Chapter 15
Seriously Mentally Ill and Integrated Care Among Hispanic Populations

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Introduction

Public Law 102-321 put forth by the Substance Abuse and Mental Health Services Administration funds programs and research for Serious Mental Illness (SMI), which they define as any DSM diagnosis (other than a substance-use disorder) with a duration of more than 12 months and functional impairment in at least two domains. SAMSHA also clarified that impairment should be measured by a Global Assessment of Functioning (GAF) score of less than 60. Clinically, we most often see this in Schizophrenia, Bipolar I Disorder, and Delusional or other Psychotic Disorders (excluding those resulting from acute substance intoxication).

As a psychologist who has worked in state and community-based health care settings as well as private practice and managed care I've had the opportunity to observe a variety of systems function (or attempt to function) in treating serious mental illness (SMI). Though state- and community-based settings, do provide individuals with SMI access to a spectrum of health care providers both within the organization as well as outside contracted providers, it is more often the case in these settings that the individual, as a result of a serious degradation in functioning (occasionally as the result of a legal entanglement) is ultimately hospitalized. Hospitalization results in significantly increased costs, both in real dollars for treating the individual, as well as costs from that individual no longer functioning in their traditional psychosocial environment (e.g. family, work, school). A primary challenge with serious mental illness is the limited continuum of care across the transition between in and outpatient care, which frequently occurs with SMI (Clarke et al., 2000). Not all hospitals provide an integrated approach to treating SMI, which is ultimately detrimental to the patient and the hospital. When comparing an

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integrated approach to mental health treatment with a general medical approach within the same hospital, researchers found that the patients demonstrated not only greater satisfaction with the care received, but also greater participation in prevention programs. Additionally, those individuals who participated in the integrated treatment were less likely to be seen in the Emergency Room and were also demonstrated better overall improvement in symptom presentation both mentally and physically, while those in the general medical treatment model reported a physical and mental decline (Druss, Rohrbaugh, Levinson, & Rosenheck, 2001). This suggests that there is likely a lot of variability among hospitals in the care provided, which can create a disparity of outcomes between those who provide integrated care and those who do not.

For SMI, Mueser and colleagues (2003) describe the implementation and components of evidence-based practice within integrated care. These components, in an integrated setting include: collaborative psychopharmacology; assertive community treatment (ACT); family psychoeducation; supported employment; illness management and recovery and for those with comorbid substance-use disorders, integrated dual disorders treatment. While most of these interventions, on their face, are intuitively understood, ACT is a process described as an integrated approach that utilizes "assertive" community outreach to engage community providers and resources to address the comorbid issues of homelessness, unemployment, and legal entanglements that are common in SMI. For a more comprehensive understanding of ACT, one should visit their informational site (https://www.centerforebp.case.edu/resources/tools/act-getting-started-guide).

From a primary care perspective, the authors indicate a strong body of literature identifying the overriding benefits of medication in reducing symptoms associated with severe mental illness (e.g. psychosis), and the secondary ability to address underlying affective symptoms as well as greater amenability to behavioral interventions and follow-up care. However, given the side-effects and problems with compliance that arise in SMI, the integrated specialty care and selective use of neuroleptics (Whitaker, 2004), underscore the need to emphasize the latter components of Mueser, Torrey, Lynde, Singer, and Drake's (2003) recommendations (e.g. that of family psychoeducation, supported employment).

The most recent data from the National Institute of Mental Health indicate that over 4 % of the adults were diagnosed in that year with a serious mental illness (SAMHSA, 2013), constituting over nine million adults in the US who are diagnosed with a serious mental illness. Of those diagnosed with serious mental illness, Hispanics constitute a large percentage, second only to those who identify as American Indian or Native Alaskan. Additionally, McGovern and colleagues (2006) found that between 16 and 21 % of those with comorbid substance-use disorders also were diagnosed with SMI.

