Mental Health Issues and Platform Committee

Executive Summary

The National Hispanic-Latino American Agenda Summit (NHAAS) Mental Health Issues and Platform Committee is pleased to present the following committee report containing specific recommendations to improve the United States mental health service delivery system for Hispanics-Latinos. The report highlights an array of barriers and disparities in access to and the provision of quality of mental health care for Hispanics-Latinos, and contains specific recommendations in four key areas identified and agreed upon by committee members as requiring immediate attention. These four areas are:

- Community Education and Outreach Awareness Activities
- Access to Care
- Workforce Development
- Culturally Competent Research and Evidence-Based Practices

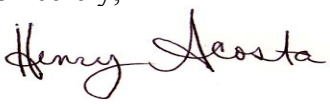
The NHAAS Mental Health Issues and Platform Committee, which is representative of national experts and leaders that includes mental health professionals, researchers, educators, family members, consumers, and advocates, and is inclusive of several of the nation's diverse Hispanic-Latino ethnic groups and regions, views these areas and the recommendations contained herein as critically important in order to significantly and meaningfully improve the mental health service delivery system for Hispanics-Latinos. The committee strongly believes that the recommendations contained herein will significantly contribute to the elimination of disparities identified in recent years that currently exist in our nation for Hispanic-Latinos with respect to accessing and receiving culturally competent, culturally relevant and quality mental health care.

The report includes numerous recommendations under each key area and highlights the need to fully implement and enforce Title VI of the United States Civil Rights Act of 1964. It stresses the need to act quickly and thoroughly, provides clear evidence on how the unmet and poorly met mental health needs of Hispanics-Latinos is impacting the Hispanic-Latino community, and urges our nation's leaders to take necessary action now.

As coordinator of the NHAAS Mental Health Issues and Platform Committee, I would like to thank all of the committee members who volunteered their time and expertise to this process and extend a special thank you to several committee members who provided additional assistance with the development of certain sections of the report: Sergio Aguilar-Gaxiola, Peter J. Guarnaccia, Juan Ramos, Roberto Ramos, and William Vega. In addition, I would like to thank all of the readers of the committee's report for their courage and anticipated leadership in advocating, planning, and eventually implementing the recommended actions.

The time for positive and meaningful change is now. Thank you for your anticipated support and your contributions to making the United States' mental health system more accessible and more culturally appropriate, competent and relevant for Hispanics-Latinos.

Sincerely,



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National Hispanic–Latino American Agenda Summit

Mental Health Issues Platform and Issues Committee

Final Committee Report

July 13, 2004

Background Information:

There are a wide range of barriers to seeking mental health care that have been identified in the Hispanic-Latino mental health literature (Hough et al., 1987; Pescosolido et al., 1998; Vega et al., 1999; Vega & Alegria, 2001; Vega et al., 2001; U.S. Department of Health and Human Services [USDHHS], 2001). These identified barriers can be organized into several dimensions: provider barriers, barriers in the service system, community-level barriers, barriers in the social networks of people in the community, and person-centered barriers. The most important system level barriers include lack of health insurance, language barriers, discrimination from the system and lack of information about services (especially in Spanish). Community centered barriers include the stigma of mental illness and the availability and size of family and other support networks. Person-centered barriers include lack of recognition of mental health problems, stigma of mental illness, and a self-reliant attitude. The recommendations that follow address many of the barriers within these referenced dimensions and require immediate attention as the Hispanic-Latino community continues to grow in the United States and experience unmet mental health needs and/or poor quality of mental health services. These unmet needs and provision of poor quality mental health services may be contributing to Hispanics-Latinos being over-represented in many of our nation's vulnerable populations and is having a tremendous impact on our nation's family, community and economic development.

In addition to identifying a wide range of barriers Hispanics-Latinos face with accessing and receiving quality mental health services, many professional studies and numerous recent reports also highlight the impact mental health issues and illnesses have on the Hispanic-Latino population, their prevalence, and how unmet mental health needs are devastating individual, family and community development among Hispanics-Latinos. These reports include: the first ever report on Mental Health by a United States Surgeon General (Dr. David M. Satcher) in 1999, Dr. Satcher's supplemental report to his 1999 report titled "*Mental Health: Culture, Race, and Ethnicity"*, and the Institute of Medicine's Report on racial and ethnic disparities in health care titled *"Unequal Treatment : Confronting Racial and Ethnic Disparities in Health Care*". In addition, these reports and many other studies show that from adolescence to adulthood, Hispanics-Latinos experience higher rates of stress and mental health problems in comparison to other racial and ethnic groups, but tend to underutilize mental health services. Below are general facts about mental health and alarming trends concerning Hispanics-Latinos that have been appearing repeatedly in professional literature as of late:

General Facts:

- Mental illness does not discriminate!
- According to the World Health Organization, one in four people in the world will be affected by mental health or brain disorders during their lives, but few will seek or receive help.
- With proper treatment, people with mental illness can lead productive lives and be a vital part of their communities (United Nations 2001, Agency's Annual Health Report).
- Mental health is fundamental to health. It is paramount to physical well-being, family relationships and successful contributions to society (Mental Health: A Report of the Surgeon General, 1999).
- Effective treatments are available for most disorders, but Americans do not share equally in the best that science has to offer (Mental Health: A Report of the Surgeon General, 1999).
- Even when help is available, nearly two-thirds of people with a known mental disorder never seek professional help, often because of shame (United Nations 2001, Agency's Annual Health Report).
- Stigma and shame deter many Americans, including racial and ethnic minorities from seeking treatment (Mental Health: A Report of the Surgeon General, 1999).
- Disparities in mental health services exist for racial and ethnic minorities, and thus, mental illness exacts a greater toll on their overall health and productivity (Mental Health: A Report of the Surgeon General, 1999).
- United States 2000 Census data shows people of Hispanic-Latino backgrounds are the fastest growing ethnic group in our country. In fact, the U.S. Census Bureau estimates that ethnic and racial minorities will constitute 47 percent of the nation's population by the year 2005.
- Multiple studies show that in comparison to the majority population, minorities have less access to and availability of care, and tend to receive poorer quality mental health services (Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General). This finding has been found repeatedly when studying use of services by Hispanics-Latinos.
- Studies show that poor mental health and psychological distress are linked to poverty – In 1999, the overall rate of poverty in the U.S. was 12 percent. The rates were much higher among most racial and ethnic minority groups (i.e., 23 percent for Hispanics; 24 percent for African Americans; and 26 percent for American Indians).
- According to Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General, those in the lowest strata of income, education and occupation are two to three times as likely to have a mental disorder as the highest strata and often lack health insurance.
- According to the U.S. Surgeon General's report, Mental Health: Culture, Race and Ethnicity, a supplement to the Surgeon General's 1999 report on mental health, "Cultural differences must be accounted for to ensure that minorities, like all Americans, receive mental health care tailored to their needs".
- Also according to the above report, cultural influences have been found to shape treatment professionals, who share a set of beliefs, norms and values with their colleagues. As a result, clinicians can view symptoms, diagnoses and treatments in ways that diverge from the views of the patients they treat.
- Mental health workers must be aware of and have an understanding of the wide-ranging role culture plays in shaping what people bring to the clinical setting and how it shapes treatment professionals.

