administrator reported being terribly disappointed when she learned that her bilingual staff had failed to inform her or to advocate for clients and their children living in squalid conditions.

> I was saddened to know that I had a lot of Spanish-speaking staff here who were very familiar with that situation and didn't, I guess, understand that it wasn't okay. They [bilingual staff] were just like, 'Well, it's better than where they came from in Guatemala.' Okay, but we're not in Guatemala. We actually have rules here.
>
> (Administrator, 2)

This administrator's reaction highlights the dangerous consequences of her agency's lowered expectations about the type of workers responsible for serving Latino clients. In relying on untrained bilingual workers, exploitation and abuse of the agency's Latino clients went unchecked. The agency's bilingual staff simply lacked the professional knowledge that would likely have enabled them to recognize such abuse and to advocate for their clients, including notifying child welfare authorities.

The existing research on human service work with immigrant clients pays scant attention to administrators and non-professional bilingual staff. Perhaps these employees exert more influence on immigrant service delivery in new destinations than they do in traditional destinations where bilingual professionals are more plentiful. Yet, this study suggests that administrators and non-professional bilingual staff play critical roles in new destination service delivery, underscoring the need for greater attention to their efforts.

CHAPTER FIVE

RESULTS: IMPROVISED AGENCY RESPONSES

Agencies used a variety of responses to address three common service challenges: 1)
language barriers, 2) cultural barriers, and 3) clients' difficult circumstances in new destinations.
In this chapter, I describe how these challenges are manifested in new growth communities and
the responses services providers in these contexts employ to address them. The approaches
individual agencies used were largely determined and implemented by the workers who served
Latino clients.

Overcoming Language Barriers

Participants from every public health department in the study emphasized the importance
of their agencies' efforts to overcome language barriers as critical to their work with Latino
clients. Yet, most agencies reported a dearth of bilingual professionals and many reported few
non-professional applicants. The challenge of finding adequate bilingual professional staff is not
unique to new destinations; providers in urban centers with large immigrant populations often
struggle with this challenge. The participants in this study noted that even basic communication
with Latino clients hinged on their institutions' abilities to recruit and retain any bilingual staff or
to find suitable interpreters. The participants in this study reinforced that the well documented
negative impact of ineffective communication between patients and providers (Diamond &
Rueland, 2009; Flores, 2006; Gregg & Saha, 2007; Piedra et al., 2011) is exacerbated by the
scarcity of bilingual workers in new destinations.

All of the study's participants highlighted their reliance on interpreters to communicate
with Latino clients.   Agencies relied on a mix of clients' family and friends, community
volunteers, bilingual staff, contracted interpreters, and telephone interpreters. However, the

overwhelming majority of respondents indicated a clear preference for face-to-face interpretation, especially by bilingual employees who could build rapport with clients and whose efforts did not generate additional expenses. Consequently, participants expressed a hierarchy of interpreter preferences, starting with bilingual employees, then contractual interpreters or clients' family and friends, followed by telephone interpreters. As one administrator explained, "We have two or three interpreters that will come onsite to be with that client, too. We definitely prefer that if our [bilingual] clerical person isn't available. That would be our next option and then the phone line" (administrator, 24). These administrators' preferences for in-person communication are not unique; other human service providers share this inclination for face-to-face interpretation (Crosnoe, et al., 2012; Perreira et al., 2012). Yet, administrators seemed unaware that the quality of interpretation varies depending on the type of interpreter used, and that professional telephone interpreters typically provide higher quality interpretation than untrained friends, family, or bilingual staff (Flores et al., 2012; Giordano, 2007; Illinois Advisory Committee, 2011; Karliner et al., 2007; Roseburg et al., 2007). Agencies' use and characterization of interpreters is described below.

Clients' friends and family. Agencies diverged in terms of whether or not they allowed clients' friends and family to interpret, sometimes citing concerns about accuracy, appropriateness, and confidentiality. Some administrators reported that their agencies no longer allowed clients' friends and family to interpret at all. Many administrators noted the inappropriateness of using clients' children as interpreters given the subject matter of health department visits:

Sometimes you're asking them questions that are way over what their knowledge is. You're talking about breastfeeding…and it made kids very uncomfortable…We do not want to use family members. We definitely don't want to use children. (Administrator, 3)

Others cited the unreliability of friends and family interpreters, who sometimes used their roles to push their own agendas or beliefs on clients. As one administrator explained, "We've pretty much figured out that the interpretation she [the client] was receiving from that friend was skewing in a way how she should respond to breast feeding. We knew the interpretation she was receiving was altered" (Administrator, 21). This administrator confirms what the research suggests about ad hoc interpreters, that without adequate training, they are prone to inject their own beliefs and priorities into the interpretation process (Downing & Roat, 2002). Yet, administrators struggled to weigh this risk of inaccuracy with the potential of alienating clients who preferred to provide their own interpreters.

In spite of their concerns, administrators wavered when asked if they explicitly prohibited the use of clients' friends and family as interpreters. One administrator clarified that although she was certain her staff would not use children to interpret sensitive information, it was sometimes expedient to use child interpreters for less sensitive information, explaining, "You can ask the kid how old is your mom or the last time they [had] seen a doctor, like that, but no real intimate questions" (Administrator, 28). Again, administrators highlighted the predicament of balancing the agency's desire for communicative accuracy with respect for the client's preferences, "That's the thing. It can be really tricky and if they are insistent [on using a friend or family member to interpret] we often will allow it to go forward because we don't want to alienate them from our agency" (Administrator, 21). Consequently, many agencies reported using clients' friends and family to interpret either out of convenience or to accommodate the

client's requests, in spite of widespread concerns about accuracy and appropriateness. The use of clients' family and friends as interpreters is certainly not unique to new destination institutions (Downing & Roat, 2002; IL Advisory Committee, 2011; Partida, 2007), although this study suggests that it may be more commonplace in these communities.

Spanish-speaking staff.   An overwhelming majority of participants preferred using Spanish-speaking staff to all other types of interpreters. Administrators noted that relying on bilingual employees alleviated costs of contract and telephone interpreters, but most importantly, that bilingual staff facilitated trust and rapport with Latino clients. Both administrators and front-line staff remarked on the close working relationships that developed between bilingual employees and their Spanish-speaking clients. One administrator noted how these relationships particularly benefitted clients who had few options for help in the community.

> If they [clients] are new to our agency, they're very happy when they discover we do have a Spanish-speaking person and they tend to trust them automatically. Then often they'll call [this worker] for even other issues because they're a trusted source of information. (Administrator, 8)

Participants went on to explain that using in-house bilingual staff to interpret gave the agency much-needed flexibility to communicate with walk-in clients, to conduct urgent home visits, to engage in community outreach, and to cover for bilingual colleagues when they were absent or otherwise engaged. Several bilingual workers, including administrative assistants, intake specialists, and outreach coordinators recalled being asked to interpret for clients with other local agencies including police, courts, schools, domestic violence agencies, and doctors' offices. Both staff and administrators believed that these efforts on the part of bilingual staff, both inside and outside of their institutions, benefited the clients, their agencies, and the broader

communities. They suggested that bilingual workers' willingness and abilities to help Latino clients elevated the perception of their agencies as helpful and supportive, both to Latino residents and to the broader community. This data suggests that in new destinations, agencies might view their roles as more than just service providers, but as advocates who signal to the community that new Latino residents deserve consideration (Lamphere, 1992).

However, in spite of administrators' concerns about accuracy in using clients' family and friends as interpreters, only two of the agencies reported making any attempts to evaluate the Spanish language skills of their employees. One administrator reported that her agency tested applicants' Spanish fluency, although she could not provide details about the type of test used. Another reported using a Spanish-speaking supervisor to informally assess applicants' conversational skills during the interview process. For the most part, administrators seemed unconcerned about their employees' levels of fluency. However, a number of Spanish-speaking staff expressed uncertainty about their own language skills, suggesting that they were inadequate or could be improved. One worker responsible for most of her agency's work with Latino clients hesitated when asked if she was bilingual. She replied, "A little bit. I'm not fluent" (Hispanic Outreach Coordinator, 1).

Similarly, one administrator seemed to recognize that even conversational fluency did not guarantee the ability to community complex health information in Spanish. She explained that a newly hired staff member, "realized she needed to brush up on some of the language that was going to come up…people aren't talking about TB [tuberculosis] very often" (Administrator, 25). Another administrator expanded on this point, explaining the need for workers to have language fluency and subject area expertise in providing effective care.

If I only had Spanish-speaking staff in my clinic side and I had to send them over to

environmental [health], the client would not get the information as accurately because

they would just be [interpreting] it instead of knowing [the] information. (Administrator,

3)

Yet, even among the few administrators who noted the potential for communicative errors using

bilingual staff, none suggested the need to evaluate workers' language skills. Again, the

participants in this study reinforce what the extensive literature on bilingual workers suggests:

that administrators presume bilingual workers have sufficient language skills, but that bilingual

workers question their abilities (Moreno et al., 2007; Verdinelli & Biever 2009a). Yet, even if

institutions wanted to objectively assess the skills of their bilingual staff, they would be hard

pressed to find standardized assessment tools (Chen et al., 2007; IL Advisory Committee, 2011;

Partida, 2007; Perreira, 2012).

Contract interpreters. Approximately half of the agencies in this study used contract

interpreters hired directly from the community or through interpretation agencies.

Administrators seemed to have little knowledge about whether and how contract interpreters

were trained or evaluated, but they expressed great relief at being able to call on them when

bilingual workers were unavailable or during times when the agency had no bilingual employees.

In addition, administrators noted that contract interpreters' experiences in the community and

connections with other agencies provided an additional resource for clients and the agency

beyond mere interpretation. As one administrator explained,

…we have interpreters that are working within the same population as us, so they

understand some of the systems that are in place and how to reach people and what some

of the resources are out there. Those interpreters are pretty valuable for us…

(Administrator, 24)

In spite of these advantages, administrators cited the costs of using contract interpreters as an obstacle. Other drawbacks included the need to know in advance that Spanish-speaking clients were coming, to work around interpreters' schedules, and to pay for interpreters' time even if clients failed to show up for scheduled appointments.

Telephone interpreters. Most agencies reported having access to telephone interpretation services, commonly referred to as the "language line," in the event bilingual staff or contract interpreters were unavailable or for interpretation of languages other than Spanish. However, several administrators characterized use of the language line as a last resort due to its time-consuming and impersonal nature, as well as its burdensome costs. As one administrator explained, "It's not the best, but we do have telephonic interpreter[s]. We contract with a service…we get on the phone and do that. Oh my God, that sounds so cold and awful!" (Administrator, 25). Another administrator required staff to obtain permission to use the language line in order to avoid what she viewed as unnecessary or non-health related calls. "We discontinued that unless we have a person that we authorize [to use] it. Otherwise you get language line calls and they [clients] just want a ride someplace. That cost me $75.00 just for that [call]" (Administrator, 19).

Only one agency reported using the language line as its primary method of communication with clients who do not speak English. Although this agency had no Spanish-speaking staff, the administrator explained that the agency used the language line as a way of ensuring clients' civil rights to accurate interpretation. This administrator went on to express her support for use of the language line.

> …it has been far more important to ensure that we do the accurate interpretation that the civil rights standards indicate they deserve as clients coming through our WIC and case management program…I'm proud of that. (Administrator, 21)

At the same time, this administrator noted that her employees were often reluctant to use the service. Further, she conceded that it was no match for "that personal connection, that face-to-face connection," generated by bilingual staff and that the agency's Latino caseload declined considerably since it began using the language line for Spanish-speaking clients. However, this administrator was one of only two participants who seemed to recognize her agency's legal responsibility to ensure accurate interpretation for clients with limited English proficiency.

