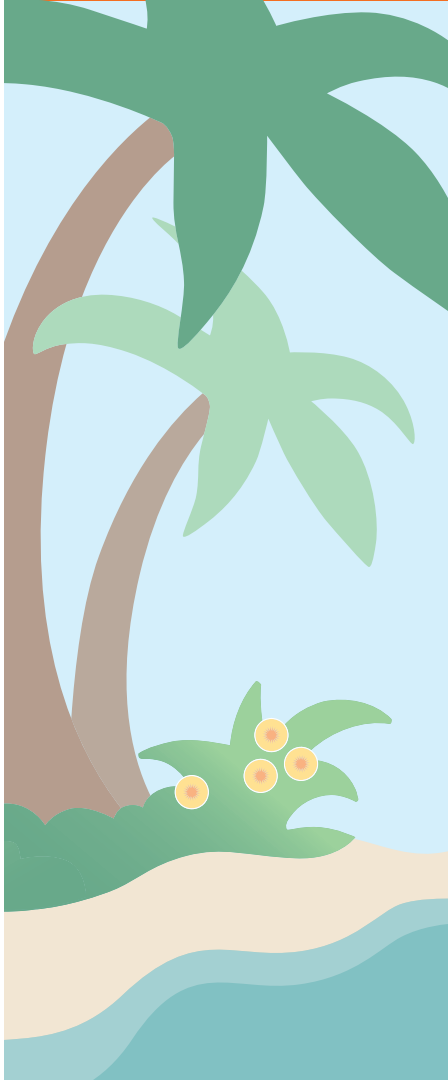


Services for Hispanic Children and Families

SUMMARY OF THE SPECIAL FORUM HELD AT THE
2006 GEORGETOWN UNIVERSITY TRAINING INSTITUTES

ORLANDO, FLORIDA • JULY 2006

PREPARED BY: BETH A. STROUL, M.ED.



Introduction

A series of Special Forums were held at the Georgetown University Training Institutes in July 2006 to provide opportunities for dialogue about critical issues in order to contribute to the development of future policy and technical assistance. The Special Forums were designed as interactive discussions about communities and populations with unique service needs, requiring specialized planning and service delivery approaches within systems of care. Specifically, the goals of the Special Forums were to:

- Summarize issues and challenges related to each topic
- Identify effective service delivery strategies for local systems of care
- Develop recommendations for policy and technical assistance that will support communities in implementing these effective service delivery strategies

Each Special Forum began with brief framing presentations summarizing issues and challenges related to the topic and offering examples of effective service delivery strategies. The remainder of the forum consisted of facilitated discussion among forum participants focusing on recommendations for services, financing, policy, advocacy, information development and dissemination, and training and technical assistance. The Special Forums were tape recorded and transcribed, and additional input was collected from participants through worksheets completed at the conclusion of each forum. These materials were used to prepare a paper summarizing the issues and recommendations resulting from each Special Forum.

This paper presents the issues and recommendations from the Special Forum on Services for Hispanic Children and Families. Presenters included:

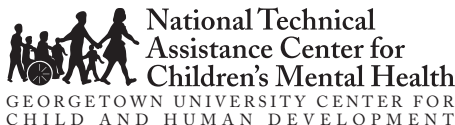
- Mario Hernandez, Ph.D., *Professor, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, FL*
- Jesse Herrera, L.C.S.W., *Behavioral Health Services Manager, Behavioral Health Division, Monterey County Health Department, Salinas, CA*
- Myriam Monsalve-Serna, M.Ed., *Executive Director, Center for Community Learning, Miami, FL*

Issues and Strategies

Framework for Culturally Competent Services

Mario Hernandez presented a framework for culturally competent services, particularly in terms of reaching populations of color. The framework was derived from a review of the research literature and site visits to identify evidence-based practices (not treatments, but rather practices) that support

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cultural competence. Hernandez presented diagrams to frame the discussion and to provide a way of organizing new ideas, depict the parts of organizations and systems within which new strategies should be implemented, and provide a better way to communicate about creating culturally competent systems of care.