- Cultural influences account for variations in the way consumers communicate their symptoms, which ones they choose to report, whether they seek treatment or not, what type of help they may seek, and what types of social support and coping styles are available.
- At a time when the United States leads the world in almost every measurable category, and when its defense budget is greater by far than that of any other nation, it's depressing to note that there is one major area in which the United States continues to lag behind other industrialized nations: the provision of health care to its people -- especially care for people with mental illnesses.
- In 2003, the President's New Freedom Commission on Mental Health declared in its final report that the American mental health system is "fragmented and in disarray . . . leading to a host of problems including disability, homelessness, school failure and incarceration." Nearly a year later, little has changed. Many people with mental illnesses lack access to affordable, adequate services or avoid treatment because of the stigma associated with their illness.
- As highlighted in numerous recent and past reports, a great deal about the magnitude and burden of mental illness is known. For example, when suicide is included, mental illness accounts for more than 15 percent of the burden of disease in industrialized countries -- more than the burden inflicted by all cancers. Additionally, almost 34 million Americans -- 21 percent of people between the ages 18 and 64 -- will have a mental illness over the course of a given year. Also known is that nearly 70 percent of people suffering from mental illness are not getting the help they should, and that 79 percent of U.S. children with mental health problems severe enough to indicate a clinical need for evaluation do not receive either evaluation or treatment. These problems exact an even greater burden on racial and ethnic minority groups and must be addressed. The time has come to take action.
- Too often, when symptoms reach the point of crisis, which many will and is common among racial and ethnic minorities, the most expensive services are required through emergency rooms and inpatient treatment. In many cases, jails and detention centers have become the front-line "providers" of mental health services, causing a much greater financial burden than if prevention and community-based resources were readily available and affordable to everyone.
- Reports also show that the burden of mental illness goes beyond the fragmented service system and into the business sector. It is in the interest of corporations to provide adequate mental health coverage as part of their employee benefits. Research shows that untreated depression costs firms $31 billion a year in lost productivity.
- On a more positive side, more is known today about the causes of mental illness than ever before, and through groundbreaking research, treatments that work are available. According to recent reports, about 70 to 90 percent of mental illness are treatable. In fact, some findings report that 80 percent of patients with depression can recover now, and 74 percent of patients with schizophrenia can live without relapses if early intervention is made. Recovery is possible, and everyone regardless of their age, sex, religion, race, ethnicity or national origin should have the same rights to meaningful access and receive these critical services.

Facts Pertaining to Hispanics-Latinos:

- While Hispanic-Latino youth are less likely to receive mental health services, they are more likely to become involved with the juvenile justice and/or child welfare systems (Vega & Alegria, 2001).

- Even when receiving services, Hispanic-Latino youth "in care" still receive fewer therapeutic services and remain "in care" for longer periods than other groups.
- Hispanic-Latino youth have the highest rate of suicidal attempts reaching 10.7% compared to 6.3% for white youth and 7.3% for African American youth – this trend clearly demonstrates the need to increase access to mental health services, especially crisis intervention services for Hispanic-Latino youth (Vega & Algeria, 2001).
- A recent study among high school students indicated that 25% of Hispanic-Latino students meet the criteria for clinical depression and the rate was even higher among Hispanic-Latina teenage females, reaching 31%, the highest rate of any group (Flores & Zambrana, 2001). Figures such as these have been repeatedly appearing in professional literature as of late, and unfortunately will continue if action is not taken immediately to address the complex issues on hand.
- A survey from the Commonwealth Fund revealed that Hispanic-Latino adults had the highest rate of depressive symptoms of any group with 53% of Hispanic-Latina females and 36% of Hispanic-Latino males reporting moderate to severe depressive symptoms a week prior to survey interviews (Collins, Hall & Neuhaus, 1999).
- According to the Youth Risk Behavior Survey of 1997, Hispanic-Latino students were significantly more likely to have consumed alcohol in their lifetime, to report current alcohol use, and to report episodic heavy drinking than African Americans (Caetano & Galvan, 2001).
- Hispanic-Latino deaths linked to cirrhosis and other chronic liver disease ranked as the eighth leading cause of death in the late 1990's for Hispanics-Latinos, but did not appear as one of the ten leading causes of death for either African Americans or whites (Caetano & Galvan, 2001
- Between 1991 and 1998, Hispanic-Latino emergency room admissions for drug use increased by 80% (United States Department of Health and Human Services, 2000).
- The use of heroin within the Hispanic-Latino community is particularly serious. In 1997, Hispanics-Latinos accounted for 32% of treatment admissions for heroin and 32% of all Hispanic-Latino drug use related deaths resulted from heroin use (Caetano & Galvan, 2001). These figures do not even include the tens of thousands of deaths among Hispanic-Latino men and women from the sharing of HIV contaminated syringes.
- A lack of qualified bilingual and bicultural health and mental health care professionals exist throughout the United States. Many Hispanics-Latinos have Limited English Proficiency and possess the legal right to have the same access rights to quality services as other groups who do not have language barriers with health care and mental health care professionals. *This right is given to them under Title VI of the United States Civil Rights Act of 1964 and must be protected and enforced.*
- Studies show that patient satisfaction is higher when the patient and doctor are of the same race or ethnicity and that minority physician tend to care for minority patients in greater numbers and to work in medically underserved areas (United States Department of Health and Human Services, 2000).
- Although Hispanics-Latinos now account for over 13% of the total U.S. population, they comprised only 4.6% of physicians, 4% of psychologists, 7% of social workers, and 2.4% of nurses in 1999 (Bureau of Labor Statistics; American Medical Association; Bureau of the Census).

- The majority of psychologist and social workers in the nation, who are the primary care providers in both the mental health and substance abuse fields, in 1998, were non-Hispanic-Latino white, 84% and 65% respectively.

It is well documented that Hispanics-Latinos underutilize mental health services and are often over represented in our nation's most vulnerable populations, such as the homeless, the incarcerated, the uninsured and the poor. Numerous professional studies and recent New Jersey Mental Health Institute, Inc. *Changing Minds, Advancing Mental Health for Hispanics* focus groups held with Spanish speaking Hispanics-Latinos throughout the State of New Jersey support the fact that the lack of knowledge about both available services and services offered by culturally competent and culturally sensitive service providers negatively impact the utilization of crucial mental health services by Hispanics-Latinos Additional studies and an array of other reports released by various private and public institutions also highlight the disparities that exist for members of ethnic minority groups with regards to accessing and receiving quality mental health services, and urge national, state, and local private and public institutions to act to bridge the gap. This report and the recommendations contained herein support this vision and urges state and federal government entities, elected and appointed representatives, and key policy makers to take necessary actions to address the critical mental health and substance abuse needs of the Hispanic-Latino community.

According to the Surgeon General's 2001 report, *Mental Health: Culture, Race, and Ethnicity,* historical and sociocultural factors suggest that, as a group, Hispanics-Latinos are in great need of mental health services. Hispanics-Latinos, on average, have relatively low educational and economic status, factors which have been linked to poor mental health and psychological distress. In addition, historical and social subgroup differences create differential needs within the Hispanic-Latino community. Central Americans for example, may be in particular need of mental health services given the trauma experienced in their home countries and acculturation issues resulting from migration to a new country and a new way of life. Puerto Rican and Mexican American children and adults may be at higher risk than Cuban Americans for mental health problems, given their lower educational and economic resources. Additionally, recent immigrants of all backgrounds, who are adapting to the United States, are likely to experience a different set of stressors than long-term Hispanic-Latino residents.