Administrators' reluctance to use expensive contract interpreters, whether in-person or over the telephone, is perhaps unsurprising given the financial constraints they experience and their unfamiliarity with the potential for errors in using untrained interpreters. The literature suggests that providers in traditional destinations also cite expenses as a benefit of ad hoc interpreters or bilingual staff over contract interpreters (Downing & Roat, 2002; Kirmayer et al., 2011). However, beyond concerns about expenses or accuracy, the new destination providers in this study seemed to prioritize in-person interpreters' abilities to gain Latino clients' trust. Both the administrators in this study and the literature suggest that in-person interpreters are better equipped to establish trust (Downing & Roat, 2002; Kirmayer et al., 2011), and the data from this study suggest that trust is a top priority – perhaps the top priority – in new destinations. Like their peers in traditional destinations, new destination administrators likely underestimate the potential for errors in using untrained bilingual staff to interpret for clients, and yet, their focus on trust suggests an important contextual difference: the need to overcome Latino clients' fear and mistrust in order to serve them.

Addressing Cultural Barriers

Nearly all participants bemoaned the constellation of cultural barriers and challenging circumstances that limited clients' access to care. These barriers ranged from cultural differences in gender norms and willingness to discuss reproductive health to the lack of referral agencies with Spanish speaking staff and fear of detection undocumented clients experienced in their new communities. Front-line workers in particular emphasized the importance of taking extra time to learn about and to help clients overcome these barriers.

Administrators and front-line staff from many agencies expressed surprise upon realizing that Latino men were more likely than men from other groups to participate in health department programs, even those typically directed at women and children. Many participants relayed the importance of including male family members in discussions as a sign of respect, saying, "When you find that Hispanic population, when they go to get primary care, the whole family comes. You speak to the family patriarch, which is usually the father or grandfather" (Administrator, 19). Similarly, one participant predicted certain failure for practitioners who failed to include men in the programming for Latinos, explaining, "One thing we learned…you're not going to get very far if you have a health fair and you're only inviting the women to come to it" (Administrator, 25). Still, others went even further, suggesting the importance of reinforcing men's interest in their partners' health. Another participant expounded on her own philosophy of incorporating male partners in her work with Latino families as a way of facilitating trust,

> To me, the goal was not only making that woman feel comfortable, but making that man [feel comfortable]…he's not going to bring his wife in to someone he doesn't feel comfortable with or [to someone] he's concerned she's not going to be taken care of [by]. (Nurse, 12)

Respondents also suggested treading lightly and taking extra care when discussing topics that may be particularly sensitive or that are not typically discussed openly among Latinos. For example, one bilingual administrative assistant recounted the extreme reactions she faced when translating information on the Human Papillomavirus (HPV) vaccine to parents at a community health event.

> Some of them [parents] are like, "Yeah, it's very good that you explained that to us." Some of them were saying that that's encouraging my child to do something [to have sex]. Some of them were like, "Ok, now we understand that. We did not know what vaccinations they take or at what age." (Bilingual Administrative Assistant/Interpreter, 11)

This worker went on to explain that her role was not only to provide information in Spanish, but also to navigate discomfort among parents for whom, "…talking about sex or things like that are like, 'Oh no, don't say that in front of them!' Then here is totally different. I think that's the main thing, the sense of the difference in culture." In this case, the worker noted the need to attend simultaneously and directly to parents' unfamiliarity with the HPV vaccine, as well as to differing cultural norms about reproductive health during the event.

Conversely, one administrator espoused using a more indirect approach when addressing sensitive topics like domestic violence with new Latino residents.

> We can't storm in saying we know you have a domestic violence problem here…because no one's going to come. [Instead], it's like, "Hey, we've got some money. We want to do a community garden. Do you want to partner with us?" Who doesn't like to garden and at least get some fresh fruit and vegetables and develop those relationships? (Administrator, 5)

This respondent emphasized the importance of reciprocity with Latino clients – in this case giving clients a resource for food and building trust, before trying to engage with clients on sensitive topics.

Similarly, participants across three counties recommended caution when addressing elevated lead levels in Latino children. The parents of these children often seemed unfamiliar with the dangers of lead poisoning and were alarmed by the home inspection protocol agencies used in response. These cases were particularly challenging for bilingual workers who were called in to assist their monolingual colleagues. Bilingual workers reported needing considerable time and patience to educate parents, to gain their trust, and to subsequently conduct a thorough investigation at the client's home to identify the source of the lead. For example, one bilingual case manager (27) relayed her efforts to build trust with a pregnant mother whose elevated lead levels threatened her health and that of her unborn child. This worker explained that only after several lengthy visits to the woman's home did the client reveal that she was ingesting lead-based, crushed pottery imported from Mexico to satisfy a pregnancy-related craving. This practice of ingesting non-food substances such as dirt or clay, often during pregnancy, is referred to as *pica* (Young, 2010). Some scholars have suggested that it is more common in certain Latino and African cultures, although the practice is poorly understood and inadequately researched, so no definitive links to culture can be made. Nonetheless, the worker who had been previously unaware of the practice described the satisfaction she felt when her efforts to gain the clients' trust revealed what other monolingual investigators had missed.

> I felt very good just knowing what the source of it was, finding that out. I don't know if
> it would've been found out later, but I always like to pat myself on the back…I felt like I
> helped out with that for sure, just from talking with her and talking with her and it

coming out…They [monolingual staff] were looking everywhere to try to figure out what

the source of it was. (Bilingual Case Manager, 27)

A bilingual administrative assistant from a different county relayed a similar story,

describing an ongoing case in which she was asked to interpret for professional staff

investigating elevated lead levels in a Latino child. This worker explained that it took some

convincing for the mother to even allow public health staff into the home.

She [mom] was a little iffy at first about [us] coming to the house. She didn't really

understand what the importance of it was. "Why do you have to come?" After explaining

to her for a while, we set up the appointment…We were there for quite a while, talking to

her, trying to explain…what a high lead level means and what she can do to lower that

level and ... what needs to happen. (Bilingual Administrative Assistant, 16)

The worker pointed out that the mother was completely unaware of the dangers of lead poisoning

and was fearful of public health employees visiting her home and interceding with her landlord.

This worker and her monolingual colleagues continued to pursue a remedy for this case, but she

noted that they were moving very slowly in light of the mother's reluctance.

Finally, nearly all of the front-line workers who participated in the study emphasized the

importance of taking extra time to explain information – repeatedly – to Latino clients who were

unfamiliar with aspects of American culture embedded in social safety net programs. One

worker noted the need to explain the uses of peanut butter, a staple in the WIC program and in

food pantries. "When you come here to the States, the food is completely different…no one out

there knows what peanut butter is, and we offer it here, so it's just more educating in what we

have to offer" (Bilingual Administrative Assistant, 4). Another worker echoed this sentiment,

especially when detailing the steps needed to apply for and to receive benefits, saying, "You

have to explain it very carefully and then more than once, so they understand how to use things or what to do or what program they qualify for or what they need to do for each thing" (Bilingual Administrative Assistant/Interpreter, 11). Latino-serving staff in particular underscored the importance of taking extra time to understand clients' needs and concerns, and responding with patiently delivered, explicit instructions.

These workers' efforts to bridge cultural differences are certainly admirable and undoubtedly helpful to their clients. Yet, institutions seem to rely on Latino workers to recognize and to remedy cultural barriers on a case-by case basis, rather than adopting systematic, evidence-based approaches to overcoming these challenges for all clients. A growing body of research suggests strategies institutions might use to provide culturally relevant care, including partnering with immigrant residents to identify clients' needs and preferences (Acevedo-Polakovic et al., 2011; Cristancho et al., 2010). Even further, the literature describes specific strategies agencies might use, including *promotora* teams to provide the health education, referral information, and mental health support the bilingual staff in this study often provide individually (Rhodes et al., 2007; Tran et al., 2012; Sauaia et al., 2007; Seth et al., 2015). Similarly, this literature also suggests strategies for educating Latino families about lead based paint (Vallejos, Strack, & Aronson, 2006), for addressing different cultural conceptions of depression (Aisenberg et al., 2012; Dwight-Johnson et al., 2011; Piedra & Byoun, 2012), and for incorporating gender and family norms into care (Davila, Reifsnider, & Pecina, 2011). Yet, the participants in this study seem unaware of this research and instead 'reinvent the wheel' by addressing these common cultural barriers one client at a time, in one agency at a time. The agencies' improvised responses to these cultural barriers highlight the gap between research and

practice, which although prevalent across human services, seems particularly vast in new destinations.

Attending to Clients' Difficult Circumstances

Respondents also described efforts to overcome barriers that stemmed from community limitations as well as from clients' extreme poverty or undocumented status. In particular, front-line workers spent considerable time and energy finding and facilitating referrals, attending to the fears of undocumented clients, and meeting clients' basic needs, regardless of whether those needs were health related.

Provide extra help with referrals. Public health agencies are not alone in struggling to hire bilingual staff; other new destinations institutions, including hospitals, government agencies, and schools experience this challenge. Consequently, respondents reported having limited options for referring Spanish-speaking clients to other providers in the community. Front-line workers often called ahead to gather information from referral agencies and then followed up with clients to make sure referrals were successful. One worker explained, "I follow-up with them. I call them and then I'm like, 'Ok, were you able to find this or did they answer you? Did they call you back?'…I am making sure that they got what they needed" (Bilingual Administrative Assistant/Interpreter, 11). These staff also described avoiding referrals to agencies they knew to be problematic for Spanish-speaking clients, offering to go with clients, or inviting referral agencies to hold regular hours at public health facilities, where Spanish-speaking staff could help with interpretation. One respondent described repeated attempts to avoid sending her clients to an agency known for its poor service to Spanish-speakers, instead encouraging clients to wait for a day when public health staff were available to go with them.

We try not to refer them [to that agency] because even if you give them the phone number, they're not going to be able to understand the options. So I will mention to them, "if you have someone that can help you [interpret], you can go to the [agency], or you can schedule something with us and someone that actually speaks Spanish will be able to do this." (Bilingual Administrative Assistant, 4)

This worker went on to explain the importance of addressing all of her Latino clients' concerns while they were still at her office to avoid miscommunication and missed opportunities for support from other local agencies. "We always try to go out of our way to support them…and what we don't support, we try to help them get the support, to actually leave out of here with an answer" (Bilingual Administrative Assistant, 04).   However, this participant noted, and other bilingual staff concurred, that such thorough service requires workers to go above and beyond, often engaging in extra tasks they would not complete for English-speaking clients. Several workers noted that Spanish-speaking workers at other agencies were not always willing to go to such lengths to help Latino clients. Along these lines, a worker described her client's frustrating experience with an interpreter at a local hospital, "She said, 'I went to the hospital. There was a translator, but she only did her job. When I told her I didn't have this or I have had this problem, they don't help with that.'…She said the person was not very helpful with extra things" such as managing her billing (Bilingual Administrative Assistant/ Interpreter, 11).

Staff respondents reiterated this willingness to go to extra lengths for their clients in many different ways. For example, one worker described driving rural clients who had no other means of transportation to hospitals and clinics in neighboring counties, saying, "I've taken people to appointments. [Clients] who had maybe a serious health issue and drove them to [neighboring county] and didn't get back here until 4:00 am… Those are the types of things I'll

do. They don't necessarily do that up there [at another agency]" (Hispanic Outreach Coordinator, 1).

The literature on bilingual professionals suggests that these workers' willingness to help immigrant clients with tasks outside their official job duties is not unique. Bilingual professionals regularly engage in such exceptional efforts (Engstrom & Min, 2004, Engstrom et al., 2009, Jones, 2012). However, bilingual professionals are typically salaried employees, not support staff earning a low, hourly wage. The Latino-serving workers in this study were not specifically asked if they were compensated for work they performed for clients outside of normal work hours or if they were reimbursed for mileage when using their own vehicles. However, because workers often did not share the details of their efforts with administrators, their out-of-work tasks most likely went uncompensated.

Respond to clients' heightened vulnerability. Administrators and front-line recognized that in addition to experiencing other barriers, their undocumented clients were among the most vulnerable members of their communities. Participants lamented undocumented clients' ineligibility for most programs and services, along with pervasive poverty from working in low-wage jobs. Further, respondents noted that undocumented clients' fear of detection by government authorities impeded their willingness to seek care and to advocate for themselves, and worse, rendered them vulnerable to exploitation. Respondents described a range of approaches they used in attempts to overcome these challenges; however, they reported only limited success.

