

CLOSING THE MENTAL HEALTH GAP:

Eliminating Disparities in Treatment for Latinos



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Forward

Closing the Mental Health Gap represents Mattie Rhodes Center's second document on the state of mental health services for Latinos. The first publication, *Cultural Competency and Mental Health in the Hispanic Community of Jackson County, Missouri*, represented demographic data to be applied toward integrating cultural competence into Hispanic therapeutic services. This second report extends that conversation, adds complexity to the needs and barriers, and considers the mental health funding climate. These reports together are intended to raise awareness and educate others about the needs, barriers, and potential solutions to improving mental health care for Hispanics on the local level, and throughout the United States.

These studies represent individual contributions to a much larger and emergent critical territory. The integration of Hispanic ethnicity into the mental health care field and research is a relatively recent occurrence, and a field rich for exploration. More scholarly work is required in this field.

This document will hopefully stimulate an understanding of the priority for enhanced mental health care for Hispanics. Unfortunately, mental health issues tend to gain public visibility primarily during public tragedies, while we often fail to recognize how issues such as depression and anxiety impact how we live, work, parent, and participate in the communities around us.

Moreover, the relevance of mental health is still not consistently reflected in funding streams. As of today, the federal government represents the primary support for mental health services. While private foundations and corporations often fund a spectrum of social services, and while the trend has been to increase funds for *physical* wellbeing, this has not necessarily been true for mental health. We would argue that the two are inseparable. Mental health is not just a personal matter but a family, community, and national issue. It is time to promote mentally healthy communities through diversified funding.

We greatly appreciate the many contributions which have informed the pages of this document, and are indebted to the Substance Abuse and Mental Health Services Administration (SAMHSA) for making this document possible.

John Fierro
Executive Director

About Mattie Rhodes Center

Mattie Rhodes Center was founded in 1894 with the creation of the Mattie Rhodes Memorial Society. Mattie Florence Rhodes was a young Kansas City woman who volunteered with a group of ten church friends called the *Little Gleaners* to raise funds for the children's hospital. Mattie was 19 years old when she died of typhoid fever and left her \$500.00 inheritance to her friends to continue helping children in the community. The *Little Gleaners* honored Mattie's wish by formally establishing an organization in her name and opening a day care center for children of working mothers. Later, the Society opened a kindergarten that offered social services and eventually became a neighborhood counseling center.

Over the past 113 years the organization has evolved based on the needs of the surrounding community. Initially located in the Northeast area of Kansas City, Missouri, in 1916 the group moved to the Westside neighborhood, which has traditionally been heavily populated by immigrants. Approximately 20 years ago, Mattie Rhodes Center began to shift its focus from providing general mental health and social services toward addressing the special needs and circumstances of the area's Spanish-speaking residents. A formalized Hispanic Behavioral Health Program was established in 1992, and the agency's first Latino Executive Director was hired in 1994. Today, the agency is the only Missouri Department of Mental Health certified provider of bilingual and bicultural behavioral health services in the greater Kansas City metropolitan area and the state of Missouri.

In 2003, Mattie Rhodes Center published *Cultural Competency and Mental Health in the Hispanic Community of Jackson County, Missouri* in an effort to raise awareness and educate others about the need to improve service delivery and funding for Hispanic mental health in Jackson County, Missouri. Since that time, the agency has expanded its prevention efforts to include health promotion, youth development, and family support and education programs. Mattie Rhodes Center also received funding for organizational and systems improvements from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Introduction

In 2003, a national study called attention to the need for change in the current United States mental health care climate. The President's New Freedom Commission on Mental Health publication, entitled, *Achieving the Promise: Transforming Mental Health Care in America* (2003), outlines goals that can serve as foundations for change for the provision of mental health care in the United States. Specifically, the President's New Freedom Commission issues a call to "improve access to quality care that is culturally competent" (Recommendation 3.1), and to "improve and expand the workforce providing evidence-based mental health services and supports" (Recommendation 5.3).

Secondly, another recent national study asserts the need to enhance mental health care access for racial and ethnic populations. Entitled the *Mental Health: Culture, Race and Ethnicity*, Supplement to the Surgeon General's Report on Mental Health (2001), it outlines the need "to eliminate racial/ethnic and socioeconomic disparities in access to mental healthcare." The report suggests that in order to accomplish this, service providers must increase access to and coordination of quality mental healthcare services.

This document, *Closing the Mental Health Gap*, responds to this research and is designed to raise awareness of the needs, barriers, and culturally competent treatments and outcome measurements which the Mattie Rhodes Center has found to be effective at increasing access to culturally competent mental health care treatment for the growing Hispanic population of Kansas City, Missouri. This document also considers the funding climate that impacts this field. Hopefully, *Closing the Mental Health Gap* will assist in enhancing the mental health care needs of Hispanic populations, and in doing so, will help create stronger and healthier Hispanic families, communities, and ultimately a stronger nation.

The necessity of improved access to mental health care for Hispanics is increasingly a critical issue. Nationally, Hispanics are the largest minority group in the United States with a population of 41.3 million, or 14.8% of the population. In Kansas City alone, the Hispanic population increased by 85% between 1999 and 2000. Due to complex social, economic, and cultural factors, Hispanic immigrants exhibit a higher need for mental health services, yet experience formidable barriers to receiving treatment. The growth in population needs to be met with a growth in culturally competent services.

Methodologically, this document weaves together national and local studies with the case studies and experience of Mattie Rhodes staff over the past twenty years. Through its distribution, Mattie Rhodes Center aims to share the stories of Hispanic mental health care with funders, policy makers, civic leaders, and other behavioral health and social service providers.

The structure of *Closing the Mental Health Gap* shifts from demonstrating the *need* to proposing *solutions* for greater mental health care for predominantly immigrant Hispanics. **Chapter one** sets the context by exploring the specific historical and cultural contexts that inform this population's distinct need for access to mental health care. **Chapter two** demonstrates why it is that, despite such high needs, Latinos tend to experience barriers to accessing adequate mental health care services. **Chapter three** then turns to the outreach and treatment methods that Mattie Rhodes Center has found to be effective. **Chapter four** focuses on organizational cultural competence to deliver effective services and describes outcome measurements that have assisted

Mattie Rhodes Center in self-reflectively improving these treatments. Finally, **Chapter five** considers the current funding climate which impacts Latino access to quality mental health care.

Regarding terminology, the terms “Hispanic” and “Latino” are used interchangeably throughout this document, as they are by the federal government to refer to a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin regardless of race (Ramirez, 2004).

The need for quality mental health care is experienced by individuals and families across all economic and ethnic sectors of society. However, as national research demonstrates, class and ethnicity present additional barriers to receiving treatment. In fact, those living in poverty are at least *twice* as likely as the wealthiest in society to experience mental health problems (Surgeon General, 2001). Racial and ethnic minorities are disproportionately represented among the poor, who are also more likely to be less educated and in poorer physical health. As Hispanic immigrants tend to be lower income and an ethnic population, they are doubly challenged.

Bearing in mind the national need for the wellbeing of the Hispanic community, mental health service providers, funders, policy makers and civic leaders all have a professional responsibility and ethical obligation to address the mental health care needs of the Hispanic population. Their response, or lack thereof, may ultimately impact the quality of life and wellbeing not only of localized communities such as Kansas City, but of the nation at large. What might seem to be the private and individualized issue of mental health has a profound community-wide and national economic impact.



Chapter 1

UNDERSTANDING THE CONTEXT: *The Immigration Experience & Mental Health*

Mental health needs are pervasive across all socioeconomic classes and ethnic groups in the United States. In fact, mental health disorders will affect nearly one in three Americans during their lifetime (Steiner & Page, 2003), and, as a whole, are the leading cause of disability in the United States (President's New Freedom Commission on Mental Health, 2003).

However, the pervasiveness of mental health needs is often *higher* among Hispanic groups. Moreover, many within the growing Hispanic and Latino populations have accelerating *unmet* needs which can potentially contribute to less healthy and resilient Hispanic families and communities.

The aim of this chapter is to raise awareness of the significant need within the Hispanic communities for quality health care. First, it draws upon research that indicates that Hispanic youth and adults often experience higher levels of depression, anxiety, substance abuse and domestic violence. Secondly, the chapter suggests *why* these levels are so high by exploring the institutional and social contexts which inform this elevated need.

An understanding of these needs can contribute to a greater awareness of the social, ethnic, and economic factors which impress so heavily upon the health and wellbeing of Hispanic families. It is also meant to dissuade from stereotypes of immigrant classes by exploring the very concrete ways that cultural isolation, poverty, and discrimination can impact the health of family life and community.

Mental Health Needs in the Hispanic Community

Ethnicity has become an increasingly critical aspect of research. Unfortunately, limited empirical and evidence-based data is available that document the mental health status and unique needs of Latinos in the U.S. Yet existing data suggests that Latinos appear to be at high risk and may suffer disproportionately from a number of mental health disorders, including depression, anxiety, and substance abuse (Rios-Ellis, 2005).

Depression and Anxiety

Relatively little is known about depression and anxiety in the U.S. Hispanic population. Yet studies do exist that indicate that depression levels are high.

- In a study conducted by Hough, Landsverk and Karno (1987), close to 18% of Latinos report having a major depressive episode in their lifetime. Moreover, depression often occurs in conjunction with other physical and mental disorders, resulting in lost productivity.

- The prevalence of depression among migrant Mexican farm workers in studies conducted in Texas, California, Michigan and Ohio has been estimated to be between 20% and 40% (Alderete et al., 1999; Hovey and Magana, 2002).
- Data collected among Latinos in the Kansas City metropolitan area (Lewis, 2005) indicated that approximately 25% of respondents have experienced a mental health disorder, primarily depression and anxiety. When stratified by gender, 30% of Hispanic women reported suffering a mental health disorder compared to 19% of men. Of the women who responded positively, over 90% reported depression while among men, 60% reported depression and 40% anxiety.

Gender appears to have an impact upon experiences of depression, as Hispanic women experience higher levels of depression than Hispanic men, at 46% and 19.6%, respectively (Vega, Kolody, Aguilar-Gaxiola, et al., 1999). This gender disparity could be explained perhaps in part by less of a willingness or ability among Hispanic men to admit to depression. According to the National Latino and Asian American Study, which included a nationally representative sample of Latinos, slightly more than half of Hispanic men with at least one episode of major depression do not recognize that they may have a mental health problem and may be more reluctant to seek treatment for fear of losing their jobs (Alegria, Takeuchi, Canino, et al., 2004).

Substance Abuse and Addiction

Although substance abuse is an issue among all ethnic groups in America, according to many studies, Latinos have higher rates of alcoholism.

- Hispanic men are more likely to report frequent heavy drinking (defined as five or more drinks per sitting at least once a week) than White or African American men (Caetano & Clark, 1998).
- In a study of Mexican men conducted in California, 12.2% of those surveyed reported abusing alcohol. Rates of alcohol abuse were estimated to be 12 times higher among Hispanic males than their female counterparts (Alderete, Vega, Kolody, et al., 2000).
- Alcohol-related cirrhosis/chronic liver disease is the seventh leading cause of death among Latino men and tenth among Latinas, while not appearing as a leading cause of death among White, African American or Asian/Pacific Islanders (CDC, 2003).
- Latino youth are more likely than their African American or White counterparts to consume alcohol prior to driving or to ride in a vehicle with someone who has been drinking, resulting in higher death rates associated with drunk driving (Rios-Ellis, 2005)

In addition to alcohol dependence, the use of marijuana, cocaine and other illicit drugs, although historically lower for Latinos compared to other racial/ethnic groups, has been showing small but consistent increases in recent years. This is especially true among Latino youth (Gil & Vega, 2001). Methamphetamine use is also increasing in the Hispanic population, particularly in certain segments of the workforce including construction, food service and agriculture because it is easily accessed, affordable and allows users to work longer hours, thus increasing earning potential (U.S. Department of Health and Human Services, 2000; Rios-Ellis, 2005). Many Hispanic Americans view use of “street drugs” as problematic, but have a more permissive attitude toward “medical” and licit drugs (Santisteban & Szapocznik, 1982).

Suicide

Recent research has demonstrated that compared to African Americans and non-Latino Whites, Hispanics are more likely to have attempted suicide, contemplated suicide and/or devised a plan (Kann, 1998). This increased risk of suicidal behavior has been associated with substance abuse, acculturative stress, family dysfunction, mental health disorders and lower socioeconomic status (Range, Leach, McIntyre et al., 1999). According to the Centers for Disease Control and Prevention, (2004) between 1997 and 2001 almost 9,000 Hispanics (age-adjusted rate: 5.95 per 100,000 population) died from suicide. Hispanic males represented 85% of these deaths and were almost six times more likely to commit suicide than women, although Latinas were more likely to contemplate or attempt suicide, with approximately one third reporting having seriously contemplated suicide (SAMHSA, 2001). Overall, among Latino youth (age 10-24), suicide was found to be the third-leading cause of death. The highest overall rate was among persons 85 years of age and older, however, approximately 50% occurred among persons aged 10 to 35. Almost half of all suicides among Hispanics were completed using firearms, followed by suffocation and poisoning (CDC, 2004).

