



**Matilda Garcia Initiative: Latin American
Research Scholars Exchange**

**A Roadmap to Reducing Mental
Health Disparities in Latinos:
Connecting the Dots**

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Acknowledgements



Matilda Garcia


Acknowledgements

Roberto A. Aguilar-Rudametkin (picture)
Larke Huang, Ph.D.
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“As with language, so with culture: how much incoherence we risk if we fall out of its matrix. We know that cultures differ in customs, food, religions, social arrangements. What takes longer to understand is that each culture has subliminal values and beliefs. They inform our most intimate assumptions and perceptions, our sense of beauty, of acceptable distances between people, or notions of pleasure and pain. On that fundamental level, a culture gives form and focus to our mental and emotional lives. We are nothing more--or less--than an encoded memory of our heritage.”

Eva Hoffman, *Wanderers by Choice*

Let's hear it from cultural sensitivity!



Cultural Differences

Horario

12 *ma* 9:30
P.M
**MÁS
O
MÉNOS**

An office somewhere
in South America.

Hours of Operation
12 noon to 9:30 P.M.
MORE or LESS

Source: Levine, 2001

The Mercury News

MercuryNews.com

San Jose Mercury News (CA)

LANGUAGE HELP FOR PATIENTS
INTERPRETERS MAY BE REQUIRED
 LINDA GOLOSTON, Mercury News

When Ellen Wu's 82-year-old grandmother goes to her HMO for treatment, Wu's 65-year-old mother goes along to translate.

"It's like the blind leading the blind," said Wu, executive director of the California Pan-Ethnic Health Network. "English is not my mother's first language."

It's a predicament millions of Californians face as the state's diverse population continues to grow.

After hearings Tuesday in Los Angeles and today in Oakland, the state will be a step closer to becoming the first in the nation to require that HMOs provide language interpreters to patients who need them.

Regulations won't be issued until May, and HMOs won't have to comply with them for at least another year, but the need will not go away, said Wu, whose Oakland-based agency worked on the legislation.

"How can you possibly receive quality care without being able to talk to your doctor?" she asked. "Even if you use family and friends, they're not qualified medical interpreters."

Source: San Jose Mercury News, Feb. 16, 2006


Let's hear it from linguistic sensitivity!

"How can you possibly receive quality care without being able to talk to your doctor?"

"Even if you use family and friends, they're not qualified medical interpreters."

Ellen Wu
Executive Director of the California Pan-Ethnic Health Network

Source: San Jose Mercury News, Feb. 16, 2006



USA
Football
BRAZIL
Football
AUSTRALIA
Football

Never underestimate the importance of local knowledge.

