Cultural Sensitive Services for Latinos

12

Andrea Mendiola-Iparraguirre, Juan Rodriguez-Guzman, and Esperanza Diaz

Introduction

Healthcare problems, including mental health issues, are exacerbated because of ethnic health disparities [1–3]. For instance, an analysis of more than 45 years of data found that Latinos have lower access to specialty mental healthcare [4], and these numbers prevail despite adjustments to socioeconomic status [5]. Factors that could explain the significant disparity in healthcare are language fluency, cultural differences, access to Medicaid specialty services in Latino neighborhoods, differences in recognition of mental health problems, and lower quality of mental healthcare [5]. Additionally, social determinants of health impact access to care, appropriate treatment, equality in treatment, follow-up and continuing care services, and recovery from mental illness [6, 7].

Therefore, developing culturally sensitive mental health services is essential to provide appropriate care and to mitigate these disparities.

In this chapter, we summarize the recovery-oriented and culturally sensitive services for Latinos, including services provided in main facilities, community organizations and peer support, their benefits and challenges, and suggestions to implement them.

A. Mendiola-Iparraguirre (✉) · J. Rodriguez-Guzman · E. Diaz
Department of Psychiatry, Yale University, New Haven, CT, USA
e-mail: andrea.mendiola@yale.edu; juan.rodriguezguzman@yale.edu; esperanza.diaz@yale.edu

© Springer Nature Switzerland AG 2022
R. Castilla-Puentes, T. Falcone (eds.), *Mental Health for Hispanic Communities*,
https://doi.org/10.1007/978-3-031-13195-0_12

Cultural Sensitive Services for Latinos in the United States over Time

The development of Hispanic mental health services needed multiple perspectives: Psychiatry, Cultural Psychiatry, Psychology, Social Work, Anthropology, Sociology, Epidemiology, Public Health, among others. Professionals from these disciplines have worked together to provide understandings, develop theories, research, and interviewing skills. The initial aim of the researchers focused on describing the different perspectives a culture could provide in mental illness and health beliefs according to religion, spirituality, terms used by the population, language, stigma of mental illness, and indigenous treatments [8–10].

In 1995, the DSM published a glossary of terms used by different cultures to talk about mental illness. For Hispanics, the examples include *susto, nervios, mal de ojo, ataque de nervios* [11]. They emphasize the importance of understanding a person's culture in order to be culturally sensitive. They provide a way to name presentations outside of the DSM psychiatric diagnoses. Along with the glossary of cultural-bound syndromes, the DSM published the Cultural Formulation outline, which is useful up to this day [12]. It is the basis for the Cultural Formulation Interview (CFI), developed and published in DSM 5 [13]. The CFI provides sixteen questions to elicit information about the person to understand the unique perspective and wishes for treatment and to develop an individualized formulation avoiding stereotypes.

The influences on Hispanic mental health outcomes were multiple: disparities, immigration, the differences between first, second and third generations of Hispanics, the diversity of Latinos, the Latino Paradox, discrimination, and diagnoses all based on studies made in America for Americans. It was noticed that the expression of emotions takes many ways, and for Hispanics, somatic symptoms were prevalent [14]. Somatization takes many Hispanic to primary care with ailments that they can never resolve, such as headache, stomach pain, chest pain, and shortness of breath. Escobar et al. researched and promoted the inclusion of mental health professionals in primary care.

Community Services for Latinos with a Cultural Approach

Reports from government agencies give us information about the use and availability of Hispanic mental health services. From SAMHSA report 2018 [15]:

- 2 in 9 Hispanics have a serious mental illness.
- 43.2% of Hispanic young adults with severe mental illness (SMI) received treatment.

– 60.4% of Hispanic Adults (ages 26–49) with SMI received treatment.

Information about substance use and Hispanics does not differ regarding disparities. For example, among those who needed treatment for drug use and alcohol, Hispanics were less likely than non-Hispanics to receive specialty treatment (data from 2003 to 2011) [16].

Unfortunately, treatment gaps remain vast. Historically Hispanics have not received mental health services as needed. For instance, over the years, there has not been a comprehensive description of Hispanic mental health services. Here are a couple of examples of the first mental health services for Latinos in the literature:

– 1979, "La Frontera" South Tucson, Arizona [17]: a clinic in Arizona that provides mental health services to Mexican Americans.
– 1974, "Hispanic Clinic" New Haven, Connecticut [18]: a pioneering development of mental health services serving Spanish speaking minorities. A collaboration from the state government and an academic institution supports the clinic. Multiple factors increased and improved the services provided at this clinic. The underutilization of services by Hispanics prompted a close relationship with the community to increase engagement, developing the clinic as a trusted place. Also, the development of programs was informed by feedback and continuous communication with religious communities and leaders, local Hispanic newspapers, radio stations in Spanish, and Hispanic related community agencies. The community outreach via conferences and family programs helped to tailor the services to the community needs. The development of links to useful agencies, legal education, substance use education, and political information persists until the present time. When a service expansion was planned, these connections facilitated the formation of a network to create the Connecticut Latino Behavioral Health Services (LBHS), providing bilingual and bicultural clinicians to chosen community agencies for clinical discussions and outcome measuring [19].

