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ACTION-RESEARCH

The Development of a Community Counseling Training Clinic for Latino Immigrants

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Latinos are the fasting growing minority in the United States, and among the least likely to access mental health services. Two reasons cited for the significant mental health disparities in the Latino community are: a lack of culturally responsive services and a lack of culturally competent mental health professionals. This manuscript describes the development of a community counseling training clinic constructed through a partnership between a community center and a counselor education and supervision program. Process and clinical outcomes data demonstrate that the program was successful in retaining clients and students had a positive experience at the training site.

Keywords: Latinx; Mental Health; Treatment

Despite being the largest ethnic minority in the United States (U.S.) and having mental disorders at rates similar to the majority culture, Latino adults are half as likely to access mental health treatment compared to non-Hispanic Whites (American Psychiatric Association, 2014; McGuire & Miranda, 2008; Office of Minority Health, 2015; Vega, Rodriguez, & Gruskin, 2009). Less than one in five Latinos with a mental health disorder contact a healthcare provider, less than one in eleven contact a mental health specialist, and even fewer Latino immigrants access any mental health services (American Psychiatric Association, 2014). Latino adults also present with a greater number of psychological symptoms and receive a lower quality of care compared to non-Latinos (Aguilar-Gaxiola et al., 2012; American Psychiatric Association, 2014; McGuire & Miranda, 2008; Miranda, McGuire, Williams, & Wang, 2008; Substance Abuse and Mental Health Services Administration, 2015).

Mental Health America (2019) reported that 20% of those residing in the U.S. experience a mental health diagnosis. However, findings from the National Latino and Asian American Study (Alegría et al., 2007) indicated that approximately 28.1% of Latinos and 30.2% of Latinas experience a psychiatric disorder in their lifetime, and the Latino Community Health Study (Wassertheil-Smoller et al., 2014) reported that 27% of their sample (N = 16000) had high levels of depression. Untreated mental health disorders are a significant public health concern leading to greater risk of suicide, addiction, criminal involvement, violence, homelessness, incarceration, disability, chronic disease, and other frequently preventable conditions (Insel, 2015; Office of the Surgeon General, 2001). Consequently, Latinos are more likely than the average American to live in poverty, qualify for food stamps, have suicidal ideation, and struggle with chronic disease (Nock et al., 2013; Office of the Surgeon General, 2001).

The factors that influence Latino mental health disparities are complex and include perceived discrimination, economic strain, lack of health insurance, a lack of culturally educated and bilingual professionals, self-reliant or negative attitudes towards mental health, and cultural stigma (Ayón, Marsiglia, & Bermudez-Parsai, 2010; Cabassa, Zayas, & Hansen, 2006; McGuire & Miranda, 2008; Molina & Simon, 2014; Substance Abuse and Mental Health Services Administration, 2015). A systematic review of epidemiological studies concluded interventions that consider the complex interplay between individual, cultural, and structural factors are needed in the Latino community to improve access to mental health services (Cabassa et al., 2006). In other words, this significant health disparity problem requires a solution that is established and facilitated through effective collaboration between researchers and the community.

Although there is no uniformly agreed upon strategy for how to improve Latino mental health, there is unanimous agreement that effective approaches should be delivered with cultural sensitivity and incorporate Latino cultural values (Aguilar-Gaxiola et al., 2012; Gutierrez, Barden, & Tobey, 2014; Kouyoumdjian, Zamboanga, & Hansen, 2003; Sue, Zane, Nagayama Hall, & Berger, 2009). Research shows that mental health interventions adapted to focus on a specific cultural group are four times more effective than those focused on the general population, and interventions provided in a client's native language are twice as effective as those provided in English (Griner & Smith, 2006). These findings indicate that evidence-based, culturally-adapted, mental health programs could significantly reduce mental health disparities, and that training students to be culturally responsive will be crucial to their success as mental health professionals working with Latino communities (Sue et al., 2009).

Current evidence (Griner & Smith, 2006) and national guidelines (American Counseling Association, 2014) have suggested that culturally competent mental health strategies are critical to effective ethical practice; yet, a limited amount of evidence-based, culturally competent interventions are available to mental health professionals (Sue et al., 2009). There is also an unfortunate disconnect between academic researchers and mental health professionals working in the community. Likewise, individuals working at research institutions seldom have the opportunity to translate their research into practice with Latino communities due to a lack of local and cultural knowledge of the Latino community as well as mistrust emanating from the Latino community.

Community-based participatory research (CBPR) is a community-directed approach to research designed to address the gap between academic research and community practice, particularly in underserved communities (Wallerstein, Duran, Oetzel, J, & Minkler, 2018). CBPR addresses a social problem within the local community through an equitable partnership between researchers and community members involving a co-learning and collaborative process that respects the needs and perspectives of the community (Wallerstein et al., 2018). Over the past several decades, CBPR has emerged as an effective means of empowering communities towards sustainable change and has made significant contributions towards increasing health equity in vulnerable communities, including the Latino population (Wallerstein et al., 2018; Las Nueces, Hacker, DiGirolamo, & Hicks, 2012; DeHaven et al., 2011).

Based on CBPR principles, the University of North Carolina at Charlotte (UNCC) and a well-established Latino-serving agency, Camino Community Center, collaborated to develop strategies to address health disparities in the Latino community of Charlotte, North Carolina (NC), a city with a rapidly growing Latino population. Camino Community Center identified a lack of linguistically and culturally competent mental health services as the biggest issue faced by Latinos in Charlotte and sought guidance from experts in community health and medicine at UNCC. Consequently, *The CommUniversity*, a formal partnership between Camino Community Center and UNCC was established.

