Office of Behavioral Health Equity Playbook Hispanic/Latino Behavioral Health Center of Excellence

July 31, 2024

HISPANIC/LATINO
BEHAVIORAL HEALTH
CENTER OF EXCELLENCE

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At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D., is the Assistant Secretary for Mental Health and Substance Use and Ibis S. Carrión-González, PsyD, served as Director of the Hispanic/Latino Behavioral Health Center of Excellence. The opinions expressed herein are the views of the authors and current staff of the H/LBH CoE and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this document is intended or should be inferred.

The Hispanic/Latino Behavioral Health Center of Excellence recognizes the complexities associated with gender and ethnic identification as well as the right of all individuals to self-identify. The Center uses the term Latine with the intention of both facilitating a fluent reading and pronunciation and supporting an inclusive and respectful language. Latine is a gender-neutral form of the word Latino that uses the letter e at the end, an idea native to the Spanish language.

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Institute of Research, Education, and Services in Addiction (IRESA)

The Institute of Research, Education, and Services in Addiction (IRESA) of the Universidad Central del Caribe leads the National Hispanic and Latino MHTTC. The Center serves as a national subject matter expert and a key resource for the workforce and communities seeking to address mental illness prevention, treatment, and recovery support to reduce health care disparities among Hispanic and Latino populations across the United States and its territories. In partnership with state and local governments, mental health providers, consumers and family organizations, Hispanic stakeholders, Substance Abuse Mental Health Services Administration (SAMHSA) regional administrators, and the MHTTC Network, the Center seeks to accelerate the adoption and implementation of mental health-related evidence-based practices.

Hispanic/Latino Behavioral Health Center of Excellence

Through funding from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration's Office of Behavioral Health Equity, our Center of Excellence is established to advance the behavioral health equity of Latine communities through the development and dissemination of culturally-informed, evidence-based behavioral health information, provision of training and technical assistance and directed support to expand the behavioral health workforce that serves Latine communities.

We serve as a resource for mental health and substance use providers, primary care providers, community-based and faith-based organizations, research institutions, Hispanic and Latine-Serving Institutions (HSIs) of higher education, peer and recovery support service providers, as well as state, regional, local, and federal entities. Our outreach also encompasses the general public, including Hispanic and Latine individuals, families, and communities, as well as persons with lived experiences. Our mission is to advance and support the sustainability of behavioral health equity by promoting community driven, culturally grounded and person-centered prevention, intervention, multiple pathways of recovery, and recovery supports for diverse Hispanic and Latine communities.

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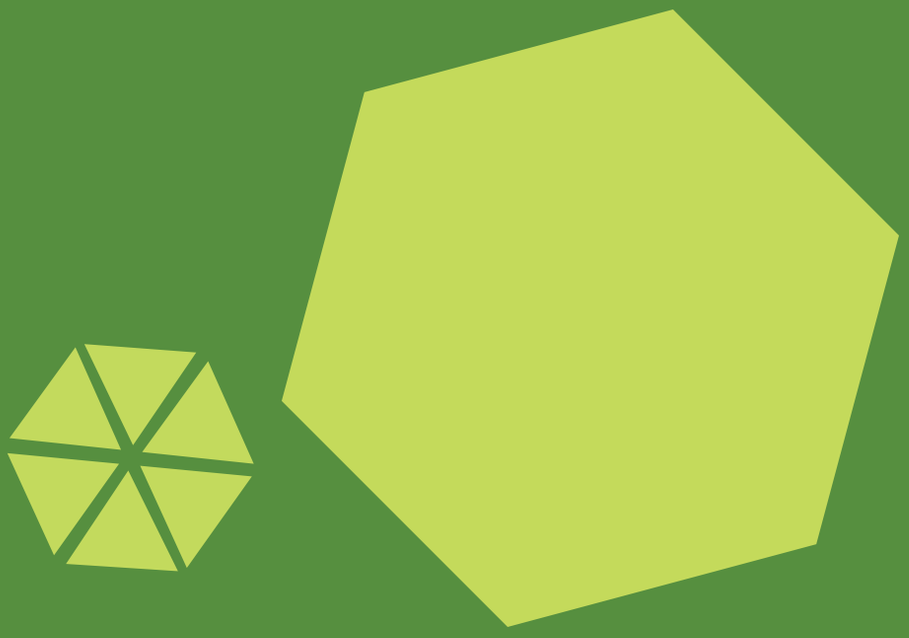


