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Mental Health Service Disparities in the Latino Population: An Exploration of Consequences,

Promising Practices, and Opportunities for Improved Access in Oregon

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## **Background**

This is a challenging time for the nation, as increasing violence and acts of racism are targeting minority populations. Combined with a national political climate of increased immigration policy enforcement and a shift away from equity and inclusion, Latino community members face an uncertain environment. Undocumented Latinos are threatened by deportation and separation from family while documented residents and citizens endure racial slurs and discriminatory remarks from the President of the United States (U.S.) (Feuer, 2018). Fear, isolation, and discrimination are real mental health threats facing Latino families and communities nation-wide, regardless of legal status. Distrust and uncertainty of policy and national reception elevate the need for quality mental health services for U.S. Latinos.

Despite this elevated need, the Latino community as a whole underutilize mental health services compared to non-Latino whites (Cabassa, Zayas & Hansen, 2006; Le Cook, Barry & Busch, 2013; Lee, Matejkowski & Han, 2017). Rural Latinos are especially vulnerable, as access to services are sparse and awareness of available services is limited. Latino youth are also of special concern, as behavioral and emotional disorders that develop in childhood have lasting effects into adulthood. Adverse Childhood Experiences – such as toxic stress due to poverty or discrimination – dramatically increase the likelihood of developing a diagnosable mental illness or substance abuse disorder (Oregon Health Authority [OHA], 2014). Latinos make up 16 % of the U.S. population and are predicted to account for 30 % of the U.S. population by 2050; they were the fastest growing ethnic minority group in the U.S. until 2010 (Brown, 2014; Lopez, 2002) and will continue rapid growth with their large youth population. Failure to address inadequate access to mental health services will ultimately generate serious economic and social costs to society.

This paper will explore disparities facing the Latino population in mental health service access as well as the consequences of these disparities. Effective models and promising practices to address these service gaps will be presented, followed by strategies for implementation within the healthcare landscape in Oregon. Ultimately, it is the responsibility of researchers, public health professionals and policy makers to identify and implement effective models to reduce mental health service disparities in this vulnerable population.

### **Mental Health Service Disparities Facing U.S. Latinos**

It is well-documented that the Latinos in the U.S. access mental health services at a disproportionately low rate compared with non-Latino whites with similar mental health conditions (Cabassa et al, 2006; Le Cook et al, 2013; Lee et al, 2017). Latinos with private health insurance are less likely to seek outpatient mental health services than their non-Latino white counterparts, and Latinos are less responsive to private insurance than public insurance: a finding not observed in the non-Latino white population (Thomas & Snowden, 2001). Factors that have been shown to negatively correlate with use of mental health services include: low acculturation/foreign-born, uncertainty of where to seek services, economic strain, and size of social support network (Cabassa et al, 2006). A positive association was found between living in an urban location and use of mental health services (Albizu-Garcia et al., 2001) while rural living was found to be positively associated with seeking mental health care from general medical providers (Vega et al., 1999). A myriad of structural, economic, and sociocultural factors exist which can create barriers or facilitators for adequate mental health service access for the U.S. Latino population. These factors and relationships are illustrated in the concept map in Figure 1. Some barriers include stigma seeking services, feelings of self-reliance, cost, availability and

access of mental health specialists, and comfort level with the provider (i.e. provider's cultural responsiveness with respect to language and culture). These factors should be considered when planning strategies and interventions to improve mental health care for Latinos. As the Latino population in the U.S. and Oregon is diverse and barriers to care multiple, a one-size fits all approach will not apply. A multi-faceted approach to increase service access and quality will be needed.

