

# Latino Executive Summary

## Introduction

Latinos, or Hispanics, are widely recognized as being a major part of the fabric of the Southwestern United States. It is less recognized that Latinos comprise significant populations in virtually all of the U.S., now numbering over 27,800,000 or 10.5% of the national population and having a significant presence in 25 metropolitan areas of the country. In addition to having Spanish as a common language, the people of Mexican, Puerto Rican Cuban, Central and South American origins also have in common a tendency to utilize mental health services less than the general population except under crisis situations.

In addition to being affected significantly by under-education, under-employment, inadequate housing, and insufficient access to health care insurance, Latinos often perceive historic U.S. mental health models as unnecessary, unwelcoming or not useful. Although it has never been firmly established, it should be assumed that the prevalence of mental health is generally distributed relatively evenly among all peoples of the world. It may also be reasonably assumed that, if the general tendency to be affected by mental illness is relatively the same, factors such as lower socio-economic status and lesser access to resources will tend to exacerbate stressors and the accompanying need for mental health services.

In May, 1995, a national conference was held in Denver, Colorado. Well over 100 Latino mental health professionals from throughout the United States met and discussed the fact that Latinos, while affected by numerous socio-economic stressors, remain likely to use mental health services primarily in crisis circumstances, drop out of services sooner and have undesirable treatment outcomes. From that conference, a national panel was created to begin the development of a set of national standards for delivering mental health services for Latino populations in a managed care setting.

When the panel began its work in January, 1996, several concepts were self evident. Latinos have disproportionate access to the full range of mental health services normally expected within any given state. They do not have comparable rates of use of ongoing outpatient services, have lower rates of voluntary hospitalization and use crisis and other higher cost services at higher rates than other populations.

Mental health staff who have trained in general practice, often do not consider cultural competence as necessary or even valid. Thus, there is a tendency not to incorporate cultural competence principles into service development and planning models at the local and state level nor to use those principles in direct service delivery.

These factors are particularly important when comparing briefly a Fee for Service to a Managed Care service model. In a Fee for Service environment, any service provided to a client results in a revenue to the organization which has provided the unit of

service. In a Managed Care or capitated rate environment, delivery of a service to an individual becomes a cost; the fewer the services delivered in a set rate environment, the higher the profits. If Latinos have underutilized mental health services in a Fee for Service environment where there are incentives to the provider to deliver the service, it follows that Latinos are more at risk in a Managed Care environment in which delivery of services becomes a cost to an organization which is paid a flat rate per person served, irrespective of what the total price of service might be.

One further consideration is important to note. In a private insurance setting, the Fee for Service vs. Managed Care example is particularly true, in that there is the ability to limit costs by limiting services. When the total number of sessions or hospitalization days allowed by an insurance company are exhausted, the remaining costs become the responsibility or burden of the insured. In a public setting, governmental sponsors have the expectation that provider organizations will deliver certain outcomes within a fixed or capitated rate and be financially at risk for costs above that.

Thus it becomes critical that costs be managed by delivering services effectively rather than by limiting benefits. In this environment, it becomes critical to understand access and utilization patterns, outcomes, outliers, cost by groups and by types of service. It is in this environment that it becomes highly important to understand service groups' and sub-groups' needs effectively in order to meet them and attain desirable outcomes within a fixed cost.

The Latino national panel has based much of its work upon the above concepts and several other assumptions.

- ~ Cultural competence comes as a result of specialized practice development rather than by having been born in or having spent significant amounts of time in a culture or by a general practitioner using an interpreter, regardless of the interpreter's linguistic expertise
- ~ Qualifications of Latino mental health specialists should include performance based competency verification
- ~ Development of specialized instruments, protocols and outcome measures must continue
- ~ Additional methods for testing and confirming the viability of specialized practice must also continue
- ~ Development of culturally competent standards are an addition to the general body of knowledge, not at the expense of service to others

The following standards for serving Latinos in a mental health managed care environment provide a guide for the shaping of Latino cultural competence at various levels. It is recognized that service delivery is dependent upon the successful partnerships of administrators, clinicians and funding sources. *The Administrative Standards* contained herein may be looked upon as the foundation for a corporate structure in which age and cultural competence are recognized and valued. The

*Clinical Standards* may be seen as guides for the continued development of direct service techniques, both of which should be viewed as added value to the total service delivery system.