As shown on Figure 1, Hernandez explained that all activity occurs in a community context. Recognition of the community context is important because findings in the literature review and site visits underscored that the community in which services are being offered has a major impact on people’s willingness to come for services, as well as on

the provider’s willingness to reach out to engage the population in services. For example, one city recently has passed a law that forbids hiring people who cannot provide documentation to prove their legal immigration status. These types of immigration issues contribute to the community context for Latino people, and affect whether or not they feel sufficiently safe to come to an agency or program that they believe might be related to a government entity and where they think they might be identified. It is difficult to be culturally competent without paying attention to the community context.

Hernandez further explained that within the community, there are

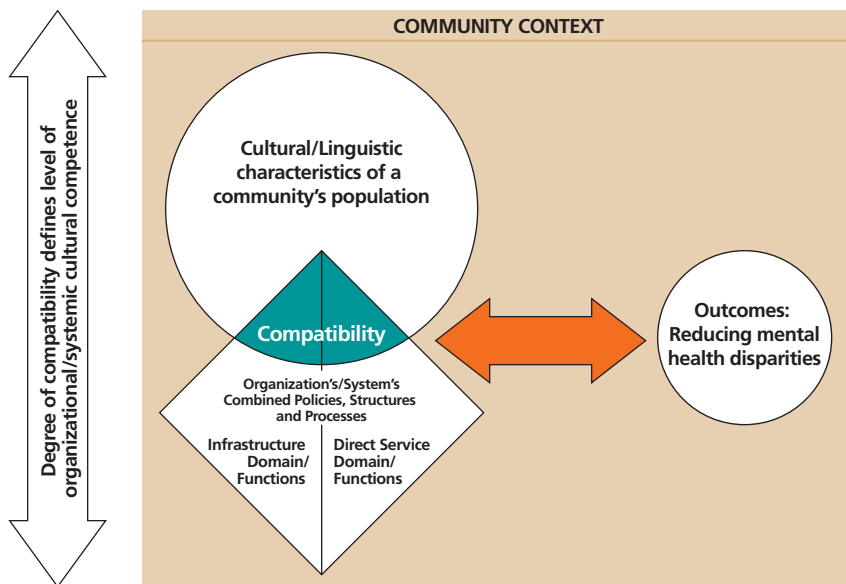
many populations, and the circle on Figure 1 represents the cultural and linguistic characteristics of the community population to be served. For Hispanic children and families, this means people who are Spanish speaking and who could come from many different countries, have many different cultures and histories, and have many different reasons for being in the United States. In order to provide culturally competent services, knowing about the population is essential, including their cultural view of mental health, their history, language characteristics, resources, and strengths.

Hernandez stated: “For instance, if you are trying to reach out to a population of Puertoriquenos, then what do you need to know about Puertoriquenos? What if it were a Cuban population? What generation of Cuban population is it? People who came a long time ago are very different from those who came more recently, in terms of many characteristics such as political views. Individuals from a Mexican population group who do migrant work have different issues; their level of literacy and familiarity with institutions might be very different from other groups. Puerto Ricans are more familiar with the institutions that are part of America, because many of these institutions are similar to those in Puerto Rico. However, in other countries, mental health often isn’t thought of in the same way. Thus, it is impossible to be culturally competent without knowing the population that you are trying to serve.” The best way to learn about the population you want to serve is to find out which individuals or organizations are the “gatekeepers” in the community. These individuals or organizations can identify people who can tell you about the populations.

FIGURE 1

Conceptual Model for Accessibility of Mental Health Services to Culturally/Linguistically Diverse Populations

Definition: Within a framework of addressing mental health disparities within a community, the level of a human service organization’s/system’s cultural competence can be described as the degree of compatibility and adaptability between the cultural/linguistic characteristics of a community’s population AND the way the organization’s combined policies and structures/processes work together to impede and/or facilitate access, availability and utilization of needed services/supports (Cross, Bazron, Dennis, & Isaacs, 1989; Siegel, 2004; CMHS, 1997).



Hernandez, M., & Nesman, T. (2006).

