# Culturally Appropriate Substance Use Disorder Treatment: CETPA's Practical Applications for Hispanic/Latino Populations

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There are many destabilizing aspects of social adaptation in the United States for Latinos; a rapidly increasing population; residential segregation; shortfalls in educational attainment; language barriers; and a new political, social, legal, financial, and educational system. Any of these issues alone may cause substance use disorders or mental health problems, let alone experienced all together.

The current system of substance use disorder treatment is not set up to serve the vast majority of Latinos in need of care. In particular, it does not address the needs of immigrant Latinos, who make the least use of behavioral health services (U.S. Health and Human Services, 2001). In addition to the many barriers faced by the general Latino population, the current system provides even a greater disservice to Latinos in jail, those who abuse alcohol and drugs, those who are entering the country because of political persecution or kidnapping in their country of origin and the involuntary immigrants who include spouses and children who did not participate in the decision to immigrate but simply followed the decision made by the head of the family.

Latino youth, who are the fastest growing subgroup of this community, are at a significantly high risk for poor behavioral health outcomes. They are usually more likely to drop out of school, to report depression and anxiety, and to consider suicide than white youth (Center for Disease Control and Prevention, 2004).

Acculturated Latinos may not seek treatment for substance use disorders primarily because of the different relationship Latinos have with alcohol, making them less likely to ask for any type of help or talk about it with clergy, relatives or friends.

## CETPA

The Clinic for Education, Treatment and Prevention of Addiction, Inc. (CETPA) was established in 1999 to address a growing need for culturally and linguistically appropriate substance abuse services among the Latino population in Georgia. Since then CETPA has grown from one program to multiple programs, from one employee to 53 employees, from serving one region in the State to serving five regions, and from providing solely substance abuse counseling to 65 adult clients annually to serving over 1,000 clients in need of substance use disorders and mental health counseling, and thousands of children and youth in prevention programs each year. CETPA is the only state licensed and nationally accredited agency in Georgia to provide behavioral health treatment and prevention services in English and/or Spanish. Our approach to serving the Latino community is a product of leaning about the history, demographics, utilization rates, cultural difference, and barriers to access over the last fifteen years. Here is what we have learned.

## History

Latinos have been present in the United States for over 500 years. They are made up of European, African, Asian, and Indigenous backgrounds, each bringing their own culture, values, attitudes, race, color and spirituality. The United States, with almost 40 million Spanish speakers, is currently fifth largest Spanish-speaking country in the world after Mexico (117 million), Spain (47.2 million), Colombia (47 million) and Argentina (41 million) (U.S. Census Bureau, 2013).

Latino immigrants in the United States come predominantly from Mexico, Puerto Rico and Cuba. It is important to know the history of each one of these countries with the United States in order to understand the frame of mind of the potential clients. Puerto Ricans enjoy the privilege of American citizenship, given by birth due to the island's status as a U.S. Commonwealth. Many Cubans in the United States have refugee status, which provides work authorization and access to social services.

Almost all other Latino immigrants must be granted legal status by U.S. Citizenship and Immigration Services (USCIS) to enter the country, work, and/or receive social services. Unfortunately, many Latino immigrants do not have legal status to live, work, or receive social services or benefits.

## Demographics

According to the 2013 U.S. Census estimate, there are over 53 million people in the United States who identified themselves as Latinos; 900,000 in the State of Georgia alone. One of the major stereotypes Latinos face is that of being recently arrived immigrants, when in fact, according to the U.S Census, more than 60% of Latinos in the United States were born in the United States (U.S. Census Bureau, 2013).

Latinos make up 17% of the U.S. population, yet, they represent nearly one out of every four uninsured Americans (Brown, Ojeda, Wyn & Levan, 2000). By the year 2012, close to 42% of Latinos in the United States were uninsured and 21.4% live below the poverty level. These high numbers are driven mostly by Latinos' lack of employer-based coverage: only 43% of Latinos are covered through the workplace, compared to 73% of whites. Medicaid and other public coverage reach 18% of Latinos. Citizenship and immigration status are other important factors that affect health insurance (Brown et al., 1999; Hanson, 2001); when you look at the insurance coverage figures closer you find that 62% of Latinos who are not yet citizens of the United States are uninsured.