## Administrative Guidelines

### **1. Planning**

Each organization, irrespective of whether it is a provider agency, the plan administrator or the single state agency, should develop and implement a Cultural Competence Plan (CCP). The CCP should be a part of the organization's over-all strategic plan and quality monitoring process. It should be structured such that there is an incremental approach to capacity building with sanctions and incentives for performance. The CCP should be developed with the participation of consumers, families, community stakeholders, direct service staff, middle and top administrators and governing board member participation and investment.

The CCP should include a process for integrating it seamlessly into the organization's over-all strategic plan. There should be a process for determining unique regionally-based needs. Service modalities and models should be geared to fit the needs of the communities served; natural and community resources should be an integral part of the service delivery structure. Key issues will need to be identified, as will the means by which they will be addressed. Specialized staff qualifications and means to achieve the full complement of personnel are an integral part of the plan. Also critical to plan for are specialized tools and practice methodologies. A means by which to evaluate progress must also be included, and indicators of progress should be germane to the population being served.

Sample performance indicators include a comparison of Latinos in the service population to the general or 200% federal poverty level population; length of stay in restrictive settings; ability to live independently or inter-dependently; utilization of the full range or available services is comparable to other served populations.

### **2. Governance**

The governing board of the organization should be reflective of the community to be served. Consumers, family members and other community representatives should be familiar with the local Latino community. Policy, funding allocation and contracting decisions should be made with involvement of individuals who know and understand the Latino community.

Complaint and grievance procedures should be carefully examined to determine whether there are structural or unintended barriers to participation as a result of limited English proficiency, lack of familiarity with systemic procedures or respect for authority. An equitable amount of funds and other resources should be invested in building systemic capacity to provide specialized service. At the contractor level, financial and liability risks should be structured such that smaller community based organization with

specialized expertise will not be seriously disadvantaged. Recognition should be given to alternate concepts and application of confidentiality, ethics and behavior.

### **3. Benefit Design**

The service system should be structured such that it assures equitable access. This should be measured by multiple measures, which should include comparable rates of participation across populations by age groupings; comparable rates of complaint and grievance processing; comparable utilization rates and positive outcomes. Cost effectiveness should be achieved through effective care delivery and resource utilization, not through restrictions in benefits.

Services should incorporate innovative and individualized treatment plans. Services should be formulated in concurrence with and delivered under the guidance of individuals who qualify as Latino Mental Health Specialists. Eligibility and level of care criteria and other critical service needs measures should be developed in partnership with Latino MH Specialists. Culturally and linguistically competent staff should perform utilization review and eligibility determinations for Latino consumers.

### **4. Quality Monitoring and Improvement**

The general means by which quality of care and best practice are measured should include indicators that are applicable to Latinos. The process should involve individuals who are knowledgeable and representative of the Latino community.

Sampling approaches should include current and past utilization patterns by modality and level of care assignments. In the absence of firmly established prevalence of mental illness, it should be assumed that Latinos have equal needs to other populations and that local socio-economic factors will tend to exacerbate need for service. Periodic assessment of functional outcomes and consumer surveys are also part of the quality monitoring and improvement process.

Credentialing and privileging standards should be specific to distinct practice disciplines and need to include cultural linguistic competence knowledge, skills and attitudes particular to Latinos. There should be tracking of high-cost consumers and service utilization across levels of care with resulting individual and group interventions aimed to bring about more desirable results. Early drop-out rates, complaint and grievance patterns and other indicators of barriers or service inequities should be closely monitored.

### **5. Decision Support and Management Information Systems**

The Health Plan should assure that specific mechanisms are established that will track utilization and outcomes for Latino consumers across all levels of care and across services. Examination of findings from these data should include Latino consumers

and professionals. The results should be used to continually assess, improve and inform strategic planning and adjustments to service delivery. Data sources should be examined at both the systemic and the individual provider agency level in order for accountability to be assured at all levels.

The Latino ethnicity category should be broad and inclusive at the same time that it is distinct, even when data collection procedures are consistent with U.S. Census Bureau practice. Diagnostic and assessment patterns should be studied as a whole and at the individual practitioner level to assure reliability and consistency. Data linkages should be established with ancillary providers such as corrections, juvenile justice, education, substance abuse, developmental disability and public health providers. In addition to affording the mental health plan valuable information about service needs of its Latino consumers, another desirable result will be joint service planning and concomitant cost-sharing of service delivery.

