COMMUNITY-DEFINED SOLUTIONS FOR LATINO MENTAL HEALTH CARE DISPARITIES

CALIFORNIA REDUCING DISPARITIES PROJECT

LATINO STRATEGIC PLANNING WORKGROUP POPULATION REPORT

UC DAVIS CENTER FOR REDUCING HEALTH DISPARITIES

2921 Stockton Blvd, Suite 1400, Sacramento, CA 95817
E-MAIL: CRHD@ucdmc.ucdavis.edu
www.ucdmc.ucdavis.edu/crhd/

Suggested Citation:

Aguilar-Gaxiola, S., Loera, G., Méndez, L., Sala, M., Latino Mental Health Concilio, and Nakamoto, J. (2012). *Community-Defined Solutions for Latino Mental Health Care Disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup Population Report.* Sacramento, CA: UC Davis, 2012.

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ACKNOWLEDGMENTS

This project conducted by the UC Davis Center for Reducing Health Disparities (CRHD) in collaboration with the California Department of Mental Health represents a comprehensive effort to reach out, engage, and collect Latino community voices that have not been previously heard. Through this project, CRHD developed partnerships with historically unserved and underserved Latino communities, community-based organizations, and a group of dedicated and passionate community leaders and advocates—The Concilio (see Appendix 2)—who are serving and understand the needs of the Latino communities. In particular, we thank the individuals who helped to organize and carry out community forums and agencies that hosted our forums. They are:

Forum Facilitators: John Aguirre – NAMI California; Leticia Alejandrez – California Family Resource Association; Sophie Cabrera – El Dorado County Health and Human Services Agency; Benjamin Flores – Ampla Health; Juan García – El Concilio de Stockton; Juan García – Integral Community Solutions Institute; Luis García – Pacific Clinics; Piedad García – County of San Diego Mental Health Services; Jesse Herrera – Monterey County; Manuel Jimenez – Merced County; Maria Lemus – Visión y Compromiso; Roger Palomino – Integral Community Solutions Institute; Hilton Perez – Ampla Health; Erika Reyes – The Wall - Las Memorias Project; Refugio "Cuco" Rodriguez – Santa Barbara County Alcohol, Drug and Mental Health Services; Ricardo Vasquez – Integral Community Solutions Institute; Henry Villanueva – Ventura County Behavioral Health Department; and Richard Zaldivar – The Wall - Las Memorias Project.

County Ethnic Services Managers: Gigi Crowder – Alameda; Piedad García – San Diego; Mario Guerrero – Sonoma; Jesse Herrera – Monterey; Nelson Jim – San Francisco; JoAnn Johnson – Sacramento; Gladys Lee – Los Angeles; Jaime Molina – Santa Cruz; Imo Momoh – Contra Costa; Refugio "Cuco" Rodriguez – Santa Barbara; Luis Tovar – Ventura; Barbara Ann White – Alameda; and Lynda Yoshikawa – San Benito.

Organizations: Ampla Health (formerly Del Norte Clinics, Inc.) – Chico; Barrio Action – Los Angeles; Boys & Girls Club – Salinas; El Centro – Oakland; El Concilio – Stockton; Fresno Center – Fresno; Health and Human Services Agency – San Diego; Pacific Clinics – Arcadia; Placerville Public Library – Placerville,; Spanish Arte – Sacramento; and The Wall-Las Memorias – Los Angeles.

Others: Marina Augusto, Staff Services Manager, and Kimberly Knifong, California Department of Mental Health, Office of Multicultural Services; California MHSA Multicultural Coalition (CMMC); and the African American, Asian/Pacific Islanders, Native American, and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) Strategic Planning Workgroups.

Student Volunteers: Mayra Gutierrez – Student, Cristo Rey High School, Sacramento, California; Mariel Lerma – Student, University of California, Davis; David Patron – Student, University of California, Davis; and Wendy Reyes – Student, Cristo Rey High School, Sacramento.

Special Thank You:

We are deeply grateful and indebted to **Rachel Guerrero**, whose vision, leadership, and advocacy led to the development and initial implementation of the California Reducing Disparities Project. She understood the need for the historically silent voices of California's diverse underserved communities to be heard, and reminded us all about the critical importance of translating those voices into community-defined evidence amenable to change policy and practices in mental health care in California.

We are very appreciative and grateful to **Ambrose Rodriguez,** CEO and founder of the Latino Behavioral Health Institute (LBHI), for his leadership and commitment to this very important project. Ambrose and his team initiated the first three forums and helped set the stage for the rest of the project.

We are most grateful and indebted to **Dr. Katherine Flores,** whose generosity and foresight allowed us to convene the first meeting through funding from the Health Resources and Services Administration (HRSA) U.S. – Mexico Border Centers of Excellence Consortium "Collaborations To Eliminate Disparities: Model Programs That Work" grant. This first meeting culminated in the formation of the Latino Mental Health Concilio of California. Dr. Flores also is a Concilio member and actively participated in the retreats and monthly calls, and made substantive contributions to the work and this report.

We are grateful to **Dr. Nina Wallerstein** for generously meeting with the Concilio members at the inception of this project, and for helping us create a model based on community-based participatory research (CBPR), which guided us throughout this project.

ACKNOWLEDGMENTS

We are also very grateful for the participation of **Yiling Loera,** who most generously volunteered her time to create the Latino Mental Health Concilio website early in the project.

We appreciate the assistance and collaboration of the **UC Davis Clinical and Translational Science Center (CTSC).** Our project was partially supported by the National Center for Research Resources (NCRR), National Institutes of Health (NIH), through grant #UL1 RR024146. The content is solely the responsibility of the authors and does not necessarily represent the official views of NIH.

Finally and most importantly, words alone cannot express our gratitude to the individuals and communities across California who participated in the community forums or *"Mesas de Trabajo"* and focus groups. We are most appreciative of the multitude of Latinos from across California for sharing their valuable time, experience, and wisdom with us, and we hope that they find their voices well represented in this report. Although CRHD staff led the process for drafting and reaching the conclusions and recommendations presented in this report, in many ways the participants figuratively wrote this report. We are forever indebted to these Latino community members for their willingness to share their perspective. Their involvement was an outgrowth of the trust that was developed and the belief that their message would be presented to mental health decision-makers and that their participation will contribute to improvement in access to quality care, reductions in mental health care disparities, and enhancements in the quality of life of Latinos and other underserved populations in California.

EXECUTIVE SUMMARY

On behalf of the California Department of Mental Health (CDMH), we are pleased to present the research results of the **California Reducing Disparities Project (CRDP): Latino Strategic Planning Workgroup (SPW).** This Executive Summary offers a brief background of the CRDP Project, followed by an overview of the research purpose, mental health status of Latinos, key findings, community-identified strategies for improving mental health treatment, and strategic directions and recommendations for reducing health disparities in Latinos.

This project examined mental health disparities for the Latino population. Our aim was to develop and implement the appropriate process for identifying community-defined, strength-based promising practices, models, resources, and approaches that may be used as strategies to reduce disparities in mental health. To accomplish this goal, we adopted a set of topics from the California Department of Mental Health (2009). We also adopted the community-based participatory research (CBPR) framework from Minkler and Wallerstein (2008) to ensure a continuum of community involvement that over time builds and strengthens partnerships to achieve greater community engagement (McCloskey et al., 2011).

Our overall findings suggest that racial and ethnic minority groups in the U.S. fare far worse than their white counterparts across a range of health indicators (Smedley, Stith, and Nelson, 2003). Non-white racial and ethnic groups now constitute more than one third of the population in the United States (Humes, Jones, and Ramirez, 2011), and as the nation's population continues to become increasingly diverse, the passing of the health care reform law (Andrulis, Siddiquui, Purtle and Duchon, 2010) becomes a critical piece of legislation in advancing health equity for racially, ethnically, and sexually diverse populations.

THE CALIFORNIA REDUCING DISPARITIES PROJECT

In order to reduce mental health disparities, improve access and quality of care, and increase positive outcomes for racial, ethnic, LGBTQ, and cultural communities in California, the California Department of Mental Health launched a statewide Prevention and Early Intervention initiative effort utilizing allocations authorized under Proposition 63, known as the Mental Health Services Act (MHSA), to fund the California Reducing Disparities Project. The project focused on five populations: (1) African Americans; (2) Asian/Pacific Islanders; (3) Latinos; (4) Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ); and (5) Native Americans. As part of the project, five Strategic Planning Workgroups (SPWs), corresponding to each population, were created to provide the California Department of Mental Health with community-defined evidence and population-specific strategies for reducing disparities in behavioral health.

The Prevention and Early Intervention (PEI) initiative is key to reducing disparities and risk factors, and building protective factors and skills. The National Research Council and Institute of Medicine (NRC/IOM; 2009) defines "prevention" as programs and services that focus on "populations that do not currently have a disorder, including three levels of intervention: *universal* (for all), *selective* (for groups or individuals at greater than average risk), and *indicated* (for high-risk individuals with specific phenotypes or early symptoms of a disorder). However, it also calls on the prevention community to embrace mental health promotion as within the spectrum of mental health research" (p. 386).

The first activity of the Latino Strategic Planning Workgroup occurred in May 2009 when 15 individuals who are researchers, policy makers, public mental health leaders, consumers and advocates, community health leaders, ethnic services managers, and education professionals attended a one-day meeting. The initial meeting consisted of (1) a presentation and discussion of the overall goals of the Latino SPW; (2) a presentation of the CBPR model as a framework to guide the work of this stakeholder group; and (3) the creation of the California Latino Mental Health Concilio (see Appendix 2 for a list of the Concilio members). The Concilio is a core stakeholder group representing a range of constituencies and various age groups. The Concilio included mental health consumer advocates, ethnic services managers, mental health providers, promotoras, educators, and representatives of a variety of groups, including migrant workers, juvenile justice workers, and LGBTQ individuals. The California Department of Mental Health supplied funding that enabled the University of California, Davis, Center for Reducing Health Disparities (CRHD) to develop the Latino SPW and plan and execute the Latino SPW's objectives and activities. The UC Davis CRHD was selected because of its history in studying and addressing mental health issues among Latinos in California. Moreover, at the meeting, the Latino SPW sought to develop a long-term research and policy agenda to help sustain strength-based strategies for reducing disparities in mental health services for Latinos in California.

EXECUTIVE SUMMARY

MENTAL HEALTH STATUS OF LATINOS

Many foreign-born Latinos entered the U.S. as migrant workers and, after years of hard work, brought their families to settle permanently in this county. However, the immigration process and transition from their country of origin to the U.S. has been difficult for this segment of the Latino population. Most have become susceptible to increased pressures to acculturate and assimilate, and additionally deal with stress from hardship and poverty that often accompany these difficult transitions. As a result of immigrating to the U.S., many Latinos have endured a range of life stressors and experiences (e.g., poor housing, abuse, trauma, stigma, and discrimination) that when left unaddressed and unresolved can lead to mental health problems.

The lack of culturally and linguistically appropriate mental health services (e.g., in the preferred language of clients), compounded by mental health stigma, keeps many Latinos with mental illness from seeking services. A lack of sufficient bilingual and bicultural mental health professionals usually translates into language barriers and often results in miscommunication and misinterpretations. Language is an important factor associated with the use of mental health services and the effectiveness of treatment. Unfortunately, the number of Spanish-proficient providers remains insufficient to meet the needs of Latinos, especially monolingual immigrants. Latinos with limited English proficiency frequently do not have critically important information, such as how and where to seek mental health services. Moreover, language barriers contribute to the problems Latinos face when accessing public transportation to visit mental health clinics and to the difficulties that they encounter with completing required paperwork at clinics.

ACCESS: INDIVIDUAL, COMMUNITY, AND SOCIETAL BARRIERS TO CARE

The central focus of this study was to identify effective, community-defined practices for increasing awareness and access to mental health services and to improve prevention and intervention for Latinos in California. This portion of the report is organized into three major areas: (1) individual-level barriers, (2) community-level barriers, and (3) societal barriers.

Key Finding 1: Study and forum participants saw negative perceptions about mental health care as a significant factor contributing to limited or no access to care. Among the many concerns, stigma, culture, masculinity, exposure to violence, and lack of information and awareness were the most common.

Forum participants reported that limited or no access to mental health services was a significant factor affecting the mental health of the Latino community. The participants also cited barriers to accessing mental health services and identified many causes related to these barriers. The content analysis of the *Mesas de Trabajo* summaries and focus groups generated five major themes related to individual-level barriers: (1) stigma associated with mental health problems, (2) cultural barriers, (3) masculinity, (4) violence and trauma, and (5) lack of knowledge and awareness about the mental health system. We have outlined each barrier, and included quotations to allow the reader to understand the views of the forum participants in their own words.

Key Finding 2: A substantial proportion of the Latino participants believe that limited access and underutilization of mental health services in the Latino community are primarily due to gaps in culturally and linguistically appropriate services, in conjunction with a shortage of bilingual and bicultural mental health workers, nonexistent educational programs for Latino youth, and a system of care that is too rigid.

From the content analysis, four persistent community-level themes emerged throughout the *Mesas de Trabajo*. The themes, which are barriers that contributed to inadequate care and overall poorer mental health and outcomes, included: (1) a shortage of culturally and linguistically appropriate services, (2) a shortage of qualified mental health professionals, (3) a shortage of academic and school-based mental health programs, and (4) structural barriers to care. These four key themes were viewed as common areas of concern in addressing the causes of mental illness, and were considered barriers to accessing and utilizing mental health services.

Key Finding 3: Participants identified social and economic factors as major causes of mental illness and significant barriers to achieving and sustaining wellness among Latinos.

Social determinants of mental health were an overarching theme across all groups. Social determinants refer to the social conditions in which people grow, live, work, and age, and which have a powerful influence on people's health (Commission on Social Determinants of Health, 2007). The content analysis revealed the following three key barriers: (1) social and economic resources and living conditions, (2) inadequate transportation, and (3) social exclusion.

STRATEGIES TO IMPROVE ACCESS TO EXISTING PROGRAMS AND SERVICES

This section of the report identifies and describes strategies that address the issues relating to reaching out and engaging the Latino community in California. Specifically, it focuses on identifying community-defined strategies to improve access, quality of care, and increase positive outcomes for Latinos in California. This portion is organized into two major areas: (1) community and cultural assets, and (2) community-identified strategies for prevention and early intervention programs.

Key Finding 4: Participants identified community assets that promoted the mental health of their communities. Our data indicated that the elements that are critically important in improving access to care consist of five community and cultural assets: (1) individual and community resiliency; (2) family involvement; (3) church and religious leaders; (4) community role models and mentors; and (5) community *Pláticas*.

Community assets and strengths can be understood as the total participation of individuals and community organizations coming together to mobilize and leverage existing community resources to improve access to existing programs. Participants believe that co-locating services is a strategy that can maximize community resources and give families and consumers a voice in their recovery. Co-location is an approach through which community-based organizations collaborate and share resources to better serve the Latino community.

Key Finding 5: Participants recommended that prevention and early intervention can best be achieved by following six strategies: (1) school-based mental health programs; (2) community-based organizations and co-location of services; (3) community media; (4) culturally and linguistically appropriate treatment; (5) workforce development to sustain a culturally and linguistically competent mental health workforce; and (6) community outreach and engagement.

Our data indicated that the practice of co-locating services may play an important role in building a mental health infrastructure that is culturally relevant and comfortable for the Latino community. The participants outlined numerous potential benefits of co-locating services for Latinos. For example, one ethnic services manager (ESM) participant remarked, "Latino families benefit when agencies collaborate and share resources within the community, as opposed to making the consumer come to our agency."

EVALUATION AND OUTCOMES

Key Finding 6: Participants identified four major evaluation areas: (1) reliability and relevance; (2) knowledge and commitment to serving Latinos; (3) consumer and family participation; and (4) accountability panels. Participants perceived these areas as key components to measure and achieve positive outcomes in which Latinos would access mental health services based on the community-defined evidence practices, have high retention rates, and experience high-quality services.

Across all forums, participants emphasized that mental health agencies need to demonstrate commitment to serving Latino communities. In other words, their recommendations suggested that mental health programs receiving funding to serve Latinos and improve mental health disparities for Latinos should be required to produce outcomes that demonstrate increases in access to services, improved retention rates, reduced dropout rates, and increased quality care. One participant recommended linking funding with the number of Latinos served and determining the effectiveness of follow-ups according to the number of consumers who terminated treatment early.

PREVENTION AND EARLY INTERVENTION EVIDENCE-BASED COMMUNITY-IDENTIFIED STRATEGIES FOR IMPROVING MENTAL HEALTH TREATMENT

Core Strategy 1. Implement peer-to-peer strategies, such as peer support and mentoring programs, that focus on education and support services.

Core Strategy 2. Employ family psychoeducational curricula as a means to increase family and extended family involvement and promote health and wellness.

Core Strategy 3. Promote wellness and illness management, and favor community-based services that integrate mental health services with other health and social services.

Core Strategy 4. Employ community capacity-building strategies that promote the connection of community-based strengths and health to improvements in Latino behavioral health outcomes.

Core Strategy 5. Create a meaningful educational campaign that is designed to reduce stigma and exclusion and that targets individuals, families, schools,

communities, and organizations and agencies at the local, regional, and statewide level.

Core Strategy 6. Include best practices in integrated services that are culturally and linguistically appropriate to strengthen treatment effectiveness.

STRATEGIC DIRECTIONS AND RECOMMENDATIONS FOR REDUCING MENTAL HEALTH DISPARITIES

Strategic Direction 1: Academic and School-Based Mental Health Programs

Focus on adolescents and the impact of failing to adequately detect and diagnose potential mental health issues in a timely manner. Schools represent a safe setting to educate families and their children about mental health. Tie mental health programs to academic achievement and performance.

Strategic Direction 2: Community-Based Organizations and Co-Locating Services

Increase collaboration among community-based organizations, schools, and other social services agencies by coordinating and maximizing community resources to achieve an increase in access to treatment among Latinos.

Strategic Direction 3: Community and Social Media

Use mainstream and Latino media to raise mental health awareness with messages that reduce stigma associated with mental health disorders and promote information and resources about early intervention.

Strategic Direction 4: Workforce Development

Develop and sustain a culturally competent mental health workforce consistent with the culture and language of Latino communities.

Strategic Direction 5: Culturally and Linguistically Appropriate Treatment

The key to providing high-quality care and treatment to Latino communities lies in instilling in mental health providers and support staff the importance of communicating with each consumer in a way that acknowledges the consumer's beliefs about mental health.

Strategic Direction 6: Community Capacity-Building and Outreach and Engagement

Provide resources for grassroots community capacity-building strategies that focus on: (1) strengthening outreach and engagement; (2) building behavioral health leadership in the Latino community; (3) defining behavioral health outcomes at the community level and in terms that matter to Latinos; and (4) building local capacity aimed at reducing disparities and improving behavioral health outcomes. The capacity-building strategies should focus on convening and developing partnerships amongst mental health professionals and the indigenous community leaders to develop and strengthen their relationships. Through these partnerships, they should collaboratively implement strategies highlighted in this report and continue to develop ways in which they can act together to reduce disparities and improve behavioral health outcomes. In addition, resources should be allocated to create partnerships between community leaders associated with local capacity-building efforts and existing statewide leadership within the Latino behavioral health field to develop strategies to support local community capacity-building and implementation of the recommendations outlined in this report. Resources should be allocated to convene local and statewide leaders to educate them about the SPW recommendations and to disseminate them through a summit, educational campaigns, and other activities to best meet the needs of the Latino community.

Strategic Direction 7. Embedding the Recommendations from this Report into All MHSA Funded Programs

Encourage counties to adopt and implement the recommendations from this report to ensure that Latinos and other diverse underserved communities gain proportional access to MHSA programs.

Despite many commonalities across the various Latino groups, the existence of cultural, linguistic, educational, and socioeconomic differences sometimes requires classification of Latinos into sub-populations for investigative purposes. Distinguishing among Latino subgroups from different regions and examination of their demography, history, culture, and views on mental health are important for future research. Health professionals and researchers should not attempt to characterize all Latinos as one homogenous group and ignore between and within-group heterogeneity. Therefore, strategies and recommendations for providing mental health care for Latinos must not be based on a "one size fits all" recipe (Aguilar-Gaxiola, Sribney, Raingruber, Wenzel, Fields-Johnson, and Loera, 2011; Aguilar-Gaxiola and Ziegahn, 2011; Willerton, Dankoski, and Martir, 2008).

Chapter 1

Introduction

A major challenge for today's health care system across the nation is the rapid growth in the number of individuals who are racial or ethnic minorities. Non-white racial and ethnic groups now constitute more than one third of the population in the United States (Humes, Jones, and Ramirez, 2011) and are projected to comprise 54% of the U.S. population by 2050 (U.S. Census Bureau, 2008). Racial and ethnic minority groups (i.e., African Americans, Asians, Latinos, Native Americans, and Pacific Islanders), in conjunction with sexual minority groups (i.e., lesbian, gay, bisexual, transgender, and questioning [LGBTQ]), transition-age youth, older adults, and persons with disabilities constitute a large segment of the U.S. population and are typically underserved in terms of accessing and utilizing health and mental health care services. To resolve the inability of increasing numbers of individuals from underserved populations to gain access to health care, health care workers and clinicians will have to be trained and educated so that they have an understanding of all health care consumers' cultures and life experiences (Anand and Lahiri, 2009; Dixon, Lewis-Fernandez, Goldman, Interian, Michaels, and Crawford, 2011). At present, a gap between policies and evidence-based mental health practices designed specifically for racial and ethnic minorities has resulted in a lack of innovative strategies that focus on prevention and early intervention for these groups. In response to this gap, the California Reducing Disparities project was established to provide the California Department of Mental Health with community-defined evidence and population-specific strategies for reducing disparities in behavioral health. The Latino Strategic Planning Workgroup (SPW) sought specifically to identify strategies for the Latino population in California.

Community-Defined Evidence ractices are defined as "A set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community."

—*Community Defined Evidence Project Work Group, 2007*

BACKGROUND ON THE LATINO POPULATION IN THE U.S. AND CALIFORNIA

The term *Latino* often is used in reference to a variety of backgrounds (e.g., people from Cuba, Mexico, Puerto Rico, South or Central America, or other Spanish culture or origin) and includes variance in immigration histories and other factors such as generational and socioeconomic status (SES) differences. Since 2000, the nation's largest segments of the Latino population have consisted of individuals with Mexican (64%); Central and South American (14%), most notably Salvadorian, Guatemalan, and Colombian; Puerto Rican (9%); Cuban (3.5%), and Dominican (2.7%) ancestry (U.S. Census Bureau, 2010). In addition, foreign-born Latinos comprise 6% of the total U.S. population (Grieco, 2010).

California's population is the most diverse in the United States and the world, and consists of immigrants from more than 60 different countries (Public Policy Institute of California, 2007). Estimated at 14 million or more than 37.6% of the nation's population, Latinos constitute the single largest racial or ethnic group in California and are increasingly shaping the demographic makeup of the state (Pew Hispanic Center, 2010; U.S. Census Bureau, 2010). More than half (53%) of California's elementary children are now of Latino origin (California Department of Education, 2012).

By 2050, Latinos will constitute 52% of the 60 million California residents, according to estimates from the California Department of Finance (2010). Latinos are the majority of the population in nine counties in California: Imperial, Monterey, San Benito, Fresno, Madera, Merced, Kings, Tulare and Colusa (Lin, 2011). They are also the majority of the population in 16 California cities and neighborhoods: Anaheim (53%), Chula Vista (58%), Downey (70.7%), El Monte (69%), Fontana (67%), Inglewood (51%), Moreno Valley (54%), Norwalk (70%), Ontario (69%), Oxnard (73.5%), Palmdale (54%), Pomona (71%), Salinas (75%), San Bernardino (60%), Santa Ana (78.2%), and West Covina (53%) (Lin, 2011).

The overwhelming majority of Latinos in California (82%) are of Mexican descent (Grieco, 2010). Mexicans are the largest segment of the Latino population that has immigrated to California. For example, between 2000 and 2010 four million (33%) Mexican people came to the U.S with 2.8 million (70%) coming to California (Camarena, 2011). According to Hayes-Bautista (2004), immigrants from Mexico have been migrating to California in large numbers for more than 150 years. In addition, significant numbers of Latinos from Central America, South America, and the Caribbean are immigrating to California (Pew Hispanic Center, 2010.

MENTAL HEALTH STATUS OF LATINOS

Many foreign-born Latinos entered the U.S. as migrant workers and, after years of hard work, brought their families to settle permanently in this country. However, the immigration process and transition from their country of origin to the U.S. has been difficult for this segment

of the Latino population. Most have become susceptible to increased pressures to acculturate and assimilate, and additionally deal with stress from hardship and poverty that often accompany these difficult transitions (Alegria, Canino, Rios, Vera, Calderon, and Rusch, 2002; Kouyoumdjian, Zamboanga, and Hansen, 2003). As a result of immigrating to the U.S., many Latinos have endured a range of adverse experiences (e.g., poor housing, abuse, trauma, stigma, and discrimination) that when left unaddressed and unresolved can lead to mental health problems (Kanel, 2002).

While other major mental health disorders, including schizophrenia and bipolar disorder, exist for Latinos, depression continues to be the biggest concern and a leading cause of disabilities among major ethnic and racial groups in the United States (McKenna, Michaud, Murray, and Marks, 2005), especially Latino youth. Latino youth face numerous stressors that may increase the risk of mental health problems (Centers for Disease Control and Prevention [CDC], 2004; Portes and Rumbant, 2001). For example, Cervantes, Zarza, and Salinas (2007) found that stress among Latino youth was manifested in mental health problems that included anxiety and depression, and eventually led to substance abuse or suicide. William Vega, professor and executive director of the Edward R. Roybal Institute on Aging at the University of Southern California, makes the case for the focus on Latino youth when he says, "Examining the Latino youth, especially transition-age youth in the system, and failing to provide continuation of services, will lead to substance abuse and the exacerbation of behavioral disorders and problems, and eventually prison and higher costs in health care" (personal communication, December 16, 2011).

In a landmark study that examined lifetime prevalence of psychiatric disorders among urban and rural Mexican-origin Latinos in California (Vega, Kolody, Aguilar-Gaxiola, et al., 1998), the authors found that nativity or country of origin was associated with mental health outcomes. For Mexican immigrants, rates of mental disorders were lower than for those who were born in the U.S. (Vega et al., 1998). Their study further found that rapid assimilation to American culture was associated with negative mental health outcomes. Newly arrived immigrants have better mental health than U.S.-born persons of the same age—a phenomenon termed the "immigrant paradox." However, as immigrants reside longer in the U.S., the protective social and cultural factors from their country of origin wear off. For Mexican immigrants, rates of mental disorders increase according to time in the U.S.; individuals living in the U.S. longer than 13 years have higher prevalence rates than those living in the U.S. less than 13 years (Vega et al., 1998). The decline in health status of immigrants over time in the U.S. is associated with higher social acculturation, including changes in lifestyle, cultural practices, increased stress, and adoption of new social norms (Alegria, Chatterji, Wells, Cao, Chen, Takeuchi et al., 2008). Alegria and colleagues (2008) found this trend to be more evident with Mexican immigrants and less apparent in other immigrant Latino groups such as Puerto Ricans.

