The CARE of Substance Use and Mental Health Disorders in Primary and Integrated Care Services for Hispanic and Latine Communities.

Hector Colon-Rivera MD, MBA, MRO, FAPA
December 17, 2024

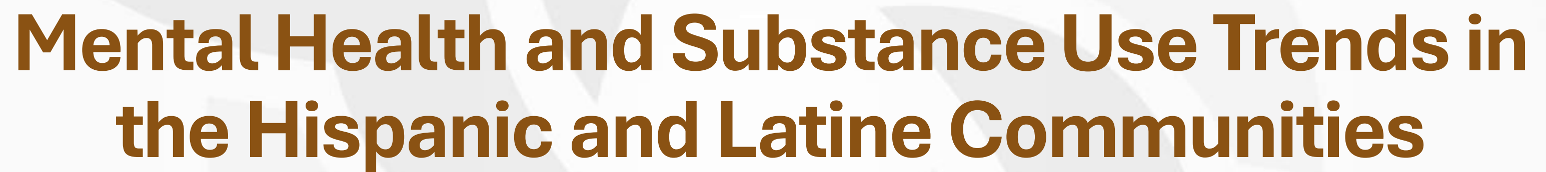
Mission

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.

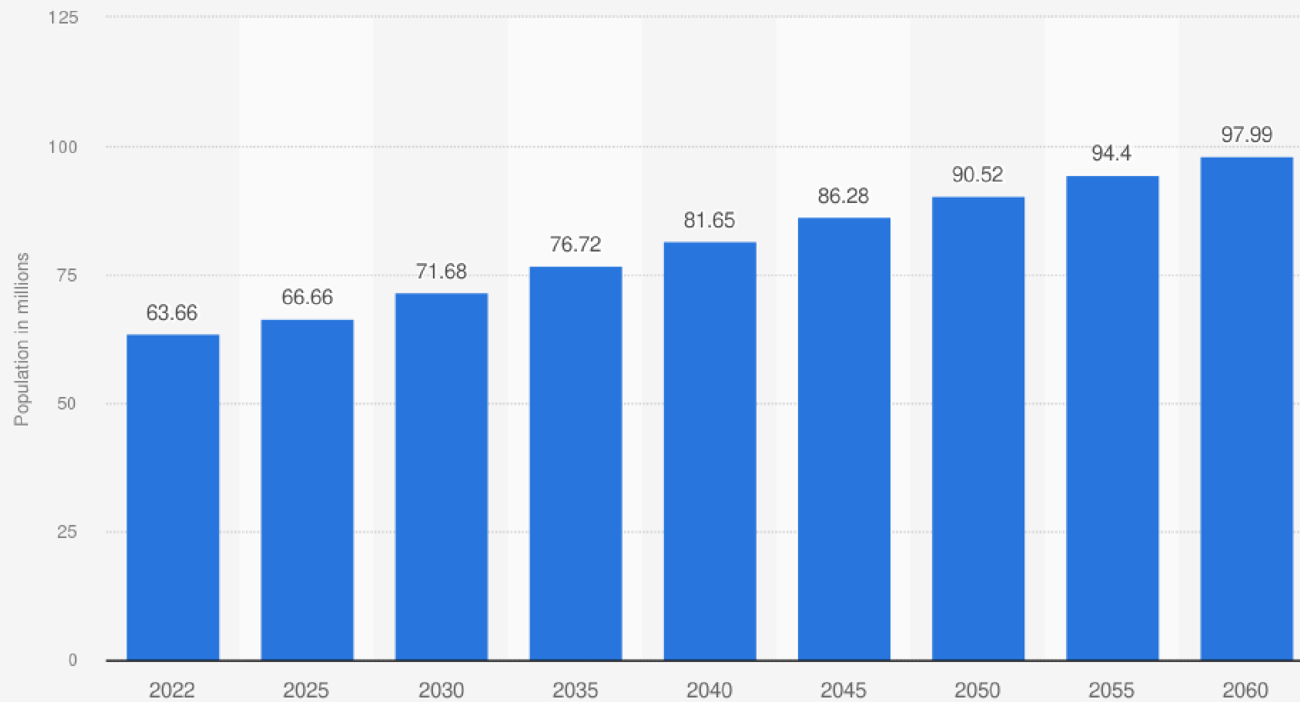
The Hispanic/Latino Behavioral Health Center of Excellence recognizes the complexities associated with gender and ethnic identification as well as the right of all individuals to self-identify. The Center uses the term Latine with the intention of both facilitating a fluent reading and pronunciation 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.

