Chapter 8
Enhancing and Improving Treatment Engagement with Hispanic Patients

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In the United States, Hispanics both use health and mental health care services at lower rates and receive lower quality care than do non-Hispanic Whites (Alegría et al., 2008; U.S. Department of Health and Human Services, 2001; Young, Klap, Sherbourne, & Wells, 2001). For example, among people with a depressive disorder, 63.7 % of Hispanics did not access mental health care (defined as having at least one visit to a mental health or general medical provider in the past year), compared to 40.2 % of non-Hispanic Whites (Alegría et al., 2008). Also, of those who did access care, 22.3 % of Hispanics received adequate treatment (defined as comprising at least four visits to a specialty or general health care provider in the past year and use of antidepressant medications for 30 days), compared to 33.0 % of non-Hispanic Whites (Alegría et al., 2008). In addition, when care is sought clinical outcomes are often worse in Hispanic patients, in large part because they are more likely to drop out of treatment prematurely compared to non-Hispanic Whites (Olfson et al., 2009). However, studies have generally suggested that successful engagement in treatment leads to comparable outcomes for Hispanics and other ethnic or racial groups (Miranda et al., 2005; Sue, 1988; Tonigan, 2003; Voss Horrell, 2008). This suggests that an important way to reduce the current health disparities experienced by Hispanics is to increase their engagement in health-related treatment services.

Integrating behavioral health services into primary clinics shows promise for increasing treatment engagement and reducing health disparities experienced by Hispanics (Bridges et al., 2014; Sanchez, Chapa, Ybarra, & Martinez, 2012). Hispanics and non-Hispanics alike seek behavioral health services more frequently from primary care providers than any other professionals, including specialty mental health providers (Bridges, Andrews, & Deen, 2012; Vega, Kolody,

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Aguilar-Gaxiola, & Catalano, 1999; Wang et al., 2005). Bridges and colleagues (2014) found Hispanic patients accessed integrated behavioral health services at comparable rates to their representation in the general clinic population, engaged in follow-up behavioral health sessions at comparable rates, and experienced clinically significant improvements in their overall well-being comparable to their non-Hispanic White counterparts.

At their core, integrated care models involve the embedded of behavioral health specialists into the primary health care team (Blount, 1998; Robinson & Reiter, 2007; Strosahl, 1998). These specialists collaborate with medical providers to deliver whole person care. The structure of behavioral health sessions in integrated care differs from more traditional care. Sessions tend to be shorter in duration (e.g., 20–30 min) and quantity (typically 2–4 sessions to address the acute behavioral health need). Integrated behavioral health services are typically used episodically for acute problems and the emphasis is on enhancing patient functioning rather than symptom amelioration (Robinson & Reiter, 2007). Typically, behavioral health specialists accept same-day referrals and frequently conduct sessions in the same medical examination room utilized by the other health care providers. Medical providers will typically introduce the behavioral health specialist using a "warm-handoff" that includes a brief description of the patient's presenting concern(s) and the role of the behavioral health specialist on the medical team. Behavioral health specialists typical use brief screening tools rather than conduct comprehensive assessments, and adapt components of evidence-based interventions to be suitable for the pace and structure of primary care (Bridges et al., 2014; Bryan et al., 2012; Corso et al., 2012; Hunter, Goodie, Oordt, & Dobmeyer, 2009; Ray-Sannerud et al., 2012).

Any integrated care clinic that wishes to serve their Hispanic patients in a culturally competent manner potentially faces numerous challenges. In this chapter, we begin by delineating the set of challenges facing integrated care providers. We follow this with recommendations for how primary care clinics can better respond to the specific cultural needs of their Hispanic patients so as to enhance treatment engagement. In so doing, we first consider policies and procedures that may be employed at the administration level, thereby articulating system-level factors that could enhance or impede treatment engagement. We then turn to the specific activities of members of the primary care team, from medical providers and assistants who may be involved in screening patients for behavioral health concerns to the specific assessments and interventions behavioral health specialists may deliver in primary care. We also describe the importance of community partnerships and outside referrals. Throughout, we weave in cultural considerations and address how language and cultural values may shift the specific practices of providers. We turn finally to a brief discussion of the focus of integrated care services—that of improving the overall health of a population—and what this focus means for reducing health disparities in Hispanic patients.