### **Mental Health Disparities - Rural Latinos**

While policy initiatives in Oregon are making great gains in expanding health insurance access,<sup>1</sup> there are still structural and legal barriers to accessing health insurance for the Latino population. Before Cover All Kids was passed, the American Community Survey estimated over a quarter of the Oregon Latino population were uninsured, compared to 13 percent of the white population in Oregon (The Oregon Community Foundation, 2016). According to a report by the Oregon Health Equity Alliance (2016), Latinos in Oregon are more likely than non-Latino whites to report poor mental health statuses. Barriers are exacerbated in rural regions, as healthcare availability and access present increased challenges than providing services in urban areas. Travel time to providers is often greater, and specialty providers are scarce. When there are available resources, services that are culturally and linguistically appropriate for both immigrant and non-immigrant Latinos are virtually nonexistent. Furthermore, awareness of the available limited resources is inadequate. In a study by Garcia, Gilchrist, Vazquez, Leite and Raymond (2011) investigating the knowledge of mental health resources, symptoms, health-seeking, and cultural beliefs in rural and urban Latino populations, there is a noted disparity for rural

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<sup>1</sup> Cover All Kids was passed in 2017, mandating health insurance for all children in Oregon, despite legal status (Oregon Latino Health Coalition, 2017).

respondents on knowing where to take an adolescent for mental health care. Only 3% of respondents felt they knew where to take an adolescent for mental health services as opposed to 18% of urban respondents. While responses from rural Latinos indicated a willingness to seek care, the barrier was knowledge of available resources.

Over 16% of Oregon Latinos, totaling 86,000 people, live in rural counties (Robert Wood Johnson Foundation [RWJF], 2018a), using the Metropolitan Statistical Area (MSA) definition of rural.<sup>2</sup> The rural counties with the highest percentage of Latino population include: Morrow (36%), Malheur (33%), Hood River (31%), Umatilla (26%) and Jefferson (20%). Of both urban and rural Oregon counties with the highest concentration of Latinos, 4 of the top 5 are rural counties; the urban county Marion, at 26% Latino, ranks 4<sup>th</sup>, with a slightly greater percentage than Umatilla county (RWJF, 2018a). There are stark differences in the availability of mental health providers in rural Oregon compared with urban Oregon, as shown in Table 1. When totaling the number of mental health providers – social workers, psychiatric nurse practitioners, psychiatrists, psychologists, family counselors – and comparing to the total population, urban counties have a 541:1 ratio of individuals per mental health provider, while the ratio for rural counties is 1,184:1 (E. Quan, personal communication, July 27, 2018; RWJF, 2018a). This represents the number of individuals served by 1 mental health provider in a county, if the population were equally distributed across providers. In Morrow county, the county in Oregon with the highest percentage of Latinos, there are two total mental health providers, giving a dramatic ratio of 4,899:1, or 4,899 individuals served by 1 mental health provider. As a point of

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<sup>2</sup> Metropolitan Statistical Area (MSA) is a county with at least one Census Bureau-defined Urbanized Area (UA) of 50,000 or more population. Any county that is not a MSA is defined as rural (Oregon Office of Rural Health [OORH], 2018a).

comparison, Marion county – the Oregon urban county with the highest percentage of Latinos, that ratio is 708:1 (E. Quan, personal communication, July 27, 2018; RWJF, 2018a). There exists a staggering disparity in access to mental health providers in rural Latino populations.

### **Disparities in Latino Youth**

Latino youth in Oregon are an important presence, comprising nearly 1 in 4 students enrolled in the Oregon public school system (Oregon Department of Education, 2018). Compared to the total percentage of Latinos in Oregon, at under 13% (RWJF, 2018a), the Latino population is poised to increase rapidly. Research has shown that Latino youth experience significant health disparities surrounding mental health ailments and service access. Nationally, 35% of Latino/a adolescents reported experiencing symptoms of depression in 2015, compared to 28% of non-Latino whites (McCord, Draucker & Bigatti, 2018). This information comes from the Youth Risk Behavior Survey, which measures feelings of sadness or hopelessness within the past 2 weeks which result in stopping their normal activities. One integrative literature review examining 33 studies found that Latino/a adolescents experience depressive symptoms at a higher level than their non-Latino white peers (McCord et al, 2018). Triggers strongly associated with these depressive symptoms include discrimination, family culture conflict and acculturative and bicultural stressors. Intragroup rejection, immigration stress and context of reception were also shown to be associated with depressive symptoms (McCord et al, 2018).