I. Statement on Behavioral Health Disparities for Latine Populations

In 1990, Latines represented 8% of U.S. workforce participation and held 3% of executive leadership positions, a relatively narrow gap of five percentage points. Twenty-one years later, the U.S. Latine workforce participation has more than doubled, increasing to nearly 20%. Yet, Latine representation in executive leadership has remained largely unchanged, widening this gap to 450%[1]. For decades Latines have lacked representation in areas of the behavioral health professions including medicine, nursing, psychology and social work. Although Latines represent the largest minority in the US, comprising 19.5% of the total U.S. population[2], few Latine professionals occupy positions of leadership, or on national board and advisory committees[3]. This lack of a representative behavioral health workforce further adds to disparities in access to quality care for Latines.

When working with ethnically diverse populations (eg. Latine populations), cultural and ethnic identity should be considered in the working relationship. Falicov (2014) has referred to the relationship between provider and client as a multicultural encounter.[4] She further elaborates that a culturally attuned position is best for Latine clients and requires an understanding and awareness of how theoretical positions as well as sociopolitical and cultural perspectives inform the clinical encounter for providers as well as for clients/participants. A clinician's and client's cultural backgrounds, values as well as meanings attached to these, may have a profound impact on the therapeutic relationship, increasing engagement and improving outcomes.

Due to the shortage of Latine professionals in behavioral health, issues pertaining specifically to Latine behavioral health are usually unnoticed and unaddressed. In the US, the racial/ethnic composition of the BH workforce is incongruent from the population seeking behavioral health services. Among Counselors and Social Workers, Latines are one of the underrepresented groups[5]. A report by the American Psychological Association[6] found that 81% of psychologists in the U.S. workforce were White, while 7.95% were Latines. Within Latine populations, demand for behavioral health (BH) services will increase 106% by 2030[5], stressing the need to increase equity in the behavioral health workforce. Furthermore, a recent Technology Transfer Network needs assessment reports that the most identified need for technical assistance among BH providers who participated was culturally responsive equitable care. The report also indicates a need among providers to further develop skills in attending trauma, depression, and substance use among Latine populations.[7]

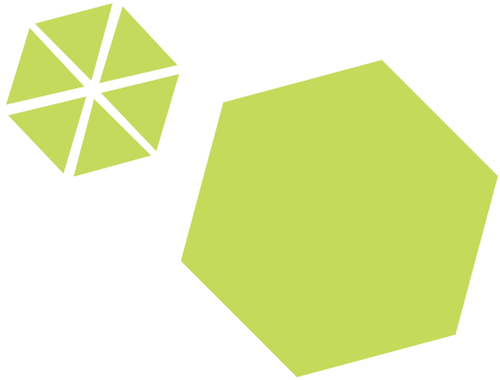
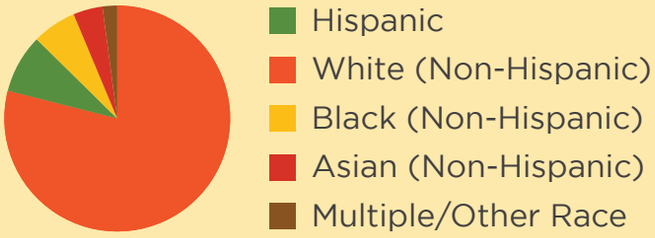


Figure 1: Ethnic Distribution of Selected Behavioral Health Occupations[8]