UTILIZATION OF MENTAL HEALTH SERVICES BY LATINOS

Current disparities in mental health care for Latinos are severe, persistent, and well documented (Alegria, Mulvaney-Day, Torres, et al., 2007; Alderete, Vega, Kolody, and Aguilar-Gaxiola, 2000; Vega, Kolody, Aguilar-Gaxiola, et al., 1999; Woodward, Dwinell, and Arons, 1995). Latinos have less access to mental health services than do whites, are less likely to receive needed care, and are more likely to receive poor quality care when treated. The reasons range from poor access and quality of care, limited insurance coverage, ineffective communication between provider and patient, patients' lack of trust, doctors' assumptions about the distribution of disease and their inability to perceive severity among minorities, and low minority representation in the workforce (with implications for health insurance coverage).

Research findings from the Mexican American Prevalence and Services Survey (MAPSS; Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano, and Caraveo-Anduaga, 1998) indicate that even more dramatic disparities in mental health care exist for Mexican-Americans compared to other Latino subgroups or other ethnic minorities. Only about one in four (27%) Mexican-origin adults who had one or more psychiatric disorders in the past 12-months receive any kind of service (this includes services performed by mental health providers, general medical providers, counselors and other professional providers, and informal providers such as *curanderos* [folk healers] and *sobadores* [masseurs]). This means that approximately three out of four Mexican-origin Latinos (73%) who have a diagnosable mental disorder and who need services remain untreated (also called the "treatment gap"). The problem of underutilization is even higher in Mexican immigrants. According to the MAPSS study, 85% of Mexican immigrants who needed services remained untreated (Vega, Kolody, Aguilar-Gaxiola, et al., 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 counseling obtain services). Research has repeatedly shown that members of this population receive no care unless they are extremely dysfunctional or a danger to themselves or others (Vega, Kolody, and Aguilar-Gaxiola, 2001). This inequity often is a result of barriers that can best be understood as problems related to accessibility, availability, appropriateness, affordability, and advocacy, briefly describe below.

Accessibility: The physical geographic isolation and dispersion of Latino subgroups such as migrant workers often results in a lack of service opportunities. For example, farmworkers often labor far longer than the eight-hour workday, leaving little time at the end of the day to obtain health care even if badly needed. Migrant workers are reluctant to take time off work for health care because any interruption of the workday decreases their income and consequently their livelihood.

Availability: The critical shortage of mental health facilities and general practitioners and specialized providers, especially in rural (and some urban) areas, has repeatedly been identified as a major problem (Badger et al., 1999; National Advisory Committee on Rural Health, 1992, 1993; Rost, Williams, Wherry and Smith, 1995). The scarcity of professionals in rural areas creates the need for health providers to be self-contained, comprehensive, and capable of managing all the biopsychosocial problems of their patients (Bray and Rogers, 1995). Long waits for appointments with mental health specialists pose additional barriers (Lambert and Hartley, 1998). Equally, Latinos in general and migrant workers in particular need services during non-conventional hours of operation.

Appropriateness: Researchers have found that availability of culturally relevant services increased Latinos' service utilization and treatment effectiveness (Rogler, Malgady, Costantino, and Blumenthal, 1987; Curtis, 1990). To understand the appropriateness of mental health services for ethnic minorities, special concerns must be considered with regard to compatibility between the patient and therapist, mutual trust, and therapeutic efficacy. Sue (1977) suggested that the lack of mental health services responsive to the needs of ethnic minorities is one of the strongest predictors of underutilization. Providers' communication style (Sheppard, 1993) and cultural competence have been found to influence patients' retention in treatment. The quality of the patient-therapist interaction, as perceived early in treatment by patients, is a better predictor of treatment outcome than is the therapeutic strategy employed. Speaking the language of a client is a key aspect of mental health treatment; yet, many mental health professionals assume that speaking the language equates to cultural competence (Guarnaccia and Rodriguez, 1996). In a case study of miscommunication between two Spanish speakers in a mental health setting, a paranoid Hispanic client described delusions about people she thought were following her as *estaban trabajando commigo,* which translated means "they were working with me." The therapist, who spoke Spanish but lacked cultural and linguistic competence, missed the double meaning of *trabajo,* which translated can mean work-occupation or work-spirit. He responded "En que trabajabas?" which translated means "What was your work?" (Guarnaccia and Rodriguez, 1996). Many Latinos and especially migrant workers are reluctant to use specialty mental health services because of the stigma attached and concerns about their immigration status (Wagenfeld, Murray, Mohatt and DeBruyn, 1994; Lambert and Hartley, 1998; Badger et al., 1999; Vega et al 2001; Vega et al., 1985). Many are reluctant to recognize their problems as psychiatric and do not want treatment that focuses on psychiatric symptoms (Hauenstein and Saby, 1996). Many migrants experience discomfort in discussing mental health problems with a therapist (Vega et al., 2001). The low availability of culturally competent or ethnically matched mental health professionals compounds this problem.

Affordability: Even though mental health services are usually available to those who need them at adjustable rates or free of charge (Stefl and Prosperi, 1985), cost of treatment has been found to be a significant barrier in mental care (Stefl and Prosperi, 1985). Therefore, the availability of health-care coverage is a salient issue. Statistics show that Mexican-Americans are the least-insured ethnic group in the United States. However, the research is inconclusive about the relationship between insurance and mental health care. Some studies have found a positive correlation between having health insurance and the likelihood of receiving ambulatory mental health services (Cunningham, Henggeler, and Pickrel, 1996). Peifer, Hu, and Vega (2000), however, reached a contrary conclusion—that health insurance availability was not significantly related to seeking mental health services. Further research is needed to discern the effect of insurance on mental health care for Mexican-Americans. Two fifths of Fresno county residents who claim Mexican ancestry have no health insurance. Insurance coverage rates are even lower among migrant workers (Vega, et al., 2001). Migrant farmworkers have more difficulty accessing Medicaid benefits than any other population in the country (National Advisory Council on Migrant Health, 1995). Farmworkers must apply for Medicaid within the state where they reside, and benefits cannot be transferred between states. Workers often move on to another state in search of employment before eligibility can be established. Even if they have Medicaid coverage, farmworkers have difficulty locating providers who will treat them (Napolitano and Goldberg, 1998).

Advocacy: Many Mexicans and Mexican-Americans do not know where to find these services (Vega et al., 2001). Fortunately, studies have shown that knowing where to find a provider significantly increased the likelihood of using a specialty mental health service.

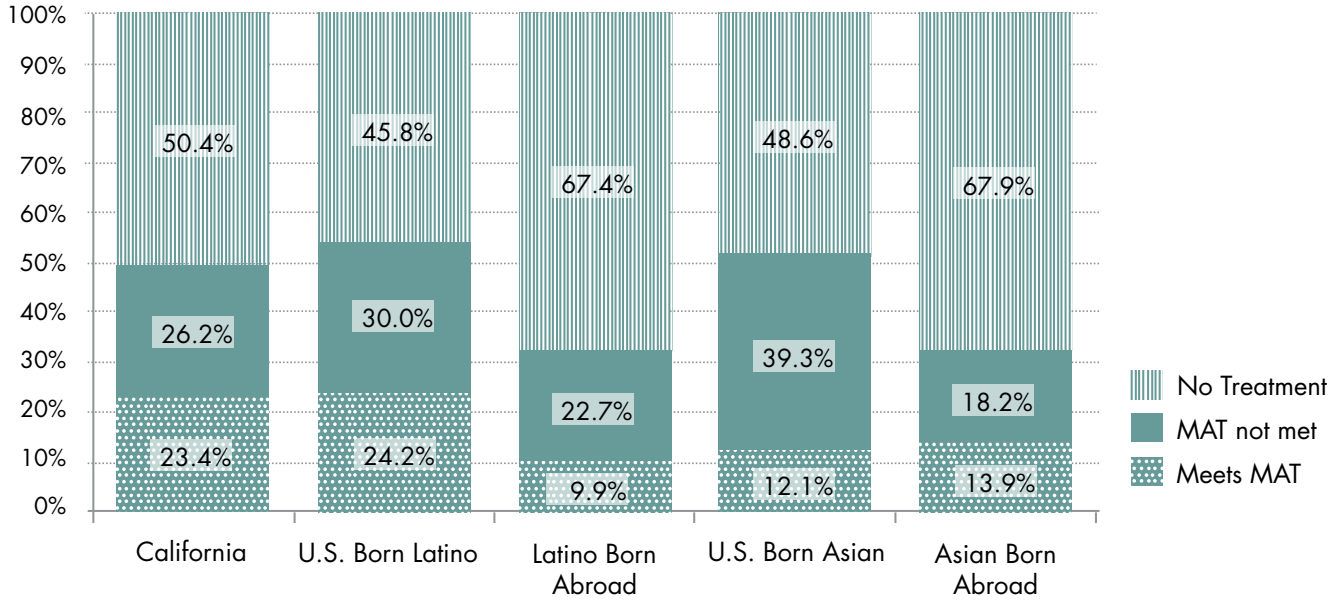
When Latinos obtain services for mental health disorders, they are significantly more likely than other clients to receive them in primary care settings rather than in

specialized settings, which is probably related to their underutilization of mental health care (Vega, Kolody, Aguilar-Gaxiola, and Catalano, 1999). The penetration rate is a frequently used measure that provides information about the amount of mental health services used by those eligible, such as those already enrolled in the Medi-Cal program. According to the California Department of Mental Health's report titled *Adult Mental Health Needs in California: Findings from the 2007 California Health Interview Survey* (CHIS; Grant, Padilla-Frausto, Aydin, Streja, Aguilar-Gaxiola, and Caldwell, 2011), utilization differs by nativity status. The authors found that approximately one quarter (24.2%) of U.S.-born Latinos received minimally adequate treatment for their mental health needs. In contrast, only 10% of Latinos born abroad, 12% of U.S.-born Asians and 14% of Asians born abroad received treatment that met the requirements for minimally adequate treatment, less than half the statewide rate (see Exhibit 1). The difference between U.S.-born Latinos and the other three groups were all statistically significant.

INTEGRATION OF MENTAL HEALTH SERVICES AND PRIMARY HEALTH CARE

The landmark U.S. Department of Health and Human Services (DHHS) report titled Mental Health: A Report of the Surgeon General (DHHS, 1999), followed by a 2001 report titled Report of a Surgeon General's Working Meeting on the Integration of Mental Health Services and Primary Health Care (DHHS, 2001), and more recently Collins (2009) all came to the same conclusion: development of partnerships among primary health care providers, local mental health practitioners, and community-based organizations as a model to appropriately move consumers across the continuum of care is critically important. Because primary care often is the initial point of contact for health problems, primary care providers play a central role in creating a system of care that prevents and treats illnesses, promote wellness, and reduces stigma associated with mental health services (Chapa, 2004; National Institute for Health Care Management [NIHCM], 2009). Findings from previous research (Katon, Lin, and Kroenke, 2007; Scott, Bruffaerts, Tsang et al., 2007) indicated that a majority of primary care consumer visits were related to mental health needs but rarely identified as mental disorders. For example, 75% of health care consumers with depression report physical complaints as a reason for seeking health care (Unützer, Schoenbaum, Druss, and Katon, 2006).

Exhibit 1: Prevalence of Minimally Adequate Treatment (MAT) by Nativity Status, Adults 18 and over, CHIS 2007



Source: California Department of Mental Health; California Health Interview Survey (CHIS), 2007.

A Robert Wood Johnson Foundation (2011) study found that 76% of physicians surveyed support a health care system that would pay for costs associated with connecting low-income health care consumers to services that address their unmet social needs (e.g., food, housing, transportation, unemployment). For Latinos, this is a relevant finding; if primary health care is their point of contact for mental health concerns, but they are unable to use primary health care because of unmet social needs, then how many low-income Latinos refrain from seeking mental health services? In other words, traditionally low-income Latino families do not have the resources, nor can they afford to take time off from work to seek treatment for their health issues. Members of these Latino families must weigh the cost of a doctor's visit with buying groceries or paying bills. Low-income Latino families commonly wait until a family member is very sick before seeking medical care. Dr. Katherine Flores, a family physician in Central California, wrote, "Many [Latino health care consumers] may never access the mental health care system, as the primary care provider either manages it, or the consumer stops seeking services beyond that—they often don't realize that they started (or ended) their mental health journey with their family physician or at the community health center's primary care provider's visit" (personal communication, February 21, 2012). She also emphasizes the importance of paying careful attention to building the skill set of primary health care providers so that they can recognize and manage care of mental illnesses and improve referrals and coordination of care with mental health care providers. Building on the notion of a continuum of integrated service model (NIHCM, 2009), co-location of mental health providers in primary care settings is an integrated approach to conduct both primary health care and mental health treatment for Latinos by providers in the same treatment location. This integrated approach offers the largest potential payoff in reduction of morbidity and mortality, and increased cost-effectiveness of care (Blount, Kathol, Thomas, et al., 2007). This integration model is aligned with the current provisions of the Affordable Care Act, which favors integrated health services delivery.

BARRIERS RELATED TO ACCESS AND UTILIZATION OF MENTAL HEALTH CARE FOR LATINOS

Numerous barriers prevent Latinos from accessing and utilizing mental health care services. One frequently studied barrier to mental health care among Latinos is stigma. Latinos fearing stigma are less likely to acknowledge their condition and more likely to avoid treatment (Vega, Rodriguez, and Ang, 2010) out of concern of being judged or victimized by discrimination. Vega and his colleagues also report that stigma is associated with lower quality of care, especially for Latinos who suffer from depression. A study (Barrio et al., 2008) that examined the unmet mental health needs of Latino older adults found that this population was hesitant to use mental health services because of fear of being labeled as mentally ill. According to the California Department of Mental Health's 2009 report titled *California Strategic Plan on Reducing Mental Health Stigma and Discrimination,* the three major types of stigma associated with mental health that affect the lives of people and their communities are (1) public stigma, (2) institutional stigma, and (3) self-stigma. Public stigma occurs when attitudes and feelings expressed by the general public have a negative impact on people living with mental illness and their family members. Institutional stigma results from education, health care, employment, and other organizations and social systems functioning in a culture of policies and practices that reinforce negative attitudes and behaviors about mental illness. Finally, self-stigma is the effect of individuals internalizing the negative attitudes and beliefs that society, community, or groups of people perpetuate. All three types of stigma can discourage people from seeking treatment for their mental health condition.

Evidence supports the notion that the social environment in which Latinos live plays a major role in shaping their views and decisions about mental health. According to Refugio "Cuco" Rodriguez, ethnic services manager for Santa Barbara County, "Latinos are less likely to voluntarily seek help than non-Latino groups, and if they do seek help it is frequently when their condition has reached a crisis or chronic level" (personal communication, November 1, 2011). He also emphasizes that only a small percentage of Latinos who do come in contact with clinical services continue treatment for long periods of time. Although the reasons why some Latinos continue treatment have not been ascertained systematically, research shows that poor outcomes and an increased dropout rate result when Latinos feel misunderstood and experience distrust due to fear of stigma, fear of deportation, and fear of shame (Falicov, 1998, 2009). However, acknowledging and integrating cultural values or cultural family preferences in treatment can increase the motivation for engagement, retention, and collaboration of Latino consumers and result in positive outcomes (Falicov, 2009; Garza and Watts, 2010).

"Latinos are less likely to voluntarily seek help than non-Latino groups, and if they do seek help it is frequently when their condition has reached a crisis or chronic level."

—Latino ethnic services manager

The lack of culturally and linguistically appropriate mental health services (e.g., language skills) discourages many Latinos with mental illness from seeking services. Data from the 2005 California Health Interview Survey (CHIS; Chen, Diamant, Pourat, and Kagawa-Singer, 2005) revealed that foreign-born Latinos reported significantly lower rates of services use (18%) compared to U.S.-born Latinos (37%), and suggest that these barriers may be more prevalent for foreign-born Latinos. A shortage of bilingual and bicultural mental health professionals usually translates into language barriers, and often results in miscommunication and misinterpretations (Schwarzbaum, 2004). According to Falicov (2009), language proficiency is a crucial element by which mental health providers can establish meaningful connections with Latino consumers and avoid causing acculturative stress for families. Other studies have indicated that Latinos prefer language to ethnic matching when seeking mental health services (Folsom, Gilmer, Barrio, Moore, Bucardo, Lindamer et al., 2007; Griner and Smith, 2006). In other words, language is an important aspect associated with the use of mental health services and the effectiveness of the treatment. Unfortunately, the number of Spanish-proficient providers remains insufficient to meet the needs of Latinos, especially monolingual immigrants (Barrio et al., 2008; Falicov, 2009). Language also can be a barrier for Latinos, especially Latinos with limited English proficiency, in terms of awareness and knowledge about mental health services available to them (Benz, Espinosa, Welsh, and Fontes, 2011). Latinos with limited English proficiency frequently do not have critical information, such as how and where to seek mental health services. Moreover, language barriers contribute to the problems Latinos face when accessing public transportation to visit mental health clinics and to the difficulties that they encounter with completing required paperwork at clinics (Barrio et al., 2008; Kouyoumdjian, Zamboanga, and Hansen, 2003).

Individual and institutional practices related to the cultural deficit perspective also may constitute a barrier for Latinos seeking to access and utilize mental health services. Researchers (e.g., Gándara, 1995; Valencia, 1997) have conducted extensive work on the harm that a cultural deficit perspective has exerted on Latino youth with respect to their poor academic achievements. They argue that this perspective takes the position that Latino students and families are at fault for poor academic outcomes. Cultural deficit practices emphasize deprivation in Latino communities (Yosso, 2005). Deficit thinking is also common in mental health care. This perspective is used when interpreting the causes for why Latinos do not access or utilize mental health services. In other words, some individuals operate under the assumption that Latinos simply do not know how to access or do not want to utilize services. Henry Villanueva, the quality assurance manager for the Ventura County Behavioral Health Department, argues that, "All resources must be relevant to the Latino community to avoid making excuses for why services aren't accessed" (personal communication, November 1, 2011). Mental health care providers must challenge the cultural deficit perspective and recognize that systemic and institutional structures continue to impede improvements in access and quality of care for the Latino individual, family, and community.

> **"All resources must be relevant to the Latino community to avoid making excuses for why services aren't accessed."**
>
> *—Latino community leader*

SOCIAL DETERMINANTS OF MENTAL HEALTH FOR LATINOS

Social determinants refer to the social conditions in which people grow, live, work, and age, and which have a powerful influence on people's health (Commission on Social Determinants of Health, 2007). A great deal of research has been conducted on social and economic factors, such as poverty, social exclusion, diminished social networks, discrimination, stress, accessibility to health care, and stigma, that affect individuals' health throughout their lives (e.g., Braveman, Egerter, and Mockenhaupt, 2011; Frieden, 2010; Wilkerson and Marmot, 2003). This research indicates that good health is grounded in a strong social and economic foundation that enables people to play a meaningful role in the social, economic, and cultural life of their communities. Furthermore, health disparities tend to reflect the underlying social and economic inequalities in society. Underserved and marginalized populations, such as Latinos, tend to lack the necessary resources to participate in the social and economic fabric of society (Woodward and Kawachi, 2000). As a result, social and economic factors combined with institutional discrimination are among the most important causes of restricted access to quality mental health care for Latinos. We believe that identifying innovative strategies that utilize individual, community, and systemic approaches would encourage new ways of thinking and providing care. These innovative strategies would help counteract the social determinants of unequal access to health care and improve quality of life for Latinos in California.

FUTURE OF AGING LATINOS IN THE FACE OF SOCIAL EXCLUSION

The aging population is a major trend shaping the 21st century, due in large part to increased longevity (Fahs, Cabin, and Gallo, 2011). One manifestation of longevity is a growing demand for special care facilities; another is that diseases become long-term and chronic, resulting in higher costs for services and more time in treatment (Cohen, 2012). The longevity among Latinos in the U.S. population has increased steadily for decades. Latinos' average life expectancy exceeds that of all Americans, despite their significantly lower education and income levels (Arias, 2011, as cited in Vega and Gassoumis, 2011).

One of the factors associated with depression and suicide among older Latinos is social isolation and loneliness (Barrio et al., 2008). For example, in 2011, Yurina Melara of *La Opinión* introduced us to 64-year-old María Barrera and her experience with isolation that led to major depression and an attempt to end her life. According to Maria, she felt excluded from society, felt unloved, and she saw no reason to continue living. This is not unique to María, according to the National Institute of Mental Health (2012); depression and suicide rates among Latinos stand at close to 18%. In a recent study by Castillo, Lloyd, and Aguilar (2012) on older Latinos and African Americans in low- and middle-income Los Angeles communities, 11% of participants living alone reported "poor" mental health. For María, finding local solutions and playing an active role in her treatment have been fundamentally important in her ability to manage her illness. Her experience is in agreement with Vega and González (2012), who emphasized that failure to focus on finding a local solution to better serve the low-income older Latino population will result in the complete collapse of aging care. Social isolation is a major problem and potential threat for low-income older Latinos.

LATINO CULTURAL VALUES THAT IMPACT MENTAL HEALTH CARE

Researchers (Añez, Paris, Bedregal, Davidson, and Grilo, 2005; Garza and Watts, 2010) emphasized three Latino cultural values that have the greatest potential to influence the delivery of mental health services to Latinos: (1) *familismo,* (2) *respeto,* and (3) *personalismo.* Each of these three cultural values, which are explained below, should be integrated within effective prevention and early intervention models for Latinos. Recognizing cultural differences among individuals from all walks of life and transforming the service delivery culture to match the cultural perspective of the mental health consumer are critically important to the consumer's quality of care and wellness (Hughes, 2008). Cultural values also are closely related to acculturation (Bhatia and Ram, 2001). We agree with Maldonado-Molina, Reyes, and Espinosa-Hernández (2006), who contend that acculturation levels and strategies must be examined to assess changes as individuals, families, and communities interact with the mainstream culture over time. It is essential to stress that changes in cultural values may vary as a function of acculturation.

Familismo (family) is the cultural value that focuses on the contribution of the extended family. Improvements in individuals' outlook on life and health have resulted from intervention models that account for *familismo* by focusing on family cohesion (Garza and Watts, 2010; Hill, Bush, and Roosa, 2003). A strong sense of *familismo* actually may contribute to individual and family wellness because family members have a sense of responsibility to participate in a treatment program.

In addition, *respeto* (respect) is the cultural value that refers to the mutual regard that develops between Latino consumers of mental health and their providers. Taking into account *respeto* requires mental health providers to work with an understanding of the hierarchical system within Latino families (Garza and Watts, 2010). According to Luis García, vice president of Latino Program Development for Pacific Clinics, "A relationship with a Latino family can be established and nurtured by simply respecting the gender hierarchical structure, especially the male role as the influential figure of the family" (personal communication, November 30, 2011). Failing to understand the hierarchical system can lead Latino consumers to feel disrespected and be more likely to terminate treatment. Furthermore, Latinos place a high value on respecting their elders and authority. Mental health providers who are working with Latinos and wish to ensure compliance with treatment and retention have a crucial responsibility to be aware of the value that Latinos place on respecting authority.

Finally, *personalismo* is the cultural value that relates to the importance of close personal relationships. Zayas and colleagues (1997) emphasized that providers should engage in a more personal style of relating to Latino families. Other researchers found that incorporating a person-centered approach that emphasizes empathy, warmth, and attentiveness and that uses titles of respect (e.g., *señor* and *señora*) and physical proximity—such as a hand on the shoulder to show concern—helps build strong relationships (Flores, Abreu, Schwartz, and Hill, 2000; Santiago-Rivera, Arredondo, and Gallardo-Cooper, 2002). Overall, *personalismo* must be genuine to be effective when working with Latinos. Having a sense of being understood and valued as consumers of mental health care increases Latinos' positive experiences with the mental health system and will help them achieve positive outcomes (Garza and Watts, 2010).

In sum, treatment that creates an environment in which the Latino consumer experiences all three of the aforementioned core Latino cultural values (*familismo, respeto,* and *personalismo*) will translate into *confianza* (trust), which is strongly associated with involvement and treatment compliance (Garza and Watts, 2010). For Latinos, trusting their therapist is of critical importance in establishing a therapeutic relationship, and in following through with and adhering to treatment. In addition, acknowledging the between- and within-subgroup heterogeneity in the Latino culture in relationship to acculturation levels is essential to gain a unique understanding of Latino subgroups' perceptions of mental health and treatment. Finally, for non-Latino mental health providers who work with the Latino community, researchers recommend treatment approaches that focus on norms, values, and beliefs that are consistent with the Latino culture (Hall, 2001; Kouyoumdjian, Zamboanga, and Hansen, 2003) or any psychotherapy that is unique to a particular culture (Hall, Hong, Zane, and Meyer, 2011). One example suggests that therapists can achieve a closer relationship with Latino consumers by sitting more closely with them (Padilla, Ruiz, and Alvarez, 1975).

LIMITATIONS OF THE EXISTING KNOWLEDGE ABOUT MENTAL HEALTH CARE FOR LATINOS

Knowledge within the mental health care field about providing care to Latinos is limited in numerous ways. One limitation of the existing literature is that few researchers have investigated Latinos' perceptions about mental health prevention or their perceptions about how to adequately measure the effects of prevention efforts on existing health disparities. Moreover, little research has been done to identify strategies to increase Latinos' access to mental health care and to improve mental health care retention rates. For example, little is known about why some service agencies exhibit higher Latino retention rates in contrast to other service agencies. Future research should be conducted to determine whether retention rates are linked to quality of care or other underlying factors.

To date, mental health preventive interventions and programs that have been designed specifically with the goal of reducing mental health disparities have been insufficient in Latino communities. Preventive interventions that focus on the value of wellness for Latinos may reduce social and economic inequalities in mental health. However, few studies have been conducted with the goal of identifying effective and culturally responsive prevention and intervention strategies that empower the individuals' and families' ability to use information to choose, use, and sustain treatment.

The current mental health service delivery system for Latinos must be reshaped to answer a central question: How do we best serve Latinos? Modifying service delivery elements to increase engagement is particularly important. However, accounting for the characteristics of the Latino mental health consumer and other cultural factors associated with their interactions with providers is equally important. For instance, consumer-provider interactions based on cultural knowledge, trust, empathy, or perceived shared life experiences can lead consumers to feel more understood and validated (Dixon et al., 2011). Moreover, to meet the mental health needs of Latino communities, the mental health care system must allow flexibility for programs exploring practices and interventions, encouraging them to take risks in their innovations.