HSBC
The world's local bank

Table 1: Use of Spanish Vocabulary in WMH-related Questionnaires

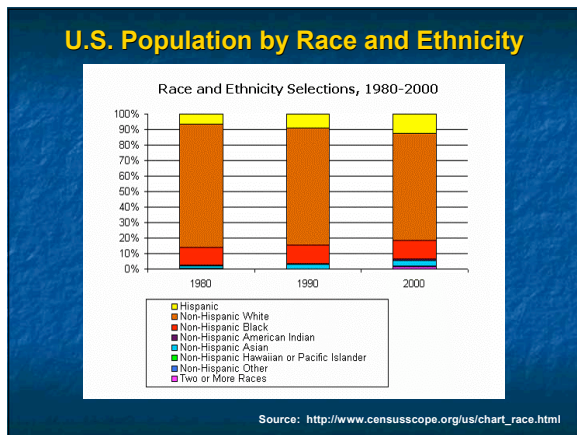
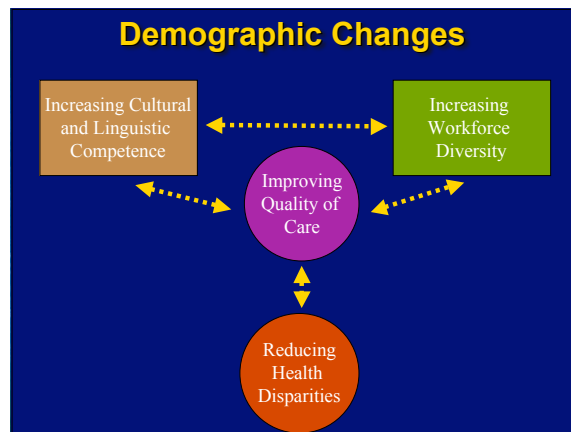
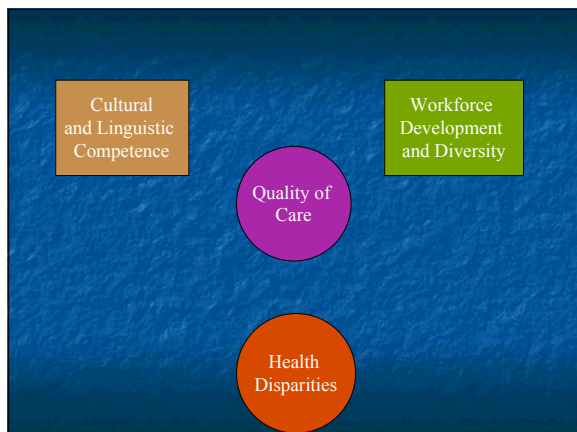
Words	Mexicans	Puerto Ricans	Cubans	Other Latinos
Piscina / Alberca (<i>Pool</i>)	Alberca	Piscina	Either	Piscina
Armarios / "Closets" (<i>Closets</i>)	Armarios	Closets	Either	Closets
Una fila / Hacer cola (<i>Stand in line</i>)	Either	Una fila	Hacer cola	Una fila
Resaca/cruda/goma/guayabo (<i>Hangover</i>)	Manejar	Manejar	Lidiar	Manejar

Role of Culture and Language in Quality of Health Care

Research has demonstrated that culture and language can profoundly affect the health and quality of care received by Latinos.

Failure to consider cultural and linguistic factors in clinical encounters can lead to a variety of adverse consequences, including lack of improvement and prolonged suffering

Source: McCabe, 2002



Hispanics in the United States- A Rapidly Growing Population

Source: Hispanics in Motion, Pew Hispanic Center, 2005

Hispanics in the United States

Source: Hispanics in Motion, Pew Hispanic Center, 2005

Latino Population Trends

There were over 40 million Latinos in the U.S. in 2004 not including the population of Puerto Rico – an additional 4 million

- 75% of the U.S. Latino population are immigrants or children of immigrants;
- 45% are foreign born;
- Most of Latino population growth results from fertility not immigration.

Source: Current Population Survey, March 2002, PGP-5

Hispanic Growth Surge Fueled by Births in U.S.

By D'VERA COHN
 Washington Post Staff Writer

Hispanics accounted for about half the growth in the U.S. population since 2000, according to a Census Bureau report to be released today that indicates the nation's largest minority group is increasing its presence even faster than in the previous decade.

In another contrast to the 1990s, births have overtaken immigration this decade as the largest source of Hispanic growth.

The new census figures paint a portrait of a Hispanic population

Hispanics accounted for

49%

(6,015,692 Hispanics)

of the nation's population growth from 2000 to 2004, according to the U.S. Census Bureau.

"It's going to have profound effects on America. They are no longer regionally concentrated in places like California and New York," said Henry P. Bobo.



Immigration Patterns

- During the past decade, immigration patterns throughout the United States have resulted in families whose members have differing legal status;
- Latino children frequently live in "mixed status" families composed of non-citizen parents and US-born citizen children;
- Roughly 85% of all immigrant families in the United States are of "mixed status."

Source: Granados, Puvvula, Berman, & Dowling, 2001

Challenges of Demographic Changes

- Workforce needs are changing with changing demographics...Are you ready for the next generation?
- Race/Ethnicity: Moving from a majority culture (1995), to diversity (2005), to multicultural (2025)

2005
 Summary Report

California Demographic Futures

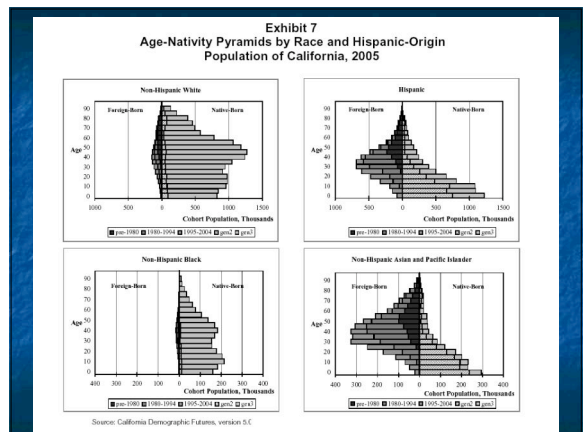
Projections to 2030, by Immigrant Generations,
 Nativity, and Time of Arrival in U.S.