Another significant finding surrounds the entry point of mental health services for Latino youth experiencing a mental health crisis. In one study examining Medicaid mental health claims data of over 20,000 youth ages 17 and younger, non-Latino whites were significantly more likely to have received mental health care three months prior to an ED crisis visit. This disparity was

not found in youth in foster care (Snowden, Masland, Fawley & Wallace, 2009). A study by Alexandre, Martins & Richards (2009) examined data from the 2005 National Survey on Drug Use and Health, which explored receipt of adequate mental health services one year prior to a major depressive episode. Self-reported survey results showed the odds of receiving adequate care for non-Latino white youth were 1.55 times that of Latino youth, while enrollment in Medicaid or the states Children Health Insurance Plan increasing likelihood of adequate care for both demographic groups. In an additional study examining self-reported service use for adolescents reporting recent suicidal thoughts, Latino adolescents were half as likely as non-Latino whites to report utilization of mental health services (Freedenthal, 2007). These studies indicate that opportunities for treatment in the early stages of mental health conditions are not being addressed in Latino youth.

### **Experiences and Consequences of Mental Health Disparities**

Without proper coping strategies, cultural stress<sup>3</sup> can have serious negative consequences on Latino families. Cultural stress is positively associated with depressive symptoms in both Latino adult and adolescent immigrant and non-immigrant populations (Cano et al, 2015; Lorenzo-Blanco et al, 2017). Depressive symptoms in parents in turn have negative consequences in children; they are predictors of parent and youth reported lower levels of family functioning and youth self-esteem. In addition, cultural stress and depressive symptoms in the Latino immigrant adolescent population is positively associated with destructive health behaviors like smoking, drinking, and poor conduct (Cano et al, 2015; Lorenz-Blanco et al, 2015).

According to a study by Kaiser Permanente and the Centers for Disease Control and Prevention

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<sup>3</sup> A term encompassing bicultural stress, negative perception of reception, and ethnic discrimination (Cano et al, 2015).

(CDC), strong associations exist between exposure to early childhood trauma and negative health behaviors and outcomes later in life, such as depression and suicide (OHA, 2014). It is imperative to intervene early and effectively in symptoms of poor mental health to prevent potentially devastating health consequences.

As depression and behavioral issues progress, adolescents may face serious risks and consequences in the academic realm. Disciplinary action for poor conduct combined with substance abuse puts youth at higher risk for poor academic performance and incompleteness of high school. Disconnected youth<sup>4</sup> are at increased risk of violence, marijuana use, and emotional and cognitive deficits. Furthermore, incomplete educational status and unemployment have been linked to poor physical health, anxiety and depression (RWJF, 2018b). With the known access disparities for Latinos in mental health, especially in rural populations, this cycle of poor academic achievement and poor health is perpetuated.

### **A National Review: Effective Models and Promising Practices**

This section will explore integrated primary and behavioral health and telemental health services as effective models and promising practices to address increased access to quality care.

#### **Integrated Primary Care and Behavioral Health**

The integration of behavioral health with primary care is a team-based care model that co-locates behavioral health clinicians within a primary care setting (see Figure 2 for definitions of related terms used in primary care and behavioral health integration). There is growing evidence that this model improves access to care, quality, and reduces costs (Cohen, Reece &

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<sup>4</sup> Teens and young adults ages 16-24 who are neither working nor in school (RWJF, 2018b)

Schwarz, 2017; Pomerantz, Cole, Watts & Weeks, 2008). Behavioral health is a broader term than mental health and encompasses conditions such as substance abuse, mental health, health behaviors, and life crises and stressors (Peek & The National Integration Academy Council, 2013). Many patients have established, trusting relationships with their primary care provider, but time constraints often prevent primary care clinicians from fully addressing behavioral and mental health issues. If referrals are placed, there are issues of access, fear, and stigma to overcome for patients to present to the specialist. It is also known that Latinos who do receive mental health treatment often discontinue anti-depressant medication at a higher rate than non-Latino whites (Interian, Ang, Gara, Rodriguez & Vega, 2011; Sanchez, Ybarra, Chapa & Martinez, 2016). By enabling a warm hand-off to a dedicated behavioral health clinician, the immediate access, provided in a trusted environment, facilitates care and treatment. Another element of integrated primary and behavioral health is involving patients in treatment decisions and plans. Research shows that compliance to treatment plans increase when patients are involved in decision making (Lindhiem, Bennett, Trentacosta & McLearn, 2014). A holistic, patient-centered approach to behavioral and mental health care is a step to addressing access issues, with promise for improved patient outcomes.