It is critical that we are aware of and acknowledge that disparities do exist in access, utilization and quality of mental health and substance abuse services for racial and ethnic minorities and understand that minorities, as reported by the former United States Surgeon General Dr. David M. Satcher, experience a "greater disability and greater burdens" due to mental illness than whites – "not necessarily because the illnesses are more severe … but because of the barriers they face in term to of access to care". As indicated by Dr. Satcher, failure to address these disparities is "playing out in human and economic terms on our streets, homeless shelters, foster-care systems and in our jails." Additionally, the problems of poor access to and poor quality of mental health services for Hispanics-Latinos may be contributing to the groups overrepresentation in many of our nation's high-need, vulnerable populations, such as the homeless, the incarcerated, the uninsured the poor, and the undocumented, and contributing to family, community decay and economic instability and burden.

The provision of mental health in a culturally competent manner is fundamental in any effort to ensure meaningful access to services by all population groups. Cultural competence is the capacity to work effectively with people from a variety of ethnic, cultural, economic and religious backgrounds. It is being aware and respectful of the values, beliefs, traditions, customs and parenting styles of those served, while understanding that there is often a wide range of differences within groups. It is also being aware of how our own culture influences how we view others. A more formal definition provided by the authors Cross, Bazron, Dennis and Isaac, (CASSP, 1980) is:
"Cultural competence is a set of congruent behaviors, attitudes, practices, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations."

Cultural competence is a goal toward which all professionals; agencies and systems must strive. Becoming culturally competent is a developmental process that incorporates—at all levels—the importance of culture, an assessment of cross-cultural relations, vigilance about the dynamics that result from cultural differences, the expansion of cultural knowledge and the adaptation of services to meet cultural needs. It is also a developmental process that can improve the quality of care and mental health service delivery system for all Americans. Citizens of the United States and those who can trace their ancestry back for generations in America need to receive all mental health services that are delivered in a culturally competent and linguistically appropriate manner. The right to receive these services is provided to all Americans under Title VI of the Civil Rights Act of 1964. This Title, within the Civil Rights Act of 1964, now in its 40th year of existence, continues to be poorly implemented and enforced. Increased education, mandates and enforcement measures must be put in place immediately so that all agencies receiving federal assistance fully understand and comply with their legal obligations. Leaders across the country must become educated on the law, and be held accountable to comply with it.

As the former United States Surgeon General Dr. Satcher reported, "Americans do not share equally in the best mental health services available." As Americans and community leaders, we need to have the vision and the commitment to ensure that all residents of the United States have equal access to high quality mental health care. It is incumbent on state and federal government agencies addressing health and mental health issues to address and plan for the elimination of racial and ethnic disparities. The Surgeon General's report of 2000 clearly identified these disparities and many still exist today. The members of the National Hispanic-Latino Mental Health Issues and platform Committee acknowledge that not all United States citizens share equally in the receipt of mental health services, the quality of those services, and the hope for recovery among Hispanics-Latinos from mental illness. This becomes very clear when looking at the under representation of ethnic and racial minorities in community based mental health programs versus the over representation of the same groups in institutional settings. Our nation's Hispanic-Latino population cannot wait another 40 years for services to improve; the system must be improved now.

The full implementation and enforcement of Title VI of the Civil Rights Act of 1964 can have a potential impact on the human services delivery infrastructure, including the mechanisms that accredit, license and certify components of the mental health system infrastructure. A systems problem requires a systems approach --- training of clinicians, research and the training of

researchers, the human services delivery agencies (mental health services), and hospitals and other facilities such as nursing homes (especially those that take persons with mental illness). We must acknowledge and fully understand the interdependence between research, training and services, since each informs the others. Research informs services and training; services informs research and training; and training informs research and services. So, when we address mental health services to Limited English Proficiency (LEP) persons, we must think of research informing services to LEP persons and the training of clinicians to deliver services to LEP persons. As indicated earlier, we must take action now before Hispanics-Latinos continue to experience a greater burden as a result of the existing disparities in meaningful access to and the quality of mental health services.

The cost of mental illness is widespread, pervasive, disabling, and very costly to society as a whole. People everywhere are affected by mental illness. In the United States, one person in four is diagnosed with a mental disorder in the last 12 months and consequently, are in need of services (The WHO World Mental Health Survey Consortium, 2004). Although there is such a tremendous need for mental health service provision, many people often go untreated. The cost of leaving mental illness and addictive disorders untreated is rapidly growing with the current cost at $113 billion annually (Labor Day 2001 Report, 2001). Loss in worker productivity due to mental illness is also widespread. In 1997, The U.S. National Comorbidity Survey (Kessler, et al., 1992) reported a total of one million lost days of productivity due to mental illness (Labor Day 2001 Report, 2001). This equals approximately $105 billion in lost revenue. This estimate represents an increase in losses of $22 billion since 1992 (The Lewin Group, 1992). The National Mental Health Association concluded that by increasing the amount spent on the prevention and treatment of mental illness by just 5.5% the losses would be cut in half. This amounts to a potential savings of over $56.5 billion for the entire U.S. economy.

It is the belief of the committee members and other experts working to eliminate health and mental health access and quality of care disparities, that the recommendations that follow, if endorsed in its entirety, will begin the process of eliminating these disparities. Mental illness affects everyone - be it through a family member, friend, business associate or personal experience. Americans deserve a transformed mental health system that envisions recovery for everyone suffering from a mental illness. Hispanics-Latinos are a critically important group in America and their needs and cultural preferences must be incorporated into this transformed system.

Issue: Community Education and Outreach Awareness Activities

Numerous professional studies have shown that Hispanics-Latinos are less likely to utilize the health and mental health care system than any other population. Frequently Hispanics/Latinos do not engage in preventive care services or seek attention before or during the early onset of an illness, which can result in more traumatic experiences for the consumer, their family, and often times requires more costly treatment and interventions. Hispanics-Latinos are also significantly underrepresented in the health and mental health care professionals, further contributing to the lack of necessary, accessible health care for this community. Outreach and educational programs in both English and Spanish are necessary to provide accurate and reliable education to Hispanics-Latinos about health and mental health issues, treatments available, how and where to

access services, as well as increase their interest and awareness of the many health and mental health professions that exist. Recent reports also show that a serious lack of knowledge of mental illness, services available, the benefits of professional treatment, the contributions of those with a mental illness to our society, mental health consumers increased ability to lead a healthy, productive and fulfilling life with proper treatment, and the lack of knowledge of how to access services contributes to Hispanics-Latinos underutilization of mental health services. Comprehensive, aggressive and nation-wide efforts are needed at all levels to educate the Hispanic-Latino population on these issues. They are also needed to increase the ability of mental health providers and advocates to be more visible within the Hispanic-Latino community. This is critically important since establishing trust and credibility among Hispanics-Latinos is very important among the Hispanic-Latino population. It can play a major role in a consumer's decision to seek or to not seek professional treatment.