Reports about admissions from facilities providing services in Spanish inform about the current delivery of services to Latinos in the United States. A report from 2010 cited that 40.7% of all admissions of Hispanic origin for substance use treatment were in the West, and only 38.5% of all facilities providing services in Spanish were located in that region. The West and North East account for 79.7% of all Hispanic admissions and 65.5% of all facilities that provided behavioral health services in Spanish [20] (Fig. 12.1).

In more recent history, after the worldwide COVID-19 pandemic preventing measures forced providers to use telehealth to follow patient care. Few reports on telehealth considering Hispanics have been published by this time. One study

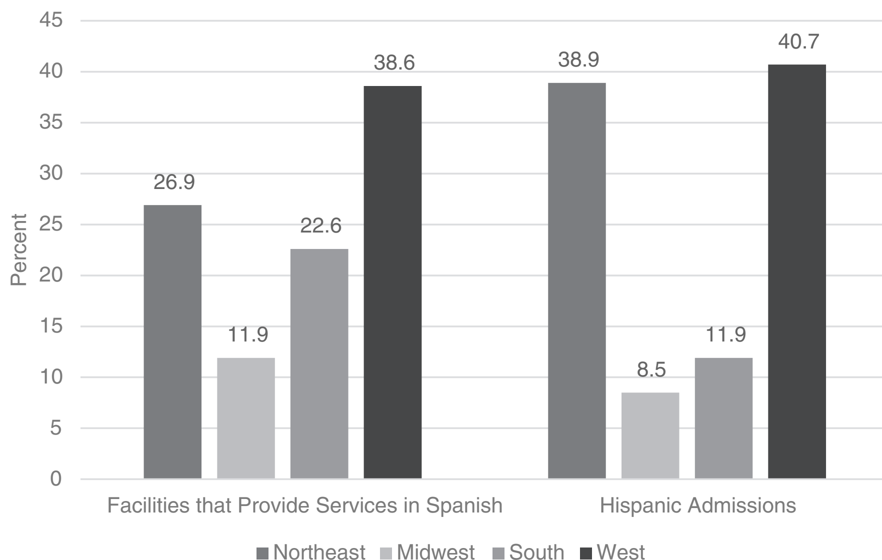

Fig. 12.1 Substance abuse treatment facilities that provide services in Spanish and admission of Hispanic origins, by region. Adapted from SAMHSA 2010

describes a favorable reception, but another pointed out that lack of insurance preclude the use of telehealth services [21].

Influences Promoting the Development of Hispanic Mental Health Services

Research

When developing culturally sensitive services, we have to confront the reality that one of the significant barriers for Hispanics in the United States is language. Besides affecting the quality of services, language is also an obstacle to obtaining information about sources of mental healthcare [22]. According to the 2017 Census, 30% of Hispanics are not proficient in English, and it is noteworthy that age and gender affect this number. Along with studies recommending that the therapist needs to look like the person in treatment [23], health service professionals need to work to address research, mental health services, and education focused on Hispanics [24].

The focus of Latino community mental health interventions turned to underutilization of services and how to increase access to care [25]. It was described that perceptions of mental illness vary culturally; thus, access to mental healthcare varies by ethnic group [22]. For instance, Puerto Ricans have a higher rate of utilization, and in general, Latinos tend to consult mental health problems in primary or family care [14]. Access continues to be a significant problem due to economic

constraints, lack of insurance, citizenship limitations, no information about where to go, and staying away from care [26].

Several authors report that Mexican American immigrants in the USA are healthier than Americans and that their offsprings were not as healthy as them, resembling more the American population. In other words, life expectancy is longer for Hispanics from abroad than Americans and second-generation Hispanics. This phenomenon is also known as the Latino Paradox. Moreover, it is suggested that the lack of extended families and social support might be essential influences in this finding. On the other hand, the Latino Paradox does not seem to affect Puerto Ricans, since this group has the worst health of Hispanic groups with increased cardiovascular disorders. A meta-analysis [27] suggests that there is enough evidence of the influence of the Latino Paradox on the health of Hispanics, and there is a need to move beyond and explore risks and resilience mechanisms for these differences. A commentary about the Latino paradox [28] emphasizes the importance of examining the data by country, as the political and socioeconomic variables are different.