While insufficient studies demonstrate the effectiveness of integrated care to reduce mental health disparities for racial and ethnic minority populations, there is promise in this model. A need for culturally and linguistically responsive healthcare providers, and a diverse workforce, are consistently reported as best practices to improving care for ethnic and racial minority populations. Having a healthcare provider that does not speak the patient's primary language is directly associated with poor outcomes of chronic disease, health disparities, patient dissatisfaction with care, lack of understanding of their medical conditions, and subpar patient

education (Sanchez et al, 2016). When treating mental health conditions, mutual understanding and trust is of primary importance. Unfortunately, achieving a properly trained and diverse workforce presents great short-term challenges, especially in rural areas. At a minimum, provider trainings in culturally responsive care should be mandated, ideally connected with the ability to claim Continuing Medical Education (CME) credits. There has been some success with J1 Visa programs, where international graduates complete residency in the U.S. and subsequently serve in healthcare shortage areas, but they stay for limited durations, and a good fit is often difficult to achieve in rural areas (RWJF, 2018c). As trust and relationships are established facilitators to effective care, this may not be an optimal solution. Plus, 80% of the 35 waivers granted in Oregon are reserved for primary care physicians by Oregon law (Stock, Coulter-Thompson, Johnson & Saulino, 2017). While this could bolster Spanish-speaking primary care physicians in rural settings, it would limit the utilization of the waiver program for practitioners specializing in mental health.

One innovative model that demonstrated success for Ell and colleagues involved treating Latino patients concurrently for diabetes and depression (Ell et al, 2010). This randomized control trial found significantly higher rates of antidepressant medication compliance, patient satisfaction with depression care, and outcomes of depression screenings. The intervention treatment utilized an integrated care model while maximizing cultural and linguistic best practices. Problem-solving therapy (PST) was offered by “bilingual graduate social work diabetes depression clinical specialists (DDCS)” (Ell et al, 2010, p. 707) in conjunction with medication treatment, if desired. The DDCS provided monthly monitoring by telephone as a method of relapse prevention, and system navigation was provided jointly by the DDCS and a patient navigator. The intervention was modeled to incorporate patient preferences, family

participation as desired, and patient education to dispel misconceptions surrounding treatment. The counseling also served to build trust and reduce stigmas associated with mental health care treatment. While all regions may not be able to utilize bilingual case managers, this model shows promising best practices and innovation in combining mental health treatment with a disease highly prevalent in the Latino population. Integrating primary and behavioral health care is a model that should not be overlooked to increase access and quality of mental health care for Latinos.

### **Telemental Health Services**

Telemental health services are mental health care visits conducted via telephone or videoconference, typically utilized as a strategy to increase access to care for rural communities that experience a shortage of qualified mental health care specialists. Services vary by program and region, but can include counseling, psychotherapy, and cognitive behavioral therapy. Often, community organizations, hospitals, or clinics will house the telemedicine equipment and provide the capacity to connect patients with real time visits with psychiatrists, psychiatric nurse practitioners, psychologists and clinical social workers (RWJF, 2018d). Three examples of effective telemental health services, detailed below, offer strategies utilizing community organizations/primary care clinics, school-based health centers, and emergency department settings.

#### **The University of Virginia Health System in Charlottesville**

The University of Virginia (UVA) Health System in Charlottesville partners with community mental health organizations and primary care clinics to provide mental health services by videoconferencing to primarily low-income adults and children in rural Virginia. The program's

innovative model utilizes psychiatric residents and fellows at the Charlottesville based UVA School of Medicine who provide care under the supervision of a faculty psychiatrist. The aim is to keep resident assignments consistent across clinics to foster trusting relationships with patients. The fellows and residents act as care consultants and fax treatment recommendations to the patient's PCP. This program is effective in reducing barriers to service access by providing visits to patients who most likely would not have received care. Between 2003-2012, nearly 13,000 adults and children benefited from this telemental health service (Agency for Healthcare Research and Quality [AHRQ], 2014c). Furthermore, patients report high satisfaction levels with the services offered, with a high percentage of parents strongly agreeing with the following statements:

‘my child was comfortable with the videoconferencing format;’ ‘I am pleased with the care my child received;’ ‘using the telemedicine facility saved me time and/or money versus driving to a more distant in person visit.’ (AHRQ, 2014c)

Telemental services utilizing psychiatric residents in urban settings demonstrates an innovative and efficient use of resources with promising patient reported outcomes.