Recommendations:

1. **Provide financial support and assistance to organizations to develop aggressive bi-lingual outreach and education campaigns aimed at heightening awareness, acceptance, and understanding of mental illness, services available, how and where to access services, and to reduce the stigma of utilizing mental health services and of people with a mental illness among the Hispanic-Latino population**. These campaigns should include material in English and Spanish geared to the Hispanic-Latino population and be inclusive of all the different mannerisms in which individuals learn and obtain information (i.e., watch television, read newspaper or other print material, hear about services from organizations or providers during community presentations or informal networks, etc.) The efforts should include support of bi-lingual culturally competent television public service announcement campaigns and documentaries on mental health, support for more positive reflection of individuals with a mental illness and the mental health professions by the media, support for the development and mass distribution of culturally and linguistically appropriate print material, support for the use of qualified mental health professionals to engage in community outreach and educational awareness activities such as, conducting bi-lingual presentations within Hispanic-Latino communities on various mental health issues at schools, churches, and other relevant events, and participating in health fairs, conferences, and other educational and informative efforts. Developing comprehensive public awareness campaigns targeted to Hispanics-Latinos will assist Hispanics-Latinos obtain a more accurate understanding of mental illness, the wide range of effective treatments available in the United States that they do not currently share equal access to, assist them with better understanding how to access those services, reduce and/or eliminate the stigma associated with utilizing mental health services, increase interest in seeking a career as a mental health professional, increase hope that recovery is possible, and may ultimately contribute to Hispanics-Latinos overrepresentation in high-need vulnerable populations that are more costly to them, their family, their communities, and our nation's economy. This issue and need is also linked to Title VI of the Civil Rights Act of 1964, which again has not been fully implemented and enforced in the human service delivery system and must be addressed. Individuals with Limited English Proficiency must have the

same rights to access information and services on mental health than English speaking individuals. The lack of information and knowledge of mental illness and other areas highlighted here among the Hispanic-Latino population significantly contributes to the poor access and underutilization of mental health services by Hispanics-Latinos and state and federal entities must take action to ensure that such critical elements are created, implemented, and monitored.

2. **Create opportunities through funding, legislative regulations and educational awareness that support community service providers such as personnel from non-profit 501 (c)(3) organizations who serve as front line direct service providers to engage in educational and outreach awareness activities and advocacy efforts with key decision makers, policy makers, and government officials**. Opportunities and support should also include provisions for allowing such providers and organizations to create and engage in coalitions and other advocacy-based movements. These individuals bring a wealth of knowledge to the table about barriers that Hispanics-Latinos face with accessing and receiving quality mental health services, barriers that they themselves experience as individual direct service providers and as direct service provider organizations with providing mental health services to the Hispanic-Latino population, and have knowledge of different strategies utilized, being utilized or needed to eliminate the disparities that exist for Hispanics-Latinos in accessing and receiving quality mental health services.
3. **Create opportunities for community-based organizations, associations, and other entities to provide outreach and educational activities aimed at increasing awareness and interest among Hispanic-Latino youth and young adults to pursue a career as a mental health professional, at both the undergraduate and graduate school level and as a direct service provider, administrator, or researcher, and to increase knowledge among the Hispanic-Latino community about the role of mental health care providers in the United States, the different treatments that exist, and the potential benefits of accessing proper treatment.** Providing funding opportunities for public relations and public education activities could increase the number of Hispanics-Latinos entering the mental health professional workforce, as well as eliminate negative perceptions that exist about some mental health professions, increase knowledge among Hispanics about mental health services and providers, and increase access to professional mental health services.
4. **Support the development of entities designed to provide education, information and research on Hispanic-Latino mental health issues that can serve as a catalyst for change, clearinghouse on information, national leader, and driving force for a more culturally competent national mental health system for Hispanics-Latinos.** Providing support for such activities and entities is critical, as so many reports have highlighted the disparities in access and mental health care for Hispanic-Latinos and have increased an awareness and interest in addressing these issues. Many providers struggle to find relevant information and technical assistance and guidance on how to best attract, retain and serve Hispanic-Latinos in a mental health setting.
5. **Support the development, expansion, and research of educational programs geared to mental health consumers and family members.** Family plays a critical

role in the Hispanic-Latino community and this must not be overlooked and undervalued. Programs that provide support and education to family members of an individual with a mental illness are critically important and needed in both English and Spanish. Support for such programs are grossly under funded, and more support is needed to both expand existing evidence-based programs, to adapt and test existing programs for cultural relevance and competence, and to create and evaluate new promising practices.

Individuals/Groups Responsible:

State Governments, Federal Government, Law Makers, Institutions of Higher Education, Middle Schools, High Schools, Community-based organizations, associations and other entities interesting in increasing access to and the quality of mental health services for Hispanics-Latinos.

Issue: Access to Care

Many of the barriers impacting meaningful access to professional, effective and quality mental health services for Hispanics-Latinos have been noted in professional literature and throughout this report. The recommendations that follow in this segment aim to provide more detailed specifics on what can and must be done in order to eliminate the disparities in access to quality mental health services for Hispanics-Latinos. The areas that follow are complex and require extensive work, support, and commitment to address. They include lack of health insurance, poor mental health coverage by insurance plans, and costs of services.

Statistics show that as a whole, Hispanics-Latinos represent the largest uninsured racial and ethnic group in the United States. The reasons for the lack of insurance vary, as does the difference in health insurance status by country of origin and by state of residence. It is important to note that immigration policy and rules impact whether or not specific groups of Hispanics-Latinos are able to access public health insurance programs like Medicaid. The differences seen in health insurance status by country of origin can be at least partially explained by these policies. For example, Puerto Ricans are United States citizens, and therefore, not barred from participating in Medicaid. Refugees are also eligible for health insurance coverage under Medicaid, and since Cubans are considered refugees by the United States government, they also can access this program. On the contrary, new immigrants (i.e., those arriving to the United States since 1996) from many other countries are banned from accessing public programs for five years. Additionally, dramatic differences in state rules and regulations regarding who is eligible for Medicaid coverage exists, so the specific state in which a Hispanic-Latino immigrant resides will also impact whether or not he or she is eligible for public programs. Overall, knowing when an immigrant came to the United States, from which country they arrived from, and in which state they reside, are important factors in understanding eligibility for public health insurance coverage.

A 2002 National Survey of Latinos by the Pew Hispanic Center and the Kaiser Family Foundation found that almost three in four Hispanic-Latino adults are either themselves without health insurance or personally know someone who does not have insurance coverage. The survey also found that a substantial number of Hispanics-Latinos report health care challenges,

such as problems with paying medical bills, delays in seeking care because of costs, and not getting needed health care services. It is important to note that a common misperception is that the majority of people without health insurance are unemployed. This is not particularly true for Hispanics-Latinos. The same 2002 National Survey of Latinos found that two-thirds of Hispanics-Latinos who report being uninsured are employed (63%). While another 20% reported being homemakers or stay-at-home parents, 12% reported being currently unemployed, 3% indicated they were retired, and 3% were in school.