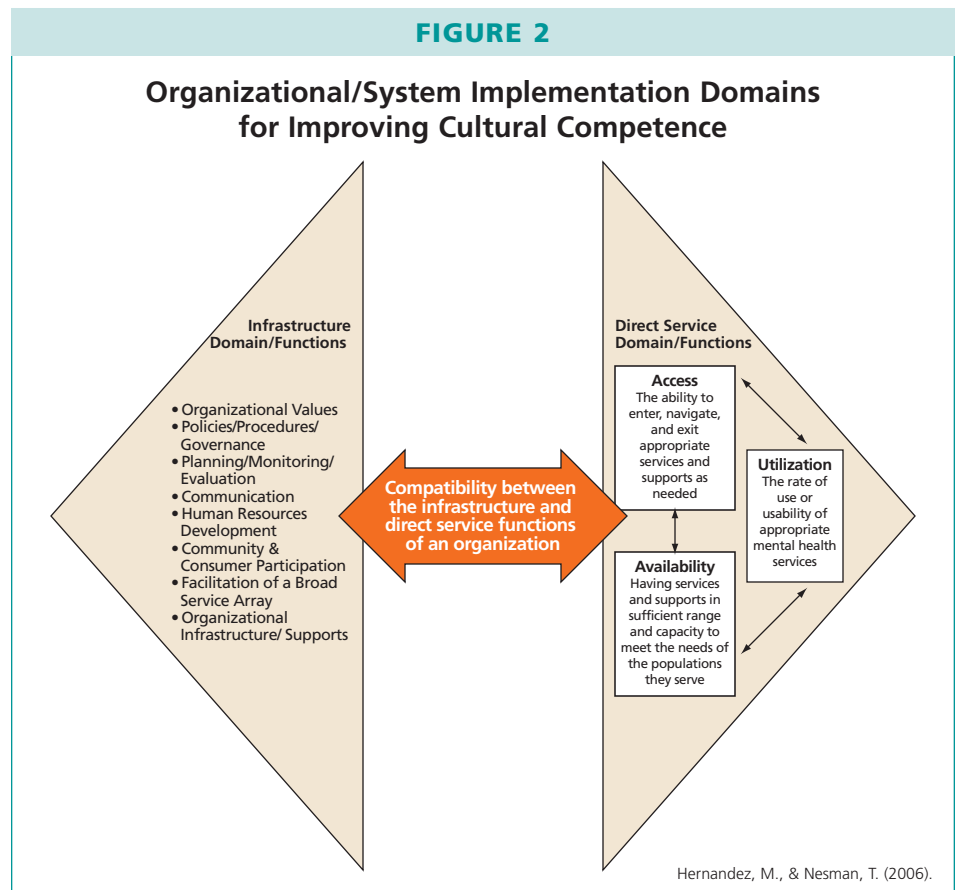
The diamond on Figure 1 represents the actual organization or the system of care. It may be a provider agency attempting to be culturally competent or a system of care comprised of different agencies and systems (mental health, education, juvenile justice, and child welfare) collectively attempting to improve cultural and linguistic competence. Hernandez noted that a working definition of cultural competence is the degree of overlap or compatibility between the cultural and linguistic characteristics of the population and the combined policies, structures, and processes characterizing the organization or system of care. The more those overlap, the more people feel comfortable coming and receiving services. Thus, the degree of compatibility defines the level of organizational or systemic cultural competence.

Hernandez reported that site visits have revealed many places with a high degree of overlap that are outstanding at providing services. “For example, in one instance, a woman might come to a provider agency saying, ‘Look, I got this paper from where I live, the apartment complex sent it to me, I don’t know what this paper is and what I’m supposed to do about it.’ She doesn’t feel as if she has to come in or have a case opened on her or have a diagnosis. Whatever her original issue, she might come four or five times and it isn’t until the fifth time that she starts revealing that her husband hasn’t been able to get a job, he’s drinking, he’s abusing her, she doesn’t know what to do, who to turn to. Her family doesn’t live here, they live in wherever their country is. But it’s a place where people can come in—there’s a front door that is highly community-based, non-mental health, and friendly. It is this overlap that leads to a reduction in disparities.”

