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Utilization of Behavioral Health Services Among the Latino Population

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Among the Latino Population

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Abstract

Limited research exists examining the effectiveness of an integrated primary care model of behavioral health service delivery among the Latino population. This descriptive pilot study addresses this gap in the literature by exploring the mechanisms that influence whether Latino integrated primary care patients who receive a Warm Hand-Off (WHO) will or will not pursue further Behavioral Health Services (BHS). Participants were recruited from Clinica Tepeyac, an integrated primary care clinic located in Denver, Colorado. Results showed that the majority of participants engaged in BHS at the suggestion of their medical provider, as opposed to initiating BHS involvement by their own accord. Additionally, participants overwhelmingly indicated that having a behavioral health provider (BHP) that was Latino/a was *somewhat important* to *very important*. Future research should focus on more rigorous approaches to exploring ways to facilitate transition from WHOs to further BHS participation for patients that identify as Latino within an integrated primary care setting.

Literature Review

Introduction to the Latino Population

The Latino population in the United States represents individuals that have ancestry in Mexico, Puerto Rico, the Dominican Republic, Cuba, and various countries located in Central and South America. Latino individuals share important commonalities including the Spanish language, music, food, and cultural values, while retaining differences based on country or region. Additionally, the Surgeon General's Report and its Supplement "Mental Health: Culture, Race and Ethnicity" (2001) emphasize the varied experiences Latinos have when it comes to their migration, stating, "To understand their mental health needs, it is important to examine both the shared and unique experiences of different groups of Hispanic Americans" (p. 1).

Mexican-origin Latinos have consistently accounted for the largest Latino-origin group in the United States. However, it is worthy to note that between 1930 and 1980, Latinos from places other than Mexico almost doubled their representation among U.S. Latinos, from 22.4% to 40.6% (Pew Research Center, 2015). According to the 2000 U.S. Census, nearly two-thirds of Latinos were born in the United States. In turn, this large growth has implications for future research focused on the Latino population's utilization of mental health services, particularly around migration experiences and U.S. residency status. Latinos are estimated to comprise 12 percent of the U.S. Population, but represent almost one out of every four uninsured Americans (Brown et al., 2000; Kaiser Commission, 2000).

Mental Health Disparities and Barriers Among Latinos

Research has consistently indicated that Latinos experience disparities in mental health care utilization and quality of care (US Department of Health & Human Services, 2001; Young, Klap, Sherbourne, & Wells, 2011). Alegria et al. (2007) found that the lifetime prevalence of psychiatric disorder among Latinos living in the United States is 28.1% for males and 30.2% for females. Additionally, Latinos who are born in the United States, are proficient in English, or are third-generation are more likely to experience a psychiatric disorder. According to the 2010 National Health Care Disparities Report, non-Latino Whites were twice as likely to receive mental health treatment as Latinos (U.S. Department of Health and Human Services, Agency for Health Care Research & Quality, 2011). Pincay and Guarnaccia (2007) found that Latinos identify various barriers to mental health services for depression including lack of insurance, cost of treatment and medications, lack of Spanish-speaking staff, and worry around immigration status. This highlights the importance of providing culturally sensitive interventions and access to care that can address these specific barriers to service utilization. The Surgeon General's Report (2001) indicates that, "Historical and sociocultural factors suggest that, as a group, Latinos are in great need of mental health services. Latinos, on average, have relatively low educational and economic status" (p. 5).

Bridges et al. (2017) explored structural and attitudinal barriers that affect an individual's decisions and abilities to seek mental health services. Bridges et al. (2014) collected data from 793 participants seen for behavioral health services in 2 primary care clinics. They found that Latino patients had significantly lower self-reported psychiatric distress, significantly higher clinician-assigned global assessments of functioning scores, and fewer received a psychiatric diagnosis at initial visit compared to non-Latino White

patients. However, they found that both groups had comparable utilization rates along with comparable and clinically significant symptom improvement and high satisfaction with behavioral health services. Bridges et al. (2007) view their results as preliminary evidence that integrating behavioral health services in primary care may help reduce mental health disparities for Latinos.

Willerton, Dankoski, and Martir (2008) propose that an effective method of reaching and treating more Latinos is through medical family therapy. They point to the research indicating that Latinos are more likely to receive their first intervention for mental illness through a physician (Diaz-Martinez & Escobar, 2002). Additionally, Vega et al. (2001) found that immigrant and U.S.-born Mexican Americans disproportionately utilized general medical providers for the treatment of mental health concerns.

Guarnaccia, Martinez, and Acosta (2005) point out that Latinos are more likely to somaticize mental health issues than other ethnicities. They report that Latinos tend to have specific experiences that can result in issues of misdiagnosis by medical providers or behavioral health professionals. The cultural syndrome of *ataque de nervios* (panic) can include trembling, heart palpitations, numbness, loss of consciousness, and difficulty breathing; it is a dramatic expression of deep sadness and distress seen mainly among Caribbean Latinos. *Ataques* can be viewed as culturally normative ways to express deep sadness such as during a funeral. However, they can also signal the presence of an anxiety or depressive disorder (Romero, 2000; Guarnaccia et al., 2005).