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Domestic Violence

Although the impact of domestic violence on the mental health of its predominantly female victims has not been well studied, victims of domestic violence are at high risk for mental health problems. Domestic violence has been associated with negative mental health outcomes including depression, post-traumatic stress disorder, anxiety, insomnia, suicide attempts and substance abuse. A study of over 1,000 low-income Latinas in three metropolitan areas found that one-quarter had experienced domestic violence (Frias & Angel, 2005). In the Kansas City area, 15% of Hispanic women surveyed reported that they had been abused by a relative (Lewis & Bautista, 2005).

A number of variables have been associated with domestic violence among Latinos including low educational levels, limited personal resources, occupational stress and heavy drinking among Latino men, and traditional socio-cultural structures and gender dynamics. Cultural norms may inhibit Hispanic women from admitting to being victims of violence, reporting their situation, and seeking assistance. In combination with these factors, Hispanic women may be reluctant to disclose their situation due to lack of awareness of their legal rights, lack of documentation and the accompanying fear of being deported, and limited availability of Spanish-speaking and culturally sensitive mental health professionals (Rios-Ellis, 2005).

Contributing Factors to Hispanic Mental Health Needs

All of the mental health issues stated above—depression and anxiety, substance abuse, suicide, and domestic violence—are experienced by people across all economic, ethnic, and social sectors. Yet in order to understand why Latinos sometimes experience higher rates than other groups, it is critical to understand the culturally bound factors which contribute to these needs, and that a current running across all of these problems is the deep isolation that an immigrant

knows well, which often accompanies the separation from extended family, friends, and loved ones.

An understanding of the factors contributing to mental health needs is also critical on the provider level. Researchers and service providers may tend to regard the Hispanic population as a homogenous group, failing to acknowledge the diversity stemming from countries of origin, nativity, and socioeconomic status, to name just a few distinctions. Prevention and treatment efforts will be more successful as researchers and providers take into account the diversity of Hispanic cultures and these issues which impact so heavily upon individual and community lives.

The following contributing factors will be explored below: (1) acculturation stress, (2) financial difficulties, and (3) racial discrimination, which are only accelerating with the current immigration debates.

1. Acculturation Stress

Although nearly 60% of U.S. Latinos are native-born, a sizeable minority are immigrants (Pew Hispanic, 2008), therefore it is important to consider the immigrant experience when exploring mental health issues faced by Hispanics. In the experience of the Mattie Rhodes Center, acculturation issues are perhaps the most pervasive factor contributing to mental health issues for the poor Latino population. Generally, the migration journey is conceptualized as a difficult one, but one which will conclude in a happier and more economically healthy life. Especially in contrast to situational poverty in Mexico and other countries, American culture still holds the promise of “the good life” for many. However, while some experience improved conditions, many others find an unexpected life with new challenges.

First, the immigration journey itself is physically and emotionally depleting. Not surprisingly, a number of aspects of the immigration experience may contribute to mental health problems. For many, the migratory journey has been fraught with negative and potentially life-threatening experiences, including violence, hunger, dehydration, injury/illness, sleep deprivation, exhaustion, fear, and depletion of monetary resources.

Although most expect a more prosperous life after arrival, many encounter unexpected anxiety associated with adapting to a new culture and environment. Those newcomers who have arrived without appropriate documentation may have increased stress associated with living in fear of being discovered and deported. Few are prepared for the loneliness and isolation which tend to be a way of life for many new immigrants.

Immigrants are often thought of as living in tightly-knit communities among many family members. Whereas this might have been the traditional system of support in their home countries, once they arrive in the United States, most find themselves separated from family and friends. Mattie Rhodes staff explain that while some share a living space with other families, these are often distant relatives, friends-of-friends, or someone they have recently met. The breakup of the family can heighten anxiety levels or contribute to depression—particularly because the value of *familismo* is such that family represents a much more central and emotionally close bond than is thought of in the United States.

This loss of family and friends can be especially difficult for Latina women, who often work inside the home raising small children. One Latina immigrant who sees a Mattie Rhodes therapist tells the story of arriving to the area with her husband, only to see him decide to rent a house with a friend near the airport, far from the established Hispanic communities in town. Not only is she isolated from family and friends in Mexico, but also from the existing networks in Kansas City. She has no transportation, and at times feels overwhelmed with isolation and grief. (The therapist often drives her home so that she can attend therapy sessions and parent group meetings.)

It is not uncommon for new immigrants to not only mourn the loss of people in their lives, but also their cultural values and way of life, or cultural identity. Some immigrants develop a sense of isolation that they have never experienced before and with which they do not know how to cope (Baptiste, 1987). This is likely more of an issue among new immigrants living in areas of the country such as the Midwest which have not historically been very diverse. Migratory transitions often result in irritability, anger, anxiety, and feelings of helplessness. Moreover, while most immigrants come to the U.S. for better economic and educational opportunities, some have fled violence or conflict in their own countries and may have psychological wounds that have not yet healed and are exacerbated by the immigration experience.

While many Latino immigrants pursue a life in the United States because they wish for better opportunities for their children, some experience deep cultural differences with their children, who struggle to adjust to living life in the 'American way,' and in doing so, often find themselves at considerable odds with their parents. In fact, the majority of parents who contact the Mattie Rhodes Center explain a sense of exasperation about the disciplinary and anxiety problems they are experiencing with their children. Yet, in most circumstances, it is this issue of acculturation, which is the primary causative factor and must be recognized as such in order to be addressed constructively in treatment.

One layer of conflict is due to the fact that the cultural world and ideological beliefs of their parents can be remarkably different from the world around the children and teens. The youth experience the strain of feeling bicultural in their world; torn between U.S. society and the more traditional world of their Hispanic immigrant parents, whom they describe to our therapists as "backwards" and "stuck in another age." They struggle between the hard work ethics and seemingly rigid belief systems of their parents, and what they see as the more enticing and leisurely lifestyle of the teens around them who hang out in malls, eat fast food, and go to slumber parties (anathema to Hispanic culture). As some young Hispanic boys confide to MRC therapists, oftentimes gangs seem more welcoming than their own homes. And so, looking for a way into the culture at large, they are apt to head toward aggression, violence and potential incarceration. These issues are only exacerbated by the employment status of their parents, many of whom work multiple jobs, ranging from factory assembly line work to cleaning houses, hotel housekeeping, nighttime janitorial services, and landscaping or yard work. There is frequently a lack of time, then, for parents to help their children in times of stress and crisis.

Another layer of conflict stems from the uneasy power imbalance, which often results between parent and child. In the Latino culture, *respeto* is a core value that represents deep respect and honor for adults and especially for parents. However, as children acculturate and acclimate more quickly than their elders, they gain access to the English language and culture so that they soon take on the role of becoming linguistic and cultural translators for their parents. Children,

always resourceful, may use this disparity to their own advantage. One Mattie Rhodes Center staff member recounts one circumstance in which a teacher called the home regarding a disciplinary problem with the child, only for the child to deftly mistranslate the content of the conversation to the parents.

2. *Financial Challenges*

In addition to experiencing difficulties adjusting to the new culture, Latin American immigrants frequently encounter difficult work conditions and economic struggles. They generally experience lower educational levels, low paying jobs, and unstable and poor quality housing.

Latinos suffer from poverty at higher rates than non-Latino whites: the poverty rate for Latinos in the U.S. was about 21% in 2002 compared to the overall poverty rate of 12% and 8% for non-Latino whites. Latinos are also more likely to be unemployed, to work in service occupations, and to earn less than non-Hispanic white workers (Ramirez & de la Cruz, 2002). The jobs available to migrants/immigrants are often physically demanding and characterized by unsafe conditions, low wages, and long hours. Most Latino individuals and families served by Mattie Rhodes staff represent the traditional labor occupations of Latino immigrants, working in factory assembly lines, housecleaning, hotel cleaning, landscaping, house painting and construction. It is not at all uncommon for a mother or father to work multiple jobs in order to make ends meet. One Latino father explained in a Mattie Rhodes Center *Vida en Balance* (Life in Balance) parenting class that he yearned to be a better father for his son while he struggled to work two jobs. His solution was that he would limit his sleep to four hours every night so that he would have meaningful family time in between shifts.

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Despite the fact that immigrants frequently work long hours and have more than one job, most continue to live in poverty. They may also experience exploitation and maltreatment by employers and co-workers, and often are not provided with standard benefits, such as paid sick leave and health insurance. Many have the additional obligation of sending money to their families back home or repaying loans they took out in order to make the journey to the U.S. A high level of job-related stress may be linked to alcohol abuse among Hispanic men, as well as domestic violence (Martinez, Guarnaccia, & Acosta, 2002).

3. *Discrimination*

Discrimination against Hispanic immigrants is indicated by anti-immigration rallies, legislation and negative coverage of immigration issues in the media. Immigration opponents work to put pressure on businesses that hire undocumented workers, creating a hostile climate for all immigrants. Pew Hispanic Center and Kaiser Family Foundation (2002) conducted a national survey of almost 3,000 Latinos in the U.S. in which they asked about experiences with and views about discrimination. Approximately 80% felt that discrimination in the workplace and schools was a problem and prevented Latinos from being successful. Almost one-third of the respondents reported that they or someone close to them had personally experienced discrimination in the last five years because of their racial or ethnic background. Survey respondents also reported more subtle forms of discrimination with 30-50% reporting unfair treatment at least once in a while. Examples of unfair treatment included being shown less

respect than others, receiving poorer service at restaurants and stores, and being called names or insulted because of their race or ethnicity.

The effects of anti-immigration initiatives are similarly felt by the approximately five million children in the U.S. with at least one undocumented parent. Between 2002 and 2006, the federal government intensified its immigration enforcement efforts, resulting in massive and rapid deportations. In a joint study of the effects of these operations on the children involved, The Urban Institute and the National Council of La Raza (2007) found that the massive roundups resulted in children left without adult supervision, sometimes for extended periods, financial hardships that exacerbated the already difficult economic conditions of the families, and disrupted school attendance and performance. Additionally, the study found that many older children witnessed the use of force against their parents and lived in a prolonged state of fear, the psychological impact of which remains to be seen. Mental health experts expect that social isolation and loss of family security may result in depression and psychological distress among parents and children alike.

Overall, the significant mental health needs related to acculturation, finances, and discrimination among immigrant Hispanic populations remain a central issue, and the need is likely to increase over the next decade. Hopefully, systems of support will increase in response to this need.



Chapter 2

DISPARITIES IN MENTAL HEALTH CARE:

Barriers to Treatment

“The women we serve have taught us humility and respect for the resiliency of the human spirit. They also remind us daily of the insurmountable barriers which impede their access to services – economic, language, cultural, and religious barriers. They lack an awareness of their rights and resources. Therefore, we have become stronger advocates for those we serve.”

- Lydia Madruga, bilingual therapist, Nuevo Día domestic violence program

As Chapter One pointed out, Hispanic immigrants tend to have a high need for mental health services. This chapter focuses on the fact that, unfortunately, the Hispanic population with such high need is also the *least* likely to access help. In general, Hispanics experience formidable barriers to effective mental health care services. Therefore, many Latinos who are suffering from mental health problems never get the help they need and deserve.

Studies indicate that Latinos with diagnosable disorders, particularly those who are recent immigrants, *underutilize* mental health services. Non-Hispanic whites are twice as likely as Latinos to seek and receive treatment for mental disorders (SAMHSA, 2003). Moreover, only 11% of Mexican Americans who had experienced mental health problems in the last six months in the Los Angeles ECA study (Hough et al., 1987) reported using both medical and mental health services compared to almost 22% of non-Hispanic whites. Compared to other racial/ethnic groups, Latinos are less likely to get care for depression and other disorders and often receive sub-standard quality of care (Schoenbaum, Miranda & Sherbourne, 2004). Moreover, Latinos are more likely to use mental health services only in crisis situations, drop out of services sooner and have undesirable treatment outcomes, particularly if the mental health system is not culturally and linguistically competent.

Latinos who do seek help often find less effective assistance. While many Americans utilize outpatient mental health services, Latinos prefer and are more likely to use emergency room and primary care settings because they are more accessible and potentially less stigmatizing. High patient volumes, financial disincentives, and inconsistent levels of training put general practitioners at a disadvantage in diagnosing and treating mental disorders among racial and ethnic minorities. Esther Wolf, Commissioner of the Kansas City, Missouri Health Department, states, “Unfortunately, when people seek treatment through an ER, the doctor they see will most likely label them with a diagnosis – one that may or may not be accurate – but is usually required for reimbursement.” The failure by providers to consider the “whole” patient, including cultural background, can confuse the diagnosis and result in the misdirection of treatment and inadvertently, rendering an inferior service to the patient (Cuellar, 1982; Vega et al., 1999) found that while rates of psychiatric disorders were similar among Mexican Americans and non-Hispanic whites, only about 27% of Mexican Americans diagnosed with more than one DSM-III-R mental disorders received any kind of treatment, compared to 77% of all diagnosed individuals.