All of the front-line staff participants and most administrators stressed the critical need to earn and to maintain clients' trust. This was especially true for undocumented clients, but it was often the most challenging task. "I mean the biggest hurdle that we have to get over is the trust

issue… When they get comfortable with us and they trust us it's amazing what they tell us…"

explained one participant (Nurse, 12). Respondents built this trust by maintaining strict

confidentiality, by reassuring clients that they had no connections with immigration enforcement

organizations, and by offering programs in places Latino clients felt safe (e.g. churches, local

restaurants).

Both administrators and front-line staff recognized that any breach of confidentiality

would spread quickly via word of mouth and would damage relationships that took years to

build. One administrator stated that her agency was "very much like Switzerland" when it came

to immigration status – not divulging anything about anyone (Administrator, 22). Another

cautioned of the potential impact on the agency's relationships with Latino clients if a worker

broke clients' trust.

> We work so hard to gain that trust of the Latino population…and that one time the
>
> confidentiality, the cultural sensitivity, or whatever, goes…Just one word, one sentence
>
> and it's just ruined our trust for the entire rest of the – ten, fifteen years later.
>
> (Administrator, 6)

Another front-line worker explained that she and her colleagues pledged confidentiality to each

client at their first visit. "We try to share with them…the first time that we sit down with them,

that we're very strict about confidentiality, that we're here to take care of them…" (Nurse, 12).

Several participants reiterated the importance of repeatedly reassuring clients, especially when

clients revealed that they were working under false names, with false social security numbers.

One worker explained that this was a routine part of her job.

> They work under a different name and they're scared to come in here because they think
>
> that we'll call immigration or something. I advise them. I just work with them and

assure them that that won't happen...That's okay. Nothing's going to happen to you. (Bilingual Intake Specialist/ Interpreter, 23)

Many participants also highlighted offering programs and services in spaces that felt "safe" to Latino clients. For some agencies this meant providing services at sites in the community, such as churches, preschools, or restaurants owned by local Latino families. One administrator suggested that "within the church they feel safe and secure…especially if they've got some government group that's going to ask questions and they're all apprehensive" (Administrator, 20). Another described the rationale for holding an outreach event for her county's small, new Latino community at a local Mexican restaurant. "If they're not familiar with you they're not gonna come, so we felt like the restaurant would be a safe place for them" (Administrator, 8). In other counties, the health department facility was already considered to be a safe place, and these agencies invited other providers to operate out of their buildings, offering parenting classes, teen clubs, English classes, and government benefits appointments.

Respondents identified a similar need to adapt programs and services to the realities of clients' work lives, living conditions, and poverty. Some agencies reported offering walk-in and evening hours to meet the needs of clients' whose low-skilled jobs offered little flexibility and time off. One agency went so far as to keep its Latino outreach center open until 9:00 pm four nights a week to accommodate shift changes at manufacturing plants that employed residents.

Our shift change here is at 6:00 p.m. for [Company X] and then 4:00 p.m. for [Company Y]. Before, we were closed when the shifts got off, but when we started doing the evening thing then people would come here either before they went to work when they had second shift or after they got off work. Our biggest traffic time here is between 6:00 and 8:00 p.m. A lot of people are closed by then. (Hispanic Outreach Coordinator, 1)

Many agencies reported using walk-in appointments, same day appointments, and extended hours to serve Latino clients with limited job flexibility and few transportation options. However, funding constraints limited agencies' efforts, especially as decreases in funding required agencies to reduce the number of hours they were open each week.

Some agencies' programmatic adaptations went well beyond changes to appointment schedules and hours of operations. Several participants disclosed making significant changes to the ways they addressed typical health issues for Latino clients whose circumstances were anything but typical. For example, the peer counselor responsible for encouraging women to continue breastfeeding when they returned to work described abandoning this effort when she discovered that many of her Latina clients were working for an employer who refused them restroom breaks, let alone time to pump breast milk.

> I remember the first client [who worked for Company X]…she said, "I don't even ask them to go to the bathroom because I get in trouble. I have to wear a diaper in line. I can't even imagine asking them to have some time to pump my milk for my baby."…Once they start talking about working at [Company X], I won't even suggest the pumping…[I tell them] they can definitely continue to breastfeed when they're at home with the baby…that their bodies are really smart and can learn to make more milk when they're home and less milk when they're at work. I try to encourage them that way… (Bilingual Peer Counselor/Intake Specialist, 10)

Similarly, an administrator from a different county described her agency's many attempts to remedy the dangerous living situations in which some of the agency's Latino clients resided. The administrator learned that these families, who were undocumented and included medically fragile young children, were renting apartments in a complex that lacked a working sewage

system, among other deficiencies. The agency followed its standard protocols to try to get the landlord, who was also a Latino immigrant, to repair the sewage system. However, when the agency's multi-year efforts failed to generate compliance from the landlord, the administrator pursued extraordinary efforts on behalf of the families she suspected of being exploited by the landlord. She explained, "There was something going on there that – I think I know what it was, but I couldn't prove it, nor did I try to prove it. There was some kind of exploitive situation going on between some of these families and the owner" (Administrator, 2). She attempted to mobilize local service providers and government authorities to address the situation, with little success.

Ultimately the administrator sought legal action to have the complex deemed uninhabitable due to health code violations. Faced with few options and little community support for these families, she found alternate housing for these families, and she and her staff relocated the families, their belonging, and even the plants from their small vegetable gardens to more suitable homes. However, she noted that her actions far exceeded her agency's authority, "I took them [the landlords] on. The beauty of that was half this [stuff] I didn't even have the authority to do, but nobody seems to know that, so it worked out."

Although Latino-serving staff regularly reported going above and beyond their job duties to help vulnerable clients, a phenomenon well documented in the literature on bilingual workers (Engstrom & Min, 2004; Engstrom et al., 2009), only this administrator described exceeding her official responsibilities and authority on behalf of these clients. In general, administrators seemed unaware that Latino-serving staff encountered this level of exploitation, especially among undocumented clients who are over-represented in new destinations (Passel & Cohn, 2009). Although substantial research underscores undocumented residents' heightened barriers

to care, vulnerability to exploitation, and poorer health outcomes (Liebert & Ameringer, 2013; Korinek & Smith, 2011; Portes et al., 2009, 2012) administrators seemed to have little practical guidance for the bilingual staff who served these clients.

Other respondents expounded on the need to meet clients' basic needs before trying to address what were often clients' secondary or tertiary concerns about health and wellness. One front-line worker described her initial approach with clients saying, "whatever they need, I try to connect them to services…whether it be food, shelter, medical, mental health, anything - all types of services" (Bilingual Intake Specialist, 13). Sometimes, clients' and workers' conceptions of basic needs differed, but respondents asserted that the agency's success in meeting its own health goals depended on first attending to clients' priorities. "We take it as our responsibility to help them with whatever issue it is, whether it's relative to …our main mission." (Hispanic Outreach Coordinator, 1). The Hispanic Outreach Coordinator in this county explained that she enlisted community partners and volunteers to provide ESL and citizenship classes, and that she personally helped with children's homework when parents indicated that they wanted to attend to these priorities before attending health programs.

The agency's administrator elucidated on this point adding, "They're thinking, 'You know what? Yeah, I can find some of that basic [stuff], but for me to be able to survive the rest of the time here, I need these ESL, citizenship [classes]" (Administrator, 6). Although the administrator supported these efforts, the burden of identifying and implementing these efforts resided on the effort and ingenuity of one employee with a college degree, tremendous energy, and Spanish language skills, but no formal human service training. This case highlights the extent to which agencies' responses hinged on the goodwill and capabilities of individual staff. Unfortunately, research on other street-level bureaucrats suggests that front-line staff are not

always so willing to extend such aid to clients, especially to those they deem undeserving (Lipsky, 1980). The presumption that bilingual workers will treat all Latino immigrant clients generously seems both misguided and dangerous for clients who have little recourse if they are mistreated or abused by workers.

Distinguishing Between Cultural Barriers and Clients' Circumstances

Respondents often had trouble determining whether barriers were due to cultural differences or to the difficult circumstances of clients' lives. For example, when describing Latino clients' propensity to arrive late or to miss scheduled appointments, some participants attributed this behavior to cultural differences while others pointed to their clients' work in low-wage jobs with rigid hours. How workers characterized these barriers impacted their responses. For example, the worker who attributed missed appointments to inflexible work schedules kept her office open later, while the workers who attributed lateness to clients' culture seemed less accommodating.

Some staff suggested that cultural differences and difficult circumstances worked in tandem to produce insurmountable barriers. The respondent whose Latina clients were unable to leave the assembly line for restroom breaks certainly faulted the company, noting that she considered demonstrating outside the facility to protest the exploitive conditions. However, at the same time, she explained, "in the Hispanic culture …you're taught to work and not complain. You're lucky you have a job" (Bilingual Peer Counselor/ Intake Specialist, 10). She contemplated how her clients' powerlessness in the workplace combined with their cultural beliefs about work to render them vulnerable to exploitation. In doing so, she reflected her own similar circumstances as a low-skilled worker who considered herself lucky to have a job.

In other cases, respondents knew that their clients had encountered significant, sometimes life-threatening barriers to care, but were unable to pinpoint which barriers were most impactful and how they should respond. A non-Latino, bilingual case manager relayed the story of a Latina mother who took her two-year-old child to multiple emergency rooms over a three-week period seeking treatment for a high fever. The mother was turned away repeatedly until the child became so gravely ill that she had to be transported to a specialized hospital several counties away, where she nearly died. The case manager expressed her suspicions about the mother's treatment by doctors at multiple emergency rooms.

> The first thing that comes to mind is, was this a language barrier issue? Could they not understand her? Or did they just dismiss her? Because I have had issues that clients have told me about where that has been the case. I don't know that that's this case, but part of me thinks if my child were sick for three weeks with a fever and couldn't breathe, I wouldn't be put off for three weeks. (Bilingual Case Manager, 26)

This respondent went on to explain that she had years' worth of stories of Latino clients who had experienced discriminatory and inappropriate treatment by providers. Unfortunately, this worker's story is not unique. Accounts of clients' similar experiences, and even deaths at hospitals in new and traditional destinations punctuate the literature on health care with immigrants (IL Advisory Committee, 2011; Partida, 2007, Portes et al., 2009, 2012). Portes and colleagues (2009) estimate that 27,000 preventable deaths occur annually in the U.S. as a result of immigrants' poor access to health care. This case manager explained that she tried to counter these types of cases by advocating for and encouraging her clients to advocate for themselves in order to receive the care they deserved. "Sometimes it takes those extra phone calls and advocating for a client and teaching them that, no, this isn't just. This is not how it works here

and this isn't how it should work for you either" (Bilingual Case Manager, 26). However, the combination of linguistic and cultural barriers combined with fear to severely constrain clients' abilities and willingness to challenge negligent providers.

Tensions for Workers

Latino-serving staff derived great meaning and satisfaction from their work, but also struggled with significant burdens stemming from their positions. They valued the autonomy they were afforded by administrators and the sense of fulfillment they received from helping their clients. However, they were sometimes overwhelmed with responsibility, frustrated by their inability to meet clients' needs, and unable to establish clear boundaries around their roles. Consequently, their work exacted a substantial emotional toll.

Some workers felt the weight of being single-handedly responsible for serving their agency's Latino clients. They noted the potential impact on the agency and on the community when they were not at work or if they were to leave their positions. One worker lamented her efforts to find and train a suitable replacement, acknowledging that if she did not succeed the "program ends with me" (Hispanic Outreach Coordinator, 1). A monolingual nurse (12) who relied on a bilingual clerical staff member for interpretation acknowledged her agency's dependence on its only bilingual employee, exclaiming that, "If [she's] not available, then we got problems!"