The National Latino and Asian American study (NLAAS) is a nationally representative community household survey estimating the prevalence of mental disorders and rates of mental health service utilization by Latinos and Asian Americans. The aim was to assess associations among social position, environmental context, and psychosocial factors with the prevalence of psychiatric disorders and compare to a national representative sample of non-Latino Whites and African Americans. NLAAS was a formal research effort to investigate cultural, ethnic, and environmental considerations often ignored in mental health research. The survey includes the major categories of DSM diagnosis as well as nervous attacks, language preference, discrimination, migration status, and history [29].

The scarcity of Hispanic mental health professionals is a target for intervention. Efforts to increase the racial and ethnic diversity in psychiatry include training of minorities from diverse backgrounds [30], encouraging homegrown candidates by offering support such as scholarships, assure the presence of role models of similar ethnicity, include minorities in boards or administrative positions, advocate for changes, and political involvement [31]. Diversity initiatives address the development of teaching, research, services, and recruitment of minorities [32, 33]. These initiatives aim to assure that educational leadership is diverse and that the new generations of health providers consist of a diverse group representing minorities and underrepresented groups.

Education

Reports from the early 1990s described the scarcity of Latino professionals able to speak Spanish and understand the Latino culture. For example, the Psychology Professional groups reported only 1% of Spanish speaking mental health providers at that time. The scarcity was magnified by the lack of culturally sensitive services for Hispanics; therefore, the efforts focused on cultural competence.

There are many models to teach cultural competence. The Tulane model [34] offers core concepts to address, avoid stereotypes of individuals and groups, learn to ask the right questions, and connect the cultural competence teaching with the clinical skills learned. Kirmayer provides a comprehensive set of educational experiences in cultural psychiatry [35], and by using social science, they aid the trainee to appreciate their backgrounds and to understand culture, ethnicity, and identity. Then the trainee learns to make cultural evaluations as part of all psychiatric assessments [33].

Understanding the ethnic identity and acculturation process that immigrants go through is crucial to provide culturally sensitive psychotherapy and psychiatric treatment [36, 37]. Respect to Hispanic values promotes easy access to treatment and promotes trust. Cultural constructs of the Hispanic population, such as empathy and honesty, are essential for engagement [38, 39]. Support for immigrants should address community and family support, acculturative stress, discrimination, migration history, history of trauma exposure, idioms of distress and resilience, native language and communication preference, and origin [19].

The revision of the DSM IV-TR prompted a look at the outline of the Cultural formulation published in 1994 [12]. In response to requests from clinicians to facilitate cross-cultural evaluations, the Cultural Formulation Interview (CFI) was developed. The use of the Spanish CFI provides information about the unique aspects of the person consulting and his/her culture. By learning the CFI themes and questions, the trainee becomes an expert in eliciting culturally relevant information in all psychiatric assessments. The use of the CFI questions aim that the person consulting reveals the belief of what causes the problem, how do they call it, a description to a friend, their identity, barriers to care, stressors, structural challenges, past and current supports, and their treatment preference [39].

The Inclusion of Culture in Mental Health Services for Latinos

Overall, one of the interventions that increase culturally sensitive services includes using bilingual health providers [40]. Bilingual and bicultural professionals can understand mental health illness from a cultural approach. Studies report that matching patients and providers by the same ethnicity and language increases the rate of resolution of symptoms and increases the patient–provider alliance. Other interventions include adding educational materials in Spanish, embedding cultural values, norms and preferences in the services, and developing tools and training materials to increase staff knowledge and skills regarding mental illness [40, 41].

A successful program that provides culturally oriented and recovery-focused services to the Latino community is the Connecticut Latino Behavioral Health System (LBHS), developed as a culturally informed community-academic collaboration focused on mental health, addiction, and behavioral health [42]. Main points and lessons from the creation and ongoing delivery of services are the inclusion of cultural Latino values, considering recovery the primary goal of treatment, increasing

access to services, and promoting the collaboration between community organizations and a state mental health facility [42].

In regard to new programs and the use of technology in mental health, there is no much research in the area of apps, websites, or e-tools in Spanish. Younger generations tend to look towards technology when trying to find more information or referrals to mental health [43, 44]. This lack of services contributes to the gap of care received by the Latino community [45]. Other barriers that contribute to the disparities in access to new programs include the insufficient funding of community programs that would deliver these services to Hispanics [46]. On the other hand, older adults also suffer from disparities in accessing appropriate mental healthcare [38]. Culturally sensitive mental health services focused on recovery must overcome the barriers affecting the older Latino population, such as identifying their particular needs, making services available and accessible, and acceptance of mental healthcare treatment [38, 47].

One of the most important cultural values in the Latino community is *familismo* (familism), the value that refers to warm, close, and supportive family relationships, and that the individual would prioritize the family before themselves [48–50]. Consequently, including and promoting family participation in the treatment of mental illness and the pursue of recovery in mental health is essential [39, 44, 51, 52].

