MENTAL HEALTH PROVISION TO HISPANICS IN IDAHO: FINDINGS FROM A PROVIDER SURVEY

by

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The following individuals read and discussed the thesis submitted by student Nicole Stickney, and they also evaluated her presentation and response to questions during the final oral examination. They found that the student passed the final oral examination, and that the thesis was satisfactory for a master's degree and ready for any final modifications that they explicitly required.

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DEDICATION

I dedicate this work to my father and best friend Joseph Coleman. Despite everything, you've stood by me. Without your continued encouragement and deep pockets, I would still be wondering: "What if?" I love you, Dad!

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ABSTRACT

Currently, Idaho's mental health resources for Hispanics are not designed to meet their mental health needs. According to Jose Valle, the Chief of Children's Mental Health at the Idaho Department of Health and Welfare Region III, there are no available data regarding prevalence rates for mental disorders among Hispanics in Idaho (personal communication, September 18, 2007), and little is known about what interventions work best among Hispanics (Gonzalez, 2006). As a first step in addressing the mental health needs of Hispanics in Idaho, information on the capacity of local providers to deliver culturally appropriate care is needed. The Idaho Partnership for Hispanic Mental Health (IPHMH) Planning Project was created to improve access to culturally and linguistically relevant mental health care for Hispanics in southwest Idaho. Researching mental health needs and identifying gaps in resources will help develop appropriate interventions for consumers and providers.

Findings from an informal interview with several local providers suggested that Hispanics in need of mental health care in southwest Idaho do not have sufficient resources. To improve access to culturally relevant mental health care, further exploration into the knowledge, attitudes, and skills of local providers is essential. The purpose of this thesis project was to answer the following questions:

1) What are the demographic attributes and Hispanic client profile of mental health providers in southwest Idaho?

2) What knowledge, attitudes and behaviors are associated with culturally competent mental healthcare among mental health providers serving Hispanics in southwest Idaho?

3) What are the perceived barriers and training needs related to providing and receiving culturally competent care?

To answer these questions, a survey was designed and mailed to a stratified randomized sample of 1,000 primary care and mental heath providers licensed in Ada and Canyon Counties. Crosstabs and frequencies were calculated to explore characteristics of providers who serve Hispanics. Chi-Square, Analysis of Variance (ANOVA), and t-tests were performed to examine relationships among provider variables and constructs of cultural competence.

Due to a relatively low response rate, the findings may not have been generalizable to the provider population in Ada and Canyon Counties. The providers who responded were predominantly, non-Hispanic white, worked as specialists in the mental health field, and worked in urban settings in Ada County. Substance abuse, anxiety disorders, depression, and adjustment disorders were the most common diagnoses of Hispanics receiving care.

Providers scored the Hispanic Cultural Awareness Scale (HCAS) and the Confidence Rating Scale (CRS). These scales were created to measure cultural knowledge and perceived ability to delivery culturally competent care. The providers scored higher on the Informal Interpreter Utilization Scale (IIUS) which measured the frequencies that providers used non-professional interpreters.

This study provided an important starting point to researching and addressing the provision of mental health care to Hispanics in southwest Idaho. Prior to this study, there was little information available on the providers that were available to Hispanics in need of care. The findings from this study indicated that although providers may lack some culturally specific knowledge, they are aware of the importance of culture and how its elements influence mental health.

Triangulating the findings from this study with those of the Hispanic interviews and the mental health provider key informant interviews will provide a foundation for the improvement of access and quality of care to Hispanics in need of mental health care. Programs will be researched and designed based on the findings of the Idaho Partnership for Hispanic Health's (IPHMH) community mental health needs assessment that will focus on provider training and culturally relevant mental health outreach.

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CHAPTER I: INTRODUCTION

In an effort to reduce Hispanic health disparities in southwest Idaho, the Idaho Partnership for Hispanic Health (IPHH) developed the Idaho Partnership for Hispanic Mental Health (IPHMH) Planning Project. The IPHMH received a grant from the National Association of Mental Health (NIMH) to conduct a Hispanic mental health needs assessment which will eventually result in the design and implementation of sustainable interventions that address the mental health needs of Hispanics.