Disparities in Care

Nationwide: Persistent ethnic disparities in health care have been recognized as a national concern. The first-ever Report on Mental Health (DHHS, 1999) was issued by the U.S. Surgeon General in 1999 followed by the Department of Health and Human Services' (DHHS) Healthy People 2010 Initiative (DHHS, 2000), which recognized mental health as an important indicator of the nation's health and directed its objectives towards the reduction of health disparities by the year 2010 at all government levels, with special attention given to ethnic disparities. Likewise, in March 2000, the National Congress for Hispanic Mental Health, convened by the Substance Abuse and Mental Health Services Administration (SAMHSA), developed a national agenda to reduce the gaps in access to, and availability of, treatment for Hispanics with mental illnesses (SAMHSA, 2000). More recently, the Institute of Medicine's landmark report on *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* provides extensive evidence that racial and ethnic minorities have less access to health care and are more likely to receive lower quality health services than white Americans (Institute of Medicine, 2002). Below are some highlights of recent findings:

For Latinos: Current disparities in health care for Latinos are severe, persistent and well documented (Padgett, Patrick, Burns, et al., 1994; Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000; Ruiz, 1995; Vega, Kolody, Aguilar-Gaxiola & Catalano, 1999; Woodward, Dwinell, & Arons, 1995). This is despite the fact that, according to the recently released Census 2000, Hispanics-Latinos are the fastest growing ethnic group in the nation. In the last decade, the Hispanic-Latino population increased by 58 percent compared with an increase of more than 13 percent (13.2%) for the total U.S. population (U.S. Census Bureau, 2001). Projections indicate that Hispanics-Latinos will comprise half (50%) of California's population by the year 2040, and a quarter (25%) of the U.S. population by the year 2050 (State of California, 1997). The National Institute of Mental Health (NIMH) has produced several Action Plans identifying specific strategies directed at improving the health of Hispanics-Latinos.

For Mexicans and Mexican-Americans: Mexican-Americans are by far the largest and fastest growing Hispanic-Latino subgroup. In 2000, Mexicans comprised 66% of all Hispanics-Latinos and had grown by 53% in the past ten years (U.S. Census Bureau, 2001). Yet research findings from the Mexican American Prevalence and Services Survey (MAPSS; Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano, & Caraveo-Anduaga, 1998) indicate that even more dramatic disparities in mental health care exist for Mexican-Americans compared to other ethnic minorities. Funded by the National Institute of Mental Health (NIMH), MAPSS is the largest epidemiological mental health study ever conducted with this population in the United States. The MAPSS study provides a strong empirical basis for this proposal. According to MAPSS

only about one in four (27%) Mexican-origin adults, who had one or more psychiatric disorders in the last 12-months, receive any kind of service (this includes services provided by mental health providers, general medical providers, other professional providers including counselors and other informal providers). This means that approximately three out of four Hispanics-Latinos (73%) with a diagnosable mental disorder and who are in need in services remain untreated. When compared to the national rate of one out of two people receiving mental health services the disparities are unacceptable.

For Migrant Agricultural Workers: The problem of underutilization is even more pronounced in Mexican immigrants. According to the Mexican-American Prevalence and Services Survey (MAPSS), 85% of Mexican immigrants who needed mental health services remained untreated (Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). This extreme underutilization of mental health services is even more pronounced among Mexican migrant agricultural workers (only 9% of those who need mental health services use services). Research has repeatedly shown that this population receives no care unless they are extremely dysfunctional or a danger to themselves or others (Vega, Kolody, Aguilar-Gaxiola et al., 2001). Often this is a result of barriers that can best be understood as problems related to accessibility, availability, appropriateness, affordability, and advocacy. *(Please note that these findings are from the MAPSS study and any reference to Mexican Americans or Mexican immigrants being migrant agricultural workers should only be viewed within this context)*.

Recommendations:

1. **Support and pass state and federal legislation on parity for mental health insurance coverage.** A huge deficit in the level of care allowed and covered under current private and public health insurance plan rules and regulations contribute to poor access, poor and often rushed treatment, and poor retention of consumers in need of mental health services. This may be particularly harmful to Hispanics-Latinos whom already have to confront so many stressful and negative variables. The lack of equal coverage for mental health services and oftentimes higher co-pays and more stringent access eligibility criteria for mental health services significantly contributes to the underutilization of mental health services by Hispanics-Latinos and the difficulties they encounter with accessing professional services. Title VI of the United States Civil Rights Act of 1964 must be fully implemented and enforced. State and federal health insurance programs must be held accountable for meeting the health and mental health needs of its entire people. The days of not wanting to raise taxes or make tough decisions to make such necessities and legal responsibilities a reality must end. Our nation depends on it. All people in the United States contribute to its success and infrastructure and all deserve, and have the legal rights, to receive health and mental health services.
2. **Support a national universal health insurance program for all Americans that provides equal and equitable coverage for health and mental health services. Countries far worse off than the United States, economically and in other means, have been able to accomplish such a task**. Elected officials must remember their role and purpose and put partisan differences aside for the well-being and betterment of the United States. The United States is comprised of people, and people of all

races and ethnicities that are physically and mentally healthy and able contribute, and must be assured the ability to continue contributing, to this nation's greatness. The issue is complex and maybe costly, but not to act would be more costly to our nation and our children, grandchildren, and their children down the road if choose not to take the necessary steps to ensure that all Americans have meaningful access to quality health and mental health services. Disparities must be eliminated in all areas, especially access to services issues.

3. **Provide significant additional financial support to community mental health providers in the way of higher cost per unit rates and higher Medicaid and other insurance reimbursement rates**. Decades of deinstitutionalization efforts throughout the country have saved states billions of dollars with unfilled promises that community mental health providers would be provided with the necessary financial resources and support to effectively achieve their mission of helping those with mental illness lead healthy, productive and fulfilling lives. These efforts and unfilled promises have contributed to increased demands on community service providers and a system that is at crisis levels. Front line providers face inadequate funding, an overabundance of contractual paperwork and stringent guidelines, and experience substandard cost of living increases, high staff turnover and difficulties with meeting operating expenses and expanding services to meet demand. Medicaid reimbursement rates for mental health services must be updated as many are several decades old. As the President's Freedom Commission on Mental Health noted last year, America's mental health system is in shambles and requires transformation. Providing necessary and realistic reimbursement for mental health services to such important partners in the mental health service delivery system is a key step in improving this system and should enhance access to services for many who never get into treatment or wait weeks and sometimes months to get services they require. Additional support and a real commitment towards transformation are needed to level the playing field for community mental health providers who provide much of the critical mental health services in our nation. These are needed so that community mental health providers can effectively meet the increased demand for mental health services and better attract and retain the small number of qualified bilingual and bicultural mental health professionals that currently exist to provide quality, culturally competent and linguistically appropriate mental health services to Hispanics-Latinos.
4. **Provide additional financial support to mental health service providers so that they can expand the availability of mental health services by increasing personnel, the days and hours they provide services on, the locations at which services are provided, and the types of treatment services they provide**. Reports have shown that many Hispanics-Latinos are not able to, or can afford to utilize services, during normal business hours or dates of service, have transportation barriers that prevent them from getting into care, and are receptive to other provision of services such as home-based treatment services. Many mental health community providers that serve a high percentage of Hispanic-Latino consumers report long waiting lists for the provision of services, as well as financial burdens on their agencies. Administrators at these organizations report that that financial burden is a result of such issues as their agencies not receiving adequate funding to meet the demand of consumers and the consumer's lack of insurance. Many agencies are left

to explore alternative funding sources from both private and public foundations and other funding organizations. The availability of other funding sources is often times very limited, time consuming, competitive and at the discretion and interest of the funding source. Additional measures from state and federal government entities are needed to address this issue.

Individuals/Groups Responsible:

State Governments, Federal Government, Law Makers, Health Care Advocates, Insurance Providers, Managed Health and Behavioral Health Care Providers, Community-based organizations, associations and other entities interesting in increasing access to and the quality of mental health services for Hispanics-Latinos.

