Chapter 1
Integrated Care: A Potential Solution to Behavioral Health Disparities Among Latinos

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Introduction: A Potential Solution to Behavioral Health Disparities Among Latinos

Latinos in the United States

Latinos constitute the largest minority group in the United States making up approximately 16 % of the total US population (U.S. Census Bureau, 2010). The Center for Disease Control defines Latinos and Hispanics as peoples of "Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race." In addition to nationality, there is substantial heterogeneity among Latinos with regard to immigrant status, English-language fluency, and acculturation, socioeconomic level, among other factors.

In the United States, persons of Mexican origin comprise the largest proportion of Latinos (almost two-thirds), with the remaining third distributed primarily among persons of Puerto Rican, Cuban, and Central American origin (U.S. Census Bureau, 2010). With regard to immigrant status, of the 55 million people in 2014 who identified themselves as of Hispanic or Latino origin, 35 % (19.4 million) were recent immigrants (U.S. Census Bureau, 2010). This constitutes about 6 % of the total US population. The other two-thirds of Latinos (64 %) living in the United Sates were born in the U.S. (Zong & Batalova, 2016). Given the high number of Latino immigrants in the United States, it is not surprising that a large portion of Latinos aren't fluent in English. Approximately 78 % of Latinos aged 5 and older speak Spanish as their primary language in the home (Weil, 2010), and less than half of Latino

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immigrants residing in the United States have *even* limited English-language proficiency (Patten, 2012). In addition to the above, acculturation level is also a relevant factor that contributes to the heterogeneity of the Latino population in the United States.

Contemporary Issues in the Latino Community

Benuto (2017) summarized the contemporary issues that Latinos face. These include issues related to cultural self-identification, acculturation level, immigration status, discrimination, English-language proficiency, and poverty. With regard to cultural self-identification and acculturation, ethnic identity can be a key component of psychosocial development and it may serve as a resource for people who experience discrimination or inequitable treatment (Brittian, Umaña-Taylor, & Derlan, 2013) and self-identity is relevant to acculturation. Acculturation is characterized by adaptation to the host culture, maintenance of the cultural practices and values of coulter or origin, or a combination of both (Berry, 2005). Latinos and other ethnic minority groups may experience a phenomenon known as acculturative stress, which is a stress reaction to the life events that are related to the acculturation process (Berry, 2005). Prevalence of mental health conditions also have been noted to be related to acculturation level. Specifically Latinos who were born in the United States have higher rates of mental health disorders (Alegría et al., 2008) and because acculturation may result in added stressors or maladaptive coping and a loss of indigenous protective factors (Alamilla, Kim, & Lam, 2010), it has been suggested that the acculturation process and acculturative stress may play a role in the development and/or maintenance of mental health conditions. This needs to be studied more.

Arguably the biggest issue that Latinos face is related to immigration status (Benuto, 2017). There are over five million undocumented Latinos in the United States (Krogstad & Passel, 2015) and undocumented Latinos have a diverse range of experiences with regard to how they arrived in United States, how their immigration status impacts their day-to-day lives, and how their immigration status affects their overall functioning in the United States. Indeed, Latinos may have suffered when crossing of the border and likely had to leave key family members behind. Moreover, working as an undocumented immigrant can be dangerous and demoralizing experience as undocumented workers may be subject to abuse and exposure to occupational hazards because of their undocumented status (Arellano-Morales, Liang, Ruiz, & Rios-Oropeza et al. 2016). Documented Latinos may also face issues including worries and concerns about their undocumented parents as well as racism and discrimination. Indeed, regardless of legal status, the chronic experience of racism is a risk factor in the development for depression, isolation, and psychological distress (Arellano-Morales et al., 2016).