The CommUniversity combines knowledge and expertise from staff and students from UNCC's ARCHES (Academy for Research on Community Health, Engagement, and Services) with local and cultural knowledge from staff and clients at Camino Community Center to improve the health and wellbeing of Latino immigrant and other vulnerable communities through service learning and research. The development of this multi-faceted community and university partnership goes beyond mental healthcare, providing other health and wellness services, such as medical care, health education, food services, homeless outreach, physical activity programs, financial counseling, as well as Spanish translation and interpretation services. Students trained under this program not only learn about culturally competent care for Latinos but also develop an understanding of integrated behavioral healthcare.

The CommUniversity serves as a catalyst for developing and implementing effective clinical strategies, while also providing students with valuable training and experience working in and with Latino communities. *The CommUniversity* allowed for the development of *Tu No Estás Solo*, a culturally competent mental health program that combines counselor education and supervision with community engaged service to address the mental health needs of Latinos. The purpose of this paper is to explain the development of *The CommUniversity* and *Tu No Estás Solo* and present findings that demonstrate the effectiveness and feasibility of a student-driven mental health clinic made possible by *The CommUniversity* and CBPR practices.

The CommUniversity

The CommUniversity was established by faculty and students from ARCHES in collaboration with staff and leadership at Camino Community Center. Members of ARCHES provide consultation through intellectual, financial, and physical capabilities to assist the agency in addressing community health issues. Sustainable change through consultative partnership is achieved through several factors, including leadership from an effective change agent; data-based intervention and implementation decision making; involvement of com-

munity partners in the development and implementation of programs; ongoing coaching; a formal structure; and connecting with universities or other agencies that can provide funding (Forman & Crystal, 2015).

Each of the preceding facets were achieved through *The CommUniversity* and the development of an advisory committee consisting of interdisciplinary faculty and students from several colleges, including counseling, health psychology, social work, education, language and cultural studies, and public health sciences. All committee members provided consultation to the community agency through intellectual capabilities including expertise in data-driven program planning, implementation, and evaluation as well as assistance with internship placements and supervision. ARCHES also provides direct financial support through gifts and donations in addition to indirect financial support through grant writing assistance. In addition, UNCC lends faculty and students to Camino Community Center, allowing them to assist with projects and programs, while receiving stipends or salaries from the university. Physically, the university has donated furniture, equipment, and other resources to the agency when possible. For example, the Kinesiology Department donated unused exercise equipment to the agency, allowing for the implementation of an all-access gym at no cost to community members.

Camino Community Center. Camino Community Center is a full-service non-profit organization dedicated to promoting holistic health and wellness among low-income and underserved Latino families in Charlotte, NC. The Latino population in Charlotte has grown rapidly over the past decade, growing by 28% from 2010 to 2017 (US Census Bureau, 2018) faster than any other group, including Non-Latino Whites and African Americans; Latinos currently account for 13% of the total population in Mecklenburg County (Mecklenburg County Public Health, 2018). Camino Community Center is located within five miles of UNCC in the University City area of Charlotte, an area with an even larger Latino population, currently at 19% and with some neighborhoods reaching 30% (Mecklenburg County Public Health, 2018).

Camino Community Center serves 20,000 clients annually, offering a variety of services, including a health clinic, thrift store, food pantry, physical activity programs, fitness center, and homeless outreach. Camino was established in 2003 and has since become the trusted source of social, economic, and health services for Latinos, providing an integrated and culturally competent medical care home for Latino families. Over the past several years, Camino has been widely recognized as an important contributor to addressing the needs of Charlotte's Latino population. The role of the agency has been described as pivotal in the evolving role of Latinos in the area by city officials and a local museum (Citty, 2016).

Identification of the Need for Culturally Competent Mental Health Services

Despite the role of Camino in addressing the needs of the Latino community, the agency lacked the capacity to address the population's growing mental health needs. Camino has an established primary care clinic, serving mostly low-income, uninsured, Spanish-speaking, Latino immigrants and families (Revens, Suclupe, Gutierrez, & DeHaven, 2017). Many patients of the clinic presented with mental health concerns, but there are few affordable, bilingual mental health services in the Charlotte area, making it difficult to access treatment. In fact, Latinos in Charlotte have identified the lack of bilingual and culturally aware health services as the most critical need in the city for several years (UNC Charlotte Urban Institute, 2006). Moreover, many patients at Camino are uninsured and undocumented immigrants, a population that often avoids mental health treatment due to the fear of deportation or stigma related to documentation status or membership in a minority culture (Ayón et al., 2010; Cabassa et al., 2006).

Despite mental health stigma and other barriers, clients sought mental health treatment at Camino, largely due to the agency's reputation and the relationship of trust between Camino and the community. However, the agency did not have an established mental health program and had only one part-time mental health counselor who was not bilingual, resulting in a long list of clients waiting to be treated for mental health concerns. Consequently, leadership, staff, and clients at the community agency, who are also members of the Latino community, partnered with faculty and staff from the university to develop an affordable, culturally competent mental health counselling program.