For Latino-serving staff, their work roles and responsibilities generated intense emotions. Several Latino staff expressed satisfaction in serving their own communities and being recognized for their work. One worker described realizing that her community members viewed her differently when she began working at the health department:

Walking out in the park or going to the grocery store, and the way that people look at you, it feels good because you could see that they are appreciative of all the help that we have provided. The fact that they're greeting you all the time and look at you different – it feels good. (Bilingual Administrative Assistant, 4)

Although this worker characterized her community as "appreciative" of her work, her friends and neighbors might also have recognized that she held a certain amount of power. That bilingual workers often held such power is highlighted by the intense frustration and sadness workers felt when they felt powerless to help desperate clients. A bilingual administrative assistant (04) described the unexpectedly difficult adjustment she endured upon starting her position. She recounted that, "in the beginning, I had a really hard time coping with the job…I mean it's very difficult sometimes. A lot of the things we see, or their struggles, because you want to help, but there's only so much that we can do."

Workers remarked on the helplessness they felt at often being unable to address the mistreatment their Latino clients faced in the broader community. The bilingual case manager (26) at one agency lamented the discrimination her agency's clients endured in the community, noting that, "…the bilingual staff that we have – we all know of these cases. We know it happens. We're all appalled with what happened [to a particular client], because we know the discrimination our clients are facing." The peer counselor/ intake specialist (10) who learned that her clients were not allowed to leave their assembly line jobs to use the restroom, let alone to pump breast milk, described feeling overcome with grief. "I cried for like two days. I couldn't believe someone would live under that condition," she explained while stifling a sob. Even worse, this worker felt defeated when she told her non-Latino colleagues about this situation only to be met with colleagues' dismissal. She relayed that her colleagues faulted the clients for

not standing up for themselves. She described feeling like there was nothing she could do to help, saying, "It was just kind of left at that. I guess there was nothing we can do, nothing we can say." The impact of these unsupportive colleagues seemed especially disheartening for this worker who was the only bilingual employee at her agency.

These participants' strong emotional reactions are consistent with prior research that identifies similar responses from bilingual professionals who have advanced training in human services and yet are still often troubled by the intensity this work entails (Castaño et al., 2007; Engstrom & Min, 2004; Engstrom et al., 2009; Lanesskog et al., 2015; Verdinelli & Biever, 2009a, 2009b). However, only a few bilingual staff in this study reported receiving the clinical supervision or opportunities to strategize and debrief with Latino-serving peers that would likely be afforded them if they held more professional job titles. When asked, the majority of workers professed that their colleagues were supportive of their work, and yet most reported working independently without the support of a team or engaged supervisor. For these staff, 'supportive' may simply mean that their colleagues do not thwart their efforts.

Boundaries

Bilingual staff reported feeling compelled to help Latino clients who had few other options, even if providing such assistance violated agency policies or placed the employee in danger. Workers from three agencies who helped Latina clients escape domestic abuse, sometimes kept their efforts and fears secret from administrators and colleagues. A nurse described helping a client and the client's children escape domestic violence. The nurse violated agency policy by helping the family flee the home in her own personal vehicle and without the knowledge of her agency's administrator.

We connected her to the domestic shelter. Then we were able to – let me just close this

door [whispering so colleagues won't hear]… we were able to connect her to the shelter.

She called us when her husband had left to work. We had to drive over there, which I

know is not a good thing. We had to drive over there because she did not have

transportation. She was afraid her husband would see her… [so] we took them over to

the shelter…Would we do it again? Yeah, we would do it again to protect the well-being

of the person and the children. Yeah, we would do it again. (Nurse, 13)

Similarly, the bilingual intake specialist at another agency described the implications of her lack

of human service training when a Latina client asked for her help in leaving a violent

relationship. Although this worker sought her administrator's permission, as well as the aid of a

domestic violence advocate and a police escort, she was unprepared to come face to face with the

client's abusive partner when they went to the client's home to retrieve her belongings.

I didn't know if he [male partner] would come after me or try to do something …He saw

me when I went there to the house, when she grabbed all of her clothes and stuff. He saw

me… (Bilingual Intake Specialist/Interpreter, 23)

She feared retaliation from the woman's partner, who would be able to recognize her in the

community. Even though this worker shared her intentions to help the client with her

administrator, her lack of experience and training left her feeling vulnerable and fearful.

Other workers described similar instances in which they transported clients in their

personal vehicles to hospitals and doctors' appointments in neighboring counties, even in the

middle of the night. The majority of front-line participants reiterated their willingness to help

their vulnerable clients in nearly any way possible. One worker reported feeling obligated to

help clients who approached her while she was working at a different job in the community.

Another worker reported doing her public health job without pay to avoid disrupting services for the agency's Latino clients during a budget crisis. Finally, a bilingual administrative assistant (4) described being tempted to bring clients home with her when she could not find housing for the client and her children. The worker decided against taking the client to her home, but explained feeling responsible for the vulnerable family. She explained that her client, "…was nothing but grateful, but personally, I didn't feel like we had done enough. I wanted to take her home because she had two little kids."

Interestingly, only one Latino-serving worker identified tasks she was unwilling to help her clients complete. This worker explained that she often refused clients' requests if they made her uncomfortable, for example, interpreting at court appearances, transporting clients by car, or serving in honorary roles such as a godparent for their children. She explained that, "there are things that if I could help with, I probably would, but I'm not the best person for it," and that a local advocacy organization was better equipped to provide such services. This worker mentioned several times the importance of teaching clients to advocate for themselves, although this is likely much easier to do in a community which has established Latino advocacy groups and ample resources for immigrants.

The majority of staff in this study seemed to take quite literally their administrators' directives to help Latino clients in any way possible. Most went to great lengths, with insufficient resources and preparation, to provide whatever help they could for vulnerable clients who had few other options. In return, all of the study's administrators expressed appreciation, and in many cases, tremendous relief for the work these workers did on behalf of their agencies. Yet, they seemed unaware that their employees were so deeply affected by their work. Administrators repeatedly suggested that their agencies "do a pretty good job" serving Latino

clients. When asked how they might improve services for Latino clients, most pointed to limited resources that hindered program expansion. Nonetheless administrators suggested that if they had the resources they would use them to hire more bilingual staff to conduct outreach, provide mental health care, or engage with Hispanic media. Conversely, front-line workers wanted to help Latino clients access the housing, food, medical care, transportation, employment, and legal status they need to care for their families. Although administrators encouraged workers to attend to these needs, the tools and resources at workers' disposal were often insufficient to meet clients' needs.

CHAPTER SIX:

DISCUSSION

This study examined how public health agencies in new destinations responded to growing numbers of Latino immigrant clients. It examined the contextual factors that shaped agency responses, the strategies agencies used to serve Latino clients, and the ways employees shaped and perceived their agencies' efforts. The study's findings suggest these institutions and their workers are largely on their own, making the best of a difficult situation in which agencies are individually responsible for responding to a nationwide, demographic change in population. They attempt to serve Latino immigrant clients in spite of insufficient structures and resources, especially bilingual professionals. In the midst of this challenging service context, agency administrators turned to their own professional values and their para- and non-professional bilingual staff to guide service delivery to Latino clients. Consequently, agencies improvised; they adopted a wide variety of unsystematic and untested strategies based largely on the resources they had available and the skills and interests of their employees. Many agencies relied on bilingual workers with limited formal education and human service training to propose and to implement these strategies. Overall, this study suggests that Latino immigrants in new destinations likely encounter very different types of programs, access to care, and quality of public health services across locations. Further, they are more likely than their native-born neighbors to be served by para- and non-professional staff who speak Spanish, but who have limited human service expertise.

Administrators and Bilingual Staff Drive Agency Responses

Underdeveloped human service infrastructure, lack of government oversight and support, and the scarcity of bilingual professionals converged to create an especially challenging human

service context in new destinations. This widespread lack of structures and resources for human services work with immigrants created a vacuum that agency administrators, and subsequently bilingual staff felt compelled to fill. Although in theory, government laws and policies, as well as evidenced-based practices should shape human services work with linguistically and culturally diverse clients, this study's findings reaffirm that especially in new destinations these parameters are inadequately communicated, funded, and enforced (Chen et al., 2007; IL Advisory Committee, 2011; Partida, 2007; Perreira, et al., 2012). Instead, these directives seemed inconsequential to administrators who were either unaware of their existence or who lacked resources and incentives to adhere to them. Rather, guided by their professional missions to protect the health of their entire communities, administrators improvised. They directed limited resources towards services for immigrants, hired bilingual staff, and encouraged these staff to do whatever they could to aid their vulnerable clients.

Across agencies, administrators exerted considerably more influence on institutions' approaches to serving Latino clients than external forces such as laws, policies, and political pressures to which institutional efforts are often attributed (Garrow-Hasenfeld, 2010). These findings suggest that in new immigrant destinations, internal institutional forces including workers' professional norms and personal beliefs wielded greater influence on agencies' work with Latino residents. This study's findings highlight the extent to which agency administrators and staff relied on their own judgment, resources, and skills to serve Latino clients. In some cases, agency administrators disregarded laws and evaded political leaders' attention in order to serve clients in ways they and their bilingual staff deemed appropriate. In other instances, administrators and their employees seemed disinterested and disengaged from efforts of peer organizations, federal and state agencies, or research that might provide guidance. In general,

the agencies' approaches to serving Latinos can be characterized as insular and circumscribed by county geographic boundaries, with only limited influence from the broader community, state, or federal government.

This study's findings are consistent with theories emphasizing the role of worker discretion in public services. These data support scholars' recent assertions that administrators rather than elected officials are more likely to drive public institutions' responses to immigrants in new destinations (Jones-Correa, 2008; Lewis & Ramakrishnan, 2007; Marrow, 2011). The administrators in this study explained that they, not elected leaders, decided to recruit bilingual staff, to expend funds, and to create or expand services for Latino residents. Further, several administrators attempted to avoid the disapproval or intervention of elected leaders by obscuring their efforts and expenditures to incorporate immigrants' needs. Similarly, the Latino-serving staff in this study reported many instances of using their considerable discretion to help Latino clients access services, manage referrals, and even escape abuse. Workers overwhelmingly characterized their clients as marginalized and deserving of extra time and attention. This data is consistent with street level bureaucracy theory that suggests public workers use their discretion to benefit clients they perceive as deserving (Lipsky, 1980). Yet, these findings should be interpreted with caution as this study relied solely on what participants said about their work, not on observations of their actual behavior with clients. Street level bureaucrats, especially in human services where time and resources are limited, often use their power to hinder access for clients they view unfavorably (Lipsky, 1980). Even though participants profess overwhelmingly positive interactions and rapport with their clients, surely this is not universally the case.

This study's findings also underscore the impact of the dearth of bilingual professionals in new destinations (Fry, 2008; Perreira, et al., 2012); however, they also reveal that agencies

attempted to fill this workforce gap using untrained bilingual workers to serve Latino clients. Administrators relied almost exclusively on bilingual staff to identify Latino clients' needs, to gain clients' trust, and to suggest and implement corresponding services. Further, administrators seemed relieved to have any bilingual employees and typically presumed that these largely untrained staff had the expertise needed to understand and to meet clients' complex needs. This presumption that bilingual professionals inherently possess the skills needed to serve immigrant clients is well documented in the literature (Castaño et al., 2007; Engstrom & Min, 2004; Engstrom et al., 2009; Lanesskog et al., 2015, Piedra et al., 2011; Verdinelli & Biever 2009a), as are workers' doubts about their abilities (Moreno et al., 2007; Verdinelli & Biever, 2009b). Yet, the bilingual workers in this study were mostly non- and paraprofessional staff with limited education and very little human service training. Even more concerning, these staff performed their duties with unprecedented autonomy, often providing direct services without the peer support, clinical supervision, or formal training and evaluation used to ensure appropriate service delivery by professional providers. Although bilingual staff enjoyed this autonomy and seemed devoted to their clients, they were hindered by their lack of professional training and expertise, as well as by the lack of institutional supports and resources needed to bolster their unusual level of responsibility.