Mental Health Stigma

Ortega and Alegria (2002) found a self-reliant attitude to be a barrier in seeking care among a Puerto Rican sample. Participants who felt they should be able to cope with

mental health problems by themselves were less likely to seek care, even when they reported symptoms that indicated the presence of mental illness. Guarnaccia et al. (2005) refer to this self-reliant attitude as *ponerse de su parte* (contributing one's part). They define this attitude as "the feeling that one should be strong enough to cope with life's problems on their own and with the help of family and not need to depend on the mental health system" (p. 37). This touches upon the concept of *familismo*, the idea that a Latino individual's social life is centered around family. This concept can be explored within the context of courtesy stigma, a term developed by Erving Goffman. Courtesy stigma refers to "stigma by association," where someone can be stigmatized for merely associating with an individual with a mental health concern (Goffman, 1963). Families, therefore, may be reluctant to encourage mental health treatment given that it may reflect poorly and lead to stigmatization and social isolation. Given the impact of immigration on one's support system, it is interesting to explore ways *familismo* can look differently among recently immigrated Latinos compared to Latinos that were born or grew up in the United States.

Corrigan (2004) tries to understand why people with mental health problems fail to engage in treatment. He proposes that stigma plays a large role in those individuals not seeking psychological help. Corrigan discusses two types of stigma: public stigma and self-stigma. Public stigma is society's perception that an individual is socially unacceptable, and typically leads to negative reactions toward that individual. Corrigan and Matthews (2003) propose that people hide psychological concerns and avoid treatment in order to limit harmful consequences connected with public stigma; this is called label avoidance. Corrigan (2004) defines self-stigma as the reduction of an

individual's self –esteem/self-worth due to the individual labeling himself or herself as someone that is socially unacceptable. Psychological and psychiatric services utilize diagnoses and labels that can be stigmatizing. Latino consumers of integrated primary care services can be further divided into the subgroup of those who utilize behavioral health services and those who not. It seems reasonable to wonder what intra-group stigmatization might take place among the different subgroups, based on overall public stigma connected to mental health.

Cheng, Kwan, and Seving (2012) investigated stigma associated with seeking psychological services by using a sample of African American, Asian American, and Latino American college students. They found, for all three groups, that higher levels of psychological distress and perceived racial/ethnic discrimination predicted higher levels of perceived stigmatization by others for seeking psychological help, which predicted higher self-stigma around seeking psychological help. Additionally, higher levels of other-group orientation (attitudes, feelings, and orientations toward other racial/ethnic groups) predicted lower levels of self-stigma for seeking psychological help. Finally, higher levels of ethnic identity predicted lower levels of self-stigma around seeking psychological help, but only for the African American students.

Nadeem et al. (2007) explored the relationship of stigma-related concerns around mental health care among low-income U.S.-born and immigrant Latina and black women compared with U.S.-born white women. Ethnic differences in stigma were most pronounced among women experiencing depression, of which black women (particularly immigrant black women) reported the most stigma concerns. Among women with depression, immigrant African women had more than three times higher odds of

reporting stigma concerns compared to U.S.-born white women; immigrant Caribbean women had over six times higher odds of reporting stigma concerns compared to U.S.-born white women. The study also found ethnic differences among women without depression. In the group without depression, the odds of reporting stigma concerns were 26% higher among immigrant Latinas, 39% higher among immigrant African women, and 45% higher among immigrant Caribbean women, when compared to U.S.-born white women. Nadeem et al. also found that, among the subsample with depression, immigrant black women, U.S.-born black women, and U.S.-born Latinas were all less likely than U.S.-born white women to want mental health care. It is interesting to note that immigrant Latinas were more likely than U.S.-born white women to want mental health care. Nadeem et al. pointed out that this was in contrast to what they expected to find, especially given that immigrant Latinas were among those most likely to report stigma concerns.

> Our clinical experience in providing depression to this population is that immigrant Latinas may feel that they are being respectful by accepting an offer for help from an interviewer, but they may later experience stigma or other barriers to care and not actually attend the offered treatment. (Nadeem et al., 2007, p. 1551)

Chang, Natsuaki, and Chen (2013) utilized data from the National Latino and Asian American Study to look at ethnic and generational differences in family cultural conflict and family cohesion and how the effects of such conflict and cohesion on lifetime mental health service use vary by generation status of Latino Americans and Asian Americans. The study found that, for Asian Americans, family cultural conflict,

but not family cohesion, was associated with mental health service use. Latino Americans who reported higher family cultural conflict and lower family cohesion were more likely to use mental health services. The study emphasizes the importance of future research in ascertaining the extent to which this tendency comes from greater reliance on family support as opposed to the stigma connected to mental health services.

Other Barriers to Service Utilization

Bridges, Andrews, and Deen (2012) explored mental health needs and service utilization patterns by using a convenience sample of Latino immigrants. They had a total of 84 adult Latino participants who completed a structured diagnostic interview and a semi-structured service utilization interview administered by trained bilingual research assistants. They found three common barriers to service utilization: cost (59%), lack of health insurance (35%), and language (31%). Additionally, participants who met criteria for at least one mental disorder were significantly more likely to have sought medical, but not psychiatric, services in the prior year and faced significantly more cost barriers than participants who did not meet criteria for at least one mental disorder. Bridges et al. stress the importance of making mental health services more affordable and linguistically accessible. Guarnaccia et al. (2005) point out the following:

> Latino clients who see Latino providers are more likely to return for follow-up visits, stay in care longer and are more satisfied with their care. Another critical factor in engagement is being able to communicate effectively with the client in his/her preferred language or combination of Spanish and English. (p. 38)

Williams and Kohut (1999) found that out of 596 licensed psychologists with active clinical practices and membership in the American Psychological Association, only 1

percent of the randomly selected sample identified as Latino, while 96 percent identified as White. The American Psychological Association - Center for Workforce Studies (2015) reported that Latino/a psychologists comprised 5 percent of the active psychology workforce between 2005 and 2013. This shows an increase from 1999, but still illustrates a substantial disparity compared to the percentage of White psychologists.

