Chapter 11
Using Integrated Care to Treat Anxiety Among Latino Populations

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Introduction: Addressing Disparities Through Integrated Behavioral and Primary Care

The growth of the nation's Latino group is estimated to nearly double over the next half century (from 13 to 24 %; U.S. Census Bureau, 2003). Most notably, while the total U.S. population increased 10 % from 2000 to 2010, the Latino population increased 43 % (U.S. Census Bureau, 2010). This growth has taken place at a time when many social service systems are not prepared to address the needs of the culturally pluralistic Latino population. For instance, a significant number of Latinos have relatively high levels of mental health problems and unmet mental health needs (Kessler et al., 1994), contributing to Latinos' overrepresentation among individuals at risk for poor mental health outcomes (e.g., groups with lower socioeconomic status, limited English proficiency) (Derose & Baker, 2000; Ku & Matani, 2001; Vega, Alderete, Kolody, & Aguilar-Gaxiola, 1998). A significant gap exists between the need for and availability of culturally competent mental health services for Latinos. With new health care reform legislation, a unique opportunity exists to enhance the accessibility and quality of mental health services that are available in primary care settings for this population.

Latinos in the U.S. experience substantial difficulties in obtaining adequate access to health care (Alegría et al., 2002) and mental health services (Blanco et al., 2007; Center for Mental Health Services, 2000), and overall are underrepresented

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in mental health settings (e.g., Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). Many Latinos seeking services for psychological problems tend to do so from their primary care providers, highlighting the need for culturally appropriate integrated care in this setting. Developing culturally competent integrated care models has the potential to significantly decrease disparities in access to and quality of behavioral health services among the Latino population in the U.S. The chief goal of this chapter is to examine how cultural considerations can be applied to evidence-based interventions for anxiety in an integrated care setting.

Latinos as an at-Risk Population

Research suggests that Latinos in the U.S. tend to have high prevalence rates of anxiety disorders and comorbidity—primarily with depression (Kessler et al., 1994). Some evidence indicates that Latinos also have higher rates of anxiety disorders when compared to other ethnic groups (Minsky, Vega, Miskimen, Gara, & Escobar, 2003). Though not statistically different, epidemiological data show that compared to whites, Latinos have greater levels of symptom severity and greater 12-month prevalence rates of anxiety disorders (21.4% vs. 18.9%) (Kessler, Chiu, Demler, & Walters, 2005). In other studies, Latinos have lower rates of anxiety disorders than non-Latino whites but, among Latinos who became ill, the disorder was more likely to be chronic than in non-Latino whites (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005). That is, Latinos may be at high risk for developing chronic anxiety disorders when left untreated.

In recent decades, the U.S. has seen the greatest influx of Latino immigrants compared to other countries (Kaiser Commission on Medicaid and the Uninsured, 2004). Like many other immigrant populations, immigration for Latinos can lead to considerable familial, social, and environmental hardships (Perez & Fortuna, 2005), including separation from family, loss of family support and social status, lack of community, poorer living conditions, discrimination, and language and communication difficulties (Finch, Kolody, & Vega, 2000; Finch & Vega, 2003; Hovey, 2000a, 2000b; Perez & Fortuna, 2005). Many Latinos immigrate to the U.S. due to economic adversities and violence resulting from political oppression or war-related violence in their country of origin (Leslie & Lietch, 1989); factors that also contribute to psychological issues related to trauma, loss, and poverty (Organista & Muñoz, 1996). Given such negative life events are frequently linked to poor psychological adjustment (Hiott, Grzywacz, Arcury, & Quandt, 2006; Perez & Fortuna, 2005; Portes & Rumbaut, 2006), Latinos may be at particularly high risk for developing psychiatric disorders—particularly anxiety and depression (Plante, Manuel, Menedez, & Marcotter, 1995).