In making all suggestions, the authors use their experience with designing, supervising in, and consulting for an integrated behavioral health care program at Community Clinic, a Federally Qualified Health Center (FQHC) located in Northwest Arkansas. Community Clinic has four free-standing primary care clinics, seven school-based health clinics, and two free-standing dental clinics. In 2013, the clinic served nearly 30,000 patients. Approximately half of the clinic's patients are ethnic and linguistic minorities and over 90 % are at 200 % or below the federal poverty level (ACHI, 2015; see also http://www.communityclinicnwa.org/about). Accordingly, half of the clinic's staff is bilingual and bicultural. The free-standing primary care clinics are staffed with myriad health service professionals, including medical doctors, doctors of osteopathy, advanced practice nurses, nurse practitioners, registered nurses, licensed practical nurses, physician's assistants, nutritionists, patient advocates, case managers, and medical assistants. Medical assistants typically serve as trained interpreters for both medical and behavioral health visits. Community Clinic welcomed licensed clinical social workers and licensed clinical psychologists as part of their health care team when they expanded to integrated medical and behavioral health services in 2009.

Challenges to Engagement in Health Services Treatment

Research showing that Hispanics are less likely to seek services for mental health problems and more likely to terminate therapy prematurely than members of other ethnic groups highlights existing challenges to the engagement of Hispanic patients in traditional mental health care (e.g., Alegría et al., 2008; Olfson et al., 2009). For example, in a study conducted by Alegría and colleagues (2008), 63.7 % of Latinos who met diagnostic criteria for a depressive disorder in the past year did not seek any mental health treatment, as compared to non-Latino white participants with a depressive disorder in the past year, of whom only 40.2 % failed to seek treatment. Using data from the National Comorbidity Study Replication, Olfson et al. (2009) found that Latinos were three times more likely to prematurely terminate therapy than non-Latinos. Both internal and external factors limit engagement. Internal factors include attitudes and beliefs patients may have about behavioral health services and help-seeking. They may also include problem recognition and health literacy. Many of these internal barriers are influenced by culture. External factors include limited availability of Spanish speaking providers or lack of culturally congruent care centers, cost and insurance barriers, and the structure of health services in the United States. These challenges are reviewed more fully below. For the purposes of this chapter, we refer to research regarding the Hispanic population overall, as there is limited relevant research comparing these factors among Hispanic subgroups.

Internal challenges. Limited mental health literacy may serve as an obstacle for treatment seeking by Hispanics and can contribute to premature termination of services. For example, Cabassa, Lester, and Zayas (2007) found that only 55 % of participants in a Latino-only sample (80 % Mexican, 14 % Central American, 5 % Caribbean) used the words "depression" or "depressed" to describe a standardized vignette of an individual who meets diagnostic criteria for major depressive disorder. Similarly, López et al. (2009) found that only 2 % of participants in a Latino-only sample were able to identify psychotic symptoms in a case vignette involving delusions and auditory hallucinations. Some empirical evidence suggests that Hispanic individuals who are experiencing psychological distress are more likely to conceptualize their symptoms as somatic and present to primary care for their problems than Whites (e.g., López, 2002; Varela et al., 2004). In a meta-analysis, Benish, Quintana, and Wampold (2011) found that the incorporation of illness myth into culturally adapted treatments resulted in better outcomes compared to unadapted bona fide therapy. Bona fide therapy was defined as involving a therapeutic relationship tailored to fit the individual client with at least two of the following: use of an established therapeutic approach, inclusion of psychological processes, use of a manual or training guide, and identification of the active components of therapy. Studies were included as culturally adapted if the purpose of the adaptation was to provide a more effective treatment to racial/ethnic minority clients; examples of adaptations include language and/or ethnic matching, inclusion of cultural values, consultation with members or experts of a cultural group, cultural sensitivity training for therapists, and adaptation of illness myth. Because a framework that fits cultural beliefs about illness is often absent in traditional mental health care, some Hispanic patients may seek help for psychological difficulties through folk healers whose methods fit more closely with their beliefs about illness (e.g., Bridges et al., 2012).