Strategies to increase accountability related to services are also essential in reshaping the nature of health care delivery. Behavioral health leaders (e.g., Concilio) point out the absence of financial incentives in the efforts to enhance accountability to adequately serve underserved communities, despite the potential of the Affordable Care Act's capacity to transform the health and mental health service delivery systems. Dixon and her colleagues (2011) support this claim by emphasizing that disparities will not decline unless doing so becomes financially advantageous. In other words, financial incentives to increase industry and employer accountability are viewed as important mechanisms to influence how services are delivered to underserved communities. Research indicates the crucial importance of developing strategies and identifying best practices for providing high-quality care to diverse populations using a system of care that focuses on building relationships and delivering culturally responsive services to the consumer in a respectful manner while building on strengths rather than deficits (Anand and Lahiri, 2009; Anand, 2004). Best practices, including ones recommended by the Latino SPW CDRP study, regarding strategies to increase access to health care, improve the quality of care, and reduce health inequities will have little value or impact without community participation in designing them (Shattell, Hamilton, Starr, Jenkins, and Hinderliter, 2008). We propose that community involvement in designing community-based approaches will be an important factor that will empower communities, improve care, and enhance the ability of existing resources to reduce racial and ethnic disparities.

COMMUNITY-BASED PARTICIPATORY RESEARCH

Community-based participatory research (CBPR) is one methodology that researchers can use to fill the gaps in the mental health care field's knowledge about providing care to Latinos. In CBPR, expert researchers conduct investigations collaboratively with members of a community. The researchers and community members are equally involved in the research process with "the aim

of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities" (W. K. Kellogg Foundation, 2000). CBPR can be used to increase our understanding of mental health disparities associated with race, ethnicity, gender, LGBTQ, and SES, and to increase community engagement to achieve mental health equity and increase access to care. A large body of work has documented investigations of community engagement and participation in research (McCloskey, McDonald, Cook, Heurtin-Roberts, Updegrove et al., 2011; Minkler and Wallerstein, 2008; Wallerstein and Duran, 2006, 2010). Much of this work is based on a model of community engagement that integrates cultural and social factors related to increasing mental health equity. The major findings from this area of research have shown significant connections between community capacity and empowerment and improvements in the effectiveness of interventions (e.g., Eng, Briscoe, and Cunningham, 1990; Israel, Checkoway, Schulz, and Zimmerman, 1994; Wallerstein et al., 2008).

Innovative community-engaged research strategies have the potential to provide practitioners with community-defined approaches to better serve Latinos while reducing mental health disparities. The basis for this body of work rests on the fundamental belief that Latino communities possess the intimate knowledge of approaches that work best for them as individuals and as a community. Understanding a Latino consumer's perspective on mental health is challenging in itself, but obtaining insight into this intimate knowledge for all Latinos in California is arguably even more complex and challenging, mainly because each Latino community is unique.

The goal for the members of the Latino SPW was to develop a workable framework that would help practitioners acquire the skills to properly explore the intimate knowledge of Latino communities in a respectful manner, and translate that knowledge into strategies to develop innovative programs and modify existing programs to better serve the Latino community. This goal is supported by Anand (2004), who contends that practitioners need to develop intercultural competencies that allow them to understand the consumer's unique perspective, and effectively adjust their approach to maximize care to meet the needs of marginalized populations. Similarly, Dixon and her colleagues (2011) emphasize the value in translating research findings into languages that community stakeholders, such as policymakers, health providers, and consumers and their families, can understand. They go on to stress that culture and ethnicity cannot be ignored but rather must be progressively defined and measured. The work of Anand and Lahiri (2009) points out that individual health care choices and outcomes must be understood by consumers in terms of their own culture and life experiences.

Moreover, these scholars highlight the impediments that the current mental health care workforce encounters in developing intercultural competencies and increasing their knowledge of Latino mental health consumers' culture and life experiences.

THE CALIFORNIA REDUCING DISPARITIES PROJECT

Background and Mental Health Services Act

In order to reduce mental health disparities, improve access and quality of care, and increase positive outcomes for racial, ethnic, cultural, and LGBTQ communities in California, the California Department of Mental Health launched a statewide prevention and early intervention effort utilizing allocations authorized under Proposition 63 to fund the California Reducing Disparities Project. The project focused on five populations: (1) African Americans; (2) Asian/Pacific Islanders; (3) Latinos; (4) Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ), and (5) Native Americans. As part of the project, five Strategic Planning Workgroups (SPWs), corresponding to each population, were created to provide the California Department of Mental Health with community-defined evidence and population-specific strategies for reducing disparities in behavioral health.

In November 2004, California voters passed Proposition 63, now known as the Mental Health Services Act (MHSA). That ballot initiative set a 1% tax on adjusted gross income above $1 million, and earmarked those tax dollars to transform California's mental health system into a consumer-and- family-driven, culturally competent, and recovery-oriented system (Cashin, Scheffler, Felton, Adams, and Miller, 2008; Scheffler and Adams, 2005). MHSA specifically calls for a major transformation consistent with the philosophy, principles, and practices of the recovery-oriented approach for mental health consumers. It outlines four key recovery areas: (1) promote hope, personal empowerment, respect, social connections, self-responsibility, and self-determination, which are concepts key to recovery for individuals who have mental illness; (2) endorse consumer-operated services as a way to support recovery; (3) reflect the cultural, ethnic, and racial diversity of mental health consumers; and (4) plan for each consumer's individual needs (MHSA, 2004, as cited in Brown, Mahoney, Adams, Felton, and Pareja, 2009). As Exhibit 2 shows, MHSA funding is divided into five main funding initiatives: (1) Community Services and Supports, (2) Workforce Education and Training, (3) Capital Facilities and Information Technology Needs, (4) Innovation, and (5) Prevention and Early Intervention. These five areas furnish guidelines for expenditure of the MHSA monies.

Although California took a giant step toward transforming the state's mental health services to support recovery for people with severe mental illness, little is known about the impact of MHSA-funded programs (e.g., Prevention and Early Intervention programs) on recovery. The Prevention and Early Intervention (PEI) initiative is key to reducing disparities and building protective factors and skills. The National Research Council and Institute of Medicine (NRC/IOM; 2009) define prevention as programs and services that focus on "populations that do not currently have a disorder, including three levels of intervention: *universal* (for all), *selective* (for groups or individuals at greater-than-average risk), and *indicated* (for high-risk individuals with specific phenotypes or early symptoms of a disorder). However, it also calls on the prevention community to embrace mental health promotion as within the spectrum of mental health research" (p. 386). The National Institute of Mental Health (NIMH, 1998) defines PEI programs and services as universal and selective prevention (occurring prior to diagnosis), and early intervention. First, *universal prevention* targets the general public or a whole population group that has not been identified on the basis of individual risks. Second, *selective prevention* targets individuals or a subgroup whose risk of developing mental illness is significantly higher than average. Finally, *early intervention* is directed toward individuals and families for whom a short duration (usually less than one year) of relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation. The aim of *early intervention* is to avoid the need for more extensive mental health treatment or services, or to prevent a mental health problem from worsening.

LATINO STRATEGIC PLANNING WORKGROUP (SPW)

The first activity of the Latino SPW occurred in May 2009 when 15 individuals who are researchers, policy makers, public mental health leaders, consumers and advocates, community health leaders, ethnic services managers, and education professionals attended a one-day meeting. The initial meeting consisted of (1) a presentation and discussion of the overall goals of the Latino SPW; (2) a presentation of the CBPR model as a framework to guide the work of this stakeholder group; and (3) the creation of the California Latino Mental Health Concilio (see Appendix 2 for a list of the Concilio members). The Concilio is a core stakeholder group representing a range of constituencies. The Concilio included mental health consumer advocates, ethnic services managers, mental health providers, *promotoras* and *promotores*, educators, and representatives of a variety of groups, including migrant workers, juvenile justice workers, and LGBTQ individuals. The California Department of Mental Health supplied funding that enabled the University of California, Davis, Center for Reducing Health Disparities (CRHD) to develop the

Exhibit 2: The Five Initiatives of the Mental Health Services Act

INITIATIVES	DESCRIPTION AND GOALS
Community Services and Supports (CSS)	• Services and strategies to serve the underserved populations. • Intended to eliminate disparities in access and improve mental health outcomes for racial and ethnic populations and all underserved populations.
Workforce Education and Training (WET)	• Workforce development programs to build human resource capacity. • Intended to fill in the shortage of qualified and well-trained individuals to provide services for cxlients with severe mental illness.
Capital Facilities and Technological Needs	• Infrastructure to support implementation of the Community Services and Supports and other programs. • Intended to ensure funding to improve or replace the existing technology system and meet the program's infrastructure needs.
Innovation	• Design and implementation of best practices specific to underserved populations. • Intended to develop and implement promising practices to increase access to and quality of services for underserved populations.
Prevention and Early Intervention (PEI)	• Support for the design of programs to prevent mental illnesses from becoming severe and disabling. • Intended to improve timely access to services for underserved populations.

Exhibit 3: Addressing Latino Mental Health Disparities in the California Logic Model

INPUTS

Latino Strategic Planning Workgroup (SPW):
- Center for Reducing Health Disparities (CRHD)
- Latino Mental Health Concilio
- Latino Behavioral Health Institute (LBHI)

Resources:
- Mental Health Services Act (MHSA)
- Partnerships with community-based organizations
- Key community cultural brokers and informants

State and county:
- California Department of Mental Health (DMH)
- California Pan-Ethnic Health Network (CPEHN)
- Ethnic services managers (ESMs)

Local partnerships:
- Latino communities (including providers, mental health consumers and families, educators, *promotores/as*, and youth)
- Secondary and higher education institutions

ACTIVITIES

Research:
- Literature review
- Community-based participatory research (CBPR) framework

Process:
- Six key strategies – Mesas de Trabajo (see Exhibit 4)
- Thirteen forum meetings in California:
  - o Northern
  - o Bay Area
  - o Central
  - o Southern
- Including lesbian, gay, bisexual, transgender, questioning (LGBTQ) group
- Ten focus groups conducted at three secondary and higher education institutions
- Data collection and analysis
- Shared data findings with community participants for their validation

Latino Mental Health Concilio:
- Community Latino experts who:
  - o Helped to identify gaps and solutions
  - o Acted as community forum liaisons and facilitators

OUTPUTS

Prevention and early intervention strategies:
- Examples:
  - o Family psychoeducation
  - o Community capacity-building strategies
  - o Integrated services to strengthen treatment

Strategic directions and recommendations:
- Examples:
  - o Community-based organizations and co-locating resources
  - o Culturally and linguistically appropriate treatment
  - o Community capacity-building and outreach and engagement

Community-defined evidence programs and practices (see Exhibit 6)

OUTCOMES

Short-term
- Increase knowledge and awareness of systems, providers, communities, schools, and resources toward prevention and early intervention
- Infuse Latino SPW recommendation into all MHSA-funded programs
- Conduct a series of statewide workshops and training sessions on implementation of Latino SPW recommendations
- Design metrics and measures to assess the impact of community-defined solutions
- Establish local capacity-building panels aimed at reducing Latino mental health disparities

Long-term
- Access to timely and high-quality health care services
- Develop a culturally and linguistically competent mental health workforce
- Design integrated mental health and primary care services that are culturally and linguistically appropriate
- Employ community capacity-building that promotes the connection of community strengths and health
- Create an educational campaign designed to reduce stigma and social exclusion

Latino SPW and plan and execute the Latino SPW's objectives and activities. The UC Davis CRHD was selected because of its history in studying and addressing mental health issues among Latinos in California. Moreover, at the meeting, the Latino SPW sought to develop a long-term research and policy agenda to help sustain strength-based strategies for reducing disparities in mental health services for Latinos in California.

The work of the Concilio is grounded in one main goal – to reduce mental health disparities for Latinos by identifying community-defined promising practices and implementing strategies to increase capacity, access, and utilization of high-quality services, improve treatment outcomes, and enhance the quality of life for Latinos. The logic model for this goal is shown in Exhibit 3. This goal is consistent with the Affordable Care Act, which also seeks to eliminate health care disparities, strengthen public health care access, expand the health care workforce, and improve patient wellness. Similarly, the Concilio priority reflects the Mental Health Services Act by emphasizing a recovery-oriented approach that facilitates services that are respectful of racial and ethnic, cultural, and gender differences. The Concilio inquiry calls for a deeper understanding of cultural thinking and how it influences the decisions that Latinos make about prevention and early intervention in order to stay healthy and strive to enhance and sustain wellness.

PURPOSE OF THE REPORT

The goal of the project was for the Latino SPW to develop and implement the appropriate process for identifying community-defined, strength-based promising practices, models, resources, and approaches that may be used as strategies to reduce disparities in behavioral health. The aim of this report was twofold: (1) outline the CBPR process used by the Latino SPW and (2) summarize the strategies to reduce the mental health disparities for the Latino population in California that the Latino SPW uncovered.

Chapter 2

Research Methodology

The Latino SPW CDRP study used grounded theory methods and analytic procedures as described by Corbin and Strauss (2007). Using these procedures, the research team allowed the key findings to emerge based on our review and analysis of the data collected for the study without holding preconceived notions about what the key findings would be (Patton, 2002). According to Charmaz (2000), grounded theory enables researchers to explore participants' worldviews and to richly describe the process. As such, grounded theory was the most appropriate methodology for exploring the perspectives and experiences of Latino stakeholders and for development of community-based strategies related to access and utilization of mental health services as well as prevention and early intervention.

ORGANIZATION OF THE STUDY

Structure of Worktables or "Mesas de Trabajo"

The overall goal of this report was to examine mental health disparities for the Latino population. Our aim was to develop and implement the appropriate process for identifying community-defined, strength-based promising practices, models, resources, and approaches that may be used as strategies to reduce disparities in mental health. To accomplish this goal, we adopted a set of topics from the California Department of Mental Health (2009). We also adopted the community-based participatory research (CBPR) framework from Minkler and Wallerstein (2008) to ensure a continuum of community involvement that over time builds and strengthens partnerships to achieve greater community engagement (McCloskey et al., 2011).

The forum meetings were the events where the Latino community members came to offer their perspectives on mental health services and strategies to reduce disparities among Latinos in California. At each of the forum meetings, all participants were divided into six to eight workgroups or work tables, with each work table consisting of six to 10 participants. These work tables were translated into thematic "*Mesas de Trabajo,*" which were organized around six topics (see Exhibit 4 for the strategies). Moreover, limitations on time and the number of participants per work table were considered to ensure that every participant was given the opportunity to fully describe the richness and complexity of their experiences. Furthermore, participants whose primary language was Spanish formed their own work table(s) to eliminate barriers to communication. Great efforts were taken to ensure that all materials, which included the *"Mesas de Trabajo"* workgroup instructions and the protocol of six strategies shown in Exhibit 4, were properly translated into Spanish and then read by a small pilot group of Spanish-speaking Latinos similar to those participating in the study with respect to SES, language ability, and experiences with the mental health system. Any questions and/or text passages that might have been confusing or difficult to understand were revised until they were comprehensible to the participants.

The *"Mesas de Trabajo"* method was a unique consensus approach in which each workgroup designated one participant to lead the discussion, one participant to document the key points of the discussion, another participant to chart key recommendations that emerged from the discussions, and one participant to report the group's priorities. Each group was assigned one of the six strategies to discuss. The bulleted sentences under each of the six strategies were intended to focus the discussion on a specific theme of that strategy. The aim was to develop four priorities or key recommendations related to the strategy they discussed, but in practice the groups devised three to five key priorities. Each "Mesa de Trabajo" first had an open discussion for approximately 30 to 40 minutes, followed by a short 10- to 15-minute discussion on identifying key recommendations. After the discussions, all participants voted on their top priorities and the votes were tallied. Then, based on the votes, the top four priorities were selected by placing a colored dot sticker next to each recommendation; red indicated the top priority item; blue identified the second; green indicated the third; and yellow identified the fourth priority. Finally, each group was allocated 60 minutes to report their top priorities. The six specific topics that were used to elicit discussions about key practices, models, resources, and approaches to mental health access and treatment are shown in Exhibit 3.

The research team collected all typed and handwritten notes and easel paper that were used by each workgroup. The research team then reviewed all the notes and summaries from each workgroup and edited them for clarity without affecting the content or the meaning of the forum summaries. All English summaries were translated into Spanish for Spanish-speaking participants to review. Quotations that appear in this report were derived from field notes that were near-verbatim transcripts of the dialogue among forum participants.

Site Selection and Participants

The research team used a three-step approach to select the forum sites for the current study. First, we selected counties based on the California Department of Mental Health's designated four geographic regions—Bay Area (including San Francisco), Central Valley Area, Southern Area (including Los Angeles), and the Superior Area—because of the relationships and interconnections among various partners in those regions associated with the study. These partners included county ethnic services managers (ESMs), who are well grounded in their

Exhibit 4: Six Key Strategies of the "Mesas de Trabajo" for Latinos

1. Strategies for increasing treatment participation of Latinos by reducing individual and community barriers to care:

- Ideas on reducing stigma (community and individual education)
- Increasing workforce appropriate to Latinos at all levels (training and education)
- Increasing family and community support
- Suggestions on appropriate mental health programs for Latinos
- Suggestions on approaches to community outreach and engagement

2. Strategies for increasing treatment participation by improving access to existing programs and services:

- Ideas on how to increase treatment participation
- Ideas on how to improve access to existing programs
- Suggestions on programs that are proven to be successful with Latinos
- Suggestions on culturally appropriate workforce development (training and education)

3. Recommendations for new programs and modification of service delivery to increase participation:

- Ideas on new programs that should be offered to increase participation
- Ideas on modification of existing programs to increase Latino participation
- Ideas on programs that have proven to be successful in serving Latinos

4. Recommendations for new programs and modification of service delivery to increase retention in services and reduce dropout:

- Ideas on how to reduce dropout rates
- Ideas on how to modify current programs to reduce dropout rates
- Determination of new programs that should be offered to reduce dropout

5. Recommendation for new programs and modification of existing services to improve successful treatment outcomes (other than retention):

- Ideas on modifying existing programs to improve treatment outcomes
- Ideas on new programs that would improve treatment outcomes

6. Strategies for designing effective approaches to the evaluation of implemented recommendations:

- Ideas on how to evaluate individual quality of care
- Ideas on how to evaluate complementary interventions
- Ideas on how to evaluate programs serving Latinos

community and serve as liaisons between the county region and a core cultural group in their communities. The main role of an ESM is to ensure that community-based mental health services are conducted in a culturally and linguistically competent manner. Another reason for the geographic regions was to reach a variety of Latinos with different demographic, economic, political, and educational characteristics (Perna, Rowan-Kenyon, Thomas, Bell, Anderson, and Li, 2008).

Second, from these four regions, 12 cities and communities (see Exhibit 5) were purposively selected. We used purposive sampling to ensure that we obtained a diverse sample of Latinos. We achieved this by asking ESMs and Concilio members to recommend community sites that contain a large Latino population. Participants from each of the 12 communities reported to a designated site; most of these sites were either community centers, local hotels, or public services agencies. Three additional

sites included two high schools and a university, and only students enrolled in those schools participated at those sites. We used the knowledge of ESMs and Concilio members to identify community sites with which Latino groups could identify and considered safe environments for discussion of mental health issues in these regional forums. Exhibit 5 also shows the penetration rates for Latinos who were eligible for Medi-Cal in each county. According to the California External Quality Review Organization, the overall utilization rate for Latinos who were eligible Medi-Cal in 2010 was 3.7%.

Third, we used initial responses from the first three regional workgroups to make changes to the proposed sites. Based on their comments and suggestions, two of the 12 sites were dedicated to the Latino LGBTQ community. Additionally, in response to their suggestions, we purposively selected two high schools and one university from the southern region to capture Latino students' perspectives.

A total of 553 participants took part in the present study. Appendix 3 shows the demographic data for the

Exhibit 5: Forum Sites by City, Region, and County

City or Community	Geographical Region	County	Study Participants by County (N = 553)	*Latino Population % of County or School	**Latino Penetra-tion Rates % by County
Oakland	Bay Area	Alameda	60	25.4 %	5.0%
Salinas	Bay Area	Monterey	69	75.0%	3.4%
San Jose	Bay Area	Santa Clara	35	33.2%	3.8%
Camino	Central Area	El Dorado	21	12.1%	3.2%
Fresno	Central Area	Fresno	40	50.3%	2.7%
Sacramento	Central Area	Sacramento	14	26.9%	4.0%
Stockton	Central Area	San Joaquin	52	40.3%	2.7%
Arcadia	Southern Area	Los Angeles	30	12.1%	3.6%
Carson (Cal State University)	Southern Area	Los Angeles	54	41.5%	3.6%
Cerritos (high school)	Southern Area	Los Angeles	13	15.2%	3.6%
Huntington Park (high school)	Southern Area	Los Angeles	20	98.5%	3.6%
Los Angeles	Southern Area	Los Angeles	32	48.5%	3.6%
San Diego	Southern Area	San Diego	39	28.8%	5.0%
Solvang	Southern Area	Santa Barbara	34	29.2%	3.1%
Chico	Superior Area	Butte	40	15.4%	4.8%

Sources: * U.S. Census Bureau, 2010; Los Angeles Unified School District, 2010; ABC Unified School District, Cerritos, 2010; California State University, 2010; California Department of Education, 2011;

**External Quality Review Organization, 2010

study participants. Because mental health is a sensitive subject for Latinos, measures were taken to ensure the confidentiality of participants, many of whom withheld demographic information about themselves. As a result, the demographic data reflects only the 260 participants who volunteered their information. The age mean of the 260 respondents was 37.7 (range 17–76). See Appendix 3 for additional demographic data.

Participants at County Forums

The first three forums in which Latinos participated in the "Mesas de Trabajo" were conducted in Southern California (i.e., San Diego, Arcadia, and Solvang), between December 2010 and February 2011. These initial meetings were within driving distance of the Concilio members who administered the "Mesas de Trabajo." The responses and suggestions from these three sessions made significant contributions to the course of the project. Most notably, the research team added an overarching question: "If you could make one thing happen in mental health that would benefit Latinos, what would it be?" With this question, we were attempting to ease the participants into an already difficult discussion while, at the same time, framing the issue of disparities. Although the preliminary data that emerged from these initial sessions were rich and significant, the data collected also identified a gap in our sample—the LGBTQ population was not represented and needed to be included.

In order to gain access to hard-to-reach segments of the Latino population, such as Latinos who have been socially marginalized and LGBTQ Latinos, we used the snowball sampling technique (Faugier and Sargeant, 1997; Frank and Snijders, 1994). In short, this technique is used to identify an initial group of appropriate participants, who are asked to help identify additional appropriate participants. Also known as chain sampling, this technique helps locate information-rich key informants (Patton, 2002). It was used to identify and recruit these hidden Latino populations by working through ESMs and/or community representatives who distributed flyers to their Latino groups and encouraged them to use word-of-mouth to recruit more Latinos of interest.

The research team conducted the rest of the forums in March, April, and June 2011. Consistent with the previous three forums, the research team obtained the names, e-mail addresses, and phone numbers of interested mental health consumers, family members, "promotoras" (i.e., community health workers), service providers, and other interested individuals and/or organizations from an ESM and/or a Concilio member. Names, e-mail addresses, and phone numbers were provided to the research team. The initial invitation e-mail message consisted of a brief description of the project and the location and agenda for the event. After the initial e-mails were distributed, one member of the research team sent subsequent e-mails reminding the participants of the upcoming forum session in their region. Also, the ESMs and/or Concilio members reinforced those messages with phone calls encouraging potential participants to attend the forums in their respective region. All e-mailed material, including the invitation, was in English and Spanish. The invitation e-mail informed participants about the opportunity to participate in a study about reducing disparities. According to ESMs and Concilio members, 100% of the participants recommended for the forums had e-mail access as well as a telephone number, and all Spanish-speaking individuals who received a phone call were addressed in Spanish. In total, 420 participants attended one of the 10 forums, not including the LGBTQ forums.

Participants at LGBTQ Forums

In the spring of 2011, the research team obtained the names, e-mail addresses, and phone numbers of interested Latino LGBTQ individuals from a community-based organization administrator who serves this population. These individuals agreed to participate after the community-based organization administrator described the study to them. After the initial invitation e-mails were distributed, one member of the research team sent supplementary e-mails reminding the participants of the April forum sessions. The staff from the community-based organization also placed phone calls encouraging prospective participants to attend the forums in Sacramento and Los Angeles. In total, 46 self-identified LGBTQ participated in one of the forums (14 participants in Sacramento and 32 in Los Angeles).

Participants at Secondary and Post-secondary School Forums

Due to the unique mental health needs of the adolescents and young adults, the research team opted to conduct focus groups with high school and university students instead of asking them to participate in the forums used for the other study participants. A total of 10 focus groups with 6 to 10 individuals per group were conducted in April and May 2011 to examine students' opinions about mental health services in a school setting. All focus groups were between 40 to 60 minutes in duration. In order to stay consistent with the previous forums, the same topics shown in Exhibit 4 were used. However, the topics were slightly modified and organized as guiding questions (see Appendix 4). Specifically, the topics were converted into a 10-question protocol focusing on Latino students' perceptions and participation in mental health services on a school campus. We also were looking for findings related to social and economic issues, family

and traditional responsibilities, immigrant status, and language barriers that may affect Latino students' education and mental health. Furthermore, we assessed respondents' knowledge of existing campus-based mental health programs and services that are Latino-specific, and assessed respondents' views on how to identify, invite and engage more Latino students in seeking and promoting access to care. Such knowledge would provide insight into students' ideas about essential characteristics of successful services programs. All focus groups were audiotaped and transcribed verbatim. The member of the research team who conducted the focus groups has experience working with Latino students in academic settings.

The focus groups encompassed 87 Latino student participants: 33 high school students recruited from two large high schools with sizable Latino populations, and 54 undergraduate students recruited from one public four-year university with a large proportion of Latino students. At the high schools, students were recruited by an administrator and/or school psychologist who visited selected Chicano/a studies classrooms and solicited their participation. The university students were given a flyer inviting them to attend a conference titled "The State of Mental Health Among Latino University Students: Issues Affecting Mental Health Disparities and Retention in Services" that occurred at the same time the research team had planned on conducting the focus groups. The flyer informed students about the opportunity to participate in a study following the conference. Most students who attended the conference volunteered to take part in the study.

Data Analysis

Members of the research team independently read the summaries and transcripts, and marked meanings in the text. Through numerous meetings, research team members discussed, developed and agreed upon a list of potential codes that could be used for all of the summaries and transcripts, to analyze the data, we created a database that included summaries from the community workgroups and transcriptions from the focus groups (Yin, 2009). We used ATLAS.ti software (Version 6; Scientific Software Development GmbH, 2009), a qualitative data analysis software package, to facilitate the coding and compiling of data into categories. The code book shown in Appendix 5 was created to ensure that only codes that were noted repeatedly by respondents and described across different groups, forums, and workgroups were included and consistently used by the coders. We then consolidated the codes to identify themes—points of interest or salience based on the researchers' interpretations. The themes were assigned brief titles and tied to phrases or longer sections of text.