Consequently, bilingual staff struggled to deal with the emotional toll generated by working with clients whose intense needs frequently exceeded workers' and institutions' capabilities. They expressed deep frustration at their inability to effectively aid clients or to address the factors such as undocumented status or a lack of community resources that rendered their clients so vulnerable. Again, these workers' experiences mimicked those of bilingual professionals in traditional destinations who simultaneously took great pride in their efforts and

felt overwhelmed (Castaño et al., 2007; Engstrom & Min, 2004; Engstrom et al., 2009; Lanesskog et al., 2015; and Verdinelli & Biever, 2009a, 2009b). Yet unlike their professional peers, these workers struggled to establish professional boundaries, instead taking literally their administrators' directives to help Latino clients in any way possible.

In stark contrast to bilingual workers' frequent feelings of powerlessness, administrators exhibited a sense of complacency about their agencies' efforts, suggesting that they did the best they could under such difficult services. Administrators seemed unaware of the tremendous burden and responsibility their bilingual workers experienced. Further, they seemed either unconcerned with the potential for communicative errors and subpar service delivery that might result from using workers whose language skills were untested and whose human service training was minimal. Similarly, they seemed unaware that the unusual level of autonomy they afforded bilingual staff might encourage workers to engage in street level bureaucracy, affording beneficial treatment to clients they valued and discriminatory treatment to clients they deemed undeserving (Lipsky, 1980). Administrators seemed not to recognize that their agencies' and clients' dependence on bilingual workers might enable inappropriate or unscrupulous workers to go unnoticed (Lanesskog et al., 2015). In short, these findings suggest the public health responses in these new destinations hinged on the good intentions, ingenuity, and capabilities of each agency's employees.

Unsystematic Responses

The unique human service context in new destinations spurred agencies to respond individually to growth in their Latino populations. The lack of funding and best practices for serving immigrants in this context required agencies to improvise, often adopting strategies that were not necessarily aligned with clients' needs or priorities, but rather with agency resources

and workers' priorities. Consequently, these responses were unsystematic and were not evidenced-based.

The study's findings underscore the critical impact of funding in providing appropriate and adequate care for immigrants, especially for those ineligible for Medicaid (Gresenz et al., 2012; Portes et al., 2012) The dearth of funding to help agencies serve culturally and linguistically diverse clients limited agencies to adopting responses they could fund by leveraging grants or to low or no-cost initiatives they could implement with existing resources. Unlike prior research, this study describes how grant-savvy administrators leveraged funds for HIV prevention, lead testing, or breast and cervical cancer screening to improve or expand services for Latino clients. However, grant funding is competitive and the small populations in many counties limited their competitiveness. Further, agencies' abilities to leverage grant funding in this way depended on administrators' awareness of this possibility and their ability to successfully navigate application processes in order to secure such funding. Agencies with little grant funding and limited resources used low or no-cost strategies to try to build relationships with Latino clients through methods such as community gardening or inviting Latino-serving organizations to co-locate in the agency's space.

Similarly, a lack of experience and the absence of best practices for serving Latino immigrants in new destinations led agencies to experiment with a wide assortment of responses., These findings underscore the gap between research and practice, which is especially well documented in fields such as public health, mental health, and social work (Kilbourne et al., 2006; Marsh, 1983; Vega & Lopez, 2001). This rift is especially wide in new destinations in part because the bulk of the research on human service delivery with Latino immigrants centers on traditional destinations, where conditions differ significantly (Fry, 2008; Perreira et al., 2012). A

smaller, but growing body of research identifies and evaluates intervention strategies new destination institutions might use, such as using *promotoras* and provider/interpreter teams, but the administrators in this study seemed unaware of its existence. In addition, although agencies experimented with their own interventions, they reported few efforts to evaluate the effectiveness of these efforts or to disseminate information on the strategies they used. Consequently, agencies reported little awareness of each other's efforts and had few opportunities to learn from one another's experiences. However, these findings also underscore the challenges institutions and workers encounter when serving a changing client population and the time needed to adapt. Although government standards and policies for serving diverse clients were put in place to guide institutions' efforts, expecting inexperienced agencies and their workers to provide high quality, culturally and linguistically accessible services within a decade or two may be unrealistic.

These findings suggest that for agencies and especially for bilingual staff, this lack of coordination generated a difficult service delivery environment. However, for new destination Latinos, especially for Spanish-speakers, the impact of this disjointed system is even more problematic. These findings suggest that Latino immigrants in new destinations are more likely than their English-speaking peers to be served by workers with limited education and human service training, using approaches that are not evidence based. Further Latino clients presumably encounter a variety of types of public health services, access, and quality of care depending on where they reside. The study's findings corroborate prior research that highlights the complexity of human service work with Latino immigrant clients and reaffirms the importance of attending to the many barriers that limit Latino clients' access to care (Fry, 2008; Gresenz et al., 2012; Harari et al., 2008; Perreira et al., 2012). However, the study emphasizes

the ways these challenges are magnified and agencies' abilities to overcome them are severely constrained in new destinations.

Tensions in New Destinations

More broadly, this study highlights tensions about the roles and responsibilities of human service professions, institutions, and workers in new destinations. The public health profession's broad directive to promote and protect a community's health can be used to make the case for addressing many of social problems participants described in new destinations. Certainly, poverty, food insecurity, unsafe housing, exploitive employment, and inadequate medical care negatively impact health; in fact, very few activities do not impact health (Duffy, 1990). Yet, many study participants seemed uncertain and even ambivalent about the extent to which they and their institutions were obliged or authorized to address conditions that contributed to the marginalization of their Latino clients. For example, administrators and staff bemoaned undocumented immigrants' ineligibility for Medicaid, public housing, and other social safety net programs, but none reported engaging in efforts to challenge these criteria. Similarly, administrators bemoaned the lack of funds other materials needed to improve services for culturally and linguistically diverse clients, especially from federal and state programs they administered. Still, they did not report lobbying funders for these resources. In short, although participants aided individual clients and families within their communities, most did not advocate publicly for Latino residents with governments, employers, landlords, or other institutions.

Scholars and practitioners in a variety of human service-related professionals have called upon their fields' members to advocate for broader social change on behalf of marginalized clients, including immigrants. For example, in the field of urban planning, the practice of

advocacy planning directs professional planners with technical expertise to identify and to pursue infrastructure improvements for historically marginalized communities, often low-income communities of color (Harwood, 2003). These planners are funded by local governments, but serve as consultants and advocates who help traditionally underserved residents effectively navigate municipal planning processes to secure improvements such as street lights, traffic calming measures, and sidewalks. In the field of social work, similar calls for re-engagement in advocacy to disrupt unjust social structures (Specht & Courtney, 1994) and to re-invigorate the profession's historical focus on immigrants (Engstrom & Okamura, 2008) underscore the importance not only of serving marginalized people, but challenging systems that diminish their life chances.

Public health scholars suggest that advocating for clients requires agencies to engage with the communities they serve in meaningful ways (Bassett, 2003), for example through the use of community-based participatory research (Minkler et al., 2003). Yet, many of the agencies in this study struggled to build relationships with the Latino immigrant communities they served. The few agencies with no bilingual staff and those that did not conduct outreach stood little chance of developing partnerships with Latino residents. However, even agencies with bilingual workers who professed strong relationships with the Latino community seemed to limit their efforts to providing direct services rather than advocating for clients' in the broader community. The agencies' over-reliance on para- and non-professional bilingual staff may contribute to their limited focus on advocacy. In spite of their autonomy in serving clients, these mostly clerical and administrative staff may not possess the clout needed to advocate for their clients with community leaders, or the skills needed to help clients organize and advocate for themselves. Further, within the agency, these staff may not have the status needed to mobilize their

monolingual peers who shoulder little responsibility for Latino clients. For example, the bilingual peer counselor whose clients were not allowed to leave the assembly line to use the restroom found she was unable to gain the sympathy, let alone the support of her monolingual colleagues.

Similarly, although administrators solicited the input of bilingual staff, many remained at arms-length from Latino clients and their circumstances. This distance may prevent administrators from fully appreciating the depth and urgency of Latino clients' needs. For example, one administrator described her intense dismay, outrage, and ultimately her sustained advocacy efforts after visiting Latino clients living in an apartment surrounded by raw sewage. Visiting the residents with bilingual staff and observing the dangerous conditions spurred the agency's leader to use her authority and her sway with public officials, options not available to her bilingual para-professional staff. Conversely, administrators who keep elected officials and government oversight boards in the dark about agency efforts or expenditures to serve Latinos may protect their agencies, themselves, and even their clients from scrutiny, but at the same time they likely miss opportunities to leverage their authority in advocating publicly for Latino residents.

Implications

Findings from this study suggest implications for research, practice, and policy regarding human service work in new destinations.

Research Implications

The study's findings suggest the need for research on effective human services interventions in new destinations where clients' needs, workers' abilities, and institutions' resources differ from those of traditional, urban destinations. Especially in light of agencies'

reliance on untrained, in-person interpreters rather than trained, telephone interpreters, research is needed to identify interpretation methods that balance workers' preferences for face-to-face interaction with agencies' responsibility to ensure communicative accuracy. Further, this research should incorporate clients' preferences, about which agencies possess only anecdotal information. Similarly, agencies and their clients would likely benefit from standardized tools to assess workers' language skills and to identify which services workers can effectively provide in the client's language. These types of objective assessments are already being developed by private health care providers (Kaiser Permanente 2014; RWJ Foundation, 2008), but are sorely needed in public settings as well.

The efficiency and effectiveness of public health education programs could likely be improved using research that develops, evaluates, and perhaps most importantly, disseminates culturally adapted education materials and intervention protocols on topics including lead poisoning, nutrition, and reproductive health. Additionally, these interventions should include information to help prepare practitioners to address the difficult circumstances many immigrants face as a result of their undocumented status. For example, protocols for addressing lead poisoning should encourage providers to proceed with caution and to evaluate alternatives for undocumented families who are vulnerable to exploitive landlords and are typically ineligible for public housing. In short, human service providers need research that identifies the best practices to use given the unique constraints providers and clients face in new destinations.

Practice Implications

This study highlights the need for protocols for the appropriate training, use, and supervision of para- and non-professional bilingual staff in new destination human services delivery. Many of these workers operate with insufficient supervision, support, and preparation,

although they care a tremendous responsibility for the health and well-being of vulnerable clients. Agencies might adopt a team approach, in which monolingual and bilingual employees are grouped together in ways that leverage team members' professional skills, language ability, and cultural knowledge to provide more comprehensive and effective service delivery. This type of approach might help reduce agencies' and clients' dependence on individual bilingual staff, easing their burdens as well as limiting opportunities for unscrupulous workers to go undetected. Further, a team approach might encourage and empower workers to collectively address unfair or exploitive treatment of clients at the agency or in the community, rather than leaving this task to individual bilingual non-professional staff.

Alternatively, institutions might use creative strategies to increase the supply of bilingual professionals in new destinations. For example, agencies might expand recruitment efforts to include cities and states with more bilingual residents, rather than local advertisements. Similarly, institutions might develop the public health counterpart to Teach for America, the education program that recruits and trains college graduates to serve two-year stints as teachers in communities with teacher shortages. These approaches would require additional efforts on the part of agencies, but they would likely bolster the bilingual workforce upon whom agencies depend.

Policy Implications

Study findings emphasize the need for more effective planning, incentives, and oversight of human service delivery with linguistically and culturally diverse clients. Federal and state policies that establish standards for appropriate service delivery have little impact if they are not adequately enforced and funded. Similarly, agencies have little impetus for collaboration and cooperation when they are competing with peer institutions for grant funding. Funders,

including many federal agencies, could alter their grant models to encourage new destination agencies to develop coordinated, efficient, multi-community efforts to address immigrants' needs. Additionally, funders could alter criteria that currently benefit communities with large immigrant populations to reflect the relatively small Latino populations increasingly found across new destinations.

Finally, this study illuminates the need for policies to address the vulnerability of the country's undocumented immigrant population, especially this group's limited access to social safety net programs. The over-representation of undocumented persons in new destinations places immigrant families, their American-citizen children, and the communities in which they reside at risk of poor health outcomes and uncertain futures. For undocumented families, limited access to human services programs and fear of detection leaves them vulnerable to health risks, extreme poverty, and exploitation. For new destinations, especially those depending on Latino newcomers to reinvigorate declining populations, the challenges of meeting undocumented residents' needs place additional stress on human services institutions and workers already struggling with insufficient resources. Many of the public health administrators and front-line staff who participated in this study already recognize that the well-being of their entire communities is linked to the well-being of its most vulnerable residents. Government safety net policies should reflect this reality.