Certain Hispanic cultural values may discourage the engagement of Hispanics in traditional mental health services (e.g., Kouyoumdjian, Zamboanga, & Hansen, 2003). *Machismo*, a value of traditional masculinity, may translate into the belief that help-seeking is weak, supported by findings that *machismo* and help seeking attitudes are inversely correlated (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006; Davis & Liang, 2015). As in some other cultures, *marianismo* depicts women as self-sacrificing in order to prioritize the needs of others; as such, Hispanic women may be too busy caring for others to attend to personal mental health needs, which could be perceived as selfish (Andrés-Hyman et al., 2006). *Familismo*, which places the family at the center of the individual's life and experience, encourages Hispanics to attempt to solve mental health problems within the family and not seek services from outsiders or share personal information about oneself or family members during therapy sessions (Antshel, 2002). Consistent with this possibility, Chang, Natsuaki, and Chen (2013) found that Hispanics with strong family bonds were less likely to seek mental health services and Villatoro, Morales, and Mays (2014) found that Hispanics with high endorsement of *familismo* were more likely to seek informal or religious assistance than traditional mental health services for mental health problems. Hispanic cultural values ascribe importance to friendly, personal relationships even in professional domains (*personalismo*); a businesslike style of interaction with mental or medical health professionals may be more unwelcoming or bothersome to Hispanic patients than to patients who expect formal interactions in these settings (Antshel, 2002). *Simpatía* refers to the importance of maintaining a pleasant demeanor and repressing anger or sadness in interactions with others (Antshel, 2002). If patients are reluctant to share unpleasant emotions in therapy, this could present challenges for establishing therapeutic alliance, conceptualizing the patient's difficulties, and determining an appropriate treatment strategy. The prospect of sharing these emotions may even deter some Hispanic patients from seeking mental health services at all. Many Hispanics ascribe to strong religious and spiritual values (*fatalismo*, *espiritualismo*) and may be more likely to seek assistance for psychological problems from religious leaders than mental health professionals (Andrés-Hyman et al., 2006). The interference of certain cultural beliefs in the engagement of Hispanic patients in traditional mental health services is likely lower as acculturation increases.

Stigma likely constitutes a significant deterrent from treatment seeking and engagement for Hispanics experiencing mental health problems as for others. Gary (2005) theorizes that mental illness is doubly stigmatizing for ethnic minorities, who may not want to add to the discrimination they already experience by seeking services for their problems. Interian, Martinez, Guarnaccia, Vega, and Escobar (2007) found stigma was a common concern for participants of a Latino-only sample who were prescribed antidepressant medication. Research with a Hispanic sample showed views of mental illness as stigmatizing discouraged participants from seeking services (Hirai, Vernon, Popan, & Clum, 2015).

Some (e.g., Kouyoumdjian et al., 2003) have speculated that low rates of mental health service use by Latinos are in part due to negative attitudes about the effectiveness of mental health care for their problems. In addition to negative attitudes about the effectiveness of psychological treatment in general, concerns about the cultural competence of such services can deter Latinos with mental health problems from seeking treatment. These beliefs are likely strengthened when the few Latinos who do seek mental health services receive inadequate and insufficiently culturally competent care. Recent studies suggest that overall, Hispanics do not have more negative attitudes about the helpfulness of mental health services than members of other ethnic groups (Gonzalez, Alegría, & Prihoda, 2005); Cabassa et al. (2007) found that 84 % of participants in a Hispanic sample believed that therapy improves depressive symptoms, with 75 % of the sample endorsing therapy as equally effective as medication for treating depression. However, one study did find that in a Hispanic-only sample of adults aged 60 and above, older age was associated with more negative attitudes about the effectiveness of therapy for addressing mental health problems, consistent with trends for members of other ethnic groups (Jang, Chiriboga, Herrera, Martinez Tyson, & Schonfeld, 2011; Kinoshita, Sorocco, & Gallagher-Thompson, 2008).

In a sample of Mexican American families, McCabe (2002) found that parents who believed they should be able to overcome their child's health problem on their own, who perceived more barriers to treatment, and who expected their child to recover quickly were more likely to terminate prematurely.

External challenges. Latinos also face external barriers that interfere with engagement in mental health services. The Hispanic population in the United States continues to grow (with 37.6 million Spanish speakers identified in 2011), yet Spanish-speaking mental health professionals remain limited (Ryan, 2013). In many studies, Hispanic participants have identified language as a significant barrier to the receipt of appropriate mental health care in traditional settings (e.g., Bridges et al., 2012; Kim et al., 2011; Rastogi, Massey-Hastings, & Wieling, 2012; Sentell, Shumway, & Snowden, 2007; Shattell, Hamilton, Starr, Jenkins, & Henderliter, 2008). Rastogi and colleagues (2012) found that Hispanic participants in their qualitative study cited low availability of interpreters as a barrier to receiving appropriate mental health services. Another study found that the availability of professional interpreter services increased medical service use by patients with limited English proficiency; however, the associated cost may pose another barrier, as interpreter services can be expensive (Jacobs et al., 2001).

Multiple studies have identified cost of traditional mental health services and lack of health insurance as significant obstacles to service utilization for Hispanics with mental health problems (e.g., Bridges et al., 2012; Kim et al., 2011). These difficulties are likely related to lower levels of full-time employment, lower salaries, and poorer benefit packages for Hispanics as compared to members of other ethnic groups (Bridges & Lindly, 2008; Kouyoumdjian et al., 2003). Wells, Lagomasino, Palinkas, Green, and Gonzalez (2013) found that many Latinos who were employed worked long hours, which they reported interfered with their ability to initiate and maintain therapy. Hispanics have also reported significant difficulties obtaining transportation to therapy appointments, which may be exacerbated in areas with few mental health providers nearby (Kouyoumdjian et al., 2003; Wells et al., 2013). In several research studies, Hispanics have reported that fear of deportation hampers their ability to receive mental health care (Bridges et al., 2012; Rastogi et al., 2012; Shattell et al., 2008; Wells et al., 2013).