Story from Mattie Rhodes Center:

“Ricky” was 15-years-old when he and his family first came to Mattie Rhodes Center. Having emigrated from a Latin American country known for oppressing its people, Ricky’s parents expected Kansas City, located in the heart of the “land of opportunity,” to be a place where they could get him the kind of attention needed to manage his special challenges — epilepsy and mild retardation. Once they arrived, however, they found this new land and its systems difficult to navigate, as do many of its natives. Imagine how overwhelmed and frustrated Ricky’s parents, who were not fluent in English, were trying to understand their rights, what services were available, and how to obtain those services.

Ricky was enrolled in a school in his neighborhood — a good school, but not equipped to recognize and address Ricky’s needs. His tendency to withdraw when unsure of what was expected of him was mistaken for “defiance of authority.” After many months of struggle and seeing no other recourse, the school administration reluctantly suspended him from classes.

Then Ricky and his family became involved with Visions with Hope 360°, a Mattie Rhodes Center program that assists Latino families who have children with developmental disabilities. Monthly support group meetings offered Ricky’s parents the opportunity to connect with other families, discuss their joys and concerns, and learn about resources. Most importantly, these support groups helped his parents realize that they were not alone.

Ricky’s parents also worked with a Visions Parent Advocate who armed them with new knowledge of their rights and hope for their son. Ricky was soon enrolled in a different school with special programs and staff where he continues to flourish and grow.

This story represents a snapshot of the diverse barriers which Hispanic individuals and families experience in accessing mental health services.

Barriers to Effective Treatment

According to existing research and the Mattie Rhodes Center experience, the reasons for the lack of access to mental health care for Latinos is twofold, resulting from social and cultural barriers: (1) *external structural barriers*, systems and practices that impede an individual’s ability to access mental health treatment, and (2) *internal cultural barriers* which can explain why a person or family may choose not to seek mental health help.

1. External Structural Barriers

Structural barriers are challenges that Latinos face on the institutional level. Among the most commonly reported barriers to accessing mental health care are lack of knowledge of where to seek help, transportation, location of treatment facilities, and lack of Spanish-speaking providers who are also trained to understand and meet the needs of Latinos (Aguilar-Gaxiola, Zelezny, Garcia, Edmonson & Alejo-Garcia, 2002; Martinez, Guarnaccia, & Acosta, 2002). Some structural factors present significant barriers not just for Hispanics, but many other low-income groups as well. Latinos may also fail to use available professional mental health services because they find them unacceptable in some way that is not exclusive to the Hispanic population (Echeverry, 1997). Traditional hours of operation may be inconvenient for those who work one or more jobs. Child care, which in their home countries would most likely be provided by family members, may be difficult to afford and is often not offered by service providers.

Transportation

Even with knowledge of services, however, access is impeded by the lack of and/or problems with transportation. New immigrants who do not know their way around, do not own their own means of transportation, or are not familiar with the public transportation system, are unlikely to seek help. According to Esther Wolf, Commissioner for the Greater Kansas City Health Department, “Transportation is an even bigger problem for Hispanic women who often don’t know how to drive or don’t have anyone to watch their children and have to take them on the bus too.” The issue of transportation may be further compounded by the distance they are required to travel, the time it takes to get there, and whether the agency or facility is located close to a bus or subway stop. For many, the amount of time, effort and money, as well as potential frustration associated with just “getting there,” far outweigh the perceived benefit of doing so, especially for those who have never sought mental health assistance before.

Cost of Services

Yet the problem is not just physically getting to the provider; it is the cost of service and lack of health insurance. For many Latinos, the lack of insurance results in the inability to afford help. The uninsured rate among Latinos in the U.S. is about three times higher (33-35%) than that of non-Hispanic whites (11-12%) and also more than African Americans and Asian/Pacific Islanders (19-20%) (Current Population Survey, Campbell, 1999; DeNavas-Walt, Proctor & Mills, 2004). Immigration status is strongly associated with insurance status, with those who are undocumented being less likely to have health insurance. For example, one study showed that 53% of non-citizen Latino youth (age birth to 17) were uninsured compared to 29% of citizen Latino children of immigrant families and 16% of children of American-born Latino parents (Brown et al., 1999). Hispanic children are also less likely to be insured than children of other racial/ethnic groups. Approximately 30% of Hispanic children are uninsured, compared to about 20% of African American children and 10% of non-Hispanic white children. For those who must pay for services out of pocket, little public assistance is available.

Moreover, for those who *do* have insurance, the co-pay itself is often an insurmountable barrier. One Mattie Rhodes bilingual therapist tells about a family who was court-mandated to receive counseling due to child abuse. Sessions with the only bilingual therapist they could locate required a twenty dollar co-pay, which was a financial impossibility. After one visit, they did not return. However, once Mattie Rhodes Center began offering no-cost services in Kansas, this family was among the first to seek help, and the mother explained that while she knew she had needed help before, and had sought it out, she had been unable to pay for it.

Lack of Bilingual Providers

There are barriers on the provider side as well, as there remains a critical shortage of Hispanic clinicians and mental health specialists in the U.S. today. Only one percent of a randomly selected sample of licensed psychologists in clinical practice who are members of the American Psychological Association identify themselves as Hispanic in a national survey (Williams & Kohout, 1999). In 1999, it was estimated that there were only about 20 Latino mental health professionals for every 100,000 Latinos living in the U.S.

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Complex health system

The U.S. behavioral health system as a whole is fragmented and complex. It can be difficult for any citizen to navigate its services, let alone someone with significant barriers. Therefore, even if an individual recognizes a mental health issue, decides to seek help, and attempts to get assistance, he or she may still not receive appropriate services due to the lack of service coordination and integration of mental health concerns across health care settings and providers (Chapa, 2004).

2. Internal Cultural Barriers

Hispanic cultural values and beliefs must be recognized in a culturally competent approach. Sometimes, aspects of these values can impede an individual or family's decision to seek mental health help, and this section explores how the following cultural areas can potentially act as barriers: (1) spirituality and traditional healing practices (2) unfamiliarity with therapeutic process, and (3) family and gender roles.

However, it is just as critical to recognize that these same Hispanic values simultaneously represent *strengths* to a person, family, and community, and should be brought out as such in therapeutic practices.

Spirituality and Traditional Healing Practices

One reason Latinos might be reluctant to seek therapeutic assistance with individual problems is the concept of *fatalismo*, which is a core facet of Latin American spiritual beliefs. In general, Latinos are highly religious and many of their cultural values and attitudes are heavily influenced by their spiritual beliefs (National Alliance for Hispanic Health, 1995). Many Latinos believe that spiritual forces have a powerful effect on their everyday lives and their health. Such beliefs often result in a strong sense of fatalism in which their ultimate fate is believed to exist in God's hands. Common cultural expressions that exemplify this belief are "*Que sea lo que Dios quiera*" (It's in God's hands), and "*Esta enfermedad es una prueba de Dios*" (This illness is a test of God). This particular cultural belief may inhibit a person suffering from anxiety, for example, from seeking treatment because he/she believes it is deserved and must be suffered through because it is part of God's plan.

Some Latinos may turn to folk or spiritual healers for help, perhaps in addition to conventional Western care and sometimes as an alternative (Arizona State University, no date; Mental Health/Aging Advocacy Project, 2004). *Curanderos* treat a variety of ailments of the body, mind or spirit using herbal remedies, aromas, massage, and ceremonial cleansing rituals (Trevino & de Viesca, 1995). Some folk healers practice *espiritismo*, believing that good and evil spiritual beings inhabit the earth and can affect the health and wellbeing of human beings either positively or negatively (Villa, Cuellar, Gamel et al., 1993). *Espiritistas*, a term primarily used by Puerto Ricans, are healers who primarily treat mental illness and often charge small fees for their services (Canino & Canino, 1993). Cubans refer to their folk healers as *santeros*. Individuals may choose such treatments because they do not have adequate resources for conventional care or due to cultural distrust of synthetic or non-natural medications (Arizona State University, no date).

In general, Hispanic cultures often adhere to a unique view of mental health, that of a naturalistic health belief system, which views illness as a result of an imbalance between "hot" and "cold"

forces in the body, mind and/or environment (Management Sciences for Health). Medications, foods, conditions, and emotions are thought to have hot and cold qualities. Preventive measures may be taken to maintain a balance of hot and cold elements; treatment remedies are designed to restore this balance. Not surprisingly, many Latinos are opposed to or suspicious of taking prescription medications, especially psychotropic medications. Concerns usually include the potential addictive nature of some medications, as well as their strength and possible side effects. In general, Latinos tend to prefer some type of therapy over treatment with medication (Martinez, Guarnaccia & Acosta, 2002).

Moreover, Latinos tend to express symptoms of mental health disorders somatically and exhibit different health-seeking behaviors (Chapa, 2004). For example, individuals who Mattie Rhodes Center therapists assist often explain that they had first gone to a primary care provider for symptoms such as a headache or stomach ache, only for the physician to be unable to locate a physical cause. They were then referred to the Mattie Rhodes Center for counseling.

Unfamiliarity with Therapeutic Process

Given the lack of open discussion about mental health among Latinos, many are completely unfamiliar with the assessment and therapeutic process. This lack of knowledge about services may be class and/or culturally bound. Many Hispanic immigrants are not aware that mental health care even exists, or they have no idea how to go about finding a specialist. Some may be aware, but think such services are just for the wealthy and privileged as they may have experienced in their home countries. Some U.S. cities have Spanish yellow pages and other print publications that are used to advertise services, and social service agencies may distribute literature in Spanish. However, it is important to recognize that many immigrants have limited education and may not be able to read well even in their native spoken language.

Even if an individual is aware of providers who may be able to help them, he or she may be intimidated by the unknown and uncertainty of entering into a new situation. Some Latinos may believe that mental health problems are incurable and uncontrollable and do not understand the difference between a mental disorder, which is a functional problem, and a mental disease, which is pathological. A qualitative study by Cortes (2005) explored individual and contextual factors that influence Latino men's pathways to mental health services. Results indicated that seeking professional services by Hispanic men may be negatively influenced by difficulty recognizing that they have a problem, not knowing what to expect from treatment, economic factors, social stigma, competing demands such as work and family, and migration-related experiences.

Bruce Eddy, Executive Director of the Jackson County Missouri Community Mental Health Fund, describes generational differences in conceptions of mental health care: "New immigrants may not have even thought about seeking it before. First-generation and second-generation Latinos relate the concept of "mental health" to family and community relationships. Those who are third or fourth generation may be more likely to have a typically American view of mental health as being related to psychological wellbeing."

Family and Gender Roles

Of all cultural values, *familismo*, or the importance of family, is probably the most influential, and includes not only the family unit, but the extended family as well. The overriding importance placed on family may result in the subordination of one's own needs, including health needs, to the greater good of the family (National Alliance for Hispanic Health, 1995). Seeking preventive

care or treatment for a problem once it arises may direct resources away from the needs of the entire family; therefore, actions that are for the benefit of an individual or interfere with their family responsibilities are considered unacceptable. These values are in sharp contrast to Anglo-American culture in which greater importance is placed on the nuclear family and individual interests.

Many Hispanic individuals also turn to family and community members for help, rather than relying on therapists. The conceptualization of mental health among Latinos is closely tied to many community-oriented characteristics and values. In a series of focus groups conducted among Latinos in New Jersey (Martinez, Guarnaccia & Acosta, 2002), participants had a broad sense of the meaning of “mental health,” including being active in the community and contributing to society. Mentally healthy individuals were described as non-aggressive, socially interactive, able to maintain friendships, and not abusing alcohol or drugs. They therefore saw communication with family and friends as a primary protective factor against mental health disorders.

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Due to cultural tendencies to not seek therapeutic assistance, Latinos living with mental health disorders face a double stigma – one imposed by society, and one imposed by their culture. In the focus group study described above (2002), participants reported that people who need mental health care might not seek it because of the shame it will bring to themselves and their families and the fear of being labeled as *loco* or “crazy.” Some reported a lack of support and understanding even within their families. Ms. Wolf, a first generation Mexican-American with expertise in community health and social services, stated that, “Latinos may be reluctant to share ‘family secrets’ because it would be considered a betrayal of trust. Obviously, the risk of being feared, judged, mistrusted or pitied for one’s mental health problem, is a deterrent to seeking treatment.”

From an early age, children learn the traditional, delineated gender roles, which are generally accepted and respected. The concept of *machismo*, which has come to have negative connotations in modern American culture, is actually a term referring to a man’s responsibility to protect and provide for his family. If a man is unable to fulfill this role, he may be considered weak or dishonorable. Therefore, assuming this role can contribute to a Hispanic man’s unwillingness to talk about depression or other mental health problems, even if he suspects that he may need help. Latinos may be more likely to attempt to hide or camouflage their symptoms or engage in reckless behavior, such as excessive alcohol consumption.

Hispanic women are considered the caretakers of the home and family and are expected to put the needs of other family members before their own (Acuña-Lillo, 1994). *Marianismo*, the female counter to *machismo*, suggests that the ideal woman is both sexually pure and self-sacrificing as a wife and mother. In many ways this concept promotes the superiority of women who not only are able to bear children, but are spiritually stronger and better able to exercise self-

control. On the other hand, women are expected to be relatively instinctive, unassertive and compliant (Stevens, 1973). Self-esteem and self-image, therefore, are often tied to her ability to fulfill these sometimes conflicting roles. Hispanic woman may be more likely to blame herself for any family conflict or disruption, such as a misbehaving child or domestic abuse. They may also put off seeking help for themselves until the problem can no longer be minimized or ignored.