## **6. Staff Training and Development**

Training and development of cultural competence should be implemented at all levels and across disciplines. Although not each person in the service delivery structure needs to be culturally competent, it is still incumbent upon governing and advisory entities to have working knowledge in order to oversee planning and establish policy effectively on behalf of Latino service recipients. Administrators and support staff should be able to minimize barriers to service. Clinical staff should have the level of expertise and credentialing for their level of responsibility. Incremental organizational and individual training and development plans should be established which contribute to the over-all mission of the organization and assure competence in serving Latinos.

Credentialing and competency requirements should be established. A recommended Latino Mental Health Specialist minimum qualification is for the individual to be a mental health professional (a master's degree with at two years experience) who has specialized in serving Latinos (at least one year full time experience with a high percentage of recipients who are Latinos) who is able to demonstrate cultural competence. Attainment of cultural competence can be demonstrated in various and combined ways, including consensual validation of others who qualify, evidence of specialized studies, and demonstration of achievements or recognition from the Latino community.

The workforce should be composed of a representative number of Latino MH Specialists and other staff. Career ladders should be established to provide for the development and advancement of Latino staff towards clinical and administrative supervisory and senior positions. Differential pay rates should be implemented for staff with specialized cultural and linguistic competence. Required training in service delivery should regularly be conducted for all staff at support, clinical and administrative levels.

## **7. Provider Competencies**

It should be recognized that the following areas of training, knowledge, skills and attitudes are essential elements of continuing education and capacity building. It should also be recognized that specialized ability to serve Latinos is value added; enhancement of capacity to serve Latinos adds to the body of knowledge and ability to serve other consumers.

Recommended training should include specialized assessment and service delivery techniques; dynamics of acculturation; specialized engagement and therapeutic alliance building techniques; culturally based folk healing systems and traditions across various Latino sub-cultures; use of language and interpreters in treatment; serving Latino children, elders, sexual minorities and other sub-populations; development, documentation and demonstration of effectiveness of specialized practice methodologies.

Critical knowledge to be imparted involves differences in symptom expression and symptomatic patterns of Latinos; differences in thresholds of distress; concepts and attribution of mental illness; acceptability and effectiveness of treatment modalities; culture-bound syndromes; use of qualified and certified interpreters; help seeking behaviors; the role of spirituality and faith; effects of organizational and related systems policies and reduction of systemic barriers to service; ways in which mainstream values may conflict with or accommodate the needs of Latino consumers.

Needed understanding includes historical factors which affect the mental health of Latinos; factors which define cultural differences; psychosocial stressors particular to Latinos (including but not limited to war, trauma, migration, acculturation, and socio-economic status); cultural variations among Latino sub-groups; traditional and indigenous healing practices as well as the role of religion in the treatment of Latinos; establishment of a community based system of mental health care.

Essential skills are, at a minimum, the ability to: conduct ethnographic interviews; ability to accurately diagnose and assign levels of care; formulate culturally competent treatment plans; engage and utilize family, other natural supports and other community resources; provide psychotherapeutic and psychopharmacological interventions which factor in biological and cultural responses; conduct research which contributes to the body of knowledge and capacity to serve Latinos; provide psycho-educational interventions; effectively use qualified and certified interpreters; assess the level of acculturation of the individual consumer; differentiate between symptoms of intrapsychic stress and stress which arises from the individual's environment; leverage resources on behalf of Latino consumers.

Needed attitudes are personal qualities which reflect genuineness, empathy, non-possessive warmth within a non-judgmental point of view; acceptance of ethnic and socio-economic differences; respect for the immigrant experience; the acceptance of alternate lifestyles; willingness to assist the consumer to acculturate rather than attempt to force the person to assimilate.

## Clinical Guidelines

## **1. Access and Service Authorization**

Access to services for Latino consumers should not be only individual oriented but should also include the family, both nuclear and extended within the broadest sense. Criteria for determination of levels of care should be multi-dimensional in four domains, psychiatric, medical, social function/behavioral and community support.

Assessments, assignment to various levels of care (particularly the more restrictive and involuntary placements), treatment planning and discharge determinations should be conducted by or in concurrence with a Latino Mental Health Specialist (LMHS). A LMHS is defined as a person who is a mental health professional and who is culturally competent.

Access points should be decentralized and facilitated through multiple outreach and case finding approaches. Legal documentation should not be a first requirement for service, and confidentiality requirements should be adapted to incorporate Latino cultural values, particularly inclusion of families and extended family networks.