Program Development

Following the CBPR conceptual model (see **Figure 1**: Wallerstein et al., 2008; Wallerstein & Duran, 2010; Wallerstein et al., 2018), a joint academic-community steering committee consisting of leadership and clinical staff from Camino and ARCHES was established to co-develop and evaluate a solution to the problem, ensuring perspectives of the Latino community were heard and respected. The steering committee built upon existing strengths and resources within the community, leveraging the relationship of trust Camino had already established with the Latino community in Charlotte.
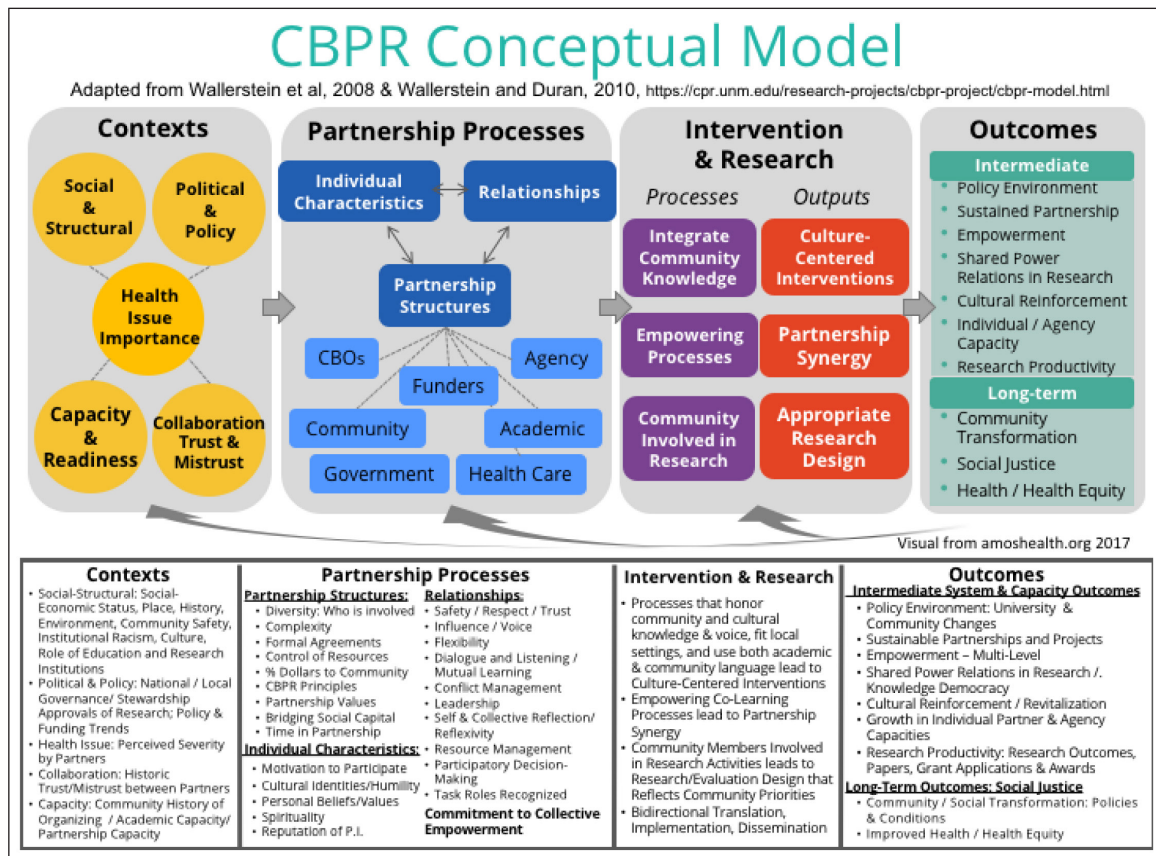
Figure 1: CBPR conceptual model explaining context, partnership processes, intervention & research, and outcomes of CBPR partnerships.

The steering committee also embraced the strengths each individual partner brought to the project, integrating knowledge from each to co-develop a mental health training clinic that addresses mental health disparities in Latinos (Wallerstein et al., 2018). For example, the executive director of the agency, a respected leader and advocate with strong ties to the Latino community, along with other staff and community leaders, provided valuable cultural and local knowledge, as well as insight into the needs and perspectives of the local Latino community; the agency staff also brought experience in patient care with Latino populations, as well as lived experiences as Latino immigrants themselves. The research team provided expertise in mental health counseling and therapy, Latino mental health concerns, CBPR, community medicine, as well as counselor education and supervision for students. Researchers also provided expertise in grant writing which helped the community agency continue to grow and improve mental health and other services.

The steering committee met regularly to co-develop *Tu No Estás Solo*, following the principles of CBPR, ensuring equal partnership, shared power, and co-learning between the university and agency throughout the entire process (Wallerstein et al., 2018). All meetings were held at the community agency and led by the agency staff to ensure community ownership of the program. The research team provided guidance and consultation on program development and implementation, but the need for the program, as well as specific protocols and procedures were identified by the community.

The title for the program was selected to send a message of hope to the Latino community – that although they may feel they struggle in silence – *they are not alone*. Choosing a title was a collaborative and purposeful process achieved through ongoing discussion and brainstorming sessions at steering committee meetings. *Tu No Estás Solo* is a 14-session, culturally and linguistically responsive, mental health counseling program for Latinos in Charlotte. The program combines primary care and behavioral health services in a patient-centered setting offering assessments, diagnosis, treatment, psychoeducation, as well as individual and group counseling. Not all clients complete 14 sessions; some are discharged early upon meeting treatment goals, while others remain in the program longer to meet their goals.

The mental health program is delivered by student trainees. The decision to create a student-driven program was made collaboratively, recognizing the social and economic circumstances of the local community.

Implementing a student-driven program allows the community agency to offer mental health treatment to clients at no cost. This is especially important in the local community where most clients are low-income and cannot afford mental health services elsewhere (Revens et al., 2017). Cost of treatment was one of the primary concerns voiced by representatives of the Latino community, while researchers voiced the need to train more bilingual and bicultural mental health professionals to meet the needs of the growing Latino community. Consequently, the program was designed in a way that allows student trainees to receive training and experience working with Latino communities, while offering bicultural and culturally competent mental health services at no cost to the Latino community.

Student trainees provide treatment through goal-oriented brief therapy. Client goals are discussed and decided on collaboratively by the client and student-trainee. The collaborative nature of the program helps ensure services are culturally responsive. In addition, student-trainees are given supervision and training with special attention to multicultural competency. Students also receive training in cultural awareness and potential cultural conflicts and education in Latino cultural values.

The counseling initiative provides all students with practicum and internship opportunities, helping them fulfill accreditation requirements for degree conferment. Students provide therapy under the supervision of clinical faculty from the university, as well as clinical staff at the community agency. Faculty provide students with group and individual supervision hours. Clinical faculty and staff provide on-site supervision to ensure ethical and professional service delivery, as well as the safety and welfare of the students at the community agency. The clinical staff member responsible for supervising student trainees is a bilingual, licensed clinical social worker with extensive experience working with Latinos. Faculty supervisors consist of counselors, social workers, and psychologists.