Within the extended family, respect and responsibility for each other are highly valued with an emphasis placed on interdependence and cooperation. Confrontation and competition are discouraged. Family members often seek each other's advice when making important life decisions or turn to them for comfort during time of hardship. This is applicable to the clinical situation as well in which multiple family members may expect to be involved in the discussion and decision making process. For those who are separated from their extended families, seeking professional help for a mental health problem may be an overwhelming task to accomplish alone.



Chapter 3

PREVENTION AND TREATMENT: *Lessons Learned at Mattie Rhodes Center*

Evidence-based Prevention Programs for Latino Mental Health

Relatively little work has been done to determine best practices for prevention of mental health disorders specifically tailored for Latinos. The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a database of evidence-based programs that are considered conceptually sound and internally consistent with appropriately related activities and have been reasonably well implemented and evaluated (www.modelprograms.samhsa.gov). Here are some examples of the programs they highlight:

Program #1: *Sembrando Salud* (Sowing the Seeds of Health),

Description: *Sembrando Salud*, initially implemented in the San Diego area, is a school-based tobacco and alcohol prevention program specifically targeting Hispanic migrant adolescents ages 11 to 16 and their families. Emphasis is placed on healthy decision making and social skills development through improving parent-child communication. Interactive teaching methods, including group discussion, videos, demonstrations, and role-playing, are implemented by bilingual/bicultural college students (Litrownik, Elder, Campbell, Ayala, Slymen, Parra-Medina, Zavala & Lovato, 2000).

Program #2: *Houston Parent-Child Development Program*

Description: This culturally-sensitive program is for low-income Mexican-American families with children ages one to three that provides a wide range of educational and support services. The program, which is designed to train mothers to be effective teachers and to counter the effects of poverty, has two stages. Beginning when the child is one year old, mothers receive twice-weekly home visits, English classes, and linkages to community resources; children receive medical examinations. During the second stage, mothers participate in homemaker lessons and have opportunities to practice childcare techniques four days a week at the program's central location. Mothers, who complete about 500 hours of training over a two-year period, are able to select more appropriate play materials, improve emotional and verbal responsiveness to their children, and avoid punishment/restriction tactics. Child participants are generally better adjusted overall than other children their age, demonstrating more emotional sensitivity and less destructive behavior and negative attention-seeking (Johnson & Breckenridge, 1982). Both *Sembrando Salud* and the Houston program are classified as Effective Prevention Programs by SAMHSA.

Program #3: *Dando Fuerza a La Familia* (Strengthening Families)

Description: The *Dando Fuerza a La Familia* (Strengthening Families) is designed to reduce mental illness risk factors in six to eight-year-old children whose parents are substance abusers. The program was developed by Aliviane No-Ad, Inc.

(<http://freshdisplay.com/projects/aliviane>), a minority-owned and operated community-based, non-profit agency in El Paso, Texas. The 14-week, culturally tailored intervention is designed to improve the family environment and the parents' abilities to nurture and support learning for their children by incorporating education and socialization activities, psycho-educational groups, and links to community resources. Topics include recovery principles, relaxation techniques, setting boundaries, stress management, risk and protective factors, and interaction with school personnel. Child participants have demonstrated improved school attendance and performance, increased educational aspirations, improved interaction with peers, reduced violence-driven behavior, better understanding of the consequences of using alcohol, tobacco and other drugs. Parents and children both report improved bonding.

Program #4: *El Proyecto de Nuestra Juventud* (Strengthening the Bonds of Chicano Youth and Families)

Description: This program is a community-based intervention model targeting high-risk Hispanic youth ages nine through 16 that was developed by the Pinal Hispanic Council, a non-profit agency in rural Arizona. This comprehensive, culturally appropriate program addresses four domains: community, school, family and individual/peer. Using a variety of methods, including camps (*campamentos*), informal talks (*platicas*), peer support groups, workshops, a homework center, business enterprise projects, parent/sibling contracts, and mural and theater projects, *Nuestra Juventud* has shown promise in improving family relationships and decreasing alcohol and drug use.

Prevention Work at Mattie Rhodes Center

From experience the staff at Mattie Rhodes has learned that when intervening with the Hispanic population, prevention information should be focused on the family and community rather than the individual. Prevention efforts that incorporate concise and easy to read materials in combination with culturally appropriate murals, posters, music, role playing, touchable objects or kits are recommended. In addition, face to face outreach and community events are preferred over information hotlines and websites.

At Mattie Rhodes Center, *Esperanza para la Familia* (Hope for the Family) took place from 2001 to 2005. Mattie Rhodes Center, in partnership with the Kansas City Missouri Health Department and with support from SAMHSA, implemented this school-based prevention and early intervention program targeting Hispanic students and their families at two elementary schools. Using the PATHS (Promoting Alternative Thinking Strategies) approach, the program sought to improve the mental and emotional competencies of children, and to engage their families through parenting groups, counseling, case management, and art education. Students showed improvement in positive attitudes and behaviors, such as self-control, concentration, taking turns, showing respect, and sensitivity to others' feelings. They also exhibited reductions in aggressive behaviors. Parent participants reported improvements in problem resolution, confidence, use of positive discipline methods, and self-sufficiency.

Another Mattie Rhodes Prevention Program is *Vida en Balance* (Life in Balance), which began in 2002 with funding from the Missouri Children's Trust Fund. In this parenting program, many of those served are from rural Mexico, and are Spanish-speaking yet are not literate in Spanish, having had a very limited educational background. Prevention information in the form of written material—even in Spanish—was inappropriate for this audience. In addition, direct 'lecturing' approach is also often limited in effectiveness for participants who did not attend class sessions for an extended amount of time. For these cultural reasons, prevention methods that incorporate visual aids and manipulatives have a much greater impact.

As part of this program, Mattie Rhodes Center began using the Latin American lay health worker model known as *Promotoras de Salud* (Health Promoters) to reach isolated and at-risk Spanish-speaking men and women. *Promotoras* are Spanish-speaking, Hispanic women from the community who are recruited and trained to do outreach and provide educational support to area families. They act as a bridge between the agency and the communities they serve because potential clients are more apt to trust someone who shares their cultural background and lives in their neighborhood. Furthermore, they act as agents of change within their naturally occurring social networks.

Initially offering only parenting classes (*Padres Activos*) for Spanish-speaking mothers and fathers, the program now includes community health and wellness education and other family supports. Program modifications and improvements were based on feedback from parenting class participants and *promotoras* who indicated that the community was in need of additional educational opportunities related to physical and mental health. These included nutrition, disease/illness prevention, income management, community resources, communication, and emotional health. Mattie Rhodes Center now offers four different educational modules including:

- **Family Development:** Focuses on enhancing marital and family relationships through improved communication and understanding between partners, parents and children.
- **Healthy Households:** Covers nutrition, buying and preparing healthy meals, hygiene, self-care, healthy lifestyles, and budgeting family income. This class promotes healthy behaviors by incorporating Hispanic traditions and values and recognizing the importance of the family unit.
- **Active Parenting:** Provides guidance to parents and caregivers on childhood developmental stages and positive disciplinary methods
- **Navigating a New Life:** Enhances understanding of U.S. laws, ability to access community resources and healthcare, how to complete applications (for jobs, government benefits, car registration, citizenship, etc.) and cultural adjustment issues.

Treatment of Mental Health Disorders among Latinos

As in the area of prevention, little empirical research has been conducted on the most effective treatment methods for Latinos with mental health disorders. The literature available to date suggests that evidence-based care is likely to generalize to the Hispanic population (Miranda, Bernal, Lau, Kohn, Hwang & LaFromboise, 2005).

- For treating depression among Hispanic clients, adaptation of the Cognitive Behavioral Therapy (CBT) has received the most attention and appears to work well with this population (Acosta, Guarnaccia & Martinez, 2003).

- A study comparing Latino to European-American youth aged 6-16 years with phobic and anxiety disorders found that the two groups responded similarly to exposure-based Cognitive Behavioral Therapy (CBT) in their treatment response and maintenance (Pina, Silverman, Fuentes, Kurtines, & Weems, 2003).
- In another study of depressed Puerto Rican adolescents, CBT and interpersonal psychotherapy (IPT) were found to be effective in reducing symptoms of depression, although IPT produced a higher level of functionality among participants (Rossello & Bernal, 1999).
- Other studies have shown that psychotherapy and family psychoeducation work well with Hispanics, as does providing in-home services.

Treatment at Mattie Rhodes Center

From the beginning Mattie Rhodes Center therapists and case managers take into account the emotional support needs of all the family members, including children. According to bilingual therapist Andrea Perdomo-Morales, “Anyone working with Latinos needs to be aware of generational differences in acculturation and the resulting tension that can occur within families. For example, teenagers are often given more responsibilities because of their English language abilities. They don’t get to fully experience being children. Sometimes this results in a shift in the balance of power within the family that they don’t know how to deal with.”

Mattie Rhodes Center also adheres to a holistic philosophy of treatment that values moving beyond the individual and family in isolation to include interactions with outside systems, institutions, and agencies as a means to address the needs of clients. Therapists and case managers take into consideration the total ecological field of every client and family member, including gender, age, race, ethnicity, social class, and educational level, as well as living and working conditions. Using this ecological-systems perspective as described by Gonzalez (2002), mental health problems of Hispanic immigrants may be lessened by helping them mediate complex social systems, obtain community resources, learn new job skills, and speak English. If needed, families receive assistance in accessing community resources and public services designed to meet basic needs such as housing, food and clothing, as well as assistance with finding employment and educational opportunities. If these priority concerns are not addressed, it is unlikely that counseling or therapy will ultimately benefit the client or family. Using a holistic perspective (Wing, 2006), physiological and individual level factors that make each case unique, as well as group level factors, such as religious and cultural beliefs are respected in the evaluation and treatment planning process.

Several factors can create more positive and culturally competent clinical interactions with Latinos. First, the ethnicity of the therapist can potentially improve the outcomes. Some research suggests that Latino clients, especially newcomers and Spanish-speaking clients, who

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see Latino therapists (bilingual and bicultural), are more likely to remain in care and to have better outcomes (Acosta, Guarnaccia & Martinez, 2003). While Latino culture in the U.S. varies by country of origin and regions and ethnicities within those countries, many Latinos share common values based on their cultural heritage (National Center for Mental Health Promotion and Youth Violence Prevention, 2004).

Yet beyond a shared ethnicity, it is critical that therapists are familiar with Latino cultural understanding and communication in a successful therapeutic relationship. The following are cultural values which, in a successful setting, infuse therapeutic practices:

Personalismo

“In graduate school we were taught not to get too personal or involved with the lives of your clients – don’t tell them too much about yourself, don’t accept gifts, decline invitations, don’t hug, etc. That doesn’t work with Hispanic people. If I can relate a relevant personal life experience to show that I am empathetic to my client’s situation or share ideas about how to cope with a problem, I do it!”

-Iberty Gedeon, a bilingual and bicultural therapist at Mattie Rhodes Center

In order for a therapist to be successful when working with Hispanic clients they must be willing to be less detached and more personal. As in the example given above, the therapist was willing to share pieces of her own story to help the client. In addition to revealing part of yourself, it is important to be warm, friendly and genuinely caring. It is also helpful to maintain eye contact and to put less physical distance between the client and therapist. This will put the clients at ease and they will be more likely to return for services in the future. In an effort to maximize efficiency, mainstream U.S. health care institutions generally lack *personalismo*. From intake to discharge, service delivery is frequently characterized by detachment and a process orientation, often a major source of dissatisfaction among Latinos (National Alliance for Hispanic Health, 1995).

Respeto

“Respect is one of the core values that can be used to help a Hispanic woman regain personal power and heal. Exploring her own attitudes and beliefs specific to gender roles helps her gain strength and re-define who she is. Reconstructing her sense of obligation and responsibility enhances her dignity, self-worth, and confidence.

-Lydia Madruga, a bilingual therapist at Mattie Rhodes Center

The value of *respeto* traditionally places importance on and gives ultimate decision-making power to authority figures, such as parents, elders, teachers, health care providers, civic leaders and government officials. Out of respect the client may avoid expressing doubt, admitting they are confused or disagreeing with their therapist. Because of this therapists must ask questions. “Listening to their story is essential in connecting with the person and validating their experiences,” advises Ms. Madruga.

Familismo and colectivismo

The Latino concepts of family and community differ significantly from traditional Anglo-American views and values of independence and competition. They instead value interdependence and cooperation, which are reflected in the cultural values known as *familismo* and *colectivismo*. The extended family serves as a support system for all members and puts family needs above those of the individual. This concept of family extends to the view of community in which members rely on and interact with one another in the way that most Anglo-Americans do with their extended families (National Center for Mental Health Promotion and Youth Violence Prevention, 2004). Because of this strong emphasis on the family, family members are more likely to be involved in the therapeutic process and may play a key role in helping the client stay in the program.