Strengths and Limitations

This study has several key strengths, the first of which is its focus on an emerging phenomenon: human services work with Latinos in new immigrant destinations. A growing body of research examines the challenges human service providers and their clients face in this context, but very little research delves into the responses agencies use. This study lays the

groundwork for future research to evaluate the strategies agencies use in an effort to improve their effectiveness and to disseminate best practices. Second, the study's triangulation of data from different types of employees across many agencies and communities allows for a broader and deeper analysis than prior studies which focus more narrowly on the experiences of bilingual professionals, of individual agencies, or of single communities. Third, the study centers on public health agencies, which are infrequently addressed in research on human services with immigrants, even though they comprise an important part of the health care safety net especially for undocumented immigrants. The existing literature on health care with Latino immigrant clients focuses instead on the roles of primary care providers and hospitals.

The study's findings are limited by its sampling and data collection methods. First, study participants may have held more positive views and greater interest in serving Latino immigrants than their peers who declined to participate. Additionally, administrators likely nominated their most competent bilingual employees to participate in the study in an effort to present their agencies in the best light. The perspectives of these eleven front-line staff may not adequately reflect the range of Latino-serving workers' experiences. Second, the study's use of single interviews provides a snapshot of participants' perspectives and agency conditions at one point in time. Repeated interviews over time may have yielded deeper participant insights and richer descriptions of events. Similarly, participant observation of agencies' operations may have revealed policies and practices with Latino clients that have become routine or unremarkable to agency staff. Finally, the study's applicability to other human services institutions beyond public health, and to other new destinations, particularly those in different states with different workforce characteristics, eligibility policies, and funding environments, is unclear.

Conclusion

A century ago, waves of immigrants to the U.S. found themselves in large, urban centers, surrounded by other newcomers who came from different cultures, spoke different languages, and struggled to adapt to a new environment. Early social workers supported many of these immigrant families, helping to incorporate these new Americans into their adopted communities and country. Today, in the cities and towns that form new immigrant destinations across the U.S., Latino immigrant families rely on human service institutions, including public health agencies, to meet their basic needs and to help them acclimate to their new communities. This study examined the ways these institutions responded to Latino residents' needs and found that the difficult service context in new destinations generated a mismatch between clients' needs and agencies' capabilities. The lack of structures, resources, and bilingual professionals in new destinations encouraged agencies to improvise, responding locally to a nationwide demographic shift. Agency administrators made the best of their limited resources, relying heavily on bilingual non-professionals to develop and implement services. Consequently, agencies across these communities used a variety of unsystematic responses to serve immigrant residents. Although both administrators and bilingual staff were proud of their efforts and seemed dedicated to their clients, bilingual workers in particular were frustrated by their frequent inability to meet clients' complex needs. The ad hoc nature of these responses likely resulted in Latino clients encountering different types of services, levels of access, and quality of care depending on where they resided. Yet, they were more likely than their traditional destination peers to be served by staff with limited education and little human service training. This study's findings highlight the need for increased planning, oversight, and resources to support human service work in new destinations. The health and wellbeing of Latino families in these

communities, and the future prosperity of new destinations across the country depend on the

ability of human service providers to ensure a basic level of care for all residents.

REFERENCES

Abbott, A. (1995). Boundaries of social work or social work of boundaries?: The social service review lecture. *Social Service Review, 69*(4), 545-562.

Acevedo-Polakovich, I. D., Crider, E. A., Kassab, V. A., & Gerhart, J. I. (2011). Increasing service parity through organizational cultural competence. In L. P. Buki, & L. M. Piedra (Eds.), *Creating infrastructures for Latino mental health* (pp. 79-98). New York: Springer.

Aisenberg, E., Dwight-Johnson, M., O'Brien, M., Ludman, E. J., & Golinelli, D., (2012). Building a community-academic partnership: Implementing a community-based trial of telephone cognitive behavioral therapy for rural Latinos. *Depression Research and Treatment, 2012*, 1-9.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog? *The BMJ (formerly British Medical Journal, 322*, 1115-1117.

Bassett, M. T. (2003). Public health advocacy. *American Journal of Public Health*, *93*(8), 1204.

Beeber, L. S., Lewis, V. S., Cooper, C., Maxwell, L., & Sandelowski, M. (2009). Meeting the "now" need: PMH-APRN – interpreter teams provide in-home mental health intervention for depressed Latina mothers with limited English proficiency. *Journal of the American Psychiatric Nurses Association, 15*(4), 249-259.

Brodkin, (2010). Human service organizations and the politics of practice. In Y. Hasenfeld (Ed.) *Human services as complex organizations*, Thousand Oaks, CA: Sage Publications, pp. 61-78.

Brown, A. & Patten, E., (2014). *Statistical portrait of Hispanics in the United States, 2012.* Washington, D. C.: Pew Research Center. Retrieved from http://www.pewhispanic.org/2014/04/29/statistical-portrait-of-hispanics-in-the-united-states-2012/

Cabell, M. G. (2007). *Mexican immigrant integration in the U.S. Southeast: Institutional approaches to immigrant integration in Owensboro, Kentucky.* (No. 153). San Diego, CA: The Center for Comparative Immigration Studies.

Castaño, T. M., Biever, J. L., Gonzalez, C. G., & Anderson, K. B. (2007). Challenges of providing mental health services in Spanish. *Professional Psychology: Research and Practice, 38*(6), 667-673.

Centers for Disease Control and Prevention (2014). *HIV among Latinos.* Retrieved from www.cdc.gov/hiv/risk/racialethnic/hispaniclatinos/facts/index.html.

Charmaz, K. (2009). Shifting the grounds: constructivist grounded theory methods. In J.M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke (Eds.) *Developing grounded theory: the second generation.* Walnut Creek, CA: Left Coast Press.

Chen, A. H., Youdelman, M. K., & Brooks, J. (2007). The legal framework for language access in healthcare settings. *Journal of General Internal Medicine*, *22*(Suppl 2), 362-7.

Corbin J. & Strauss, A. (2008). Basics of qualitative research. Los Angeles, CA: Sage Publications.

Cristancho, S., Peters, K. E., & Garcés, D. M. (2011). Latinos in rural areas: Addressing mental health disparities in new growth communities. In L. P. Buki, & L. M. Piedra (Eds.), *Creating infrastructures for Latino mental health* (pp. 215-231) New York: Springer.

Crosnoe, R., Pedroza, J. M., Purtell, K., Fortuny, K., Perreira, K. M., Ulvestad, C. W., & Chaudry, A. (2012). Promising practices for increasing immigrants' access to health and human services. Washington, D.C.: U.S. Department of Human Services.

Davila, Y. R., Reifsnider, E., & Pecina, I. (2011). Familismo: influence on Hispanic health behaviors. *Applied Nursing Research*, *24*, e67-e72.

Diamond, L. C., & Reuland, D. S. (2009). Describing physician language fluency. *Journal of the American Medical Association, 301*(4), 426-428.

Donato, K. M., Tolbert, C., Nucci, A., & Kawano, Y. (2008). Changing faces, changing places: The emergence of new nonmetropolitan immigrant gateways. In D. A. Massey (Ed.), *New faces in new places: The changing geography of American immigration* (pp.75-98), New York: Russell Sage Foundation.

Downing, B. & Roat, C. E. (2002). *Models for the provision of language access in health care settings.* The National Council on Interpreting in Health Care. Retrieved from http://www.ncihc.org/assets/documents/workingpapers/NCIHC%20Working%20Paper%20-%20Models%20for%20Provision%20of%20Language%20Access.pdf

Duffy, J. (1990). *The sanitarians: A history of American public health.* Chicago: University of Illinois Press.

Dwight-Johnson, M., Aisenberg, E., Golinelli, D., Hong, S., O'Brien, M., & Ludman, E. (2011). Telephone-based cognitive-behavioral therapy for Latino patients living in rural areas: A randomized pilot study. *Psychiatric Services*, *62*(8), 936-942.

Ehrenreich, J. H. (1985). *The altruistic imagination: A history of social work and social policy in the United States*. Ithaca, NY: Cornell University Press.

Engstrom, D. W., & Min, J. W. (2004). You just have to do a lot more for them: Perspective of bilingual social workers. *Journal of Ethnic & Cultural Diversity in Social Work, 13*, 59-82.

Engstrom, D. W. & Okamura, (2007). A nation of immigrants: A call for a specialization in immigrant well-being. *Journal of Ethnic and Cultural Diversity in Social Work, 16*(3-4), 103-111.

Engstrom, D. W., Piedra, L. M., & Min, J. W. (2009). Bilingual social workers: Language and service complexities. *Administration in Social Work, 33*(2), 167-185.

Fee, E. (2015). Public health past and present: A shared social vision. Introduction to G. Rosen, *A history of public health*. Baltimore, MD: Johns Hopkins University Press.

Fix, M. E. & Passel, J. S. (2002). *The scope and impact of welfare reform's immigrant provisions.* Discussion paper no. 02-03, Washington, D.C.: Urban Institute.

Flores, G. (2006). Language barriers to health care in the United States. *The New England Journal of Medicine, 355*(3), 229-231.

Flores, G., Abreu, M., Barone, C. P., Bachur, R., & Lin, H. (2012). Errors of medical interpretation and their potential clinical consequences: A comparison of professional versus ad hoc versus no interpreters. *Annals of Emergency Medicine, 60*(5), 545-553.

Fong, R. (Ed.) (2004). *Culturally competent practice with immigrant and refugee children and families.* New York, NY: Guilford Press.

Fortuny, K. & Chaudry, A. (2011). A comprehensive review of immigrant access to health and human services. U.S. Department of Health and Human Services.

Fry, R. (2008). *Latino settlement in the new century.* Washington, D.C.: Pew Hispanic Center.

Garrow, E. & Hasenfeld, Y. (2010). Theoretical approaches to human service organizations. In Y. Hasenfeld (Ed.) *Human services as complex organizations, (pp 33-58),* Thousand Oaks, CA: Sage.

Giordano, S. (2007). Overview of the advantages and disadvantages of professional and child interpreters for limited English proficiency patients in general health care situations. *Journal of Radiology Nursing, 26*(4), 126-131.

Gregg, J., & Saha, S. (2007). Communicative competence: A framework for understanding language barriers in health care. *Journal of General Internal Medicine, 22*(Suppl. 2), 368-370.

Gresenz, C. R., Derose, K. P., Ruder, T. & Escarce, J. J. (2012). Health care experiences of Hispanics in new and traditional U.S. destinations. *Medical Care Research and Review, 69*(6), 663-678.

Harari, N., Davis, M., & Heisler, M. (2008). Strangers in a strange land: Health care experiences for recent Latino immigrants in Midwestern Communities. *Journal of Health Care for the Poor and Underserved, 19*(4), 1350-1367.

Harwood, S. A. (2003). Environmental justice on the streets: Advocacy planning as a tool to contest environmental racism. *Journal of Planning and Education Research, 23*, 24-38.

Hasenfeld, Y. (2010). The attributes of human services organizations. In Y. Hasenfeld (Ed.) *Human services as complex organizations* (pp. 9-32*),* Thousand Oaks: Sage.

Illinois Advisory Committee to the U.S. Commission on Civil Rights, (2011). *Health Facilities in Illinois and Patient Access to Quality Language Interpreters.*

Institute of Medicine of the National Academies (2003). *The future of the public's health in the 21st century.* Washington, D.C.: The National Academies Pres..

Jiménez, T. R. (2007). From newcomers to Americans: An integration policy for a nation of immigrants. *Immigration Policy in Focus, 5*(11), 1-10.

Jiménez, T. R. (2010). *Replenished ethnicity: Mexican-Americans, immigration, and identity.* Berkeley, CA: University of California Press.