Student trainees are from a Council for the Accreditation of Counseling and Related Educational Professions (CACREP) accredited masters-level clinical mental health program and a Ph.D. counselor education program, which requires they receive additional supervision from qualified faculty on campus using audio/video recordings and transcriptions. Most of the faculty supervisors are bilingual, but when the supervisor is monolingual, the student translates the audio recordings of sessions into English. Other students are from an American Psychology Association accredited health psychology Ph.D. program and a master of social work program accredited by the Council on Social Work Education. These students also receive supervision at Camino and on campus from licensed and qualified providers. Most student trainees are bilingual in English and Spanish, with only one student using a Spanish language interpreter.

Student trainees provide culturally and linguistically competent mental health services, allowing the community agency to provide timely and continued care for clients already in the program while increasing access to mental/behavioral health services for new clients. The implementation of the mental health program allowed for the placement of six to seven student trainees per semester at the community agency, allowing waitlisted clients, as well as new clients to be treated. The program was implemented in fall 2015 and continues to be in place today. The program follows a schedule consistent with the university to allow for training of new students each year. Some students are in place at the agency for one semester while others are there for a year. Many students chose to remain at the agency as a volunteer counselor after completion of their practicum or internship.

Program Evaluation and Improvement

CBPR is a cyclical and incremental process where researchers and community members consistently strive to evaluate and improve the program or intervention (Wallerstein et al., 2008). Consistent with this principle, feedback from student trainees, along with process and clinical outcomes were used within the first year of program implementation to assess the feasibility and effectiveness of the program and understand how the program could be improved in the future.

Feedback from student trainees. Student trainees were given evaluations at the end of the first semester of program implementation. The evaluations included six open-ended questions. There questions were co-developed by the steering committee, but the final decision on what questions to include was made by the agency director. Questions included:

- To what degree, if any, did the actual internship experience meet your expectations?
- To what degree, if any, did the actual internship experience differ from your expectations?
- Has the internship enhanced your self-understanding and professional development in important ways?

· Mention the most important gain you had in the actual internship.
· Mention some of the obstacles you had in the actual internship experience.
· What are some suggestions for improvement?

Five students completed the evaluation. The director of the community agency then met with all students to discuss the questions, recording the session. Although the recording was not transcribed verbatim, common themes were extracted from the written evaluations and recordings by a doctoral student who is a member of *The CommUniversity.* Students identified aspects of the practicum experience that differed from their expectations, including the need for more training, prior to practicum, on how to diagnose and code symptoms as well as issues with interpreters, such as the interpreters' lack of familiarity with the counseling process and inconsistent procedures that resulted from using different interpreters at each session.

Other obstacles reported by students included staying on time in each session; issues of space at the agency; and understanding the challenges of implementing a new program. Suggestions for improvement included the need for more supervision time with faculty supervisors to discuss protocols; additional training on coding and diagnosing disorders; the development of referral forms to refer clients to other services at the community agency; and the development of no-show and inclement weather policies. Gains from the program reported by students included the opportunity to practice Spanish language skills; the opportunity to work with people who are culturally different; experience helping clients work through difficult issues, including depression and suicidal thoughts; the unique opportunity to work with an interpreter; and a better understanding of how to integrate a holistic approach, including mental, physical, and spiritual health into a primary care setting.

Feedback and suggestions provided by student trainees were used to make improvements to the program. To address concerns with diagnosis and procedures, more training via a formal orientation was provided to all students. In addition, faculty from the Language and Cultural Studies Department were invited to join the steering committee and *The CommUniversity* to address challenges related to language brokering. As a result, master's level student translators and interpreters were placed at the agency to provide translation and interpretation services under the supervision of a certified translator, interpreter, and faculty member at UNCC, allowing the community agency to provide more consistent interpretation services, ultimately improving the quality of treatment received by clients and the quality of the internship experience for the student. Moreover, in fall 2018, student trainees began receiving training on how to work with interpreters, increasing the likelihood of a successful and comfortable experience for the student trainee, client, and interpreter.

To alleviate spacing concerns, additional rooms were dedicated to the program at the agency, and clocks were placed in all rooms to assist with time keeping. To address the need for additional supervision for students, a mental health coordinator was hired at the agency, allowing for onsite supervision, in addition to faculty supervision at UNCC. The hiring of an onsite mental health coordinator was made possible by a collaborative grant written by *The CommUniversity* using pilot data from a feasibility study (explained below), further highlighting the importance of the community-university partnership in the expansion of community services at the agency.

Feasibility Study

The skills and expertise provided by members of *The CommUniversity* allowed for the opportunity to conduct a pilot study to assess the feasibility and effectiveness of the mental health program, something that may not have been possible without the community-university partnership. The feasibility study included retrospective clinical chart reviews of clients who received mental health treatment services in 2016–2017 to examine process and clinical outcomes. The researchers sought to determine: Is the implementation of a student-driven mental health program feasible and effective?

Procedures and participants. After receiving approval from UNCC's Institutional Review Board, the research team began conducting a retrospective clinical chart review of all clients who participated in the mental health program from January 2016 to December 2017. Chart review studies are popular approaches applied widely in medical, epidemiology, and quality assessment research to help researchers develop and design follow-up intervention studies (Vassar & Holzmann, 2013). Chart reviews from 2016 were conducted in December 2016 by two doctoral students and chart reviews for 2017 were conducted from May to June 2018 by two doctoral students and a master's student, all of whom are members of *The CommUniversity.* All data was collected, managed, and de-identified by the staff at the community agency and student trainees prior to chart reviews. Only clients who attended at least one session were included in the chart review.

Clients participating in *Tu No Estás Solo* were asked to complete several assessments on mental health and wellness and were informed that the collected data would be used to evaluate and improve services. Clinical charts included the following forms: patient referral forms when applicable; psychological intake reports completed by student trainees at the beginning of the program; a treatment plan completed by student trainees and clients at session three; educational progress reports completed by student trainees at each session; a discharge form completed by student trainees at the end of the program, and the Depression, Anxiety, and Stress Scale (DASS) completed by the client at the first, fourth, and last session.