In late 2006, “José” began to work with a bilingual therapist. José suffered from stress, anxiety, and panic attacks. His therapist met him at his school during homeroom hour, as he was unable to meet elsewhere. After initial meetings, she saw that José’s anxieties stemmed from the domestic abuse he witnessed against his mother in his home. As a young Latino man, honor and familismo are critical values, and he felt it was his role to protect his mother, even as she repeatedly returned to the abuse. He had in many ways taken over the role of his father for the family, spending most evenings taking care of his younger siblings, and most weekends taking care of the home and paying bills. Overwhelmed with frustration and anxiety, José longed for a life more like that of his 16-year-old friends, with fewer family responsibilities and more weekend evenings out. He also sensed that Belinda would understand, often remarking, “You know how it is,” of growing up in a Latino household. Yet he also spoke to her in defense of his life as he had come to know it: “This is what I do in my culture. We look after our family. This is just what we do.”

Since these initial meetings, Belinda has met with José every week at his high school, and has seen relief. He has gained greater feelings of security and confidence in his life. Recognizing that honor and familismo matter deeply to José and are positive cultural strengths to him, his therapist has worked with him to find a balance between his positive Latino beliefs and the American culture of teen independence and ‘freedom’ in which he lives. She has also helped him to continue to support his mother—but in a more detached way, so that he no longer feels continually responsible and frustrated for and by her. José now feels healthier and more balanced in his life, and looks forward to a brighter future for himself.

Immigration and Intergenerational Conflict

Central to effective treatment is the understanding that acculturation is one of the most common reasons Latin American immigrants in the U.S. seek therapy. At Mattie Rhodes Center, individuals often seek therapy or parenting classes in order to resolve family conflicts and behavioral problems with their children, yet most often, these conflicts are broader in nature and actually stem from unanticipated stress and difficulty adapting to their new home (Baptiste, 1987; Downs-Karkos, 2004). Quite often, a mother or father will bring a child for therapy because he or she is exhibiting behavioral problems. In actuality, conflict and stress within the family may be resulting from differential rates of acculturation. Children are often more adaptable to change and quickly take on “American” attitudes, values and behaviors. Fearing that they may lose control over their children, parents often implement stricter rules and put pressure on their children to stay loyal to the “old country” (Baptiste, 1987).

Children also tend to learn to speak English at a faster rate than their parents and are often called on to help with interpretation and navigation of social systems. This role reversal in which parents are dependent on their children to intervene on their behalf may result in a loss of the respect children have for their parents and a subsequent change in family power dynamics (National Center for Mental Health Promotion and Youth Violence Prevention, 2004). Teenage children may also simultaneously be experiencing peer pressure to act more “American” and feel that identification with their native culture is a disadvantage rather than an asset (Downs-Karkos, 2004). Parents sometimes blame the new culture for corrupting their children, resulting in polarization that threatens the traditional family value system (Baptiste, 1987).

IN THE CASE OF INTERGENERATIONAL CONFLICT WITHIN HISPANIC IMMIGRANT FAMILIES, THE CENTRAL ISSUE OFTEN STEMS FROM UNREALISTIC AND UNFULFILLED EXPECTATIONS FOR THE NEW COUNTRY AND FAILURE TO MOURN THE LOSS OF THEIR NATIVE COUNTRY OR CULTURE.

The job of any therapist is to get to the root of the problem. In the case of intergenerational conflict within Hispanic immigrant families, the central issue often stems from unrealistic and unfulfilled expectations for the new country and failure to mourn the loss of their native country or culture. Families who find themselves in this situation may be reluctant to seek assistance because it may be perceived as an admission of incompetence. Because they may be unfamiliar with and fearful of the therapeutic process, families in conflict might initially send conflicting messages. While they indicate a desire for change, they occasionally paint a more positive picture than actually exists (Baptiste, 1987).

The therapist may need to act as a surrogate extended family in order to preserve the dignity and self-worth of all involved. In order to facilitate resolution, the therapist first needs to identify each family member’s current phase in the migratory and acculturation process and clarify the differential adaptation rates (Baptiste, 1987). The assessment process should also consider the hierarchical and authority structure of the family and the relative strengths and weaknesses of relationships within the family (Altarriba & Bauer, 1998). Active grieving should be encouraged for those family members who have not allowed themselves to mourn. The family may need assistance with achieving a balance between old and new rules that is more conducive to successful family functioning.

Several effective treatment approaches to address intergenerational conflict and acculturation disparities among Latinos have been identified, primarily through research with Cuban immigrant families. From an ecological systems perspective, Hispanic clients benefit from receiving help in navigating complex social systems, learning to speak English and other new job skills, and accessing community resources (Gonzalez, 2002). Ecological structural family therapy (Szapocznik, Kurtines, Santisteban et al., 1997) emphasizes the interaction between internal factors and external environmental factors on family dynamics during the acculturation process. Bicultural effectiveness training, developed by the University of Miami (Szapocznik, Rio, Perez-Vidal, et al., 1986), has been empirically tested and found to be effective in resolving conflict within Cuban American families following reunification. Using a psychoeducation treatment approach based on structural family theory, the training is designed to reduce acculturation stress in two-generation immigrant families. The social/environmental change agent role model emphasizes the importance of the mental health practitioner acting as a consultant or advisor in strengthening support systems and promoting

psychological growth and development among ethnic-minority clients (Atkinson, Thompson & Grant, 1993b).

Many families find it helpful to be connected to other families with whom they share similar experiences. A therapist or case manager can be instrumental in helping such families come together, replacing lost support networks (Baptiste, 1987). Therapists who work with Hispanic immigrant families are encouraged to focus on their strengths and assets rather than the pathological aspects of their relationships in an effort to keep them engaged and facilitate self-determination. Lastly, mental health service providers should be prepared to extend their role beyond that of therapist or counselor to that of educator, mediator, and advocate (Gonzalez, 2002).

Mattie Rhodes Center Philosophy and Treatment Model

The philosophy of Mattie Rhodes Center is guided by the preservation and protection of human rights, social equality, and respect for cultural, ethnic, and religious diversity. The agency uses a client-centered, holistic approach to treatment that moves beyond the individual and family to include the entire ecological field in which clients function. To effectively address the needs of clients, their interactions with outside systems, institutions, and agencies are considered, as well as the environments in which they live, work, study and worship.

The agency consciously and continuously strives for cultural and linguistic competence. Within the walls of Mattie Rhodes Center, culture is considered an asset, not a liability, a concept that permeates throughout the agency and is promoted in all its external endeavors. Staff views knowledge of and respect for culture, ethnicity, and religious beliefs as essential to successful treatment and recognizes that ongoing examination of one's personal prejudices and values, as well as their potential impact on clinical outcomes, is necessary on the path to achieving cultural competence. The agency has attempted to create an atmosphere of trust and openness in which staff and clients alike feel free to explore and evaluate their own attitudes, beliefs, values, and behaviors in relation to others without fear of being judged or discriminated against. Because linguistic competence is also critical to providing a positive, welcoming environment in which clients can develop a sense of comfort and connectedness, all services are offered in Spanish and English.

At Mattie Rhodes Center, the dignity and worth of individuals are highly valued regardless of gender, race, ethnicity, sexual orientation, age, physical and mental abilities, religious beliefs, documentation status, or socioeconomic class. Stemming from an agency legacy that has primarily sought to reach out to the poor and disenfranchised, the agency upholds the right of all people to access quality mental health and social services regardless of ability to pay or immigration status. Mattie Rhodes Center works to promote social change on behalf of oppressed and vulnerable members of society who are at risk for or suffering from mental health disorders by enhancing awareness and sensitivity among clients, staff, stakeholders and the community about relevant issues.

Mattie Rhodes Center's treatment model is unique to the agency, having been cultivated over more than twenty years of providing mental health services to the Hispanic population in Kansas

City, Missouri. The client-centered treatment model used incorporates a variety of approaches and methods, including:

- **Family systems approach:** Research points to the effectiveness of treatment modalities that incorporate the family and community into the treatment of Latinos. *Familismo*, the tendency to extend relationships beyond the nuclear family, has been shown to help facilitate emotional proximity, affective resonance, interpersonal involvement and cohesiveness. (Falicov, 1998; Comas-Diaz, 1997). Mattie Rhodes Center therapists utilize a family systems approach in serving Latinos because it is critical to the wellbeing of clients from a cultural standpoint.
- **Solutions focused treatment:** This treatment approach stresses the internal, external and cultural resources clients bring to therapy when exploring possible solutions to problems or challenges. This approach encourages meaningful participation by clients in making choices and decisions that directly impact their lives, thus cultivating their right to self-determination.
- **Strengths based approach:** Therapists and case managers capitalize on the strengths of clients to assist them in accessing the necessary resources to live a well-balanced, healthy life. The therapeutic process focuses on the client's interests, skills, culture, aspirations, achievements, and resources, rather than his or her weaknesses or deficits. The therapist does not ignore problems and difficulties, but attempts to help the client resolve them by developing a collaborative, trusting relationship and reflecting the belief that clients have the ability to learn, grow and change (Options for Southern Oregon, 2002).
- **Bicultural/bilingual emphasis:** Encouraging Latinos to retain their cultural values and behaviors while adapting to a new culture has been shown to develop protective and resilient characteristics in those seeking services (Szapocznik, Rio, Perez-Vidal et al., 1986). Research suggests that a combination of maintaining traditional, positive cultural traits while acquiring the skills and flexibility needed to function in a new cultural context maximizes positive mental health outcomes. Mattie Rhodes Center therapists and case managers help guide recent immigrants through the process of acculturation while addressing their mental health needs simultaneously. Educating clients about acculturation stressors greatly reduces anxiety and provides individuals and families with the skills necessary to begin a healthy acculturation process (Santisteban & Szapocznik, 1982).

Therapists at Mattie Rhodes Center report that they try to introduce potentially beneficial characteristics of U.S. culture into their therapeutic interactions while being sensitive to clients' own cultural values. For example, parenting in the U.S. involves not only taking care of one's children at home, but being involved in their educational process at school, according to therapist Iberty Gedeon. Luis Cordova, substance abuse program coordinator and therapist, often encourages Hispanic fathers to be more involved in raising and nurturing their children and to show more respect for women. *Vida en Balance* project coordinator Cielo Fernandez reports that while learning English is a choice, it should be encouraged as a survival mechanism.



Chapter 4

CLOSING THE GAP: *Linguistic and Cultural Competence*

Linguistic Competence

Whether implementing prevention or intervention programs, effective support services must be offered in the language spoken by clients and in a manner that demonstrates awareness and respect for their cultural values and traditions. The National Alliance for Hispanic Health (2001) describes *language* as “a communication tool by which cultural meaning is transferred and its complexity understood. In its simplest form, each word has a meaning. The combination of words within a particular context takes on a specific cultural meaning.” (p.17). Direct translation is not always effective in understanding and expressing symptoms of mental health disorders. Language has many layers with literal and culturally specific meanings, as well as non-verbal cues and characteristics that, if not properly understood, can result in miscommunication and confusion on the part of both the client and provider (National Alliance for Hispanic Health, 2001).

For this reason, linguistic competence has recently come to the forefront in the provision of health care services. The National Center for Cultural Competence developed the following definition of *linguistic competence*:

“Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.” (Bronheim, Goode & Jones, 2006, p. 4).”

The importance of linguistic competence is perhaps obvious within the therapist-client relationship; however, favorable first impressions are also critical. To enhance initial impressions and the comfort levels of potential clients, the organization’s receptionist and/or telephone operator should also be bilingual (American Institutes for Research, 2005; National Alliance for Hispanic Health, 1996). For all staff who claim to be proficient in Spanish, a formal assessment of his or her language ability should be conducted based on the demands of the position. The likelihood that a potential client will walk through the door for the first time or return a second time will be increased if all agency signage, both inside and outside, are posted in Spanish and English. Any educational materials and forms used within an agency serving Latinos should also be available in both languages.

Simply speaking Spanish and providing written information in Spanish, however, is sometimes not enough. Materials should be culturally appropriate in terms of design, images, and verbiage,

not just translated from English to Spanish (American Institutes for Research, 2005; National Alliance for Hispanic Health, 1996). Agencies should also keep in mind that many Latin American immigrants have limited formal education and may lack functional reading skills even in their native language. Some clients may not readily volunteer this information; therefore, staff should informally assess reading ability and assist clients as needed when completing forms or understanding new information. Organizations that produce their own educational materials should attempt to keep them below a sixth-grade reading level as this is often the highest grade that many new immigrants have completed.

Some clients, though functionally literate, may have a low level of health literacy, described as the “degree to which individuals can obtain, process and understand the basic health information and services they need to make appropriate health decisions” (Healthy People 2010, 2000). Nearly half of all adults in the U.S. have some difficulty understanding health information. While health literacy is related in part to educational level, cultural and social factors also come into play (Institute of Medicine, 2004). Therapists at Mattie Rhodes Center report that they often modify traditional therapy sessions when working with Hispanic clients by spending a significant amount of time teaching and sharing information.