### **The University of Texas Medical Branch**

With the dual objectives to overcome barriers to timely mental health care, including “poverty, social stigma, and transportation difficulties,” (AHRQ, 2014a) – and improve student behavior and mental health outcomes, The University of Texas (UT) Medical Branch implemented videoconferencing capabilities and case management in the Galveston Independent School District School-Based Health Centers (SBHCs). This program serves primarily low-income and minority populations, with a 35% Latino student population. Referrals for the program come from various sources, including schools and community-based organizations.

Social workers act as case workers, and UT Medical branch child and adolescent psychologists and psychiatrists provide the consults. Counseling services range from treatment for anxiety, eating and conduct disorders to family and academic counseling. A web component provides online resources for students and their families, and students can access a case worker 24 hours a day via a telephone hotline. Preliminary data suggest the program is effective in increasing the number of minority students accessing mental health services, as most new patients report not having received mental health services in the previous year (AHRQ, 2014a). Combining telemental health services with SBHCs is one innovative strategy to increase access for racial and ethnic minority youth populations.

#### **South Carolina Department of Mental Health - University of South Carolina School of Medicine**

This unique program partners the public South Carolina (SC) Department of Mental Health with the private, academic institution, the University of South Carolina (USC) School of Medicine to offer telepsychiatry to 18 rural hospitals throughout South Carolina. This partnership focuses on reducing Emergency Department (ED) wait times and inpatient admissions, as cost savings and patient satisfaction initiatives. Often, rural emergency departments do not have a psychiatrist on staff to stabilize and treat someone in a mental health crisis. Consequently, hospital admission is often a result as waiting for a consult can take days. State employed psychiatrists cover a 7 day/week, 16-hour available time frame. Teleconsults occur on average 12 times a day in this program, for reasons including psychoses, drug-related mental health problems, and mood disorders (AHRQ, 2014b). The ED physician shares medical records via the Electronic Health Record (EHR), and the psychiatrist provides treatment recommendations, referral recommendations and a follow-up plan via videoconferencing with

the ED care team. Impacts of this program include a dramatic decrease of ED wait times for mental health problems by 50% over 3 years; a rate of hospitalization for mental health issues half of that of similar SC EDs not offering this program (11% vs 22%); increased compliance of follow-up within 30 days (from 16% to 46%); and high satisfaction rates among patients and ED providers alike (80%, 84%) (AHRQ, 2014b).

Telemental health services present effective solutions to problems of mental health care access. Promising practices have been seen in primary care and community settings, school settings, and hospital emergency departments. Combined with the appropriate partners, technology, funding, and policy support, telemental health services could offer added support to rural communities with shortages in mental healthcare professionals.

## **Opportunities and Strategies for Local Implementation (Oregon)**

### **Integrated Primary Care and Behavioral Health**

Oregon is well poised to strengthen known, effective models in integrated primary and behavioral health care. In 2011, the first Patient-Centered Primary Care Home (PCPCH) was recognized, and by 2016, the program expanded to include more than 600 clinics adhering to this new model of primary care, providing care for 75% of Oregonians (Smith & Merrithew, 2017). A variation of the Patient-Centered Medical Home (PCMH) (see Figure 2), the PCPCH is a five-tiered model, aligning efforts around six attributes: 1) Access 2) Accountability 3) Comprehensive, Whole-person care 4) Continuity 5) Coordination and integration 6) Person and family-centered care (Smith & Merrithew, 2017). Any type of clinic, primary care or otherwise, can apply and be registered as a PCPCH, which allows their formation in behavioral health clinics, where patients diagnosed with severe and persistent mental illness may have existing

strong, established relationships. According to Smith and Merrithew (2017), refinements made to the program in 2017 will focus on more robust integration of behavioral health services in primary care.