The Affordable Care Act and mental health parity in the U.S. has led to an expansion of coverage that should theoretically increase access to mental health treatment, and that treatment should also be largely covered by a combination of public and private insurance providers (Mechanic, 2012). This is particularly salient to the treatment of serious mental illness, which was previously costly with limited reimbursement, limiting profitability, and thus relegated the responsibility of providing services to public/state hospitals. Though budgets have been expanded to cover mental health treatment (for example California's Proposition 63 Mental Health Services Act, while in Nevada, state agencies have adopted the role of coordinating care among newly available private beds), and researchers (Patel et al., 2013) while investigating challenges in integrating mental health care called for specific emphasis on serious mental illness. However, though these changes increase coverage and in some ways improve technology that would facilitate integrated care, they do not require integrated care, which is particularly problematic when treating serious mental illness. Specific to integrated care, it is estimated that between 20 and 25 % of patients in a primary care setting have a mental illness (Spitzer, Kroenke, & Williams, 1999), with only 2/3 of those being referred for mental health treatment seeing the referral through (Grembowski et al., 2002).

The challenge with serious mental illness is daunting, due in large part to its chronic nature and high costs (estimated to be over 192 Billion annually; Insel, 2008), as well as the nature of the condition itself (e.g. psychosis and avolitional behaviors that contribute to overall poor health and quality of life). However, mental illness is not alone in being a chronic disease. Diabetes provides us with a good example of how to manage chronic, and potentially life-threatening illness with a stepped-care approach. Researchers (Von Korff, Glasgow, & Sharpe, 2002) proposed just such a process for effectively managing chronic illness that can be applied across domains.

Von Korff and colleagues (2002) suggested that the common elements to care for chronic conditions (in their case, diabetes) include not only reaction to the presenting systems, but also indicated a need to be preemptive in planning follow-up visits utilizing a protocol to implement the stepped-care. Similarly, the World Health Organization recognizing the variability in health care systems and, in particular the limited number of mental health providers, proposed a systematic approach to treating mental health diagnoses, including serious mental illness, via a stepped-care approach formally presenting this information at the 2008 Geneva Convention (WHO, 2010). Eventually, this was formalized and expanded with specific recommendations, that included recommendations at all levels of the stepped-care system (psychoeducation, community involvement, patient follow-up and monitoring, involvement of specialists, etc.) specific to the most chronic mental health issues including: substance use, psychosis, depression, and bipolar disorder as well as broader issues of Alzheimer's and developmental and childhood behavioral disorders (WHO, 2010). However, the challenge of SMI as compared to those that serve as the foundation for this model, include the severity of symptoms and a higher degree of noncompliance both as a direct (Wang, Demler, & Kessler, 2002) and indirect result of those symptoms (e.g. the loss of support benefits due to a commitment, homelessness or incarceration; Ries & Comtois, 1997).

Population Characteristics

The most recent U.S. Census data for Hispanic populations indicated over 55 million people identified as Hispanic, with California, Texas, and Florida (in rank order) having the highest numbers of Hispanics (Krogstad & Lopez, 2015). This is described as representing a slowing in the previous growth rate of 4.8 % annually (reported in the decade between 200 and 2010) to a more modest 2.1 % growth rate. However, it still represents an increase to 17.5 % of the population, meaning nearly one in five individuals identifies as Hispanic. Finally, the authors indicated that the median age for this population has increased from 27 in 2010 to 29 in 2014, which still represents a younger demographic group, when compared to non-Hispanic Blacks (34); non-Hispanic Whites (43) and Asians (36).

Prevalence Rates of Serious Mental Illness in Hispanics

As discussed in the outset of this chapter, the most recent data indicates the prevalence rate of 3.5 % for SMI in U.S. Hispanic populations, which is slightly lower than the 4.1 % prevalence rate of the overall U.S. population. This suggests a prevalence rate of SMI for Hispanics that approximate the overall population.