Regarding peer support in mental health services to the Latino community, the lack of Spanish speaking peers is unfortunate and detrimental to the recovery of this community affected by mental health problems. Studies have shown the positive impact of incorporating peer support in the Latino community to new mothers in perinatal care [51]. Utilizing services with same culture peer support increased retention of participants and enhanced participant motivation [53].

Cultural competence in outpatient and inpatient providers is a crucial component of culturally sensitive services and their impact on patients' recovery [52, 54]. For example, the participation of culturally competent health providers in health programs has shown to increase engagement in treatment, retention, and response in family-based interventions [55, 56].

Benefits of Implementing and Protecting Cultural Sensitive Services for Latinos

The two most significant benefits of implementing culturally sensitive services for Latinos relate to decreasing barriers to engage and complete treatment [57] as well as increasing the therapeutic alliance between provider and patient [58].

Culturally sensitive services aim at the engagement and retention of patients in treatment. Latinos tend to be skeptical of diagnostic labels and the benefits of standard forms of mental health treatment [59]. Successful culturally sensitive programs target the gap between ethnic and medical culture as it has been shown that the differences between provider–patient explanatory models of illness are a barrier in accessing mental healthcare [60].

Independence and the belief of being able to treat mental health issues with home remedies is another vital factor related to Latino immigrants and access to treatment [61]. Programs that address Latino's self-sufficient attitudes of behavioral health, a cultural aspect of the Latino community, may increase initiation and reduce attrition from treatment [62]. Concerning ways of expressing distress and understanding of symptoms, Latinos are more likely to conceptualize mental illness as a somatic problem [59]. Therefore, the models that emphasize behavioral change interventions that target physical ailments may seem less stigmatizing and more culturally relevant because they match Latinos' somatic beliefs about mental illness [63].

Culturally sensitive programs take advantage of the strong social ties in the Latino community to engage patients with treatment. Though social collectivism can make engagement in treatment among Latinos a more laborious process [64], peer navigator programs take advantage of this cultural element to enhance service engagement and recovery among Latinos with serious mental illness [65].

Successful culturally sensitive programs breach the gap between language and culture. Though language is a barrier to access care among Latino immigrants [61], mastery of Spanish without an understanding and curiosity for specific cultural details might lead to less successful treatment results. For example, culture-bound syndromes such as *mal de ojo* or *ataque de nervios* can be better understood when a provider is culturally aware of the significance of those terms in the Latino community [66]. Latino proverbs and sayings *(*known as *dichos)* are another essential cultural element that culturally competent providers can use to connect with patients. As outlined by psychologist Marlene de Rios, *dichos* "can link the phenomenological world of the Latino immigrant with the symbols and metaphors available" [67], which in turn can create a stronger therapeutic alliance between provider and patient.

Challenges Encountered When Incorporating Culturally Sensitive Services

Despite the many benefits that culturally sensitive services can provide, unfortunately, these competences are not widespread across the country. One of the main challenges in implementing these services is the availability of qualified staff to provide local training and implementing these programs. Highly successful, culturally sensitive programs rely on bilingual staff to adapt and adequately tailor successful behavioral models into culturally sensitive interventions. Unfortunately, the number of bilingual mental health providers in the United States is not enough to widely disseminate these programs [68]. Without adequate qualified bilingual trainers, it is difficult to emphasize and disseminate the importance of not only language but culture-bound nuisances of mental health seen in the Latino community.

Adapting culturally sensitive services to the Hispanic community has its challenges; however, it is essential. Maintaining content equivalency between the original intervention and the culturally sensitive intervention can prove challenging and raise into question the validity of the latter [69]. This difficulty can be minimized by using a systematic approach that documents the different adaptations and focuses on understanding theoretical driven principles and processes instead of making a rigid translation of the first intervention [70]. By following the above, cultural adaptation models of services can provide flexible guidelines to work with minority populations, such as Latinos [70].

In the presented context, another barrier to the delivery of culturally sensitive services is the diversity within the Latino community. Even though most Central and South America share the same language, specific culture-bound mental health syndromes, for example, "*susto,*" appear to have different treatments and descriptions among different regions [71]. The above leads for a need to further specialize in different interventions based on specific Latino demographics, which, in turn, makes it more challenging to implement these programs on a national scale widely.

Lastly, implementing any kind of additional training incurs financial and time constraints. Persuading administrators of an already financially burden medical system requires cultural humility that might not always be present. It is presumed that as cultural sensitivity becomes more widespread and accepted as a norm, the implementation of culturally sensitive services can be more warmly welcomed.

Advocacy for Development and Maintenance of Culturally Sensitive Services for Hispanics

The development of services has been guided by advocacy from multiple disciplines to address policies, education, research, and funding for Hispanic mental health services [Table 12.1].