We used several strategies to ensure the trustworthiness and credibility of the study's findings and conclusions (Yin, 2009). Most importantly, we collected information from multiple sources, including participants with different perspectives, such as health care providers and consumers, family members, administrators, LGBTQ individuals, and secondary and post-secondary students. We also produced a draft template of the findings for each of the six topics. These templates consisted of three categories: (1) statements and quotes, (2) codes, and (3) patterns and themes. Finally, we asked 22 Concilio members who are mental health experts and have extensive experience working with Latinos with mental health issues to review the templates and evaluate whether the preliminary results made sense to them based on their experiences.

Chapter 3

Findings and Discussion

During the community forums and focus groups, the participants discussed barriers that inhibit access to mental health services for the Latino population in California. The participants also discussed strategies to reduce the mental health disparities that exist for Latinos, and they prioritized the key strategies as proposed solutions for the disparities. These barriers and proposed solutions are presented below as findings at the individual, community, and societal levels.

ACCESS: INDIVIDUAL, COMMUNITY, AND SOCIETAL BARRIERS TO CARE

The central focus of this study was to identify effective practices for increasing awareness and access to mental health services and to improve prevention and intervention for Latinos in California. This portion of the report is organized into three major areas: (1) individual-level barriers, (2) community-level barriers, and (3) societal barriers.

Individual-Level Barriers to Accessing Mental Health Care

Key Finding: Study and forum participants saw negative perceptions about mental health care as a significant factor contributing to limited or no access to care. Among the many concerns, stigma, culture, masculinity, exposure to violence, and lack of information and awareness were the most common.

Forum participants reported that limited or no access to mental health services was a significant factor affecting the mental health of the Latino community. The participants also cited barriers to accessing mental health services and identified many causes of these barriers. The content analysis of the *Mesas de Trabajo* summaries and focus groups generated five major themes related to individual-level barriers: (1) stigma associated with mental health problems, (2) cultural barriers, (3) masculinity, (4) violence and trauma, and (5) lack of knowledge and awareness about the mental health system. We have outlined each barrier, and included quotations to allow the reader to understand the views of the forum participants in their own words.

Stigma associated with mental health problems

Descriptions by most of the participants associated mental illness with being "crazy"; stigma manifested itself in the form of shame and fear of being judged. This theme was best expressed in the story shared by one participant about a family member's bouts with depression:

> I think it [stigma] is true in the Latino community. I have an aunt with a lot of problems but she doesn't want to go ask for help. She would rather just stay at home … suffering from depression than go out and look for help. It has to do with [her] not wanting other people to find out what she's going through, and sometimes it has to do with not being told that you're like crazy. It's based on being labeled and how we are seen in other people's eyes. We [Latinos] are scared of what other people have to say. We don't like to be judged.

Even though lack of health insurance coverage, inadequate transportation, and lack of awareness of existing mental health services are formidable barriers to accessing mental health services, stigma continues to be a main contributing factor that deters Latinos from mental health treatment. It is possible that Latinos who do not seek mental health services feel more comfortable dealing with their mental illness on their own rather than disclosing the illness and potentially appearing weak to others. In addition, many Latinos may avoid seeking treatment because they may be in denial about their illness.

Stigma may manifest itself in the form of distrusting others. An individual may be unwilling to trust an outsider with intimate information, for example, even if that outsider is a Latino mental health professional. One Latina depicted her frustration with her mother's resistance to trusting her therapists and, as a result, not benefiting from the treatment:

> My mother is receiving mental health services and she still … she denies it.… She sees a psychiatrist and a psychologist to deal with her anxiety and depression … but she holds back.… I tell her 'if you don't say exactly how you're feeling to that professional, then how is it really gonna be 100% effective?' I feel like I can't tell my mom what to do.… I think it has to do with your culture.… It's very hard to accept that … but at least she is making one step further from breaking the chain.

Along similar lines, Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) participants described stigma as a major cause of the disconnection between LGBTQ individuals and their families, and the social isolation they experience

> **"…therapists need to understand how to help LGBTQ individuals become more accepting of who we are … [and] increase our self-esteem."**
>
> *—LGBTQ participant*

after coming out. Stigma also stifles LGBTQ individuals' help-seeking behaviors. Most of the participants described the detrimental effects of stigma on their self-esteem. Participants saw building an LGBTQ persons' self-acceptance as a primary responsibility of a provider and an essential component of any treatment in order to facilitate the coming out process. A participant noted, "…therapists need to understand how to help LGBTQ individuals become more accepting of who we are … [and] increase our self-esteem."

Another LGBTQ participant described how the use of negative labels, especially from the Spanish-language news and entertainment media, promotes homophobia and stigma at the individual level. These labels portray same-sex activities as an illness, particularly among Latino LGBTQ persons with HIV. An overarching social stigma against LGBTQ is normalizing homosexuality by challenging heteronormativity. In other words, communication media tend to portray gay characters (especially men) in a "flamboyant or stylish" manner and reinforce a stereotype that has nothing to do with one's sexual orientation. Disparaging portrayals in the media often mock gay characters and lack the educational component that can eliminate fear, stereotyping, homophobia, and hatred. One participant noted that:

Media plays a role in showing negative aspects of what it is to be LGBTQ [Latino].… Media needs to show positive aspects of being LGBTQ [normalize LGBTQ].… Gays and lesbians are your neighbors, they have homes, children, pay taxes, are doctors, nurses, lawyers.… They live amongst us and are part of the fabric of our community.

Overall, our findings are consistent with previous research showing that homophobia and the stigmatization of LGBTQ individuals and the LGBTQ community further isolates them and contributes to an LGBTQ subculture of concealment and denial (Guarnero and Flaskerud, 2008).

Consistent with the Latino adults who participated in the forums, the Latino high school students attached a stigma to mental health problems. For example, when Latino high school youth were asked, "As a Latino/a what does mental health mean to you?" the majority of the students used words like "psycho," "crazy," "schizophrenic," "bums," and "retarded" to describe a person with a mental illness. These high school youth often verbalized their fear of being perceived as weak and labeled "crazy" if they had a mental health problem. The origins of the stigma connected with getting treatment for mental illness were rooted in Latinos' family structures and cultural values. In other words, obtaining help from a therapist equated to abandoning their family unit and cultural values. A female participant said, "the reason [we] don't seek help is because there is more to lose than there is to gain," referring to shaming her family and being disowned by her family for disclosing her depression to the public. Another student summarized it this way:

> Psychology and therapists isn't the way we would go through.… It's always been like that.… It's like if you have problems, you always have to take care of it yourself [with family], you know … like no one is gonna sit there and baby you.… But I guess in the [Latino] culture, it's more frowned upon … like 'Oh, you're going to therapy? What kind of a person are you? Like you can't handle [it] yourself?'

Cultural barriers

Culture influences the ways in which individuals interpret psychological distress. Culture also determines the types of treatment or help sought, and may affect individuals' willingness to access services in the traditional mental health system. For example, a young Latina expressed her feelings about the traditional mental health system and her cultural beliefs and suspicions about mental health services:

> I'm trying to answer some of those [barriers to treatment] questions, but I can't come up with an answer because I'm struggling with the idea that mental illness is due to one's poor luck. I've thought about it [mental health] from time to time, but I've suppressed those thoughts because it's not culturally accepted and I don't want people to think that I'm crazy.… I know I have an opinion about it [mental health], I just don't know if my cultural upbringing allows me to agree with my own opinion.… My opinions are debatable because as a young Latina who values cultural stability, I battle with my own opinions and I can't really bring myself to seeking help for stress or any form of mental health problems.

Participants suggested that Latinos' cultural beliefs (e.g., faith, spirituality, and religion) are often used to explain mental illness as fate, and may lead to their reluctance to seek mental health services. Our data revealed that a sizable percentage of Latinos hold the belief that mental illnesses are caused by God's will or by evil done by others. For example, some Latinos believe that *mal de ojo* (evil eye) and *susto* (fright or shock) can be healed only through cleansing (*limpia*) by a folk-healer (e.g., *un curandero*). These cultural manifestations are described by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* as culture-specific conditions. These simple expressions of physical and mental distress lessen Latinos' beliefs in mainstream mental health services.

Masculinity

Latino young males who took part in the forums view masculinity or "machismo" as an important factor. Conversations about masculinity focused on the understood belief that Latino males need to exert themselves more to appear in control and strong. Machismo was described as a Latino man's ability to care for his family as well as work through problems on his own. Many of the youth and young adults who participated viewed machismo as a positive attribute in men in terms of having a dignified presence and being the pillar of strength of the family. The following statement from a Latino male typified these sentiments, "You're built to be a Mexican man … a Latino man, you have to be strong." However, participants also recognized machismo as a barrier to seeking mental health services and complying with treatment. Participants suggested that males seeking mental health services often were viewed as weak individuals who are exposing their families' weaknesses. For example, one Latino male described his views about asking for help:

> Coming from a Latino family it's always that traditional perspective where the male is the type of guy that has to kind of be the head of the house.… Being a kid and growing up in that certain perspective, it's normal for the male to be like, "you know what? There's no point in me looking for help. I can handle my own.… I have to maintain my head up strong because if I show weakness, then they're going to take advantage of me." I remember the man has to be the head of the household and if he has problems, he has to hold it in. He has to keep his head together because if he shows his weakness, then he shows his family's weaknesses.…

Participants identified a consistent generational view on the issue of machismo. Most of the male participants, who self-identified as third and fourth generation, agreed that their beliefs were strongly influenced by first-generation Latino males. One 50-year-old male who self-identified as being a first-generation Latino did not view his perspective on masculinity as a barrier, but the younger generations felt the older generation's perspective on masculinity was a barrier. The 50-year-old stated:

> It's the way men should be. I am a 50-year-old [Latino] and he [youth] is not my age and still, he's thinking the same way. We are males … [we] were not built different. But you know, society pushes us to be different [more emotional]. And then sometimes we give in. [As a Latino] I am aware and I've been pushing and kicking [against change] and I am very happy with that.

Young female participants reinforced this cultural norm, suggesting that they also expect Latino men to be the strong ones in the family. One young Latina said, "Sometimes us women are like 'yeah, they [Latino men] are the strong ones,' so when we see that they are getting weak … you know, [we're] looking up to you and then you're weak so it makes us weak." Although the authors of this study encourage caution when using the term "macho," it did emerge as a concern among the youth participants in which dominance and control were common in their household, and often was seen as a barrier to seeking mental health treatment.

Violence and trauma

Conversations about violence and trauma focused on exposure to violence in the home, school, and community. Participants indicated that violence or threats of violence were barriers that prevented Latinos from obtaining the mental health services that they need. Furthermore, participants suggested that violence in the home often is accompanied by limited or lack of education and limited resources regarding mental health services. One participant reported that when her brother was diagnosed with schizophrenia, he was criticized for being weak, and her father viewed physical punishment as the treatment for his son's illness. Another young participant reported that when the family urged him to obtain help for his anger and potential mental health problem, his father's anger spiraled out of control. The youth recalls his father's anger getting progressively more severe and leading to physical and emotional abuse.

In addition to exposure to violence in the home, youth reported experiencing violence in their schools. Many of the young participants suggested that being bullied and subjected to violence often contributed significantly to their feelings of anxiety and fear. Youth participants believe that schools are not equipped with appropriate counseling staff and supportive resources to help students and their families. In other words, due to the amount of violence in urban schools, the number of school psychologists and counselors available to work with youth is insufficient. For example, schools serving 4,000 students commonly have only one school psychologist on

campus. Participants indicated that schools are supposed to be safe places in which to learn in pursuit of a life better than that of their parents. However, concerns over gangs, drug use, and crime in general are significant stressors. One young Latina stated:

> When I was in the ninth grade, I had all this stress … fights, guys [in gangs] wanting to beat me up.… It was a hard world.… These guys with shanks, they wanted to like shank me.… I was pretty terrified. [At school] I didn't know who to go to.

These findings are consistent with the recent work by Kataoka and her colleagues (2009) who found that Latino youth exposed to high levels of violence on their school campus were not adequately treated for these traumatic experiences. Moreover, they concluded that school educators and administrators need to do more to improve violence prevention and early intervention efforts. Many study participants shared stories about young Latinos attempting suicide because they were too stressed with school life and fed up with the psychological distress experienced in their communities and neighborhoods.

Youth participants suggested that failing to address the psychological distress that youth experience in their homes, schools, and communities eventually will lead to more severe outcomes, including suicide. This theme was particularly relevant for LGBTQ youth, who reported that rejection from their family, school, and community contributed to feelings of bereavement, hopelessness, despair, and suicidal thoughts and actions. This finding agrees with prior research (Mustanski, Garofalo, and Emerson, 2010) that has found LGBTQ youth reporting higher rates of suicide attempts. Suicides by LGBTQ individuals also can traumatize family members who rejected their LGBTQ family member. A father described his life overshadowed by sadness after his son completed suicide days after being rejected for being gay. "I live every day wanting a moment with my son to speak and reconnect with him," the father said.

One participant observed that the discussions overlooked the traumatic experiences that many Latinos have while crossing the border. This participant noted that Latino adolescents in particular become the most susceptible to post-traumatic stress disorder and other mental disorders during and after their border crossings. This claim is consistent with the work of Shattell et al. (2008), who found this particular subgroup of the Latino population to be the most vulnerable to risk factors, including acculturation stress, drug use, gang involvement, teen pregnancy, and dropping out of school, as they struggle to form their personal identity in a new country after crossing the border.

Knowledge and awareness barriers

Most participants believe that Latinos lack information and strategies on how to access mental health services and treatment options. One participant commented that unfamiliarity with warning signs of mental illness contributes to many Latinos' lack of awareness of the problem and potential actions to address it. Responses such as, "Educate people [Latinos] on these critical points of access, so they know where to go for help, know how to obtain a referral, and be assertive in requesting a referral to a Latino provider," were commonly articulated when Latino participants discussed ways to improve access to existing programs and services. Participants also commented that Latino families, in particular immigrant groups, lack a network of people from whom to obtain information about available services. One participant suggested that educating entire households, including extended family members, might help to produce a knowledgeable network:

> Sometimes the extended family does not understand what is happening and becomes suspicious and negative [toward seeking services].… The family doesn't have support from the extended family. Implement a family advocacy program so that family members interested in knowing more about mental health can do so and at the same time learn strategies to support their loved ones.… [Latino] consumers feel they don't have family support and that their family lacks an understanding about mental illness.

Many participants stated that even when services are available, individuals who need the services might not have sufficient familiarity with the mental health system to take advantage of them. In other words, making information available without supportive activity may be insufficient; empowering individuals and families to use information to examine and choose the appropriate treatment option is also necessary in order to overcome culture-based resistance to mental health services. Participants believe that increasing one's knowledge about how to use treatment options through empowerment can translate into reducing barriers to care.

In summary, the predominant concern regarding access to mental health care was the perceptions of individuals about mental health care. Participants identified numerous barriers to care that are deeply

rooted in cultural influences in conjunction with exposure to stressful conditions and limited knowledge or unawareness about navigating the mental health system. These barriers reduced Latino individuals' willingness and motivation to engage in treatment.

Community-Level Barriers To Accessing Mental Health Care

Key Finding: A substantial proportion of the Latino participants believe that limited access and underutilization of mental health services in the Latino community are primarily due to gaps in culturally and linguistically appropriate services, in conjunction with a shortage of bilingual and bicultural mental health workers, nonexistent educational programs for Latino youth, and a system of care that is too rigid.

From the content analysis, four persistent community-level themes emerged throughout the *Mesas de Trabajo*. The themes, which are barriers that contribute to inadequate care and overall poorer mental health and outcomes, included (1) a shortage of culturally and linguistically appropriate services, (2) a shortage of qualified mental health professionals, (3) a shortage of academic and school-based mental health programs, and (4) structural barriers to care. These four key themes were viewed as common areas of concern in addressing the causes of mental illness, and were considered barriers to accessing and utilizing mental health services.

Lack of culturally and linguistically appropriate services

Among the forum participants, cultural incompatibility was one of the most cited causes for low utilization of services by Latinos. "Many providers do not speak the language of the client or lack cultural competence," stated one forum participant. The ability to understand mental disorders within the context of the Latino culture and the ability to perform culturally sensitive and acceptable treatment was of great importance to the participants. Forum participants expressed frustration and described difficulties associated with seeking appropriate care from providers. Many participants spoke about the difficulties they had finding care that was aligned to their cultural values and beliefs, life experiences, and family practices. One said:

> First of all, it's hard for us to go and look for help. And then, when you do look for help and that professional is not familiar with you and he opens your "Pandora's Box" then you know … it's like "My God! I was crazy!" They [professionals] lay you out in the open while they look for a diagnosis from a book, and now I'm crazy and all alone to fend for myself! That is worse than not seeking help in the first place. It's, like, why did I go in the first place?

This challenge was critical for participants who had a hard time finding value in seeking treatment and felt disappointed with a diagnosis from a provider with whom they did not identify and perceived as lacking awareness of their culture. The failure of mental health care providers to attend to cultural issues may contribute to Latinos' reluctance to seek care. Many LGBTQ participants described past and ongoing difficulties with finding mental health services that are culturally and linguistically sensitive and compatible with their sexual orientation. Participants described experiences of homophobia, particularly from providers who were not LGBTQ or LGBTQ-sensitive. One young woman who self-identified as a Latina lesbian stated, "I've seen doctors who were not sensitive to the LGBTQ community, and most seemed uncomfortable treating me once I told them I was a lesbian." A lack of LGBTQ-appropriate services combined with providers' negative perceptions and attitudes toward LGBTQ people were perceived to be barriers to care for LGBTQ participants.

> **"I've seen doctors who were not sensitive to the LGBTQ community, and most seemed uncomfortable treating me once I told them I was a lesbian."**
>
> *—LGBTQ Latina*

Lack of qualified mental health professionals

The shortage of a bilingual and bicultural workforce available to serve Latinos was an issue that participants discussed. Many participants attributed their reluctance to seek care to the lack of well-trained care providers who are familiar with the Latino culture. A common idea that kept emerging among the participants was the shortage of bilingual and bicultural mental health providers who can deliver mental health services that are culturally and linguistically appropriate. The participants also highlighted the need to "grow our own" mental health providers. A major gap, according to the participants, is the lack of pipeline programs and curricula in the secondary and post-secondary educational system. Participants reported insufficient communication and alignment among the mental health field, education system, and Latino community to educate youth about careers in mental health, and design curriculum that focuses on culturally and linguistically competent skills.

The forum participants also viewed the lack of Spanish-language training for the current mental health professionals equally as important as the lack of cultural competence. Many participants described their unsatisfactory experiences with the interpretation procedure, including interpreters who were not able to relate to consumers' life experiences. Bilingualism and biculturalism are not only measured in an individual's ability to speak the language proficiently, but also involve genuinely understanding the consumer's historical background and using the language to connect and communicate within that historical context (González, Tarraf, and Vega, 2010).

The lack of LGBTQ culturally competent mental health professionals and the added burden of repeated requirements to disclose their sexual identity were apparent in the LGBTQ participants' responses. The LGBTQ participants believe that a workforce of mental health providers who are able to relate to the LGBTQ participants' experiences does not exist. This theme was best expressed in the words of an LGBTQ person who self-identified as a gay man with depression:

> I don't like seeking help from providers who are not educated and trained on use of language and LGBTQ terminology. They need to be better equipped to help someone like me who is a gay man with depression. There needs to be specialization in treating LGBTQ consumers. Currently, there is no system in place for Latino LGBTQ [like me] to access LGBTQ-friendly services … or programs that convey to the LGBTQ consumer that that agency is LGBTQ-friendly. It's a terrible feeling to have to constantly fill out more forms where I have to check the category of "other" and disclose my sexual identity for the one thousandth time.

A majority of participants noted positive experiences working with *promotoras/es* or health navigators. For instance, one participant stated, "[I found] *promotoras* to be a peer support model that provided [me and my family] survival skills as well as living and socialization skills around issues of mental health." The role of *promotoras/es* is to serve as a communication broker with communities in need of increased preventive care. More must be done to increase acknowledgement of *promotoras/es*, not as substitutes to an academically trained workforce, but rather as well-respected individuals in the community who can help improve Latinos' access to care. The "Strategies" section of this report includes more information about the *promotoras/es* model as a potential approach to achieve improvements in care access and quality.

> **The school district denied my son services even though they knew there was something wrong with him, but they could not diagnose or treat him."**
>
> —*Latina parent*

Lack of academic and school-based mental health programs

Participants expressed concern about the general level of support for school-based mental health programs. Many participants spoke about the funding difficulties that schools encountered as they worked to keep programs and services available, typified by one person who said, "Make sure funding is available to support activities leading to education and outreach … [and] ensure that the services are for free." This concern was multilayered for participants who also mentioned the need to train parents, teachers, and educators about mental health issues, proper ways to identify signs of mental illness, and appropriate methods to provide adequate help for students. One parent who has experienced frustration working with school district administrators said, "The school district denied my son services even though they knew there was something wrong with him, but they could not diagnose or treat him." Participants emphasized that schools have an important responsibility to provide appropriate services for their children. Latino parents also expressed concern about the tendency of school personnel to mistake a mental health issue for a behavioral problem, resulting in labeling their children as "at-risk" and leading to unnecessary expulsions, continuation school, or eventually prompting affected students to drop out. "When schools misdiagnose our children and label them as a 'behavioral issue' without proper assessment for other developmental issues … they [schools] resolve it by simply sending out children to a continuation school, where the 'pipeline to prison' starts," said one Latina parent.

Although participants noted the difficulties of ensuring the availability and accessibility of school-based mental health programs for students experiencing mental illness, they saw great potential in the ability of schools to promote the mental health field as a viable career path for Latinos and to begin educating mental health workers. Building on the previous notion of "growing our own," participants emphasized mental health career pathways at the high school level and certification programs at the community college level for persons interested in pursuing a career in mental health.

All of the youth participants observed how the lack of classroom instruction about mental health issues may have created a barrier to their help-seeking behaviors. Participants also noted the lack of continuity in educational material about mental health topics from middle school to high school and on through post-secondary education. One youth stated:

> I think there's negativity about mental health in our schools. A lot of teachers and administrators try to deny it.… I think it's time, like, that teachers and administrators started paying attention to what's going on in their schools 'cause sometimes they limit the health education that teaches students about basic health and life skills to just one semester.

Many of the youth and young adults who participated believe that schools often miss an opportunity to integrate mental health topics into the curriculum and maximize youths' knowledge and interest in mental health. Others spoke of the missed opportunity to also improve teacher knowledge and classroom instruction.

Structural barriers to care

Organizational and systemic barriers. Participants expressed concern over the misalignment of the culture and context of mental health agencies with the culture and context of the Latino individual and community. Specifically, participants say that the procedures and protocol of mental health agencies and providers frequently conflict with the cultural values and beliefs of the Latino consumer. In these situations, the participants believe that mental health agencies and providers are not equipped to respond appropriately to conflict. Latinos commonly value the idea of touching one's hand or hugging to show concern and support, for example. However, this idea comes into conflict with agency guidelines and other compliance protocols prohibiting proximity between the consumer and the provider, reinforcing the perception of providers' failure to become culturally attuned to treatment needs of Latinos (Falicov, 2009). As previously mentioned, failure to consider the Latino consumer's values and beliefs and incorporate them as part of the treatment can lead to detrimental consequences and eventually to premature termination of the treatment. This finding is consistent with previous research (Anand and Lahiri, 2009) that emphasized the importance of the ability of providers to think through how they will respond in the event of a conflict between what they believe and what the patients believe.

> **"Waiting in a line outside the door, it made for a stressful situation.… It cut down on [my] privacy.… A person doesn't want the next person in line to know what you are here for."**
>
> *—Latino consumer*

Along similar lines, one Latino community leader suggested that listening and paying attention to Latinos' immediate reactions to clinical environments are not the only means by which to measure stress and stigma, but also can help determine how successful the treatment will be for that individual. The majority of participants emphasized their frustrations and dissatisfaction with the current mental health system, and cited a lack of attention to Latinos' need for a sense of safety, normalcy, and dignity that is violated when they are subjected to seemingly meaningless rigid protocol that include long waiting lists and stressful settings. Describing her experience at a clinic, one participant said, "Waiting in a line outside the door, it made for a stressful situation.… It cut down on [my] privacy.… A person doesn't want the next person in line to know what you are here for."

Flexible hours of service. Mental health care providers' lack of flexible schedules or service hours emerged as a major concern, especially for participants who sought mental health services after working long hours. If something as simple as providing services around Latinos' work schedules is ignored when developing and implementing strategies for addressing poor access and utilization rates, achieving prevention effectiveness and wellness might be compromised because Latinos rarely exchange a day of work for a clinical appointment.

Societal Barriers to Accessing Mental Health Care

Key Finding: Participants identified social and economic factors as major causes of mental illness and significant barriers to sustaining wellness among Latinos.

Social determinants of mental health were an overarching theme across all groups. The content analysis revealed three key barriers: (1) social and economic resources and living conditions, (2) inadequate transportation, and (3) social exclusion.

Social and economic resources and living conditions

Participants cited difficulties related to poverty, including obtaining housing, health insurance, and food for their families simultaneously, as contributors to mental health problems. In particular, many participants reported that

they experience a significant degree of anxiety related to providing food and housing for themselves and their families. Mental health concerns linked to poverty frequently fell into two categories: (1) internalizing disorders (e.g., depression, stress, and suicide) and (2) violence or other criminal activities. Overall, participants expressed despair, depression, and suicidal thoughts related to the burden of poverty, and the responsibility of providing for family members. Because Latino families had to focus on the basic necessities of life, they frequently did not have the time or resources to obtain mental health care.

The youth and young adults who took part in the focus groups described the academic difficulties they encountered while they and their families struggled with poverty. For many youth, the necessity to miss school to watch siblings or drop out of school to work to support their families were common experiences. Many of the youth also reported that their parents saw the value of an education, but that family and the household were the priorities. After missing too many days of school, many youth indicated that motivation to finish school was difficult to achieve, which for some led to stress and depression. One student's comments exemplified these experiences:

> Well, a lot of us are born at a disadvantage … like when my dad got locked up my mom was the only one working, so I had to miss a lot of school to take care of my brother.… I was missing a lot of school … I'd only go to school like one day [out of the week]. I wouldn't be able to do homework 'cause I had to go home and like clean and cook and watch my brother. That's how I ended up in an alternative school. I stopped doing things at school and it hurt me mentally.

Some participants identified poverty as a key contributor to violence and crime in their communities. Participants described continual frustration with the lack of opportunities for employment. They suggested that unemployment and financial instability lead individuals in their communities to resort to illegal activities to support themselves and their families. In addition to concerns related to financial stress, many participants reported living in poor housing conditions. Some participants indicated that they did not have access to running water, while others spoke of living in neighborhoods with high levels of crime and drug use.