OBJECTIVES

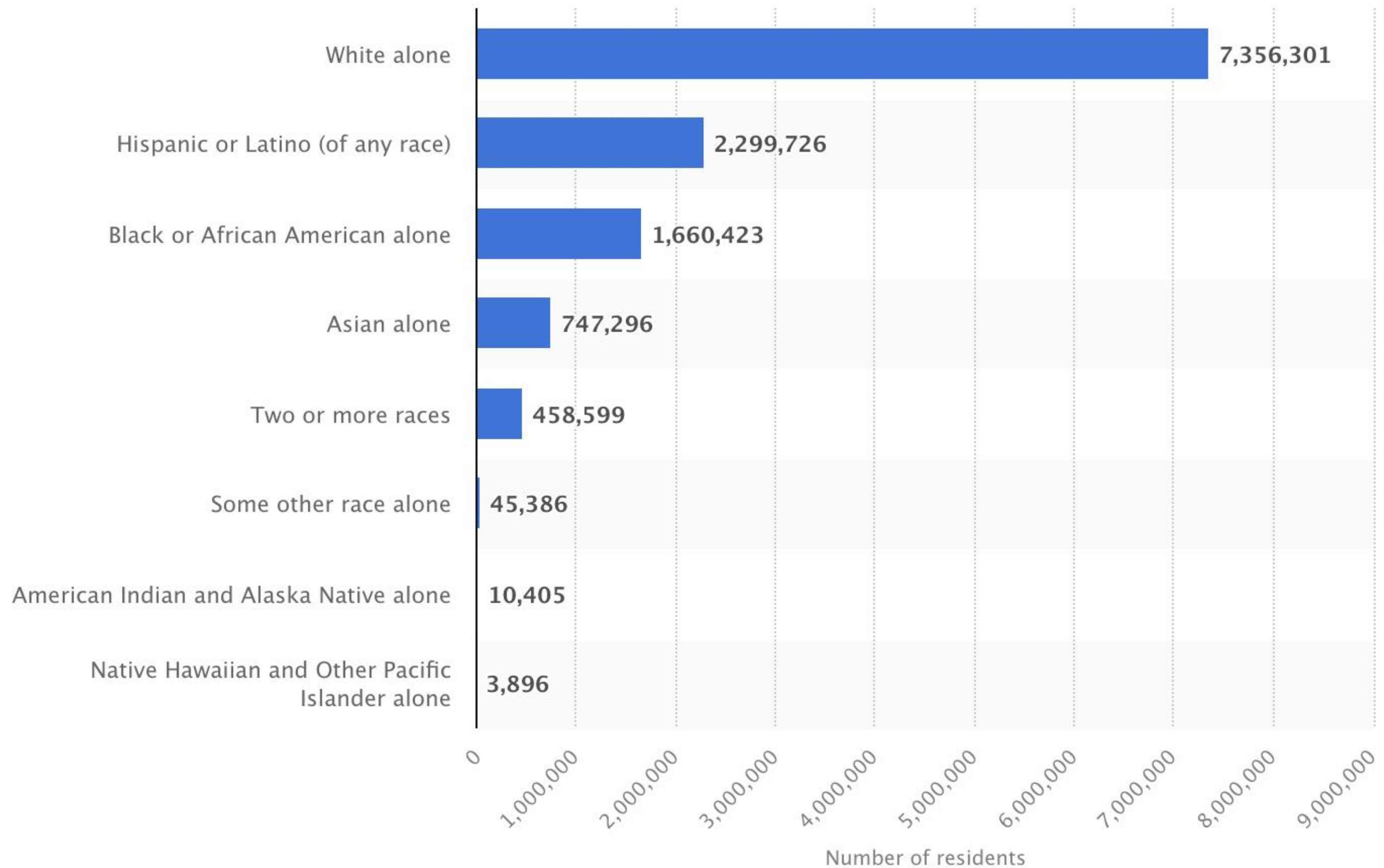
- Discuss mental health and substance use trends in the Hispanic and Latine communities.
- Define integrated health care and review research on the need and evidence for integration.
- Describe the prevention, assessment, and continuum of integrating behavioral treatments into primary healthcare settings for Hispanic and Latine patients.
- Discuss various integrated care models, multidisciplinary practice, and the different healthcare languages.
- Discuss facilitators and barriers, payment models, and the implications of treatment of mental health substance use disorder in primary care for Hispanic and Latine communities.



Mental Health and Substance Use Trends in the Hispanic and Latine Communities


Forecast of the Hispanic population of the United States from 2022 to 2060 (in millions)
125
100
75
50
25
0
Population in millions
63.66
66.66
71.68
76.72
81.65
86.28
90.52
94.4
97.99
2022
2025
2030
2035
2040
2045
2050
2055
2060
Source
US Census Bureau
© Statista 2024
Additional Information:
United States; US Census Bureau; 2022

RESIDENT POPULATION OF ILLINOIS IN THE UNITED STATES IN 2022, BY RACE AND ETHNICITY



HISPANIC/ LATINE HEALTH DISPARITIES

Fifty percent more likely to die from diabetes (CDC Vital Signs 2015)

Nearly nineteen percent (18.8%) of Latino adolescents report suicidal ideation and one-in-ten (11.3%) report having attempted suicide (CDC, 2015)

Hispanic binge drinking rates for the past year are the highest compared to other racial ethnic groups (NIAAA updated June 2019)

One in six Hispanics with HIV are unaware they have it.

Puerto Ricans had the highest overall prevalence rate among the Latino ethnic groups assessed

DEMOGRAPHICS / SOCIETAL ISSUES

According to the U.S. Census Bureau, the Hispanic population in the United States is expected to grow to 26.9% of the total population by 2060, up from 19.1% in 2023.

58.9 % percent of U.S. Hispanic/Latine people have a Mexican background, followed by 9.3 percent with a Puerto Rican background.

Nineteen percent of Latine/Hispanic people in the U.S. live in poverty.

Latine/Hispanic people are highly concentrated in a few states in the U.S.

There is a perception in Latine/Hispanic communities, especially among older people, that discussing problems with mental health can create embarrassment and shame for the family

Pew Research Center tabulations of the 2017 American Community Survey (1% IPUMS). https://www.pewresearch.org/fact-tank/2019/09/16/key-facts-about-u-s-hispanics/

IMMIGRANT HEALTH IN THE US

Latino immigrants in the US are healthier than their US-born Latino and non-Latino counterparts, but this health advantage diminishes over time and with higher levels of acculturation.

Acculturative stress, the stress associated with being a Hispanic immigrant and acculturating to the US, is a key driver of this decrease in health.