Professional groups providing mental health services have debated how to assure that all people from all races and Culturally And Linguistically Diverse (CALD) populations receive equitable and effective healthcare. Formal efforts to address cultural sensitivity to minorities started in 1980; it was named cultural competence. The guidelines from the Accreditation Council for Graduate Medical Education (ACGME) competencies related to cultural competence, as well as the American Academy of Child and Adolescent Psychiatry's (AACAP) recommendations for the cultural competence training of child/adolescent fellows are useful. However, they have not solved the problem of health disparities and the scarcity of minorities in Psychiatry.

Table 12.1 Funding sources for Hispanic mental Health

Affordable Care Act (ACA)	After the ACA Hispanics, had the most significant percentage increased in health coverage from 32.6% to 19.1% in the states where the expansion took place [26, 72]. This coverage affected Hispanics eligible for Medicaid. Undocumented Immigrants do not qualify for government coverages and continue to struggle with disparities in healthcare.
Substance Abuse and Mental Health Services Administration (SAMHSA)	SAMHSA Grants provide financial support for agencies to increase substance use and behavioral health services to Latinx yearly. They also provide education on evidence-based medicine and culturally competent services. SAMHSA website provides a behavioral health treatment services locator, but they do not identify what agencies offer treatment in Spanish. The seeker would have to call the agency to obtain that information. https://findtreatment.samhsa.gov
National Alliance on Mental Illness (NAMI)	NAMI provides support and information in Spanish for people in need of mental healthcare and their families. https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Latinx-Hispanic/La-salud-mental-en-la-comunidad-latina
National Institute of Mental Health (NIMH)	NIMH provides research support to understand healthcare by ethnicity, study health outcomes, and try new interventions.
American Psychiatric Association (APA)	The APA, specifically the Hispanic caucus, aims to address mental health services for Hispanics and to educate the group
American Society of Hispanic Psychiatry (ASHP)	ASHP is a professional organization of mental health professionals interested in supporting the development of Hispanic services and research since 1982. This group was created to address research, services, and education in Latino mental health professionals. Senior members provide guidance and mentorship to younger generations to advance the field of Hispanic psychiatry and contribute to the pipeline of bilingual, bicultural, psychiatrists. The latter could provide not only adequate services but also do research.

Spurlock leadership was the first formal intervention to promote a diverse workforce. The minority fellowship program was funded in 1974 by the National Institute of Mental Health to train underrepresented minorities, contributing to diverse and culturally sensitive professionals. Examples of successful outcomes are the formation of scholarly networks on Hispanic mental health [73] and the support to create new educational programs in medical schools of states in need of culturally sensitive psychiatrists.

Conclusions

Delivery of culturally sensitive mental health services helps provide high quality and appropriate care. Most care models are developed in a non-Hispanic culture; therefore, these services need to be translated and culturally adapted to the

population that will serve. The bilingual and bicultural professionals should take the task of adapting and translating such models.

As mentioned in this chapter, continued research, and clinical and community programs focused on the Hispanic culture are a crucial piece to develop services that help equally to this population and consider culture as a principal pillar [74]. However, in order to provide the best care to Hispanic patients, culturally sensitive mental health services must be accompanied by social justice, advocacy, dissemination of research, and policies [75]. As mental health professionals, we must develop and protect those tools in order to fulfill the essential needs of the Latino population.