Lack of health insurance was cited as a major barrier to Latinos' access to mental health services. Some of the participants who do not have health insurance believe that no mental health services are available for them; that perception is especially pervasive among undocumented Latinos who constantly fear being deported if they seek help for themselves and/or family members. Statements arising from discussions about economic barriers to care concurred with that of the participant who said, "I have no way of paying for help. If you don't have means to pay for services, you have nothing [no services] because there is no way to pay for them … [and] if my family is not legal, I don't know where to get them help because they are fearful of immigration [authorities]." This perception is consistent with previous studies that have found that Latinos have lower rates of health insurance compared to other ethnic groups (Rutledge and McLaughlin, 2008). But, even when insured, Latinos have less access to health care than other Americans (PEW Hispanic Center and Kaiser Family Foundation, 2002).

For migrant workers, in particular, poor living conditions contributed to stress and depression. Migrant workers who participated indicated that they were unable to obtain running water and lived in geographically isolated areas where access to grocery stores, water, laundry facilities, and recreation for their children was limited. Geographic isolation was a barrier to accessing mental health services.

Inadequate transportation

Participants overwhelmingly cited the inadequacy of transportation services, which contributed to isolation and limited access to mental health services. The cost of public transportation also was mentioned as a significant limiting factor. Although transportation is a simple barrier, it often is overlooked. One participant noted, "You don't have a way to go out. [If] you don't have a car … you are nothing. You feel desperate because there is no way to get to town … if you get sick or you need something." Another participant emphasized the importance of having reliable transportation, especially in rural areas, to ensure that follow-up services are administered and to increase the likelihood that clients complete their treatment. One participant stated:

Latinos in rural areas need transportation to and from services and appointments. If a patient has a doctor's appointment in the morning and wants to participate in other services offered in the afternoon or evening, most cannot benefit because they don't want to wait, and simply go home.… If they go home, they don't have a ride back to the facility.

Transportation is a simple yet critically important need that rarely is considered when promoting access to mental health services.

Social exclusion

Social exclusion is the process by which individuals and groups of people are wholly or partly barred from participation in social activities. In this process, some individuals, due to their background, life experiences, or circumstances, are denied access to society's resources, resulting in poor living conditions, physical and mental health problems, and other interrelated problems. Social exclusion is measured not only in an individual's or community's living conditions (i.e., poverty), but also in an individual's sense of not belonging to a community or, on a broader scale, a community not belonging to a larger society. Many participants expressed the belief that they could not access mental health services due to social exclusion.

A number of students in the focus groups said they felt excluded in their environment because they were poor. Despite their desire to obtain an education and live a healthy life, they often felt ignored by their school and community and, as a result, they did not have aspirations to seek help when they were overwhelmed with stress and eventually developed depression. An 18-year-old Latina youth described her experience of feeling disregarded and the difficulties she had in accessing mental health care in her community:

> When I was 15 and depressed, I remember it [community counseling environment] wasn't welcoming.… I went to all the local places in my area because I wanted to give it [therapy] a try, I wanted to see what services they would have for me.… They made me feel out of place. Maybe it was the area, the location, the people in that place, but I felt out of place. I think like right now the scene for poor kids isn't really being focused on their health or getting help because we think there is no help out there for poor people. I focused on friends and other bad things and got kicked out of my regular high school.… I don't think the environment is good right now.

For the youth participants, feeling excluded from the larger society in general and disconnected from the Latino community was associated with increased substance abuse and other risky behaviors that can lead to mental health problems.

Along similar lines, many participants verbalized the reason for their mental health problems and poor advancement in society as "lacking information about my human and legal rights." Some participants expressed fear and mistrust of government agencies, including agencies that offer mental health services. Participants described their fear of deportation as a social condition that kept them from seeking mental health services. Although most service systems do not inquire about legal status, many undocumented immigrant Latinos fear being reported and ultimately deported. Fear of deportation is a significant barrier that discourages Latino immigrants from seeking mental health services. One Latina participant stated, "I know families where the parents are undocumented, but their children are documented and they are afraid to ask for help because they might get deported and separated from their kids.… As a mother [I know] it's a scary thing."

STRATEGIES TO IMPROVE ACCESS TO EXISTING PROGRAMS AND SERVICES

This section of the report identifies and describes strategies by which to contact, invite, and engage the Latino community in California. Specifically, it focuses on identifying community-defined strategies to improve access, quality of care, and positive outcomes for Latinos in California. This portion is organized into two major areas: (1) community and cultural assets, and (2) community-identified strategies for prevention and early intervention programs.

Community and Cultural Assets

Key Finding: Participants identified community assets that promoted the mental health of their communities. Our data indicated that the elements that are critically important in improving access to care consist of five community and cultural assets: (1) individual and community resiliency; (2) family involvement; (3) church and religious leaders; (4) community role models and mentors; and (5) community *Pláticas*.

Individual and community resiliency

The data revealed that the most notable protective factors that strengthened community resiliency were attributable to three cultural core values: (1) the value of family (*familismo*), (2) respect (*respeto*) for community members

> **"We need to focus on strategies that empower community groups at the local level … encouraging Latino individuals and communities to grow and change according to their needs and priorities."**
>
> *—Latino community leader*

who are perceived in authority positions, and (3) the value of personal relationships (*personalismo*) with people and institutions. (These values are described in detail in the literature review portion of this report.) Participants emphasized community resiliency as an asset developed as a result of families, friends, churches, schools, and community groups working together to strengthen individuals and communities alike. In a particularly salient account, a participant described a sense of resiliency that he experienced in his community while in treatment: "[I developed] a sense of resiliency and persistence in treatment using [my] community resources to increase protective factors, and working closely with schools, [my] clergy and faith-based programs." In this instance, simply feeling a sense of connectedness and tapping into the strengths of his community resulted in the increase of protective factors and persistence in the face of challenges. A Latino community leader emphasized a strategy that focuses on a community development framework. "We need to focus on strategies that empower community groups at the local level … encouraging Latino individuals and communities to grow and change according to their needs and priorities," said this community leader. Mental health providers who participated in the forums also highlighted the critical role of community development on building individual and community resiliency. In particular, providers believe that co-locating services to maximize community resources and integrating mental health services as part of the community helped to normalize mental health. Furthermore, providers recommended building on protective factors (e.g., *familismo*) to help Latino consumers overcome barriers in accessing care.

Family involvement

Building on the cultural core value of *familismo*, participants who actively sought mental health treatment or had a family member seeking help described the significant role that family plays in the success of individuals' recoveries. Providers who participated in the forums also put an emphasis on integrating family as part of the consumer's treatment, and referring to family members as essential resources when coping with mental health conditions. However, providers also highlighted the complexities that accompany disclosure of mental health illnesses to family members. In particular, participants noted the antagonism that LGBTQ individuals face when disclosing their mental illness and their sexual orientation. One provider gave this striking account:

> I was working with an LGBTQ youth who was suffering from depression and contemplating suicide because he feared being rejected by his family once he came out. When he came out to his parents, his father immediately kicked him out and told him he was never to step foot in his home. The youth's mother pleaded with her husband not to abandon their son.… The mother was also asked to leave if she continued to support their son's sexual identity.… The youth went and jumped off a bridge in an attempt to end his life. I made several attempts to connect with the youth's father and he refused to speak with me, cursing me out [at] every attempt I made.… When he finally took my call, he asked what I would have done if one of my sons came out to me? I responded with "my love for my son would not change just because he is gay, [and] I would love him no matter what … This is what family does." He invited me to his home to continue our conversation.… During our face-to-face talk, he continued expressing his difficulties with accepting his son's sexuality,… Respecting his position, I demonstrated concern by simply placing my hand on his shoulder while we talked about the importance of family involvement.… During our conversation, we realized that we both grew up in the same town in Mexico … [and] our conversation became more about family and no longer about his son being gay.… He finally came around and embraced his son and actively participated in his son's treatment.

In this instance, the level of family involvement was dependent on the approachability of a community mental health provider with a common family and cultural understanding and expression of *familismo*, combined with *respeto* and *personalismo*. Latino LGBTQ participants also identified engaging extended family members as a strategy in the coming-out process. Extended family plays a key role as a support system for both the parents and the LGBTQ person. One Latino LGBTQ participant noted:

> When I came out to my mom, she was devastated and could not understand. She was, like, "How can this be? You went to school, you got a master's degree?" She thought I must have gotten it from school or my friends.… But my niece who also has a master's degree in social work, she educated her [mother].… "grandma, this is normal, he was born this way," so she was my resource to talk to my mom. My mom trusted my [niece], she was educated, so a new generation educated her [the mother], because she was not ready to listen to me … and that support system helped me focus on treatment for my depression.

Prior research has shown that Latino family members are important resources and are integral parts in the successful treatment of a family member (Garza and Watts, 2010), especially children and youth (Shetgiri et al., 2009).

Participants also seemed to agree that family plays an important role in promoting resilience among young Latinos. Participants suggested one strategy to engage struggling families: to ask individuals from other families who had a striking success story conduct home visits and share their knowledge, skill, and experience in overcoming barriers. The basis for this strategy is to focus on family members rather than on the youth with mental health problems, and thereby build families' confidence in handling crises. This strategy is in line with the National Alliance on Mental Illness (NAMI) Family-to-Family Educational Program, which is designed to encourage family members to become actively involved in the treatment process by gaining the knowledge and skills needed to cope with crises more effectively. Home visits, and particularly a family-to-family approach, were described as beneficial for youth with mental health problems. One young Latina participant spoke clearly about her beneficial experience with a family-to-family approach:

> I've just always been like going through stuff … through addictions and stuff like that.… I was going through drama in life.… At the time it doesn't seem like it affects you … but having families of youth with similar issues educate my parents on where to go for help, [and] how to obtain a referral, helped me deal with my issues, and even though I'm in an alternative school, I'm graduating and I'm doing it for my [family].

Church and religious leaders

Many participants identified churches as significant sources of strength and support in their communities. Participants also described their preference for seeking support from church priests, pastors, or other non-traditional service providers in times of emotional crisis. Overall, the participants believed that churches were in a better position than agencies to effectively disseminate mental health information to the community. One strategy envisions persuading church leaders to become involved by providing them with information and training regarding mental health illness and interventions. One Latina mother of three summarized the importance of community and mental health education through the church:

> Many children in my community have mental health challenges and are often mistreated because nobody knows how to address their needs. Many of these children including my three go to catechism, and parents are in mass every Sunday.… I think it is important for priests and other church leaders to be properly educated about mental health issues and available resources so that it becomes part of their sermons and catechism education.

Moreover, participants believe that their faith and religion play a major role in their healing. This revelation is consistent with the findings from other studies on faith, spirituality, and religion (Falicov, 2009). Many LGBTQ participants emphasized the need to focus on reconnecting Latino LGBTQ to their spirituality and on the importance of being connected to one's spirituality as a strategy in dealing with rejection and achieving good health. One LGBTQ participant stated:

> In my perspective, a large majority of the LGBTQ people are still out there floating, they're in limbo because they want to belong to an institution [church] but feel betrayed by the institution.… We have learned that spirituality is the number one important thing for Latino LGBTQ, then comes the mother, then the self … so they put God first and all this ties into one's validation of who they are as people. [Being connected to one's spirituality] helps an LGBTQ person accept himself and in defining how do they deal with shortcomings, how do they deal with mental health issues, how do they deal with substance abuse, and all things that put them at higher risk.

Community role models and mentors

The function of community role models and mentors emerged as an important theme across the range of forum participants. Role models and mentors were seen as particularly important in increasing individuals' and communities' knowledge and awareness of barriers to care. Many participants emphasized the importance of increasing the numbers of professional role models who are knowledgeable of the Latino culture and community as an overall strategy to enhance knowledge about mental health services and reduce stigma.

The involvement of *promotoras/es*—community health advocates, leaders, educators, and outreach workers in the Latino community—emerged as a strategy to bridge the mental health care system and Latino communities using a

peer-to-peer format. A peer-to-peer approach in the current study is defined as the involvement of people or "peers" who share similar life experiences and are able to relate and empathically connect with others in need. Participants suggested that *promotoras/es* can help compensate for the shortage of mental health workers. Many participants described the demonstrably beneficial influence of *promotoras/es* on their mental health treatment, including their impact on reducing the stigma associated with mental health treatment. As one *promotora* stated:

> Promotoras/es … connect consumers with resources, mentor, and train others to serve as promotoras/es.… These trainings focus on [preparing] people to go out into the community where they are able to relate to the community and build trust.… Promotoras/es talk to the community about [accessing] resources, while at the same time, outreaching and linking people in need of services.… The promotoras/es model builds on community strengths and [is] guided by one goal … to [empower and] organize the community so that they know what to do during a crisis.

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Promotoras/es seemed to be a crucial vehicle to communicate with the Latino community and increase awareness and access to mental health services and reduce stigma. Another benefit of the *promotoras/es* is that they constitute a local workforce strategy. The use of *promotoras/es* aligns with one participant's sentiments: "Service providers should be people from our culture that have more education [and training].… This will help to increase capacity of our community."

Although participants noted that schools were not equipped with adequate school-based mental health programs, they highlighted the important role that teachers and professors have as role models and mentors in encouraging and engaging students in mental health awareness activities. One university student stated:

> I think professors should be like … encourage students.… Professors themselves have to be more knowledgeable and know about everything that's going on in this school … like [mental health] services … [so] they can inform their students … because right now, we ask them a question and it's like, "oh, I don't know." Well, thank you for nothing, you know? Knowing that one [Latino] professor … you can relate to and who is knowledgeable and … actually does care … you're gonna feel comfortable talking about it [mental health].

In this example, having a knowledgeable role model from her own culture was important for the university student. The lack of school-based mental health programs seemed to be secondary to the participant relating to the professor and the professor being well informed about the services available to students.

Participants also described experiences working with mentors—specifically those who are familiar with the mental health system. In a particularly salient account, a respondent described a comfortable and humorous experience with her mentor: "You know you will feel like you're gonna go and sit in [his talks] and feel that relaxation right away.… You're like … 'Ohhh, okay … I can be myself.' And I think that like with [mentor] … he's like the same Latino culture, we can relate a lot to his jokes and to his, you know, his George Lopez personality.… I think it's great that he has the ability to make us laugh." The availability of role models and mentors who are able to relate to the Latino consumer and able to create a relaxing atmosphere where the consumer feels at ease communicating about mental health issues is crucially important.

Community pláticas (conversations)

Pláticas or conversations emerged as a prominent theme to promote Latino mental health. In a particularly striking account, a parent participant described the sense of helplessness she experienced in her attempt to obtain help for her son: "[My] teenage son was having a crisis and I called a mental health hotline.… They didn't speak Spanish and [I] was told to call the police for them to arrest [my son].… I immediately hung up the phone and tried to get him under control because I couldn't bear seeing [my son] arrested.… I wish I could talk to other parents who went through this." Of particular importance to this parent and other participants was the notion of community *Pláticas* used in support groups composed of Spanish-speaking people with similar experiences and well-informed community leaders (e.g., *promotoras/es*). Participants also expressed the value of *Pláticas* that

incorporate the testimonials of Latino consumers with successful recovery stories as an inspiration and sign of hope. Participants demonstrated significant awareness of the extent to which community *Pláticas* enormously benefited Latino communities in addressing issues that affect various segments of the Latino community (e.g., women, men, youth, elderly). Using this format, domestic violence, drug and alcohol abuse, discrimination, mental health, stigma, and other topics of interest were discussed in a place where people felt safe sharing personal accounts.

A young Latina teacher who participated in the focus groups suggested conducting a series of *Pláticas* at schools for faculty, students, and parents on issues and topics relevant to Latinos and mental health. The Latina teacher advocates "on-site training of professionals working in schools with kids … [in] regular community [*Pláticas*] that educate on services and programs and networks so that providers and community [educators] know where to access services and what those services provide." Many participants emphasized the importance of using schools as a vehicle to host these community Pláticas, including parenting classes, faculty meetings, and visual and performing arts. Another participant suggested use of theatrical presentations directed toward children and youth in schools to teach them about mental health issues in a non-threatening manner.

Community-Identified Strategies for Prevention and Early Intervention Programs

Key Finding: Participants recommended that prevention and early intervention can best be achieved by following six strategies: (1) school-based mental health programs; (2) community-based organizations and co-location of resources; (3) community media; (4) culturally and linguistically appropriate treatment; (5) workforce development to sustain a culturally competent mental health workforce; and (6) community outreach and engagement.

School-based mental health programs

Participants emphasized the importance of building partnerships with schools and noted that schools are easily accessible and convenient for both mental health treatment and prevention programs. In particular, participants discussed the importance of mental health education in schools to improve understanding among students and their parents about mental health problems, signs and symptoms, and treatment. Participants also noted that mental health promotion programs in schools, including early detection and prevention programs, could result in reductions in school dropout rates.

Participants agreed that secondary schools, colleges, and universities are in a unique position to promote mental health education and to help increase knowledge and awareness about mental health issues and barriers to care. When asked about strategies to increase mental health treatment participation at an individual and community level, participants overwhelmingly suggested implementing more programs on school campuses to promote mental health awareness. School-based mental health services may be essential for Latino youth, whose access to specialty mental health services has been compromised (Kataoka, Zhang, and Wells, 2002). Kataoka, Zhang, and Wells stressed early identification of adolescents who have mental health problems that have never been detected or properly diagnosed, as well as early intervention with these adolescents. Community education with a focus on early detection and intervention was recognized as an essential strategy not only for raising awareness, but also for taking swift action in reducing the severity of a disorder and the cost of care.

The participants emphasized the importance of family support and involvement in a school context as a strategy to educate Latino families and communities about mental health services. Participants recommended scheduling parenting classes on mental health, which would include core classes before their children pass through critically important school transitions (e.g., the transition from elementary to middle school). More programs are needed to strengthen families, such as parent-to-parent training sessions conducted by parents with relevant experience. Furthermore, participants advocated creation of more support groups on school campuses. Another parent participant noted:

> [We] need to be positive advocates.… Our kids don't even really hear about it going to school … [and] they don't really hear about it in their family.… I think mental health is just one of those things that we need to promote.

Adolescence is a crucial period because it coincides with the time during which many individuals begin to experience mental health problems that will persist into adulthood (Keller, Salazar, and Courtney, 2010). Acknowledging and acting on the early identification and mental health intervention of adolescents may decrease incarceration rates, drug use, and eventually severe mental illness. Early detection and community-defined best practices can change the course of young people's lives and mental health disorders. Accurate and early detection of mental health conditions for this segment of the Latino population is critically important and could lead to nationwide reductions in health care costs. Furthermore, failure to work with high schools on school-based mental health programs could result in consignment of more youth, in particular transition-age

youth, to the juvenile justice system, where mental health services are seriously lacking.

Community–based organizations and co-locating resources

Participants identified co-locating existing community resources as a potential strategy to improve the provision of mental health services, by means of innovative methods to maximize resources and engage individuals and agencies. Collaboration among all parts of a community, including homes, schools, and churches, helps Latinos establish trusting relationships that can significantly influence their decisions regarding accessing services and deciding upon treatment options. Churches, schools, community centers, and other organizations were identified as community settings where Latinos can feel safe and comfortable visiting frequently without fear of discrimination or deportation. The ability to empower a Latino community and strengthen its capacity to serve its members is of great importance to the participants.

Community assets and strengths can be understood as the total participation of individuals and community organizations consolidating to mobilize and leverage existing community resources and natural communities of support. Doing so can help enhance access to existing programs and lead to improved behavioral health outcomes for the Latino community. Participants believe that the strategy of building on assets and establishing a collaborative network could maximize community resources and give families and consumers a voice in their recovery. Also, ethnic services managers (ESMs) who participated consistently endorsed the value of nurturing and coordinating collaborative partnerships to increase access to care. One ESM described community-based organizations in collaboration as:

> A strategy that builds on the strengths of Latino communities by focusing on partnerships within the community.… The idea is not to make the consumer have to travel a long distance and come to us, [but] rather [to] engage the community and build services around the community by maximizing already existing resources.

Co-location is an approach that integrates mental health services into primary care as a pathway to improving access to and utilization of mental health services. This approach is in accordance with the National Institute for Health Care Management Foundation's (2009) definition of co-location as primary health care and mental health providers within the same treatment setting, including non-traditional settings (e.g., schools and community-based organizations). Co-location enables organizations to collaborate and share resources to better serve the Latino community. As previously mentioned, a potential benefit of co-locating resources is increased likelihood that primary health care providers will be able to recognize and manage care of mental illnesses and coordinate referrals with their mental health provider counterpart (Katherine Flores, 2012). As a result, this collaboration will reduce the long waiting lines for mental health services, and increase the likelihood that Latino consumers and their families will use and adhere to their mental health treatment at their point of entry into the health system (NIHCM, 2009).

Our data indicated that the practice of co-locating services may play an important role in building a mental health infrastructure that is culturally and linguistically relevant and comfortable for the Latino community. The participants outlined numerous potential benefits of co-locating services for Latinos. For example, one ethnic services manager (ESM) participant stated, "Latino families benefit when agencies collaborate and share resources within the community, as opposed to making the consumer come to our agency." Educators emphasized the importance of co-locating mental health services and academic counseling where students could access mental health services during non-school hours. They also mentioned that AB 540 students or undocumented students would be able to benefit from co-locating services. AB 540 is a California law that enables undocumented students to attend a California public college or university and pay in-state tuition.

Another benefit of co-locating services is the ability to maintain alternative operating schedules, with services in the evenings and/or weekends. The idea of offering mental health services on different days and times and being flexible to accommodate Latinos' work schedules was a critical factor that related to the participants' ability to attend their appointments. One participant noted: "I work long hours and I can't afford to lose work to attend an appointment. Work around my work schedule if you want me to show up." The majority of participants spoke about the great importance transportation in accessing mental health services, especially for low-income families. One ESM who participated in the Solvang forum suggested establishment of pilot transportation programs with routes customized to serve consumers during their treatment (depending on their need and the recommendation of the clinician), and with monitoring and evaluation for cost

> "I work long hours and I can't afford to lose work to attend an appointment. Work around my work schedule if you want me to show up."
>
> —*Latino adult*

efficiency. Some participants also recommended mobile clinics that are dispatched to the consumer's community for treatment as a strategy. A mobile clinic is a special-purpose coach or bus in which mental health services are performed for members of underserved communities who do not have means of transportation.

Another alternative to co-locating services is the "collaborative care model" (Katon and Unützer, 2006). This evidence-based model of integrated care includes six key ingredients: (1) care management [i.e., patient education and empowerment, ongoing monitoring, and care-provider coordination]; (2) evidence-based treatments [i.e., effective medication management and/or psychotherapy]; (3) expert consultation for patients who are not improving; (4) systematic diagnosis and outcome tracking; (5) stepped care; and (6) technology support [i.e., creating and maintaining registries]. Research from Katon and Unützer shows that the collaborative care model is strongest for treating depression, anxiety, and other common mental disorders in primary care settings. Emerging evidence also indicates that the collaborative care model is effective at improving medical care for patients with severe mental illness (Katon and Unützer, 2006). The collaborative care model has been shown to reduce suicidal ideation in depressed older patients, as well as to improve the rates of diminishing pain severity and depression in patients with arthritis (Lin, Katon, Von Korff, et al., 2003).

A meta-analysis study consolidating the results from 37 randomized studies, which encompassed 12,355 patients who received treatment for depression in primary care settings utilizing the collaborative care model, found that collaborative care is more effective than standard care in improving depression outcomes, in long-term and short-term time frames (Gilbody, Bower, Fletcher, et al., 2006). The "active ingredients" in positive depression outcomes in collaborative care for depression in primary care settings included improved identification of depressed consumers, professional education of the staff, and on-site psychiatric supervision (Gilbody, Bower, Fletcher, et al., 2006). A collaborative care model adapted for cultural and social factors has been used with low-income, diabetic Latinos receiving care in safety-net clinics, and it has been found to improve depression, functional outcomes, and receipt of depression treatment (Ell, Katon, Xie, et al., 2010).

Community media

Participants attained consensus that communication media could play a critical role in educating Latinos about mental health services as well as removing barriers to care, particularly for Latino immigrants. The participants viewed this type of media approach as a way to increase community education, reach out to more Latinos, "plant the seeds" regarding mental health care, and decrease stigma related to mental illness.

Participants reported that *fotonovelas* could be particularly important sources of information for mental health issues. A *fotonovela* is a culturally informed health literacy media tool that presents information in familiar, readable, and entertaining format. For example, in San Diego, participants credited the bilingual (Spanish and English) *fotonovelas*, a media booklet that educates Latinos about mental health issues, with increasing awareness about available resources and services. In addition, one participant emphasized doing more to "use social media, Facebook, and Twitter for the younger (Latino) population." These suggestions are consistent with the research showing that media such as film or the Internet are critical tools in promoting access and reducing disparities (Dixon et al., 2011). After examining depression *fotonovelas*, Cabassa, Molina, and Baron (2010) proclaimed *fotonovelas* as engagement tools for providers to educate consumers about depression and said they can enhance existing depression treatments in primary care and specialty care settings.

LGBTQ participants also discussed the use of community radio as an asset to educate the community about issues related to mental health and homophobic violence. A respondent suggested that *Radio Bilingüe* (Bilingual Radio; www.radiobilingue.org/), which broadcasts Spanish-language radio *novelas* (soap operas), could convey salient stories about being an LGBTQ individual, while at the same time promoting acceptance and equality. Participants understood the critical role of *novelas* as part of a strategy for addressing stigma and giving the LGBTQ community a voice. For example, a *novela* could depict a gay character living with HIV/AIDS and enjoying life with proper treatment. A key idea would be conveyance that being gay does not automatically translate into having HIV/AIDS, and having HIV/AIDS does not mean a "death sentence."

Culturally and linguistically appropriate treatment

A major theme that emerged from the discussions that occurred during the forums was the importance of understanding an individual's or a community's assumptions and perspective on mental health. The participants achieved consensus that integration of clients' cultural values and beliefs, life experiences, and family practices as part of their treatment plan is a fundamental element in working effectively with Latino individuals. This is an important finding because it differentiates between "simply being aware," such as textbook knowledge, and "putting into practice" by immersion into a patient's everyday life experiences. In other words, the forum participants advocated for culturally appropriate approaches to treatment of mental health problems.

Participants believe that a culturally appropriate approach could be achieved through quality time spent building a relationship and conducting informal but relevant conversations (Plática y conocimiento) about one's cultural values and beliefs, way of life, and family practices. The participants also cited the need to ensure that clinics and providers are specialized in the language of the community they are serving. Failure to use proper language consistent with the Latino culture could make Latino mental health consumers feel misunderstood and foster distrust toward the provider. Participants likewise noted that the terminology used when discussing mental health with Latinos often is too technical, which may contribute to potential vulnerability and stigma. For example, one participant commented:

> Change the terminology or soften the language when discussing mental illness in order to promote acceptance and reduce the stigma.… Mental illness should be perceived the same way as other illnesses are perceived, such as diabetes. [Providers] must know the education level of the people that they serve.… Often times this aspect is unknown when serving patients and their mental health, and they don't know how to provide literature that is at their level.