Psychologists by Ethnicity



Substance Use and Behavioral Disorders Counselors

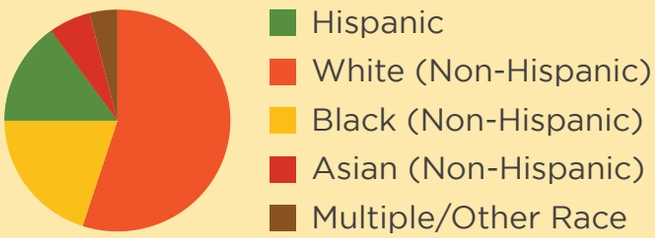


Table 1: Other Health Care Professions by Race/Ethnicity[8]

Occupation	Total	Hispanic	White (Non-Hispanic)	White (Non-Hispanic)	Black (Non-Hispanic)	Native Hawaiian/ Pacific Islander	American Indian/ Alaska Native	Multiple/ Other Race
Educational, guidance, and career counselors	45,131	11.5%	64.2%	18.4%	3.0%	**	**	2.4%
Marriage and family therapists	26,763	11.7%	70.6%	11.1%	3.3%	**	**	3.0%
Mental health counselors	112,948	13.4%	62.1%	17.7%	2.8%	0.1%	0.2%	3.7%
All other counselors	153,287	11.7%	60.7%	20.7%	2.9%	0.2%	0.7%	3.2%
Child, family, and school social workers	39,928	14.8%	55.8%	21.7%	3.1%	**	**	4.0%
Health care social workers	78,009	13.2%	54.9%	24.3%	3.0%	**	0.7%	3.8%
Mental health social workers	23,121	12.9%	67.6%.	13.4%	1.8%	0.1%	0.3%	4.0%
All other social workers	412,832	14.9%	58.3%	19.7%	3.4%	0.1%	0.5%	3.1%
U.S. Population	329.7 Million	18.4%	59.4%	12.2%	5.6%	0.2%	0.6%	3.5%

Source: HRSA calculations using data fromthe U.S. Census Bureau, American Community Survey: 2017-2021 Public Use Microdata Sample (PUMS) Files. ** Indicates datawithheld due to a high standard error. Limited to practitioners employed in a medical setting, defined as employed in NAICS sector 62 (health care and social assistance), excluding NAICS 6242 (community food and housing, and emergency services), 6243 (vocational rehabilitation services), and 6244 (child day care services). 2 Includes dietetic technicians, psychiatric technicians, surgical technologists, veterinary technologists and technicians, and ophthalmic medical technicians.

Language fluency data indicates that 68% Latines speak Spanish at home (US Census Bureau, 2023. Between 2014 and 2019, the U.S. Hispanic population increased by 4.5%, while facilities that offered mental health treatment in Spanish declined by 17.8%.[9]

The uneven distribution of this workforce further complicates the lack of sufficient diverse behavioral health providers. The concept of maldistribution refers to the fact that mental health and substance use providers tend to be concentrated in selected geographic areas, such as the northeastern U.S. and areas of the West Coast, with much less concentration in rural areas. A report by the University of Michigan's Health Workforce Research Center[10] estimated that 13% of rural counties do not have a single behavioral health professional and that approximately 60% of mental health provider shortage areas in the U.S. are in rural or partially rural areas. In 2018, Latines were the fastest-growing segment of the rural population, accounting for 8.6 percent of the rural regions.[11]

Healthy People 2030 includes Health Care Access and Quality domain, which accounts for a population's ability to receive healthcare services.[12] Data from the National Substance Use and Health Data Survey[13] indicates that of the 2.4 million Latines who experienced both a mental and substance use disorder in the past year, only 25.4% received any mental health treatment, and only 10.8% received both mental health and SUD treatment. H/L adolescents (37.0%) had lower levels of access to depression treatment than non-Hispanic White adolescents (49.1%). The lack of a diverse workforce has been identified as one key variable limiting access to culturally responsive care. It is well documented that other factors such as stigma, immigration status, trauma, lack of health insurance, and poverty also adversely affect the likelihood for Latines to receive mental health services and contribute to higher rates of unmet mental health needs. However, it is important to highlight and address issues related to the shortage of bilingual, bicultural behavioral health providers to adequately attend to the needs of Latine communities. Studies indicate that BH workforce capacity could be strengthened by ensuring that providers are diverse in race, ethnicity, and other demographic and socioeconomic factors.[14] Providers who identify as part of a minority group are more likely to meet the service needs of underserved populations.