The President's New Freedom Commission on Mental Health in their final report *Achieving the Promise: Transforming Mental Health Care in America,* addresses disparities in mental health by reporting:

> "Unfortunately, the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often under serving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing minorities in the criminal and juvenile justice systems."

Additionally, striking disparities in mental health services for racial and ethnic minority populations are highlighted in the report, *Mental Health: Culture, Race and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General.* It states that racial and ethnic minorities:

- Are less likely to have access to available mental health services,
- Are less likely to receive needed mental health care,
- Often receive poorer quality care, and
- Are significantly under-represented in mental health research.

Although some progress has been made in the (0.1% in the last 10 years) utilization rates of mental health, addictive disease and developmental disabilities community services in the state of Georgia continue to show a great disparity when measured by race and ethnicity (Georgia Department of Behavioral Health and Developmental Disabilities, Table 1). They are:

**FY 2012 - Utilization of Community Services per 1000 population By Disability Program & Ethnicity**

| | Not Hispanic/Latino | Hispanic/Latino |
|---|---|---|
| C&A MH | 14.8 | 8.0 |
| C&A AD | 0 .5 | 0.4 |
| Adult MH | 17.1 | 6.3 |
| Adult AD | 4 .5 | 1.0 |

## Cultural Differences

In addition to language, it is important to note several differences among the members of this community, which may play a role in the seeking and utilizing addictive disease and mental health services. The different patterns of immigration include those who enter as permanent residents, holding work and student visas, visitor visas and those with undocumented status.

The personal conditions affecting quality of life also differ since the socio-economic position of the members of this community greatly varies. There are wealthy Latinos who identify more with the host culture and those who identify more with their Latino roots. Conversely, there are recently arrived immigrants who forego their Latino roots in order to try to 'fit in' faster or become 'Americanized'.

The Diagnostic Statistical Manual 5 (DSM 5) is divided into three sections – Section 1: Introduction ("DSM-5 Basics"); Section II: "Diagnostic Criteria and Codes"; Section III: "Emerging Measures and Models" – and an Appendix, which includes a "Glossary of Cultural Concepts of Distress." Section III includes a chapter on cultural formulation, featuring an updated version of the outline introduced in DSM-IV as well as an approach to assessment, using the Cultural Formulation Interview (CFI). The chapter also includes a section discussing "Cultural Concepts of Distress" (pp. 758–759). It is imperative that clinicians learn these concepts when working with consumers who come from different cultures and different parts of the world.

## Barriers

The primary barrier for Latinos in accessing current available services for substance use disorders is language. The lack of Spanish-speaking mental health treatment providers is a major problem since close to 40% of Latinos living in this country have limited English proficiency. Second language conversational skills are acquired in one or two years and academic language proficiency is acquired over a longer period of time of five to seven years (Ortiz, 1997). Diagnosis and treatment of mental disorders depends greatly on the ability of the patient to explain the symptoms to a clinician and understand steps for treatment. The triangulation of this critical phase through a chance interpreter, a family member and an unqualified or untrained interpreter can be devastating. However, studies reveal that there are few Spanish-speaking and Latino providers. One survey found that there were 29 Latino mental health professionals for every 100,000 Latinos in the U.S. population. For non-Latino Caucasians, the rate was 173 providers per 100,000 (Center for Mental Health Service, 1999).

Additional organizational, systemic, and clinical barriers must also be addressed in order to provide culturally appropriate services.

Organizational barriers address the current systems of care, which include the health policies, and the people entrusted to carry them out. It is imperative that the people charged with the delivery of services include the members of this community within the ranks of its leadership, boards, staff and providers.

Systemic barriers in the structures of the health care system create major challenges for Latinos seeking addictive disease and mental health services. The operating circumstances include location, transportation, long wait times, bureaucratic intake procedures and the lack of qualified interpreters (or any interpreter services) and bilingual services.

Clinical barriers include the chronic shortage of qualified Spanish-speaking support personnel and staff. The number of bilingual/bi-cultural psychiatrists, psychologists and licensed counselors in many states is totally disproportionate to the fast growth of the Latino community including Georgia.

The absence of qualified personnel give way to ineffective and inappropriate therapies including offering services to clients who may only speak functional or conversational English. In some levels of care, it has become common practice to ask a client to bring an interpreter to the evaluation or the actual therapy session.