Impersonal staff and culturally incongruent care constitute additional barriers to appropriate mental health services for Hispanics. When Uebelacker and colleagues (2012) asked Hispanic patients at a medical health center to report barriers to engagement with medical providers, they indicated short allotments of time in appointments, lack of timely access to appointments, disregard for mental health problems, and being treated in a "dehumanizing" manner by medical health professionals. These patients reported they would be more engaged if medical providers were to make eye contact, ask about family members, ask directly about problems, and form a social partnership with them in addressing their medical and mental health problems; although these preferences likely generalize to members of other ethnic groups, they may be particularly important for Hispanic patients in consideration of cultural values (e.g., *personalismo*).

Hispanics tend to show a pattern of having a crisis orientation by seeking services during a crisis and terminating them abruptly when the crisis passes (Antshel, 2002). It may be due to the numerous barriers faced by Hispanics that the benefits of seeking traditional therapy services may only outweigh the cost in the case of an emergency. Culturally adapted therapies have been found to reduce some of these barriers to treatment engagement for Hispanics and integrated behavioral health care shows promise for reducing many internal and external barriers as well (Benish et al., 2011; Bridges et al., 2014).

Recommendations to Increase Engagement in Health Services Treatment

Systemic considerations. Before ever stepping foot into a medical examination room, or even into the building, primary care clinics already communicate their cultural responsivity to the patients they serve. Advertisements, websites, promotional materials, and outreach efforts all provide a public face of the clinic to the community. The use of bilingual and bicultural clinic representatives for community outreach, for example, can help make clinic services more accessible to the Hispanic community, especially recent immigrants (Musser-Granski & Carrillo, 1997). Having website and promotional resources available in Spanish as well as English can also assist in increasing engagement (Glasgow et al., 2011; Matthews, Darbisi, Sandmann, Galen, & Rubin, 2009). Even considering carefully the location of the clinic is important. For example, locating satellite sites in or near Hispanic communities and ensuring clinics are near major public transportation routes can reduce disparities associated with transportation (Bridges & Lindly, 2008).

Once patients arrive at the clinic, signage and other visual indicators can promote engagement by conveying to the patient that the clinic is aware of and responsive to their cultural and linguistic needs. For example, Community Clinic has artwork that reflects the diverse patients served by the clinic (professional photographers took portraits of patients and, with patient consent, these enlarged black and white photographs pepper the halls of the clinic). They also display maps and other artwork reflective of the Hispanic and Marshallese communities served by the clinic. This is consistent with Bathje and Shelton (2012), whose checklist for cultural competence in traditional mental health care clinics emphasizes the display of artwork and other visual cues indicating cultural responsivity.

Clinics should provide materials and have staff members who can speak the preferred language of patients. Having front office staff and telephone receptionists who speak Spanish will reduce the linguistic barriers often associated with lack of treatment engagement in Hispanics, especially recent immigrants (Bridges et al., 2012). Clinic forms, patient consent forms, notices of privacy, prescription information, pamphlets and brochures, and other paper products should be easy to read and understand. This requires clinics to invest in good interpreter services to ensure that the language of all forms is conceptually equivalent (and appropriate for the specific subgroups of Hispanics the clinic serves).

Relatedly, clinics where Hispanics represent a sizeable portion of patients served should strongly consider hiring trained interpreters (Jacobs et al., 2001). Research has consistently documented the beneficial effects of trained interpreters on treatment engagement in Hispanics; often, the therapeutic alliance between behavioral health specialists and patients is just as strong when a trained interpreter is present as when the patient and provider are able to communicate directly, and treatment outcomes are comparable (Brune, Eiroá-Orosa, Fischer-Ortman, Delijaj, & Haasen, 2011; Schulz, Resick, Huber, & Griffin, 2006; Villalobos et al., 2016). Increasingly, technology is assisting with linguistic barriers patients often face. For instance, telehealth allows for consultation with interpreter services that are provided at a distance and translation applications on the computer or on smart devices are increasingly sophisticated and helpful.

Other clinic policies and procedures, aside from artwork and linguistic services, can promote treatment engagement in Hispanic patients. For instance, having extended hours for services allows patients who may experience difficulties attending appointments because of relatively inflexible work schedules additional opportunities to engage in treatment (Bridges & Lindly, 2008). Having options for child care, or providing concurrent child—and parent—appointments or behavioral health education groups, can increase willingness to engage in treatment (Snell-Johns, Mendez, & Smith, 2004).