Points to consider:

- The lack of a bilingual and bicultural behavioral health workforce plays a significant role in disparities across key areas of behavioral health care service delivery.
- Meaningful access to behavioral healthcare for Latine in the U.S. is a social justice issue.
- Latine deserve a diverse, multidisciplinary, bilingual and bicultural behavioral health workforce.
- Racial and ethnic diversity among health professionals is essential to health equity and has been shown to promote better access and healthcare for underserved populations, as well as better meet the health needs of an increasingly diverse population. [5],[15]
- Providers who identify as part of a minority group are more likely to meet the service needs of underserved populations, as Black and Hispanic practitioners tend to practice in communities with higher concentrated populations of their respective racial/ethnic group and fewer physicians per capita.

II. Context

Studies demonstrate that training and retaining a diverse workforce is a key strategy to eliminate behavioral health disparities. However, establishing a "pipeline to practice" requires active engagement and relationship building with individuals and populations that motivates their participation in the behavioral health workforce. A diverse workforce is essential to engaging minoritized groups who have experienced historic and structural disparities to accompany them in building trust with providers and the health care system. It requires rethinking and modifying training and retention approaches, including communities, and paying attention to inclusive environments that are not based on white organizational structures.[16]

Historically and currently, most clinical training and clinical theoretical models that inform behavioral health supervision and practice have largely been influenced by westernized notions of psychopathology.[17] Imposing a westernized conceptualization of mental health on racially and ethnically minoritized populations is problematic, as cultural nuances, ethnic differences, and lived experiences are indirectly dismissed.[18]

Efforts to recruit diverse students into psychology look promising: The percentage of racial- and ethnic minority psychology graduate students grew from 27% in the 2006–07 academic year to 35% in 2016–17, with increases for every ethnic-minority category tracked, according to a new analysis of data from APA's annual Graduate Study in Psychology survey of psychology graduate programs.[19]

In 2016, the total college enrollment rate was higher for Asian young adults (58 percent) than for young adults who were of Two or more races (42%), White (42%), Hispanic (39%), Black (36%), Pacific Islander (21%), and American Indian/Alaska Native (19%). From 2000 to 2016, total college enrollment rates increased for White (from 39% to 42%), Black (from 31% to 36%), and Hispanic young adults (from 22% to 39%) but were not measurably different for the other racial/ethnic groups during this time period.

Yet in the last years retention of a behavioral health workforce has been particularly challenging.

Challenges related to shortage of, and low retention of a behavioral health workforce:

- **Increased Need for Services and Limited Access to Care:** The increased demand for mental health services is outpacing the supply of providers. Also, communities, especially those in rural areas, often have limited access to care because of a lack of public transportation or proximity to a mental health facility. Many mental health providers often choose not to work in rural areas because of poor reimbursement rates and low pay. These factors can prevent people from getting the treatment they need.[20]

- **An Aging Workforce:** Many of the mental health professionals in the United States are nearing retirement age. As some professionals retire, they are not being replaced by younger professionals at the same rate, creating a shortage in the field. According to the APA[6] the average age for psychologists is 48.9yrs.