Issue: Workforce Development

A critical shortage of qualified bilingual and bicultural health and mental health care workers exist in many states and throughout the United States as whole. The lack of bilingual and bicultural mental health providers (e.g., defined here as a master's level mental health or substance abuse professional who holds a respective license or drug abuse credential to provide clinical services) who can provide mental health and substance abuse services in Spanish in many of the mental health, social service, and substance abuse arenas (e.g., outpatient counseling, crisis services, domestic violence programs, inpatient units, child welfare agencies, etc.) creates a huge barrier for many Hispanics-Latinos including:

1. The inability to provide mental health services in a language that many Hispanics-Latinos either only know or feel more comfortable communicating in.
2. The inability to provide culturally and linguistically appropriate mental health services to monolingual Spanish speaking individuals or to adequately involve monolingual; Spanish speaking family members in the treatment process.
3. The inability of agencies to attract Hispanics-Latinos in need of mental health services to treatment as a result of the organization's inability to effectively provide outreach to the consumer, to educate the community about available services and the benefits of those services, and to engage the consumer in treatment..
4. The inaccurate, and at times inappropriate, assessment, diagnosis and treatment of a Hispanic-Latino mental health consumer due to lack of knowledge of cultural bound syndromes, and the culture from which a Hispanic-Latino belongs to and identifies with.

The lack of available bilingual and bicultural psychiatrists and psychologists is also a major issue impacting the Hispanic-Latino community in need of mental health services. The recommendations that follow not only focus on increasing the number of Hispanics-Latinos entering the mental health profession, but also focus on strengthening and enhancing the skills of the current mental health workforce to better understand the barriers, belief systems, attitudes, needs (both mental health and others such as social service and concrete needs) and cultural preferences of Hispanics with respect to utilizing mental health services. The implementation and enforcement of Title VI of the Civil Rights Act of 1964 is also key in this area. The helping professional schools (psychiatry, psychiatric nursing, psychologists and psychiatric social workers) must recruit bilingual/bicultural students; the licensing exams should include

bilingual/bicultural questions; assessment instruments should have bilingual/bicultural factors and must be valid for diagnostic purposes; and national and state mental health organizations must have staff members and board members who are bilingual and bicultural. Further, the helping professional schools, mental health centers and other facilities should meet criteria established by accrediting bodies to ensure quality services to LEP persons. This is the action that is required since it is a systemic problem and must be addressed from a systemic perspective. We need regulations to enforce Title VI of the Civil Rights Act of 1964. Violations of this Act have gone on for far too long, as has the harm inflicted on generations of LEP persons and their families. These violations have placed a social and financial burden on our nation as a result of poor meaningful access, misdiagnosis, inadequate and culturally incompetent treatment - wrong medication, misunderstanding, and poor care, and will result in negative consequences for years to come.

Recommendations:

1. **Create opportunities for community-based organizations, associations, and other entities to provide outreach and educational activities aimed at increasing awareness and interest among Hispanic youth and young adults to pursue a career as a mental health professional, at both the undergraduate and graduate school level and as a direct service provider, administrator, or researcher, and to increase knowledge among the Hispanic community about the role of mental health care providers in the United States, the different treatments that exist, and the potential benefits of accessing proper treatment**. Providing funding opportunities for public relations and public education activities could increase the number of Hispanics-Latinos entering the mental health professional workforce, as well as eliminate negative perceptions that exist about some mental health professions, increase knowledge among Hispanics-Latinos about mental health services and providers, and increase access to professional mental health services.
2. **Create readily accessible financial assistance programs for graduate mental health education and/or other incentives, such as scholarship programs or loan forgiveness programs, for Hispanics to pursue a mental health profession at the graduate level**. Many professional positions in mental health require a license to practice, which entails having a master's degree in psychology, social work or related field. As national statistics show many Hispanics-Latinos unfortunately do not pursue a graduate education, and even fewer choose to become a mental health professional. The reasons why Hispanics-Latinos do not pursue a graduate education vary, but the costs of higher education and the lack of financial assistance provided at this level is often cited as the number one barriers. In addition to costs and lack of financial assistance for graduate education, barriers often cited by undergraduate mental health professionals with respect to pursuing a graduate education in mental health include the perceived, and at times accurate, reality that mental health professionals are underpaid and overworked, the fact that many graduate mental health programs such as social work are much longer than other masters programs and require much more time and commitment to complete as they entail not only coursework, but field work, process recordings of field work, and licensing exams after the formal educational process is completed in order to practice.

3. **Create an even playing field for community-based mental health providers who serve as "front line" providers of mental health services by increasing reimbursement rates for services provided and/or providing annual service bonuses to agencies that serve a specified percentage of individuals with Limited English Proficiency so that these agencies can attract and retain qualified bilingual and bicultural clinicians**. Many agencies struggle to attract and retain such personnel as they cannot afford to compete with the better salaries and benefits offered by other entities requiring masters level professionals with a degree in psychology, social work, or a related field such as state child welfare agencies, the criminal justice systems, the school system, and hospital-based providers.
4. **Require institutions of higher education to create and/or enhance their current training and curriculum of new mental health professionals to include a minimum number of credits and/or classes in topics such as cultural competence, cultural diversity, racial relations, or on working with specific racial and ethnic minority groups.**
5. **Require institutions of higher education to create and/or enhance their offering of trainings for existing mental health professionals on topics such as cultural competence, cultural diversity, racial relations, or on working with specific racial and ethnic minority groups.**
6. **Introduce, support, and enforce legislation that requires new certified and licensed mental health professionals to have obtained a specified number of undergraduate and/or graduate credits or successfully completed a specified number of classes on topics such as cultural competence, cultural diversity, racial relations, or on working with specific racial and ethnic minority groups.**
7. **Introduce, support, and enforce legislation that requires existing certified and licensed mental health professionals to participate and successfully complete a minimum number of continuing education units each renewal cycle in topics such as cultural competence, cultural diversity, racial relations, or on working with specific racial and ethnic minority groups.**
8. **The use of translators and interpreters in the delivery of health and mental health services has received some attention over the past several years. This issue has raised discussions among mental health professionals and advocates about its use and effectiveness in the delivery of quality mental health services, especially in lieu of or as a supplement to the current system's lack of qualified bilingual and bicultural mental health providers. This area requires further exploration and must be seriously considered**. Appropriate communication and effective consumer/provider interaction is fundamental to any form of human service delivery. This is especially true in the delivery of quality mental health services. Effective interaction that is sensitive to culture is particularly relevant in mental health services, where the relationship between the provider and the consumer is only meaningful to the extent that the provider establishes trust and rapport with the consumer and/or family members. Oftentimes, mental health providers' indifference to issues of culture and language result in the consumer avoiding treatment or terminating treatment earlier than is medically beneficial to the consumer. The consumer/provider relationship in a mental health setting differs widely from that of a recipient of primary health services as one must also consider the

importance of non-verbal communication and other forms of expressions displayed by a consumer in diagnosing and treating an individual with a mental illness.

9. **State and federal government entities should mandate that all human service providers conduct regular community needs and demographic assessments, have active cultural competence plans, conduct organizational cultural competence self-assessments, and require that staff at all levels participate and satisfactorily complete trainings in cultural competence upon hire and annually thereafter**. Financial and other types of support should be provided by the states and federal government to create such cultural competence trainings and to evaluate their effectiveness and outcomes. It is believed that these types of efforts would improve consumer satisfaction with mental health services, increase access to such services, decrease poor retention of racial and ethnic minority consumers in treatment, contribute to lower costs on other systems such as emergency care and the justice system, decrease overrepresentation of racial and ethnic minorities in high-need vulnerable populations, and increase individual, family and community development. Training modules in cultural competence should be developed for all levels of staff and should be incorporated into all human service delivery provider agencies. In addition, all these efforts must be monitored for compliance. These mandates should be tied to licensing, contracting, accreditation, monitoring, and enforcement of organizational providers.
10. **Develop cost efficient and easy to follow mechanisms under which foreign-trained mental health professionals can be assessed and credentialed in the United States if qualified.**

Individuals/Groups Responsible:

State Governments, Federal Government, Law Makers, Institutions of Higher Education, and Governing Licensing Boards of Mental Health Professionals, Community-based organizations, associations and other entities interesting in increasing access to and the quality of mental health services for Hispanics-Latinos.