The IPHMH is currently conducting a study of Hispanics in Ada and Canyon Counties to investigate Hispanics' perceptions and beliefs about mental health problems, experiences with local mental health providers, and their preferences regarding mental health treatment. As a supplement to this research, this thesis project was created to explore provision of mental health services from providers' perspectives. To improve access to culturally relevant mental health care, exploration into the knowledge, attitudes, and skills of local providers is essential. It was hoped that, by interviewing providers who serve Hispanics, the gaps in knowledge about Hispanic mental health and the needs of providers could be identified and addressed. A key informant interview on area providers will be conducted in 2010. The triangulation of the data will provide a starting point for the creation of community-based services that can provide culturally relevant care that can address the identified mental health needs of the Hispanic population.

Hispanics constitute the largest minority population in Idaho. According to the Idaho Commission on Hispanic Affairs (2007), Idaho's Hispanic population has grown

by over 36% since 2000 to 139,000 persons. Over 80% of this growth has occurred in Ada and Canyon Counties. Table 1, shown below, reflects the growth of the Hispanic population from 2000-2007 in Ada and Canyon Counties (Idaho Department of Labor, 2008).

Table 1

Population Growth of Hispanics in Southwest Idaho from 2000-2007

County	Population	% of Total	% Increase from 2007	% Increase from 2000
Ada	24,510	6.6%	8.9%	82.0%
Canyon	37,540	20.9%	7.7%	53.5%

As Idaho's Hispanic population continues to grow, services that address its unique mental health needs are vital. The resources that are available are not designed to meet their mental health needs. So far, cultural competence, which guides the delivery of culturally relevant services to racial and ethnic groups, has not been incorporated into the State Mental Health Plan (Idaho Department of Health and Welfare, 2007).

Statement of the Problem

Mental health resources are limited for the entire population of the State of Idaho, not just for Hispanics. In fact, the Federal Health Resources and Services Administration (HRSA, 2008) designated the entire State of Idaho a Mental Health Professional Shortage Area in 2008.

In 2007, the National Alliance on Mental Illness (2007) gave Idaho a failing grade for its public mental health system for the following reasons:

- Idaho had one of the lowest mental health spending rates in the United States.
- Idaho had an insufficient number of mental health providers.
- Idaho's mental health funding had not kept up with the growing population, especially the influx of non-English speaking Hispanic immigrants.

To begin the research process, the IPHMH held an informal meeting in 2007 with local mental health providers from the public and private sectors to gather their opinions regarding mental health care services for Hispanics in Idaho. Findings from this meeting suggested that Hispanics in need of mental health care in southwest Idaho did not have sufficient resources. In addition, little is known about the current the types of challenges that Hispanics with mental health needs experience in Idaho. For example, according to Jose Valle, the Chief of Children's Mental Health at the Idaho Department of Health and Welfare in Region III, there are no available data regarding prevalence rates for mental disorders among Hispanics in Idaho (personal communication, September 18, 2007). During that meeting, the following issues were raised:

- There are very few Hispanic/bilingual providers in Idaho.
- Few resources are available for the uninsured.
- Terry Reilly Health Services, a non-profit organization that provides mental health services on a sliding fee scale, has a one-month waiting period for an appointment with a bilingual mental health counselor.
- In the health districts of southwestern Idaho, the Idaho Department of Health and Welfare provides services for children without documentation of legal residence, but little is available to adults.
- An estimated 25% of Hispanics with mental health issues need medications and cannot afford the cost. They often forego medication and remain medically noncompliant.

To improve access to culturally relevant mental health care, exploration into the knowledge, attitudes, and skills of local providers is needed.

Purpose and Significance of the Study

To reduce mental health disparities experienced by Hispanics in our community, it is essential to understand the current climate of mental health care provision. The objectives of this study were as follows:

1) To describe the demographic attributes and Hispanic client profile of mental health providers.
2) To assess the knowledge, attitudes and behaviors associated with culturally competent mental healthcare among providers serving Hispanics.

3) To gain knowledge on barriers and training needs of mental health providers serving Hispanic clients.

The need for culturally relevant services has been well established (Health Resources and Services Administration, 2001; New Jersey Mental Health Institute, 2003; Surgeon General Report, 2001). Guidelines at clinical, training, and agency levels have been developed however, to date few models exist that have shown promise (Bernal & Sáez-Santiago, 2006; Sue, 2003). Knowledge of cultural beliefs, values and practices can reduce the risks of misdiagnoses, treatment adherence problems, and inappropriate use of the health care system. In addition, it can improve provider-patient communication, and minimize issues of mistrust of providers (Brach & Fraser, 2000; Bhui, Warfa, Edonya, Mckenzie, & Bhugra, 2007; Davis & Voegtle, 1994, as cited in Bradshaw & Biggs, 2007; López & Hernandez, 1987).