Dorell Myers
 John Pitkin
 Julie Park

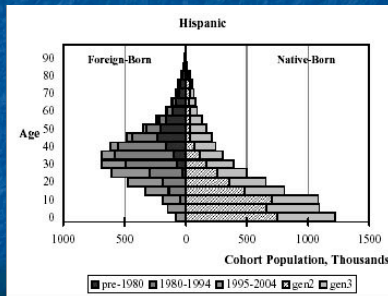
January 2005

School of Policy, Planning, and Development
 University of Southern California

www.usc.edu/schools/spd/research/popdynamics



So, what's in store for us...



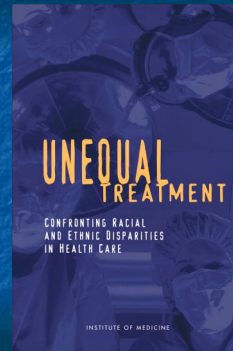
“As many as 40 percent of Hispanic Americans report limited English-language proficiency... most Hispanic Americans have limited access to ethnically or linguistically similar providers.”

Source: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General, 2001

Challenges for the US Workforce

- Insufficient numbers of staff;
- Unsatisfactory skill and proficiency levels;
- Inappropriate training to deal with a changed delivery environment;
- Racial and ethnic diversity;
- Racial and ethnic disparities in access to and quality of care.

Disparities in Health Care



- In 2002 the Institute of Medicine published *Unequal Treatment* which compiled research demonstrating substantial racial and ethnic variation in quality of health care.
- It brought healthcare disparities to the attention of the nation, placing the issue on the forefront of the nation's health policy agenda.

Source: "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care", IOM, 2002

Disparities in Health Care



Distinction Between Health Disparities

- It is important to distinguish between disparities in
 - health status;
 - health care access;
 - quality of health care received; and
 - healthcare outcomes.
- The cause of each of these are likely related, but they are different phenomena.
- Thus, the solutions will likely be different.

Source: La Veist, Isaac, 2006

Factors Related to Disparities in Health Care

Disparities seem to be the end result of a complex set of causal factors that include:

- differential access to care;
- doctor-patient communication barriers and lack of trust;
- limited cultural competence of providers and health care organizations;
- patients' health beliefs and behavior;
- stereotypical thinking and biased decision-making among providers;
- problems with literacy and limited English proficiency; and
- differential access to high-quality hospitals and other facilities.

Source: Smedley, Stith, & Nelson, Eds. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: National Academies Press.

Evidence of Racial and Ethnic Disparities in Healthcare

- Disparities are consistently found across a wide range of disease areas and clinical services.
- Disparities are found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals, etc.
- Disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account.
- Disparities in care are associated with higher mortality among minorities.

Source: Smedley, Stith, & Nelson, Eds. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: National Academies Press.

Disparities for Children of Diverse Racial and Ethnic Groups (1)

- Latino and African American youth identified/referred at same rates as general population, but less likely to receive specialty mental health or meds (*Kelleher, 2000*)
- Latino and African American children have highest rates of unmet need (*Sturm, 2000*)
- Latino and Asian American female teens have highest rates of depression (*Commonwealth Fund, 1997*)

Disparities for Children of Diverse Racial and Ethnic Groups (2)



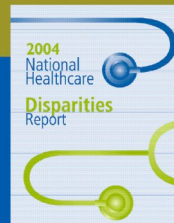
- Minority children tend to receive mental health services through juvenile justice and child welfare systems more often than through schools or mental health setting (*Alegria, 2000*)
- In child welfare, minority youth have poorer outcomes, fewer services, less likely to have plans for family contact and more likely to be in out-of-home placements (*Courtney et al, 1996*).