At the level of individual interactions with clinic staff and providers, it is helpful to consider the following. First, as reviewed above, many Hispanics approach physical and behavioral health problems from a crisis orientation; that is, they tend to seek services during periods of crisis and may end treatment abruptly, as soon as the crisis subsides (Rosado & Elias, 1993). Integrated care is especially responsive to this cultural style of help-seeking during crisis; the lack of a significant waiting period between when a need is identified and when the patient can receive services may be seen as particularly helpful. The crisis orientation approach, however, means expectations providers have for how long patients should remain in treatment should be adjusted, with behavioral health specialists recognizing that a decision not to return for a planned follow-up does not mean the services were perceived as unhelpful, or that the patient was disengaged. Instead, the flexibility of the integrated care model and the benefit of having patients return to their primary care medical home frequently for myriad services can help behavioral health specialists "check in" on clients after a critical incident to ensure the situation was adequately resolved. This flexible approach to services may significantly increase treatment adherence in Hispanic patients, compared to more traditional mental health services that require weekly 1-h appointments for many months (Antshel, 2002; Snell-Johns et al., 2004).

Second, clinic staff and providers may want to engage in small talk and some degree of self-disclosure with their Hispanic patients. This behavior is consistent with the Hispanic value of *personalismo*, a communication style that encompasses warm and friendly exchanges and a relationship between people, rather than between a person and an institution (Añez, Silva, Paris, & Bedregal, 2008). When interactions are perceived as warm and friendly, Hispanic patients may see the clinic and its personnel more positively and this, in turn, can enhance treatment engagement.

Finally, directors of primary care clinics that seek to enhance the cultural competence of their services should make it their mission to train *all* clinic staff, from the executive team on down, in multiculturalism and cultural sensitivity (Bathje & Shelton, 2012). This training can also include information about the diverse clientele served by the clinic, important historical facts or events that may shape the experiences of clinic patients, and even how culture impacts health behaviors and expressions of behavioral health concerns.

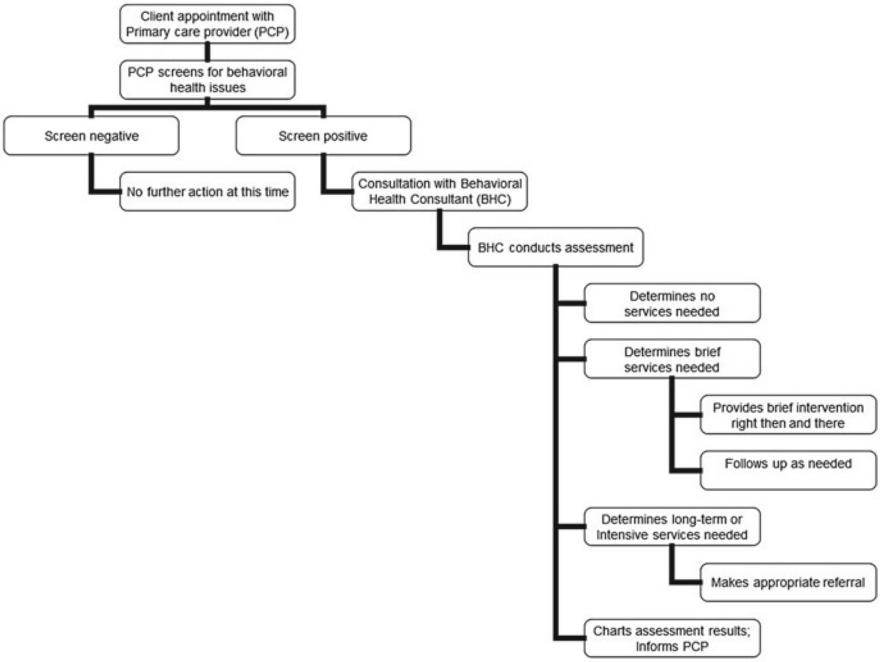

Fig. 8.1 Steps for integrated care patients' screening, treatment, and referral

We turn next to increasing treatment engagement at the various steps of integrated behavioral health care services. We have developed a brief flow chart to illustrate the various steps of patient screening, treatment, and referral that are commonly utilized in integrated care programs (Fig. 8.1). We organize our set of recommendations by these steps, beginning with screening, followed by warm hand-offs, intervention activities, and making outside referrals.