Currently, in many states, efforts are being made to develop culturally relevant interventions that address Hispanic mental health disparities. In Idaho, the Idaho State Office of Rural Health and Primary Care (SORH) has been researching and designing programs to address the communication barriers experienced by Hispanics with limited English proficiency (LEP). In 2006, SORH surveyed acute care hospitals, certified rural health clinics, and federally qualified health centers on linguistic services. It was found that, of the 57% facilities that responded, only 9% always provided written follow up instructions in a language that the LEP patient could read. SORH (2007) also conducted a focus group study on LEP consumers' perspectives on using interpreters. Generally, the

participants reported dissatisfaction, confusion, and mistrust with interpreter services in past experiences with Idaho's health care system.

More information is needed about the level of cultural competence of Idaho's mental health providers, the Hispanic clients being served, and the perceived barriers of providing and receiving culturally sensitive mental health care. The primary goal of this study was to explore the provision of culturally competent mental health care to Hispanics. A questionnaire was developed that examined the following components of culturally competent care: knowledge, attitudes, and culturally congruent behaviors. To explore potential areas to target and research for interventions, the providers were also asked to identify the barriers that prevent them from providing quality mental health to Hispanics. In addition, providers were asked to identify the barriers that Hispanics in need of mental health services experience in accessing quality mental health care. Providers were also asked to list some of their training needs. The findings of this exploratory study will inform the development of training programs, interventions, and continuing education for local mental health providers.

Specific Research Questions

To explore the provision of mental health services to Hispanics, three specific questions were defined:

1. What are the demographic attributes and Hispanic client profiles of mental health providers in southwest Idaho?

2. What knowledge, attitudes and behaviors are associated with culturally competent mental healthcare among mental health providers serving Hispanics in southwest Idaho?
3. What are the perceived barriers and training needs related to providing and receiving culturally competent care?

Limitations

One limitation of this study was the time of year that the survey was distributed. Providers, particularly school counselors and psychologists, may have been on vacation during the summer months. This may help explain the relatively low response rate. Another possible limitation was that responses may have been biased if the providers felt inclined to appear more culturally aware or sensitive than they actually were. Hopefully the anonymity of the survey instrument reduced the possibility of this happening. Another limitation was the length of the questionnaire. Providers might have chosen not to respond due to the time required to do so.

Due to the scarcity of available research on providers' perceptions of mental health care delivery to Hispanics, another potential limitation of the study was the validity and reliability of the questionnaire itself. This instrument was designed for exploratory purposes, and its sole purpose was to provide a starting point to inform further research and assessment development.

Delimitations

This study was delimited to licensed social workers, nurse practitioners, physicians, physician assistants, counselors, and psychologists who worked in Ada and/or Canyon County in southwest Idaho in 2007-2008.

Assumptions

Due to the relatively low response rate, these findings may not be wholly applicable to the general population of mental health providers in southwest Idaho. It was assumed that providers who completed and returned the survey were open and objective with their responses.

Definition of Terms

Acculturation: The process in which members of immigrant groups adapt their cultural practices as a result of interactions with the majority or dominant culture (Rogler, Cortes, & Malgady, 1991).

Confianza: Trust that requires a long time to develop and forms the basis for personal relationships. Provider patient relationships are most effective when *confianza* has developed (National Alliance for Hispanic Health [NAHH], 2007)

Cultural competence: A set of congruent behaviors, practices, attitudes, and policies that come together in a system or agency or among professionals, enabling effective work to be done in cross-cultural situations (Cross, Bazron, Dennis, & Issacs, 1989, as cited in Brach & Fraser, 2000).

Culturally congruent care: Health care provision that is intentionally designed in accordance with individual, group, or institutional cultural values, beliefs, and life ways in order to provide or support meaningful, beneficial, and satisfying health care or wellness services (Schim, Doorenbos, & Borse, 2005).

Cultural sensitivity: The acknowledgment of personal attitudes, values, beliefs and practices within one's own culture and insight into the effect of self on others (Van Ryn & Fu, 2003).

Culture: Integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group (Cross et al., 1989, as cited in Brach & Fraser, 2000).