Past Year Substance Use Disorder (SUD): Among Hispanic People Aged 12 or Older

	Number (Percent)
No Past Year SUD	42.0M Hispanic People (82.6%)
Past Year SUD	8.9M Hispanic People (17.4%)

Number of People with Specific Past Year SUD among Hispanic People Aged 12 or Older	
Alcohol Use Disorder	5.5M (10.8%)
Drug Use Disorder[1]	5.0M (9.9%)
Marijuana Use Disorder	3.6M (7.2%)
Pain Reliever Use Disorder[2]	1.0M (2.0%)
Methamphetamine Use Disorder	353K (0.7%)
Stimulant Use Disorder[2]	279K (0.5%)
Cocaine Use Disorder	275K (0.5%)
Heroin Use Disorder	103K (0.2%)

Note: The estimated numbers of people with substance use disorders are not mutually exclusive because people could have use disorders for more than one substance.

[1] Includes data from all past year users of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives).

[2] Includes data from all past year users of the specific prescription drug.

23

Source: NSDUH, 2022

MENTAL HEALTH CARE FOR HISPANICS

Measure	Most Recent Disparity	Disparity Change
Adults who received mental health treatment or counseling in the last 12 months	Worse	No Change
Adults with a major depressive episode in the last 12 months who received treatment	Worse	No Change
Children ages 12-17 with a major depressive episode in the last 12 months who received treatment	Worse	No Change
Suicide deaths per 100,000 population	Better	Narrowing

HISPANIC/LATINO
BEHAVIORAL HEALTH
CENTER OF EXCELLENCE

INTEGRATED HEALTH CARE AND RESEARCH ON THE NEED AND EVIDENCE FOR INTEGRATION.

BEHAVIORAL FACTORS HIGHLY RELEVANT IN PRIMARY CARE

- Behaviorally-related physical complaints
  - Up to 70% of primary care visits are related to behavioral health needs
- Behavioral health disorders
  - 1 in 5 Americans are affected by behavioral health disorders during any given year
  - 50% of all behavioral disorders are treated in primary care
- Health behavior issues
  - On average, 97% of Americans need to change one or more health behaviors to maintain or regain health

PRIMARY CARE TRANSFORMATION

Hispanic Americans are less likely than other Americans to have a primary care provider and to have seen a health care provider recently.

Preferences for seeing a Hispanic health care provider are similar to preferences for a Spanish-speaking provider.

A comprehensive biopsychosocial approach.

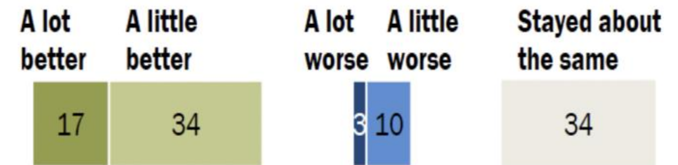
Patient-centered

Team-based care that integrates behavioral health assessment and intervention.

Meet the diverse needs of patients and their families in primary care.

51% of Hispanic adults think health outcomes for Hispanic people have gotten better in past 20 years

% of Hispanic adults who say that in the past 20 years, health outcomes for Hispanic people have gotten ...



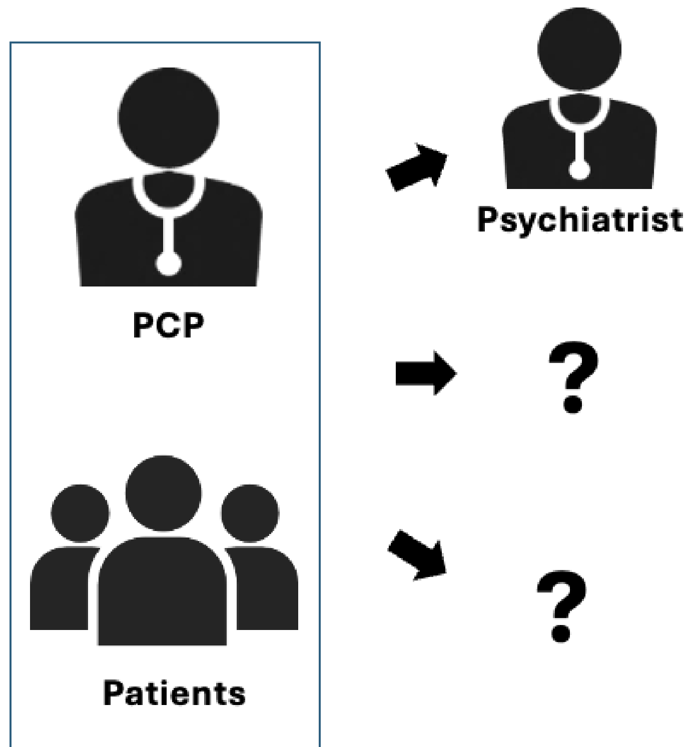
Note: Respondents who did not give an answer are not shown.
Source: Survey conducted Nov. 30-Dec. 12, 2021.
"Hispanic Americans' Trust in and Engagement With Science"