In 2016, 88 total clients had a chart on file; nine of these were referred to the program but never began and thus were eliminated from review. In 2017, 88 clients had a chart on file, but 16 were eliminated for never attending a session. A total of 151 clients attended at least one session from January 1, 2016 through December 31, 2017 and were included in the chart review.

Instruments

Chart reviews. Process outcomes include demographics, place of referral, presenting symptoms and associated experiences, kept appointments, program completion rates, discharge reasons, and reasons for withdrawal from the program (when applicable). Demographics, place of referral, presenting symptoms and associated experiences were obtained for all clients. However, kept appointments, completed sessions, program completion, discharge, and withdrawal reasons were only obtained for discharged clients; the inclusion of active clients would likely skew the data as the number of total sessions for those clients is unknown. Demographics include gender, age, country of origin, race, ethnicity, and marital status, and were self-reported by the client and obtained from the psychological intake form. Place of referral was obtained from the referral form; if there was no referral form, self-referral was assumed.

Presenting symptoms were the complaints reported by clients (e.g., feeling sad or depressed) and associated experiences were the overall reason given by the client for seeking treatment (e.g., relationship problems, losing a loved one). Presenting complaints and associated experiences were self-reported by the client and obtained from the psychological intake form. Kept appointments, the number of scheduled appointments completed by each client, and program completion rates were reported by the student trainee and obtained from weekly educational progress notes. Discharge and withdrawal reasons were reported by the student trainee and obtained from the discharge form. Clients were discharged from the program once they met program goals or withdrew; for those who withdrew, the reason was obtained from the discharge form when available. All nominal data was coded using a code sheet created by the research team prior to chart reviews.

DASS-21. Clinical outcomes were determined by an evaluation of total scores on the DASS-21. The DASS-21 was administered to clients at the first, fourth, and last session. The DASS-21, a shorter version of the original DASS-42, is a 21-item self-report instrument for measuring depression, anxiety, and stress. The DASS-21 has three subscales: depression, anxiety, and stress; each of the three subscales contains seven items (Brown, Chorpita, Korotitsch, Barlow, 1997). Clients were asked to use four-point severity/frequency scales to rate the extent to which they have experienced various states of depression, anxiety, and stress over the past week (Brown et al., 1997).

Each subscale of the DASS-21 was scored independently; scores characterize the degree of symptom severity of depression, anxiety, and stress experienced by the individual relative to that of the population (Brown et al., 1997). Depression, anxiety, and stress severity labels used on the DASS-21 include: normal, mild, moderate, severe, and extremely severe (Brown et al., 1997). The DASS-21 data was reviewed and scored by the mental health program coordinator at the community agency, a clinical social worker and experienced therapist. The outcome variable was the total DASS score which is often used in the literature as a measure of negative affect or mood.

Data Analysis

Data was analyzed using SPSS Version 25. Descriptive statistics were used to examine process outcomes, such as demographics, presenting symptoms and experiences, attendance, adherence, referral source, and withdraw reason. For clinical outcomes, a repeated measures one-way ANOVA was conducted to evaluate changes in mood between the initial, middle, and last session using the DASS-21 total score for clients who completed the 14-week program. Time was used as the within-subjects factor to measure changes in client mood throughout the course of the program.

A paired sample t-test was used to evaluate changes in mood from the initial to last session to include clients who completed at least four sessions and terminated the program early or achieved treatment goals

prior to session 14. Prior to conducting the analysis, data was screened for missing values, outliers, and assumptions. Less than 5% of the data was missing, and Little's MCAR test indicated that the data was missing completely at random (Little & Rubin, 2002). To manage missing data, multiple imputation was performed (van Ginkel & Kroonenberg, 2014). There were no univariate outliers, and data were normally distributed according to the plots and skewness values. The assumption of sphericity for ANOVA was met according to Mauchly's Test of Sphericity ($p > .05$).

Results of the Feasibility Study

Process outcomes. Of the 151 clients included in the study, 95% ($n = 144$) were first generation Latino immigrants and more than half were from Mexico ($n = 68$, 58%). The majority were female ($n = 118$, 78%), between the ages of 18 to 45 ($n = 109$, 74%), and were married or in a committed relationship ($n = 97$, 66%). All demographic data is presented in **Table 1**. Eighty-three percent ($n = 125$) of clients were referred from Camino's primary care clinic ($n = 34$) or were self-referred ($n = 32$); the others were referred by another physician or elsewhere. Nearly half of clients ($n = 66$, 46%) presented with two or more symptoms upon seeking treatment.

The following numbers represent the number of clients who reported experiencing each symptom; some clients are represented more than once. A total of 77 clients reported symptoms of depression, 73 reported anxiety, 20 reported feeling stressed, 12 reported trauma or symptoms of post-traumatic stress disorder (PTSD), 9 reported feelings of anger, 8 reported self-harm or suicidal ideation, and 4 reported experiencing grief; 22 clients reported experiencing other symptoms. Most clients ($n = 128$) discussed personal experiences related to the symptoms they experienced. Fifty-one percent of clients reported family ($n = 25$) or marital/relationship distress ($n = 40$); other clients reported experiences related to previous trauma, such as sexual assault, robbery, or injury ($n = 24$), migration or acculturation ($n = 15$), health or medical issues ($n = 11$), social isolation ($n = 8$), and other issues ($n = 5$).

At the time of the study, ($n = 127$) clients had been discharged from the program and ($n = 24$) were currently active. Of 806 total sessions completed by 127 clients, 64% ($n = 519$) of appointments were completed as scheduled, 17% ($n = 135$) were cancelled and rescheduled, and 19% ($n = 152$) were no-shows with no

Table 1: Demographic data of clients.