Rural Disparities



- Rates of mental disorders are similar between rural and urban youth, although limited sampling in rural America
- Exception: Rural adolescents have higher rate of suicide than urban counterparts
- Significantly higher rate among Native American youth
- Child poverty higher in rural areas; children of color at-risk with 41% Latino rural children in poverty


Key Themes from the National Healthcare Disparities 2004 Report



For policymakers, clinicians, health system administrators, and community leaders:

- Disparities are pervasive;
- Improvement is possible;
- Gaps in information exist, especially for specific conditions and populations.

The National Healthcare Disparities 2005 Report

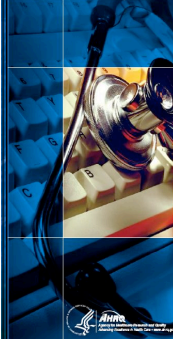


2005 National Healthcare Disparities Report

Tracks disparities in:

- Quality of healthcare:
 - Effectiveness
 - Patient safety
 - Timeliness
 - Patient-centeredness
- Access to care:
 - Facilitators and
 - Barriers to care and health care utilization

Key Themes from the National Healthcare Disparities 2005 Report



2005 National Healthcare Disparities Report

Key themes for policymakers, clinicians, health system administrators, and community leaders:

- Disparities still exist;
- Some disparities are diminishing;
- Opportunities for improvement remain;
- Information about disparities is improving.

“However, this trend has been reversed for Hispanics, where we saw disparities in quality and access to care growing wider in a majority of areas. Only 41 percent of quality disparities were narrowing for Hispanics, while 59 percent were growing larger. The report also indicated that disparities were growing for most measures related to access. For example, the quality of diabetes care declined among Hispanic adults as it improved among white adults. In addition, the quality of patient-provider communication (as reported by patients themselves) declined from among Hispanic adults as it improved among white adults. Access to a usual source of care increased more slowly among Hispanics than among whites.”

Source: Remarks by Carolyn Clancy, M.D., Director of the Agency for Healthcare Research and Quality, The Office of Minority Health National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, January 9, 2006

2005 Disparities Report: How are Hispanics Faring?

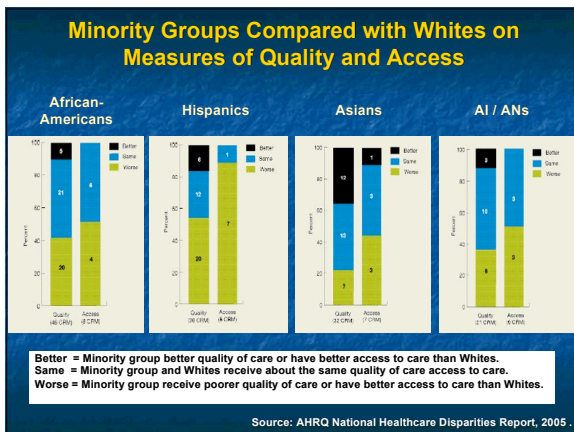


2005 National Healthcare Disparities Report

Access and Quality of Care are NOT Improving for Hispanics

The quality of American health care continues to improve at a modest pace, with health care disparities narrowing overall for many minority Americans.

But for Hispanics, disparities have *widened* in both access to care and quality of care measures.



MAPSS

Mexican American Prevalence and Services Survey (MAPSS)

NIMH: 1R01 MH51192-01

P.I. William A. Vega, Ph.D.
 Robert Wood Johnson Medical School
 University of Medicine and Dentistry of New Jersey

On-Site P.I. Sergio A. Aguilar-Gaxiola, M.D., Ph.D.
 University of California, Davis

MAPSS

RATES OF SERVICE UTILIZATION

- 37.5% of **U.S. born** received care
- 15.4% of **immigrants** received care
- 9% of **migrant agricultural workers** received care

Underutilization of Mental Health Services by Latinos

75-90 % of adult Latinos in need of mental health services fail to access such services

Source: Vega, Aguilar-Gaxiola

Barriers to Services

- Under-recognition of mental health problems
- Referral bias;
- Perceived need for care and expectations
- Cultural and linguistic insensitivity;
- Lack of insurance;
- Immigration patterns;
- Poverty;
- Service cutbacks.