Anxiety and Service Use in Primary Care Settings

Currently, anxiety disorders are the most prevalent mental health problems seen in primary care settings (Kessler et al., 2005). Latinos, like other groups, underutilize psychiatric services. However, unlike other groups, Latinos overutilize primary care health services and are twice as likely to seek treatment for psychiatric disorders in publicly funded primary care rather than mental health specialty settings (U.S. Surgeon General, 2001). Overutilization of services may be due, at least in part, to differences in beliefs about psychiatric disorders and treatment preferences. For instance, the tendency for Latinos to believe that psychiatric disorders are biologically based makes them more likely to seek and receive mental health treatment in primary health care settings (Givens, Houston, Van Voorhees, Ford, & Cooper, 2007). Further, given the stigmatizing attitudes associated with visiting a mental health professional (Azocar, Areán, Miranda, & Muñoz, 2001), Latinos may feel more comfortable seeking services from their medical providers (i.e., primary care providers and allied professionals) than mental health specialists in community mental health agencies or private practices (Vega, Kolody, & Aguilar-Gaxiola, 2001).

Disparities in Quality of Care for Latinos in Primary Care

Disparities exist in detection and treatment of depression and anxiety in primary care. In a study that examined ethnic/racial disparities over a 10-year period, Latinos with anxiety and depression who had visits to primary care had significantly lower odds of receiving a diagnosis than non-Latino whites. Additionally, Latinos had significantly lower odds (compared with whites) of receiving an antidepressant prescription, and of receiving any care at all. Despite the significant number of patients with diagnosable anxiety disorders that present in primary care, it appears that anxiety is infrequently detected among ethnic/racial minorities (Stockdale, Lagomasino, Siddique, McGuire, & Miranda, 2008). Further, when anxiety is recognized, evidence-based psychological interventions are rarely used, and are particularly unlikely to be used when treating Latinos (Stockdale et al., 2008; Young, Klap, Sherbourne, & Wells, 2001).

Evidence-Based Treatments for Anxiety

At present, there is an abundance of data suggesting that psychosocial (i.e., cognitive behavioral therapy [CBT]), pharmacologic treatments (i.e., psychotropic medications) or a combination of the two are efficacious for the treatment of anxiety disorders (Norton & Price, 2007; Roy-Byrne & Cowley, 2007). A growing body of

literature also suggests that these evidence-based interventions are effective in real-world settings, including primary care (Roy-Byrne et al., 2005, 2010). Moreover, clinical outcomes appear similar for Latinos and non-Latino whites who receive pharmacological and psychosocial interventions in primary care settings (Chavira et al., 2014). Below, we briefly describe pharmacotherapy and CBT for anxiety disorders.

Pharmacotherapy

Antidepressants are the first-line medication treatments for anxiety disorders, particularly the selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs). Response rates are in the range of 50–70 % (Stein, 2005). These classes of medication include fluoxetine (Prozac), fluvoxamine (Luvox), citalopram (Celexa), escitalopram (Lexapro), paroxetine (Paxil), and sertraline (Zoloft) for the SSRIs, and venlafaxine (Effexor) and duloxetine (Cymbalta) for the SNRIs. Although there is a 3–4 week delay in response, the reduced potential for addiction makes these medications more desirable for long-term management of anxiety symptoms. For patients with major functional impairments requiring short-term symptom relief, benzodiazepines like clonazepam (Klonopin) or alprazolam (Xanax) may be indicated for faster response or until satisfactory symptom reduction has been achieved with an SSRI, SNRI, or other treatment. Benzodiazepines can also be used on an as-needed basis. However, continuous long-term use of benzodiazepines can lead to physiological tolerance, abuse, and dependence, while discontinuing their use can lead to symptom relapse and abrupt discontinuation can lead to withdrawal symptoms (e.g., seizures). Other widely used pharmacotherapies for anxiety include Buspirone (Buspar), an anxiolytic that is primarily used for the treatment of generalized anxiety disorder (GAD).