Barriers to Treatment in Serious Mental Illness

Across treatment domains (e.g. mental health, substance use) a primary barrier to care has been the ability to pay for the services (Mojtabai, Chen, Kaufmann, & Crum, 2014), but it is proposed that the Affordable Care Act will address this issue of affordability. However, as will be discussed below, this assumption is problematic for some Hispanics. The second most commonly reported barrier, specifically relevant to SMI, was the fear of being committed, followed by a lack of information about where to get services, and finally the perception that an individual should be able to resolve their own mental health problems. The authors also described a lack of a perceived need as a potential additional barrier, specifically in the context of those individuals with comorbid disorders of substance use and mental illness.

When we look at actual treatment rates for those with SMI we see that only 40–55 % receive "minimally adequate treatment" [this term was defined by best practices based in the empirical literature and corresponding to the diagnosis] (Wang et al., 2002). That same research also shows that among those that did not receive minimally adequate treatment over 95 % of them had a "nonaffective" psychosis (e.g. Schizophrenia). Further, the best outcomes were those that were treated by specialty mental health care and the worst outcomes were those that were treated in a general medical setting or that utilized both general and specialized care (not through a program of integrated care). Finally, specific to Hispanics, the evidence is mixed with some research (Wang et al., 2002) showing that there was a greater likelihood that Hispanics were likely to benefit from care, once accessed, as well as be more likely (as compared to non-Hispanic Whites and Black/African Americans) to be treatment compliant, which the authors attributed to a greater cultural perception of the severity of psychosis and serious mental illness. However, others found lower treatment compliance (based on a percentage of the sample rather than a comparison among ethnic and racial groups), in particular for studies that included only Hispanics (Lanouette, Folsom, Sciolla, & Jeste, 2009), which they attributed to barriers of language, affordability of the treatment regimen and related problems related to socioeconomic issues (e.g. transportation, the ability to access specific services or systems based on legal status).

Culture-Specific Barriers

From a practical standpoint, the primary barrier to treatment for Hispanics, in particular those with limited or no proficiency in English, is language. In a review of the literature Timmins (2002) found that language was a primary barrier to access to care for Hispanics, largely due to the limited number of Spanish speaking providers, as well as a lack of appropriately qualified interpreters. Specific to mental health, it has been shown that the language barrier directly leads to an overdiagnosis of SMI (Flores, 2006). Once access was achieved, a lack of a provider or interpreter for the individual's language corresponded with poorer ratings for quality of care as well as worse health outcomes. Similarly, Hispanic patients are vulnerable to the same barriers to access and treatment that exist for individuals of low socioeconomic status in general (Benuto & Leany, 2011), including issues of transportation and a general inability to navigate the healthcare system (Timmins, 2002). Though it might seem intuitive to hire interpreters for the provision of services (and research has shown that an ad-hoc interpreter is better than no interpreter; Brisset, Leanza, & Laforest, 2013), professional guilds are likely to regulate the qualifications and use of translators (e.g. the APA code of ethics related to translators) and there are potentially life altering consequences due to misinterpretation by an unqualified or poorly qualified interpreter (e.g. an inappropriate referral to child protective services for undocumented immigrants or a referral and subsequent prescription of psychotropic medication; Flores, 2006). Thus, we may wish to consider as a field a program of training or perhaps a paraprofessional field for bilingual mental health translators.

Given the aforementioned challenge of the cost of care, one needs to consider the eligibility of the Hispanic client for coverage under the Affordable Care Act. In fact, it was predicted that although differences in insured and un-insured rates among race and ethnicity would be reduced by the Affordable Care Act, Hispanics would remain underinsured (Clemans-Cope, Kenney, Buettgens, Carroll, & Blavin, 2012). This projected residual difference is posited due to the Act's application limited to "Lawfully residing immigrants". The authors also indicated a need for programs to accommodate income and language barriers as well as develop programs for retention.