PEW RESEARCH CENTER

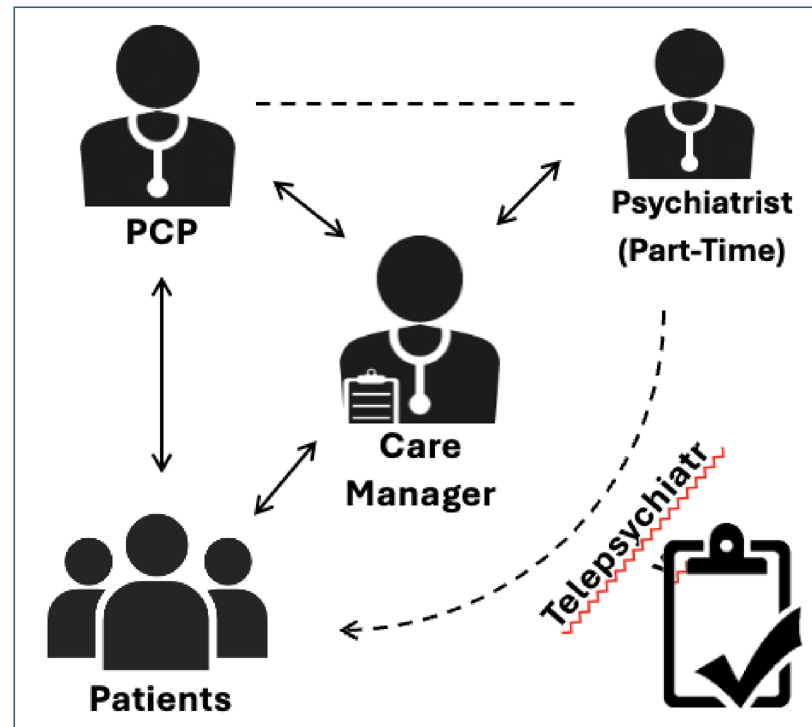
HISPANIC/LATINO
BEHAVIORAL HEALTH
CENTER OF EXCELLENCE

THE CONSULTANT: A FLEXIBLE & PATIENT CENTERED APPROACH TO ASSESSMENT AND INTERVENTION

Traditional Model



Collaborative Care Model



Co-location/Co-located Service

A behavioral health provider working in a space that is embedded in (or in close proximity to) a primary care clinic.

Collaborative Care/Collaboration

The interactions between primary care and behavioral health providers for the purpose of developing treatment plans, providing clinical services and coordinating care to meet the physical and behavioral health needs of patients.

Collaborative Care vs. Traditional MH

	Co-Located Collaborative MH Care	**Mental Health Specialty Care**
Location	In PC Clinic	A different floor, bldg…
Population	Most are healthy	Most have MH Diagnoses
Inter-Provider Communication	Collaborative & On-going Consultations via PCP's Method of Choice	Consult reports CPRS notes
Service Delivery Structure	Brief appointments (20-30') Limited number of appointments (avg. bet 2 & 3)	50 - 90 minute psychotherapy sessions 14 week minimum
Approach	Problem-focused Solution Oriented Patient Centered	Varies by therapy Diagnosis-focused
Treatment Plan Leader	PCP continues to be lead	MHP is lead
Primary Focus	Support the over-all health of the Veteran Focus on function	Cure or Ameliorate Mental Health Symptoms

Brief Assessment Tools

Not Rorschach or MMPI or…., but brief evidence-based screens such as

- PHQ 9 or PHQ 2
- GAD 7
- PCL-M
- AUDIT C
- Blessed Orientation Memory Concentration
- Others?

Interview Assessments

Focus on functioning, and tailored around PCP reason for referral

This 30 min. challenge can be organized around 5 A's:

- ***Assess***
- ***Advise***
- ***Agree***
- ***Assist***
- ***Arrange***

5 A's Model

Integrated approach to assessment and intervention

Well-established & evidence-based

Familiar to PC clinicians & PC teams

Can be applied to any patient with any problem

Highly adaptable to the preferences of patients

Applying the 5 A's to a Common Primary Care Problems

DEPRESSION IN THE PRIMARY CARE SETTING

- 10%-30% of patients have depression
- Frequently unrecognized by PCPs
- Time-limited psychotherapies often effective when combined with antidepressant treatment
- Patients with mild to moderate depression can be effectively treated in PC
  - Referral may be needed for patients with higher levels of severity

ASSESS DEPRESSION

- Introduce, identify, clarify
- Assess the patient's goals and motivation
  - What does the patient want to change?
  - What are the patient's levels of motivation and confidence?
- Conduct symptom assessment
  - Tools: PHQ-2, PHQ-9, MDQ, 'SIGECAPS'
- Conduct functional assessment
  - Onset, duration, intensity, frequency, effects on functioning
  - Potential biological causes: thyroid disorders, nutritional deficits, neurological damage (eg, head trauma, stroke), substance use
  - Suicidal ideation: history, precipitants, frequency, method, impulsivity
  - Assess medication adherence if antidepressant has been prescribed

ADVISE

- **Identify the patient’s solutions**:
  - Inquire about what has helped patient with depression previously, and what they were doing differently then and what we do now.
- **Discuss options**
  - Consider antidepressant prescription, watchful waiting, referral to specialty and options suggested by the patient
- **Develop a plan**
  - Present evidence-based options for depression: behavioral activation, cognitive disputation, problem-solving, patient’s own method
  - Describe what each option involves and how it may help
  - Begin motivational interviewing with patients not ready to take action

AGREE

- Engage the patient in discussing the options put forth in the ‘Advise’ step
- Allow the patient to suggest new options of her own
- Give the patient the opportunity to discuss options with family or friends if they wish
- A follow-up appointment may be necessary to discuss the options further

ASSIST

- Implement one or more interventions chosen by the patient
  - Selected Intervention: Behavioral activation
    - Help the patient set specific and realistic goals to increase enjoyable and meaningful activities
    - Explain why and how the patient should monitor her mood daily