Jones, S. (2012). Working with immigrant clients: Perils and possibilities for social workers. *Families in Society: The Journal of Contemporary Social Services, 93*(1), 47-53.

Jones-Correa, M. (2005). *The bureaucratic incorporation of immigrants in suburbia.* Paper prepared for presentation at the conference on "Immigration to the United States: New Sources and Destinations," Russell Sage Foundation, New York; February 3-4, 2005.

Jones-Correa, M. (2008). Race to the top? The politics of immigrant education in suburbia. In D. Massey (Ed.), *New faces in new places: The changing geography of American immigration* (pp. 308-340). New York, NY: Russell Sage Foundation.

Kaiser Permanente Institute for Health Policy, (2014). Kaiser Permanente's Qualified Bilingual Staff model. *Kaiser Permanente Policy Stories*, *3*(2).

Kandel, W., Henderson, J., Koball, H., & Capps, R. (2011). Moving up in rural America: Economic attainment of nonmetro Latino immigrants. *Rural Sociology, 76*(1), 101-128.

Kandel, W., & Parrado, E. A. (2005). Restructuring the US meat processing industry and new Hispanic migrant destinations. *Population and Development Review, 31*(3), 447-471.

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Research and Educational Trust*, *42*(2), 727-754.

Kilbourne, A. M., Switzer, G., Hymen, K., Crowley-Matoka, M., Fine, M. J. (2006). Advancing health disparities research within the health care system: A conceptual framework. *American Journal of Public Health*, *96*(12), 2113-2121.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K., (2011). Common mental health problems in immigrants and refugees: general approach in primary care. *Canadian Medical Association Journal*,

183(12), E959-E967.

Korinek, K., & Smith, K. R., (2011). Prenatal care among immigrant and racial-ethnic minority women in a new immigrant destination: Exploring the impact of immigrant legal status. *Social Science & Medicine*, *72*, 1695-1703.

Lamphere, L. (1992). Preface and Introduction. *Structuring Diversity: Ethnographic Perspectives on the New Immigration.* Chicago: University of Chicago Press, pp. vii-ix, and 1-34.

Lanesskog, D., Piedra, L. M., & Maldonado, S. (2015). Beyond bilingual and bicultural: Serving Latinos in a new growth community. *Journal of Ethnic and Cultural Diversity in Social Work*, *24*(4), 300-317.

LaRossa, R. (2005). Grounded theory methods and qualitative family research. *Journal of Marriage and Family*, *67*(4), 837-857.

Leach, M. A., & Bean, F. D. (2008). The structure and dynamics of Mexican migration to new destinations in the United States. In D. Massey (Ed.) *New Faces in New Places: The Changing Geography of American Immigration* (pp. 51-74), New York: Russell Sage Foundation.

Lewis, P. G., & Ramakrishnan, S. K. (2007). Police practices in immigrant-destination cities: Political control or bureaucratic professionalism. *Urban Affairs Review, 42*(6), 874-900.

Lichter, D. T. (2012). Immigration and the new racial diversity in rural America. *Rural Sociology, 77*(1), 3-35.

Lichter, D. T., & Johnson, K. M. (2009). Immigrant gateways and Hispanic migration to new destinations. *International Migration Review, 43*(3), 496-518.

Lichter, D. T., & Johnson, K. M. (2006). Emerging rural settlement patterns and the geographic redistribution of America's new immigrants. *Rural Sociology, 71*(1), 109-131.

Liebert, S. & Ameringer, C. F. (2013). The health care safety net and the affordable care act: Implications for Hispanic immigrants. *Public Administration Review*, *73*(6), 810-820.

Lincoln, Y. & Guba, (1985). *Naturalistic inquiry.* Newberry Park, CA: Sage.

Lipsky, (1980). *Street-level bureaucracy: Dilemmas of the individual in public services.* New York, NY: Russell Sage Foundation.

Livingston, G. (2009). *Hispanics, health insurance, and health care access.* Washington, D. C.: Pew Research Center. Retrieved from

http://www.pewhispanic.org/2009/09/25/hispanics-health-insurance-and-health-care-access/

Livingston, G., Minushkin, S., & Cohn, D. (2008). *Hispanics and health care in the United States: Access, information, and knowledge.* Washington, D. C.: Pew Research Center. Retrieved from http://www.pewhispanic.org/2008/08/13/hispanics-and-health-care-in-the-united-states-access-information-and-knowledge/

Marrow, H. B. (2011). *New destination dreaming: Immigration, race, and legal status in the new American south.* Stanford, CA: Stanford University Press.

Marsh, J. C., (1983). Research and innovation in social work practice: Avoiding the headless machine. *Social Service Review*, *57*(4), 582-598.

Massey, D. S. (2008). Assimilation in a new geography. In D. Massey (Ed.) *New faces in new places: The changing geography of American immigration* (pp.343-353), New York: Russell Sage Foundation.

Maxwell, J. A. (2005). *Qualitative research design: An interactive approach.* Thousand Oaks, CA: Sage.

Menéndez Alarçon, A. V., & Novak, K. B. (2010). Latin American immigrants in Indianapolis: Perceptions of prejudice and discrimination. *Latino Studies, 8*(1), 93-120.

Meyer, J., & Weiselberg, L., (2009). *County and city health departments: the need for sustainable funding and the potential effect of health reform on their operations.* Report prepared by Health Management Associates for the Robert Wood Johnson Foundation and the National Association of County and City Health Officials.

Minkler, M., Blackwell, A. G., Thompson, M., & Tamir, H. (2003). Community-based participatory research: Implications for public health funding. *American Journal of Public Health*, *93*(8), 1210-1213.

Moreno, M. R., Otero-Sabogal, R., & Newman, J. (2007). Assessing dual-role staff-interpreter linguistic competency in an integrated healthcare system. *Journal of General Internal Medicine*, *22*(Suppl 2), 331-335.

National Association of County & City Health Officials. (2014). *2013 National profile of local health departments*.

Organista, K. C. (2009). New practice model for Latinos in need of social work services. *Social Work, 54*(4), 297-305.

Park, Y. (2006). Constructing immigrants: A historical discourse analysis of the representations of immigrants in US social work, 1882-1952. *Journal of Social Work, 6*(2), 169-203.

Park, Y., & Bhuyan, R. (2012). Whom should we serve? A discourse analysis of social workers' commentary on undocumented immigrants. *Journal of Progressive Human Services, 23*(1), 18-40.

Park, Y., Bhuyan, R., Richards, C., & Rundle, A. (2011). U.S. social work practitioners' attitudes towards immigrants and immigration: Results from an online survey. *Journal of Immigrant & Refugee Studies, 9*, 367-392.

Park, Y., & Kemp, S. P. (2006). "Little alien colonies": Representations of immigrants and their neighborhoods in social work discourse, 1875-1924. *Social Service Review, 80*(4), 705-734.

Partida, Y. (2007). Addressing language barriers: Building response capacity for a changing nation. *Journal of General Internal Medicine, 22*(Suppl 2), 347-349.

Passel, J. R., & Cohn, D. (2009). *A portrait of undocumented immigrants in the United States.* Washington, D. C.: Pew Hispanic Center.

Patten, E. (2014). *Why is the teen birth rate falling?* Washington, D.C.: Pew Research Center. Retrieved from http://www.pewresearch.org/fact-tank/2014/04/21/why-is-the-teen-birth-rate-falling/

Patton, M. (1990). *Qualitative evaluation and research methods* (pp. 169-186). Beverly Hills, CA: Sage.

Perkins, J. & Youdelman, M. (2008). *Summary of state law requirements addressing language needs in health care.* Washington, D.C.: National Health Law Program.

Perreira, K. M., Crosnoe, R., Fortuny, K., Pedroza, J., Ulvestad, K., Weiland, C., Yoshikawa, H., & Chaudry, A. (May 2012). *Barriers to immigrants' access to health and human services programs.* U.S. Department of Health and Human Services, Office of Human Services Policy.

Pew Research Center (2013). *U.S. Hispanic Population by County, 1980-2011.* Retrieved on December 14, 2014 from http://www.pewhispanic.org/2013/08/29/u-s-hispanic-population-by-county-1980-2011/

Piedra, L. M., Andrade, F. C. D., Larrison, C. R. (2011). Building response capacity: The need for universally available language services. In L. P. Buki & L. M. Piedra (Ed.), *Creating infrastructures for Latino mental health* (pp. 55-75) New York: Springer.

Piedra, L. M. & Byoun, S. (2012). Vida Alegre: Preliminary findings of a depression intervention for immigrant Latino mothers. *Research on Social Work Practice*, *22*(2), 138-150.

Portes, A., Fernández-Kelly, P., & Light, D. (2012). Life on the edge: Immigrants confront the American health system. *Ethnic and Racial Studies*, *35*(1), 3-22.

Portes, Light, & Fernández-Kelly, P. (2009). The U.S. health system and immigration: An institutional interpretation. *Sociological Forum*, *24*(3), 487-514.

Rhodes, S. D., Foley, K. L., Zometa, C. S., & Bloom, F. R. (2007). Lay health advisor interventions among Hispanics/Latinos: A qualitative systematic review. *American Journal of Preventive Medicine*, *33*(5), 418-427.

Robert Wood Johnson Foundation, (2008). Kaiser Permanente: Qualified Bilingual Staff Model. *Promising Practices on Disparities,* National Health Plan Collaborative.

Rosen, G. (2015). *A history of public health.* Baltimore, MD: Johns Hopkins University Press.

Rosenberg, E., Seller, R., & Leanza, Y. (2007). Through interpreters' eyes: Comparing roles of professional and family interpreters. *Patient Education and Counseling*, *70*, 87-93.

Rubin, A., & Babbie, E. (2011). *Research methods for social work.* Belmont, California: Brooks/Cole, Cengage Learning.

Ruiz, E., Aguirre, R. T. P., & Mitschke, D. B. (2013). What leads non-U.S.-born Latinos to access mental health care? *Social Work in Health Care*, *52*(1), 1-19.

Ryan, G. & Bernard, H. R., (2003). Techniques to identify themes. *Field Methods*, *15*(1), 85-109.

Sauaia, A., Min, S., Lack, D., Apodaca, C., Osuna, D., Stowe, A., McGinnis, G. F., Latts, L. M., & Byers, T., (2007). Church-based breast cancer screening education: Impact of two approaches on Latinas enrolled in public and private health insurance plans. *Preventing Chronic Disease: Public Health Research, Practice, and Policy, 4(*4), 1-10.

Shaw, I., & Gould, N. (2001). *Qualitative research in social work.* London: Sage Publications.

Schneiderman, N., Llabre, M., Cowie, C. C. Barnhart, J., Carnethon, M., Gallo, L. C., Giachello, A. L., Heiss, G., Kaplan, R. C., LaVange, L. M., Teng, Y., Villa-Caballero, L., & Avilés-Santa, M. L. (2014). Prevalence of diabetes among Hispanics/Latinos from diverse backgrounds: The Hispanic community health study/study of Latinos (HCHS/SOL). *Diabetes Care*, 37, 2233-2239.

Schyve, P. M. (2007). Language differences as a barrier to quality and safety in health care: The joint commission perspective. *Journal of General Internal Medicine, 22*(Suppl 2), 360-361.

Seth, J. G., Isbell, M. G., Atwood, R. D., & Ray, T. C. (2015). Addressing language barriers in client-centered health promotion: Lessons learned and promising practices from Texas WIC. *Health Promotion Practice*, *16*(3), 320-328.

Skerry, P. (2003). Citizenship begins at home: A new approach to the civic integration of immigrants. *The Responsive Community, Winter*, 26-37.

Specht, H. & Courtney, M. E. (1994). *Unfaithful angels: How social work has abandoned its mission.* New York: The Free Press.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* London: Sage Publications.

Taylor, S. J., & Bogdan, R. (1998). *Introduction to qualitative research methods: A guidebook and resource.* New York, NY: Wiley and Sons, Inc.

Tran, A. N., Ornelas, I. J., Kim, M., Perez, G., Green, M., Lyn, M. J., & Corbie-Smith, G. (2014). Results from a pilot promotora program to reduce depression and stress among Immigrant Latinas. *Health Promotion Practice, 15*(3), 365-372.