Figure 2 divides the diamond that represents the system into two domains. Hernandez explained that one is the infrastructure domain, or what can be called “corporate headquarters”—the policies, the executives, the rules, and the procedures. The other is the direct service domain, which comprises the providers and the services that actually work with the people who come for help. Just as an organization must be compatible with the population that it is trying to serve by having knowledge and understanding of the populations it serves, there also must be compatibility *within* the organization or system between its infrastructure and direct service functions.

Sometimes, in order to provide culturally competent services, workers do things “under the radar”

about which the administration might not even be aware. Hernandez described a situation in which a therapist is seeing a Mexican client as an example. “The client feels respected and has formed a trust, and three months later, brings his sister in to see the therapist also. If the therapist said, ‘Oh, I can’t do that, she has to fill out the paperwork,’ it would be an insult to the client and his sister. So the therapist sees the sister as a collateral session, when perhaps it really wasn’t. This is still not a culturally competent system or organization, since the organization’s policies do not support culturally competent direct services. Conversely, consider another system where the direct service providers are resistant to dealing with the large populations of Mexican and Guatemalan people who don’t speak English, and the



management is trying to change this. The arrow requiring compatibility flows in both directions.”

The infrastructure domain includes organizational values; policies, procedures, and governance; planning, monitoring, and evaluation; communication; human resources development; community and consumer participation; service array; organizational infrastructure and resources; and informal supports. These categories were derived from a review of 22 different cultural competent assessment protocols.

The direct service domain includes access to services and supports (the ability to enter, navigate, and exit appropriate services and supports as needed), availability of services and supports (having appropriate services and supports in sufficient range and capacity to meet the needs of the populations to be served), and utilization of services and supports

(the rate of use or usability of appropriate mental health services). In each of these areas, there are barriers. An example of a barrier to access can be found in systems of care that sought to create a single point of entry, thinking it would be helpful to be able to go to one place for services. Individuals working in the community, however, related that this practice results in fewer people accessing services, because that one door may not work for all people and some do not want to go there. The requirement to give extensive information to the intake person may be very scary for some people and also may constitute a barrier.

Hernandez noted that research in each of these areas has pointed to “facilitators” or strategies and practices that increase cultural competence. Research was found to support ways that systems can provide better access; research also has shown that types of services and

supports offered contribute to cultural competence. For example, one counseling center in Seattle offers acupuncture as part of the system because people in the population can relate to that service. There is also literature on increasing utilization, in recognition that when someone finally comes for help, they often do not come back. In some cases, the place may have scared them or they were embarrassed while in the waiting room where other people could see them. Sometimes they lost their transportation or experienced another practical problem that had nothing to do with stigma. Research has documented effective methods for finding out what occurred in these situations and for increasing the use of services. These are evidence-based practices. They are not treatments, but they are practices that address such things as how to create a climate where people feel that they can come for help and feel safe. Figure 3 summarizes the barriers and facilitators for the direct service domain in areas of access, availability, and utilization.

FIGURE 3

Facilitators and Barriers for Culturally Competent Direct Services

ACCESS

• **Facilitators**

- **Hours:** Hours are flexible to accommodate the population’s schedule
- **Knowledge:** Efforts to increase awareness of services and mental health issues
- **Language:** Bi-lingual staff available, documents and signage in population’s primary language
- **Location:** Location is convenient to population
- **Materials and Training:** Literature and training geared to increasing awareness of services and mental health issues
- **Outreach:** Community fairs, booths, etc.

• **Barriers**

- **Hours:** Hours are not flexible enough to meet population’s need
- **Knowledge:** Obstacles in access due to lack of awareness of services
- **Language:** Staff with population’s primary language is not present or limited
- **Location:** Location of services is not convenient to population
- **Materials and Training:** Difficulties in providing literature and training to a specific population
- **Outreach:** Obstacles the organization experiences or perceives in reaching the population

AVAILABILITY

• **Facilitators**

- **Advocacy:** Empowering families to promote their own best interests
- **Education of Parents:** Teaching parents about mental health, mental illness, and the mental health system
- **Ethnic Match:** Bilingual/bicultural providers
- **Linkages:** Linkages between providers/organizations within a community to provide services to children in a primary environment
- **Paraprofessionals**
- **Service Types**