### **School-based Health Centers**

Oregon also boasts a robust School Based Health Center (SBHC) program. Initiated in 1986, 78 SBHCs now operate in twenty-five rural and urban counties throughout Oregon. (OHA, 2018a). This care model also integrates physical and behavioral health, with a holistic vision of preventive, physical and mental health services. Nearly half of Oregon SBHCs are certified as PCPCHs and over three-quarters are Federally Qualified Health Centers (FQHCs) (OHA, 2018b). SBHCs have been shown effective in reducing barriers to care, such as access, transportation, stigma, and ability to pay for services for families of low socio-economic status and are promising models for reduction of access disparities for minority populations (Guo, Wade & Keller, 2008; Guo, Wade, Pan & Keller, 2010). According to the 2018 status report, nearly 60% of youth utilizing SBHCs in Oregon identified their school health clinic as their primary source of mental health, and all SBHCs have a licensed mental health clinician on staff (OHA, 2018b). To address disparities facing Latino youth, increased efforts to expand the SBHC model while incorporating culturally and linguistically appropriate care is recommended.

### **Telehealth Services**

Oregon Senate Bill (SB) 144, passed in 2015, allows for health service providers licensed in Oregon to provide telemedical services (OORH, 2018b). While private payers are not required to reimburse providers if the services are not covered by the patient's health plan, there is a

comprehensive list of scenarios requiring this coverage by health plans. Mandated reimbursement is for two-way, live videoconferencing only. Both Medicaid and Medicare offer reimbursement for telemedicine initiatives, with Medicare only reimbursing if the patients receiving treatment live in a Health Professional Shortage Area (HPSA) or outside a MSA (OORH, 2018b). Telehealth partnerships between health systems and community-based organizations could enhance health service access in rural areas.

### **Culturally and Linguistically Appropriate Care**

With these existing models in place, there is opportunity to integrate promising practices in culturally and linguistically responsive care. There is already legislation supporting these priorities in Oregon – House Bill (HB) 3100, cultural competence continuing education legislation – passed in 2012 (Tillman, 2017). This legislation is an addition to HB 3650, the bill resulting in Oregon’s Health Systems transformation. It outlines several policy priorities advocated for by community leaders on a local and national level, including the following: “culturally appropriate health care delivery;” “culturally relevant community-based care settings;” “culturally appropriate care and service delivery;” “culturally diverse workforce;” “community health workers;” “focus on eliminating differences in health outcomes between racial and ethnic groups;” “culturally and linguistically appropriate health care.” (Tillman, 2017, p. 162- 164). While the intention is clear, Tillman identifies a lack of financial incentives tied to health equity measures for Oregon’s Coordinated Care Organizations (CCOs) and health care practices as the reason for limited progress and movement in this area.

To develop improvements in culturally appropriate care, a long-term plan is needed to build increased diversity in the mental health workforce in Oregon. Pipelines for racial and

ethnic minority students, including increased scholarship programs to access masters level education, should be considered. While not a perfect model, increased J1 visas for Spanish-speaking mental health clinicians could be a short-term fix for rural areas in dire need of service access. Financial incentives for CCOs and health systems should also be explored to create a sense of urgency to address this public health crisis.

### **Conclusion**

Latinos across the nation and in Oregon experience inequity in access to mental health services. These disparities cause serious consequences to the health of individuals, families and society. Effective models and promising practices exist to address disparities in mental health access for Latinos and other vulnerable populations, including integrated primary care and behavioral health and telemental health services. The development of a linguistically and culturally diverse workforce will be critical in improving quality of care and patient satisfaction in mental health. Combined with Oregon's existing framework for integrated behavioral health within primary care and school-based health centers, there is great promise to improve access and quality of mental health services for Latinos in Oregon. Community and health service organizations in Oregon are increasingly incorporating health equity into their strategic plans. Strategic partnerships and creative interventions have the potential to create a lasting impact for Latino communities, both rural and urban, with limited access to mental health specialty care.