Issue: Cultural Competence Research and Evidence–Based Practices

Significant and unacceptable disparities in access to and the provision of quality health and mental health care for members of racial and ethnic minority groups in the United States has been well documented. In particularly, recent studies and reports have clearly highlighted an array of disparities for Hispanic-Latino Americans, African-Americans, American Indian, and Asian Americans in accessing and receiving culturally competent and quality mental health care. The need for enhanced knowledge about culturally appropriate and competent mental health care for individuals of racial and ethnic minority groups is direly needed and hampered by the lack of racial and ethnic minority practitioners, researchers, and study participants in the field of mental health. The U.S. Surgeon General (DHHS, 2000) reported on a few published studies in the scientific literature about outcomes of mental health care specifically for ethnic minority populations. This report, and a 2001 supplemental report, highlighted the importance of culture in the mental health process and must be taken seriously. Additional research and knowledge about what works and what doesn't with members of racial and ethnic minority groups with respect to accessing mental health services, service retention, and provision of quality care is

critical to eliminate the current disparities in access to and the provision of quality mental health care. This current lack of knowledge, the severe disparities that currently exist, and the impact of these disparities on members of these racial and ethnic minority groups on individuals, families, communities and the overall Unites States economy and stability will only get worse if not properly addressed. According to U.S. Census Bureau projections, these four racial and ethnic minority groups will comprise roughly 50% of the total U.S. population by 2050. In fact, in the last twenty years the Hispanic-Latino American population grew faster than any other ethnic minority group in terms of the actual number of persons. The majority of this growth has occurred as the result of natural births and not immigration, as most would assume. More significantly was the fact that during the last census reporting in 2000, the Hispanic-Latino Americans constituted the second largest population segment in the United States.

During the last decade, the drive toward quality and accountability in mental health care, coupled with novel research on mental health service delivery has directly resulted in a growing desire on the part of researchers and policy-makers to use this research in mental health system planning and service delivery. Unfortunately, the amount of research information that exists regarding the Hispanic-Latino American community is very scarce and limited. Evidence Based Practices (EBP) have not been designed with Hispanic-Latino Americans or other minorities in mind. They have been standardized on mainstream and Caucasian American populations. The needs and cultural preferences of racial and ethnic minorities has not been adequately assessed and incorporated into these practices. There is some movement to take established EBPs and adapt them to minority populations. That may be helpful, but it is not the same as Hispanic-Latino American communities taking established practices or promising practices that were created within their own working environments and demonstrating that they are evidence-based. In general, evidence-based practices have demonstrated efficacy and effectiveness in the treatment of mental health disorders. The evidence is based on controlled research comparing a practice with usual care or alternative treatments. The application of these practices is intended to improve the success of consumer outcomes.

Culturally competent service systems are intended to improve access to and the quality of mental health treatment for underserved and inappropriately served ethnic and cultural minority groups. Culturally-specific or sensitive practices are one effort to promote a culturally competent mental health service system. Culturally-specific/sensitive practices are tailored to the unique cultural context of each group**.** Their goal is increase the likelihood that ethnic minorities will remain in treatment after entering mental health care and optimally benefit from it. Many of the current evidence-based practices have not been specifically tested on diverse ethnic or cultural groups.

Evidence-based practice is a concept receiving significant attention in public and private health and behavioral health systems of care throughout the nation. However, it is clear that research or information on evidence-based practice in general, and those regarding the Hispanic-Latino American community is lacking (DHHS, 1999 & 2001). Increasingly, there are controlled research trials, evaluations, and demonstrations developing information about more effective mental health practices. However, this rapidly evolving research and information about evidence-based practices is slow to be synthesized, translated, and/or adopted by providers (DHHS, 1999; CIMH, 2003). As is stated in a NIH and NIMH report, *Bridging Science and Service: A Report by the National Advisory Mental Health Council's Clinical Treatment and*

Services Research Workgroup, connecting research to practice and policy decisions is often very difficult. These difficulties may occur in obtaining knowledge about relevant research and in the lag time between research findings and their subsequent publication**,** estimated to be about 18 years from development to full implementation in clinical medicine.
There are a number of issues that contribute to the slow integration of evidence-based practices and our nation's leaders must work to address this situation. The U.S. Department of Health and Human Services, Office of Minority Health set forth the National Standards for Culturally and Linguistically Appropriate Services in Health Care as a guide to improve the delivery of quality health care services for racial and ethnic minorities. These guidelines are critically important to improve the health and mental health care delivery for racial and ethnic minority groups. They are:

- Health care organizations should ensure that patients/consumers receive from all staff-members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
- Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
- Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
- Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
- Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

- Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
- Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
- Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
- Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

The Office of Minority Health (2001) stated that the CLAS standards were developed because culture and language are vital factors in how health care services are delivered and received, and it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse consumers bring to the health encounter. Culture is important and additional research is needed to enhance the nation's scientific knowledge of what works and what doesn't with members of racial and ethnic minority groups with respect to accessing mental health services, service retention, and provision of quality mental health care.

Recommendations:

The following recommendations regarding Hispanic/Latino Americans are offered to guide mental health care research and practice which promotes cultural competence and greater consumer outcomes. The majority of these recommendations were derived from a multitude of sources including the members of the committee, reports and papers from the California Institute for Mental Health, Yale University's recent study on cultural competence, and a general review of the literature on cultural competence.

1. **Research of culturally-specific evidence-based practices needs to be enhanced and adequately funded. Additionally support is also needed for research on other areas such as understanding the relevance of culture and language in the utilization of mental health services by Hispanics-Latinos, on the incidence and prevalence of mental illness among the Hispanic-Latino population, and on Hispanics-Latinos response to psychopharmacological and psychosocial treatment.**
2. **Evidence-based practices which have been proven to be effective with non-ethnic minority populations, if implemented with ethnic minority groups must track its effectiveness with these groups.** Adequate support for these type of activities must be provided in funding opportunities and be incorporated into such funding opportunities with reasonable time for the proper development and documentation of such activities.
3. **Evidence-based practices which have been proven to be effective with non-**

ethnic minority populations must track any modifications and/or adaptations made, to collect and generate new information to enhance the effectiveness of these evidence-based practices to ethnic minority populations. Adequate support for these type of activities must be provided in funding opportunities and be incorporated into such funding opportunities with reasonable time for the proper development and documentation of such activities.