U.S. Census Bureau (2014). County business and demographics. Retrieved from http://www.census.gov/cbdmap/

U.S. Census Bureau (2013). Core based statistical areas (CBSAs) and combined statistical areas (CSAs). Retrieved from http://www.census.gov/population/metro/data/def.html

U.S. Department of Health and Human Services (2001). National standards for culturally and linguistically appropriate services in health care. Retrieved from www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf

Vallejos, Q., Strack, R. W., & Aronson, R. E. (2006). Identifying culturally appropriate strategies for educating a Mexican immigrant community about lead poisoning prevention. *Family and Community Health, 29*(2), 143-152.

Vega, W. A., & Lopez, S. R. (2001). Priority issues in Latino mental health. *Mental Health Services Review, 3*(4), 189-200.

Verdinelli, S., & Biever, J. L. (2009a). Experiences of Spanish/English bilingual supervisees. *Psychotherapy Theory, Research, Practice, Training, 46*(2), 158-170.

Verdinelli, S., & Biever, J. L. (2009b). Spanish-English bilingual psychotherapists: Personal and professional language development and use. *Cultural Diversity and Ethnic Minority Psychology, 15*(3), 230-242.

Wu, S., Ridgely, M. S., Escarce, J. J., & Morales, L. S. (2007). Language access services for Latinos with limited English proficiency: Lessons learned from Hablamos Juntos. *Journal of General Internal Medicine, 22*(Suppl 2), 350-355.

Young, S. L. (2010). Pica in pregnancy: New ideas about an old condition. *Annual Review of Nutrition, 30*, 403-422.

Zuniga, V., & Hernández-Léon, R. (2005). *New destinations: Mexican immigration in the United States.* New York, NY: Russell Sage Foundation.

APPENDIX A:
HISPANIC POPULATION GROWTH IN TARGET COUNTIES

	1990 Total Population	1990 Hispanic Population	1990 Hispanic Share of Population	2011 Total Population	2011 Hispanic Population	2011 Hispanic Share of Population	% Change in Hispanic Population 1990-2011
Boone	30,806	2,065	7%	54,367	11,011	20%	433%
Bureau	35,688	1,003	3%	34,606	2,747	8%	174%
Cass	13,437	56	0%	13,579	2,351	17%	4098%
Champaign	173,025	3,485	2%	201,685	11,021	5%	216%
Clinton	33,944	336	1%	37,956	1,101	3%	228%
Coles	51,644	405	1%	53,916	1,231	2%	204%
Douglas	19,464	292	2%	19,836	1,278	6%	338%
Henry	51,159	797	2%	50,328	2,471	5%	210%
Iroquois	30,787	660	2%	29,475	1,680	6%	155%
Jackson	61,067	1,082	2%	60,365	2,568	4%	137%
Kankakee	96,225	1,946	2%	113,698	10,459	9%	437%
LaSalle	106,913	3,249	3%	113,518	9,419	8%	190%
Lee	34,392	727	2%	35,467	1,820	5%	150%
Livingston	39,301	826	2%	38,885	1,585	4%	92%
McLean	129,180	1,671	1%	170,556	7,876	5%	371%
Macon	117,206	540	0%	110,730	2,211	2%	309%
Madison	249,238	2,713	1%	268,459	7,723	3%	185%
Ogle	45,957	1,379	3%	53,115	4,813	9%	249%
Peoria	182,827	2,596	1%	186,834	7,485	4%	188%
Rock Island	148,723	8,084	5%	147,556	17,531	12%	117%
St. Clair	262,852	3,861	1%	270,259	9,303	3%	141%
Sangamon	178,386	1,275	1%	198,844	3,799	2%	198%
Stephenson	48,052	283	1%	47,563	1,464	3%	417%
Tazewell	123,692	825	1%	135,661	2,739	2%	232%
Vermilion	88,257	1,405	2%	81,509	3,572	4%	154%
Warren	19,181	207	1%	17,818	1,577	9%	662%
Williamson	57,733	448	1%	66,622	1,356	2%	203%
Winnebago	252,913	7,771	3%	293,993	33,061	11%	325%

Source: Pew Hispanic Center (2013) U.S. Hispanic Population by County, 1980-2011.

APPENDIX B:
INTERVIEW GUIDES

INTERVIEW GUIDE FOR PUBLIC HEALTH DIRECTORS

Purpose:
The purpose of this interview is to get your insights about providing public health services to Hispanic residents in your county. I am interviewing public health directors in counties with growing Hispanic populations in Illinois. I will ask you to describe the needs of Hispanic residents, the public health services Hispanic residents use, and any strategies your agency has used to serve Hispanic residents. I will also ask you to describe a specific case, program, or service area in which your agency attempted to address a public health issue for Hispanic clients. If you have any questions of me while we're talking, please feel free to ask! Also, if there are any questions you do not want to answer, just say so. Anything you tell me today will be kept confidential. I will use the information from these interviews in journal articles and conference presentations, but I will not identify you, your agency, or your county. Do you have any questions before we begin?

Background questions: *First, I'd like to start off by asking about your role and your background.*
1) *Please describe your role at <insert county name> public health.*
2) *How long have you held this position?*
3) *What other positions have you held at this agency? At other agencies/organizations?*
4) *How long have you worked or lived in this county?*
5) *Describe your educational background.*

Knowledge and perception of local Hispanic population: *Next, I'd like to ask you about <insert county name> County and it's Hispanic population.*
6) *How would you describe the overall population of <insert county name> County?*
7) *What are the primary public health concerns for the county overall?*
8) *How would you describe the Hispanic population in <insert county name> County?*
   a. *PROMPT: How many Hispanic residents are there?*
   b. *PROMPT: Where do Hispanic residents live and work?*
9) *What are the public health concerns for Hispanic residents?*

Knowledge and perceptions of local public health agency's work with Hispanic populations: *Now let's talk about <insert county name> County public health agency's work with Hispanic residents.*
10) *What public health programs or services do Hispanic residents use?*
11) *What practices or policies does the agency use in serving Hispanic residents?*
   a. *PROMPT: What happens if someone who speaks only Spanish walks into the agency?*
   b. *PROMPT: Do you have materials available in Spanish?*
   c. *PROMPT: Who serves Hispanic clients? Do you have bilingual staff?*
12) *What are the overall barriers to serving Hispanic residents?*
13) *What resources can the public health agency leverage to serve Hispanic residents?*
   a. *PROMPT: What sources of funding can you access?*
   b. *PROMPT: Which staff can you rely upon?*

      c.   PROMPT: Which community resources/partners can you call upon?

14) *Are there any areas in which you wish you could improve services for Hispanic residents? Describe these areas and the ways you might improve services.*

15) *How might your staff members respond to the previous question regarding improving services for Hispanic residents?*
      a.   PROMPT: What would staff members who serve Hispanics say?

Knowledge of specific case, program, or service area in which public health agency served or attempted to serve Hispanic residents. *Now I'd like to ask you to think back over the past few years and to tell me about a specific effort the public health agency made to serve Hispanic residents. This could be one particular case, a program, or a broad service area.*

16) *Tell me about the case or program and the agency's response.*
      a.   PROMPT: What was the need or issue that prompted the agency's response?
      b.   PROMPT: How did the agency find out about or become involved?
      c.   PROMPT: Who was involved? Clients? External agencies/individuals? Internal staff/programs?
      d.   PROMPT: What steps or actions did the agency take? What resources were used?
      e.   PROMPT: What other possible responses were considered?

17) *What was the outcome of this response? For Hispanic residents? For the staff and agency?*

Closing questions. *We are nearly finished with the interview. I'd just like to ask a few more questions.*

18) *What advice do you have for an agency or county facing a similar issue?*

19) *Could you recommend one or two staff members in your agency who work directly with Hispanic clients and who might be able to provide additional information on this topic?*

20) *Are there other public health directors who might provide additional insights on serving new Hispanic populations?*

21) *Is there anything I should have asked you but didn't?*

22) *If I have additional questions, may I contact you with brief follow up questions?*

INTERVIEW GUIDE FOR PUBLIC HEALTH STAFF

Purpose:
The purpose of this interview is to get your insights about providing public health services to Hispanic residents in your county. I am interviewing public health workers in counties with growing Hispanic populations in Illinois. I will ask you to describe the needs of Hispanic residents, the public health services Hispanic residents use, and any strategies your agency has used to serve Hispanic residents. I will also ask you to describe a specific case, program, or service area in which your agency attempted to address a public health issue for Hispanic clients. If you have any questions of me while we're talking, please feel free to ask! Also, if there are any questions you do not want to answer, just say so. Anything you tell me today will be kept confidential. I will use the information from these interviews in journal articles and conference presentations, but I will not identify you, your agency, or your county. Do you have any questions before we begin?

Background questions: *First, I'd like to start off by asking about your role and your background.*
1) *Please describe your role at <insert county name> public health.*
2) *How long have you held this position?*
3) *What other positions have you held at this agency? At other agencies/organizations?*
4) *How long have you worked or lived in this county?*
5) *Describe your educational background.*

Knowledge and perception of local Hispanic population: *Next, I'd like to ask you about <insert county name> County and it's Hispanic population.*
6) *How would you describe the overall population of <insert county name> County?*
7) *What are the primary public health concerns for the county overall?*
8) *How would you describe the Hispanic population in <insert county name> County?*
   a. *PROMPT: How many Hispanic residents are there?*
   b. *PROMPT: Where do Hispanic residents live and work?*
9) *What are the public health concerns for Hispanic residents?*

Knowledge and perceptions of local public health agency's work with Hispanic populations: *Now let's talk about <insert county name> County public health agency's work with Hispanic residents.*
10) *What public health programs or services do Hispanic residents use?*
11) *What practices or policies does the agency use in serving Hispanic residents?*
   a. *PROMPT: What happens if someone who speaks only Spanish walks into the agency?*
   b. *PROMPT: Do you have materials available in Spanish?*
   c. *PROMPT: Who serves Hispanic clients? Do you have bilingual staff?*
12) *What are the overall barriers to serving Hispanic residents?*
13) *What resources can the public health agency leverage to serve Hispanic residents?*
   a. *PROMPT: What sources of funding can you access?*
   b. *PROMPT: Which staff can you rely upon?*
   c. *PROMPT: Which community resources/partners can you call upon?*

14) *Are there any areas in which you wish you could improve services for Hispanic residents? Describe these areas and the ways you might improve services.*

15) *How might other agency staff (administrators, supervisors, colleagues) respond to the previous question regarding improving services for Hispanic residents?*
   a. *PROMPT: Do administrators/supervisors understand Hispanic residents' needs?*
   b. *PROMPT: Do your colleagues understand Hispanic residents' needs?*
   c. *PROMPT: To what extent are you able to influence your agency's work with Hispanic residents?*

Knowledge of specific case, program, or service area in which public health agency served or attempted to serve Hispanic residents. *Now I'd like to ask you to think back over the past few years and to tell me about a specific effort the public health agency made to serve Hispanic residents. This could be one particular case, a program, or a broad service area.*

16) *Tell me about the case or program and the agency's response.*
   a. *PROMPT: What was the need or issue that prompted the agency's response?*
   b. *PROMPT: How did the agency find out about or become involved?*
   c. *PROMPT: Who was involved? Clients? External agencies/individuals? Internal staff/programs?*
   d. *PROMPT: What steps or actions did the agency take? What resources were used?*
   e. *PROMPT: What other possible responses were considered?*

17) *What was the outcome of this response? For Hispanic residents? For the staff and agency?*

Closing questions. *We are nearly finished with the interview. I'd just like to ask a few more questions.*

18) *What advice do you have for an agency or county facing a similar issue?*

19) *Could you recommend one or two staff members in your agency who work directly with Hispanic clients and who might be able to provide additional information on this topic?*

20) *Are there other public health directors or agencies that might provide additional insights on serving new Hispanic populations?*

21) *Is there anything I should have asked you but didn't?*

22) *If I have additional questions, may I contact you with brief follow up questions?*