Screening. Aside from receiving referrals directly from primary care providers, behavioral health specialists working in integrated care settings may want to use behavioral health screening tools with all or a subset of patients. Screening instruments may also be used at initial sessions and follow up encounters to track patient progress on key behavioral health indicators. In general, screening instruments appropriate for primary care will be brief (typically no more than 5–20 questions), appropriate for a wide audience (e.g., adolescents, young adults, older adults), easy to read, and easy to score. Ideally, screening instruments will be normed with Hispanic patients and already translated into Spanish, so that they may be readily incorporated into practices with diverse patients.

Numerous Internet resources are available that provide integrated care clinics with free screening instruments. For example, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) website has a list of screening tools appropriate for primary care (http://www.integration.samhsa.gov/clinical-practice/screening-tools#sample screening forms). The screening instruments cover a range of behavioral health topics, including depression, anxiety, trauma, drug and alcohol use, suicide, and general health/functional impairment. Most are freely available on the website and many contain scoring information, but many of the instruments are not available in Spanish. The Integrated Behavioral Health Project also lists many brief screening instruments available in English and Spanish that are appropriate for primary care (http://www.ibhp.org/uploads/file/IBHScreeningToolsRevFinal100313.pdf). This large portable digital file also includes pictorial symptom checklists appropriate for use with pediatric and low-literacy populations.

One concern that may arise for behavioral health care providers working with Hispanic patients is that many Hispanic patients report somatic symptoms of distress, rather than mood or anxiety concerns (Escobar et al., 1987). As such, screening instruments that assess behavioral and health concerns broadly, and that include items assessing somatic concerns, may be more beneficial that more focused screening instruments. For example, the Kessler Psychological Distress Scale (K10; Kessler et al., 2002) is a ten-item screening instrument that assesses depression and anxiety, but includes items such as feeling “tired out for no good reason,” “restless or fidgety,” and “that everything was an effort.” In addition, the Kessler 10 asks a few questions assessing the functional impairment patients experience because of their symptoms, including number of days in the past month the patient was unable to work or carry out normal daily activities and degree to which physical health problems caused the symptoms.

A second concern, one not well addressed by existing screening instruments, is that many Hispanic patients will see problems from a family or multisystemic perspective. Indeed, this more systemic approach to treatment is considered culturally responsive and even recommended by some scholars and clinicians (e.g., Añez, Paris, Bedregal, Davidson, & Grilo, 2005; Chowdhary et al., 2014). In our own practice, we often give screening instruments to patients and to a family member, such as a spouse, in order to gather multiple perspectives on the patient’s functioning. While we cannot use these data in a normative fashion, the results are descriptive and can help inform treatment, particularly if the behavioral health specialist opts to include family members in the session.

A third concern in using screening instruments with Hispanic primary care patients is that the psychometric properties of these instruments are often unknown, particularly when one considers that country of origin, years living in the U.S., and literacy rates are all likely important factors that would affect screening norms. The literature is mixed with regard to the appropriateness of norms developed on primarily White nonminority patients for Hispanic patients. For example, Novy, Stanley, Averill, and Daza (2001) found comparability across many measures of anxiety disorders in English and Spanish with bilingual and literate adults. Similarly, Ruggero, Johnson, and Cuellar (2004) reviewed Spanish language measures of depression and mania and evaluated them with bilingual college students, finding psychometric equivalence across English and Spanish versions. However, both of these studies were conducted with people of high English and Spanish fluency and of high educational attainment. It is not certain that similar comparability would be obtained in low-literacy Spanish-speaking patients or in monolingual Spanish-speaking populations.

Dawes and colleagues (2010) found scores on the Beck Depression Inventory (BDI) had to be adjusted for formal education and gender in Spanish speakers near the U.S.-Mexico border. Specifically, women and respondents with lower formal education tended to endorse greater symptoms of depression than men or people with higher educational attainment. The authors recommend clinical cut-off scores of screening instruments be adjusted for these demographic variables, although they recognize their study was unable to determine whether differences in BDI scores were because of true differences in the base rates of depression, artifacts of measurement, or due to something else, such as level of acculturation or socioeconomic stress.

Other scholars have suggested cut-off scores of screening instruments may need to be modified for Hispanic populations, especially those with little formal education and limited literacy (in both English and Spanish). For instance, Reyes de Beaman and colleagues (2004) examined scores on a revised and translated Mini-Mental State Exam (MMSE) in a sample of 203 Mexican older adults (age 60 years or greater). In order to achieve good sensitivity and specificity associated with detection of true cognitive impairment, the authors had to adjust MMSE cut-off scores by level of formal education; otherwise, persons with low educational attainment were more likely to be incorrectly identified as having cognitive impairment.