References

1. Alegría M, Canino G, Ríos R, Vera M, Calderón J, Rusch D, et al. Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites. Psychiatr Serv. 2002;53(12):1547–55.
2. Burnett-Zeigler I, Lee Y, Bohnert KM. Ethnic identity, acculturation, and 12-month psychiatric service utilization among black and Hispanic adults in the U.S. J Behav Health Serv Res. 2018;45(1):13–30.
3. López SR, Barrio C, Kopelowicz A, Vega WA. From documenting to eliminating disparities in mental health care for Latinos. Am Psychol. 2012;67(7):511–23.
4. Chang C-W, Biegel DE. Factors affecting mental health service utilization among Latino Americans with mental health issues. J Ment Health. 2018;27(6):552–9.
5. Margarita Alegría PD, Glorisa Canino PD, Ruth Ríos PD, Mildred Vera PD, José Calderón MS, Dana Rusch BA, et al. Mental health care for Latinos: Inequalities in use of specialty mental health services among latinos, African Americans, and non-Latino whites. Psychiatr Serv. 2002;53(12):1547–55.
6. Ortega AN, McKenna RM, Kemmick Pintor J, Langellier BA, Roby DH, Pourat N, et al. Health care access and physical and behavioral health among undocumented Latinos in California. Med Care. 2018;56(11):919–26.
7. McGinty EE. Interventions to address medical conditions and health-risk behaviors among persons with serious mental illness: a comprehensive review, Schizophrenia Bulletin. 2016;42(1)
8. Kirmayer LJ, Young A. Culture and somatization: clinical, epidemiological, and ethnographic perspectives. Psychosom Med. 1998;60(4):420–30.
9. Alarcon RD, Bell CC, Kirmayer LJ, Lin K-M, Ustun B, Wisner KL. In: Kupfer DJ, editor. Beyond the funhouse mirrors: Research agenda on culture and psychiatric diagnosis; 2002. p. 219–81.
10. Mezzich JE, Ruiz P, Munoz RA. Mental health care for Hispanic Americans: a current perspective; 1999. p. 91–102.
11. Kirmayer LJ. The place of culture in psychiatric nosology: Taijin kyofusho and DSM-III-R. J Nerv Ment Dis. 1991;179(1):19–28.
12. Mezzich JE, Kirmayer LJ, Kleinman A, Fabrega H Jr, Parron DL, Good BJ, et al. The place of culture in DSM-IV. J Nerv Ment Dis. 1999;187(8):457–64.
13. Lewis-Fernández R, Aggarwal N, Lam P, Galfalvy H, Weiss M, Kirmayer L, et al. Feasibility, acceptability and clinical utility of the cultural formulation interview: mixed-methods results from the DSM-5 international field trial. Br J Psychiatry. 2017;210(4):290–7.
14. Escobar JI, Rubio-Stipec M, Canino G, Karno M. Somatic symptom index (SSI): a new and abridged somatization construct. Prevalence and epidemiological correlates in two large community samples. J Nerv Ment Dis. 1989;177(3):140–6.

15. Administration SAaMHS. National Survey on drug use and health: Hispanics, Latino or Spanish Origin or Descent. Rockville MD U.S. Department of Health and Human Service, 2018.
16. Substance Abuse and Mental Health Services Administration. Results from the 2018 National Survey on Drugs Use and Health: Detailed Tables. 2019 (Center for Behavioral Health Statistics and Quality, Rockville, Maryland 20857).
17. Martin PP. La Frontera perspective: Providing mental health services to Mexican Americans Tucson Az1979.
18. Abad V, Ramos J, Boyce E. A model for delivery of mental health services to Spanish-speaking minorities. American Journal of Orthopsychiatry. 1974;44:584–95.
19. Paris M, Silva MA, Diaz E, Bedregal LE, Cole RA, Añez-Nava L. The Connecticut Latino behavioral health system: a culturally informed community-academic collaboration. Psychol Serv. 2016;13(2):140–7.
20. Quality CfBHSa. Substance Abuse Facilties with Services in Spanish are available in all regions for Hispanic clients admitted to treatment in 2010. Human Health Services: Rockville MD; 2010.
21. Hilty D, Lim R, Nasatir-Hilty S, Koike A, Ton H, Nesbitt T. Planning for Telepsychiatric consultation: a m=needs assessment for cultural and language Services at Rural Sites in California. J Rural Ment Health. 2015;39(3–4):153–61.
22. Martinez Tyson D, Arriola N, Corvin J. Perceptions of depression and access to mental health care among Latino immigrants: looking beyond one size fits all. Qualitative Health Reserach. 2016;26(9):1289–302.
23. Sue S. In search of cultural competence in psychotherapy and counseling. Am Psychol. 1998;53(4):440–8.
24. Services USDoHaH. Mental Health: Culture, Race, and Ethnicity–A Suppl to Mental Health: A Report of the Surgeon General. Rockville, Md.: 2001.
25. Vega WA, Kolody B, Aguilar-Gaxiola S, Catalano R. Gaps in service utilization by Mexican Americans with mental health problems. Am J Psychiatry. 1999;156(6):928–34.
26. Jennifer T, Kendal O, Natalie S, Anthony D. Key facts about the uninsured population. DC: Washington; 2019.
27. Ruiz JM, Steffen P, Smith TB. Hispanic mortality paradox: a systematic review and meta-analysis of the longitudinal literature. Am J Public Health. 2013;103(3):e52–60.
28. Abraído-Lanza AF, Dohrenwend BP, Ng-Mak DS, Turner JB. The Latino mortality paradox: a test of the "salmon bias" and healthy migrant hypotheses. Am J Public Health. 1999;89(10):1543–8.
29. Alegria M, Takeuchi D, Canino G, Duan N, Shrout P, Meng X-L, Vega W, Zane N, Vila D, Woo M, Vera M, Guarnaccia P, Aguilar-Gaxiola S, Sue S, Escobar J, Lin K-M, Gong F. Considering context, place and culture: the National Latino and Asian American study. Int J Methods Psychiatr Res. 2004;13(4):208–20.
30. Lokko N, Chen J, Parekh R, Stern T. Racial and ethnic diversity in the US psychiatric force: a perspective and recommendations academic psychiatry 2016.
31. Statement on the Better Care Reconciliation, (2017).
32. Lim R, Luo J, Suo S, Hales R. Diversity initiatives in academic psychiatry: applying cultural competence. Acad Psychiatry. 2008;32:283–90.
33. Lim RF, Lu FG. Culture and psychiatric education. Acad Psychiatry. 2008;32(4):269–71.
34. Pena JM, Manguno-Mire G, Kinzie E, Johnson JE. Teaching cultural competence to psychiatry residents: seven Core concepts and their implications for therapeutic technique. Acad Psychiatry. 2016;40(2):328–36.
35. Kirmayer LJ, Groleau D, Guzder J, Blake C, Jarvis E. Cultural consultation: a model of mental health Service for Multicultural Societies. The Canadian Journal of Psychiatry/La Revue canadienne de psychiatrie. 2003;48(3):145–53.
36. Delgado-Romero EA, Hernandez CA. Empowering Hispanic students through student organizations: competencies for faculty advisors. J Hisp High Educ. 2002;1(2):144–57.