Fatalismo: Fatalismo (fatalism) refers to a general belief that the course of fate cannot be changed and that life events are beyond one's control. The term is cited as a dominant cultural belief that deters Latinos from engaging in various early detection and other health preventive behaviors, such as cancer screenings, diabetes and HIV testing and prevention (Abraído-Lanza et al., 2007).

Mal de ojo (evil eye): Any illness or negative feelings brought on by a person with bad intentions towards someone (NAHH, 2007).

Nervios: A general sense of vulnerability and stress brought on by difficult events. Symptoms include headaches and "brain aches," irritability, stomach pains, sleep problems, nervousness, easy tearfulness and mareos (dizziness or spells of lightheadedness.) This is a very broad syndrome. It may be mild and temporary or very serious and long-lasting (American Psychiatric Association, 2008).

Personalismo: The tendency to prefer personal contacts over impersonal or institutional ones (NAHH, 2007).

Susto (fright): A term that means "fright" or "soul loss." It is an illness due to a frightening event that causes the soul to leave the body, resulting in unhappiness and sickness. Typical symptoms include changes in appetite, troubled sleep and dreams, headache and stomach aches, sadness, and lack of motivation (American Psychiatric Association, 2008).

CHAPTER II: LITERATURE REVIEW

Hispanic Mental Health Disparities

Despite the fact that Hispanics in the United States have the same rates of mental health problems as non-Hispanic whites, quality and utilization of specialty mental health services are not similar (Alegría et al., 2007). For example, studies such as the 1990-1992 National Comorbidity Survey and the Collaborative Psychiatric Epidemiology Survey (CPES) have indicated that Hispanics have less access to services and receive a lower quality of care compared to non-Hispanic whites (Agency for Health Research and Quality, 2008; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999).

Low utilization rates of mental health services among Hispanics have been attributed to a number of related to socio-cultural and environmental factors, and provider traits. A large body of research shows that cultural competence among providers plays a significant role in the quality of mental health care received by Hispanics (Sue, 2003). Cultural competence, simply put, is a combination of behaviors, awareness, and sensitivity that enables providers to effectively serve individuals from backgrounds different than their own. Examples of provider cultural incompetence include: lack of knowledge of Hispanic culture's influence on health beliefs and practices, bias, prejudice, and stereotyping (National Association for Hispanic Health [NAHH], 2007; Snowden, 2003).

Cultural incompetence can compound the mental health disparities experienced by many Hispanics (NAHH, 2007). To illustrate, Hispanics living in rural areas experience even more barriers to mental health care than their urban counterparts.

Limited financial resources, lack of insurance due to work in seasonal jobs, social isolation, experiences of racism, inadequate means of transportation, and the low number of available providers are some of the barriers that contribute to these disparities (Bradshaw & Biggs, 2007; Soto, 2000). As a result, rural Hispanics with mental health needs are at a higher risk of deteriorating mental health. Incidentally, many Hispanics who live in southwest Idaho live in rural areas. Because Ada and Canyon Counties, particularly Canyon County, are composed of large rural areas, data gathered on rural health providers' knowledge and attitudes about providing mental health care to Hispanics would be useful in identifying the gaps in quality care and in developing interventions to address any gaps in services.

Hispanic Culture and Health

Particularly among recent Hispanic immigrants with low education levels, the understanding of causations of illness is based on the premises that: the mind, body and soul are inseparable; that balance of mind, body and soul is essential for well-being; that the patient is an innocent or passive victim onto which nature, magic, and/or the spiritual world can inflict illness and distress; the family is needed for curing or wellbeing to be restored; and that the healer should be open and engaged with the family. When providers understand the Hispanic clients' explanatory views, they can use that information to

communicate effectively and to achieve better outcomes (Maduro, 1983). The terms such as *susto*, *mal de ojo*, *fatalismo*, *confianza*, and *personalismo* are representative of the Hispanic cultural understanding of disease causation (Maduro, 1983). For example, *susto*, ties in the premises that the patient is a passive victim with the inseparable nature of the mind, body and soul. A traumatic event that causes *susto* can be cured with the inclusion of the family, and aid of a healer that has *personalismo* and instills *confianza* (Maduro, 1983).