Lack of English-language proficiency can also pose a significant problem for Latinos. Because less than half of Latino immigrants residing in the United States have *even* limited English-language proficiency (Patten, 2012), many Latinos face

language barriers that make it challenging for Latinos to access healthcare, impacts their ability to be employed, and can impact how others perceive and treat them (Benuto, 2017). Finally, Latinos are disproportionately impacted by poverty and have lower household income than Whites in this country (Feeding America, n.d.). This indicates that Latinos may live in substandard housing, have inadequate nutrition, live in unsafe neighborhoods, and attend under-resourced schools (American Psychological Association, 2016). There is also extensive documentation that Latinos experience barriers to accessing healthcare and the majority of these barriers are related to socioeconomic status (Benuto & Leany, 2011). However, because there is so much heterogeneity in the broad classification of "Latinos" it is also important to say that none of the above may be true: Latinos also comprise middle- and upper-class socioeconomic strata and enjoy all the benefits associated with this.

The Behavioral Health of Latinos

With regard to prevalence rates of mental health disorders among Latinos, in the most comprehensive study of Hispanics/Latinos of different national backgrounds conducted to date (the HCHS/SOL), the prevalence of depression among Latinos was found to 27 % and while the authors did look at anxiety they did not provide an actual prevalence rate but indicated that the rates were similar for anxiety (Wassertheil-Smoller et al., 2014). While this is not higher than what is seen with non-Latinos, this does suggest that, similarly, a large number of Latinos experience depression and anxiety. This study also found that factors such as US-born status was related to prevalence rate with US-born Latinos having higher rates of depression and anxiety than foreign-born Latinos and this highlights some of the intricacies that can be seen with this group. In fact, across the board US-born Latinos experience higher rates of depression, anxiety disorders, and substance use disorders (Alegría et al., 2008). Alegria and colleagues have also noted that lifetime prevalence rates of mental health disorders vary by country of origin with Puerto Ricans experiencing the highest lifetime disorder rate (37.4 %), followed by Mexicans (29.5 %), Cubans (28.2 %) and other Latinos (27 %).

Challenges in Accessing Behavioral Health Services

Latinos experience a number of barriers to accessing behavioral health care, many of which are related to socioeconomic status. Benuto and Leany (2011) have summarized these as consisting of lack of transportation, long waits, inflexible hours, distance between the home and treatment location, lack of health insurance, cost, language, and stigma surrounding the use of mental health disorders. The bulk of the literature on addressing the needs of Latinos is focused on the application of culturally adapted service delivery.

Over the last several decades, two parallel movements have been at play in the field of clinical psychology: the movement toward the use of evidence-based interventions and the cultural sensitivity movement. Indeed, the field of clinical psychology is currently oriented towards evidence-based practice (e.g., Chambless & Ollendick, 2001) and increasingly clients are delivered empirically supported treatments (ESTs: Chambless & Ollendick, 2001). Benuto and O'Donohue (2015) discussed how the focus on ESTs is consistent with the Affordable Care Act, which emphasizes efficient, effective health care interventions in an attempt to improve safety, costs, and outcomes (Wendel, O'Donohue, & Serratt, 2013). With regard to the push towards the provision of culturally sensitive services, the extent to which ESTs generalize to ethnic minority clients has been questioned. Specifically some have alleged that ethnic minorities are underrepresented in the original outcome research (Bernal & Scharró-del-Río, 2001), the majority culture values and assumptions are exclusively represented in these therapies (Benish, Quintana, & Wampold, 2011), and the dependent measures used to assess the outcomes of these therapies were not validated on ethnic minority clients (Cardemil, 2010).

Given these two parallel movements, Benuto and O'Donohue (2015) reviewed the literature to determine what "culturally sensitive" interventions (whereby "culturally sensitive" was defined as any study that included a specific focus on the cultural group of interest) could be considered well-established, beneficial treatments for use with Latinos. They noted that while there are several hundred publications on the general issues related to Latinos and cultural sensitivity, there were only 12 peer-reviewed articles that evaluated empirically supported treatments for the mental health disorders most commonly diagnosed among this population. Benuto and O'Donohue noted that these 12 studies had significant methodological limitations and few employed the "gold standard" designs associated with randomized clinical trials. From this review Benuto and O'Donohue concluded that there is evidence that Latinos may be effectively treated using conventional cognitive behavioral therapy (perhaps translated into Spanish) and that there is little evidence that cultural adaptations result in consistently improved effect sizes. In addition, they noted that the cultural adaptation process was quite variable with different assumptions and assertions across studies regarding what constituted Latino culture. Thus while the majority of the literature has focused on the delivery of culturally sensitivity interventions, there is little empirical support to suggest that such an approach is necessary. However, the barriers to behavioral health services that Latinos experience are substantial and well documented. Thus, it is necessary that a means to address these barriers be established. One possible solution is integrated care.