Clomipramine (Anafranil) is a tricyclic antidepressant used specifically for the treatment of obsessive-compulsive disorder (OCD) or for patients with anxiety that do not respond well to SSRIs and SNRIs. Adverse side effects for tricyclics include anticholinergic symptoms (jitterness, postural hypotension, dry mouth, constipation), which makes tricyclics a less desirable form of treatment for patients with anxiety disorders. Monoamine oxidase inhibitors (MAOIs), like phenelzine (Nardil) and tranylcypromine (Parnate), are sometimes used for the treatment of panic disorder or generalized social anxiety. Importantly, their use requires strict dietary restrictions (limit foods rich in tyramine); otherwise, MAOIs have the potential to increase the risk of a hypertensive crisis, stroke, or even death. Because of this side effects' profile, health professionals limit their use for the treatment of anxiety, as other efficacious pharmacotherapies with more benign side effects (e.g., SSRIs) are available. Finally, beta-blockers, such as propranolol (Inderal) and atenolol (Tenormin), reduce tachycardia, trembling, and blushing and can be helpful on an as-needed basis for the treatment of anxiety related to performance situations.

Psychosocial Intervention: Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is an empirically supported treatment and the gold standard psychosocial treatment for the anxiety disorders (Chambless & Ollendick, 2001; Hofmann & Smits, 2008). Briefly, CBT involves systematic exposure to feared stimuli in order to reverse patterns of avoidance, as well as cognitive restructuring to alter irrational thoughts and beliefs. More specifically, over the course of treatment, individuals learn through direct experience (i.e., exposure) that fear, anxiety, and the associated stimuli and contexts are not harmful and that they can cope with anxiety-producing situations; this learning is facilitated by discussion and verbal processing (i.e., cognitive restructuring; Craske, 1999).

Integrated Models of Care

Despite demonstrated effectiveness of evidence-based treatments (e.g., CBT) for anxiety disorders, the majority of patients do not have access to these interventions partially due to fragmentation of behavioral and primary health care and lack of coordinated care among providers. Health care reform legislation aims to reduce ineffective silo-based systems of care by creating integrated behavioral and medical health care systems. The more successful integrated care efforts do not solely rely on being co-located, but improve care quality and outcomes through integration of screening, assessment, and treatment of behavioral health conditions into the overall health care of patients entering the primary care setting. In this model, all primary care staff and providers are part of the collaborative effort, from the front desk and office personnel, to the nurses, the PCPs, the behavioral health team, and the administrators and site leadership. For example, the front desk staff is often the first point of contact for the patient and can be responsible for handing out the behavioral health screen and briefly explaining the primary care physician's interest in the patient's overall health care, both behavioral and medical. The nurses can then collect and review the screen while rooming the patient for the primary care physician. The primary care physician, typically operating as the center of the team overseeing all aspects of the patient's care, can then confirm any symptomatology, possibly make a preliminary mental health diagnosis, and then either provide a brief intervention (including prescribing an antidepressant), seek consultation, or introduce the services provided by the behavioral health team and make a referral.

The integrated care team can consist of one or more behavioral health care specialist(s) (BHS; e.g., care manager, psychologist, consulting psychiatrist, and/or social worker) and their roles will vary depending on the model, the patient's needs, and the resources available (Collins, Hewson, Munger, & Wade, 2010). In a partially integrated model, communication between the BHS and the primary care providers (PCPs) is routine and on-site counseling and concrete services are offered or referrals are made to specialty providers. In a fully integrated model, behavioral health care is often co-located in primary care and treatment plans integrate

behavioral and medical aspects, with a high degree of shared treatment responsibility between the BHS and primary care provider. Behavioral health treatment options can consist of medication management, evidence-based psychotherapy (e.g., CBT, Problem-Solving Therapy, Behavioral Activation, Motivational Interviewing), and/or care and case management. A stepped-care approach is often utilized to deliver treatments that are effective but conserve behavioral health resources. Monitoring the patient's progress using treat-to-target measures ensure the patient is moved to the next level of stepped care when necessary.