Treatment Dropout and Retention

Latinos are more likely than Non-Hispanic Whites to terminate treatment prematurely, with as many as 60–75% of Latinos dropping out after just one session.

Source: McCabe, 2002

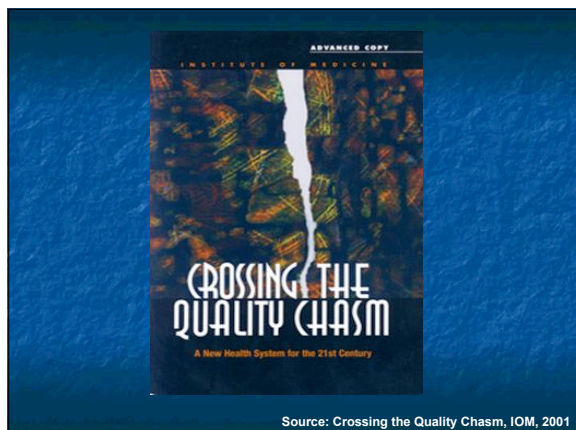
So, what's going on...

Underutilization raises questions about the ability of health systems to provide quality care to a diverse population.

What is quality of care?

The capacity to deliver safe, appropriate, timely, efficient, effective, and equitable treatment

Source: Crossing the Quality Chasm, IOM, 2001

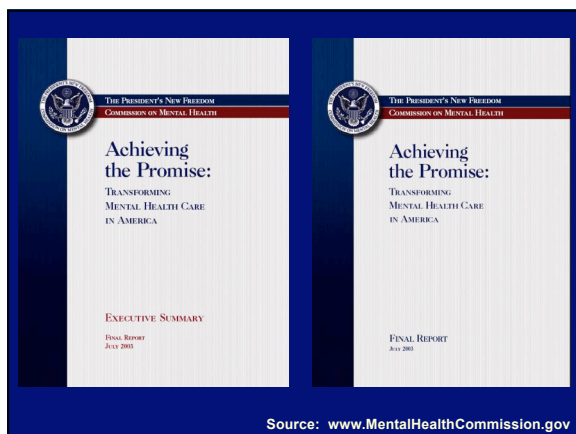


Source: Crossing the Quality Chasm, IOM, 2001

Crossing the Quality Chasm Conclusions

- There are serious problems in quality:
 - Between the health care we have and the care we could have lies not just a gap but a chasm.
- The problems come from poor systems...not bad people:
 - In its current form, habits, and environment, US health care is incapable of providing the public with the quality health care it expects and deserves.
- We can fix it... but it will require changes.

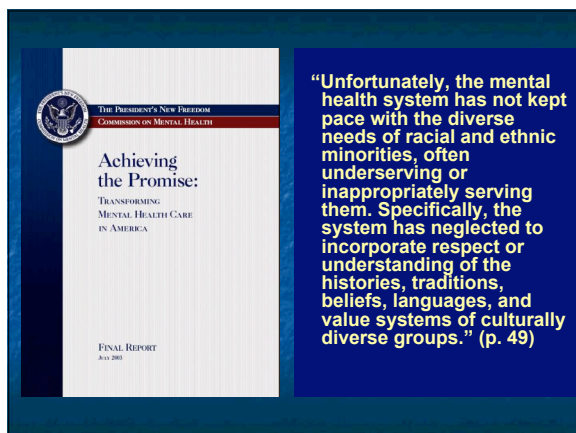
Source: Crossing the Quality Chasm, IOM, 2001