Integrated Care as a Potential Solution for Latinos

Integrated care is a mechanism of delivering care that attempts to make service delivery more efficient, effective, and client-centered. The basic idea is to collocate and coordinate behavioral health care in a medical setting, particularly primary care.

This allows "one stop" care where both the physical health needs and behavioral health needs can be identified and treated. Part of the rationale for this is that patients' bodies and minds are interconnected and as such cannot be cleanly parsed and treated in two distinct and usually uncoordinated treatment centers. For example, diabetes often has behavioral health components such as comorbid depression, treatment compliance issues, and lifestyle change issues. A coordinated team of medical and behavioral health providers in one treatment center can provide more efficient and effective care than siloed specialty care. In addition, the goals of primary care are not to miss behavioral health problems sand create medical errors in the medical setting as well as to provide prevention services. Interestingly the goals of integrated care match nicely to the needs of Latinos.

Integrated care fits with the needs of Latinos in several ways. First, integrated care is more comprehensive. Specifically, integrated care offers a comprehensive and team-based approach to care so that the patient can have both physical and behavioral healthcare needs met in a single location. It is well documented that Latinos have high-comorbidity between mental health disorders and physical conditions (Sin, 2012). For example, comorbid depression and anxiety and heart disease among Latinos it is well documented in the literature (Wassertheil-Smoller et al., 2014). Given the high comorbidity that Latinos experience, providing comprehensive care in a single location is ideal. Moreover, given the barriers to care that Latinos experience, proving care in a single location can help alleviate some of the challenges Latinos experience in terms of physically accessing care.

Second, integrated care is patient-centered. Patient-centered care places the patient and their families as core members of the care team and actively involves them in treatment planning. Latino culture tends to be focused on the nuclear and extended family (Smith, 2000) so including families as members of the treatment team is consistent with Latino cultural values. Third, integrated care is coordinated across the healthcare system. Given the barriers that Latinos face in accessing care, having care coordinated is critical to removing the barriers that Latinos face in accessing treatment. Lastly, integrated care is accessible. For example in patient-centered medical homes care settings there are enhanced in-person hours so that patients have access to more hours of service. Because issues of access are one of the most pressing issues that Latinos face, flexibility is key.

The Unmet Research Agenda

There is an evidential burden that must be met both with respect to integrated care in general and integrated care with Latino populations. Integrated care delivery models must be evaluated to see to what extent they actually represent a solution to problems encountered by Latinos. The promise of integrated care is just that: a promise and this delivery model must be evaluated in each setting in which it is implemented to actually determine the extent to which this promise is met.

There are reasons to be only cautiously optimistic. Integrated care does not solve the workforce problem in behavioral health but may in fact exacerbate it (O'Donohue & Maragakis, 2016). There are still too few behavioral health professionals with skills in integrated care service delivery and fewer who have these skills and can deliver services in Spanish. This is a key problem in workforce development that there is too little work is done either in a strategic vision or in practical implementation. Also there is the question raised earlier of what cultural adaptations for what problems for what kind of patients need to be developed and evaluated. There is too little research addressing this question for Latinos in the integrated care service model. Of course this question is made more complex by the diverse number of cultural minorities that may present in integrated care. The same lack of evidence is found in screens and other assessment devices for Latinos in integrated care. Similarly, as one of the goals of integrated care is prevention, more prevention research is needed with Latinos in integrated care.