Regardless of the level of integration, the goal is to have the BHS collaborate with the primary care physician to design, implement, and adjust, as necessary, a treatment plan for every patient. If the behavioral health team consists of a consulting psychiatrist, their role may vary from providing consultation and supervision to the medical care team to becoming the primary provider for a complex patient who needs specialty behavioral health treatment. Ultimately, the BHS will be essential in providing a comprehensive assessment, confirming diagnoses, and monitoring the patients' mental health symptoms and needs within the parameters of a primary care setting. Coordination and communication amongst the health care team (e.g. BHS, PCP), including regular team meetings, is crucial to best synchronize health care visits, share knowledge of the patient's care, and monitor the patient's progress using treat-to-target measures.

Integrated models of care for anxiety are relatively new but are supported by a substantial body of research on integrated care for depression, which demonstrates their effectiveness in improving early detection, treatment, and short- and long-term mental health and medical care outcomes when compared to standard care (Gilbody, Bower, Fletcher, Richards, & Sutton, 2006; Katon et al., 2012; Katon, Unützer, Wells, & Jones, 2010; Unützer et al., 2008), including those utilizing psychological interventions (Coventry et al., 2014). In the presence of minor sociocultural adjustments to the model, similar improvements in health care outcomes and patient satisfaction in minority populations have been demonstrated, including in predominantly low-income Latino groups (Ell et al., 2010; Miranda et al., 2003).

Integrated Models of Care for Anxiety

Integrated care models for anxiety disorders have also shown promise. One study combining pharmacotherapy and a cognitive behavioral intervention for the treatment of panic disorder in primary care settings demonstrated significantly greater improvements across all outcome measures compared to treatment as usual (i.e. typical pharmacotherapy) (Roy-Byrne et al., 2005; Roy-Byrne, Katon, Cowley, & Russo, 2001). The collaborative care intervention included up to 6 sessions, across 12 weeks, of CBT modified for the primary care setting and provided by the BHS. Pharmacotherapy in the collaborative condition was provided by the primary care physician with guidance from a psychiatrist.

A subsequent study which included more anxiety disorders within an integrated care model sought to provide treatment for panic disorder and GAD using a

telephone-based collaborative care intervention (Rollman et al., 2005). In the intervention group, non-mental health professionals provided psychoeducation, assessed preferences for guideline-based care, monitored treatment responses, and informed physicians of their patients' care preferences and progress via an electronic medical record system. The intervention proved more effective at improving anxiety symptoms, health-related quality of life, and work-related outcomes compared to care as usual (Rollman et al., 2005). Additional trials of integrated treatment of GAD support findings that the model is generally superior to care as usual in reducing symptoms (Archer et al., 2012; Muntingh et al., 2013; Price, Beck, Nimmer, & Bensen, 2000), as well as improving patients' satisfaction with their health care (Price et al., 2000). An integrated anxiety care approach within the practice of cardiology further addressed the interplay between behavioral and medical health, and helped patients adapt a more healthy lifestyle to improve health care outcomes (Janeway, 2009). While results are promising, these studies have not included adequate representation of Latinos; additional research is necessary to examine these models in ethnic minority populations.

The largest trial of integrated anxiety care to date is the Coordinated Anxiety Learning and Management (CALM) model, based on the IMPACT intervention for depression. The CALM model used a computer-assisted CBT program with possible phamacotherapy to treat four of the major anxiety disorders seen in primary care (i.e., GAD, panic disorder with or without agoraphobia, social phobia, and posttraumatic stress disorder). Treatment included approximately eight sessions of CBT and/or medication management treatment over 10–12 weeks, with follow-up phone calls for up to 1 year (Sullivan et al., 2007). Outcomes for intervention patients were significantly better than control patients for all measures, except physical health and satisfaction, at all time points (6, 12, 18 months). The CALM study was highly flexible and effective for a wide range of patients and targeted multiple anxiety disorders, making this model's application feasible and applicable in primary care settings. The computer assisted-CBT was also acceptable to patients and improved effectiveness of care (Craske et al., 2009; Roy-Byrne et al., 2010).