Racial/Ethnic Matching of Clients and Therapists

Coleman, Wampold, and Casali (1995) conducted a meta-analysis of 21 studies conducted between 1971 and 1992. Results indicated a strong preference for a therapist of one's own race/ethnicity and a small tendency to perceive therapists of one's own race/ethnicity as better than others. Maramba and Hall (2002) looked at 7 studies conducted between 1977 and 1999. They found virtually no effect between racial/ethnic matching and premature termination of clients, number of sessions attended, and client functioning level at termination. Shin et al. (2005) conducted a meta-anaylsis of 10 studies conducted between 1991 and 2001. They found minimal effects of racial/ethnic matching on dropout, sessions attended, and functioning level after treatment among African American clients.

Cabral and Smith (2011) conducted a meta-analysis of 3 variables that have been used frequently in research on racial/ethnic matching of clients and therapists: (1) an individual's preference for a therapist of his/her same race/ethnicity, (2) clients' perceptions of therapists across racial/ethnic match, and (3) therapeutic outcome across racial/ethnic match. From 52 studies of preferences, the researchers found a moderately strong preference for a therapist of one's own race/ethnicity. Looking at 81 studies of individuals' perceptions of therapists, the meta-analysis found a tendency to perceive

therapists of one's own race/ethnicity somewhat more positively than other therapists. From 53 studies of client outcomes in mental health treatment, there appeared to be almost no benefit to treatment outcomes from racial/ethnic matching of clients with therapists. Interestingly, studies involving African American participants showed the highest effect sizes across the three areas of interest: preferences, perceptions, and outcomes.

Taking these findings into account, it appears that clients show a preference for a same race/ethnicity therapist and believe that therapist might be better prepared than a distinct race/ethnicity therapist. However, it appears that outcomes are not significantly affected by whether a client worked with a same race/ethnicity therapist or not. In turn, race/ethnicity might be a more salient factor in the beginning of therapy when rapport is being built, as opposed to later on in the course of treatment.

Integration/Collaboration Models

Primary Care Behavioral Health (PCBH) is a model in which " behavioral health providers (BHPs) embedded in primary care deliver brief assessment and intervention for mental and behavioral health concerns to patients as well as provide consultation to primary care providers" (Beehler et al., 2017, p. 257). This model is considered a population-based model due to its focus on improving the overall health of a population by delivering less intensive services to almost all patients as opposed to delivering high-intensive services to only patients with the highest needs who are seeking care. Implementation of the PCBH model can vary significantly from setting to setting, which can affect how providers deliver services to patients, and may in turn affect patient

outcomes (Beehler et al., 2017). Sanchez, Ybarra, Chapa, and Martinez (2015) propose the following:

> To eliminate disparities in health care, it is essential to identify the critical components of successful integrated health care models for racial and ethnic minority groups and to focus on leveraging cultural protective factors, provider language fluency, and a trained workforce. (p.15)

Depending on the specific setting, Behavioral Health Providers (BHPs) initiate contact with patients and/or get referrals from Primary Care Providers (PCPSs). In "Warm Hand-Offs," Primary Care Providers ask for Behavioral Health to join them in the room during the patient's medical visit. This provides the PCP with an opportunity to introduce the BHP as part of the interdisciplinary team and emphasize that the goal is to address the patient in a holistic manner with respect to physical and emotional wellbeing. (Hunter & Goodie, 2010; Strosahl & Robinson, 2008). Kessler and Stafford (2008) are cognizant that there are many levels of integration, which can affect terminology, amount of communication between medical providers and BHPs, and the overall referral process for Behavioral Health. Blount (2003) finds that the terms "collaborative care" and "integrated care" are often used interchangeably, which can lead to much confusion around an agreed meaning or definition. Blount defines integrated care as care that involves one treatment plan with behavioral and medical elements, as opposed to two treatment plans; collaborative care and integrated care are described as "not mutually exclusive categories" (p. 123).

Berge et al. (2017) reports that there is a growing evidence base supporting the use of integrated BH care in primary care and family medicine. However, they highlight

the fact that there is still much to investigate regarding best practice when implementing integrated BH care. Sanchez et al. (2015) highlight the following:

> Meta-analyses, clinical trials, and case studies have provided conclusive evidence of the effectiveness of integrated care. However, it has been difficult to discern whether certain elements result in improved outcomes or whether an overall increased attention to mental health results in the improved outcome. (p. 13)

The data described above comes from 32 trials that explored the impact of integrating mental health providers into primary care settings. Twenty-five of these studies explored depression, and four studies addressed anxiety. The remaining studies were single studies for somatizing disorders, ADHD, and one study that addressed depression and alcohol-related disorders. These trials were reviewed for characteristics of provider integration, elements of the care process, and a descriptions of the care manager role to provide an overview of the usefulness of an integrated primary care model (Butler et al., 2008).

Sanchez et al. (2015) describe the lack of studies focusing on integrated primary care for racial and ethnic minority groups and for people with limited English proficiency. In turn, this leads one to wonder which aspects of integration are key mechanisms of change for the Latino population, which led to this pilot study's focus on Warm Hand-Offs.

Levels of Integration

In 2013, The Center for Integrated Care in connection with The Substance Abuse and Mental Health Services Administration (SAMSA) and Health Resources and Services Administration (HRSA) published a standard framework that outlined 6 levels of integrated care services (Heath, Wise-Romero, & Reynolds, 2013). These levels were

divided into the three main categories of coordinated care, co-located care, and integrated care, each one including two levels of care.