Many studies have reported that when Hispanics experience mental health problems, they commonly will go to a primary care provider (McKenzie & Bushy, 2004). In one study that screened low-income Mexican Americans in a primary care setting, primary care providers diagnosed less than a quarter of Hispanics that were previously screened for depression by the researchers (Schmaling & Hernandez, 2005). Primary care providers may lack the cultural knowledge needed to understand the patient's cultural interpretation of illness and manifestation of symptoms. For example, a large body of research suggests that for many Hispanics, mental health problems such as depression or anxiety are accompanied by physical pain and discomfort and may not be seen as mental health problems (Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008). Somatic symptoms such as body aches and pains that persist despite medical treatment are commonly reported (National Council of La Raza, 2005). Research suggests that primary providers, particularly in rural areas do not identify these cases as indicators of mental distress (Soto, 2000).

Acculturation influences the prevalence of mental health problems among Hispanics. Studies such as the Epidemiological Catchment Area Study (Burnam, Hough, Karno, Escobar, & Telles, 1983, as cited in Escobar, Nervi, & Gara, 2000) and the Mexican American Prevalence and Services Survey (Vega et al., 1998) found that newly arrived immigrants have lower prevalence rates of mental health problems compared to Hispanics that were born in the United States or were long time United States residents.

Measuring Cultural Competence

According to the National Alliance for Hispanic Health (2007), few providers have received adequate training on the basic components of cultural competence: awareness, sensitivity, and skill. Cultural awareness, sensitivity, and culturally congruent skills and behaviors are essential in addressing Hispanic mental health disparities. Concordantly, organizations are beginning to recognize the importance of incorporating cultural competency into their training curricula (Bradshaw & Biggs, 2007). Although policies to incorporate cultural competence into care are becoming a standard, no consensus has been made on what cultural competence entails (Bhui et al., 2007; Sue, 2003).

Cultural awareness, a component of cultural competence, refers to a provider's knowledge of the differences and similarities that exist within and between diverse groups, including one's own. Cultural knowledge also involves an understanding of cultural concepts and how these concepts influence clients' behaviors. This awareness or lack of awareness influences the provider's ability to make accurate assessments based on

individual traits (e.g., socio-economic status, educational attainment, age, etc.) and cultural traits (e.g., the role of family in making health care decisions). As a result, cultural awareness is a determinant in the quality and outcome of mental health care for diverse populations. An example of cultural knowledge is the concept of acculturation. The ability to assess the Hispanic client's acculturation level is essential in avoiding the dangers of stereotyping and generalizing (Sharma & Keri, 2002).

When mental health providers serving Hispanics lack cultural awareness, their patients' explanatory causations of disease or malaise can be misinterpreted and patients are at risk of being misdiagnosed and/or receiving improper treatment (Maduro, 1983). Unfortunately, there have been instances when Hispanic patients were misdiagnosed as having a severe mental illness when Hispanic symptom clusters such as *susto*, *nervios*, *mal de ojo*, presentations of somatic symptoms, hallucinations and hearing voices have been misinterpreted (López & Hernandez, 1987).

Cultural sensitivity refers to the provider's acknowledgment of the personal attitudes, values, beliefs and practices within one's own culture and insight into the effect of self on others. The lack of cultural sensitivity leads to bias and attitudes that contribute to poor patient-provider relationships (Van Ryn & Fu, 2003). An example is stereotyping or making generalizations about a culture based on experiences with a small sample of people from that culture. Culturally congruent behaviors and skill sets arise from previous training on cultural issues, experiences with patients from different cultural backgrounds, and from developing cultural awareness and sensitivity (Schim, Doorenbos, Benkert, & Miller, 2007).

Few studies were found on mental health providers' provision of culturally competent mental health care. Many of these were pre-test/post-test studies in professional schools, or were qualitative in nature. Four provider studies exploring relationships between Hispanic cultural factors and mental health provision identified associations between prior training on cultural issues, and the traits of the providers (López & Hernandez, 1987; Ramirez, Wassef, Paniagua, Linnskey, & O'Boyle, 1994; Rojas-Guyler, Wagner, & Chockalingam, 2006; Schim et al., 2005). Prior training on cultural issues was strongly associated with providers' perspectives on the importance of culture. In one of these studies (Ramirez et al., 1994), the researchers examined the association between provider variables and cultural competence. In addition to prior training on cultural issues, cultural competence was associated with the educational attainment of the provider.

The Current Study

As previously stated, the majority of cultural competence assessments have been associated with universities and in the training curricula for health care professionals. To my knowledge, this is one of the few studies that attempted to measure cultural competence as a component of a Hispanic community needs assessment. Findings from this study and the scales that were created to measure cultural competence may have value for future studies.