To our knowledge, the CALM study is the largest clinical trial examining CBT for anxiety in Latino adults (Chavira et al., 2014). Rates of treatment preference for Latinos in this study were similar to non-Latino whites; 40 % of Hispanic patients preferred CBT only, 52 % preferred CBT and medication, and 9 % preferred medication only (Chavira et al., 2014). Findings from this study suggest that the CBT intervention was similarly effective for Hispanic and non-Hispanic Whites with anxiety disorders, although the study's sample was made up of a primarily acculturated Latino group (e.g., bilingual, higher income). Scores on engagement-related outcome measures (e.g., adherence, commitment, treatment completion) were also mostly similar among Latinos and non-Latino whites, other than a measure on understanding of CBT principles. Studies examining the effectiveness of CBT for other psychiatric conditions, such as depression, also demonstrate favorable outcomes for Latinos (e.g., Markowitz, Speilman, Sullivan, & Fishman, 2000; Miranda, Azócar, Organista, Dwyer, & Areane, 2003). This growing body of research suggests CBT may be a promising therapeutic modality for integrated care models with Latinos.

Identification and Assessment of Anxiety

The success of behavioral health integration also relies on improving the utilization of mental health screenings. Accurate screening and diagnosis is the first step to ensuring early identification of individuals in need of mental health treatment within primary care. This is particularly true for anxiety disorders, which are often misdiagnosed in these settings (Menninger, 1995) and can lead to significant impairment in both mental and physical health functioning (Revicki, Brandenburg, Matza, Hornbrook, & Feeny, 2008).

Only a handful of screening measures available today have proven feasible in the typically fast-paced primary care setting where limited time and resources are common. The Patient Health Questionnaire (PHQ), 2-item and 9-item version, is commonly used in medical settings and has shown utility in monitoring depression symptom severity and treatment response and remission, even in practices with limited resources (Duffy et al., 2008; Katzelnick et al., 2011). The Overall Anxiety Severity and Impairment Scale (OASIS) is another highly useful screener for primary care settings. It is a 5-item self-report questionnaire that is brief, has demonstrated validity, includes a measure of functional impairment, and is able to capture the severity of any or multiple anxiety disorders (Campbell-Sills et al., 2009). However, it may not discriminate well between depression and anxiety (Campbell-Sills et al., 2009). The Generalized Anxiety Disorder 7-item scale (GAD-7) is also increasingly being used in medical settings, evidencing good sensitivity and specificity as a screener for GAD (Spitzer, Kroenke, Williams, & Lowe, 2006), panic, social anxiety, and post-traumatic stress disorder (PTSD; Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007). Similarly, the Anxiety and Depression Detector (ADD) was developed as a time-efficient screen for GAD, panic disorder, PTSD, social phobia, and depression in primary care settings (Means-Christensen, Sherbourne, Roy-Byrne, Craske, & Stein, 2005). However, the specific items measuring PTSD and social phobia may not be as valid as those for the other anxiety disorders and depression (Chavira, Stein, & Roy-Byrne, 2008). To screen for specific anxiety disorders like PTSD and social phobia, the abbreviated versions of the PTSD Checklist (Lang & Stein, 2006) and the Social Phobia Inventory (SPIN) (Connor, Kobak, Churchill, Katzelnick, & Davidson, 2001) have been useful in primary care. Several of these more commonly used measures have been validated in Latino populations, including the PHQ-9 (Huang, Chung, Kroenke, Delucchi, & Spitzer, 2006) and GAD-7 (Mills et al., 2014). More research is needed in this area to ensure these measures of anxiety are valid in ethnically diverse patient populations.