Many find it helpful to use simple illustrations and diagrams in this process. For example, Andrea Perdomo-Morales, a bilingual and bicultural therapist at Mattie Rhodes Center, explains, “Sometimes I draw family diagrams to illustrate how behavior patterns in families can affect children and adults across generations. This helps them identify from where their issues stem and break the cycle that is feeding the turmoil.” Other therapists make use of analogies that resonate with the culture. Therapist Iberty Gedeon relates mental health to learning a new dance. “Everyone progresses at different rates, learns from his or her mistakes, and has to adapt depending on the situation - just like learning a new dance.”

In addition, a number of barriers to accurate communication across and within cultures have been identified other than language (Rodriguez, 1995-96). Miscommunication can occur as a result of dialectical differences, word choice, context, and past experiences. Non-verbal factors including posture, physical proximity, gestures, touching, vocal tone, eye contact, and facial expressions carry meaning and may impact comprehension and interpretation (Rodriguez, 1995-96). Lastly, preconceptions and expectations, often based on inaccurate stereotypes, may negatively impact interactions and result in misunderstandings. When in doubt, it is always appropriate to ask questions in a respectful and curious manner.

Given the shortage of bilingual service providers, some mental health organizations are forced to engage the services of interpreters or other language access resources. To respect privacy and encourage honest dialogue, mental health providers should avoid recruiting agency support staff and family members, especially those who are younger than the client, as interpreters during treatment sessions. Trained medical interpreters who have demonstrated language competency, have knowledge of service-specific topics, and with whom the client is not familiar should be

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used whenever possible (National Alliance for Hispanic Health, 2001; Siegel et al., 2002). Training should also be offered to providers regarding effective practices for working with interpreters. Lastly, other language access resources, such as internal language banks and phone-based interpreter services, should only be used as back-up measures or in the case of an emergency (National Alliance for Hispanic Health, 2001).

Cultural Competence

While it is important that language preference, reading ability and health literacy be assessed during the initial intake, service providers often neglect to take culture into account while trying to be rigorous and impartial (National Alliance for Hispanic Health, 1995). The term *culture* has been defined in many ways. For the purposes of this discussion, the National Center for Cultural Competence's definition of culture was chosen:

“Culture is an integrated pattern of human behavior which includes but is not limited to thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles relationships, and expected behaviors of a racial, ethnic, religious, spiritual, social or political group; the ability to transmit the above to succeeding generations; and dynamic in nature (Bronheim, Goode & Jones, 2002, p. 3).”

The term *cultural competence* as it relates to health care began to appear consistently in the literature in the early 1990s, growing out of increased awareness of racial and ethnic health disparities (Martinez & Wu, 2006). In general, the aim of cultural competence is to equalize access to quality care and the outcomes that result from that care. Over the years, cultural competence in terms of health care has been defined in numerous ways:

“A set of academic and interpersonal skills that allows individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs, and to work with knowledgeable persons of and from the community in developing focused interventions...” (Orlandi et al., 1992).

“...the attainment of knowledge, skills and attitudes to enable administrators and practitioners within systems of care to provide for diverse populations. This includes an understanding of the group's or member's language, beliefs, norms, values, as well as socioeconomic and political factors that may have a significant impact on their wellbeing, and incorporating those variables into assessment and treatment” (CSAP, 1993).

In *Culture Handbook* (Family Violence Prevention Fund, 2005), author Sujata Warriar argues that the commonly used definitions of cultural competence are inadequate in that they suggest “a fixed point in time we can all become competent by the development of certain skills which can be attained by attending a certain number of trainings or by being exposed to certain groups and individuals over time” (p. 5). What is missing, according to Warriar, is the idea that cultural competency is a process, rather than a result, of self-evaluation and critical thinking throughout one's life, enabling better understanding of one's own biases and ability to serve others effectively.

In addition, the following are modified benchmarks of cultural competency as developed by the Center for the Study of Issues in Public Mental Health (Siegel, et al., 2002). The Center for the Study of Issues in Public Mental Health (CSIPMH) promotes the integration of research, policy and practice in public mental health. Established in 1993 under a grant from the National Institute of Mental Health, this organization has a very comprehensive list of cultural competency guidelines. The following benchmarks are recommended for organizations that are seeking to create a culturally sensitive environment and provide culturally competent services to ethnic or racial populations.

Organizational Structure and Governance
Mission Statement: Mission statement must include a goal of achieving cultural competency
Plan: A Cultural Competency plan must exist if there is at least one threshold-level cultural group in the target population (a threshold level cultural group is a cultural group that numbers 5 percent or more of the target population)
Funds: There is an identifiable provision of monies earmarked for CC activities
Monitoring: Quality assurance programs must be required to monitor cultural competence
Services: Culture-specific services and interventions must be provided
Staff and Board Representation
Management: The agency must have representatives from the predominant cultural group of the target population in leadership and executive management levels
Clinical Staff: The agency must have representatives from the predominant cultural group of service users among direct clinical staff
Recruitment of staff: The agency must provide evidence that recruitment procedures have been used to obtain bilingual staff of the threshold culture
Expert: A person responsible for cultural competency must be named and must coordinate with quality assurance
Board: Board of directors must contain members from the three most predominant cultural groups in the target population
Committee: A CC Advisory Committee must exist if there is at least one threshold-level cultural group in the target population
Recruitment involving bilingual: Recruitment strategies must mention that bilingual skills and/or prior experience with threshold-level cultural user group is desirable
Evaluations: Staff performance evaluation must include items related to CC

Organizational Data

Populations: The agency must obtain population-level data for its target population on characteristics such as race, ethnicity, age, gender, education, poverty-level, income, employment, and languages spoken other than English

Religious Representation: The agency must have “contact” information on at least one religious/spiritual entity in the service area for each predominant cultural group

Collecting Data: The agency must have a systematic way of collecting and aggregating data on its users

Outcomes: Outcome data can be analyzed for specific cultural groups within programs

Communication

Community Reception: Telephone instructions must be available in language of predominant cultural group

Bilingual oral: Language assistance must be available at all points of service delivery for persons with limited English proficiency

Interpreters: All persons used as interpreters, including bilingual staff, must be assessed for the competence of language assistance with topics that are specific to the service provided

Bilingual written: The agency must provide written information in languages other than English

Bilingual forms: Vital forms such as applications and consent forms must be available in the language of the threshold cultural group

Bilingual physical setting: In addition to signage and posted information, there must be magazines, newspapers, posters, art work or other decorative features that reflect the cultures of threshold-level cultural groups of service users

Organizational Development

Professional education: Culture/race/ethnicity must be incorporated into continuing professional education and other training

Training: Employee orientation and training material must include CC policies

Availability and Flexibility for Community

Transportation: Transportation assistance is made available for persons who indicate a need

Flexible hours: The service site must be open evenings and/or weekends or special accommodations must be made on an individual basis for persons who indicate a need

Cultural competence, while frequently considered in relation to individual service providers, is also applicable to the organizations and institutions that employ them. According to the National Alliance for Hispanic Health (2001), “Culturally competent agencies are characterized by acceptance and respect for culture, careful attention to the dynamics of differences, continuous expansion of cultural knowledge and resources, and adaptations of service models in order to better meet the needs of different racial and/or ethnic groups.” The literature on organizational cultural competency theories and practices is growing rapidly, although the evidence that recommended actions ultimately make a significant difference in clinical outcomes is limited (Goode, Dunne & Bronheim, 2006).

“Organizations that work towards cultural competence must be open and flexible in creating an environment among staff that values quality of care, embraces diversity, conducts self-assessments and nurtures a culture of learning and growth. If the commitment to cultural competence is genuine, at times the journey will be uncomfortable and challenging. Organizations must be courageous to begin this journey and to keep it alive day to day. Not only must the staff embrace this, but also volunteers, management and the board of directors. The journey may become easier with time, but we will never reach the final destination – cultural competence is an ongoing process.”

- Gayle Erikson-Laney, LCSW, Mattie Rhodes Center Clinical Director

The New Jersey Mental Health Institute (Acosta, Guarnaccia & Martinez, 2003). has identified five areas that should be addressed in order for mental health agencies serving Latinos to be considered culturally competent:

(1) Outreach and educational awareness activities: Educational activities are important for addressing the lack of knowledge regarding mental health and available specialty services within the Hispanic population, especially among newcomers. Staff may set up displays or make presentations at local schools, churches and community events such as health fairs and festivals. In terms of marketing, Spanish-language media outlets can be used for print and audio advertisements. Staff should be encouraged to participate and should be supported in their efforts to be involved with community stakeholder groups and coalitions. Another opportunity for outreach is through involvement with Hispanic events such as parades and fundraising events.

(2) Organizational cultural awareness and sensitivity: The agency should be well informed about the population it is serving, including demographic information, cultural values, sociopolitical history of home country, and trends in utilization of health care. Therapists and case managers should assess each client’s ethnic identity, psychosocial history, social connections, family structure and support, migration experience, and level of acculturation. Cultural competency should be incorporated into the mission and vision, as well as the strategic plan, of the organization. For example, personnel may be asked to periodically perform cultural self-assessments and contribute to the planning and monitoring of progress toward achieving cultural competence.

(3) Program staffing: Bilingual and bicultural personnel should be present in all areas of staffing including clinical, administrative and medical positions and be valued for their additional skills and expertise. Financial support for continuing education and professional

development activities for all levels of staff is essential. It is important that staff have non-punitive attitudes and be sensitive to the barriers that clients face in accessing their services, making every effort to assist them in overcoming these barriers. Because family is a strong cultural value among Latinos and child care may not be available, therapists and case managers must be flexible, allowing family and children to accompany clients when necessary. Organizations should work with local universities and corporations to make agency locations available for intern and volunteer field placements. Many of the staff at Mattie Rhodes Center initially became familiar with the agency through internships and volunteer activities.

(4) *Program delivery system and treatment availability:* Emphasis should be placed on making treatment user-friendly and flexible. This can be accomplished by having locations accessible to public transportation, making services available when convenient for clients, offering in-home services when needed, and not penalizing clients for being late for or canceling appointments. As Mattie Rhodes Center has learned from experience, clients find it difficult to focus on mental health needs if they are overwhelmed by their daily living needs; therefore, treatment should be holistic and comprehensive. Therapists and case managers must be aware of social services and community resources outside the scope of the agency in order to make appropriate referrals.

(5) *Program environment:* A comfortable waiting area, bilingual receptionist, clean facility, popular Spanish reading material, and artwork reflecting cultural themes all contribute to a welcoming and nurturing experience that can greatly impact a client's experience.

Personal and Professional Cultural Competence

At the individual provider level, cultural competency should be considered a necessity if one intends to successfully rise to the challenges that come with rapid societal changes and globalization. Soto (2001) outlined a number of personal and professional competencies to help providers survive and thrive in multicultural treatment settings in the 21st century. Some of these competencies include:

- Develop and embrace a personal ethic of social responsibility and service within communities that are racially, culturally, ethnically, and linguistically different than your own.
- Ensure that you exhibit ethical behavior in all activities – personal and professional – which involve individuals of diverse backgrounds.
- Expand your knowledge base to ensure that your professional services and interpersonal interactions are competent and effective within the context of racial, cultural, ethnic, and linguistic differences.
- Value and incorporate the determinants of multiple world-views and culture/race/ethnicity/language in planning, developing and providing services and programs
- Ensure that your critical thinking, reflection, and problem-solving skills incorporate culture, race, ethnicity and language as fundamental considerations.
- Promote and support primary prevention and education as tools to improve well being of individuals and communities.

- Develop and use communication and information technology that effectively and appropriately deliver information to individuals and communities of diverse racial, ethnic, cultural and linguistic backgrounds.
- Ensure that your decisions and services balance individual, professional, system and societal needs.
- Advocate for public policies that promote and support culturally competent services, and the inclusion, representation and participation of individuals who reflect the increasing diversity of your community.
- Commit to being a life-long learner, and to helping others learn about the value and dynamics of difference.

While mental health and social work practitioners should consider cultural competence a professional obligation, it is also a personal responsibility that not only has the potential to enhance the lives of those they have chosen to serve, but their own lives as well. As with organizational competencies, pursuing personal and professional cultural competence is an ongoing process of self-assessment and learning rather than being something one can ever achieve absolutely.

Measuring Effectiveness: Lessons Learned by Mattie Rhodes Center

AS A PROVIDER OF
COMMUNITY-BASED
MENTAL HEALTH AND CASE
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LIKE OTHER AGENCIES,
MATTIE RHODES CENTER
(MRC) FACES THE
ONGOING CHALLENGE OF
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SERVICES THAT ARE
PROVIDED.

As a provider of community-based mental health and case management services, like other agencies, Mattie Rhodes Center (MRC) faces the ongoing challenge of determining the best way to measure the effectiveness of the services that are provided. Not only are appropriate outcome measures important for demonstrating effectiveness with clients, they are also vital for funders who want to document the cost-effectiveness of dollars invested in the agency.

Because a majority of the clients served by MRC are Latino, the organization faces the added challenge of ensuring that the outcome measures used produce results that accurately represent the status and progress of clients. Agency staff has sought to identify appropriate assessment instruments that have been developed in Latin American countries and standardized on a Spanish-speaking population; however, exhaustive searches and multiple international contacts in the field of psychology have not led to any such published or unpublished tools.