37. Akhtar S. Immigration and acculturation mourning, adaptation, and the next generation. Lanham: Jason Aronson; 2011. p. xvi, 294.
38. Costantino G, Malgady RG, Primavera LH. Congruence between culturally competent treatment and cultural needs of older Latinos. J Consult Clin Psychol. 2009;77(5):941–9.
39. Diaz E, Anez LM, Silva M, Paris M, Davidson L. Using the cultural formulation interview to build culturally sensitive services. Psychiatr Serv. 2017;68(2):112–4.
40. Lewis-Fernández R, Aggarwal NK, Bäärnhielm S, Rohlof H, Kirmayer LJ, Weiss MG, et al. Culture and psychiatric evaluation: operationalizing cultural formulation for DSM-5. Psychiatry. 2014;77(2):130–54.
41. Cabassa LJ, Manrique Y, Meyreles Q, Capitelli L, Younge R, Dragatsi D, et al. "Treated me … like I was family": qualitative evaluation of a culturally-adapted health care manager intervention for Latinos with serious mental illness and at risk for cardiovascular disease. Transcult Psychiatry. 2019;56(6):1218–36.
42. Paris M, Silva MA, Diaz E, Bedregal LE, Cole RA, Anez-Nava LM. The Connecticut Latino behavioral health system: a culturally informed community-academic collaboration. Psychol Serv. 2016;13(2):140–7.
43. Chaet AV, Morshedi B, Wells KJ, Barnes LE, Valdez R. Spanish-language consumer health information technology interventions: a systematic review. J Med Internet Res. 2016;18(8):e214.
44. Kapke TL, Gerdes AC. Latino family participation in youth mental health services: treatment retention, engagement, and response. Clin Child Fam Psychol Rev. 2016;19(4):329–51.
45. Ospina-Pinillos L, Davenport T, Mendoza Diaz A, Navarro-Mancilla A, Scott EM, Hickie IB. Using Participatory Design Methodologies to Co-Design and Culturally Adapt the Spanish Version of the Mental Health eClinic: Qualitative Study. J Med Internet Res. 2019;21(8):e14127-e.
46. Rosales R, Calvo R. Characteristics of Hispanic-serving mental health organizations in the U.S. J Health Care Poor Underserved. 2019;30(2):547–59.
47. Guzman ED, Woods-Giscombe CL, Beeber LS. Barriers and facilitators of Hispanic older adult mental health service utilization in the USA. Issues Ment Health Nurs. 2015;36(1):11–20.
48. Campos B, Ullman JB, Aguilera A, Dunkel SC. Familism and psychological health: the intervening role of closeness and social support. Cultur Divers Ethnic Minor Psychol. 2014;20(2):191–201.
49. Ayón C, Aisenberg E. Negotiating cultural values and expectations within the public child welfare system: a look at familismo and personalismo. Child Fam Soc Work. 2010;15(3):335–44.
50. Calzada EJ, Tamis-LeMonda CS, Yoshikawa H. Familismo in Mexican and Dominican families from low-income, urban communities. Journal of Family Issues. 2012;34(12):1696–724.
51. Valdez CR, Ramirez Stege A, Martinez E, D'Costa S, Chavez T. A community-responsive adaptation to reach and engage Latino families affected by maternal depression. Fam Process. 2018;57(2):539–56.
52. Villatoro AP, Morales ES, Mays VM. Family culture in mental health help-seeking and utilization in a nationally representative sample of Latinos in the United States: the NLAAS. Am J Orthopsychiatry. 2014;84(4):353–63.
53. Lutenbacher M, Elkins T, Dietrich MS, Riggs A. The efficacy of using peer mentors to improve maternal and infant health outcomes in Hispanic families: findings from a randomized clinical trial. Matern Child Health J. 2018;22(Suppl 1):92–104.
54. Sanchez K, Killian MO, Eghaneyan BH, Cabassa LJ, Trivedi MH. Culturally adapted depression education and engagement in treatment among Hispanics in primary care: outcomes from a pilot feasibility study. BMC Fam Pract. 2019;20(1):140.
55. Kumpfer KL, Alvarado R, Smith P, Bellamy N. Cultural sensitivity and adaptation in family-based prevention interventions. Prev Sci. 2002;3(3):241–6.