For a more thorough assessment, The Mini International Neuropsychiatric Interview (MINI) has demonstrated accuracy in diagnosing anxiety disorders such as GAD and panic disorder, is perceived positively by patients, and has been feasibly administered in primary care facilities (Pinninti, Madison, Musser, & Rissmiller, 2003). The MINI also has demonstrated validity as a screener for all the disorders it covers (Lecrubier et al., 1997). The PRIME-MD is also well validated, covers a range of psychiatric disorders, and includes a 26-item self-report screening questionnaire, and a structured interview completed by the provider (Spitzer,

Kroenke, Williams, & Patient Health Questionnaire Primary Care Study Group, 1999). The Brief Symptom Inventory-18 (BSI-18) is a sensitive, well validated measure for psychological distress (Carlson & Bultz, 2003; Degoratis, 2000), though it may be lengthy in comparison to other measures used in primary care settings (Chavira et al., 2008). Such measures are not only important for identifying individuals at risk for mental illness, but also in providing measurement-informed care which is key in tracking progress and outcomes.

Cultural Conceptualizations of Anxiety

The manner in which anxiety manifests may be different for Latinos and should be considered when conducting culturally informed assessments (Benuto, Olmo-Terasa, & Reyes-Rabanillo, 2011). In addition to standard assessments of anxiety, it can be important for a provider to ask questions that allow a patient to explain their understanding of an illness, including causes and expectations of treatment. In doing so, providers will have access to patients conceptualizations of anxiety that may be different from traditional psychiatric and medical explanations. For Latino patients, assessments that include such an approach may improve the strength of the patient-provider relationship and improve detection of problematic anxiety.

Somatic Symptoms

Several studies have found that Latinos are more likely to endorse somatic symptoms as a key feature of anxiety/worry. In particular, findings from clinical samples of patients with anxiety and depressive disorders, suggest that Latinos report more somatic and physiological sensations than their non-Latino white counterparts (Canino, Rubio-Stipec, Canino, & Escobar, 1992; Escobar, Gomez, & Tuason, 1983; Mezzich & Raab, 1980). Some have proposed that Latinos may perceive somatic complaints as less stigmatizing, and therefore more readily report such symptoms. Others have explained that Latinos believe that they are more likely to receive care if they disclose physical problems rather than mental health problems (Canino et al., 1992). Variations in symptom expression across cultures underscore the need for providers to exercise flexibility when assessing Latino patients (Hackethal et al., 2013; Hirai, Stanley, & Novy, 2006; Lewis-Fernandez et al., 2010). Specifically among Latinos (especially Spanish speaking Latinos), physiological/somatic symptoms may be a better indicator of an anxiety disorder, such as GAD, than questions that tap into psychological and cognitive worry.

Ataques de Nervios

Much research surrounds the cultural idiom of distress called ataques de nervios. Translated as “nervous attacks,” symptoms of “ataques de nervios” include trembling, crying spells, screaming uncontrollably, and sudden verbal and physical

aggression (Lopez & Guarnaccia, 2000). Additional symptoms may include dizziness or fainting, dissociation, and suicidal gestures. These attacks are most prevalent among Puerto Rican and Caribbean populations and episodes often occur after a stressful life event or significant loss (e.g., divorce, death of close family member) (Lopez & Guarnaccia, 2000). Indeed, reports show overlap between ataques de nervios and panic disorder (Lewis-Fernandez et al., 2002; Salman et al., 1998). However, only a third of ataques fulfill DSM-IV criteria for panic attacks and only 17 % fulfill panic disorder criteria, suggesting that ataques are not completely accounted for by DSM criteria. While in some cases, ataques may be indicative of an anxiety disorder, in other cases, it may simply be a transient expression of distress among Latinos.

Nervios

"Nervios" is another cultural idiom of distress that is related to anxiety. Nervios differs from ataques as it represents more of a generalized state of distress rather than a discrete episode. Among Latinos, the concept of nervios represents an expression of both physical and emotional distress that often emerges from conflicts in various life domains (family, legal status, parenting, gender roles, etc.) and most often occurs in the context of social disadvantage (Guarnaccia & Farias, 1988). Somatic symptoms associated with nervios include headaches, backaches, trembling, lack of appetite and sleep, fatigue, physical agitation, difficulty breathing, chest pain, gastrointestinal problems, dizziness, blurred vision, fevers, and sweating, among other symptoms (Salgado de Snyder, de Jesus Diaz-Perez, & Maldonado, 1995). Psychological symptoms associated with nervios include irritability, anger, sadness, obsessive ideation, overwhelming concerns, lack of concentration, confusion, crying spells, fears, anxiety, and erratic behavior (Finkler, 1985; Salgado de Snyder et al., 1995).