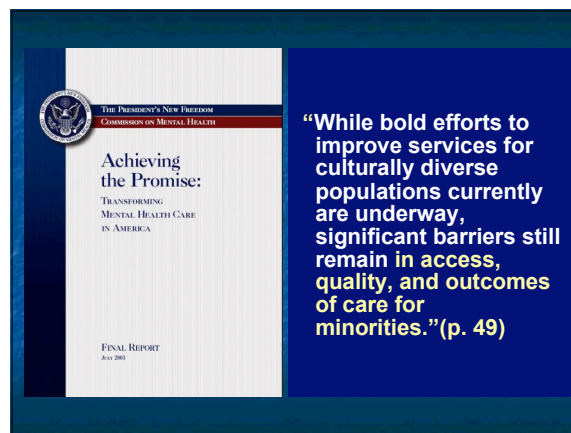
Source: www.MentalHealthCommission.gov

New Freedom Commission Conclusions

- Behavioral health systems in the United States are:
 - fragmented;
 - fraught with barriers;
 - leaving too many people seeking mental health care, with unmet needs.
- This is particularly true for minority populations who are often over represented in our nation's most vulnerable populations.



“Unfortunately, the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups.” (p. 49)



“While bold efforts to improve services for culturally diverse populations currently are underway, significant barriers still remain in access, quality, and outcomes of care for minorities.’’(p. 49)

Aims for National Quality Improvement

- Safety -- As safe in health care as in our homes;
- Effectiveness -- Matching care to science; avoiding overuse of ineffective care and underuse of effective care;
- Patient Centeredness -- Honoring the individual, and respecting choice;
- Timeliness -- Less waiting for both patients and those who give care;
- Efficiency -- Reducing waste;
- Equity -- Closing racial and ethnic gaps in health status.

Source: Crossing the Quality Chasm, 2003; www.nap.edu

What are the obstacles?

- Cost
- Lack of knowledge
- Lack of acceptance by health professionals
- Organizational resistance

Source: Vega, 2005

Three Levels of Change Required

- Changing the care, itself;
- Changing the organizations that deliver care;
- Changing the environment that affects organizational and professional behavior.

Source: Berwick, 2003

Remaining Challenge

- The challenge that remains is the development of indicators, measures, and data to help evaluate performance and improvement over time within these six aims.

Source: Berwick, 2003

Recommendations from the IOM's Unequal Treatment

- Increase awareness of racial/ethnic disparities in health care;
- Collect patient data by race/ethnicity;
- Increase diversity of the health care workforce;
- Integrate cross-cultural education into the training of all current and future health professionals;

Source: Smedley, Slith, & Nelson, Eds. (2002). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Washington: National Academies Press.

What is the Goal of Cultural Competency?

To improve the ability of health care providers to effectively communicate and care for patients from diverse social and cultural backgrounds

Cultural and Linguistic Competence is about improving Quality of Care

Source: Betancourt, 2005

The Need for Cultural Competence in Health Care (1)

- The perception of illness and disease and their causes varies by culture;
- Diverse belief systems exist related to health, healing and wellness;
- Culture influences help seeking behaviors and attitudes toward health care providers;

Source: Cohen & Goode, National Center for Cultural Competence, 1999

The Need for Cultural Competence in Health Care (2)

- Individual preferences affect traditional and non-traditional approaches to health care;
- Patients must overcome personal experiences of biases within health care systems, and;
- Health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system.

Source: Cohen & Goode, National Center for Cultural Competence, 1999

Latent Resistance to Cultural Competence

- It's fluff – minimal clinically relevant content, tokenism for minorities;
- You can't learn cultural competence in a training course, you learn it on your "grandmother's knee";
- No demonstrated effect on cost, patient satisfaction, effectiveness in retention, compliance, medical adherence, or clinical outcomes.

Source: Vega, 2005

Unrealistic Assumptions about Cultural Competence

- It can remedy all disparities in treatment;
- It is easily dispensed in short training sessions;
- Client outcomes can be improved without disturbing "business as usual" such as patient management routines of behavioral health providers;
- It won't cost much money;
- It satisfies the ethical requirement for responsiveness to diversity.

Source: Vega, 2005

Diversity in the Health Care Workforce

Improvements in mental health services aimed at maximizing recovery can only be achieved by a well trained and diverse workforce that is equipped to respond to the unmet mental health needs of diverse consumers.

Why Seek Greater Diversity?

Who Gets the Benefit?