56. Semansky RM, Altschul D, Sommerfeld D, Hough R, Willging CE. Capacity for delivering culturally competent mental health services in New Mexico: results of a statewide agency survey. Admin Pol Ment Health. 2009;36(5):289–307.
57. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O 2nd. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep. 2003;118(4):293–302.
58. Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Med Care Res Rev. 2000;57(Suppl 1):181–217.
59. Carpenter-Song E, Chu E, Drake RE, Ritsema M, Smith B, Alverson H. Ethno-cultural variations in the experience and meaning of mental illness and treatment: implications for access and utilization. Transcult Psychiatry. 2010;47(2):224–51.
60. Cortes DE, Mulvaney-Day N, Fortuna L, Reinfeld S, Alegría M. Patient--provider communication: understanding the role of patient activation for Latinos in mental health treatment. Health Educ Behav. 2009;36(1):138–54.
61. Falgas I, Ramos Z, Herrera L, Qureshi A, Chavez L, Bonal C, et al. Barriers to and correlates of retention in behavioral health treatment among Latinos in 2 different host countries: the United States and Spain. J Public Health Manag Pract. 2017;23(1):e20–e7.
62. Ransford HE, Carrillo FR, Rivera Y. Health care-seeking among Latino immigrants: blocked access, use of traditional medicine, and the role of religion. J Health Care Poor Underserved. 2010;21(3):862–78.
63. Jimenez DE, Burrows K, Aschbrenner K, Barre LK, Pratt SI, Alegría M, et al. Health behavior change benefits: perspectives of Latinos with serious mental illness. Transcult Psychiatry. 2016;53(3):313–29.
64. Hough RL, Hazen AL, Soriano FI, Wood P, McCabe K, Yeh M. Mental health services for Latino adolescents with psychiatric disorders. Psychiatr Serv. 2002;53(12):1556–62.
65. Corrigan P, Sheehan L, Morris S, Larson JE, Torres A, Lara JL, et al. The impact of a peer navigator program in addressing the health needs of Latinos with serious mental illness. Psychiatr Serv. 2018;69(4):456–61.
66. Romero AJ, Edwards LM, Corkery S. Chapter 17–assessing and treating Latinos: overview of mental Health Research. In: Paniagua FA, Yamada A-M, editors. Handbook of multicultural mental health. 2nd ed. San Diego: Academic Press; 2013. p. 327–43.
67. de Rios MD. Brief psychotherapy with the Latino immigrant client. New York, NY, US: Haworth Press; 2001. p. 191.
68. Demographics of U.S. Psychology Workforce [Interactive Data Tool] [Internet]. 2019 [cited 07/05/2020]. Available from: https://www.apa.org/workforce/data-tools/demographics
69. Bernal G, Bonilla J, Bellido C. Ecological validity and cultural sensitivity for outcome research: issues for the cultural adaptation and development of psychosocial treatments with Hispanics. J Abnorm Child Psychol. 1995;23(1):67–82.
70. Domenech Rodríguez MM, Baumann AA, Schwartz AL. Cultural adaptation of an evidence based intervention: from theory to practice in a Latino/a community context. Am J Community Psychol. 2011;47(1–2):170–86.
71. Weller SC, Baer RD, de Alba Garcia JG, Glazer M, Trotter R, Salcedo Rocha AL, et al. Variation and persistence in Latin American beliefs about evil eye. Cross-Cult Res. 2014;49(2):174–203.
72. Artiga S, Orgera K, Damico A. Changes in Health care coverage by Race and Ethnicity since the ACA, 2010-2018. KFF, 2020.
73. Harris B, Mian A, Lomax J, Scott-Gurnell K, Sargent J, Phillips J, et al. The Texas regional psychiatry minority Mentor network: a regional effort to increase Psychiatry's workforce diversity. Acad Psychiatry. 2012;36(1):60–3.
74. Manuel JI. Racial/ethnic and gender disparities in health care use and access. Health Serv Res. 2018;53(3):1407–29.
75. Torres SA, Santiago CD, Walts KK, Richards MH. Immigration policy, practices, and procedures: the impact on the mental health of Mexican and central American youth and families. Am Psychol. 2018;73(7):843–54.