Level 1 *Minimal Collaboration* describes behavioral health and primary care providers working at different facilities and having separate systems, with very infrequent communication between providers. Level 2 *Basic Collaboration at a Distance* describes behavioral health and primary care providers being at separate facilities and having separate systems, but they have a small amount of collaboration and view each other as resources. Level 3 *Basic Collaboration Onsite* describes a situation where behavioral health and primary care providers are co-located in the same facility, but may or may not share the same space. Providers use separate systems, but have more regular communication due to working nearby one another. In Level 4 *Close Collaboration with Some System Integration*, there is closer collaboration among primary care and behavioral healthcare providers due to co-location in the same practice space, and there is the beginning of integration in care through some shared systems. Level 5 *Close Collaboration Approaching an Integrated Practice* describes high levels of collaboration and integration between behavioral and primary care providers. Providers begin to function as a true team, but some issues, such as the availability of an integrated medical record, may still not be solved. Level 6 *Full Collaboration in a Transformed/Merged Practice* is the highest level of integration and involves fuller collaboration between providers, where there is a single health system treating the whole person.

In the Primary Mental Health Care (PMHC) model (also known as the Primary Care Behavioral Health (PCBH) model), primary care physicians (PCPs) refer patients to behavioral health consultants (BHCs) so they can conduct assessment and provide

intervention with the goal of improving detection, diagnosis, and treatment of psychosocial health issues (Ray-Sannerud et al., 2012). The BHC provides recommendations and feedback to the PCP in order to improve the overall treatment plan for the patient.

> The PCBH model provides real-time access to care at the exact time the need is identified. This is the only model where one of the primary espoused goals is to transfer behavioral intervention skills to the PCP through repeated application of consultative interactions. (Ray-Sannerud et al., 2012, p. 310)

The PMHC Model relies on brief appointments (usually 15 to 30 minutes) that are time-limited in nature (occasionally only consisting of one or two appointments) (Ray-Sannerud et al., 2012). BHPs address a wide range of concerns that patients bring to the clinic, including those typically addressed by clinical health psychologists and behavioral medicine specialists (e.g., chronic pain, headache, health risk behavior, medical nonadherence, sleep disturbance, smoking cessation, weight management) (Hunter & Goodie, 2010). Mauksch and Peek (2017) ask what makes the PCBH model so appealing to many service providers and patients. They describe the benefits of the "warm handoff," where the PCP facilitates an introduction between the patient and the BHC to facilitate provision of BH services. This interaction results in: (1) the patient feeling immediately cared for, (2) the PCP feels supported and given an opportunity to learn, (3) the BHC feels appreciations from all parties involved, which leads to a sense of contribution and value, and (4) the three-way meeting can quickly generate a team mentality that results in improving the commitment to care for the patient.

Methods

Participants

Participants were recruited from Clinica Tepeyac, a Federally Qualified Health Center (FQHC) located in Denver, Colorado, which serves a large Latino population. The sample was recruited through voluntary email collection, flyers in English and Spanish, and word of mouth. Participants included patients who met the following requirements: (1) they were at least 18 years of age and (2) they had experienced at least one interaction with Behavioral Health Services (BHS) at Clinica Tepeyac. This interaction could include warm hand-offs, brief visits (30 minutes), individual, couples, or family therapy (each 50 minutes). Flyers were posted in the clinic waiting room, bathrooms, and exam rooms to promote participation. Additionally, a secured drop-off box was located in the waiting room, where participants could drop off their email address if they wanted to be emailed a link to the survey.

Procedures

The study recruitment flyer prompted individuals who met criteria for participation to go to the Qualtrics platform link that automatically brought up the online survey; Qualtrics is a research platform utilized by the University of Denver and other business and educational entities. Of note, there was no official method to screen out individuals who did not meet criteria, as everything was done through self-report. The beginning of the survey provided participants with a quick overview of the survey, as well as collected their consent to participate before they proceeded with the body of the survey. The first question provided participants with the ability to choose whether they wanted to take the English or Spanish version of the survey. To promote recruitment,

participants were entered into a raffle where five individuals were selected to receive one of 5 $50 Amazon gift cards. There was no other compensation provided for participation.

Measures

Participants were asked 20 questions (developed by this investigator and doctoral paper chair, Dr. Judith Fox, and included as Appendix A) that addressed their experience receiving behavioral health services at Clinica Tepeyac; questions asked, among other things, demographic information, number of interactions with Behavioral Health, what barriers made it difficult to continue engagement with BH, and how they initially made contact with Behavioral Health. All questions were based on self-report; some questions were open-ended, while others prompted participants to choose one or more of the available answers.

In addition to the first 20 questions, participants were asked to complete the 27-item questionnaire developed by Dr. Patrick Corrigan (AQ-27) and translated and validated in Spanish (AQ-27-E) by Dr. Manuel Munoz, in their preferred language. The AQ-27 and AQ-27-E provide a brief vignette around Harry, a man with schizophrenia. The attribution questionnaires were developed to address nine stereotypes about people with mental illness. They include three test items that are summed for each of the nine stereotypes:

1. Blame: people have control over and are responsible for their mental illness and related symptoms
2. Anger: irritated or annoyed because the people are to blame for their mental illness
3. Pity: sympathy because people are overcome by their illness
4. Help: the provision of assistance to people with mental illness
5. Dangerousness: people with mental illness are not safe
6. Fear: fright because people with mental illness are dangerous
7. Avoidance: stay away from people with mental illness
8. Segregation: send people to institutions away from their community

9. Coercion: force people to participate in medication management or other treatments

Participants are asked to rate the 27 items on a Likert-type scale ranging from 1 to 9, where 1 indicated "not at all" and 9 indicated "very much." The items are grouped in nine factors. To obtain the score of a factor, you add the 3 corresponding items that make up that factor. The score for each factor ranges from 3 to 27, where higher scores indicate higher values in the corresponding factor for that participant (Munoz, Guillen, Perez-Santos, & Corrigan, 2015).