Though varying to some degree across Hispanic cultures and socioeconomic status among those cultures, values related to family, interpersonal relations, and religion are most prominent. When we consider the barrier of individual's ability to address mental health cultural beliefs that one should be able to overcome any issues on their own, or a fatalistic view that the symptoms were God's will, may overlap or superimpose itself on a lack of a perceived need for services (Caplan et al., 2013; Vargas et al., 2015), and can often be seen in phrases such as "that's just how they are" or "They're just lazy (capricious, etc.)", and thus the primary care provider's awareness of this barrier is critical in this initial contact (Ishikawa et al., 2014).

Stepped-Care Approach General

Though integrated care is indicative of a systematic approach, the application has flexibility in application that is reflective of available resources. For example, Thornicroft and Tansella (2004) describe approaches that divide this systematic approach by resources. The resources are categorized into low, medium, and high (in terms of resources available), recommending lower resource areas emphasize primary care that utilizes specialists as a fallback while high resource areas would utilize outpatient teams and clinics with a high degree of specialization. Logically, medium resource areas would utilize a blend of clinics and outpatient teams dependent on available resources (e.g. if a high number of specialists were available, one could create a specialty outpatient clinic).

The notion of integrated care, and specifically integrating mental health care into primary care settings has many benefits (Patel et al., 2013) that also address barriers to health care access for minorities in general (Benuto & Leany, 2011). Primarily, integrated care is intended to improve both physical and mental health by reducing the barriers and strengthening the overall system, through a process of patient-centered care that utilizes screening in the primary or prominent care system to identify auxiliary challenges to the person as a whole (Patel et al., 2013). Researchers have shown that when integrating care, even in systems that integrate public and private services, there is a substantial cost reduction, in particular when that integrated system incorporates a system of checks for quality assurance (Unutzer et al., 2012). Further, a primary component of the ACA is a reduction in rapid readmissions (which is defined as those that occur within 30 days of the initial admission), which can result in reduced payments from insurers such as Medicare (Katon & Unützer, 2013). In a review of how stigma impacts mental health treatment Corrigan, and colleagues (2014) found that integrated care in and of itself is an evidence-based practice that has been found to help reduce stigma, and that the ability to further reduce the impact could be augmented by developing better understandings of culture-specific conceptualizations of stigma, in an effort to help provide better tailored psychoeducation for overcoming that stigma.

Both the chronic-illness approach (Von Korff et al., 2002) and the WHO mhGAP (2010, 2015) approach, lend themselves well to the current emphasis on providing culturally sensitive, person-centered treatment. This is because many of the identified components of this approach incorporate individualized treatment based on patient perspectives, which are applicable across cultures (for example identifying personal barriers to treatment implementation, but also taking into consideration individual and familial beliefs). However, this approach does not suggest avoiding best practices because of a patient's (or family's) beliefs, but rather, indicates that the team should agree upon a standard of evidence that incorporates support from a specialist for the domain of interest.

Aligning Stepped Care to Overcoming Identified Barriers

To implement effective stepped care in mental health requires systematic changes in the structure of the current healthcare system that spans from or current healthcare culture through models for provision of services, adapting current limitations in technology, payment, and ideology (Pincus et al., 2015). Researchers have suggested (through an evaluation of a cross-section of integrated models; Pincus et al., 2015) that current payment systems and structure (e.g. the private practice model of mental health services) creates challenges to implementing stepped care on a broader level that can be addressed through training (e.g. emphasizing the imperative nature and benefits of a more integrated system), but also need to be addressed through better collaboration and coordination among providers and payers of service (for example reorganizing the structure of payment to reinforce effective implementation of more cost-effective treatment).