When discussing cultural and linguistic competence for the LGBTQ community, most participants emphasized LGBTQ culturally competent services and recommended creation of a specialized certificate that requires therapists and clinicians to receive training to become LGBTQ culturally competent.

Workforce development—sustaining a culturally competent mental health workforce

The majority of the participants believe that the number of qualified bilingual and bicultural mental health care workers in California is insufficient. Some participants expressed frustration with the lack of communication and collaboration among the mental health industry, schools and colleges, and the Latino community to educate youth about careers in mental health and design curricula that focus on culturally and linguistically competent skills. One overarching strategy to diversify the mental health workforce would be dissemination of information and engagement in recruiting in high schools to encourage students to consider entering social work or other mental health professions. Better and more consistent educational programs must be established to teach students how to enter the mental health field. One Latino community leader stated:

> **"Promote positive exposure to behavioral health careers through experiential learning and education … [and] work with schools to inform students about mental health career programs."**
>
> *—Latina university student*

There is a lack of bilingual and bicultural mental health providers who can provide mental health and effective prevention services that are culturally responsive to the Latino community.… More should be done to establish scholarship and loan forgiveness programs for Latino students interested in a career [in] mental health care … [accompanied by] additional funding to colleges and universities to develop [a] curriculum in mental health.… Getting high school students interested in mental health is key to a strong workforce.

Along similar lines, participants noted the potential of the Fair, Accurate, Inclusive, and Respectful (FAIR) Education Act as a framework to begin aligning mental health and LGBTQ issues and classroom instruction to better educate youth, and also to promote career readiness opportunities for youth. For instance, one participant said: "Provide young Latinos who are interested in pursuing a mental health career with resources such as [a] specialized curriculum, professional mentors, and course of study to achieve their career goals." The FAIR Education Act is not only about teaching adolescents about LGBTQ issues. It also promotes classroom instruction about civil and social movements, and history of all people (e.g., people with disabilities, Latinos, and LGBTQ people) in ways that reduce social exclusion.

With regard to career pathway programs, one participant stated, "Promote positive exposure to behavioral health careers through experiential learning and education … [and] work with schools to inform students about mental health career programs." The participants clearly recognized the need to work with schools to educate parents and families, while at the same time helping schools and educators modify their curricula and establish learning conditions that would shape perceptions about using mental health services and choosing mental health careers for Latino students. Working with schools to promote mental health careers can be a strategy that could help counteract the low academic expectations that plague many schools and the lack of school continuity beyond high school. Participants emphasized the value in working with high schools on career pathway programs that could help smooth the transition into adulthood

> **"I've found that quality time between me and my provider where I can discuss issues without a time limit to me makes all the difference in the world to me."**
>
> —*Latina consumer*

for Latino youth, reduce high expulsions, and decrease alternative school designations for Latino youth.

Moreover, participants place high priority on collaboration between colleges and universities and Latino communities to create a culturally and linguistically appropriate workforce serving Latinos. School workforce pipeline programs that include career pathway academies, associate degree and certificate programs at community colleges, as well as other educational and career-related curricula were of particular importance to many participants. One participant noted:

Develop a culturally appropriate workforce by providing students with loan forgiveness programs, state and federal grant money, free financial aid, distance learning opportunities, college credit for work or lived experience such as a certificate process for lived experience, and employee benefits once they start working.

Another participant emphasized that "more internship programs at the master's degree and doctoral levels for [Latino students] in a mental health career track" are needed. Other forum participants suggested developing an associate of arts degree program at a community college as a strategy to enlarge the pool of bilingual and bicultural mental health workers. In short, participants believe that more should be done to define and develop the elements that help structure a successful pipeline to maximize students' interest in health care and their understanding of the industry's focus on prevention and early intervention as a result of the Mental Health Services Act. Ultimately, the goal of the education system should be to implement a pipeline structure with content that emphasizes activities that promote career readiness and knowledge, experiential learning, and self-efficacy related to mental health care careers.

Community outreach and engagement

Community outreach and engagement are necessary to disseminate more information about mental health issues and treatment, how and where to access services, and knowledge about existing mental health professions. Participants recognize that, for the most part, Latinos do not engage in preventive care services or seek help before or during the early onset of an illness. The resistance to preventive care or early action results in prolonged suffering for consumers and their families, and often requires more costly treatment as the illness progresses. When asked why some Latinos continually access and use mental health services while other Latinos terminate treatment early, many participants attribute the consumer-therapist relationship and the relationship between the consumer and the agency as critical factors. This finding is consistent with the results of Lewis and Osborn's (2004) study, which found that successful outreach and retention rates are associated with relationship-building.

Two critical questions to consider regarding mental health services for Latinos are: (1) What is the nature of the relationship between consumers and the agency or provider with which they come into contact? And (2) What about this contact encourages consumers to continue and follow through with treatment? "Leverage the culture and the community assets of the consumer so that he or she feels acknowledged and validated," said one participant. One Latino community leader recommended establishment of pilot outreach and engagement programs focusing on comprehensive bilingual educational and co-location programs to reduce stigma and develop strong ties with the Latino community to enhance treatment participation and retention. Ruben Imperial, program manager for Stanislaus County Behavioral Health and Recovery Services, supports this notion and expands on the idea of capacity-building: "Strengthen the capacity of our local [Latino] communities by developing strategies that promote the health and well-being of individuals … leveraging what already exists in the form of community assets and natural communities of support" (personal communication, March, 9, 2012).

The majority of participants described the influence of the consumer-therapist relationship on achieving successful outcomes. "I've found that quality time between me and my provider where I can discuss issues without a time limit to me makes all the difference in the world to me," said one consumer participant. Another participant noted the reciprocal learning that occurs between the consumer and the provider, with the provider learning from the consumer and the consumer learning from the provider. This participant says that viewing treatment of the conversation between the consumer and provider as an expert-to-expert dialogue is more constructive than seeing it as an expert-to-patient one-way conversation.

EVALUATION AND OUTCOMES

Strategies for Designing Effective Approaches for the Evaluation of Implemented Recommendations

Key Finding: Participants identified four major evaluation areas: (1) reliability and relevance; (2) knowledge and commitment to serving Latinos; (3) consumer and family participation; and (4) accountability panels. Participants perceived these areas as key components to measure and achieve positive outcomes in which Latinos would access mental health services based on the community-defined evidence practices, have high retention rates, and experience high-quality service.

Reliability and relevance

Several studies of both adult and youth populations suggest that Latinos are more likely than non-Hispanic whites to prematurely drop out from treatment, with as many as 60 to 75% of Latinos dropping out after just one session (McCabe, 2002). Understanding why Latinos drop out of mental health treatment after the first session continues to be a huge concern for the Latino community. Many of the forum participants suggested that irrelevance of mental health services to Latinos who seek help contribute to high rates of client withdrawal from treatment programs. Most of the participants recommended dedication of more attention to understanding the relationships between the consumers and providers, as well as to measures to ensure that treatment and interventions are the right fit or relevant to the Latino consumer. This recommendation is consistent with Lewis and Osborn's (2004) finding that relationships can engender high retention rates. In addition, as a way to achieve strong retention rates, participants asserted that mental health agencies should rethink and reorganize their evaluation strategies and interventions to include consumer criticisms and suggestions.

Knowledge and commitment to serving Latinos

Across all forums, participants emphasized that mental health agencies need to demonstrate commitment to serving Latino communities. In other words, their recommendations suggested that mental health programs receiving funding to serve Latinos and improve mental health disparities for Latinos should be required to produce outcomes that demonstrate increases in access to services, improved retention rates, reduced dropout rates, and increased quality of care. One participant recommended linking funding with the number of Latinos served and determining the effectiveness of follow-ups according to the number of consumers who terminated treatment early. Specifically, this participant noted that, "Good evaluation methods means ensuring that [mental health] agencies are following up with clients who don't show up and following up with the other services the [social] worker has referred the client to.… Determining how the funding is being disbursed is one way to evaluate an agency's commitment [to Latinos]."

Consumer and family participation

Participants recommended participation of consumers in the evaluation approach used to measure improvements in mental health conditions. Additionally, the participants suggested that providers should routinely check in with consumers to determine the effectiveness of the treatment and services. Other participants recommended an evaluation strategy that included the participation of family members. The consumer participants said that treatment and evaluation methods with greater family focus could result in reduction in consumer early treatment termination or dropouts. As one participant noted, "A well-structured evaluation is one where the consumer and family members are involved and provide feedback based on the treatment and services."

Accountability panels

The participants recommended formation of accountability panels that would monitor the effectiveness of mental health programs. Participants said these panels would review the way in which Latino programs and practices are implemented and ensure that services are relevant to Latinos. The panels also would monitor to see whether services are being administered consistently and in accordance with the needs of Latino communities and their treatment goals. The accountability panels, according to the participants, could consist of consumers; family members; legislators and other civil servants; personnel from nonprofit organizations; representatives from educational institutions and law enforcement and criminal justice systems, and general public community advocates. The general assumption was that these accountability panels would develop culturally attuned evaluation instruments that would measure the impact of the services Latinos received, and identify baselines to better gauge penetration and retention rates over time.

PREVENTION AND EARLY INTERVENTION EVIDENCE-BASED COMMUNITY-IDENTIFIED STRATEGIES FOR IMPROVING MENTAL HEALTH TREATMENT

Core Community-Identified Strategies to Improve Community Services and Treatment

These core strategies reflect the merging of participants' opinions from the various participating Latino communities in California, and were put forth and prioritized as a guide to generating a set of statewide strategic directions to promote prevention and early intervention solutions to improve community services and mental health treatment.

Core Strategy 1. Implement peer- to-peer strategies, such as peer support and mentoring programs, that focus on education and support services.

One main finding from this report was that in order to be effective in improving mental health treatment for underserved Latinos, organizations and community services and supports must adopt peer-to-peer approaches. The key goals of peer support and mentoring programs are reduction of stigma and increases in accessibility to treatment by focusing on building trust, maintaining open communication, and developing relationships. Participants regard the promotoras/es model, family-to-family programs, and other peer-to-peer strategies as effective means of reaching out and educating Latino communities about mental health. The participants also highlighted the benefits associated with positive role models who come from their communities.

Core Strategy 2. Employ family psychoeducational curricula as a means to increase family and extended family involvement and promote health and wellness.

As noted in the findings and discussion section of this report, another strategy to which participants assign prominence is education of the whole family and relatives, close friends, and other people who are in supportive roles to Latinos receiving mental health services. The desire to educate the whole family aligns with high value that Latinos place on *familismo*. The critical goals are to help families learn more about mental illness and learn ways to prevent or intervene before common stressors and other problems lead to severe mental disorders. The focus of the curriculum will be to teach families the basic information about mental illness, as well as provide resources that Latino families can use to support the recovery and wellness of their family member. Research has shown family psychoeducation to be helpful for Latino individuals with bipolar disorder and depression, as well as helpful for members of families that have individuals with these disorders (e.g., Dixon, McFarlane, Lefley, et al., 2001).

Core Strategy 3. Promote wellness and illness management, and favor community-based services that integrate mental health services and other health and social services.

Holistic well-being at the individual, community, and societal levels—emphasizing the whole person and his or her interactions with their environment—was a recurring theme uncovered by this report. Prevention and early intervention strategies must focus on empowering individuals, families, and communities. The key goal is to develop interventions that empower Latino communities to adopt healthy behaviors, improve health status, and better manage chronic conditions. For example, the Alliance for California Traditional Arts (ACTA) is a program that emphasizes the use of traditional art forms of mental health consumers' cultures to help individuals and communities achieve wellness, spiritual and emotional connections, resilience, and an understanding of health from a holistic perspective.

Community-informed practices and programs that can be piloted and evaluated to determine their potential in serving Latino communities must be carefully identified. That process must be accompanied by assessment of whether these practices and programs generate sustainable outcomes through activities that can be identified as a best practices.

Core Strategy 4. Employ community capacity-building strategies that promote the connection of community-based strengths and health to improvements in Latino behavioral health outcomes.

Community-based assets can be understood as the total participation of individuals and community organizations collaborating to mobilize and leverage resources to improve health and mental health promotion and prevention. As this report highlights, many of the strategies suggested to improve behavioral health for Latinos are rooted in community action, participation and partnership, leveraging indigenous and cultural healing practices, and natural communities of support, with culturally and linguistically competent, accessible professional mental health services. Incorporating public health community development and principles of community engagement, strategies should focus on building the capacity of the local Latino community, including (1) political, (2) community leadership, (3) residents, and (4) family members and consumers, to define behavioral health outcomes at the community level and mobilize and align the various community partnerships and resources described in this report. Using community strategic action plans at the local level,

community-based organizations and county and local government agencies should convene local stakeholders to design mental health programs that meet local mental health needs, reduce mental health disparities, and improve results. Counties and local governments should collaborate with community groups and allow diverse local community stakeholders to agree on desirable outcomes, plan how and when to achieve them, and annually report progress. A statewide Latino behavioral health leadership initiative should be developed to focus on strengthening the capacity of local community efforts to develop strategies and actions to improve behavioral health outcomes for Latinos.

One main goal is to implement strategies that rely on community-based organizations, community leaders, and advocates to help reduce stigma. Another goal is to create an environment in which concern for others' welfare translates into a healthy community with effective crisis prevention, which could lead to lower health care costs in the future. A key finding from this report was the notion of co-locating services and the important role that doing so plays in establishing a mental health structure that is culturally and linguistically relevant and comfortable for Latino communities. Attention should be given to implementing a comprehensive system of care for Latinos that focuses on building on existing community assets and resources to improve access to care. Strategies that aim to increase consumer and family engagement also are important in prevention and early intervention planning and programs. Consistent with the methods used by the Latino Access Project (Latino Behavioral Health Institute, 2010), employing strategies that were aligned with the individual's culture and language proved to be an effective approach to engage Latino individuals and families in treatment.

Core Strategy 5. Create a meaningful educational campaign that is designed to reduce stigma and exclusion and that targets individuals, families, schools, communities, and organizations and agencies at the local, regional, and statewide level.

This report presented evidence showing an association between stigma and mental health treatment. The overall finding was that stigma manifests itself in the form of shame and fear of being judged and ultimately can deter an individual from seeking treatment. Surmounting this barrier requires design of a stigma reduction educational campaign that focuses on changing the Latino community's attitudes about mental health while increasing awareness and knowledge about mental health. The campaign would rely on a multifaceted approach incorporating numerous media methods to reach a large number of Latinos and achieve changes in attitudes and behaviors. Radio and television programs that are entertaining and aim specifically to influence Latino communities could be used for this purpose.

Core Strategy 6. Include best practices in interated services that are culturally and linguistically competent to strengthen treatment effectiveness.

Attention should be given to integrating mental health treatment with primary care and substance abuse treatment programs. The mental health programs should be housed in existing community-based organizations serving far-reaching Latino communities. For treatment to be effective, community-defined practices and programs must embrace behaviors, attitudes, and policies that are compatible with the culture and language of the Latino consumer and his or her family. The participants were particularly interested in seeing the adoption of evidence-based practices for Latino communities that traditionally are the most difficult to engage and serve. Therefore, the focus should be on coordination of care encompassing an array of behavioral health services to create a comprehensive system of prevention and early intervention.

STRATEGIC DIRECTIONS AND RECOMMENDATIONS FOR REDUCING MENTAL HEALTH DISPARITIES

Strategic Directions and Recommended Actions

The six aforementioned core strategies provided the foundation from which these seven strategic directions were developed and prioritized. These key recommendations can serve as guiding principles to promote and enhance the ability to identify community-defined promising practices, increase access and utilization of quality services, and improve treatment outcomes and quality of life for Latinos.

Strategic direction 1: academic and school-based mental health programs

Focus on adolescents and the impact of failing to adequately screen, detect, and diagnose potential mental health problems in a timely manner. Schools constitute a safe setting in which to educate families and their children about mental health. Tie mental health programs to academic achievement and performance.

Recommended actions at the local and state level

1.1 Increase county collaboration with secondary schools to identify mental health problems among Latino adolescents and provide interventions aimed to decrease the risk of incarceration, drug use, and mental illness. Stress that early detection and identification translate into reductions in cost of care.

1.2 Increase advocacy efforts and programs in schools to ensure accurate and early detection of mental disorders among Latino youth, as a strategy to change the course of a potential mental disorder as well as to avoid possible misdiagnosis that may result in mistreatment and high dropout rates.

1.3 Develop a plan to create and integrate mental health educational standards and topics into the schools' curricula.

1.4 Develop and offer parenting classes or seminars to educate Latino parents about the school system and to increase their awareness of available free or inexpensive academic and mental health services.

Strategic direction 2: community-based organizations and co-locating resources

Increase collaboration among community-based organizations, schools, and other social services agencies by coordinating and maximizing community resources to achieve an increase in access to treatment among Latinos.

Recommended actions at the local and state level

2.1 Engage a consortium of faith-based organizations to develop and implement strategies to promote pathways to wellness, reduce mental health stigma, promote social inclusion, and advocate for the importance of spirituality to one's well-being.

2.2 Encourage expansion of Latino older adults' social and family networks, and help increase their social engagement and emotional support by focusing on the integration of health and mental health providers at the community level. Optimize their health and functioning with co-located services and an emphasis on access and a comprehensive continuum of care.

2.3 Develop and support networks of individuals and organizations so that more co-location of resources and services can occur. Ask networks to work together in coordination, integration, and improvement of policies and practices to produce better mental health treatment and outcomes. Network partners can consist of:
- Mental health agencies
- Community clinics and hospitals
- Churches and other faith-based organizations
- Local law enforcement agencies and units of the adult criminal justice system
- Juvenile justice agencies
- Child protective services
- Foster care agencies
- Elementary and secondary schools
- Colleges and universities
- The business community
- Non-traditional organizations (e.g., soccer groups, cultural arts sponsors, youth development programs)

2.4 Following implementation of item 2.3, coordinate with network partners to develop and activate a transportation system to convey consumers to appointments and other activities related to their treatment.

2.5 Invest in training opportunities for primary health care and mental health providers to coordinate and manage the care of mental health illnesses, in order to reduce the wait for mental health services and increase access and retention rates of mental health treatment.

2.5.1 The following recommendations were adopted and slightly modified from the Report of a Surgeon General's Working Meeting on the Integration of Mental Health Services and Primary Health Care (U.S. Department of Health and Human Services, 2001):
- Design and incorporate a survey tool that measures skills, knowledge, and attitudes, and reflects evidence-based "best practices" and treatment management.
- Create and implement a set of education and training standards for the integration of mental health and primary health care involving academic stakeholders and accreditation bodies.
- Evaluate implemented programs and best practices to determine if the integration leads to reduction of health and mental health disparities, accompanied by improvements in treatment outcomes and quality of life.

Strategic direction 3: community and social media

Use media to raise mental health awareness with messages that reduce stigma associated with mental health disorders and promote information and resources about early intervention.

Recommended actions at the local and state level

3.1 Engage Latino news media and the entertainment industry in supporting educational programs that promote balanced and informed portrayals of mental health problems, LGBTQ issues, and mental health services.

3.2 Create and disseminate f*otonovelas*, which are stories told with photos and dialogue, to promote greater understanding of mental health problems and services.

3.3 Coordinate with Spanish radio and television stations that have large Latino audiences, and promote educational programs that can raise awareness about mental health issues. Direct many of the messages to youth audiences. Some of the Spanish radio and television stations, programs, and personalities that can be targeted include:
- Piolín por la Mañana, Mexican radio personality for KSCA, 101.9 FM in the Los Angeles area
- Radio Bilingüe
- *Telenovelas* (soap operas)

3.4 Create recordings of meaningful conversations or Pláticas in which Latino families with individuals who are successfully recovering from a mental illness share their stories and unique perspectives. Deliver the *Pláticas* via various mainstream and ethnic media outlets.

3.5 Convene youth workgroups to design thoughtful messages relevant to youth and mental health stigma, and disseminate these messages using Facebook, Twitter, YouTube, blogs, and other social media outlets.

Strategic direction 4: workforce development

Develop and sustain a culturally and linguistically competent mental health workforce consistent with the culture and language of Latino communities.

Recommended actions at the local and state level

4.1 At various academic levels, support career pathway activities that lead to certification programs and advanced degrees with a focus on bicultural and bilingual training and other population-specific subject matter, including courses related to geriatrics and addiction treatment.

4.2 Establish a certificate course of study at the community college level through which individuals interested in the mental health field can be certified as a Latino mental health specialist.

4.3 Following implementation of items 4.1 and 4.2, expand opportunities for promotoras/es to enroll in higher education to further their education in behavioral health, which will allow them to perform a greater range of services and assume leadership positions in their communities.

4.4 Increase the priority of offering loan forgiveness programs for Latinos pursuing a career in the mental health field and for current Latino and non-Latino providers looking for retraining opportunities.

4.5 Strengthen connections with Chicano/a or Latino studies and LGBTQ studies programs on post-secondary campuses to increase education and training opportunities for Latinos and LGBTQ Latinos seeking careers in the mental health field.

Strategic direction 5: culturally and linguistically appropriate treatment

The key to providing high-quality care and treatment to Latino communities lies in conveying to mental health providers and support staff the importance of communicating with each consumer in a way that acknowledges the consumer's beliefs about mental health.

Recommended actions at the local and state level

5.1 Convene a small workgroup made up of the Latino Concilio members to develop and implement training guidelines that adequately assess the ability of the current and future workforce to effectively conduct culturally and linguistically appropriate care for Latinos.

5.2 Assign high priority to collaboration with community-defined evidence programs in creation of a set of key characteristics of a welcoming environment that emphasizes Latino mental health consumers' sense of comfort while accessing services.

5.3 Following implementation of items 5.1 and 5.2, direct the same Concilio workgroup to develop a "Latino cultural and linguistic assessment tool" to assess how well providers and support staff comply with the recommended community-defined evidence practices mentioned in this report.

5.4 Expand the opportunities for promotoras/es who are proficient in Spanish and other dialects (e.g., Mixteco) to receive education, training, and eventual employment to meet the needs of the Latino community.

Strategic direction 6: community capacity-building, outreach, and engagement

Provide resources for development of grassroots community capacity-building strategies that focus on: (1) strengthening outreach and engagement; (2) building behavioral health leadership in the Latino community; (3) defining behavioral health outcomes at the community level and in terms that matter to Latinos; and (4) building local capacity aimed at reducing disparities and improving behavioral health outcomes. The capacity-building strategies should focus on convening and developing partnerships amongst mental health professionals and the indigenous community leaders to develop and strengthen their relationships. Through these partnerships, they

should collaboratively implement strategies highlighted in this report and continue to develop ways in which they can act together to reduce disparities and improve behavioral health outcomes. In addition, resources should be allocated to create partnerships between community leaders associated with local capacity-building efforts and existing statewide leadership within the Latino behavioral health field to develop strategies to support local community capacity-building and implementation of the recommendations outlined in this report. Resources should be allocated to convene local and statewide leaders to educate them about the SPW recommendations, and to disseminate the recommendations through a summit, educational campaigns, and other activities to best meet the mental health needs of the Latino community.

Recommended actions at the local and state level

6.1 Increase the priority of identifying Latino leaders who are ready to make a commitment to play an active role in advocating and disseminating this report's strategies and recommendations.

6.2 In each county create and implement a Latino Concilio of leaders who will help to facilitate development of the necessary partnerships and relationships amongst Latino community leaders and the professional mental health system in implementation of promising practices, and will help shape the next steps in improving behavioral health outcomes for the Latino community.

6.3 Following implementation of items 6.1 and 6.2, establish specific actions for follow-up care focused on connecting with natural communities of support after a consumer drops out from treatment. Also, provide funding to these Concilios to develop local community Latino behavioral health collaboratives to sustain community capacity-building efforts, and comprehensive, bilingual outreach and education campaigns aimed at increasing awareness and understanding of: (1) how Latinos can improve their behavioral health by connecting to culture and natural communities of support; (2) mental health issues and services available; (3) how and where to access services; and (4) ways to reduce the stigma that Latinos with a mental illness may experience when using mental health services.

Strategic direction 7. Embedding the recommendations from this report into all MHSA funded programs

Encourage counties to adopt and implement the recommendations from this report to ensure that Latinos and other diverse underserved communities gain proportional access to MHSA programs.

Recommended actions at the local and state level

7.1 Incorporate the recommendations from this report into all MHSA funding programs and components.

7.2 Develop a Prevention and Early Intervention funding structure that will support the recommendations from this report and ensure that the funding is aligned to the demographic representation of the Latino population in California, in particular Latinos living below the poverty level.

7.3 Evaluate the influence of these seven recommendations for each of the MHSA components, in particular the inclusion of Latinos in community services and supports, full-service partnership programs, prevention and early intervention programs, workforce and education training programs, and innovation programs.

Chapter 4

Community-Defined Evidence Programs and Practices

Participants emphasized that promising programs and practices with potential to resolve barriers to care do not operate with a "one-size-fits-all" approach. We adopted the community-defined evidence practices that the National Latino Behavioral Health Association (NLBHA) devised, along with that organization's criteria for identifying existing programs for Latinos in California, because they compose the most comprehensive body of material on this topic.

NLBHA used the following seven-item complement of criteria to identify promising practices and programs: (1) capacity building and consciousness-rising, which focuses on building capacity to improve behavioral health or wellness; (2) raising public awareness about mental health, which emphasizes raising mental health awareness within Latino communities through media formats; (3) community outreach, which focuses on community outreach to improve access and follow-up services; (4) increasing service accessibility, which gives attention to reducing barriers and increasing access to care for Latinos; (5) innovative engagement practices, which emphasize the importance of using cultural values in engaging Latino consumers; (6) local adaptations of evidence-based practices for Latino populations, which focus on a provider-consumer relationship; and (7) interventions and treatment, which focus on interventions or treatment developed specifically for Latinos. Using those eight criteria and the recommendation from the forum participants, the research team identified the programs shown in Exhibit 6 as community-defined evidence programs and practices that merit consideration for increased funding and use in California. Although no specific measures guarantee the effectiveness of these community-defined evidence programs and practices, the CRHD research team completed each of the following procedures: (1) conducted content analysis on the website and annual reports for each of the community-defined evidence programs and practices; (2) e-mailed to each of the organizations a short self-report instrument with the eight-criteria set, and asked each to articulate a rationale for each of the criteria that best applies to their promising practice; (3) conducted a second content analysis examining the rationale of each organization's promising practices and rated their potential using NLBHA's eight-item list of criteria. A symbol (✔) indicates that the program is fulfilling those criteria. An evaluation tool, to be developed as part of this project, will test each instrument for its feasibility, acceptability, and trustworthiness, as part of the process of measuring the effectiveness of the promising practices mentioned in this report.