Results

A total of 7 participants completed the online survey in its entirety. Four other participants began the study but only answered the language preference question and were thus excluded from the study. The sample consisted of 5 females and 2 males. Four participants indicated that their preferred language was Spanish and subsequently filled out the Spanish version of the survey; the other three participants filled out the English version. The median age of participants was 39 (with a range from 22 to 59), and all participants identified as *Hispanic*. Educational attainment of participants included: 3 with an Associates Degree, 3 with high school diploma/GED, and 1 with *some high school*.

Six participants indicated that they had received mental health counseling prior to engaging in BHS at Clinician Tepeyac, while 1 participant answered that he had experienced previous mental health counseling before Clinica Tepeyac. The range endorsed for Behavioral Health interactions was from 0 to 20, with an average of 7 interactions. Participants indicated that they utilized a variety of different therapies: 1 participant reported engagement in family therapy, 1 reported engagement in individual

and family therapy, 4 reported engagement in individual therapy, and 1 reported he had not received therapy at Clinica Tepeyac. Six Participants reported that their PCP recommended they speak with BH, compared to only 1 participant who reported that she asked to speak with BH by her own accord. Four Participants indicated that it was *very important* that their therapist identified as Latino/a, 2 reported that it was *somewhat important,* and 1 reported that it was *not important*. Six participants indicated they had not received psychiatric medication at Clinica Tepeyac, while one participant indicated *yes* to having received psychiatric medication. Below are examples of some of the first 20 questions of this online survey, along with the results from the 7 participants.

Question 15: Did having mental health services in the same location as your medical appointments, make it (please choose one) …

More likely
Less likely
Neither more or less likely

Four participants answered *More likely* and three participants answered *Neither more or less likely*.

Question 18. Did any of the following make it harder for you to access behavioral health services? (Please circle all that apply)

Transportation
Language Barriers
Cost of service
Days/Times offered

Transportation was circled once. *Language Barriers* was circled once. *Cost of service* was circled once. *Days/*Times *offered* was circled three times.

The AQ-27 and AQ-27-E yielded the following information. The range of scores for each factor is listed the table below.

BLAME	5	8	11	11	7	16	12

ANGER	5	7	8	7	8	3	16
PITY	15	22	19	15	21	27	20
HELP	8	9	10	3	10	9	18
DANGEROUSNESS	5	*	10	18	13	19	21
FEAR	5	14	8	17	13	23	21
AVOIDANCE	7	16	13	6	14	20	14
SEGREGATION	4	5	5	11	13	7	19
COERCION	6	25	12	19	21	24	21

* - Item not answered

Average scores are indicated:

Blame: 10
Anger: 7.7
Pity: 19.9
Help: 9.6
Dangerousness: Unable to average, as one participant did not answer item
Fear: 14
Avoidance: 12.9
Segregation: 9.1
Coercion: 18.3

Discussion

Results from the first 20 questions of the survey provide support for the effectiveness of integrative primary care when working with a Latino population. It is striking to note a ratio of 6:1 when examining the impetus for patients seeking Behavioral Health Services (i.e., referred by their med provider versus sought BHS services on their own). This highlights the collaborative and integrative nature of settings like Clinica Tepeyac, where the goal is for medical providers to easily facilitate warm-hand offs that connect patients with the BHS team in a quick, efficient manner. Additionally, this may

be a result of the reverence that many Latino patients express in wanting to show respect for medical providers' suggestion/advice. Existing literature discusses the concepts of *respeto* (respect for one's elders and authority figures) and *personalismo* (preference for formal but warm and supportive interactions over casual ones) (Organista, 2007). Maneolas (2008) elaborates this further by stating:

> … for Latino patients, the BHS is brought into the patient's care *por referencia personal*. This personal vouching for the BHS, done by the primary care provider, helps extend the clinical relationship enjoyed by that provider to the BHS. This extension forms the basis for the engagement of clients, via the primary care clinic into a variety of behavioral health services. (p. 440)

The finding that six out of seven participants endorsed that it was *somewhat important* to *very important* that their Behavioral Health Provider was Latino/a seems to coincide with the benefits that Guarnaccia et al. (2005) list in their results of Latino patients having Latino therapists. They found that Latino patients who see Latino providers are more likely to return for follow-up visits, stay in care longer and are more satisfied with their care. There was one participant who responded that it was *not important* that the BHP was Latino/a. Cabral and Smith (2011) conducted an extensive meta-analysis and found that racial/ethnic matching between patient and therapist is most pertinent prior to therapy and during initial sessions while the therapeutic alliance is being formed. They found that Latinos expressed strong preferences for therapists of the same racial/ethnic background, but their evaluation of therapists different only as a slight function of racial/ethnic match.