Questions regarding these expressions of distress should be included in assessments with Latinos. Further, efforts are necessary to educate providers about variations in how Latinos may experience and describe anxiety symptoms. Providers also should be advised that many of these complaints overlap with symptoms of depression and anxiety but are not necessarily synonymous with these disorders.

Cultural Considerations Applied to Evidence-Based Interventions in an Integrated Model of Care

Integrated care efforts in primary care settings may improve the screening and treatment of Latinos with mental health needs simply through accessibility, given they are more likely to seek these services from their primary care providers. Indeed, integrating a consulting psychiatrist and psychological services within primary care has improved access to mental health care among typically underserved minority

and low-SES populations (Schreiter et al., 2013). However, access alone does not necessarily improve treatment outcomes (Areán et al., 2008). Culturally appropriate health care practices are necessary to improve diagnosis and quality of care (Young et al., 2001).

Some have proposed that adaptations to interventions are necessary to improve the culturally appropriateness, satisfaction and response rates associated with evidence-based interventions for ethnic/racial minorities. However, debate about the utility of cultural adaptations continues (Benuto & O'Donohue, 2015; Lau, 2006) and few cultural adaptations have been examined in the primary care setting. At present, most findings suggest that Latinos who receive minimally adapted CBT have similarly favorable outcomes as non-Latino whites in both primary care and non-primary care settings (Chavira et al., 2014; Pina, Silverman, Fuentes, Kurtines, & Weems, 2003). Unfortunately, findings are often limited by the fact that most trials have only recruited small proportions of Latinos and many have not been conducted with Spanish speaking or less-acculturated populations. More consistently, data have emerged to suggest potential differences in the social validity (e.g. adherence, engagement) of existing evidence-based interventions such as CBT (Chavira et al., 2014; Lau, 2006) when used with ethnic minorities such as Latinos, underscoring the need for interventions to consider the impact of engagement-related concerns in this group.

Engagement of Latinos in Integrated Models of Care

Studies examining engagement-related outcomes (e.g., treatment uptake, adherence, and attrition) have mostly focused on patients with depression; these studies have found higher attrition rates (drop-out) in both pharmacological and psychosocial interventions for Latinos when compared to whites (Arnow et al., 2007; Chavira et al., 2014; Organista, Muñoz, & Gonzalez, 1994). Problems with medication compliance, CBT attendance, and completion of CBT homework assignments, also have been reported (Aguilera, Garza, & Muñoz, 2010; Miranda & Cooper, 2004). Differences in attendance rates and premature termination have been attributed to logistic (e.g., multiple competing demands, transportation etc.), motivational, and attitudinal factors (e.g., outcome expectancies and stigma) (McCabe, 2002; Miranda, Azócar, et al., 2003). Other factors such as perceived cultural fit of the program, beliefs about causes of mental illness, and therapist-client ethnic match, may also have an impact.

Recommendations for Primary Care

Interventions that are delivered in primary care settings are advised to attend to these differences and utilize strategies to improve engagement in services for Latinos. When working with Latinos in primary care, it is advisable to clarify the need for services and to provide education about the therapy process itself. More

specifically, PCPs and behavioral health specialists should be prepared to explain the "therapy" process and to dispel potential myths about therapy (e.g., therapy as long-term, therapy as too difficult, etc.). Further, providers should be active in discussing stigma related concerns, given their frequency in the Latino population. Previous data suggest that stigma associated with mental illness can prevent individuals from seeking care and lead to premature termination and poor adherence (Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007; Nadeem et al., 2007; Sirey et al., 2001). In addition, previous negative experiences with mental health treatment may lead to premature dropout and less future use (McCabe, 2002; McKay, Stoewe, McCadam, & Gonzales, 1998). Important to note, the experience of discrimination has been posited as one explanation for low service use among Latinos with mental health care needs and findings suggest that the perception of discrimination itself, is associated with negative mental health outcomes such as suicidal ideation, state anxiety, trait anxiety, and depression (Hwang & Goto, 2008; Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005).