• **Barriers**

- **Financing Services**
- **Gaps in services**
- **Workforce Issues**

UTILIZATION

• **Facilitators**

- **Rates of Return**
- **Strategies to get people to appointments** (reminder call)

• **Barriers**

- **Drop-out rates/Retention rates**
- **Over-representation/Under-representation**

Hernandez (2006)

Community Health Workers—Promotores

Myriam Monsalve-Serna described the use of community health workers (CHWs—Promotores and Promotoras) in Miami-Dade County, Florida. Community health workers are used throughout the health care system to provide outreach and education and to link people to service providers. They are used to increase access to services in systems including maternal and child health, child abuse prevention, school-based health services, HIV/AIDS, and health care in general. They connect people to services by: 1) empowering them with information about what

services are available; 2) helping them obtain those services and navigate often cumbersome systems; and 3) connecting them to a medical home that provides primary care, prevention, necessary referrals, and coordination of services. Examples of what community health workers can do in systems of care include:

- Identifying new children and families to enroll in specific programs
- Finding out what health and social services children/families need and helping to link them with these services
- Helping parents learn what they can do to assist their children in school
- Helping parents to set attainable goals and to accomplish them
- Helping to empower parents in every aspect of their lives
- Providing emotional support and mentoring to parents
- Working with parents to develop their child-rearing skills
- Helping parents learn problem-solving skills
- Helping children/parents learn to cope with the stress in their lives

Monsalve-Serna emphasized that community health workers increase the rate of use of appropriate mental health services by removing barriers, engaging families, and facilitating service delivery. They also increase rates of follow through for services because they provide transportation, help families complete necessary documentation, interpret providers' requirements, and make sure families keep appointments.

The use of community health workers is a culturally competent service approach because most

community health workers share the cultural values and traditions of the communities they serve. They share and understand the cultural perception of mental health, know and share the history of the community, speak the language, and understand the communities' traditional health beliefs, values, and practices. Community health workers often:

- Recognize cultural variations in the perception of illness and disease and their causes
- Interpret and/or translate information from one language to another
- Understand and practice the tenets of effective cross-cultural communication
- Know about cultural influences on help-seeking behaviors and attitudes toward health care providers
- Understand and use the indigenous and traditional health practices of their cultural group
- Recognize that in under-represented populations, verbal and nonverbal communication have greater importance in the equation of health outcomes on a societal and systemic level

Monsalve-Serna explained that to enhance their ability to provide cultural competent services, ongoing training for community health workers is needed in order to: increase their awareness of issues and resources; assist in developing educational materials that will help participants to learn about the various health care settings and their functions; increase sensitivity to literacy issues related to materials and training; interpret materials, documents, and forms; learn how to train participants using examples

from their own life histories; and to become familiar with appropriate materials and teaching approaches. For community health workers new in the field of children's mental health, it is important to increase their knowledge about how to access services and to build trust with service providers. In order to be successful, community health workers must:

- Have the ability to enter into, navigate, and exit appropriate services and supports needed by participants
- Create new links and develop new procedures to increase access to services
- Know the barriers to access
- Know what works and what does not work
- Address the reality that what limits access to services is more than lack of adequate insurance and transportation, but includes a range of cultural and other barriers

Challenges of Serving Hispanic Children and Families: A Case Example

The following case example, presented by Jesse Herrera, anchors the challenges of serving Hispanic children and families in real life:

A family is comprised of Maria who is 29, Juan who is 9, and Manuel who is 7. Juan was experiencing some problems in school and was referred to the children's mental health system due to disruptive behavior, fighting, and impulsive behavior in the classroom. Maria was only Spanish speaking; Juan and Manuel were bilingual. Juan received services for about six months when neighbors reported their concern that Juan and Manuel were outside of their apartment in the parking area quite late at night. The child welfare system

went to investigate along with the police. Maria was described as being very depressed, hearing voices, and unable to cope or manage herself and her two children. She was hospitalized and, since there was nobody who was able to take care of the children, they were taken by the child welfare system.