When we consider that the primary barrier to mental health treatment is cost (Mojtabai et al., 2014), it makes sense to improve the method and systems of payment across may reduce this barrier. For example, it would be challenging to provide support services for an individual with SMI or their family, if the services are not coordinated/covered under their existing insurance. Additionally, the leveraging of technology to reduce costs and increase the number of providers, particularly in areas with low to medium resources may help overcome traditional barriers, and facilitate the integrated treatment model. For example, research (Mohr, Burns, Schueller, Clarke, & Klinkman, 2013) has shown the efficacy of telehealth for psychotherapy that, though not directly assessed for SMI, could provide the supportive home or tertiary care. Similarly, Ben-Zeev, and colleagues (2013) have shown an increasing utilization of mobile phone technology, with a high interest in utilizing the phone specifically for mental health treatment. Given the high degree of homelessness and number of emergent situations that individuals with SMI are likely to encounter, the ability to utilize this technology may serve both as a method of reducing cost, but also a method of improving the continuity of care across services (e.g. by improving the ability to coordinate supportive services and follow-up on compliance with those services). The latter issue also suggests that a primary role of behavioral health professionals (e.g. social workers and caseworkers, would be related to connecting these individuals to the supportive home or tertiary care previously discussed).

WHO mhGAP (2010, 2015)

The WHO mhGAP (2010, 2015) provides a simple to use decision-making chart (available at http://www.drugsandalcohol.ie/13984/1/WHO_mhGAP_intervention_guide.pdf) that uses color-coded decision trees and easy to identify alerts. This system can be used across disciplines, and lends itself well to overcoming many of the barriers to treatment (identified earlier), and thus can serve as the primary screening tool for primary care physicians. Though this guide is specific to nonspecialized care settings (e.g. those outside of mental health facilities) it can be beneficial to provide this resource to all providers within the integrated system for continuity of care and clarity of referral purposes.

The benefit of this guide is that it is color coded by possible disorder, and is organized into three sections classified as "assess, decide, and manage". The assessment and decision points are very brief and often include iconic indicators (e.g. "!" for potential problem issues or a pill bottle for medication decisions). A major benefit promoted by WHO is that the chart provides recommendations about "what to do, but not how to do it", with the specific intention being that the "how" of intervention is to be determined by the specialists to which the primary or secondary care provider refers the patient to.

Additionally, the mhGAP guide emphasizes six "General Principles of Care" that align with the overall notion of integrated care (e.g. that described by Pincus et al., 2015; Thornicroft & Tansella, 2004), including: communication (to include caregivers and family); assessment; treatment and monitoring; mobilizing social support; protection of human rights and overall well-being. Again, these principles provide opportunities to address culture-specific barriers, in particular at the points of communication and mobilizing social support.

mhGap is designed to be used within a system of care, thus it is assumed that the initial barrier of cost has initially been addressed once the system has been accessed. However, the aforementioned emphasis on what and not how to provide services helps to reduce costs, by allowing the administrator(s) to determine cost-effective models of specialized service. Further, because this process is one that emphasizes the protection of human it is designed to reduce unnecessary involuntary hospitalizations. The principle of communication along with processes that mobilize social supports help to reduce the stigma associated with mental health treatment, and again provides an opportunity to generate culturally appropriate interventions. Again, the actual implementation, of those culturally appropriate interventions would occur after the warm handoff, but serves primarily to reduce stigma as well as assuage concerns about hospitalization.

Kessler K6 Nonspecific Distress Scale (K6; Kessler et al., 2002)

The K6 is derived from the K10 as a screening instrument for SMI (Kessler et al., 2002). This scale, as the name implies, consists of six, self-report items scored with a value of 1–4 for each. A score greater than or equal to 13 indicates the likely presence of SMI, with some research indicating that a score between 5 and 13 indicating subthreshold clinical treatment needs (Kessler et al., 2010). Thus, this measure has been identified as a reliable and valid screen for SMI in less than 2 min. Though it does not provide the robust recommendations related to system flow and possible interventions, it is like of the most utility in a Primary Care setting. When compared to other screening instruments (e.g. the WHO-DAS or the CIDI-SF and even the K10) it has the greatest sensitivity, takes the least amount of time to administer and is the least cumbersome to administer (Kessler et al., 2003). Thus, this measure appears to be the most pragmatic screener in a primary care setting.