In the past MRC has used a number of instruments published in English and attempted to modify or translate them to fit this special minority population; however, the instruments were derived from Eurocentric models that had not been standardized with a representative Hispanic sample and did not necessarily resonate with them. For example, many of these instruments used a detailed Likert scale in which clients were asked to rate their degree of agreement with a statement. Clinical experience demonstrated that such graduated scales did not translate well to Spanish, leaving clients

unsure of their responses and clinicians doubting reliability. In addition, some clients exhibited poor Spanish literacy skills and were not able to complete questionnaires independently. As a result, these tools were used inconsistently and the results were not utilized in any constructive or meaningful way for the benefit of clients or the agency. Lastly, many such instruments are quite lengthy and time-consuming to administer, and appeared to deter clients from continued attendance.

Over the years, Mattie Rhodes Center has worked to fine tune what works best for the population it serves and determine the most crucial information needed to measure client progress. In doing so, the agency has been able achieve the dual goals of meeting the agency's needs and the funders demands for quantifiable results. Ultimately, the clinical and supervisory staff made the decision to focus on changes in general wellbeing. While striving for the gold standard, the agency has also taken into consideration feasibility in terms of cost, time and clinical practicality. Since 2005, clinicians at MRC have used the *Outcome Rating Scale (ORS)*, developed by Miller and Duncan (2000) as an alternative to the more complex and popular *Outcome Questionnaire 45* (Lambert, Hansen, Umphress et al., 1996), or OQ45, to measure and document client progress. Research studies have shown the ORS to be as reliable and valid a measurement tool as the OQ45 (Miller, Duncan, Brown, et al., 2003). In addition, it was consistently reliable and valid when tested with a large culturally and economically diverse population sample of men and women that included Latino participants (Miller & Duncan, 2004).

The *Outcome Rating Scale (ORS)* is a four-item instrument, available in written and oral formats, designed to monitor client change and perception of therapeutic alliance based on self-report (Miller & Duncan, 2004). To minimize content and complexity, a visual analog scale is used in which the client draws a vertical line, or hash mark, on a horizontal line nearest to the side that best corresponds to his or her current experience or emotional status. Three basic areas of functioning are assessed – individual functioning (symptoms), interpersonal relationships, and social role performance (work, school, quality of life) – all of which are considered good indicators of progress. The 40-point scale is self-administered at the beginning of each treatment session following instruction by a bilingual receptionist or the clinician. The receptionist is present, if needed, for assistance, including verbal administration. Administration and scoring usually takes less than two minutes per session.

Monitoring of ORS results have yielded valuable clinical information for the agency. Approximately two-thirds of clients served at Mattie Rhodes Center in 2006 were female and 90% were 47 years old or younger. The agency serves a large number of children and youth with one-quarter of clients being 16 years old or younger. For all clinical services in 2006, average minimum and maximum ratings improved from 20.2 to 30, which was a statistically significant change (See Figure 1). Clients were more likely to improve the younger they were, if they were women, and the more therapy sessions they attended. The degree of change in the average ORS ratings across sessions was similar for men and women.

2006 ORS All Agency

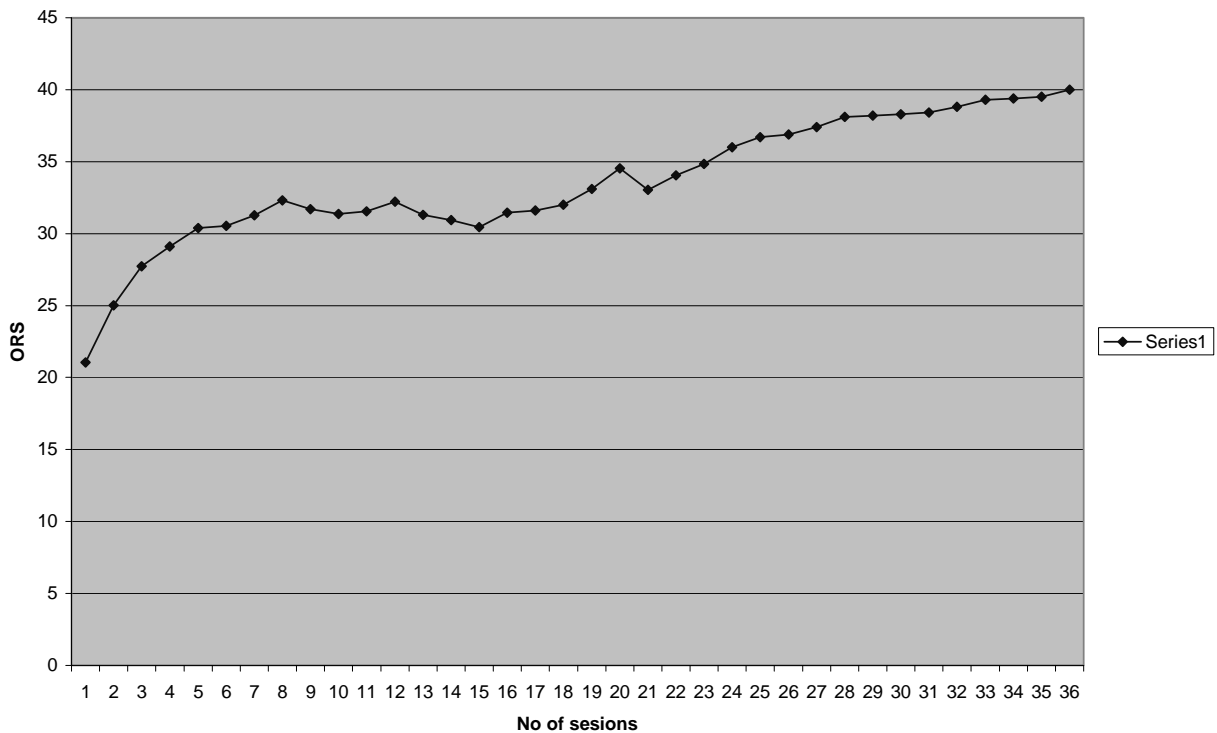


Figure 1. Change in average ORS rating score (scale of 0-40) across sessions for all clients seen at Mattie Rhodes Center in 2006.

The implications of the results of both the ORS and SRS in terms of agency and therapist practices reflect not only cultural dynamics, but strengths and weaknesses as well. A high percentage of MRC clients are Hispanic females, supporting the cultural observation that Hispanic men are less likely to recognize or seek out assistance for emotional trauma and mental health problems. The population served by MRC is relatively young, which is reflective of the demographic characteristics of this minority group overall. Therefore, these results suggest that the agency as a whole should make a more concerted effort to reach out to Latino men and older adults, actively engaging them and determining how to best meet their needs.

Results also highlight the importance of the therapeutic alliance and its potential impact on compliance and long-term outcomes. Mental health practitioners can fulfill multiple roles (e.g. listener, educator, advisor, healer/doctor), but if he or she is not fulfilling the expected role, the client will be less likely to continue in therapy. Culturally, Latinos tend to view therapists as teachers and may not be comfortable expressing dissatisfaction with the role of therapist if it differs from what they expected. Rather than offering feedback and giving their honest opinions, they may simply elect not to attend subsequent sessions. It is the responsibility of the therapist to work within cultural standards to determine the goals of the client, their needs, and points-of-view. MRC therapists can use results not only to track their clients' progress, but to assess the degree to which they are using client-directed approaches and meeting client needs.

In 2004, under the direction of then Executive Director Mary Lou Jaramillo, Mattie Rhodes Center received financial support from the Substance Abuse and Mental Health Services Agency

(SAMHSA) through a Congressional earmark. This national-level support helped solidify the agency's commitment to ensuring quality mental health services for Latinos with the creation of a formal position entitled "Director of Quality and Compliance," currently held by David Stadler, LPC (Missouri), LCPC (Kansas). Mr. Stadler has implemented a new database tracking system that allows therapists and case managers to work more efficiently and supervisors to make more appropriate client assignments and provide more relevant and concrete feedback.

The process of learning to use and appreciate outcome measures and electronic data tracking has been an evolutionary one for Mattie Rhodes Center clinical staff who now recognizes the benefits of monitoring the therapeutic relationship on a regular basis and is eager to participate in quality improvement efforts. At the organizational level, there is a commitment to measuring outcomes as a means of keeping the agency on track and promoting better quality of life for its clients. Outcome measures used in the context of a client-centered approach complement efforts to provide culturally competent treatment through the identification and incorporation of client strengths, values, perceived benefits of therapy, goals, and methods to achieve their goals, thus strengthening the client-clinician alliance.



Chapter 5

THE BOTTOM LINE: *Funding Issues*

The past fifty years have seen dramatic change to the delivery and funding of mental health care in the U.S. In the 1950s, government owned psychiatric facilities that provided specialized services in an inpatient setting accounted for 84% of the total spending on mental health care (Fein, 1958). Today that figure is less than 15%, with most individuals receiving treatment as outpatients and living in community settings (SAMHSA, 2000). The shift to insurance based financing has allowed the individual with mental illness greater autonomy as a consumer than he once had. Many of the organizations providing mental health services today – from community based agencies to large medical institutions – function as members of the not-for-profit sector. Such organizations typically rely on a combination of public and private funds. Public funding is available through federal, state, county and city governments and includes reimbursements from Medicare and Medicaid. Private funding may come from corporations, foundations, and individual contributions, as well as reimbursements from private insurance companies. Among non-profit providers of health and mental health services, the competition for funding can be fierce, and often requires that organizations make substantial investments relative to fundraising in terms of staff time, technology, and marketing efforts.

Public Sources of Funding

Public financing, through the federal, state, and local governments, covers the bulk of mental health care treatment costs. In 1997, government financing paid for 58% of mental health and substance abuse spending, compared to 46% of spending on health care overall. State and local governments financed 28% of mental health and substance abuse spending, while covering approximately 13% of health care services in general (SAMHSA, 2000).

At the federal level, funding for mental health services is available through grants from the Department of Health and Human Services, as well as third-party reimbursement from Medicare. Medicare provides reimbursement for inpatient and outpatient mental health care; however, coverage is significantly limited, generally to less than half of the cost of providing the services (Coviello & Glaun, 2003). Medicare Part A covers a portion of mental health care received in hospitals, including room, meals, nursing and related services and supplies. Medicare Part B covers a portion of both inpatient and outpatient physician visits, outpatient therapy and social work services, lab tests, and prescriptions that can not be self-administered (Centers for Medicare & Medicaid Services, no date). Only providers who are Medicare-certified can receive reimbursement and then only for psychoneurotic conditions or personality disorders diagnosed based on *DSM-IV-TR* criteria (Coviello & Glaun, 2003; Moore, 2000).

At the state level, funding is typically available through state departments of mental health and third-party reimbursement through Medicaid or state-sponsored managed care plans. Currently Medicaid is the largest single payer for mental health services, representing 21% of federal spending in this area (SAMHSA, 2000). Although the federal government provides matching

funds to state Medicaid budgets, states are responsible for defining what services will be covered, which providers are eligible for reimbursement, and how claims are to be submitted. Although in theory Medicaid should cover inpatient, outpatient and physician treatment for

ESTHER WOLF,
COMMISSIONER FOR THE
GREATER KANSAS CITY
HEALTH DEPARTMENT,
"MEDICAID FUNDING FOR
MENTAL HEALTH IS IN
JEOPARDY IN MISSOURI
AND KANSAS."

mental health, states can set limits on which services can be reimbursed, availability in terms of number of providers and locations, and amount of payment for services rendered (Center for Health and Health Care in Schools, 2006). Many states, including Missouri and Kansas, are cutting their Medicaid budgets and creating tighter restrictions on mental health coverage. According to Esther Wolf, Commissioner for the Greater Kansas City Health Department, "Medicaid funding for mental health is in jeopardy in Missouri and Kansas."

In order to be eligible for Medicaid, applicants must be U.S. citizens or have legal immigration status. New federal guidelines implemented July 1, 2006 require individuals applying for Medicaid to show proper identification and documentation. Under these new guidelines, states are responsible for ensuring compliance and will obtain matching funds dependent upon results of federal audits (Centers for Medicare and Medicaid Services, 2006).

In Missouri, the Department of Mental Health funds prevention and treatment of mental health disorders, developmental disabilities, substance abuse and compulsive gambling for qualified individuals without any type of health insurance coverage. Services are available through state-operated inpatient psychiatric facilities, a sex offender treatment center, six habilitation centers and eleven regional centers for developmental disabilities. In addition, services are provided through contracts with approximately 4,000 private institutions and practitioners statewide. Mattie Rhodes Center is contracted through Truman Behavioral Health Care, an administrative agent for the state, to provide outpatient mental health care to Spanish-speaking individuals. Across the state, however, there is a major lack of bilingual and culturally appropriate mental health and substance abuse recovery services, especially in state-operated inpatient facilities and among Department of Mental Health contracted providers, according to Luis Cordova, *Nuevo Amanacer* (New Dawn) substance abuse program coordinator.