Maria had come across the border. She had met Juan's father at that time, but he was no longer involved. Manuel's father, a different man, was now married with his own family, was abusive, and provided no support. Maria's brother lived in the area, but was unwilling to help. Maria's work was seasonal, so she would not be working for several more months. She reported that what little money she had was stolen, and she was unable to pay her overdue rent. She had little food in the house and was unable to manage the stress in her life, ultimately resulting in the hospitalization.

The average length of stay in the hospital is very brief in this community, so Maria was discharged after a short inpatient stay with follow-up case management. The children were returned to her custody, but the child welfare worker remained seriously concerned that she could not parent well and that the children were out after dark without supervision in an area with significant gang activity.

The child welfare worker requested an assessment of what was taking place in the family home, and a psychologist did some testing that indicated that the mother could not parent effectively. A bilingual therapist from the adult service system who was assigned to the case thought Maria would benefit from parenting classes. Maria had concerns

about all of these people coming into her life suddenly telling her what to do. She was trying to comply with everything, but was overwhelmed with her difficult situation.

Juan continued to have difficulties in school, and things did not seem to be improving. The therapist was discouraged with the perceived lack of progress in Maria's management of the children. Although the home was clean and Maria obtained some public assistance, the child welfare system took the children from the home again after another incident where the children were out late at night. Maria tried to be cooperative, but she was distraught and did not really understand what was taking place. She was now being asked to voluntarily give up custody of the children so that they could be placed in a good home while she recovered.

The children's system of care ultimately became involved. In assessing the situation, staff saw a family that was struggling, but with a lot of good bonding between the children and the mother. The home looked like nice and the children were being cared for, but Maria had difficulty taking the material that she was learning in parenting classes and operationalizing it at home. A case aide was obtained who could work with the family much more closely and spend a lot more time with Maria and the children. This helped Maria to implement some strategies with the children and allowed the aide to model approaches for Maria. All of these services were offered in Spanish so that Maria understood what was taking place. She was also provided with assistance in understanding and interacting with the school and the child welfare system. A big brother was found to be a role model for both children and to provide Maria with the support that she wasn't getting

elsewhere. Members of Maria's church also were enlisted to visit her at home and provide her with support, respite, and social connections. The child therapist engaged a school liaison to be involved in monitoring and following up with Juan and Manuel at school and to provide a school contact to involve on the team. Work with the teachers also was initiated to help support the family. All of these supports were provided with the goal of helping the family to stay together. A connection also was made with the California Rural Legal Association, which helped Maria with her legal case to get her children back permanently.

Herrera noted that, in retrospect, this was a situation which quickly spiraled out of control. The stress became so great for Maria that she was not able to function and ended up in the hospital. This is what happens to many of our families. Often, there is a lack of services and a lack of available resources for poorer families who don't know what their rights are and for which services they may be eligible. Access to services was limited, and utilization marginal until someone became involved and took the time to organize and connect the pieces together so that they made sense and enlisted supports in Maria's natural community that were available but just needed someone to request.

It took a joint plan among the children's mental health system of care, adult mental health, child welfare, the school, and community resources including legal services and the church to help the family stay together. Understanding and responding to the cultural issues involved was a critical component of the intervention and of doing something positive to help this family. Many of these individuals

were working outside of their agency's policies.

Herrera reported that the family is doing much better now: "The children are still at home, and Maria is back at work. She is probably not going to make 'Mother of the Year' and staff continue to support the family. With support, this is a family that was able to stay together

because a few people decided that they could make a difference and didn't just go with the flow and didn't just go with established policies and say, 'There is nothing that we can do about it.' There were enough people who looked at the whole picture and recognized that maybe with a little more support, a little more concern about keeping the family together, and more understanding of the

cultural barriers and issues, the family could be helped. We ought to be able to provide training, supervision, and consultation to staff so that they can look at situations like this one with a greater understanding of cultural issues, with the ability to recognize the strengths in families, and with an appreciation of the benefits of keeping families together."