Technology is likely to revolutionize the way behavioral health specialists conduct screenings in integrated care. In our own clinical work, we have begun using iPads and electronic medical records in order to help expedite screening and assessment in a culturally responsive manner. For example, given the relative low literacy rates among our patients, especially our Hispanic patients, we have created an application to be used with our iPads that allows us to input freely available behavioral health screening instruments. The application also permits us to record audio files of us reading the questions (and answer options) aloud. These audio files are automatically played for participants when they highlight questions and response options, allowing them to complete screenings in private. The application automatically scores the screener and provides the behavioral health specialist with the score and interpretation, so the information can be used in real time, during the behavioral health encounter. One need not hire computer programmers to take advantage of this technology: similar applications are now available and providers can create customized screenings for patients using commercial survey software such as Qualtrics offline (http://www.qualtrics.com/research-suite/mobile-surveys/).

Warm hand-offs. After a provider identifies a behavioral health concern in a patient or a patient screens positive on a behavioral health instrument, such as those described above, the next step is for the provider to introduce the behavioral health specialist in what has been called a warm hand-off (Strosahl, 1998). The hand-off allows the provider to introduce the behavioral health specialist as a member of the health care team and is thought to facilitate the development of rapport with patients. This facet of integrated services is particularly well suited for many Hispanic patients, as it naturally incorporates aspects of Hispanic culture that are important for treatment engagement. First, a warm hand-off by the primary care medical provider to the behavioral health specialist is highly personal—typically the medical provider explains to the patient why the behavioral health specialist is being included in the patient's care (therefore it corresponds with the value of *personalismo*). Second, the chance for the behavioral health specialist to talk briefly with the patient about the patient's presenting concerns also allows the behavioral health specialist to solicit information from the patient about *why* patients believe that they are experiencing these symptoms. This solicitation from the patient about their own illness myth (or explanation for the symptoms), and the incorporation of the patient's beliefs about the causes of their symptoms into the rationale for treatment, is a critical moderator of the effectiveness of cultural adaptations of psychotherapy on therapy outcomes (Benish et al., 2011). Third, following the solicitation from the patient about their explanation for their symptoms, behavioral health specialists are able to provide brief education to the patient about the rationale for integrated services and set expectations for the behavioral health session, including expectations for any potential follow-up visits. In so doing, the behavioral health specialist avoids using stigmatizing terms and opts instead for culturally responsive phrasing, such as describing behavior as "unhelpful" rather than "maladaptive." Such orientation to services and avoidance of stigma may be especially helpful at increasing treatment engagement and reducing premature drop-out in minority patients (Hays, 2009; Swift, Greenberg, Whipple, & Kominiak, 2012), who may not have the same cultural expectations about therapy as nonminority Whites (Kouyoumdjian et al., 2003).

Interventions. After conducting a warm hand-off and introducing behavioral health services to patients, behavioral health specialists are ready to begin their interventions. As reviewed above, often we meet with patients only one or two times for a particular presenting concern (Bridges et al., 2014; Corso et al., 2012), although we may meet with them multiple times over the years for different concerns, as the need arises. In each episode of care we provide, we approach interventions in a stepped care fashion (Bower & Gilbody, 2005; O'Donohue & Draper, 2011). Stepped care models begin by providing minimal treatment (or low treatment intensity) to patients. These "minimal treatments" must have some degree of efficacy, of course, so that it is likely many people will benefit. If a patient does not respond positively to this minimal treatment, then the patient receives more intensive treatment. For example, minimal treatment in integrated care may involve the provision of psychoeducation about panic disorder in someone who recently experienced a first panic attack. The hope is that with some education about the nature of panic, panic attacks, and why panic disorder develops in some people, the patient is able to use the information to avoid catastrophic evaluation of future fear responses and therefore will not develop full-blown panic disorder. Indeed, we have had such successes in our own clinical practice. However, for some patients this small dose of intervention is insufficient to ward off symptom development or ameliorate existing symptoms; for these patients, follow-up behavioral health sessions may include exposure to interoceptive panic cues and assignment of homework that involves approaching feared situations. If the patient's symptoms worsen or seem to require more than 4–6 sessions, typically we would make a referral to a traditional mental health care provider for continued treatment (see next section).

In general, research has shown that if Hispanics are able to initiate and remain in treatment, they receive comparable benefits as their non-Hispanic White counterparts. For instance, Bridges and colleagues (2014) demonstrate outcomes of integrated behavioral health care services are comparable between Hispanic and non-Hispanic White primary care patients (both pediatric and adult). Voss Horrell (2008) reviews the literature on the efficacy of traditional cognitive-behavioral therapy for ethnic minority patients; while the author notes the literature is quite sparse, the bulk of studies suggest it is effective for diverse patient groups.