Primary Care in Behavioral Health Settings

Given the aforementioned issues of co-occurring chronic health conditions and SMI, it is likely that a PCP would be co-located in a Behavioral Health Setting. The intent being to facilitate access to ongoing care and increased treatment compliance for chronic health issues such as diabetes and obesity. SAMSHA and HRSA have developed specific funding to study the integration of primary care in behavioral health settings (PCBHI Grants), but early research has been variable in terms of identifying clear determinants or predictors of success in treatment, with researchers most often citing difficulties related to licensing, patient recruitment as well as patient and staff retention as confounds in the evaluation of the programs (Gerity, n.d.; Scharf et al., 2013). Nevertheless, those studies describe perceptions about benefits that include the ability to collaborate and share patient healthcare information that are continuing to be studied, especially in light of their report that many states are now legislating required integration of PCP care in behavioral healthcare settings.

Recommendations

As discussed, a primary issue for treating Hispanic patients with SMI, is the need to incorporate Spanish, medical interpreters (specifically interpreters with sufficient mental health training) and bilingual practitioners (as well as paraprofessionals) into the primary care setting. It may well be time to create a program of training of Associate or Bachelor's level paraprofessionals who are bilingual, in order to fill the gap of non-Spanish speaking providers.

Once we can overcome the logistical issues of language, there is an overarching need to improve understanding of the process of stepped care in mental health in general, and specific to this chapter, a need to improve the understanding across practitioners who service individuals with serious mental illness. A primary resource guide to help improve understanding and expectations is the mhGAP intervention guide for mental, neurological, and substance-use disorders in nonspecialized health settings (WHO, 2015).

Though the guide provides the foundation and explicit protocols for implementing stepped care, many of the identified barriers to implementation are issues related to real costs and availability of providers, which has consistently been identified as the most prominent barrier to mental health treatment in general. As discussed, the implementation of stepped care has the potential to reduce costs across a variety of systems, primarily through early identification and intervention for historically chronic and thus expensive mental health problems. If we recall the recommendations of Thornicroft and Tansella (2004) the goal is to provide the services within the system that exists, and this is true for mhGAP guidelines, which were designed to raise global standards of care for SMI. However, in terms of sheer efficiency, the K6 appears to serve as an excellent screener for identifying SMI, and taking the next step in handing off the patient to a behavioral healthcare specialist.

Particularly relevant to the issue of SMI, the next largest barrier to cost (involuntary commitment; Mojtabai et al., 2014) is a real and salient issue. Thus, practitioners, and more importantly health care administrators, need to create and or evaluate their integrated care system to ensure it not only supports a program that reduces the probability of hospitalization, but also a system that promotes education and a message for how intermediate services can reduce or prevent the likelihood of hospitalizing an individual with SMI. This is a role that can be largely accomplished by non-primary care practitioners, and paraprofessionals.

We need to train and utilize new types of healthcare works to fill the intermediary steps that are shown to be part of an effective process of reducing costs and maintaining mental health. In developed systems, such as the U.S., the challenge is not just the cost, but the coordination among professional licensing boards to define what these positions are, and are not. Specific to Hispanic patients, these newly trained workers would benefit by introducing more individuals who are fluent in Spanish at critical points in the stepped-care process (e.g. psychoeducation, social skills training, and monitoring). Given the critical role of monitoring, it is important that the individual have a clinical base of knowledge to assess compliance with treatment recommendations (e.g. at least a rudimentary ability to assess mental status, for example to assess and report back to other members of the treatment community about compliance, noncompliance or potential points of intervention such as stressors or failed interventions).

In addition to trained professionals and paraprofessionals, the role of nonprofessionals plays a critical role, in particular for psychosocial interventions, specifically those recommended (Dua et al., 2011) for vocational and economic inclusion as well as those designed to improve community attitudes. For the Hispanic population, this would include community outreach that includes both monolingual

Spanish speakers as well as bilingual community members. Given the research (Clarke et al., 2000) on re-hospitalization and other negative outcomes (e.g. homelessness and arrest) which is directly correlated to the time to implementation of comprehensive support services, the primary importance of these nonprofessionals is ensuring the continuity of care by persisting in implementing the external support systems as the patients transition from inpatient settings back to the community.

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