Variable	N	%
Gender	151	
Male	33	22
Female	118	78
Age	148	
1–17	9	6
18–45	109	74
46 and older	30	20
Marital Status	148	
Married	76	51
Separated	14	9
Divorced	10	7
Committed Relationship	21	15
Single	27	18
Country of Origin		
Dominican Republic	7	5
El Salvador	14	11
Honduras	20	16
Mexico	68	53
USA	7	5
Other	13	10

call. The average number of sessions attended by clients was six; the average number of cancellations and no shows per client was one. Of clients who completed between 6 to 13 sessions, 75% met their treatment goals early and were discharged before reaching session 14. Forty-six percent of clients ($n = 54$) completed the program and were discharged by the counselor while 28% ($n = 33$) had to withdrawal from the program and 29% ($n = 36$) were discharged by the provider for three consecutive no shows. Most clients did not give a reason for withdrawing but those that did cited that work schedule conflicts, transportation issues, and moving to another area were the most common reasons for program withdrawal.

Clinical Outcomes

A total of 37 clients had all three DASS assessments on file and are included in the ANOVA analysis. A priori power analysis using G*Power (Faul, Erdfelder, Lang, & Buchner, 2007) with an effect size at 0.3, 0.05 error probability, and two measurement points indicated a sample size of 24 is sufficient to achieve 0.80 power. Therefore, 37 clients were deemed to be a sufficient sample size for this analysis. Findings show statistically significant differences in mood from the beginning to end of the program, $F(2, 35) = 6.281$, $p < .01$, $\eta^2 = .264$. Post hoc pairwise comparisons reveal statistically significant differences in mood from the initial session ($M = 30.62$, $SD = 17.57$) to the final session ($M = 21.70$, $SD = 16.30$; $p = .006$). There were no statistically significant differences in mood from the initial session ($M = 30.62$, $SD = 17.57$) to the middle session ($M = 24.84$, $SD = 17.17$; $p > .05$) or the middle session to the last session ($M = 21.70$, $SD = 17.17$; $p > .05$).

Eighty-five clients who completed at least four sessions and terminated the program or met treatment goals early were included in the paired t-test analysis. Results indicate significant higher levels of stress, anxiety, and depression at the first session ($M = 29.85$, $SD = 17.51$) compared to the last session of counseling ($M = 22.67$, $SD = 17.15$), $t(83) = 3.96$, $p < .001$, $d = .41$). Results suggest that levels of stress, anxiety, and depression decreased from the initial session to the last session, regardless of completion of the full program, with a medium effect size ($d = .41$) (Cohen, 1988).

Discussion

There is a shortage of mental health treatment programs and culturally competent, trained mental health providers for addressing the increasing needs of Latinos with mental health concerns (Ayón, et al., 2010; Cabassa et al., 2006; McGuire & Miranda, 2008; Miranda et al., 2008; Molina & Simon, 2014; Substance Abuse and Mental Health Services Administration, 2015). University mental health trainees and faculty collaborating with a trusted community agency offer an innovative means of providing low-cost mental health care to underserved Latino clients. Preliminary findings indicate that student trainees can manage the mental health needs of Latino patients in a way that contributes to high levels of patient appointment-keeping.

Sixty-four percent of scheduled appointments were kept and the average number of completed sessions was six. Although there is a lack of sufficient research on the treatment compliance of Latinos, existing research indicates most clients miss about 60% of their sessions (Grunebaum et al., 1996). Having an intervention that demonstrates good adherence is especially important given the significant health disparities in Latinos and the stigma often associated with mental health treatment in the Latino community. Data from the feasibility study also shows clients benefited from the services provided; total DASS scores significantly improved from the first to last session, indicating a significant improvement in client mood by the time of discharge. Results show most clients (75%) who completed more than six sessions met treatment goals and were discharged from the program before reaching session 14, suggesting that the program is effective in helping clients meet their goals. In addition, even clients who did not complete the entire program benefited through decreased symptoms of depression, anxiety, and stress.

The partnership between the university and the community agency provided a unique learning experience for master's and doctoral level students while also providing much needed care to numerous underserved families in the area. Data from student evaluations shows students enhanced their self-understanding and professional development. Student trainees learned from working through sessions with clients independently and felt the multicultural aspect of the agency provided a unique experience they would not receive elsewhere. Students also felt their experience at the agency helped them understand how to provide mental health services within a community health setting, something they hope to continue after graduation.

Implications for Practice

The field of counseling has long promoted the integration of multicultural counseling competency into the counselor education curriculum (American Counseling Association, 2014; Council for Accreditation of Counseling and Related Educational Programs, 2016). Providing students with cultural knowledge and

awareness activities through lecture and classroom discussion is the traditional approach to equipping students with multicultural competence. We believe this approach is important and value it as a first step. However, our findings suggest that students will further benefit from immersive clinical experiences where they can apply skills learned in the classroom in real-world settings with diverse populations. Students in our program reported being exposed to experiences they did not receive at their other sites (e.g., working with interpreters and practicing Spanish) and commented on the opportunities presented by working so closely with a culture different from their own. Additionally, students had considerable learning opportunities, beginning with understanding the challenges of consulting and partnering with community agencies, as well as serving clients faced with common stressors associated with acculturation and immigration.

Findings from this study help address the significant mental health disparities in the Latino community. Through a partnership between a Latino-serving community agency and a university with a CACREP accredited counseling training program with adequate supervision and qualified interns, our team provided a method for increasing access to affordable, linguistically, and culturally competent mental health services in the Latino community. The provision of these services helped reduce a significant strain on existing agencies (e.g., eliminated a waiting list at Camino) and raised self-awareness and enhanced the skill-level of counseling students, better preparing them to provide services to this population in the future.