4. **Implementation of the CLAS standards within behavioral health organizations with accountability mechanisms.**
5. **Accelerated cultural competence research (Policy, Organizational and Clinical) sponsored by federal agencies to develop a scientifically grounded body of knowledge for improving clinical practices and treatments.**
6. **The use of cultural competence educational curricula as mandatory in clinical training programs and continuing professional education in medicine, social work, and clinical psychology.**
7. **Better tools for assessing language abilities in clinical assessment and linguistic and cultural issues in the diagnostic process are needed.**
8. **The selection of a treatment practice needs to be based on mutual decision-making between informed clients, and for children their family/guardians, and their providers.**
9. **Efforts to eliminate barriers to accessing mental health care including stigma, discrimination, bias, and costs need to be continued and expanded.**
10. **Efforts to eliminate disparities in access to and quality of mental health care for ethnic and cultural minorities need to be continued and expanded.**

Individuals/Groups Responsible:

Federal Government, State, County, and City Governments, Law Makers, Health Care Advocates, Insurance Providers, Managed Health and Behavioral Health Care Providers, Community-based organizations, health and mental health associations, and other entities interested in increasing access to and the quality of mental health services for Hispanics-Latino Americans.

Closing Statement:

The National Hispanic-Latino Agenda Summit Mental Health Issues and Platform Committee is pleased to be able to submit this report and the recommendations contained herein aimed at improving the mental health service delivery system for Hispanic/Latinos in the United States. Although all areas requiring attention are not or could not be covered in this report, the committee strongly believes that these critical areas would bring about meaningful change in access to and the quality of mental health services for Hispanics/Latinos. We urge our elected representatives, state and federal officials, formal and informal community leaders, and all Americans that believe and understand that everyone deserves and has the right to have meaningful access to and receive quality mental health services, to seriously review and consider the recommendations contained herein. In addition, we urge these individuals and key stakeholders to begin implementation of these recommendations immediately and to accept the fact these disparities in access to and the provision of quality mental health care to Hispanics-Latinos exist and are unethical and illegal. We must not be satisfied with the status quo any

longer and must elect to educate and empower ourselves and those around us to make meaningful change. We must also be ready to move beyond being an advocate and serve as activists. One cannot be a great advocate if one does not engage in activities or create opportunities for change. We invite you to join us in our quest to an improved mental health system for Hispanics-Latinos in the United States and thank you in advance for your attention to this critical problem that can and must be addressed.
The committee members would also like to strongly urge those with the will, energy and power, be it prescribed or self-assumed, to continue educating themselves on the issues at hand and begin taking the necessary actions to address these critically important issues. Below is a listing of some tools that may be helpful in accomplishing such tasks:

National Congress on Hispanic Mental Health
http://www.mentalhealth.samhsa.gov/cmhs/SpecialPopulations/HispMHCongress2000/

National Health Law Program – *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*
nhelp@healthlaw.org

President's New Freedom Commission on Mental Health
http://www.mentalhealthcommission.gov/

Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda
http://www.omhrc.gov/CLAS/

Model Mental Health Program for Hispanics Report
http://www.njmhi.org/modelenglisha.htm

In closing, the committee would like to highlight a report by Dr. Juan Ramos on the need to assess the impact of certain mechanisms on multi-cultural human service programs, which eloquently covers many of the areas and recommendations discussed.

The meaning and ingredients of cultural competence are being sought by a growing number of professionals, agencies, and institutions; becoming culturally competent is the developmental process that is beginning to be seen as an integral part of professional competence. Increasing recognition is being given to developing multi-cultural human services and to assess the cultural aspects of services delivery. Unfortunately, neither the intended or unintended consequences of the organization, financing and delivery of human services to culturally diverse populations have received serious attention in the past from scholars, policy makers, and human services practitioners.

The goal is to ameliorate the symptoms, consequences, and outcomes generated by a human services infrastructure that remains almost immune to any discourse on its effectiveness with culturally diverse populations, and that is surrounded by walls of indifference and ethnocentrism. This infrastructure needs to be challenged; strategies must be designed to open the process to evaluation and to important work that is currently being done.

Discourses on these critical issues have become even more important as the helping professions advanced through the 1990s and advance through the 2000's. Specifically, the dramatic increase and changes in the culturally diverse populations in the United States will bring new and exciting challenges to the human service infrastructure, including public and private social welfare agencies, research and training programs. While some of the responses will be a reaction to the increase in population as reflected in the clients, there is an urgent need to take initiative in addressing the impact of societal mechanisms on the human services infrastructure. Thus, the challenge to the helping professions is not limited to the assessment of the impact and consequences of their assumptions and concepts on culturally diverse populations or to the identification of strategies to change the human services infrastructure so that it can respond appropriately to their growing needs. While these are crucial, they are not sufficient, since various mechanisms have more influence than the response. Influential agents with jurisdiction over the human services infrastructure that traditionally have been overlooked and taken for granted in the change process are the legitimizing and authorizing bodies with responsibility for the accreditation of facilities providing inpatient and outpatient care, accreditation of educational institutions and specialized training in the helping professions, accreditation of services for families and children, licensing and certification of human services professionals, and the sanction and support of diagnostic and assessment tools extensively utilized by the helping professions, usually for reimbursement claims. These self-governing bodies are parties to the social contract with society designed to protect it from quacks and incompetents. Organization and delivery of services must abide by the rules established by these bodies if they are to receive sanction and survive. There has been no visible effort to incorporate the needs and specific characteristics of the culturally diverse populations in the standards and criteria established by these authorizing bodies. As experience indicates, present policies and procedures have enormous impact, mostly negatively, on culturally diverse populations since they do not reflect standards and criteria representative of these groups. The much needed policy analysis and evaluation in these areas have not been done. We are now experiencing considerable activity triggered by budgetary constraints resulting in a significant negative impact on population groups which have no representation or database to counter the actions taken against them. In fact, the challenge to the legitimizing and bodies to negotiate a social contract with culturally diverse population groups to protect them from quacks and incompetents is long overdue, and may result in a higher degree of adherence to changes than all the conferences and workshops on culturally diverse populations.

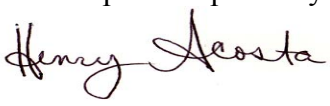
Recognizing the negative impact of the value base of the human services infrastructure and how that infrastructure negatively affects various culturally diverse populations, we can begin the process of overhauling the infrastructure according to a different set of assumptions, standards, and criteria. Although such work will require considerable effort and time, it is imperative that the reform process include several key tasks. Retraining helping professionals through continuing education, changing and improving the effectiveness of the service delivery system as it pertains to culturally diverse populations, adding multicultural content to certification and licensing examinations, and including multicultural criteria in the accreditation process are all initial steps in improving services for culturally diverse populations. These tasks must be incorporated in the processes of the legitimizing and authorizing bodies. Such changes require ongoing commitment as well as a passion for justice on the part of helping professionals and

institutions. While there has been some significant work in modifying criteria in the accreditation of educational institutions, this is a significant step that must be followed-up in other sectors. These initial steps must be followed by a comprehensive overhaul of the assumptions underpinning the value frameworks of the legitimizing and accrediting bodies.

It is the work of institutional change that must take place as a next step to the voicing of concerns. Unfortunately, the helping professions prefer to change individuals rather than the legitimizing and authorizing bodies that hamper their work with culturally diverse populations. In the past, the rhetoric of institutional change was not followed up with action on systems change. We look forward to the time when services will be provided by licensed or certified helping professionals who have passed examinations with sections on multicultural content and who have been trained in accredited programs that incorporate multicultural content as required by accreditation criteria. We also look forward to the time when treatment facilities and the helping professions will have to meet accreditation standards and criteria that incorporate multicultural content. The time for action is at hand.

Indeed, the time for action is upon us!

Draft Report Respectfully Submitted and Prepared By:



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