Recommendations

Service Delivery

- *Include community-based organizations in systems of care*—Community-based organizations (such as the Hispanic Services Council in Tampa) often are not included in system of care work because they are not "mental health" agencies. However, organizations like this often are the first stop for Hispanic individuals, and they become informal providers of mental health services and a source of referral for more formal mental health care. These organizations should be included in systems of care since they serve as the gatekeepers and the leaders; Hispanic individuals come to them and trust them.
- *Provide outreach to Hispanic communities*—Reach out to Hispanic communities to engage them in services.
- *Use service providers with strong bilingual skills and certified interpreters*—Mental health agencies should have service providers with Spanish language skills that are tested prior to hiring. Offer additional pay as an incentive to attract bilingual staff. Use certified interpreters in all encounters for which bilingual staff are not available.
- *Use promotores*—Using promotores, or community health workers, is an effective strategy for increasing access for Hispanic children and families and engaging them in services.
- *Listen to families and focus on strengths*—Historically, we have focused on the deficits of families rather than their strengths (as in the case study), and we dictated to families what they needed, thinking that we were the experts. We have come a long way to recognize the importance of listening to families and helping them to identify both their strengths and their needs.
- *Hire Hispanic families*—Hire Hispanic families who have "graduated" from systems of care to work with other families to increase engagement and provide support.
- *Understand the acculturation of Hispanic children and family dynamics*—Many providers lack an understanding of the acculturation of Hispanic children. Many learn English and learn the culture much faster than their parents, and they end up becoming the "parent" of the parents, sometimes running the household. Often, parents, in particular mothers, suffer severely from a lack of self-esteem as parents when in their countries of origin, they may have been excellent parents. Strategies are needed to raise the self-esteem of these adults as parents given this cultural challenge and the cultural differences in parenting. Parent training needs to be adapted to these cultural differences.
- *Provide a network with multiple doors to access services*—Offer multiple pathways to services that are organized into a coordinated network. Community-based agencies that have purposes and competencies in mental health and have staff (promotores) who are culturally connected to the community can provide effective access points.
- *Engage informal, natural supports in services*—Enlist natural supports in the community, such as extended family, religious and cultural organizations, etc. to provide support to families when appropriate.

Recommendations

- *Use culturally appropriate assessment instruments*—Develop and use assessment instruments and methods that are culturally and linguistically appropriate.
- *Increase early literacy and social-emotional growth opportunities*—Increase Head Start, Early Head Start, child care, preschools with family components, etc. in communities with Hispanic populations.
- *Provide bilingual school liaisons*—Make bilingual school liaisons available to help families understand school-related issues and processes.
- *Hold parent support groups in Spanish*—Organize parent support groups that are held in Spanish as a way to engage Hispanic families.
- *Increase service delivery hours*—Provide services in the early mornings and evenings when families are better able to attend.

Financing

- *Finance natural helpers*—Ensure the availability of flexible funding to pay for natural helpers (such as home or community partners, family partners, promotores, etc.)
- *Ensure payment mechanisms for engagement, outreach, advocacy, and education*—Ensure that engagement, outreach, advocacy, and education are reimbursable services since they are critical in serving Hispanic populations. Amend Medicaid plans or develop other financing mechanisms to support these services.

Policy and Advocacy

- *Develop coalitions of community-based organizations*—Develop coalitions of organizations providing services and supports to Hispanic/Latino populations.

Information Development and Dissemination

- *Educate Hispanic/Latino communities and families*—Communities and families should be educated about mental illness, their rights, and available services and systems.
- *Increase understanding of the differences among Hispanic populations*—Educate systems of care and providers about the differences among Hispanic/Latino population groups.
- *Provide understandable Spanish materials*—Ensure that materials and literature translated into Spanish are clear and understandable.
- *Conduct research on promising approaches*—Identify and research promising practices for mental health services to children and families that are occurring in Hispanic/Latino communities.
- *Analyze data for Hispanic populations*—Data collection and analysis should identify outcomes for Hispanic/Latino groups (and other racial/ethnic populations).

Training and Technical Assistance

- *Train community workers*—One of the strategies used in Miami is training community workers through a community college. Different levels of training provide the equivalent of a vocational degree or an associate's degree. Agencies then hire the workers to provide a range of natural supports.
- *Develop a curriculum*—Develop a curriculum on cultural awareness and how to work with Hispanic/Latino families.
- *Train providers*—Provide training for providers on working with Hispanic/Latino families. Consider mandating that providers complete a cultural competence course.

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