Recommendations for Future Research and Practice

Addressing the mental health disparities of Latino communities involves a long-term investment and commitment, as well as collaboration between researchers and communities. *The CommUniversity* provides an example of a sustainable community-university partnership with the capacity to reduce disparities in mental health treatment in Latino communities. We recommend that future researchers continue down the path of developing accessible treatment programs to meet the growing mental health needs of this population. To this aim, we present a consultation model (**Figure 2**) that provides a conceptual framework for implementing a community-university partnership to meet the needs of Latino and underserved communities elsewhere. Our approach also provides a framework for training students to be bicultural health professionals and counselors, preparing them to work with culturally and linguistically diverse populations in the future. Training programs that utilize models like the one presented in **Figure 2** may help reduce the shortage of qualified mental health professionals to serve the Latino community by training culturally competent counselors with unique clinical experiences in the community.

The CommUniversity consultation model was essential to the implementation and maintenance of the community counseling training clinic. The continued partnership and findings from the feasibility study have led to significant improvements to the program since its beginning in 2015, including the placement of student interpreters; training on how to work with interpreters; a paid, onsite clinical supervisor; group counseling; improved organization and record keeping; and referral to other services within the community agency. In addition to the growth of *Tu No Estás Solo*, *The CommUniversity* has also made significant progress towards improving the health and wellbeing of the Latino community. UNCC has worked with Camino for many years to establish a relationship of trust and has now grown into a training center for service-learning and research opportunities. Since the development of *The CommUniversity*, Camino has become an established internship site with UNCC; students from a variety of colleges and departments provide unique skills and resources from a wide range of experience levels, including undergraduate students, master's students, and doctoral students and candidates.

In addition, several courses offered by UNCC are now held at the agency. For example, a course in the Master of Social Work Program provides students the opportunity to engage in service-learning projects, receiving hands on experience working with Latino families and communities. Focus group data with students showed experiences and encounters at the community agency led to an increased awareness of the Latino community and issues related to mental health concerns; a new-found perspective on the Latino community and culture; and a desire to advocate for Latino clients and families in the future (Revens, Reynolds, Suclupe, Rifkin, & Pierce, 2018).

The CommUniversity has also expanded to include new faculty and colleges, extending beyond mental health services to provide other social and educational services, such as Afro-Latin dance classes, physical activity classes, and reading for English language learners. Services such as these are made possible by *The CommUniversity* and have the potential to create sustainable change in the community, as well as in the trajectory of students, ultimately resulting in more bicultural and bilingual health professionals prepared to work in the Latino community upon graduation. Moreover, the expansion of *The CommUniversity* provides additional social support to Latino families, which may increase levels of resilience, the ability to recover from stress, and decrease levels of psychological distress (Revens, 2019).
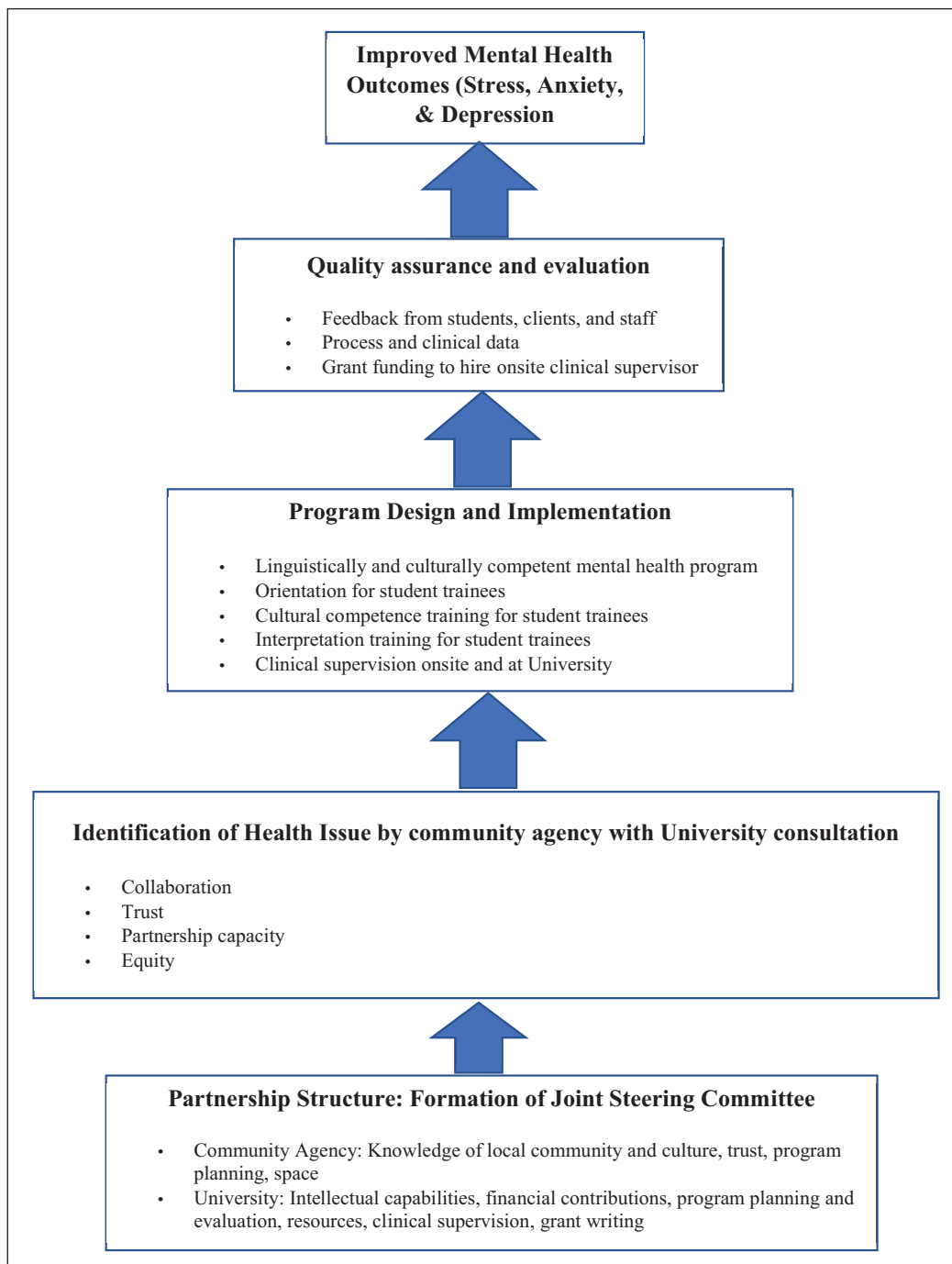
Improved Mental Health Outcomes (Stress, Anxiety, & Depression