ARRANGE

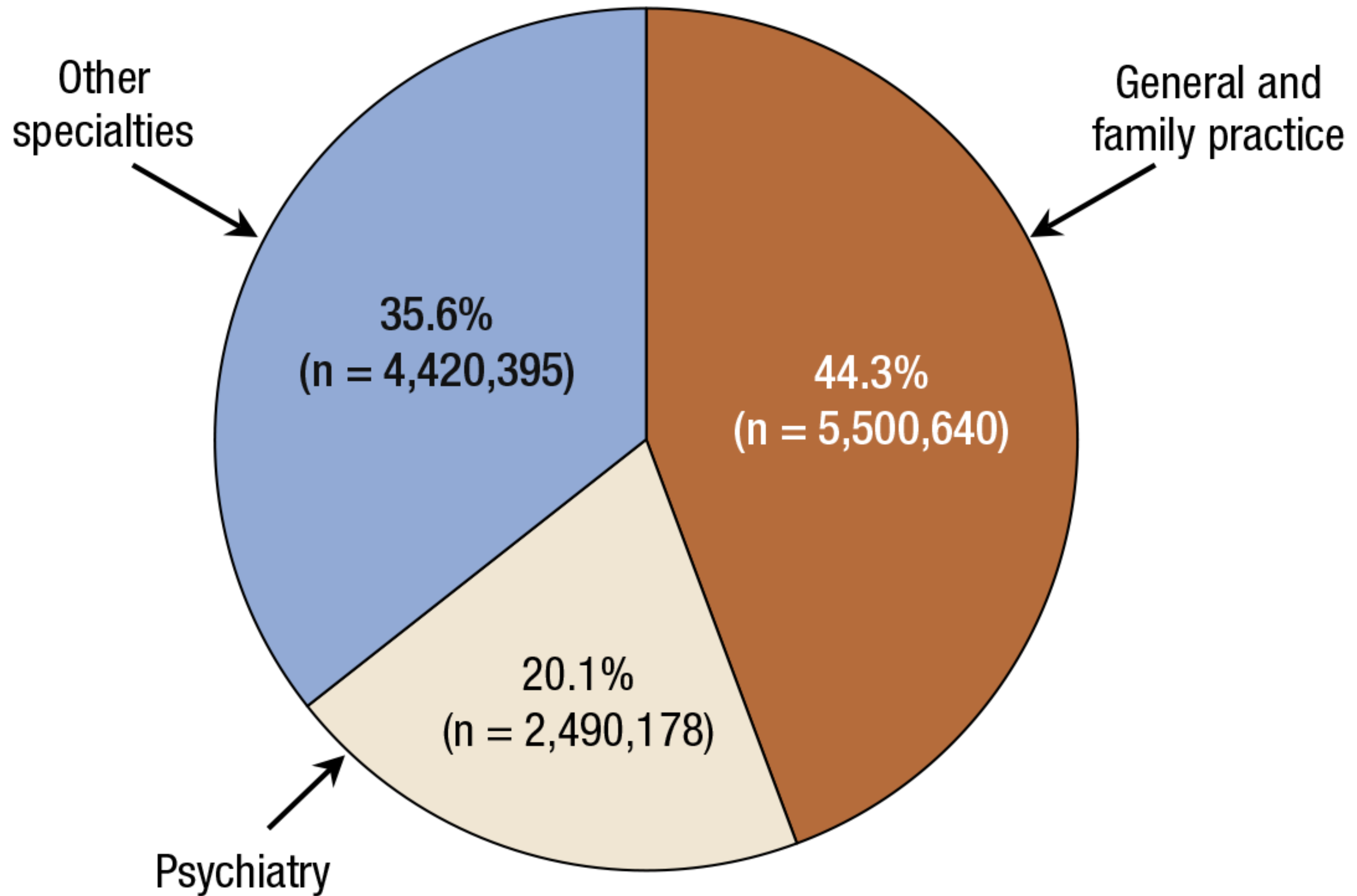
- Follow-up visits can vary greatly between individuals
- If patient is not having success after 2 or 3 visits and barriers are difficult to overcome, consider referral to specialty mental health
- Keep PCP apprised of patient's progress

PREVENTION, ASSESSMENT, AND TREATMENT AND THE CONTINUUM OF INTEGRATION OF BEHAVIORAL TREATMENTS INTO PRIMARY HEALTHCARE SETTINGS FOR HISPANIC AND LATINE PATIENTS.

Relapse Prevention in Primary Care

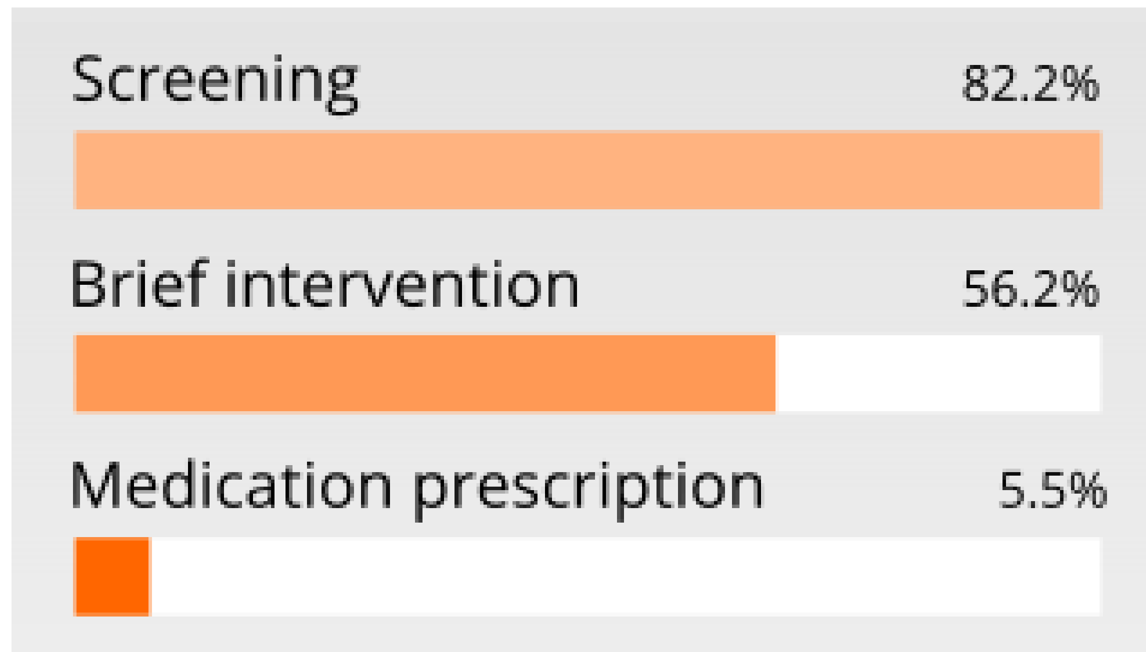
Table 1.—Relapse Prevention Strategies in the Primary Care Setting
Identify patients in recovery
Establish a supportive patient-physician relationship
Schedule regular follow-up
Mobilize family support
Facilitate involvement in 12-step recovery groups
Help recovering patients recognize and cope with relapse precipitants and craving
Advise recovering patients to develop a plan to manage early relapse
Facilitate positive lifestyle changes
Manage depression, anxiety, and other comorbid conditions
Consider adjunctive pharmacotherapy
Collaborate with addiction specialty professionals