- **Reimbursement Rates:** A report by the U.S. Government Accountability Office found that low reimbursement rates for the behavioral health workforce contribute to low recruitment and retention rates.[21]

- **Education:** Most programs that are designed to recruit a diverse workforce, recruit those who are already students in the field. The lack of a pipeline for minoritized groups to enter the workforce results in lower diversity.[21]

- **Workplace:** There is a dearth of supervisors and available internship programs in rural areas, further contributing to shortage of opportunities for providers in these areas.[21]

III. Proposed Solutions/ Best Practices Strategies

The Empowerment Leadership Academy (ELA) is an initiative designed to train and retain a diverse Hispanic and Latine behavioral health workforce. It focuses on capacity building, cultural responsiveness, and leadership development to equip practitioners with the skills needed to serve and advocate for diverse Latine communities effectively. The primary goal is to foster leadership skills among Latine providers in the behavioral health workforce which help facilitate transformative changes in their behavioral health organizations, improve service delivery and advance behavioral health equity.

The ELA aligns with the U.S. Department of Health and Human Services' Health Workforce Strategic Plan[22] which aims to enhance healthcare quality and expand the health workforce to meet the needs of diverse communities by offering health professionals development opportunities, encouraging integrated collaborative healthcare, strengthening workforce skills and increasing diversity, inclusion, and representation in health professions. As a best practice strategy, its focus on culturally grounded transformative leadership has been identified as one necessary for improving standards of care in minority health, including in substance use.[23] Given that Latine professionals often face barriers in their career and leadership trajectory as well as limited opportunities to advance despite feeling qualified for leadership positions[24], the academy offers participants a series of supportive resources, training offerings and learning experiences to navigate these challenges, build confidence, and leverage their unique perspectives to advance within the field.

The ELA's training structure also incorporates recommendations from the SAMHSA's Treatment Improvement Protocol on Improving Cultural Competence.[25] These include strategies for workforce and staff development, recruitment, retention, and promotion, all of which are reflective of the populations served. ELA therefore offers a comprehensive approach to developing a culturally responsive and diverse behavioral health workforce, integrating experiential learning, self-reflection, interprofessional education, and mentoring through and by members of the Latine behavioral workforce.

Through these efforts, the ELA aims to train and retain a Latine behavioral health workforce skilled in culturally responsive practices, enhancing care quality and ensuring the workforce can adapt to future challenges. This initiative contributes to a more inclusive and effective healthcare system by implementing culturally responsive learning frameworks that address disparities in behavioral health services and strategies for inclusive leadership within diverse Latine communities.

Ongoing Collaborative Capacity Building: Research indicates that single-day workshops are insufficient for building cultural competence or assuring implementation of evidence practices among behavioral health providers[26],[27]. The ELA acknowledges that cultural competence is an ongoing process, providing immersive professional development opportunities aligned with personal, professional, and organizational goals. Therefore, ELA emphasizes continuous, spaced learning, including follow-up sessions, as more effective than single-session training. It employs diverse learning strategies such as experiential learning, cultural and leadership self-awareness assessments, group sessions, mentoring and project development as a practical context for skill development.

ELA adopts an Interprofessional Education (IPE) approach, which enhances communication, team building, and patient outcomes by facilitating learning among professionals from various disciplines within the behavioral health workforce[28],[29]. This learning approach improves training effectiveness by forming peer-to-peer networks that support information exchange about implementation challenges and solutions[29]. As part of these collaborative learning environments, behavioral health practitioners have the space to engage directly with one another, consult, cooperate, and share insights, resources, successful implementations, and common obstacles. One of the significant benefits of adopting such an approach is the enduring connections and collaborations it fosters among participants. These relationships, built during the academy sessions, continue to provide support and facilitate professional growth and community impact long after the formal training has concluded.

Culturally Responsive Mentoring: Culturally responsive mentoring is a cornerstone of the ELA, focusing on the experiences and relationships of Latine mentors and mentees. This mentorship practice is vital for promoting leadership, growth, and retention within the Latine behavioral health workforce by establishing a relational and explorational foundation to identify strengths and leadership skills, build self-confidence, and reflect on personal and professional experiences. In the context of culturally diverse backgrounds, mentors provide vital insights and guidance on navigating the complexities of behavioral health settings while addressing its unique challenges.