Even clinicians who identify themselves as Latino, speak Spanish or originate from Latin America are not necessarily culturally competent to serve this community. Socio-cultural barriers include the need for language appropriate services, acknowledges underutilization rates for addictive disease and mental health services, takes into account the patient's level of acculturation, addresses the stigma associated with these illnesses in the Latino culture, has intimate knowledge of available resources, understands the client's uncertainty about established educational, social, financial and medical system and respects Latino beliefs in spirits or sins as reason for illness or hardship.

## Limited English Proficiency

The issue of providing services to persons with limited English proficiency (LEP) is actually addressed by the federal government under Title IV of the Civil Rights Act of 1964 which states "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance". The courts have interpreted national origin to include individuals with limited English proficiency. In August 2000, President Clinton, reiterated this policy by issuing Executive Order (EO) 13166, *Improving Access to Services for Persons with Limited English Proficiency,* which applied to all federal agencies.

The system of care may address this issue in several different ways. It may choose to provide the very minimum level of service in order to meet the aforementioned requirements or it may choose to truly apply the research-based data and provide the highest level of service, linguistic and culturally appropriate direct services, to serve the Latino community. Not addressing this issue is unacceptable.

The ramifications of poor linguistic access include decreased access to health services, poor patient comprehension, low patient satisfaction, reduced quality of care and an increase in health care costs.

Many Latinos today are suffering in silence from addictive diseases and mental illness in part because of these barriers.

Many Latinos who receive services for these illnesses are living healthy and productive lives today thanks, in part, to the advances achieved in pharmacology and psychotherapy. Still, many who have received successful treatment choose not to share the fact that they were helped for fear of being judged or labeled negatively. Continued efforts from advocates, providers and community members is needed to deliver to the Latino community the very important message that mental illness and addiction are treatable and that there is no shame in acknowledging the fact that we have been helped.

## Solutions

In order to meet the addictive disease and mental health services of the growing number of Latinos, regardless of their socio-economic, educational, linguistic and acculturation levels, major changes need to take place at all service levels.

Policy recommendations include setting as a priority the establishment of a specific programmatic focus and supporting policy framework including access and workforce development. This will reduce systemic barriers and increase the number of substance use disorders and mental health professionals who are linguistically and culturally skilled. CETPA begins recruiting at the high schools during career days. We motivate young minds to think about the counseling field. We identify those who are bilingual and sometimes are able to offer them non-clinical recovery support jobs while they attend college. Training recommendations include developing and expanding the knowledge base for educating and training current and future mental health and addiction professionals.

The most critical and enduring service delivery issue is accessibility. Efforts should be focused on creating financial and other incentives for developing systems of services/care and utilizing innovative services alternatives that meet the identified needs of the Latino community. CETPA's hours of operation are from 9 am until 9 pm and some of our services operate on Saturday. We learned that those are the times our community can access our services. We sometimes help with bus tokens and child care. And lately we have been providing tele-counseling through a SAMHSA Health IT grant where consumers can access their counselor through a secure server for an internet-based, face-to-face session from the comfort of their own home at the most appropriate time in the language they best communicate in.Research typically drives policy, funding and system development decisions. Little information exists, and so much is needed to better understand the mental health, and addictive disease service needs of all Latinos and especially those who live in rural communities. Research must be supported and funded to make this happen.

Affordability of services is key. CETPA serves a community who is highly uninsured, underinsured and due to different types of visas or lack of legal status, are unable to be insured. CETPA has a sliding scale fee and we provide free services to those that do not have the ability to pay. We rely on foundations and donations to cover these costs. And we receive state and federal grants, and accept Medicaid and third party payers. Lately we have also begun to see adults formerly uninsured showing up with policies purchased through the Marketplace from the Affordable Care Act.

Leadership must be developed and committed to at individual and institutional levels – cultural competence must be part of the agenda and a priority for Latino leaders. CETPA would not have been able to accomplish all of this without the support of the Georgia Department of Behavioral Health and Developmental Disabilities, SAMHSA's Center for Substance Abuse Treatment and all of the supporters we have in Georgia and throughout the nation.

The message is clear, affordable, cultural and linguistically appropriate substance use disorder and mental health counseling is achievable.

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