Friedmann, P. D., Saitz, R., & Samet, J. H. (1998). Management of adults recovering from alcohol or other drug problems: relapse prevention in primary care. *Jama*, *279*(15), 1227-1231.



Margaret E. Mattson, Ph.D. and Sean Lynch, Ph.D., L.C.S.W. (2015) The CBHSQ Report: Medication Prescribing and Behavioral Treatment for Substance Use Disorders in Physician Office Settings. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD.

ALCOHOL USE DISORDER



Ornstein, S. M., Miller, P. M., Wessell, A. M., Jenkins, R. G., Nemeth, L. S., & Nietert, P. J. (2013). Integration and sustainability of alcohol screening, brief intervention, and pharmacotherapy in primary care settings. *Journal of studies on alcohol and drugs*, *74*(4), 598-604.

BARRIERS ON IMPLEMENTATION

System Level

– Government and insurance policies, program characteristics (such as treatment philosophy), lack of pharmaceutical industry support, and logistical issues like lack of equipment or access to prescribing clinicians

Provider Level

– Informational Deficits / Perceptions and Concerns (Attitudes)

Patient Level

– Informational Deficits / Perceptions and Concerns (Attitudes)

Oliva, E. M., Maisel, N. C., Gordon, A. J., & Harris, A. H. (2011). Barriers to use of pharmacotherapy for addiction disorders and how to overcome them. *Current psychiatry reports*, *13*(5), 374-381.

OVERCOMING BARRIERS

Training speeds implementation of pharmacotherapy, but is not sufficient in changing provider behavior

Clinical support systems that provide mentorship, consultation, and educational support improve provider self-efficacy

Oliva, E. M., Maisel, N. C., Gordon, A. J., & Harris, A. H. (2011). Barriers to use of pharmacotherapy for addiction disorders and how to overcome them. *Current psychiatry reports*, *13*(5), 374-381.

EVIDENCE BASED MODELS FOR MAT IN PRIMARY CARE

Hub and Spoke Model

Collaborative Opioid Prescribing (Co-OP) Model

Office-Based Opioid Treatment (OBOT) (Yale)

Massachusetts Nurse Care Manager Model

Buprenorphine HIV Evaluation and Support (BHIVES) Collaborative Model

One Stop Shop Model

Project Extension for Community Healthcare Outcomes (ECHO)

Medicaid Home Model for Those With OUD

Southern Oregon Model

Emergency Department Initiation of OBOT

Inpatient Initiation of MAT

Integrated Prenatal Care and MAT

Chou R, Korthuis PT, Weimer M, Bougatsos C, Blazina I, Zakher B, Grusing S, Devine B, McCarty D. Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings. Technical Brief No. 28. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No. 16(17)-EHC039- EF. Rockville, MD: Agency for Healthcare Research and Quality. December 2016. www.effectivehealthcare.ahrq.gov/reports/final.cfm - Accessed 12/6/2016.

Discuss Various Integrated Care Models, Multidisciplinary Practice, and the Different Healthcare Languages

INTEGRATION SERVICES

- Consultation/Liaison C/L
- Collaborative Care
- Coordinated-Care and Care Management
- Co-located MH/BH services
- Integrated Care
- Patient Centered Medical Home (PCMH)
- Person Centered Care
- Shared Care

CONSULTATION/LIAISON C/L

- Developed in 1950s to extend mental health services to medical and surgical inpatients
- Studies of C/L in primary care have demonstrated better treatment outcomes and decreased cost when mental health care is readily available in primary care settings

ELEMENTS OF COLLABORATIVE CARE

- Routine screening for mental and behavioral health conditions conducted in primary care settings.
- Referral relationship between primary care and mental health providers.
- Routine exchange of information between providers
- Primary care providers deliver specific mental health interventions using treatment protocols and algorithms
- Case managers facilitate communication between providers, monitor treatment outcomes and make referrals for the patient to resources in the community

CO-LOCATED MEDICAL AND MENTAL/ BEHAVIORAL HEALTH SERVICES

- Co-location describes where services are provided rather than a specific approach to care.
- Medical and mental/behavioral health services are located in the same facility
- Referral is made for medical patients to be seen by mental health specialists
- Consultation between medical and mental health providers is facilitated by co-location and that holds the potential to increase the skills of both groups