On the other hand, there is increasing evidence that interventions are enhanced when cultural modifications are made (Benish et al., 2011). For example, Kanter, Santiago-Rivera, Rusch, Busch, and West (2010) show evidence that culturally adapted behavioral activation is effective for reducing depression in Latinos at a community mental health center. Adaptations included simplification of treatment rationale and case conceptualization, addition of structure, including the family and community into intervention, and patient-therapist linguistic and ethnic match. As mentioned above in the section on screenings, López et al. (2009) and Chowdhary et al. (2014) discuss the importance of including family members and other key people into treatment as a culturally-congruent way to intervene. Fortunately, in primary care settings we oftentimes have the option of easily including key family members into treatment. We have taken advantage of this and often include spouses, grandparents, nephews, or other important persons into the treatment of our patients. When doing so, however, additional concerns emerge and the behavioral health specialists must take care to explain carefully to patients and others the extent of and limits to confidentiality.

Hays (2009) has a list of several recommendations for doing brief, action-oriented interventions in a culturally sensitive manner, including things like framing certain beliefs as being “unhelpful” rather than “irrational,” recognizing, assessing, and valuing the patients’ experiences of discrimination and oppression, and clarifying what aspects of the problems are primarily external (environmental) or internal (part of the patient’s belief system). All of these modifications can easily be incorporated into brief behavioral health interventions delivered to Hispanic primary care patients.

Outside referrals. One challenge we face in providing culturally responsive services to our Hispanic patients is coordinating care with outside providers and other community partners. Whether it is because the scope of services the patient requires is outside that which we can provide in our integrated care clinics, or because the patient prefers seeking more traditional therapy, we have a difficult time finding bilingual service providers who are able to accept our referrals. Many of the external barriers we articulated above as challenges to engaging Hispanics in treatment resurface when we need to make an outside referral: lack of insurance and low income serve as critical barriers for many of our patients. We have partnered with our local university’s Psychological Clinic to accept referrals for traditional therapy.

While this significantly reduces cost barriers, the clinic is located at some distance from the primary care clinics transportation can be difficult. In addition, oftentimes the bilingual student clinicians have full caseloads; therefore wait times for services may extend to many months. Nevertheless, we have continued to forge relationships with other providers. In our experience, two significant efforts on our part help reduce frustration for our patients. First, we are likely to pick up the telephone and make a first contact with a new referral source. We ask questions about the scope of their services, wait times, eligibility requirements, payments accepted, availability of Spanish-speaking providers, locations, and other factors relevant for our patients. Second, we employ behavioral health case managers who can assist our patients with ensuring the outside referrals we make are utilized by our patients. Our behavioral health case managers will call patients to ensure they were able to make appointments, or will even call referrals on our patients' behalf (with proper consent). If patients do not follow through with outside referrals, our case managers can work with our patients to problem-solve barriers and, if need be, schedule them to return to us for additional services within the primary care clinic.

A Public Health Perspective

The integrated care model promises to reduce the large health disparities experienced by many minority groups in the United States, including Hispanics. Integrated care operates from a public health perspective, meaning the emphasis of interventions is on their *impact* rather than efficacy. The impact of an intervention is a function of the efficacy of the intervention and the rate of participation, or percentage of the population that is able to access the intervention (Impact = Participation Rate × Efficacy; Whitlock, Orleans, Pender, & Allan, 2002). For instance, an intervention for depression that is 80 % efficacious but can only be delivered to 5 % of patients will have an impact that is five times lower (impact = 0.8 × 0.05 = 0.04) than a depression intervention that is only 50 % efficacious but reaches 40 % of patients (impact = 0.5 × 0.4 = 0.20). Brief interventions delivered "just in time" in primary care settings to patients are responsive, efficacious, and can reach a great deal more patients than more intensive interventions delivered over many months. In addition, these interventions can be delivered before or shortly after behavioral health symptoms emerge, possibly preventing the onset of more serious illness. López and colleagues (2009) discuss the importance of increasing mental health literacy in Hispanic family members of people suffering from schizophrenia—the recognition of symptoms of psychotic disorders can help people seek services early on, before symptoms worsen or full relapse occurs.

Conclusions

The growing emphasis on integrating behavioral health services into primary care coincides with an increasingly diverse population in the U.S. This coinciding of events is quite fortunate, since the integrated approach to whole-person care is in fact quite amenable to culturally responsive behavioral health care service provision, especially for Hispanic patients. Integrated services reduce many of the intrinsic and external barriers Hispanics face when seeking care, from reducing stigma and responding to somatic expressions of distress to reducing cost barriers and delivering care in a brief, personal manner. Clinics that move towards embracing the growing diversity of their patients, and who opt to integrate behavioral health services into their medical homes, have the potential to make a significant impact on the health and well-being of their patients.

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