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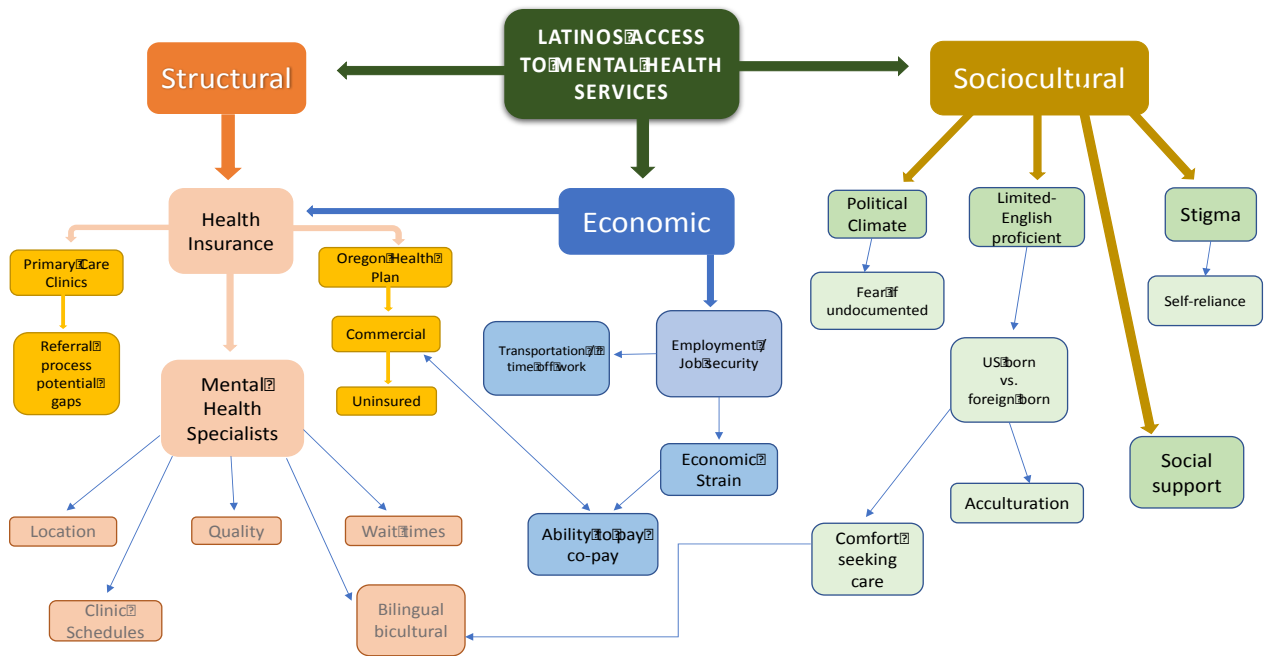
**Table 1.** Distribution of Mental Health Provider Types – Urban vs. Rural

## Types and Numbers of Mental Health Providers – Urban vs Rural (2017)

|              | <b>Social Workers</b> | <b>NP Psychs</b> | <b>Psychiatrists</b> | <b>Psychologists</b> | <b>Family Counselors</b> | <b>Total MH Providers</b> |
|--------------|-----------------------|------------------|----------------------|----------------------|--------------------------|---------------------------|
| Urban Total  | 2,888                 | 233              | 322                  | 1,555                | 1,345                    | 6,344                     |
| Rural Total  | 317                   | 39               | 26                   | 54                   | 123                      | 560                       |
| Urban Median | 155                   | 11               | 11                   | 54                   | 80                       | 327                       |
| Rural Median | 8                     | 1                | 0                    | 1                    | 2                        | 4                         |

compiled from data provided by: (E. Quan, personal communication, July 27, 2018)

**Figure 1.** Concept map showing the structural, economic, and sociocultural factors influencing access to mental health services for the Latino population



(Hernandez, E., 2017)

**Figure 2: A Family Tree of Related Terms Used in Behavioral Health and Primary Care**

## Integration

**Illustration: A family tree of related terms used in behavioral health and primary care integration**

See glossary for details and additional definitions

### Integrated Care

Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. "Altitudes" of integration: 1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

### Patient-Centered Care

"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"—or "nothing about me without me" (Berwick, 2011).

### Coordinated Care

The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care" (AHRQ, 2007).

### Shared Care

Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

### Collaborative Care

A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

### Co-located Care

BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

### Integrated Primary Care or Primary Care Behavioral Health

Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

### Behavioral Health Care

An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

### Patient-Centered Medical Home

An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

### Mental Health Care

Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

### Substance Abuse Care

Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

### Primary Care

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

(Peek, C.J. & the National Integration Academy Council, 2013)