Information gathered in this study will be triangulated with data gathered from key informant interviews of mental health providers and mental health administrators and

with data from interviews conducted with Hispanic individuals regarding their experiences with Idaho's mental health care system. The findings from these endeavors will lead to the creation of programs and interventions slated to improve access and quality of care to Hispanics with mental health needs.

CHAPTER III: METHOD

The survey's development and design was based on a literature review of Hispanic mental health issues and adapted from existing provider questionnaires. The development of the instrument, collection methods, and data analysis focused on the characteristics of mental health providers available to Hispanics in southwest Idaho and to estimate the level of cultural competence in provision of care.

Participants

The sampling frame of mental health-care providers was composed of those individuals with an active professional license in 2008. The professional composition of providers in Ada and Canyon Counties in the sample consisted of: psychiatric and primary care nurse practitioners; psychiatric and primary care physicians; psychiatric and primary care physician assistants; social workers; counselors; and psychologists. Lists with individual names and mailing addresses were acquired from the Idaho Board of Medicine, the Idaho Bureau of Occupational Licenses, and the Idaho Board of Nursing.

A stratified, randomized sample of 1,000 providers was drawn from the 2,492 providers identified to be currently licensed in Idaho's Ada and Canyon Counties in 2008. The sampling frame contained 242 counselors, 54 psychologists, 434 social workers, 194 physicians and physician assistants, and 76 nurse practitioners; reflecting the proportion of each provider in the population of interest.

Study Design

This study used a cross-sectional survey approach. It was intended as an exploratory study on the provision of mental health services to Hispanics in Ada and Canyon Counties in southwest Idaho.

Measurement Tools

The questionnaire was designed to meet the following objectives: create a patient and provider profile, measure the level of cultural competence among providers in southwest Idaho, and to identify factors that can be addressed to reduce Hispanic mental health disparities.

To create a provider profile, the survey contained common demographic questions (e.g., age, ethnicity, and educational attainment). To develop a Hispanic patient profile a question from a human resources tool for mental health professionals was adapted to identify some of the more common reasons that Hispanics are in mental health treatment (Substance Abuse and Mental Health Administration, 2005).

To measure cultural competence, literature on assessing cultural competence, Hispanic mental health issues, and provider perspectives was reviewed. Questions were created, adopted or modified to estimate the following components of cultural competence: cultural sensitivity (attitudes), cultural awareness (knowledge) and culturally competent skills and behaviors. Table 2 identifies the variables associated with each component of cultural competence.

Table 2

Elements of Cultural Competence and Associated Study Variables

Components of Cultural Competency	**Study Variables**
Cultural awareness/knowledge	Role of culture in assessment/diagnosis Role of acculturation affecting mental health Perception of skill in assessing acculturation Hispanic Concept Awareness Scale (HCAS) Awareness of barriers encountered by Hispanics Prior training experience
Culturally competent skills (behavior and experience)	Informal Interpreter Utilization Scale (IIUS) Confidence Rating Scale (CRS) Years working with Hispanics Annual percentage of Hispanic client load
Cultural sensitivity	Perceptions of barriers to providing care Attitudes regarding Hispanics' receptivity to therapy Perceived need of training on cultural issues

Cultural Awareness

Cultural awareness/knowledge was evaluated in several ways. The instrument contained questions on prior training experiences. In addition, five items featuring Likert scales were created that examined familiarity with the terms *susto*, *personalismo*, *confianza*, *fatalismo*, and *tristeza*. These terms were selected because of their cultural significance to Hispanic mental health. Responses to these ratings were combined and became the Hispanic Concept Awareness Scale (HCAS). A maximum score of 20 indicated a high familiarity and therefore a high indication of knowledge of Hispanic concepts of health. Conversely, a score of 0 indicated no familiarity with the five terms. Other constructs that examined cultural knowledge included: providers' knowledge about the role of acculturation on mental health, their awareness of barriers encountered by Hispanics, and provider's knowledge about the role of family in treatment process.

Culturally Competent Skills and Behaviors

Culturally competent skills were explored using constructs related to providers' behaviors and about their experiences with Hispanic patients. The ability to provide adequate mental health services in Spanish was one measure that explored culturally congruent behaviors. To assess appropriate interpreter usage, five items featuring Likert scales measured the frequency that informal interpreters such as friends, family, and strangers were used. Scores of responses were reversed and combined becoming the Informal Interpreter Utilization Scale (IIUS). A maximum score of 20 indicated that

informal interpreters were never/rarely used. The questionnaire also explored the frequency that professional providers were used.