Six out of seven participants denied receiving psychiatric medication at Clinica Tepeyac. However, this survey did not differentiate if this was due to: 1) Medical provider not deeming psychiatric medication as necessary or 2) Patient refusing a medical provider's suggestion for psychiatric medication. Antidepressant nonadherance is common in the general population, but research indicates that it is more common among Latinos (Olfson et al., 2006; Sleuth, Rubin, & Huston, 2003). Maneolas (2008) points to the fact that less acculturated Latinos have a more holistic view of the mind-body connection that does not always coincide with a more stringent biomedical model. Additionally, the low number of participants in this pilot study who endorsed receiving psychiatric medication might be influenced by fear of stigma around being seen as someone who is *loco*, severely mentally ill, potentially violent and unable to be cured (Guarnaccia et al., 2005). Since BHPs often try to de-stigmatize the experience of receiving psychological help, one wonders if patients view "having stress" and receiving therapy as acceptable, but view taking medication as proof of being *loco*. Taken together, this highlights importance of future research in exploring stigma for Latinos around behavioral health services such as therapy vs. psychopharmacology interventions within an integrated primary care model. Guarnaccia et al. (2005) state:

> Latinos appear to have significant concerns about psychotropic medication. These include both the strength and the addictive potential of those medications. At the same time, psychotropic medications may be more easily available in Latino's home countries. Those migrants who have been treated for mental illness in their home countries may continue to receive medication from relatives there. (p. 40)

The AQ-27 and AQ-27-E results show that Pity and Coercion were the most elevated factors when averaging participants' responses. Pity refers to sympathy because people are overcome by their illness; Coercion refers to forcing people to participate in medication management or other treatments. This seems to highlight that participants could sympathize with the hypothetical "Harry" diagnosed with schizophrenia in the vignette.. However, it also seems to indicate that participants felt forcing "Harry" into medical compliance or treatment to address his mental illness would be justified. This makes one wonder if survey participants would have replied the same way had the mental illness been something other than schizophrenia.

Finally, the "other barriers" question showed *Transportation, Language Barriers, Cost of service, and Days/Times offered* were each endorsed (to varying degrees). *Transportation* was circled once. *Language Barriers* was circled once. *Cost of service* was circled once. *Days/*Times *offered* was circled three times. This result was somewhat surprising, given that the other barriers have been more discussed in the existing literature. However, one could hypothesize that scheduling concerns could be attributed in part to a smaller available social support network in the United States for recently immigrated Latinos. For example, how can one attend a medical appointment or BHS appointment if no one can help with childcare or other daily responsibilities that need to be addressed?

Limitations

This was a descriptive pilot study and should be taken as such. This study attempted to provide an initial exploration of the mechanisms involved in whether WHOs translate into continued BHS utilization in integrated primary care. The primary aim of

this study was to provide a starting point from which future endeavors can pull to understand how to properly allocate their resources when researching the effectiveness of integrated primary care as a model of service delivery for Latino patients.

As always, there are limitations to this study that should be noted. First, the study had a relatively small n of 7. In turn, this limits generalizability. The study could have yielded more participants if the researcher was able to tap into the *personalismo* value documented in previous literature around working with the Latino community. For the benefit of time, it was decided that study would be an online survey on the Qualtrics platform. However, an in-person interview might have allowed for more trust, connection, and an overall warmth that could have resulted in more participants and helped increase word of mouth recruitment after a participant had a positive experience. Additionally, the in-person approach would have helped curb the reality that not all Clinica Tepeyac patients have easy access to the internet or have working knowledge of how to use a computer. This could also be a factor in thinking of generational differences or lower SES patients.

Secondly, the study relied on self-report, which can be problematic as participants' recollections are not always reliable. It would have been beneficial to have access to their records at Clinica Tepeyac in order to directly look up how many interactions they had with BHS. Additionally, it would have been beneficial to have access to any BHS mental health diagnosis patients might have been provided. Since we were examining stigma, it makes sense to wonder if that played a role in how participants answered survey questions.

Finally, there has been much political focus on undocumented individuals, immigration reform, and what has been interpreted a possibly unsafe, unwelcoming climate for immigrants. In turn, it would be remiss not to wonder if this impacts potential participants interest in engaging in research. While it was made clear that the survey was anonymous, participants had to email the primary investigator after completing the survey and ask to be entered into the raffle for the Amazon gift cards. While they did not need to provide their name, they did need to at least provide an email address.

Future Research

Future research can build on this descriptive pilot study. Additional research should focus on establishing more concrete guidelines for effective warm hand-offs (ones that lead to increased patient follow-up with therapy) among the Latino population. Heath et al. (2013) describe the varying levels of integration when discussing behavioral health services, highlighting the fact that there can be a great deal of variety in how behavioral health services are introduced to the patient. In turn, this introduction to the world of behavioral health services (warm hand-off) is important in establishing patient "buy in" and deserves further investigation. Sanchez et al. (2015) highlight the lack of existing literature on effectiveness of integrated primary care among minority populations and people with limited English language proficiency. In turn, it seems appropriate to investigate the development of a measure that can quantify effectiveness of warm-hand offs for Latino patients.

Corrigan (2004) emphasizes that stigma can play a strong role in deterring individuals from seeking mental health services. Fox (2011) proposes that courtesy stigma can be problematic when parents of children/youth with mental health problems

can experience feelings of shame or inferiority through their association. While the present pilot study focuses on adult Latinos' use of behavioral health services, one can see that this concept could apply to family members of adults receiving BH services in integrated primary care. Additionally, Latinos are more likely than Whites to express mental health concerns through somatic symptoms, which makes it likely they will express these concerns with a medical provider (Escobar, Burnam, Karno, Forsythe, & Gloding, 1987; Kolody, Vega, Meinhadt, & Bensussen, 1986). It will be important to further evaluate how warm hand-offs can be structured to help address and/or decrease stigma during BHS interaction in integrated primary care clinics.