Barriers such as lack of time, inability to obtain permission to leave work, lack of childcare, and transportation are common logistic barriers that may interfere with initial attendance or ongoing treatment (Alvidrez & Azocar, 1999; Fortuna, Alegria, & Gao, 2010; McKay, McCadam, & Gonzales, 1996; Miranda, Duan, et al., 2003; Miranda & Green, 1999). Such barriers may need to be discussed and problem-solved on a regular basis. In a study of 339 Latino primary care patients with depressive disorders, education sessions, telephone sessions, transportation assistance, and family involvement, were engagement strategies that increased the likelihood of service utilization in this group (Dwight-Johnson et al., 2010). To ensure effective engagement, it is likely that these same issues will need to be addressed in integrated models of care for Latinos with anxiety disorders.

Lastly, bilingual and culturally competent providers as well as well-trained interpreters are necessary in integrated models of mental health care. Unfortunately, recent results from a 10-year perspective examining efforts to diversify the mental health workforce and increase the pool of bilingual providers, suggest that little progress has been made in this area (DeCarlo Santiago & Miranda, 2014). In the absence of a small bilingual mental health workforce, novel models of treatment and service delivery may be required. For example, it is possible that the shortage of bilingual clinicians could be addressed in part through the use of a bilingual and culturally competent paraprofessional workforce (e.g. patient navigators, peer counselors, and/or community health workers/promotoras) to facilitate the delivery of services with Latino communities. Additionally, technological advances including therapies delivered via computer can be translated and used as part of integrated care models for Latinos with anxiety disorders. Future research is necessary to examine such innovations broadly and in primary care models specifically.

Moving toward an integrated health care model that adequately addresses the needs of the Latino population, involves significant administrative, operational, and technical challenges. Leadership and administration are responsible for the development of program protocols that train staff and providers in the fundamentals of integrated care, and also in the fundamentals of culturally competence. Training should focus on how to provide patient-centered health care through the incorporation

of the patient's values, needs, and concerns in order to foster a more personalized, culturally appropriate treatment approach. Leadership in primary care must take an active role in reinforcing these messages, with ongoing in-service trainings, and continually encourage the shift away from fragmented, silo-based health care, to one of culturally competent collaboration and information sharing. It is also necessary to ensure that a solid interoperable information technology infrastructure is in place to: (a) promote and monitor collaborative, evidence-based practice, (b) allow for timely sharing of patient health records and treatment plans across providers and care or case managers, and; (c) assist in preventing unnecessary or duplicate procedures and treatments.

Conclusions and Future Directions

Integrated health care has potentially vast implications for improving mental health care amongst the Latino population, especially those who are socially disadvantaged, but more research is required to empirically validate this position. Particularly important is greater examination of cultural factors that may need to be considered in models of integrated care. The current chapter provides a discussion of culturally related assessment and treatment factors that may need to be considered to improve the quality of integrated models of care.

Meeting the aims of current health care reform efforts—to improve quality of care, provide better health for populations, and lower health care expenditures, necessitates the full integration of behavioral health care for underserved populations. The passage of the Affordable Care Act makes it more likely that the number of Latinos with health insurance will increase. In fact, it was recently estimated that the rate of uninsured Latinos has already decreased from 36 to 23 % (Doty, Blumenthal, & Collins, 2014), and increased utilization of mental health by Latinos have been observed (Schreiter et al., 2013). Whether there will be optimal quality mental health services to meet the needs of this population, particularly in primary care settings, remains uncertain. Efforts to improve the availability, accessibility, and quality of behavioral health care for Latinos in primary care, is an important avenue of research that has the potential to deter the chronic course of anxiety that can be so debilitating when left untreated in this population.

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