Exhibit 6: Latino SPW Matrix of Organizations with Community-Defined Evidence Programs

COMMUNITY-DEFINED EVIDENCE PROGRAMS (CDEP)

Identified by the forum participants as promising practices for Latinos in California

Program	Brief description	California region	Criterion 1 Capacity building	Criterion 2 Awareness about mental health	Criterion 3 Community outreach	Criterion 4 Latinos' access to services	Criterion 5 Meaningful practices	Criterion 6 Local adaptations for Latinos	Criterion 7 Interventions and treatment
Bienestar – serves Latino LGBT youth, gay and bisexual men, transgender, and HIV/AIDS communities	Operates culturally and linguistically appropriate programs for the Latino community. Understands how important culture intertwines with HIV and seeks to meet the needs of each community.	**Southern:** Los Angeles County	✔	✔	✔	✔	✔	✔	✔
Bienvenido Program – serves Latino youth, families, and consumers	Is a prevention and intervention program that increases access to mental health services, and improves mental health and quality of life of Latino immigrants.	**Central:** All counties in the Central Valley	✔	✔	✔	✔	✔	✔	
Casa de La Familia – serves at-risk Latino male youth and victims of crime	Specializes in treatment of post-traumatic, anxiety, and depressive disorders of children, adolescents, adults, and elderly clients through crisis intervention and long-term individual and family therapy.	**Southern:** Los Angeles and Orange Counties	✔	✔	✔	✔	✔		✔
Center for Community Advocacy – provides training to farmworkers to serve and advocate for improved housing and health conditions	Provides leadership through a Mexican promotoras/es-based model. Promotoras/es are trained using a curriculum designed by the center with a focus on reaching out to rural communities.	**Bay Area:** Monterey County	✔	✔	✔	✔	✔	✔	

Exhibit 6: Latino SPW Matrix of Organizations with Community-Defined Evidence Programs (continued)

Program	Brief description	California region	Criterion 1 Capacity building	Criterion 2 Awareness about mental health	Criterion 3 Community outreach	Criterion 4 Latinos' access to services	Criterion 5 Meaningful practices	Criterion 6 Local adaptations for Latinos	Criterion 7 Interventions and treatment
Centro La Familia – serves Latino youth, children, families, and consumers	Conducts direct advocacy and intervention services for low-income residents. Its mission is to empower low-income people to access life-sustaining resources.	**Central:** Fresno County	✔	✔	✔	✔	✔	✔	
Familias Unidas – serves Latino youth, families, and consumers	Strives to integrate individual, family and community treatment to increase the wellness, empowerment, and self-sufficiency of consumers.	**Bay Area:** Contra Costa County	✔	✔	✔	✔	✔	✔	✔
Family Acceptance Project – serves lesbian, gay, bisexual, and transgender (LGBT) youth	Focuses on community outreach, intervention, education and policy initiative to decrease health and mental health-related risks for LGBT youth.	**Bay Area:** San Francisco County	✔	✔	✔	✔	✔		
Latino Community Relations, Engagement & Outcomes (CREO) – serves indigent Latinos and those in underserved and unserved areas	Strives to form partnerships with natural support systems in Latino communities through churches, schools, health clinics, and community centers to create community awareness of mental health issues and increase access to mental health treatment.	**Southern:** Los Angeles County	✔	✔	✔	✔		✔	✔

Exhibit 6: Latino SPW Matrix of Organizations with Community-Defined Evidence Programs (continued)

Program	Brief description	California region	Criterion 1 Capacity building	Criterion 2 Awareness about mental health	Criterion 3 Community outreach	Criterion 4 Latinos' access to services	Criterion 5 Meaningful practices	Criterion 6 Local adaptations for Latinos	Criterion 7 Interventions and treatment
Manitos – serves primarily Spanish-speaking older Latino populations.	Focuses on social and recreational activities that educate older Latinos on nutrition, exercise, health, and well-being.	**Central:** Sacramento County		✔	✔	✔	✔	✔	
National Latino Fatherhood and Family Institute – works with fathers of all ages	Provides training services using culturally competent curricula focusing on family violence, gangs, teen pregnancy, teen fatherhood, and Latino male youth rites of passage.	**Statewide:** services to many counties in California	✔	✔	✔	✔	✔		✔
Northern Valley Catholic Social Service Promotores Program – serves Latino populations in rural areas	Promotes awareness about domestic violence, depression, substance abuse, and anxiety	**Northern:** Butte County	✔	✔	✔	✔	✔		✔
Pacific Clinics – serves Latino children, youth, adults, families, and consumers	Provides an array of services ranging from prevention and early intervention to recovery and wellness maintenance, with a major emphasis on programs for children and families.	**Southern:** Los Angeles, Orange, Riverside, San Bernardino, and Ventura Counties	✔	✔	✔	✔	✔	✔	✔

Exhibit 6: Latino SPW Matrix of Organizations with Community-Defined Evidence Programs (continued)

Program	Brief description	California region	Criterion 1 Capacity building	Criterion 2 Awareness about mental health	Criterion 3 Community outreach	Criterion 4 Latinos' access to services	Criterion 5 Meaningful practices	Criterion 6 Local adaptations for Latinos	Criterion 7 Interventions and treatment
Retiro de Hombres Campesinos – serves male farmworkers www.education-leadership.org	Provides training sessions to educate fathers about the role they play as a man and head of their household. Also provides advocacy training.	**Central:** Fresno, San Joaquin, and Tulare Counties	✔	✔	✔	✔	✔	✔	✔
The Wall-Las Memorias Project – serves Latino LGBTQ youth and adults and families: www.thewalllasmemorias.org	The agency provides a wide array of support services and community involvement opportunities for families, churches, and individuals at high risk for HIV.	**Southern:** Los Angeles County	✔	✔	✔	✔	✔	✔	✔
Ventanillas de Salud – serves Latino Families	Provides knowledge about lifestyles and prevention measures through education and health priorities.	**Statewide:** services to counties statewide	✔	✔	✔	✔			
Visión y Compromiso – serves Latino families, consumers, and uninsured and underinsured communities	Dedicated to improving socioeconomic and health outcomes of underrepresented communities through support, enhancement, and advocacy of promotoras and community health workers (CHWs).	**Statewide:** services to counties statewide	✔		✔	✔	✔	✔	

1. BIENESTAR

Background: Bienestar was founded in 1989 as a grassroots community-based organization to address the HIV/AIDS prevention and care needs of the Latino community in Los Angeles. Since its establishment, Bienestar has evolved into a multi-service, multi-center agency, becoming one of the leading HIV/AIDS service provider agencies in Southern California, with eight centers located throughout Los Angeles, San Bernardino and Riverside counties.

Promising Practices for Latinos in California: The organization runs several campaigns to raise awareness within the Latino community about homophobia, discrimination, mental health, sexuality, self-esteem, and stigma related to HIV/AIDS. An example of one campaign is Amor de Madre. The campaign consists of a *fotonovela* and a press conference focusing on acceptance, the LGBT community, and a mother's love. The *fotonovela* focuses on an LGBT child coming out, and how doing so affects self-esteem and the mental sense of well-being.

Community outreach – Bienestar performs outreach and education services for LGBT Latinos and individuals living with HIV/AIDS in Los Angeles County. The organization connects the target population to individual counseling, weekly support groups, skills-building intervention sessions, free rapid HIV testing, mental health services, case management, housing, STD screening, substance abuse services, community forums, and social and cultural events. Bienestar uses the peer model to connect, educate, and outreach to the identified community. The organization conducts outreach and education services at nightclubs, identified streets and intersections, health fairs, methadone clinics, needle exchange sites, and shopping centers.

Meaningful engagement practices – Bienestar conducts organizational assessments to determine the level of an agency's needs in developing culturally specific programs. Bienestar conducts training to teach the staff members of community-based organizations how to adapt and tailor their own programs and offer one-to-one peer mentoring and customized support.

Local adaptations of evidence-based practices – Bienestar has successfully adapted eight HIV effective behavioral interventions (EBIs), including empowerment for gay and bisexual Latino youth ages 14–24, "Many Men, Many Voices" for Latino gay and bisexual men, Voces (Voices) for Men Who Have Sex With Men and Women (MSMW), and SISTA for male-to-female transgender individuals.

Website: www.bienestar.org

2. BIENVENIDO PROGRAM

Background: The Bienvenido program is a strengths-based mental health promotion curriculum that focuses on building the emotional and behavioral health of Latinos and helps reduce the risk of reliance on substance abuse due to potentially living in an ongoing marginalized social status.

Promising Practices for Latinos in California: The Bienvenido program conducts sessions exclusively in Spanish primarily for individuals who have arrived in the U.S. during the past decade. It helps participants gain potentially new mental health knowledge and cope with the trauma of their immigration experiences through discussion and dialogue. A successful radio campaign (consisting of 20 Spanish-language public-service announcements) promotes good mental health and suicide prevention. The program represents an innovative step to respond to the needs of an emerging Latino community.

Community outreach – The Bienvenido program operates in multiple locations, both urban and rural, and outside of the agency itself, incorporating community members as facilitators. The organization takes steps to meet consumers on their familiar territory: restaurants, parks, soccer fields, schools, churches, health centers, youth centers, and juvenile correctional centers.

Meaningful engagement practices – One of the strengths of this program is the reliance on community networking and team building. This endorsement of the "it's our community" principle is an innovative and unique approach to responding to individuals with emotional or behavioral problems. A second distinctive characteristic of this program is the treatment of participants not as stigmatized individuals but rather as a group of people who have the choice of recognizing and using their strengths to contribute to a better community.

Local adaptations of evidence-based practices – The trained facilitator uses the Bienvenido curriculum, a Spanish language-teaching tool, at each class session. The Bienvenido program's curriculum is novel in that facilitators who deliver the material are instructing Latino immigrants on topics of acculturative stress and mental health needs, and building relationships with Latino immigrants who would not otherwise have had contact with this type of educational material. The curriculum encompasses fundamental aspects with a focus on: (1) relationship-building, (2) awareness of mental health topics, and (3) consumer engagement.

Website: www.necmh.org/body.cfm?lvl1=servic&lvl2=latino

3. CASA DE LA FAMILIA

Background: Casa de la Familia performs outreach, including presentations, conferences, and active participation in the community, for prevention of mental illness and promotion of mental health wellness. The organization's goals include creation of an open forum for discussion of topics such as mental illness stigma elimination and healthy communities.

Promising Practices for Latinos in California: Casa de la Familia conducts presentations using multiple sources of media, including theatrical plays, self-help material, radio, television, books, curricula for teenage empowerment, and other means of conveying ideas and information.

Community outreach – The organization uses a promotora model and has reached communities that otherwise would have no access to mental health information and services.

Meaningful engagement practices – Casa de la Familia personnel understand that the agency must have a presence in the community and do not expect community members to simply come to the organization's quarters. Casa counselors realize that trust is an essential factor and that word of mouth is invaluable in encouraging participation.

Local adaptations of evidence-based practices – Members of the Latino community know who they can and cannot trust. Being exploited by many unscrupulous people, community members have become distrustful of people who unexpectedly offer help, and they use their "feelings" to decide whom they can trust. Providers need to be genuine in their interactions, commitment and dedication.

Website: www.casadelafamilia.org

4. CENTER FOR COMMUNITY ADVOCACY (CCA)

Background: CCA was founded in 1989 as a farmworker housing advocacy organization, and since 2000 has expanded its mission to improve the health of farmworkers and their families in the Monterey Bay region.

Promising Practices for Latinos in California: CCA uses promotoras/es and community leaders' networks as advocates for their program. CCA participates with Radio Bilingüe regularly. CCA disseminates educational information through health fairs and presentations at churches, schools, and through migrant programs. Most presentations are in Spanish.

Community outreach – The organization reaches out to the community through the use of promotoras/es who have built trust over time and have a relationship with the community. CCA offers expert referral when appropriate. A program that CCA developed in collaboration with the Monterey County health department assigns a specific therapist to people that CCA refers for services.

Meaningful engagement practices – CCA representatives develop trust with community leaders, listen to community members, ask consumers about their needs and which aspects of the current models they have found helpful, and also seek their comments about changes they believe should be made. The organization engages in true partnership collaboration with other agencies. Their promotoras/es are made to feel welcome; treated well, and appreciated.

Local adaptations of evidence-based practices – The organization performs services for clients locally at a convenient time, not just from 9 a.m. to 5 p.m. Therapists are asked to be flexible with their time in their local areas. Doctors come after 6 p.m. to do presentations and to speak to clients. CCA offers food and gas money to encourage prospective clients to attend, especially because many attendees come after work. Community members are asked to come with "*confianza*."

Website: www.cca-viva.org

5. CENTRO LA FAMILIA ADVOCACY SERVICES, INC. (CLFA)

Background: Centro La Familia Advocacy Services (CLFA) is a community-based nonprofit organization that has served low-income families throughout Fresno County for more than 30 years.

Promising Practices for Latinos in California: CLFA recruits, trains, and monitor community health workers who ensure that individual, group, and classroom-based instruction are conducted for Latino families. Community presentations at schools, churches, and community centers stress the importance of breaking the myths and stigma associated with mental health problems and treatment. CLFA raises awareness by utilizing local Latino television station KFTV Univision channel 21, local radio outlets, and Radio Bilingüe, as well as community conferences, community forums, and presentations at local health fairs.

Community outreach – Outreach strategies enable mental health participants to reduce the number of crisis events and to maintain a personal and family commitment to wellness and recovery through: (1) "*platicas*" (a community forum-focus group); (2) one-day workshops introducing the *What to Do in a Mental Health Crisis* guide for families, friends, and law enforcement agencies, along with the 2011 *Guide to Local Mental Health Resources*, a comprehensive overview of all available mental health resources in the area; (3) community health workers in rural communities; (4) the community health workers who design and conduct longer series (4–6 weeks) of presentations on specific mental health topics—e.g., depression, stress, or anxiety.

Meaningful engagement practices – CLFA establishes trusting relationships with community members by showing a respect for culturally specific ways of accomplishing goals. The promotora-mentoring concept is rooted in the notion that intergenerational transfer of information, skills, and knowledge results in empowerment, especially within minority communities.

Local adaptations of evidence-based practices – CLFA acquaints clients with cancer awareness support groups in urban and rural Fresno with the assistance of a "*comadre*," a term used to describe the non-biological close female kinship that exists in the Hispanic-Latino extended family. This approach lends a sense of trust and confidentiality among participants of the support groups.

Website: www.centrolafamilia.org

6. FAMILIAS UNIDAS

Background: Familias Unidas was founded in 1979 by Contra Costa County educators, civic leaders, mental health professionals, and residents. The nonprofit organization envisions a "community counseling and information center" helping people in a holistic and culturally appropriate manner.

Promising Practices for Latinos in California: Culturally and linguistically appropriate information is available over the phone, in person, or through distribution of bilingual self-help directories. Familias Unidas assists clients with language interpretation services (English-Spanish), cultural orientation, and advocacy.

Community outreach – The organization takes advantage of every opportunity to promote its services, which include participation in local health fairs, Cinco de Mayo events, and Kaiser Permanente health fairs. Familias Unidas distributes brochures and other literature. The organization has become well known in the community through word of mouth and grassroots community exposure because of its longevity and the various services it offers.

Meaningful engagement practices – Trauma-informed therapy best practices have contributed to establishment of a comfortable space that families find acceptable and welcoming. The organization has built a library of age-appropriate instructional books in English and Spanish, and bilingual and bicultural Familias Unidas representatives acknowledge every person who walks in the door. Staff members apply *personalismo* to make a difference and maintain a tightly knit group. Familias Unidas employees are interested and engaged in serving their local communities.

Local adaptations of evidence-based practices – Familias Unidas offers counseling interventions that are both innovative and culturally relevant to the Latino population and other diverse communities. The therapeutic approach integrates individual therapy, group therapy, case management, and medication services. Familias Unidas offers psychiatric services, including evaluation and medication prescriptions, to patients receiving mental health services in order to enhance their treatment and therapeutic outcomes.

Website: www.familias-unidas.org

7. FAMILY ACCEPTANCE PROJECT

Background: The Family Acceptance Project™ is a community research, intervention, education, and policy initiative that works to decrease major health threats and related risks—including suicide, substance abuse, HIV, and homelessness—for lesbian, gay, bisexual, and transgender (LGBT) youth, in the context of their families.

Promising Practices for Latinos in California: The project is being carried out in collaboration with key community groups and representatives from community organizations that work with youth in schools and health-care settings, and with families.

Community outreach – Members of the target population, providers, teachers, parents, and youth collaborate on the project by participating in a community research council and providing guidance on outreach activities, developing protocols, analyzing data, developing publications, and disseminating findings.

Meaningful engagement practices – Participatory research is a core approach. The Family Acceptance Project is committed to developing new models of participatory research, not only to inform research and planning, but also to share these approaches with other researchers and decision makers to ensure that research reflects the lives, needs, and experiences of individuals and groups in the context of their cultures and communities. One outcome of the Family Acceptance Project is a model of participatory research for prevention and health services research.

Local adaptations of evidence-based practices – The Family Acceptance Project puts research into practice through an evidence-based family model of wellness, prevention, and care to strengthen families and promote positive development and healthy futures for LGBT children and youth.

Website: familyproject.sfsu.edu

8. LATINO COMMUNITY RELATIONS, ENGAGEMENT AND OUTCOMES (CREO)

Background: Founded in 2001, CREO is a nonprofit organization that strengthens peer-to-peer opportunities for individuals and families with mental health needs. One of their successful programs is Un Paso Más which is a part of Project Return Peer Support Network. Both Un Paso Más and Project Return were created by and continue to be affiliated with Mental Health America of Los Angeles, a nonprofit organization that is nationally recognized for helping low-income individuals with serious mental illness recover to lives of wellness in their communities.

Promising Practices for Latinos in California: The cultural values of *familismo, respeto* and *personalismo* – elements that create *confianza* – are constants of CREO's approach. It incorporates the strength of family and faith, and the sense of community and sensitivity to personal attention, as it engages individuals, educates them about mental illness, extends service resources, and encourages development of grassroots advocates. CREO publishes instructional materials—flyers for schools and libraries and bulletin announcements for churches—in Spanish and English. The organization also administers support groups.

Community outreach – The organization identifies and develops relationships with natural support systems, including churches, schools, and community centers, and conducts its outreach and engagement activities at these natural support locations. CREO co-locates programs with El Centrito, a mental health peer-run center, and the two organizations collaboratively identify mental health needs of the community by interviewing key leaders.

Meaningful engagement practices – CREO outreach and engagement activities recognize that "one size does not fit all." The organization's practice concentrates on the faith and family structures that traditionally are important to the culture and customs of the community it serves. CREO personnel have found that churches and schools often are considered trusted resources, and their services for Latino families may overlap with mental health issues. As another strategy for using natural support, CREO cultivates community mentors.

Local adaptations of evidence-based practices – The California Institute for Mental Health reviewed and accepted CREO as a community-defined evidence model in the Los Angeles County Department of Mental Health's PEI planning in 2010. CREO adapts evidence-based practices such as the Wellness Recovery Action Plan (WRAP) or Seeking Safety (for trauma) to the Latino community.

9. MANITOS

Background: Manitos is a large social group open to older adults who speak Spanish. The group's meetings, conducted entirely in Spanish, feature games, food, songs, exercise, and more. Educational seminars and other presentations are scheduled frequently.

Promising Practices for Latinos in California: All information presentations are printed for sharing with friends and relatives. Manitos encourages its members to participate in community health clinics and wellness events, and cultivates family awareness of activities and support. All information is presented in Spanish to surmount social, cultural, and linguistic barriers and nurture effective communication.

Community outreach – *La Familia* and E*l Hogar* are two agencies through which members receive services. Senior Link has helped members obtain health services and support. Manitos seeks participation of other agencies that can offer services to members.

Meaningful engagement practices – Many agencies ignore or are unaware of the linguistic needs of members. Difficulties related to rapid transit, parking, directions, and availability of facilities are discussed during gatherings.

Local adaptations of evidence-based practices – Music activities, exercise, and information presented are evidence-based. Manitos encourages seniors to participate in physical exercise at the gym, at swimming pools, and through participation in other outdoor and indoor activities with personnel who are bilingual and bicultural.

10. NATIONAL LATINO FATHERHOOD AND FAMILY INSTITUTE (NLFFI)

Background: NLFFI, which operates under the auspices of the National Compadres Network, is a nationwide program that brings together nationally recognized leaders in the fields of Latino fatherhood, rites of passage, health, education, juvenile justice, social services, and advocacy.

Promising Practices for Latinos in California: NLFFI is working in collaboration with President Barack Obama's effort to help men better understand the positive role they play in adding protective factors to their children's lives. These activities will help build strength and resilience in children to enable them to achieve their goals and dreams. At the national level, the center conducts services for associated professionals, including consulting, seminars and conferences, on-site training and curricula, and publications.

Community outreach – NLFFI builds a strong network of organizations that will influence the direction of the initiative in order to: 1) identify existing policy gaps preventing the development of effective fatherhood and to create involvement programs and, 2) develop positive fatherhood and male involvement policies and programs that build on the strengths of fathers and other male mentors.

Meaningful engagement practices – Through research, training, and direct services, the institute helps fathers of all ages develop strong, active roles in the lives of their children, while concurrently addressing the very painful aspects of child abuse, domestic violence, gang violence, school failure, illiteracy, teen pregnancy, and other related issues.

Local adaptations of evidence-based practices – The center performs culturally sensitive social and educational services with programs designed to strengthen and preserve families, prevent teen pregnancy, influence men to become strong fathers and responsible men, and instill the importance of culturally sensitive physical and mental health services.

Website: www.nlffi.org

11. NORTHERN VALLEY CATHOLIC SOCIAL SERVICE PROMOTORES PROGRAM

Background: The Northern Valley Catholic Social Service's Promotores Program, based in Chico, was established to respond to and resolve cultural barriers as a means of increasing awareness and facilitating access to mental health services. The cultural barriers that impede access to mental health services include language, stigma, legal status, and acceptance of alternative healing practices.

Promising Practices for Latinos in California: The Promotores program participates in a Chico-area Latino radio station to offer services and raise awareness about mental health. The broadcasts are intended to increase awareness of the mental health services available in the community.

Community outreach – The Promotores program regularly conducts outreach to community agencies to explain its core services: case management, support groups, and a direct connection to mental health services. The promotores are bilingual Spanish and English speakers.

Meaningful engagement practices – Innovative ways that have been used to engage the Latino population include sponsorship of soccer teams, posadas, and offering services at the Catholic church during mass. Cultural food and music have also been utilized and proven to be successful when engaging the community.

Local adaptations of evidence-based practices – Support groups that meet weekly in areas populated by Latinos host mental health presentations in a safe and nurturing environment. Discussion topics often include sensitive issues that are seldom discussed openly among the Latino culture, including domestic violence, depression, substance abuse, and anxiety. Guest speakers, participation-focused groups, presentations, and group discussion are used to deliver information to the groups.

Website: www.nvcss.org/programs/buPromotores.aspx

12. PACIFIC CLINICS

Background: Pacific Clinics, a private, nonprofit community behavioral health-care agency, was established in 1926 as Pasadena Child Guidance Clinic. Since then, the organization has expanded its focus to encompass the mental and behavioral health concerns of families and individuals of all ages.

Promising Practices for Latinos in California: The organization has conducted mental health education and awareness programs through local churches, county and community agencies, schools, the YMCA, city programs, parks and recreation collaboration, National Association of Mental Illness (NAMI), conferences, workshops, beauty salons, PTA meetings, and other opportunities. A collaboration has been built with celebrity and high-profile people such as Congresswoman Grace Napolitano, boxer Mia St. John, actor Edward James Olmos, dancer Mark Ballas, and other prominent figures who have helped in promoting awareness among the community on a wide variety of topics about mental health. Pacific Clinics produced a Spanish-language video in 1999 about cultural factors, religious beliefs relating to mental illness, and concerns about stigma that impede access to professional care. The video details the symptoms of major illnesses, including schizophrenia, depression, and bipolar disorder. The DVD was promoted throughout Los Angeles County, as well as nationwide and internationally.

Community outreach – Pacific Clinics' Latino services incorporate a comprehensive approach that includes five key components: 1) prevention; 2) outreach; 3) community education and awareness; 4) parents' psycho-educational support groups; and 5) comprehensive mental health services.

Meaningful engagement practices – The organization builds rapport by being attentive to cultural orientations. For many families, social agencies can be intimidating and frightening depending on previous interactions with mental health providers or "the system," in which they may have experienced stigmatization or other forms of discrimination. Factors the organizations considers include 1) language, 2) ethnicity, 3) cultural aspects, 4) values, 5) beliefs, 6) religion, 7) myths, and 8) legal status.

Local adaptations of evidence-based practices – Pacific Clinics makes cultural modifications during engagement and treatment; the organization uses 1) *personalismo*, 2) *familismo*, 3) *colectivismo* and *comunidad*, 4) *respeto*, 5) *simpatia* and *amabilidad*, 6) *confianza* (trust), 7) *espiritualidad* and *religion*, 8) *marianismo* and *machismo*, and 9) *fatalismo* (fate).

Website: www.pacificclinics.org

13. RETIRO DE HOMBRES CAMPESINOS

Background: Retiro de Padres was founded in 2008 in response to the need to improve the educational environment of Latino public school students. The activities of Retiro de Hombres Campesinos, target males who are farmworker parents and are designed around their particular needs.

Promising Practices for Latinos in California: Clients learn about the program mainly by word of mouth and on a referral basis. Retiro de Hombres Campesinos has established a partnership with CSU Fresno migrant education program, which promotes the organization's activities.

Community outreach – Networks are utilized through the CSU Fresno migrant education program and through contact with migrant personnel from the local school districts. Parents are informed about the program through the school districts. Retiro de Hombres Campesinos program personnel contact parents who express interest.

Meaningful engagement practices – Workshops topics, determined by the participants, include; 1) improving your role as a father figure; 2) improving your home environment; 3) improving your relationship with your wife and your children; 4) improving your family's mental and physical health; 5) providing an academic environment at your home; and 6) accepting yourself for who you are.

Local adaptations of evidence-based practices – The services are delivered in a circle format to allow each participant to develop his or her own plan for change, and to give participants the opportunity to share their experiences with others.

* Website: ums.csufresno.edu/
* The coordinator responds to inquiries.

14. THE WALL - LAS MEMORIAS PROJECT

Background: Founded in 1993, The Wall - Las Memorias Project is dedicated to promoting wellness and preventing illness among Latino populations affected by HIV/AIDS by using the inspiration of the AIDS Monument as a catalyst for social change. During the past 14 years, The Wall - Las Memorias has built strong community support for its innovative educational programs and awareness events. The agency conducts a wide arrange of support services and community involvement opportunities for families, churches, and individuals at high risk for HIV.

Promising Practices for Latinos in California: The organization promotes awareness about stigma, bigotry, and mental health throughout all of its activities. The project hosts an annual conference on Latinos, faith culture, HIV, and mental health for more than 350 parish and congregant leaders of Los Angeles County.