Quality assurance and evaluation

- Feedback from students, clients, and staff
- Process and clinical data
- Grant funding to hire onsite clinical supervisor

Program Design and Implementation

- Linguistically and culturally competent mental health program
- Orientation for student trainees
- Cultural competence training for student trainees
- Interpretation training for student trainees
- Clinical supervision onsite and at University

Identification of Health Issue by community agency with University consultation

- Collaboration
- Trust
- Partnership capacity
- Equity

Partnership Structure: Formation of Joint Steering Committee

- Community Agency: Knowledge of local community and culture, trust, program planning, space
- University: Intellectual capabilities, financial contributions, program planning and evaluation, resources, clinical supervision, grant writing

Figure 2: Consultation model for developing a community counseling training clinic.

Despite the success of *The CommUniversity* and *Tu No Estás Solo*, there are also many challenges to implementing a community counseling training clinic. Challenges, along with recommendations for addressing such challenges, can be seen in **Table 2**. First, we recommend providing increased supervision and cultural competency training, as well as training in language brokering to students placed in cross-cultural settings. Students were ambitious and excited about working in the setting but also found themselves challenged, and at times frustrated, by some of the subject matter that surfaced during sessions, such as trauma resulting from immigration, language barriers, and diverse cultural expectations. We quickly realized there was an increased need for additional group supervision and trainings in our program and suggest others learn from our experience.

Language barriers were also a considerable barrier to establishing effective treatment services. The current mental health program uses interpreters and bilingual counselors. Although bilingual counselors have a considerable advantage and more readily established rapport with clients, there is a shortage of bilingual counseling students, especially in areas such as Charlotte where the Latino population is relatively new. As

Table 2: Recommendations for developing a community counseling training.

Challenges	Recommendations
1. Building trust in the community	1. Listen to community needs and priorities 2. Partner with an established and trusted community agency 3. Share power and decision making 4. Understand that community members are experts on community needs 5. Be willing to invest a significant amount of time to build trust, co-develop programs, and conduct quality assurance assessments
2. Language brokering	1. Recruit bilingual student trainees when possible 2. Use interpreters for monolingual student trainees 3. Provide training for students and supervising staff on how to work with interpreters 4. Establish protocols for interpretation that honor the natural rhythm of counseling and Latino culture
3. Providing culturally responsive services	1. Collaborate with the Latino community to co-develop services 2. Provide training on cultural awareness, cultural conflicts, and Latino cultural values to student trainees 3. Provide clinical supervision with special attention to multicultural competency
4. Providing affordable services to low-income populations	1. Develop a student-driven program that allows student-trainees to provide services at low or no cost to individuals or the agency
5. Managing attrition	1. Provide Psychoeducation using a brief model 2. Provide wrap-around services at the agency allowing clients to receive multiple services with one visit 3. Engage families in therapy 4. Provide flexible hours, including evenings & weekends
6. Recruiting student trainees	1. Collaborate with several different colleges, including Counseling & Education, Health Psychology, and Social Work 2. Provide training and professional development
7. Providing adequate supervision to students	1. Hire onsite coordinator who is a licensed professional counselor with experience and training in multicultural services 2. Provide supervision from faculty at the University
8. Coordination & organization of services: Administration & record keeping	1. Utilize graduate students through The CommUniversity to assist with continuous quality assurance and chart reviews 2. Provide feedback to agency staff and supervisors on how to improve recording keeping and organization of project materials, including client paperwork and forms 3. Collect process and clinical data that can be used for grant funding and quality improvement

such the use of interpreters is often necessary. If interpreters are needed, we recommend providing trainings on appropriate medical interpretation; establishing protocols for interpretation that honor the natural rhythm of counseling sessions, as well as Latino culture (e.g., instructions on when an interpreter can interrupt); and having students practice working with interpreters before working with clients.

We also suggest paying close attention to record keeping. Due to time constraints and related diverse cultural perceptions of time; reliance on public transportation; language barriers; stigma, which may lead to a mistrust of documentation; and general record-keeping error, it can be difficult to ensure that documentation is completed fully and accurately by all clients. However, extensive clinical records, clinical questionnaires, and quality improvement measures are necessary to establish program effectiveness and ensure the highest quality of treatment.

Lastly, we want to underscore the importance of establishing confianza (translated as trust and confidence) with the Latino population before implementing any program. Given the high levels of stigma and distrust towards mental health professionals in the Latino community, it is critical that helping professionals do their best to build partnerships and relationships with local institutions, such as Latino-serving agencies,

Spanish-speaking churches, recreational centers, and small business owners. Our experiences have taught us that nothing is more important than building trust in the community. We were fortunate enough to partner with a community agency which has worked to establish trust in the Latino community for more than 15 years; without this relationship of trust, the community counseling training clinic would not have been possible. Finally, we highly encourage counselor educators and supervisors to thoughtfully consider how they can further equip students and supervisees with the knowledge, skills, and awareness needed to meet the growing mental health needs of the Latino population.

In a time with heightened stress and controversy surrounding the Latino community, we hope this paper encourages counselor educators and supervisors to put to action the mission of the American Counseling Association and American Psychological Association, which is based on the charge to improve lives and society. Helping professionals equipped with the skills to tear down the walls that divide us, not only will increase access to treatment services for the underserved Latino population but begin to build bridges that lead us to a healthier (and better) future.

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Competing Interests

The authors have no competing interests to declare.

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