Additionally, it seems logical to utilize the concepts of *respeto* y *personalismo* in order to gain more information from Latino patients through conducting research that includes face-to-face inquiry. Since this survey was conducted online, one wonders if it would have garnered more participation if questions had been asked in person. Creswell, Hanson, Plano, & Morales (2007) described the utility of qualitative inquiry when researchers are interested in a discovery-oriented approach to understanding a topic. Given that there is a scarcity of literature on integrated primary care effectiveness with Latinos, it seems appropriate to utilize this model of inquiry in future research endeavors.

Summary

The purpose of this study was to investigate an area that has not received much attention: how does integrated primary care work for Latino patients? Integrated primary care has received a great deal of attention during the past several years. However, there continues to exist a dearth of studies around its effectiveness with minorities.

Additionally, if it does work well for Latino patients, which components are the most salient? How effective are warm hand-offs for this population?

This descriptive pilot study found that the vast majority of participants sought Behavioral Health Services at the suggestion of their medical provider. Additionally, it seems that participants thought it was important to have a Latino/a therapist. Finally, it was important to note that only one participant indicated usage of psychiatric medication prescribed during their time at Clinica Tepeyac. These themes require further investigation using procedures that will help yield a much larger n and also utilize participant health records in order to not only rely on self-report measures.

Stigma around mental illness has been well documented in the general population and also in minority populations. In turn, it will be vital to gain a more in-depth understanding of how providing psychoeducation around mental health can help combat this stigma. The hope is to utilize future research in a meaningful way that will make it easier and more likely for people to push through barriers and meaningfully engage in treatment.

Appendix A

Survey (English Version)

Thank you for taking the time to participate in this quick survey. Please answer the following questions.

1. What is your preferred language?

_____

2. How old are you?

_____

3. What is your sex?

_____

4. Ethnic origin: Please circle below or write-in your response

White not Hispanic
Black not Hispanic
Hispanic
Asian or Pacific Islander
American Indian
Other _____

5. What is the highest degree or level of school you completed?

No formal schooling
Nursery school to 8th grade
Some high school
High school graduate or equivalent (ex: GED)
Associate degree
Bachelor's degree
Master's degree
Doctorate degree

6. What is your marital status? Please choose below.

Single, never married
Married or domestic partnership
Widowed
Divorced
Separated

7. How long have you been a patient at Clinica Tepeyac?

_____

8. How long have you lived in the United States?

_____

9. If you immigrated to the United States, what country did you immigrate from?

_____

10. How long did you receive Behavioral Health services at Clinica Tepeyac?

_____

11. How many Behavioral Health sessions/interactions did you have at Clinica Tepeyac?

_____

12. What kind(s) of counseling did you have at Clinica Tepeyac? (Please choose all that apply)?

Individual
Couples
Family

13. Did you have mental health counseling prior to your Behavioral Health interaction(s) at Clinica Tepeyac?

If yes, in what language was it conducted? _____

14. Have you had subsequent mental health counseling after your Behavioral Health interaction(s) at Clinica Tepeyac?

If yes, in what language was it conducted? _____

15. Did having mental health services in the same location as your medical appointments, make it (please choose one) …

More likely
Less likely
Neither more or less likely

… for you to continue coming back for therapy appointments?

16. Did you …. (Please choose below)

- Ask to meet with someone from the behavioral health team?

or

- Did your doctor suggest it to you during your medical appointment?

17. If you had behavioral health interactions in Spanish, how important was it to you that the counselor identified as someone of Latino ethnicity? (please circle one).

Very important
Somewhat important
Not important

18. Did any of the following make it harder for you to access behavioral health services? (Please circle all that apply)

Transportation
Language Barriers
Cost of service
Days/Times offered

19. Did you ever receive psychiatric medication at Clinica Tepeyac?
Yes or No?

20. Is there anything that would have made your experience with Behavioral Health more beneficial?

_____

AQ-27
PLEASE READ THE FOLLOWING STATEMENT ABOUT HARRY:

Harry is a 30 year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He has been hospitalized six times because of his illness.

NOW ANSWER EACH OF THE FOLLOIWNG QUESTIONS ABOUT HARRY. CIRCLE THE NUMBER OF THE BEST ANSWER TO EACH QUESTION.

1. I would feel aggravated by Harry.

1 2 3 4 5 6 7 8 9
not at all very much

2. I would feel unsafe around Harry.

1 2 3 4 5 6 7 8 9
no, not at all yes, very much

3. Harry would terrify me.

1 2 3 4 5 6 7 8 9
not at all very much

4. How angry would you feel at Harry?

1 2 3 4 5 6 7 8 9
not at all very much

5. If I were in charge of Harry's treatment, I would require him to take his medication.

1 2 3 4 5 6 7 8 9
not at all very much

6. I think Harry poses a risk to his neighbors unless he is hospitalized.

1 2 3 4 5 6 7 8 9
none at all very much

7. If I were an employer, I would interview Harry for a job.

1 2 3 4 5 6 7 8 9
not likely very likely

8. I would be willing to talk to Harry about his problems.

1 2 3 4 5 6 7 8 9
not at all very much

9. I would feel pity for Harry.

1 2 3 4 5 6 7 8 9
none at all very much

10. I would think that it was Harry's own fault that he is in the present condition.

1 2 3 4 5 6 7 8 9
no, not at all yes, absolutely so

11. How controllable, do you think, is the cause of Harry's present condition?

1 2 3 4 5 6 7 8 9
not at all under personal control completely under personal control