## **2. Triage and Assessment**

Assessments should be based upon a multi-dimensional review of the consumer's functioning within his usual environment, physical health, psychiatric status and social and family supports. In addition, cultural and socio-economic stressors should be factored into the evaluation.

Cultural factors include but are not limited to age, gender, sexual orientation, relational roles, immigration and primary language. The assessment should identify the beliefs and practices, family organization, level of assimilation or acculturation, beliefs of the consumer related to health and mental health, and previous attempts at help-seeking. Clinical and functional assessment scales should be culturally based and validated for Latino populations.

LMHS should conduct or concur with triage and assessment processes, especially at the time of care decisions and prior to initiation of restrictive placements.

## **3. Care Planning**

Care plans for Latino consumers should be compatible with the conceptual framework and community environment of the individual to provide for maximum potential for success. Consumers and family members (with families defined in the broadest sense, not just from a legal viewpoint) should be partners in care planning. The goal of the plan should be functional adjustment as contrasted to assimilation into mainstream values and lifestyle.

Care planning, reviews, discharge determinations and other critical treatment decisions should be performed by or conducted in concurrence with a Latino Mental Health Specialist (LMHS). Care plans should incorporate consumer driven goals and objectives that are functionally defined and oriented toward rehabilitative outcomes. They should include family and cultural strengths, traditional healers, natural supports

and community organizations. Delivery of care should include consumer and family education about problems and conditions being addressed, respecting the consumer and family's own traditional viewpoints and coping mechanisms.

#### **4. Treatment Services**

Services available to Latino consumers should be comparable to those provided to others and should include a full array of available treatment modalities that have been tailored to be culturally acceptable and effective. Latino consumers and families should be well informed about available treatment choices, over which they should have the final decision.

Treatment should be consumer driven and performed by culturally competent, clinically qualified staff (LMHS) or under their supervision. Assignment of provider clinicians and other service delivery staff should be based on a match between clinical skills and the consumer and family clinical, cultural and linguistic needs. Treatment services should recognize, legitimize and compensate the utilization of Latino traditional healers and therapies. Treatment services should also promote early intervention and prevention.

Psychotherapeutic interventions should be goal oriented, proactive and family oriented. They should address issues particular to Latinos such as acculturation, inter-generational conflicts and gender role distinctions. Psychopharmacological interventions should be conducted by psychiatrists, nurse practitioners and physician assistants trained in culturally and ethnically based biological variables and differential medication response.

The optimal utilization of the Latino clinical workforce includes affording those clinicians a variety of clinical experiences, including services to consumers other than Latinos. The workload of LMHS and other Latino staff should be structured to meet the needs of Latino consumers while maintaining comparability of overall workload to other clinical providers. Staff should be compensated for their specialized skills, which include clinical specialization and linguistic abilities.

#### **5. Case Management**

Case management should be central to the implementation inter-disciplinary treatment services. Case managers for Latinos require special linguistic and clinical skills in accessing of community based systems and supports. Case management should be consumer and family driven. The case manager should serve as a single point of contact in order to facilitate access to the care system, the community and other sources of support.

Case managers serving Latino consumers and families should be able to demonstrate their level of cultural competence as part of the privileging and credentialing process.

Latino Mental Health Specialists should supervise them. Practice privileges should be afforded across the entire system of care, including settings such as inpatient facilities.

## **6. Linguistic Support**

Linguistic support should be provided at the option of consumers and families at no cost to them. It should be available at the point of entry (crisis, intake or other) and throughout the course of services. Bilingual and bicultural staff should be certified for their level of communication responsibility. Interpreters, who should also be certified, should be utilized only in the absence of qualified clinical staff.

Use of family members as interpreters, especially children, should be strictly prohibited. Monolingual Spanish speaking or limited English speaking consumers should only be placed in restricted or residential settings that have the capacity communicate with them effectively.

State and court certification standards and testing methodologies should be used to certify clinical staff and interpreters. Use of tertiary telephonic interpreters should be discouraged or used only in emergencies due to lack of mental health training by those interpreters. Interpreters who work with Latino consumers and families should be trained in mental health basic principles and interpretation techniques specific to Latinos. English monolingual clinicians who work through interpreters should first be trained how to work them. Latino Mental Health Specialists should supervise those clinicians.