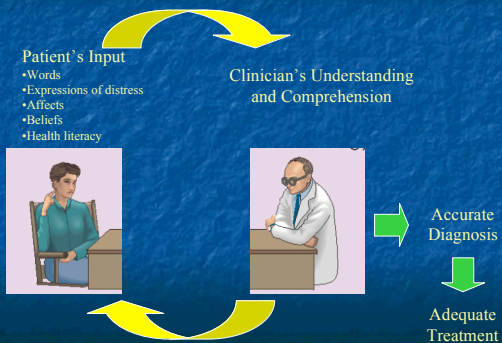
Benefits of Racial and Ethnic Diversity Among Health Professionals

- Racial and ethnic minority health care providers are more likely to serve minority and medically underserved communities, thereby increasing access to care;
- Racial and ethnic minority patients report greater levels of satisfaction with care provided by minority health professionals;
- Racial and ethnic minority health care providers can help health systems in efforts to reduce cultural and linguistic barriers and improve cultural competence.

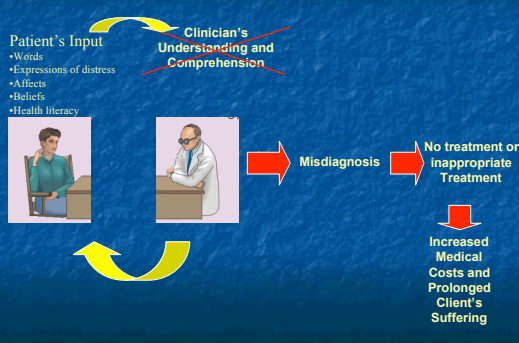
Reducing Disparities in Health Care

Improving Treatment Quality through Culturally and Linguistically Appropriate Care at the Clinical Encounter Level

The Clinical Encounter



The Clinical Encounter



Five Goals for Culturally and Linguistically Educated Health Professionals

- **Self-awareness.** This includes understanding one's own personal cultural values and beliefs and their impact on health and health care delivery.
- **Cross-cultural knowledge.** This includes understanding how beliefs, cultures, and ethnic practices influence health behavior and health status.
- **Language diversity.** This addresses the need to provide or advocate for information, referrals, and services in the language appropriate to the patient as well as the interpreters, when needed.

Source: http://www.dentalpipeline.org/home/697/curriculum_development-behavioral_sciences

Five Goals for Culturally and Linguistically Educated Health Professionals

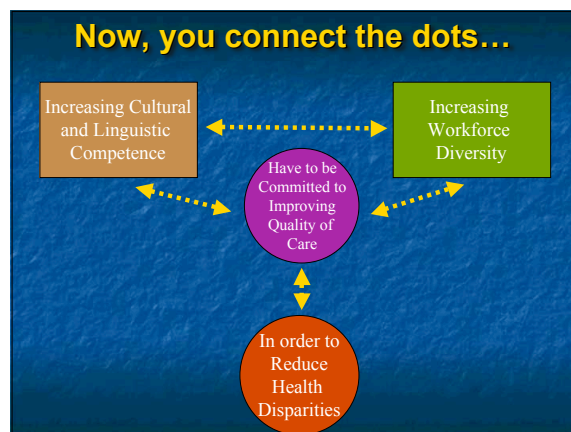
- **Competence to deliver.** The ability to provide culturally and linguistically appropriate and competent services, programs, and interventions that meet the needs of the community of interest.
- **Advocacy.** The willingness to advocate for public policies that promote and support culturally and linguistically responsive services and the inclusion of representation and participation of individuals who reflect the diversity of our communities.

Source: http://www.dentalpipeline.org/home/697/curriculum_development-behavioral_sciences


Keeping it Alive!

- Cultural competence must fit healthcare organizational priorities even while it seeks to change them;
- Must not attach ourselves to the vehicle of “cultural competence” but to the goal of improving quality of care.

Source: Vega, 2005



So, What?



- How is this relevant to what you do?
- How does this information may guide restructuring services and supports for those with unmet needs and who have limited or no access to care?

Call for Action

You are “front line” professionals who would be key to quality of care and helping reduce health care disparities in our current mental health care system.

What do you think that you can realistically do?

Remember, the younger generations are watching what you do!

“WE SHALL HAVE ALL OF ETERNITY IN WHICH TO REST. NOW, LET US WORK” – FOR THEIR SAKE AND OURS