12. How irritated would you feel by Harry?

1 2 3 4 5 6 7 8 9
not at all very much

13. How dangerous would you feel Harry is?

1 2 3 4 5 6 7 8 9
not at all very much

14. How much do you agree that Harry should be forced into treatment with his doctor even if he does not want to?

1 2 3 4 5 6 7 8 9
not at all very much

15. I think it would be best for Harry's community if he were put away in a psychiatric hospital.

1 2 3 4 5 6 7 8 9
not at all very much

16. I would share a car pool with Harry every day.

1 2 3 4 5 6 7 8 9
not likely very likely

17. How much do you think an asylum, where Harry can be kept away from his neighbors, is the best place for him?

1 2 3 4 5 6 7 8 9
not at all very much

18. I would feel threatened by Harry.

1 2 3 4 5 6 7 8 9
no, not at all yes, very much

19. How scared of Harry would you feel?

1 2 3 4 5 6 7 8 9
not at all very much

20. How likely is it that you would help Harry?

1 2 3 4 5 6 7 8 9

definitely would not help — definitely would help

21. How certain would you feel that you would help Harry?

1 2 3 4 5 6 7 8 9
not at all certain — absolutely certain

22. How much sympathy would you feel for Harry?

1 2 3 4 5 6 7 8 9
none at all — very much

23. How responsible, do you think, is Harry for his present condition?

1 2 3 4 5 6 7 8 9
not at all responsible — very much responsible

24. How frightened of Harry would you feel?

1 2 3 4 5 6 7 8 9
not at all — very much

25. If I were in charge of Harry's treatment, I would force him to live in a group home.

1 2 3 4 5 6 7 8 9
not at all — very much

26. If I were a landlord, I probably would rent an apartment to Harry.

1 2 3 4 5 6 7 8 9
not likely — very likely

27. How much concern would you feel for Harry?

1 2 3 4 5 6 7 8 9
none at all — very much

Thank you for your participation!

Appendix B

Encuesta

Gracias por tomar el tiempo en participar en esta breve encuesta. Por favor conteste las siguientes preguntas.

1. Cual es su idioma preferido?
_____

2. Cuantos anos tiene?
_____

3. Cual es su sexo?
_____

4. Origen Étnico: Por favor escoge o escribe su respuesta

Blanco no Hispano
Negro no Hispano
Hispano
Asiático o de Las Islas Pacificas
Indio Americano
Otro _____

5. Cual es el titulo o nivel mas alto de escuela que completo?

Ninguna educación formal
Preescolar a octavo grado
Una porción de la secundaria
Titulo de la secundaria o el equivalente (ejemplo: GED)
Titulo asociado
Titulo maestría
Titulo doctorado

6. Cual es su estado matrimonial? Por favor escoge abajo.

Soltero, nunca casado
Casado, o en unión civil
Viudo
Divorciado
Separado

7. Cuanto tiempo que es paciente de Clínica Tepeyac?
_____

8. Cuanto tiempo ha vivido en los Estados Unidos?
_____

9. Si emigro a los Estados Unidos, de cual país emigro?
_____

10. Cuanto tiempo ha recibido Behavioral Health servicios en Clínica Tepeyac?
_____

11. Cuantas sesiones/interacciones de Behavioral Health ha tenido en Clínica Tepeyac?
_____

12. Que tipo(s) de consejería ha tenido en Clínica Tepeyac (Por favor escoge todos lo que aplican)?

Individual
Pareja
Familia

13. Tuvo consejería de salud mental antes de sus interacciones de Behavioral Health en Clínica Tepeyac?

Si lo tuvo, en cual idioma? _____

14. Tuvo consejería de salud mental después de su interacciones de Behavioral Health en Clínica Tepeyac?

Si lo tuvo, en cual idioma? _____

15. Teniendo servicios de salud mental en el mismo edificio que su citas medicas, lo hizo (por favor escoge uno) …

Mas probable
Menos probable
Ni mas probable o menos probable

… para que usted continuara con sus citas de terapia?

16. Usted … (Por favor escoge abajo)

- Pregunto a ver alguien del equipo de Behavioral Health?

o

- Su doctor lo sugirió durante su cita medica?

17. Si usted tuvo interacciones con Behavioral Health en español, que importante fue que el consejero se identificaba como alguien de etnicidad Latino? (Por favor escoge uno)

Muy importante
Algo importante
No importante

18. Alguno de los siguientes lo hizo mas difícil para que usted use Behavioral Health servicios? (Por favor escoge todos que apliquen)

Transportación
Barreras de Lenguaje
Costo de servicio
Días/Tiempos ofrecidos

19. Alguna vez recibió medicina psiquiátrica en Clínica Tepeyac?
Si o no?

20. Hay alguna cosa que hubiera hecho su experiencia con Behavioral Health mas beneficial?

Appendix C

The AQ-27 Score Sheet
Name or ID Number_____ Date _____
The AQ-27 consists of 9 stereotype factors; scores for each factor are determined by summing the items as outlined below: Note: items are reversed score prior to summing up for the Avoidance scale.

_____ Blame = AQ10+ AQ11 +AQ23
_____ Anger = AQ1 + AQ4 + AQ12
_____ Pity = AQ9 + AQ22 + AQ27
_____ Help = AQ8 + AQ20 + AQ21 (Reverse score all three questions)
_____ Dangerousness = AQ2 + AQ13 + AQ18
_____ Fear = AQ3 + AQ19 + AQ24
_____ Avoidance = AQ7 + AQ16 + AQ26 (Reverse score all three questions)
_____ Segregation = AQ6 + AQ15 + AQ17
_____ Coercion = AQ5 + AQ14 + AQ25

The higher the score, the more that factor is being endorsed by the subject.

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