The major problem is that for some integrated care is seen by some as such a "good idea" (as compared to fractionated care)—that too little concern has been placed on the question of demonstrated quality in integrated care. Too many integrated care service delivery settings for any populations hire professionals untrained in integrated care, do not clearly and properly define clinical and operational pathways; do not train medical personnel to work as part of an integrated care team, do not train support staff, do not use appropriate screens, do not utilize psychometrically proper follow up assessment, do not use evidence based treatments, do not use a step care approach, do not properly treat the full range of behavior health problems, do not properly coordinate interventions with the medical teams, do not deliver prevention when called for, miss intervening with important problems like smoking and obesity, do not have the behavioral health provider sufficiently productive, do not show cost reductions, and do not utilize quality improvement procedures to measure and improve key aspects of the integrative efforts. These are many of the problems that also can be found in specialty care in traditional mental health. It is unfortunate and will limit or doom the integrated care movement if the same or similar weaknesses found in traditional mental health also find a place in "new" integrated care settings (see O'Donohue & Maragakis, 2016 for an extended treatment of quality improvement tools in integrated care). Thus, we recommend highly that any integrated care program oriented toward Latinos orient toward these quality issues and not just assume that because the label of "integrated care" is being applied that the program is good.

It is useful to evaluate any program on several quality improvement indices including these 14:

1. Patient satisfaction
2. Physician satisfaction
3. Clinical improvement
4. Use of integrated care interventions vs. Specialty care
5. Medical cost offset
6. Kinds of problems addressed

7. Use of evidence based assessments and interventions
8. Proper use of behavioral health screens
9. Productivity of behavioral health staff
10. Appropriate documentation
11. Prevention
12. Appropriate referrals
13. Comprehensive care
14. Coordination of care

We recommend a quarterly quality improvement report where each of these dimensions is measured and strategies are used to make continual improvements in these.

Summary and Organization of the Book

In sum, integrated care is perfectly positioned to solve many of the issues that Latinos face with regard to behavioral health care. There is some limited research on using integrated care with this population---Bridges and colleagues (2014) found that both non-Latino whites and Latinos had comparable utilization rates and comparable and clinically significant improvements in symptoms when they accessed integrated care. Latinos also expressed high satisfaction with integrated behavioral services. These data provide preliminary evidence suggesting that the integration of behavioral health services into primary care clinics may help reduce mental health disparities for Latinos.

While the field is shifting rapidly towards an integrated care model, discussions on cultural factors and how they interplay with integrated care are largely lacking. This book attempts to fill this gap and provides practical and easy to use solutions to the issues that the behavioral health care specialist is likely to encounter when working with Latinos in a primary care setting. The health disparities among Latinos are vast and this text provides culturally relevant recommendations that could ultimately lead to a reduction in these disparities.

The book is organized so that there are several chapters dedicated to a discussion on working with Latinos who might present with variable circumstances (i.e., immigrants have characteristics and experiences that are fairly distinct from non-immigrants, Cubans and Puerto Ricans both have distinct histories given the relationship with the United States and Cuba and Puerto Rico—thus there are specific chapters on these special populations). Because there are financial elements to healthcare, there is a specialty chapter on community health centers and payment for integrated care. Similarly given recent legislation that has changed the health care system, we also included a chapter on health policy. Finally, there are chapters that focus on the major mental health conditions that are likely to present in an integrated care setting (including presentations such as chronic disease that have important behavioral health implications). Each of these chapters includes recommendations for screening instruments that can be administered to this population in an integrated

care setting; how the issue in question (e.g., depression, chronic disease) might present in an integrated care setting; what transpires are the hallway hand-off occurs (i.e., in a primary care setting or patient-centered medical home) and the person is placed in the care of the behavioral healthcare specialist; stepped-care options for the behavioral healthcare specialist; how cultural considerations can be made and applied to evidence-based interventions in an integrated care setting; and how behavioral health care specialists can work in concert with medical professionals to improve the health of Latinos in this country.

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