Community outreach – In conducting its services, The Wall - Las Memorias Project uses a community mobilization model that encourages consumers and community members to discuss their needs and disparities. The agency also trains community members to promote public policy to create systems change as a means by which agencies can better serve community members.

Meaningful engagement practices – Because of the important contribution of religious faith to culture, mutually respectful linkages with faith communities as full partners promote wellness and have eliminated stigma among all people. Individual voices of the community are heard, and all are in agreement on the essential need for social change.

Local adaptations of evidence-based practices (EBPs) – The Wall-Las Memorias provides educational opportunities and training to consumers. It identifies specific cultural and linguistic needs and adapts evidence-based best practices to all of its current programs.

Website: http://thewalllasmemorias.org/

15. VENTANILLAS DE SALUD (VDS)

Background: The Mexican government, through its consulates and the Instituto de los Mexicanos en el Exterior (IME), has taken an active role in promoting the rights and welfare of Mexican people in the United States.

Promising Practices for Latinos in California: Ventanillas de Salud (VDS) raises awareness and educates the community about health issues through workshops, referrals to health practitioners, and education about health concerns.

Community outreach – Ventanillas de Salud has a variety of outreach strategies, including services within the Mexican Consulate, mobile units, community health fairs, and organizing a binational week program each October. VDS partners with numerous local health organizations, as well as academic and social sectors.

Meaningful engagement practices – Ventanillas have been established at 10 locations in California. These ventanillas are based in the Mexican Consulate's offices in Sacramento, San Francisco, San Jose, Oxnard, Los Angeles, Fresno, Santa Ana, San Bernardino, San Diego and Calexico. In addition, each ventanilla provides periodic services in rural and remote areas through their mobile units.

Local Adaptations of Evidence-Based Practices – Not available

For more information visit the local Mexican Consulate office.

16. VISIÓN Y COMPROMISO (VyC)

Background: Visión y Compromiso (VyC) expresses its mission as *Hacia una Vida Digna y Sana*/Working Towards A Healthy and Dignified Life for All. That mission reflects the work of the organization to improve socioeconomic and health outcomes of underrepresented communities. By building promotores' capacity, VyC strengthens the ability of Latino communities to identify issues of concern, confront barriers, propose locally defined solutions, inform policies, change organizational practices, and improve individual and community health outcomes.

Promising Practices for Latinos in California: VyC, which was founded in 2000, operates with leadership committees made up of promotores, community workers, and other leaders who represent diverse groups and organizations. They meet monthly, and as a coalition, they identify local needs of the community and of the promotores, and identify the region's priorities. With that information, they develop, implement, and evaluate a yearly work plan that supports the local promotores with capacity building, work tools, and resources to strengthen their work.

Community outreach – Local promotoras conduct outreach in their community to inform residents of local health resources or community services available, and they assist clients in accessing these services.

Meaningful engagement practices – The network has five main strategies: to advocate, build capacity for promotores, collaborate with other leaders, communicate, and validate the promotores model.

Local adaptations of evidence-based practices – Promotores offer servicio de corazón (heartfelt service) and culturally relevant health prevention education to native-born and immigrant communities. They "give their time, their charisma, their passion." Promotores are sensitive to the practical and cultural realities that increase health risks for Latinos, and they are aware of the health system barriers that limit access to preventive services. They use personal contacts, trust and respect to address sensitive topics, counter misinformation, and advocate for quality health care, acting as cultural, linguistic and socioeconomic allies to the community. Promotores have access to valuable information about what is (and is not) working in health-care systems, and can suggest realistic solutions to respond to the critical issues in their communities.

Website: www.visionycompromiso.org

CONCLUSION

Latinos comprise nearly 40% of the California population and are increasingly shaping the demographic makeup of the state. More than half of California's newborn children and those attending elementary school are of Latino origin. Latinos compose the majority of the population in nine California counties: Colusa, Fresno, Imperial, Kings, Madera, Merced, Monterey, San Benito and Tulare (Lin, 2011) as well as the majority of the population in 17 California cities and neighborhoods.

The overwhelming majority of Latinos in California (82%) are of Mexican descent. Despite many commonalities across the various Latino groups, the existence of cultural, linguistic, educational, and sociopolitical differences sometimes requires classification of Latinos into sub-populations for investigative purposes. Distinguishing among Latino subgroups from different regions and examination of their demography, history, culture, and views on mental health are important for future research. Researchers should not attempt to characterize all Latinos as one homogenous group and ignore between and within-group heterogeneity. Therefore, strategies and recommendations for providing mental health care for Latinos must not be from a "one size fits all" recipe (Willerton, Dankoski, and Martir, 2008).

When Latinos do suffer from mental illness, they are not as likely as members of other population groups to access mental health care and services. Underutilization of mental health services is even higher in Mexican-Americans and even more pronounced among Mexican migrant agricultural workers. This report sheds some light on the nature of the gaps in mental health service utilization by Latinos. The report describes strategies and recommendations by Latino community members that must be taken into account in order to reduce disparities in access and in mental health service utilization by Latinos.

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APPENDIX 1: POLICY IMPLICATIONS, STRENGTHS AND LIMITATIONS, AND RECOMMENDATIONS FOR FUTURE RESEARCH

Policy Implications

The findings and recommendations of this report suggest implications for practice in relationship to the Affordable Care Act (ACA). First, the findings suggest the need to invest in integration of mental health services and primary care while at the same time building capacity and workforce diversity in Latino communities. Second, building on community assets through collaboration between state and local public and private agencies can ensure that all Latinos have equal access to affordable and culturally and linguistically appropriate care. Third, evaluation and data collection should be strengthened to better assess the reduction of mental health disparities and the effectiveness of community-defined evidence practices for Latinos from different backgrounds. Fourth, community outreach and engagement and social media can be used to promote prevention and wellness. Finally, MHSA and ACA resources should be targeted to unserved and underserved Latino consumers and their families—especially those traditionally low-income individuals and families, including immigrants, who have limited English proficiency and who do not have access to adequate resources. These policy implications are in accordance with Gans and colleagues (2012), who examined the potential and implications of implementation of the Affordable Care Act; they made a call to action to launch culturally and linguistically appropriate outreach and education to facilitate enrollment in coverage among all those who are eligible for California's Health Benefit Exchange programs, in order to ensure that health care costs are reduced as much as possible for California's working families.

Studies have well documented evidence that racial and ethnic minority groups in the U.S. fare far worse than their white counterparts across a range of health indicators (Smedley, Stith, and Nelson, 2003). As the nation's population continues to become increasingly diverse, the passage of the health care reform law (see Patient Protection and Affordable Care Act of 2010) becomes critically important in advancing health equity for racial, ethnic, language, gender, and LGBTQ diverse populations. Although the Affordable Care Act calls for an increase in health coverage and changes to the workforce necessary to meet the increase in demand for health care services (Institute of Medicine of the National Academies, 2010), more must be done to recognize and address other areas necessary to reshape health care and reduce disparities. Necessary changes include more: (1) health disparities initiatives in prevention, (2) workforce diversity, (3) cultural competence among health care workers, (4) data collection and evaluation, and (5) access to high-quality care.

Friedman and Adashi (2010) argue that a compelling case has yet to be made to morally and legally bind the U.S. to improve quality and value of care, and eliminate health disparities, while reducing the cost of health care. Recent research has shown that if health care inequalities remain unresolved, they will impose a significant burden on individuals and their communities (Angeles and Somers, 2007). For example, LaVeist, Gaskin, and Richard (2009) indicated that between 2003 and 2006, the toll of racial and ethnic health disparities in direct medical costs and lost productivity in the U.S. exceeded $1.24 trillion. Researchers have argued that health disparities affect everyone and that reducing these disparities will benefit all populations and not just those with the worst health (Woodward and Kawachi, 2000). As more Latinos are slated to have access to health care under the Affordable Care Act, we can expect even greater demands on the current mental health workforce and the mental health care system (Robert Wood Johnson, 2011).

Strengths and Limitations

This report had some important strengths and notable limitations. Among its strengths are the rigorous ground theory method used to gather data from different sources (consumers, family members, mental health providers, youth, students, and members of LGBTQ groups). Participants were contacted and asked to review preliminary results and then comment. Overall, participants responded positively. One participant stated: "the summaries reflect the general ideas that were discussed during the forums."

Finally, to assess the readability of the key sections in the draft report (e.g., literature review, methods, findings, and recommendations) by the general Latino population, the CRHD research team convened a small sample consisting of 10 Latinos (seven females and three males) from a low-income community in southeastern Los Angeles County to review the text of the draft report. The 10 participants who volunteered were between 19 and 47 years old. The three most prevalent types of occupations reported by this group were service-related, laborer, and homemaker. Four participants described themselves as mental health consumers, and the remaining six as family members and advocates. Two participants completed elementary school, seven received a high school education, and one had an associate's degree from a community college.

All participants were native Spanish speakers, with the majority speaking both Spanish and English equally in their home and community.

After the participants finished reading text from the report, they were asked to spend 15 minutes writing down on a piece of paper their interpretation of the text in their own words. Eight of the ten (80%) participants were able to write and verbally articulate their interpretation using examples from the report effortlessly. For example, one participant stated, "I liked all the information that was given.… I learned a lot, especially that the [Latino] community doesn't get help because of what their family might say." Another said, "It is not that the text is not readable, [but that] Latinos in general don't know the mental health issues that affect them.… This report will provide them with good information to learn about those issues." On the other hand, one participant stated, "The hard part is that we are not familiar with the studies cited in the report." Although the majority of the participants considered the report too long, the consensus on the readability of the report was favorable. Moreover, the group indicated that a Spanish version of the report would be easier to read.

This report's significant contributions to the community-defined evidence literature outweigh its limitations. Because the study was qualitative and used a small sample, it cannot be generalized by extension to other populations. Specifically, its reliance on volunteers and recruiting participants using the snowball sampling or word-of-mouth method may have limited the variability of participants. This limitation also points to the possibility that indigenous populations (e.g., mixtecos and zapotecos) and biracial or multiracial Latinos who also struggle with mental health issues may not have known about or may not have volunteered to participate in the study. The sample was adequate, however, for "ground theory" methods (Patton, 2002), and our intent was to capture cross-sections of Latino subgroups throughout the state and present sufficient information to enable readers to decide if the findings and recommendations of this report are relevant to their community.

Recommendations for Future Research

Future research on Latinos and mental health services is needed in a wide variety of areas to determine whether these findings would replicate themselves in different Latino population subgroups. This is especially true for Latinos who communicate using a language other than Spanish or English (i.e., indigenous dialects such as nahuatl, mixteco, zapoteco and triqui) and those who self-identify as being biracial or multiracial. Additionally, collecting data that compares immigrant Latinos with second, third, and fourth generations would generate more comprehensive results. Future research using an ethnographic method could shed more light on these concerns and strengthen the findings. More time and expanded financial resources would have helped to conduct a more in-depth investigation and deepen our understanding of different segments of the Latino population. One of the future directions that will move this body of work further is formation of an advocacy group to design an action plan outlining and prioritizing strategies to identify and work with key legislators, including the Latino Caucus. Such an advocacy group could begin a dialogue regarding distribution of MHSA available funds and help guide dissemination so that equal access to affordable coverage, care, and quality of life can be achieved for Latinos in California.

APPENDIX 2: LATINO MENTAL HEALTH CONCILIO MEMBERS

Name	Title	Affiliation
Sergio Aguilar-Gaxiola, MD, PhD	Director	Center for Reducing Health Disparities, University of California, Davis
Leticia Alejandrez	Executive Director	California Family Resource Association
William Arroyo, MD	Medical Director	Los Angeles County Department of Mental Health
Monica Blanco-Etheridge	Executive Director	Latino Coalition for a Healthy California
Denise Chavira, PhD	Associate Professor	University of California, San Diego, and California State University, San Marcos
Sonia Contreras	Executive Director	Eastlake Consulting, and Advisor to the Secretary of Health of Mexico
Jorge Fernandez	Program Coordinator	Center for Human Services
Benjamin Flores	Chief Executive Officer	Ampla Health (formerly Del Norte Clinics, Inc.)
Katherine Flores, MD	Director	University of California, San Francisco, Fresno, and UCSF Fresno—Latino Center for Medical Education and Research
Rogelio Flores, LLD, JD	Superior Court Judge	Santa Barbara Superior Court
Juan García, PhD, LMFT	Professor and Associate Director	Fresno Family Counseling Center, California State University, Fresno
Luis García, PsyD	Vice President	Latino Program Development, Pacific Clinics
Piedad García, EdD	Assistant Deputy Director	County of San Diego, Mental Health Services
Al Hernandez-Santana, JD *	Past Executive Director	Latino Coalition for a Healthy California
Ruben Imperial	Program Manager	Stanislaus County Behavioral Health & Recovery Services MHSA
Manuel Jimenez	Director of Mental Health	Merced County
María Lemus	Executive Director	Visión y Compromiso Promotoras Program
Gustavo Loera, EdD	Director	Educational Research & Development, Mental Health America of Los Angeles
Irma Martinez *	Program Director	Los Angeles County Department of Mental Health
Miriam Martinez, PhD *	Chief of Clinical Initiatives	Department of Psychiatry and Behavioral Health, St. Luke's and Roosevelt Hospital Center, New York, NY
Lina Méndez, PhD	Project Manager	Center for Reducing Health Disparities, University of California, Davis

APPENDIX 2: LATINO MENTAL HEALTH CONCILIO MEMBERS (CONTINUED)

Name	Title	Affiliation
Lali Moheno	President	Lali Moheno & Associates
Roger Palomino	Past Executive Director	Economic Opportunities Commission, Fresno County
Senobia Pichardo	Family Advocate	Migrant Representative
Ambrose Rodriguez *	CEO and Founder	Latino Behavioral Health Institute
Refugio "Cuco" Rodriguez	Program Manager	County of Santa Barbara Department of Mental Health
Marbella Sala	Operations Manager	Center for Reducing Health Disparities, University of California, Davis
Jesus Sánchez	Recruitment Coordinator	LabAspire Program, Center for Transnational Health, University of California, Davis
William Vega, PhD	Professor and Executive Director	Edward R. Roybal Institute on Aging, University of Southern California
Henry Villanueva, EdD	Manager of Quality Assurance	Ventura County Behavioral Health Department
Richard Zaldivar	President and Founder	The Wall-Las Memorias Project

* Past Members

APPENDIX 3: DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS OF THE FORUMS AND FOCUS GROUPS

Demographic Characteristics of the Forum and Focus Group Participants	n	%
Gender		
Female	72	26.3%
Male	188	68.6%
Sexual Orientation (total % was totaled as part of gender)		
Gay	5	1.8%
Lesbian	6	2.2%
Bisexual	2	0.7%
Declined to answer	1	0.4%
TOTAL	**274**	**100.0%**
Country of Birth		
United States	163	63.7%
México	68	26.6%
El Salvador	7	2.7%
Guatemala	2	0.8%
Chile	3	1.2%
Colombia	3	1.2%
Dominican Republic	2	0.8%
Honduras	2	0.8%
Declined to answer	6	2.2%
TOTAL	**256**	**100.0%**
Country of Identification		
United States	108	36.2%
México	157	52.7%
El Salvador	15	5.0%
Guatemala	4	1.3%
Chile	4	1.3%
Colombia	2	0.8%
Dominican Republic	1	0.3%
Honduras	2	0.8%
Costa Rica	1	0.3%
Nicaragua	1	0.3%
Declined to answer	3	1.0%
TOTAL	**298**	**100.0%**

Note: The participants were allowed to select more than one response; not all participants completed the survey.

APPENDIX 3: DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS OF THE FORUMS AND FOCUS GROUPS (CONTINUED)

Educational, Sector, and Regional Background	n	%
Education Level		
Elementary school	3	1.1%
High school graduate or GED recipient	92	34.9%
Associate's degree	40	15.2%
Bachelor's degree	50	18.9%
Master's degree	57	21.6%
Professional degree	6	2.3%
Doctoral degree	15	5.7%
Declined to answer	1	0.3%
TOTAL	264	100.0%
Sector		
Advocacy group	50	11.4%
Academic or schools	30	6.8%
Faith-based	15	3.4%
Farmworker	8	1.8%
Community-based organization	46	10.4%
Mental health consumer	26	5.9%
Family member	33	7.5%
Promotora/es	28	6.4%
Youth	49	11.1%
College student	54	12.2%
Clinician	25	5.7%
Provider	35	7.9%
Disabled community	7	1.6%
County or state employee	35	7.9%
TOTAL	441	100.0%
Regional		
Bay Area	62	27.0%
Southern	125	54.3%
Central	36	15.7%
Superior	7	3.0%
TOTAL	230	100.0%

Note: The participants were allowed to select more than one response; not all participants completed the survey.

APPENDIX 4: STUDENT FOCUS GROUP GUIDING QUESTIONS

Welcome and Overview:

We thank you for your participation in our reducing disparities focus group. I'm _____, and I will be moderating this focus group. This session will be recorded so that we capture more accurate data, so please speak one at a time. Is everyone okay with that?

And very important—your participation today is strictly voluntary; you may withdraw at any time, for any reason. Your responses will be completely confidential. Your responses will not affect your student status here at the university. Also, each one of you will receive a $10 Starbucks gift certificate for your participation.

Your opinions are extremely important to us. We want you to feel free to tell us exactly what you think, and we hope that your ideas will create discussion among all of us.

The purpose of the focus group is to get your thoughts about mental health services and how academic settings can better serve Latino university students. Specifically, we want to understand what barriers Latinos encounter when seeking mental health services, what you know, and your thoughts on overcoming those barriers.

Before we start, do you have any questions?

----------Start the recording----------

1. **What is it like to be a member of your ethnic group on this campus?**

   We start with this question, because the assumption is that respondents will be more familiar and comfortable with talking about their ethnicity, and it eases them into a discussion about mental health. With this question, we are trying to get respondents' perceptions of cultural awareness, discrimination, stigma, and other considerations related to their ethnicity on their school or university campus. Probing for differences in what the respondent experiences in the school or university campus in contrast to their home or community environment may be particularly effective. This question may help us address the differences in these contexts.

   1a. As a Latino on this campus, what does mental health mean to you?

   Here, we are trying to get more in depth with the meaning of mental health in relationship to the respondents' ethnic identity. This encompasses issues such as how closely the concept of mental health correlates to his or her sense of self. We also want to know the respondents' thoughts about mental health services. Why does the respondent either feel willing or averse to seeking mental health services?

2. **Do you think Latino males and females at this school or university have different issues that affect their education? If yes, why?**

   In this question we want to learn about gender differences and if the respondents perceive differences in issues that affect their mental health and their education. We are interested in social and economic issues, family and traditional responsibilities, immigrant status, language barriers, and other factors that may affect the schooling and mental health of respondents.

3. **Do you know of any strategies that would increase mental health treatment participation of Latinos on a school or university campus? What are they?**

   This question has two intentions: (1) assess respondents' knowledge of existing mental health programs and services on campuses that are Latino-specific; and, (2) learn respondents' views about how to reach out and engage more Latino students in seeking and promoting access to care. Such knowledge provides insight into students' ideas about essential characteristics of successful services programs.

   3a. Can you think of a way to reduce individual and community barriers to mental health care for Latinos?

   This probing question is intended to isolate the community barriers that prevent access to care and that focus on solutions that reduce barriers, and to increase family and community support and engagement.

4. **Studies have documented that Latinos are reluctant to access existing school or university mental health programs and services. What strategies would improve access to these programs and services?**

   This question is intended to elucidate how much respondents know about existing programs and services on their school or university campus, and how accessible these programs are. We also want to know what ideas respondents have to improve Latinos' access to services that these programs offer.

5. **Can you make two or three recommendations that would increase Latino students' participation in school or university mental health programs and services?**

   This question seeks respondents' perceived ideas about specific components that new programs should have in order to increase Latinos' participation in treatment. We also want to know their ideas on enhancing existing programs to better meet the needs of Latino students. We are interested in their thoughts about which ingredients are necessary in order for a school or university program to succeed in serving Latinos.

5a. What recommendations can you offer to increase retention in mental health services and reduce drop-out rates?

This question solicits respondents' perceptions of "serious and compelling reasons" that may lead Latino students to drop out of services and school. We also want to know their ideas on ways to modify and enhance school and university mental health service program in order to encourage students to continue participation and to help reduce dropout rates.

6. **We have talked a lot about mental health and what it means to you in different contexts, and ways to improve services on your campus. Please summarize your recommendations for establishing new mental health programs and enhancing existing services in order to improve Latino treatment outcomes in a school or university setting.**

   This is a restructuring of questions 5 and 5a. Now that respondents have had the time to think about improving mental health services on a school or university campus, we want to know how they want to change, expand, or add to programs to improve treatment outcomes other than just retention. This question also provides respondents with a sense of closure. If they have any other thoughts they want to express, this question gives them the opportunity to do so.

APPENDIX 5: *MESAS DE TRABAJO* CODE BOOK

Reducing Individual and Community Barriers to Care

0101 Opinions and feelings about mental health services

0102 Treatment culture aligned with community and individual needs

0103 Education and training to change negative perceptions

0104 Changing perceptions of treatment from negative to positive

0105 Relationship of consumer to program or provider

0106 Creating safe spaces

0107 Normalizing being LGBTQ

0108 Education and counseling for LGBTQ coming out

0109 Building individuals' self-efficacy and self-image

0110 Education and training of community leaders

0111 Educating about and normalizing mental health and illness

Improving Access to Existing Programs and Services

0201 Provider's characteristics

0202 Provider's and media's knowledge about community, culture, and language

0203 Provider's or educator's role in continuing education through new trainings

- 0203A Improve (cultural) training for other mental health and non-mental health specialists

0204 Funding (method of distribution)

0205 Purpose of program to focus on holistic wellness

0206 Program effectiveness in reaching out to the community

0207 Establishing a welcoming and engaging environment

- 0207A Creativity in outreach and delivery of service

0208 Program or provider's relationship to schools

0209 Loan forgiveness programs

Characteristics of Treatment Programs (to increase participation)

0301 Culturally and linguistically competent staff, including academic educators

- 0301A Latino culturally and linguistically competent immersions (e.g., trainings in clinical skills and tools)

0302 Age- and gender-appropriate mental health services

0303 Outreach to the community and special populations

0304 Program effectiveness and accessibility

0305 Program effectiveness in collaborating with other community-based organizations

0306 Program support services and resources (e.g., transportation and child care)

0307 Hours of operation of program (flexible service hours)

0308 Use of media to elevate awareness

0309 Cultural and generational differences

0309A Acculturation differences between parents and their children

0310 Role models and mentors (e.g., *promotoras* and *promotores*)

- 0310A General positive role models (e.g., educators)

0311 Bilingual and bicultural services (translations, interpretations, providers)

- 0311A Establishment of a standard for characterizing a staff as bilingual

Factors and Effects on Retention in Services (reducing dropout rates)

0401 Interactions with consumers during services

0402 Interactions with faith-based organizations, including interactions with priests

0403 Time that the provider dedicates to the consumer or patient

- 0403A Feedback from consumers to providers

0404 Integration of mental health services and topics with schools

- 0404A Co-location of services with schools

0405 Integration with social networks (e.g., Facebook and Twitter)

0406 Program effectiveness in providing comprehensive services

0407 Education and advocacy

APPENDIX 5: *MESAS DE TRABAJO* CODE BOOK (CONTINUED)

Modifying and Improving Existing Services (successful treatment outcomes)

0501 Changing appointment and assessment practices

0501A Workforce with proficient clinical skills

0502 Increase mental health career pathways, pipelines, and curricula

0502A Recruitment in secondary and post-secondary schools

0503 Changing cost structure of services (e.g., affordable programs)

0504 Changes in method of services to a peer-to-peer or role model interaction (e.g., *promotoras/es*)

0505 Modifying services to include family involvement and support

0506 Improving services to address the needs of undocumented consumers and families with mixed undocumented and documented immigration status

Evaluation Approaches and Implementation

0601 Methods appropriate to community needs

0602 Service-driven approaches with follow-up structure

0603 Comprehensive measures

0604 Evaluator's role in data collection

0605 Evaluator's role in final report and dissemination

0606 Consumer's role in data collection

Factors Affecting Mental Health Utilization

0701 Fear (in general)

0701A Fear of deportation

0702 Cultural beliefs

0703 Discrimination and marginalization

0704 Lack of trust

0704A Ensure that people trust the agency providing services and are not required to show proof of legal immigration status for services

0705 Lack of funding or insurance

0706 Stigma, labeling, and communication media

0707 Inadequate resources

0708 Inadequate workforce capacity

0709 Immigration legal status and related issues

Promising Community Practices and Characteristics

0801 Characteristics of successful community-based programs

0802 Community-defined promising practices (e.g., the *promotoras/es* model)

0802A Development of infrastructure (e.g., integrating the *promotoras/*es model into the structure)

Other Key Factors

0901 Promotion of cultural values through personalismo (e.g., appropriate physical contact)

0901A Promotion of *familismo* support through which extended family members support treatment

0902 Support and encourage higher education attainment in the Latino population

0903 Promote representation of Latinos at all levels of management

0904 Modify the social delivery system to include a patient liaison

APPENDIX 6: ABBREVIATIONS AND ACRONYMS

ACA Affordable Care Act

ATLAS.ti Archiv fuer Technik, Lebenswelt und Alltagssprache (German for: Archive for Technology, the life world, and everyday language)

CBPR Community-Based Participatory Research

CDC Centers for Disease Control

CDEP Community-Defined Evidence Program or Practice

CDMH California Department of Mental Health

CHIS California Health Interview Survey

CMMC California Mental [Health Services Act] Multicultural Coalition

CRDP California Reducing Disparities Project

CRHD Center for Reducing Health Disparities

CSS Community Services and Supports

DSM-IV Diagnostic and Statistical Manual [of Mental Health], Fourth Edition

ESM Ethnic Services Manager

FAIR Fair, Accurate, Inclusive, and Respectful [Education Act]

LBHI Latino Behavioral Health Institute

LGBTQ Lesbian, Gay, Bisexual, Transgender, and Questioning

MAPSS Mexican American Prevalence and Services Survey

MAT Minimally Adequate Treatment

MHSA Mental Health Services Act

NAMI National Alliance on Mental Illness

NIHCM National Institute for Health Care Management

NLBHA National Latino Behavioral Health Association

PEI Prevention and Early Intervention

SES Socioeconomic Status

SPW Strategic Planning Workgroup

WET Workforce Education and Training

UCDAVIS HEALTH SYSTEM | CENTER FOR REDUCING HEALTH DISPARITIES

Prepared for the:

Office of Multicultural Services
California Department of Mental Health
Under California Reducing Disparities Project #09-79055-003
Funded by the Mental Health Services Act

By the:

University of California, Davis
Center for Reducing Health Disparities
www.ucdmc.ucdavis.edu/crhd
and
The Latino Mental Health Concilio
www.latinomentalhealthconcilio.org

JUNE 2012