Training and Experiential Components: Training at the ELA is experientially based and process-oriented, with self-reflection as a core component on both intrapersonal and interpersonal dimensions of leadership and workforce development capacity building. Participants engage in reflective practices to understand their cultural perspectives, self-awareness, and leadership styles. These activities are ongoing, with assignments and discussions extending between training sessions to reinforce and deepen learning.

Key areas of development include:

- **Self-Awareness:** Fostering understanding of participants' own cultural identities, histories and lived experiences as leaders in culturally responsive care and health equity.

- **Modeling Equitable Practices:** Learning experiences that facilitate the modeling of culturally responsive behaviors within their organizations, promoting inclusivity and supporting colleagues as part of the behavioral health workforce.

- **Knowledge Sharing:** Encouraging participants to share insights, literature, data and best practices as part of fostering a collaborative learning environment which can lead to tailor treatment services in culturally responsive care.

- **Decision-Making Proficiency:** Training on making informed and culturally sensitive decisions in clinical and organizational settings.

- **Cross-Sector Partnerships and Advocacy:** Equipping participants to develop partnerships between behavioral health systems and community-based organizations, essential for addressing comprehensive community needs.

Individual Mentoring and Group Sessions: Participants engage in monthly virtual one-on-one mentoring sessions, where they receive personalized guidance on leadership skills and project development. These sessions are crucial for addressing individual barriers and opportunities, allowing participants to apply their learning in real-world contexts. The mentoring focuses on implementing culturally responsive practices within their current roles and demonstrating tangible changes in their organizations.

Additionally, the ELA includes ten monthly ninety-minute group sessions led by experts in culturally responsive behavioral health. These sessions provide interactive educational experiences, fostering a collaborative learning environment where participants can share resources, successful implementations, and common challenges.

Project Outcomes: Participants are expected to lead organizational changes that reflect their learning and leadership development over the 10-month program. These projects, developed with mentor guidance, aim to demonstrate the participants' leadership skills and commitment to culturally responsive practices. Examples of organizational changes include incorporating bilingual materials, creating inclusive waiting areas, integrating cultural aspects into assessment forms, promoting inclusive hiring practices, and implementing multicultural supervision practices.

IV. Key Takeaways

Training, Recruitment and Retention Recommendations for a Diverse Latine Behavioral Health Workforce:

1. **Emphasize Culturally Responsive Competencies:** Develop culturally responsive skills and leadership abilities among Latine health professionals to address historical and structural disparities. This approach ensures providers can meet the unique needs of minority communities, improving care quality and service delivery.

2. **Promote Culturally Grounded Transformative Leadership:** Implement leadership training that focuses on the specific needs of Latine communities and the Latine behavioral health workforce. This training should address barriers, enhance health outcomes, and foster leaders advocating for culturally sensitive practices.

3. **Facilitate Discussions on Organizational Values:** Encourage open discussions about organizational values and norms, aiming to create an inclusive and equitable work environment. Address structural barriers and integrate the cultural awareness and experiences of Hispanic and Latine providers.

4. **Support Practice Changes Aligned with Cultural Values:** Develop strategies that incorporate the cultural knowledge and experiences of Latine providers into clinical practices. This approach builds trust with both providers and the healthcare system by ensuring services are culturally appropriate and respectful.

5. **Foster Networking, Mentoring, and Community Building:** Create opportunities for mentorship and peer connections among Latine professionals. This support network enhances resilience, job satisfaction, and retention, while encouraging the sharing of experiences and strategies to overcome workplace challenges.

6. **Recruit and Train Bilingual and Bicultural Professionals:** Address behavioral health care disparities by recruiting and training more bilingual and bicultural professionals. This ensures that the workforce reflects the diversity of the populations they serve, improving communication and service accessibility.

7. **Advocate for Policy Changes and Provide Workforce Incentives:** Support policy initiatives that promote diversity in the healthcare workforce, including funding educational programs for Latine students in behavioral health fields. Develop internship opportunities for diverse students in rural and provider shortage areas. Additionally, provide economic reimbursements for bilingual, bicultural providers who manage increased caseloads, thus attracting and retaining diverse talent in the field.

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