INTEGRATED CARE

- Comprehensive and coordinated/team-based approach to care and decision-making for medical and mental health conditions
- Ideally, integrated at one site with a unified care plan covering mental/behavioral and medical care needs
- Typically employs a multidisciplinary team working together often using a prearranged protocol and evidence-based practices (e.g. CBT, Solution Focused Therapy)
- Frequently includes close organizational integration and the monitoring and tracking of patients over time

PATIENT–CENTERED MEDICAL HOME

- A place and a model of holistic person-centered healthcare that is often team-based, comprehensive and coordinated
- Provides care through a physician-directed interprofessional care team usually composed of a physician, advanced practice nurse or physician assistant, social worker, and pharmacist
- Medical homes vary in size and provide a regular source of healthcare for individuals with a broad range of medical, mental and behavioral healthcare needs

PERSON-CENTERED HOLISTIC/SHARED CARE

- Person-Centered Care: services that are responsive to individual patient preferences, needs, and values ensuring that patient preferences guide all clinical decisions
- Shared Care: primary care and mental health professionals work together in a shared system in which providers maintain one treatment plan addressing all patients' health needs in a shared medical record (e.g. Canadian Model)

Care Management

Algorithm-based care that includes routine monitoring/assessment of patients focusing on

- Psychoeducation; encourage self-management skills
- Brief treatment including (but not limited to) medication
- Adherence to medication, treatment plan

In consultation with the supervising clinician, provide relevant information to the PCP to allow collaboration for appropriate care decisions

Key Components of CM

- Offer telephonic contact
  - Much appreciated by patients
- Stepped Care Approach
- Strong ties to mental health supervision
- Initial decisions and prescribing in primary care
- Assessment based
- Tracking important
- Emphasis on patient self-management support
- Care manager – facilitates communication

Why care management?

Supports patient-centered care – incorporates convenience and preference

Better symptom and functional outcomes

Greater adherence to treatment

Reduced mortality

Greater engagement in care

Role of the Care Manager

- Assessment and triage
- Decision support
- Patient education and activation
- Monitor adherence to treatment, treatment outcomes, and medication side effects
  - Follow-up with pts 6-8 times over 6 months
- Collaborate with mental health specialists
- Support patient self-management
- Referral management

Care Managers

Nurses and social workers most commonly, but others serve as care managers including psychologists

Content of contacts may differ depending on discipline – but includes active follow-up, measurement-based care, medication monitoring (when appropriate) and supporting patient self-management

ALL-PAYER HEALTH EQUITY APPROACHES AND DEVELOPMENT (AHEAD) MODEL

DESIGNED TO IMPROVE HEALTH EQUITY BY INCREASING INVESTMENTS IN PRIMARY CARE AND INTEGRATING BEHAVIORAL HEALTH AND SOCIAL NEEDS.

THE MODEL INCLUDES COMPONENTS TO IMPROVE PRIMARY CARE AND LEAD TO BETTER CARE MANAGEMENT AND BEHAVIORAL HEALTH INTEGRATION.

MAT Sub analysis in AHEAD Trial

Journal of Substance Abuse Treatment 52 (2015) 17–23

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

The Prescription of Addiction Medications After Implementation of Chronic Care Management for Substance Dependence in Primary Care

Tae Woo Park, M.D. [a,b,c,*], Jeffrey H. Samet, M.D., M.A., M.P.H. [b,d], Debbie M. Cheng, Sc.D. [b,e,f], Michael R. Winter, M.P.H. [f], Theresa W. Kim, M.D. [b], Anna Fitzgerald, M.D. [c], Richard Saitz, M.D., M.P.H. [b,d]

Park, T. W., Samet, J. H., Cheng, D. M., Winter, M. R., Kim, T. W., Fitzgerald, A., & Saitz, R. (2015). The prescription of addiction medications after implementation of chronic care management for substance dependence in primary care. Journal of substance abuse treatment, 52, 17-23.

SUMMIT STUDY

Research

JAMA Internal Medicine | Original Investigation

Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care

The SUMMIT Randomized Clinical Trial

Katherine E. Watkins, MD, MSHS; Allison J. Ober, PhD; Karen Lamp, MD; Mimi Lind, LCSW; Claude Setodji, PhD; Karen Chan Osilla, PhD; Sarah B. Hunter, PhD; Colleen M. McCullough, MPA; Kirsten Becker, MS; Praise O. Iyiewuare, MPH; Allison Diamant, MD; Keith Heinzerling, MD; Harold Alan Pincus, MD

Watkins, K. E., Ober, A. J., Lamp, K., Lind, M., Setodji, C. M., Osilla, K. C., ... & Diamant, A. (2017). Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care. JAMA Internal Medicine [Epub August 2017]. doi: 10.1001/jamainternmed.2017.3947

Ober, A. J., Watkins, K. E., Hunter, S. B., Lamp, K., Lind, M., & Setodji, C. M. (2015). An organizational readiness intervention and randomized controlled trial to test strategies for implementing substance use disorder treatment into primary care: SUMMIT study protocol. *Implementation Science*, *10*(1), 1.

SUMMIT STUDY

Federally Qualified Health Center in Los Angeles

Patients with Alcohol and Opioid Use Disorders

Focused on the clinical application of:

- Screening, Brief Intervention, Referral to Tx
- Buprenorphine / naloxone
- Naltrexone Long Acting Injection
- 6 motivational interviewing based sessions

Ober, A. J., Watkins, K. E., Hunter, S. B., Lamp, K., Lind, M., & Setodji, C. M. (2015). An organizational readiness intervention and randomized controlled trial to test strategies for implementing substance use disorder treatment into primary care: SUMMIT study protocol. *Implementation Science*, *10*(1), 1.