County and city funding may be available through special programs which tax payers have voted to support. One such taxpayer-approved funding source is COMBAT (Community Backed Anti-Drug Tax), which was passed by Jackson County Missouri voters in 1989. The initiation of COMBAT made Jackson County the first county in the U.S. to implement an anti-drug sales tax dedicated to a holistic and broad-based effort to prevent and reduce drug use and related crimes. COMBAT is now in its third seven-year cycle. A network of 80 qualified service providers is allocated funds annually through a fee-for-service contract agreement (Jackson County Prosecutors Office, 2005).

One obstacle to meeting the mental health needs of minority and special populations such as Latinos is that some agencies who are receiving public funding meant to serve such populations are not necessarily providing the treatment, according to Bruce Eddy, Executive Director of the Jackson County Missouri Community Mental Health Fund. This taxpayer-funded program provides support exclusively for mental health services in Jackson County. Eddy states, "Many publicly funded organizations refer Spanish-speaking clients out to other agencies for mental

health services because they don't have the capacity to serve them." One way to address this issue is to make funders more aware of the value of cultural and linguistic competency standards and attach conditions for funding based on these standards. The Jackson County Community Mental Health Fund has begun such a process by requiring that agencies who receive funding have a cultural competence plan on file. In the future, grantees will be required to submit reports detailing progress in this area.

According to the President's New Freedom Commission on Mental Health (2003) funding for the prevention and treatment of mental health disorders is a moral issue that must be addressed in order to ensure social and civil rights for minorities and those suffering from mental disorders. Ironically, a greater emphasis on security at all levels of government since 9/11 has driven increased military and public health spending away from mental health, often at the expense of Medicaid and other funding programs (National Mental Health Association, 2006). In addition, although funding for community-based mental health services in Kansas City area has gained support at the county government level over recent years, local private funders have yet to make mental health a priority.

Private Entities

Collectively, private funding sources, including family and community foundations, individuals, corporations and corporate foundations have increased their level of giving in recent years. According to the Foundation Center, an organization that has been tracking grant making patterns among a sample of the nation's largest private and community foundations since 1996, giving rose from \$15.5 billion to \$16.4 billion between 2004 and 2005, an increase of over six percent. The overall number of grants awarded increased from 126,497 to 130,961 during the same time period. In terms of recipient categories, Education received the most funding, while Human Services lead in number of grants. International Affairs and Environment exhibited the largest gains in overall funding. Mental health, although not being designated with its own category, was assumed to fall under Health, which received the second greatest amount of funding overall at 21% (Foundation Center, 2007). Among beneficiary groups, children and youth accounted for largest share of grant dollars and number of grants in 2005. The largest share of grant dollars went to Program Support, which accounted for more than 40% of funding awarded.

Family foundations and trusts managed by financial institutions on behalf of families are generally a reliable source of funding for non-profit organizations. Such entities often have carefully defined missions and focus areas based on the wishes and priorities of the family. The compatibility between the foundation and applying organization in terms of mission and goals is crucial for securing funding. Family foundations range in geographic focus from local to national. Application processes are generally more rigorous the larger the geographic focus and amount of funding available.

Community foundations make up about one percent of all grant making foundations in the U.S., but supply roughly 10% of grant dollars distributed. As a share of all foundation giving, community foundation contributions have risen steadily since 1990 reaching a record \$3.2 billion in 2005. Economically disadvantaged, children and youth have benefited the most for community foundation giving, which is consistent with independent and corporate foundations.

Education (24%) and Human Services (22%) ranked as top priorities in 2004 with Health receiving 12% of the share of funding by community foundations the same year. The Greater Kansas City Community Foundation ranked ninth nationally with total giving of more than \$63 million in 2004 (Foundation Center, 2006a).

Corporate foundation giving, adjusted for inflation, has almost doubled since the late 1980s, but as a share of all foundation giving has declined, representing only about 10% of total foundation giving in 2004. As a share of companies' pre-tax profits, corporate giving peaked at 2% in 1986 followed by a steady retreat to just 1% of pre-tax profits in 1996. Pre-tax profit giving rebounded to 1.6% in 2001 and in 2004 stood at 1.2%. Corporate foundations tend to favor Program and General Operating Support, which is consistent with independent family and community foundations. Again Education (26%) was the top priority of corporate foundations in 2004, followed by Public Affairs/Society Benefit (24%). Health received 11% of grant dollars from corporate foundation; however, regional differences in the amount of funding allocated to health were observed. Notably, the Midwest ranked lowest in terms of health funding from corporate entities at 7.3% compared to highest in Northeast at 19.5% (Foundation Center, 2006b).

There are now almost 2,600 grant making corporate foundations that together gave a record \$3.6 billion in 2005 (Foundation Center, 2006b). For corporations and their foundations in particular this increased giving may be tied to public relations and marketing efforts. In some cases, corporations actually spend more advertising their "good deeds" than they do on the actual humanitarian effort. Corporate giving is also tied to work force needs; thus, health, education, and youth programs tend to be popular recipients as a means to ensure a successful future for the company.

Contributions by individuals, which rose approximately four percent in 2004, make up the majority of private sources of funding, followed by independent/family and community foundations and corporate entities. Individuals gave close to \$188 billion in 2004, which represented 76% of all private funding. This did not include \$20 billion in philanthropic giving through estate bequests (Foundation Center, 2006b; Giving USA Foundation, 2005). Contributions to faith-based organizations account for the bulk of individual giving, accounting for more than \$88 billion in contributions in 2004. The next-largest giving category was Education, which received about \$34 in private individual contributions in 2004 (Giving USA Foundation, 2005).

Non-profit mental health services have not necessarily benefited from increases in private funding and are often a low priority among individuals who prefer supporting churches or emergency funds, as well as foundations that tend to support programs rather than individual counseling or case management (Wolf interview, November 9, 2006). Notable exceptions are the Greater Kansas City Community Foundation (GKCCF) and the REACH Foundation based in Missouri and Kansas, respectively. These two foundations were created in 2003 with funds from the Health Midwest lawsuit settlement. Both are dedicated to improving healthcare access for the poor and underserved and provide funding for mental health services in these two states.

Another source of private funding comes from private health insurance and managed care organizations. Many of the individuals who need mental health services do not have this benefit, and those who do are finding it increasingly difficult to obtain and/or continue these services because insurance carriers and managed care organizations often limit number of sessions or

exclude mental health services from coverage. Plans that do cover mental health services typically come with higher premiums, require higher cost sharing and limit coverage for mental health treatment (Center for Health and Health Care in Schools, 2006). One survey found that 83% of uninsured and 53% of privately insured respondents cited cost as the main consideration that prevented them from seeking mental health care (Sturm, 1999). Moreover, community-based mental health agencies face the challenge of securing reimbursement from private third-party payers for services provided. Often the amount reimbursed is substantially less than the actual cost of providing the service. This becomes an even greater challenge for non-profit agencies working with minority populations that may employ para-professionals who, although not licensed, are trained and representative of the population served, but for whose time agencies are not reimbursed (Wolf interview, November 9, 2006).

Accountability and Sustainability

Whether public or private, funding entities are becoming more stringent in terms of financial accountability and documenting the impact of their contributions. More sophisticated data collection and outcomes monitoring is expected in order to demonstrate the degree of effectiveness of mental health prevention and treatment efforts. Collaboration and sustainability are also becoming more important, according to Manuel Pérez who has 25 years of experience in the administration of substance abuse, mental health and social service programs: “Many funders expect programs to be based on needs assessments, which take an organized effort. Agencies are expected to involve community participants and key stakeholders in the design and implementation of new programs. If they don’t, how do they really know what the community needs? Funders would like to have a 360 degree view of what is being implemented,” states Pérez.

One problem with many sources of public funding is the lack of guarantee of their availability over time; therefore, mental health agencies are continuously faced with the threat of falling short the level of support needed to maintain service provision. Funding through taxpayer dollars is subject to fluctuations in the economy, as well and public sentiment. State government funding sources may reduce allocated amounts or not renew provider contracts. Federal funding is always subject to political forces and economic priorities.

In order to ensure sustainability, not-for-profit and community-based mental health service providers must diversify across funding sources. They may need to deal with third-party payers and managed care organizations, which require investments in technological and human resources and with which many have little experience. While sustainability is often associated with ongoing financing of a particular program or service, agencies should also consider the ongoing legacy or influence of what they are doing and whether their actions make a long-term impact (Pérez interview, October 26, 2006).

ONE PROBLEM WITH MANY SOURCES OF PUBLIC FUNDING IS THE LACK OF GUARANTEE OF THEIR AVAILABILITY OVER TIME; THEREFORE, MENTAL HEALTH AGENCIES ARE CONTINUOUSLY FACED WITH THE THREAT OF FALLING SHORT THE LEVEL OF SUPPORT NEEDED TO MAINTAIN SERVICE PROVISION.

Despite the focus on accountability, collaboration and sustainability, some private and public funders are not doing an adequate job of addressing the needs of the Hispanic population, which has historically been a weak advocate for itself (Eddy interview, November 7, 2006). As Greater Kansas City Health Commissioner Esther Wolf points out, “Cultural competence is often not taken into account. Funders, whether public or private, need to offer incentives to those agencies and providers who are formally addressing cultural issues or have demonstrated proficiency.” Manual Pérez, project director for the Kansas City, Missouri Health Department, states, “Sometimes service delivery systems lag behind in addressing changing demographics and service demands, failing to make an ethical shift in response to their own stated missions. Legal system intervention is sometimes required in the form of class action lawsuits to address the moral issues underlying issues of language access, profiling and discrimination. There is plenty of precedence for this in other communities. Systems do not often change without challenge.” Moreover, mental health care advocates need to do a better job of educating the private sector about the profound effects of mental health disorders on mainstream society.

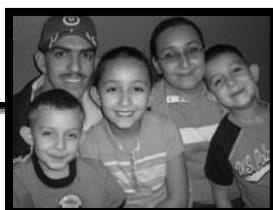
The National Comorbidity Survey (NCS) reports that although about 19% of the population has a diagnosable mental disorder, only 37% of those individuals receive the necessary treatment (U.S. DHHS, 1999). We have shown that among those left untreated, Hispanics represent a disproportionate share of the population. Failure to treat these disorders not only causes unnecessary personal suffering and a diminished quality of life, but also takes a toll on businesses and the economy. Corporate leaders need to realize that these untreated disorders can lead to decreased work productivity and disability. According to the Commonwealth Fund’s *Trends in Mental Health Care*, in 1994 alone, mental illness related disabilities resulted in a \$112.3 billion loss to the U.S. economy (Barry, 2004). These figures demonstrate that mental health care is everyone’s concern, and funding appropriate services needs to move into the mainstream private sector. There is evidence that by increasing investment in prevention efforts just 5.5%, the country could experience up to ten times the savings in reduced absenteeism, unemployment, welfare, and other direct and indirect costs of mental health disorders (Surgeon General’s Report, 2007). Corporate leaders can invest in the economic health of their own enterprises by donating funds to nonprofit organizations that are addressing these needs.

Conclusion

Estimates indicate that Hispanics will comprise more than 25% of the U.S. population by the year 2050. With a median age significantly younger than that of the population at large, Latinos will make up an even greater percentage of the U.S. workforce. In *Closing the Mental Health Gap* we have demonstrated that Latinos face a heightened need for mental health services, yet face significant disparities in accessing quality treatment. Clearly, developing strategies that address the mental health needs of this segment of our society is essential for the overall wellbeing and continued economic prosperity of the entire nation. It is our hope that the mental health concerns of the Hispanic population will move into the mainstream and that civic leaders and policy makers, the business community, and mental health service providers will take responsibility for supporting services that eliminate the barriers to effective treatment faced by Latinos. This document is intended to be used as a tool to facilitate this goal. Some recommended uses are as follows:

- Mental health service providers use the Mattie Rhodes Center model of treatment as a tool for providing culturally and bilingually competent services and, over time, contribute to the body of knowledge being compiled in this area.
- Policy makers and other public officials look to the information contained in this document and the expertise of Mattie Rhodes Center staff for understanding the needs of their Hispanic constituents.
- Institutions that serve immigrant communities make mental health services a key component of their response efforts.
- Corporations and other members of the business community invest in the wellbeing of their workforce by contributing funds to organizations providing mental health services.
- Students and researchers at educational institutions draw upon the findings presented in this document to enhance their own understanding of the unique mental health needs of Hispanics and recognize the need for additional empirical studies that further document mental health needs, trends, and efficacy of treatment among Latinos.
- Media and communications outlets use the demographic information compiled in this report to raise awareness of mental health concerns and disparities in treatment to promote access to services and intervention.

The last half a century has witnessed dramatic changes in mental health, most notably in increased access and funding for treatment, advances in the diagnosis and treatment of mental illness, and decreased stigmatizing of mental disorders. Mental health care providers, indeed, *all* segments of society, must now build upon these gains and continue the positive trends in the field of mental health by recognizing and responding to the new demographic reality of our nation and by eliminating the disparities in mental health services among racial and ethnic minorities.



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Mission

Mattie Rhodes Center bridges cultures and communities through arts, mental health and social services. We empower individuals and families through culturally competent, bilingual services in a respectful and compassionate environment.