SUMMIT STUDY TAKE-AWAYS

Take-away 1

- A strategy consisting of BOTH organizational readiness and collaborative care can facilitate implementation of OAUD treatment in primary care and lead to improved patient outcomes

Take-away 2

- Collaborative Care leads to increased OAUD treatment access in primary care

Take-away 3

- Patients who receive any treatment (with CC) do better than those who do not, regardless of type of treatment

Take-away 4

- Despite perceived barriers, treatment can be successfully integrated

Slide courtesy of Watkins, et al.

IMPLEMENTATION, FACILITATORS AND BARRIERS, PAYMENT MODELS, AND THE IMPLICATIONS OF TREATMENT OF MENTAL HEALTH SUBSTANCE USE DISORDER IN PRIMARY CARE FOR HISPANIC COMMUNITIES.

Case

You are a consulting psychiatrist working at a FQHC

No MAT services for SUD or LAI for psychosis

Medical Director, “well, we refer out for that.”

How would you respond?

Meeting the Challenge

There are not sufficient psychiatrists and addiction specialists to provide treatment for addictions

Internists and Family Medicine clinicians have stepped up to the challenge and are treating addictions

They need mentorship from Behavioral Medicine

HOW TO IMPROVE PSYCHIATRIST LIAISON IN BEHAVIORAL TREATMENT

Primary care physicians appreciate

- Brevity
- Timeliness
- More frequent written correspondence

The quality of communication between treating physicians affects the quality of care provided to the patients

STATE REIMBURSEMENT OPTIONS

- Fee-for–service
- Practice-based care/case management under contract to health plans
- Pay-for-performance
- Flexible payments for chronic care and disease management
- Global capitation
- Hybrid models

FACILITATORS FOR INTEGRATED HEALTHCARE

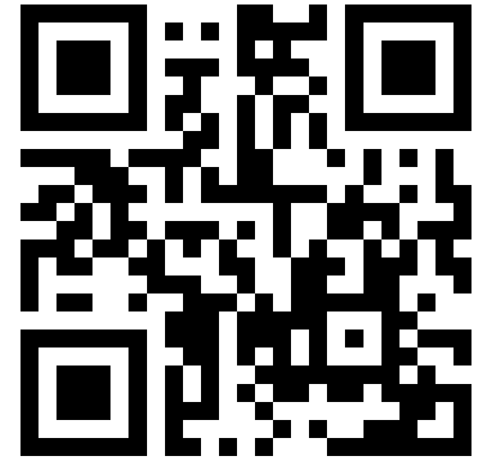
- Co-location of behavioral health providers in primary care sites
- Routine screening strategies to increase behavioral health diagnoses
- Computer-based screening
- Co-treatment by primary care and BH providers
- Unified medical record for physical and mental health
- Use of medication algorithms for MH disorders
- Organizational support for collaborative care
- Tracking of behavioral health care outcomes
- Training of primary care providers on BH conditions
- Use of evidence-based practice protocols

BARRIERS IN INTEGRATED HEALTHCARE

- Perceived loss of autonomy
- Primary care providers' limited training in MH treatment
- Workforce shortages
- Limited time in primary care clinics
- Lack of agreement as to who is in charge
- Lack of reimbursement for screening and/or consultation between primary care and BH providers
- Same day billing restrictions
- Social Workers limited training in interprofessional team-based practice and primary care settings

¡Gracias! Thank You!

Your opinion is important to us!
Fill out your evaluation form.
Just scan this code with
your smartphone.



If you cannot complete the evaluation with the QR code, an email with the link will be sent to you after the webinar.

CONTACT US

Website: www.hispaniclatinobehavioralhealth.org
Email: info@hispaniclatinobehavioralhealth.org

@hlbhcoe

RESOURCES

COMPETENCIES FOR MENTAL HEALTH IN PRIMARY CARE SETTINGS

Core Competencies for Behavioral Health Providers Working in Primary Care

- http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf

Competencies for Psychology Practice in Primary Care

- https://www.apa.org/ed/resources/competencies-practice.pdf

NASW Standards for Social Work Practice in Health Care Settings

- https://www.socialworkers.org/LinkClick.aspx?fileticket=fFnsRHX-4HE%3D&portalid=0

FUTURE DIRECTIONS IN MENTAL HEALTH IN PRIMARY CARE

Not all patients fit into manualized protocols and will require the skill and supervision of trained providers.

We will only meet the needs of older adults if we integrate Mental Health into Primary Care.

Digital literacy increases access to health information

A multi-pronged approach is essential to meet individual digital skills needed among the Latino community.

Partnerships are crucial to developing culturally tailored interventions to reduce digital health barriers.

More focus on patient-centered interventions to support underserved populations' culturally humble health needs.

OTHER REFERENCES

AMERICAN PSYCHIATRIC ASSOCIATION

United States Census Bureau. United States Census Quick Facts. United States Department of Commerce. 2020. https://www.census.gov/quickfacts/fact/table/US/RHI725219.

United States Census Bureau. 2020 Census Illuminates Racial and Ethnic Composition of the Country. https://www.census.gov/library/stories/2021/08/improved-race-ethnicity-measures-reveal-united-states-population-much-more-multiracial.htm.

Sewell AA. Disaggregating ethnoracial disparities in physician trust. Soc Sci Res. 2015; 54, 1–20.

Fields A, Abraham M, Gaughan J, et al. Language matters: race, trust, and outcomes in the pediatric emergency department. Pediatr Emerg Care. 2016; 32(4): 222–226. 1

López-Cevallos DF, Harvey SM, Warren JT. Medical mistrust, perceived discrimination, and satisfaction with health care among young-adult rural Latinos: satisfaction with care among rural Latinos. J Rural Health. 2014; 30(4):344–351.