Perceived cultural competence was assessed as a measure of confidence. Six items featuring Likert scales were included that rated provider satisfaction and comfort in communicating, meeting treatment goals and delivering culturally competent care. The questions were adapted from Ramirez et al. (1994), and were combined to create the Confidence Rating Scale (CRS).

Culturally competent skills and behaviors were also evaluated as a measure of experience. The questionnaire included a question about the number of years serving Hispanic clients and about the provider's estimate of his or her annual Hispanic client load.

Cultural Sensitivity

To assess cultural sensitivity, the instrument examined attitudes regarding Hispanics' receptiveness to therapy as a treatment for mental health problems. This question was used to measure sensitivity by estimating the presence of provider bias which could influence their treatment practices with Hispanics. Cultural sensitivity was also measured by having the providers rate their need for training on Hispanic cultural issues. Furthermore, providers were asked to report what barriers prevent them from delivering culturally competent care.

Targets for Intervention Development

The questions regarding barriers experienced by providers and Hispanic patients were also examined for potential targets for the future development of culturally competent interventions. Providers were also asked to offer suggestions on the types of future training in cultural competence that they would be interested in attending.

Survey Validation

The questionnaire was reviewed by two Hispanic mental health care professionals for face and content validity and revised based on their suggestions. In addition, internal consistency was calculated to ensure that the scales measured the constructs of the study.

Procedures

This study was approved by the Institutional Review Board of Boise State University. To improve the odds of obtaining an adequate response rate, a cover letter printed on Idaho Area Health Education Center's (AHEC) letterhead accompanied the survey because many providers receive continuing education credits from AHEC and are therefore familiar with the program (Appendix B). The cover letter described the purpose of the study and explained how confidentiality would be handled.

The survey was distributed July 11, 2008 (Appendix C). Respondents were asked to return the surveys by July 18, 2008. A reminder postcard was sent to non-respondents on July 18, 2008 (Appendix D).

Statistical Analysis

All analyses were performed with SPSS for Windows 17.0. Frequencies, crosstabs, Chi-Squares, ANOVAs, and t-tests were performed to examine relationships between provider characteristics and their perceptions regarding provision of mental health services to Hispanic clients.

Dissemination

The findings were shared with the Idaho Partnership for Hispanic Health to supplement the Hispanic Mental Health planning project to form recommendations for provider trainings. In addition, these findings will be triangulated with data collected from Hispanic individuals and from mental health organization administrators. The results will provide an impression of the gaps in service delivery and provision attributed to the provider and health care system, and the mental health needs of Hispanics in southwest Idaho.

Moreover, the findings will be instrumental in developing culturally relevant mental health interventions and in supplementing results from key informant provider interviews that will take place in the spring of 2010. Preliminary findings of this study were presented at the 2009 National Association of Rural Mental Health Conference in Albuquerque, New Mexico.

CHAPTER IV: RESULTS

One thousand surveys were mailed to primary care and mental health providers licensed to practice in Ada and Canyon Counties, Idaho. Of the 1,000 providers invited to participate, 87 had undeliverable or invalid addresses. Eight of the invited participants were retired, not currently practicing, or ineligible for the survey. Of the remaining 905 invited participants, 159 returned completed surveys that were eligible for analysis, resulting in a 17.6% response rate.

Provider Demographics and Client Profile

Table 3 provides a summary of the demographic data collected in this study. The mean age of the respondents was 46 years old with a range from 24 to 86 years old. The majority of respondents were female (71.7%) and identified their ethnicity as "non-Hispanic white" (91.7%). The respondents were highly educated; 65.4% had a Master's Degree and another 20.8% self-reported a doctoral degree (MD, DO, or PhD). Thirty-eight percent had 16 or more years of experience in their field. The majority (73.4%) of providers who responded to this survey practiced in Ada County and 16.5% practiced in Canyon County. Of those respondents, 8.2% reported working in both counties.

Overall, 71% of the respondents self-reported working in an urban setting. Of the 159 respondents, 23% reported working in primary health care and 77% reported specializing in mental health care. The professional compositions of the respondents was 60 social workers (37.7%), 45 counselors (28.3%), 15 psychologists (9.4%), 13 Primary

Care Nurse Practitioners (8.2%), 12 Primary Care Physicians (7.5%), 11 Primary Care Physician Assistants (6.9%), two Psychiatrists (1.3%), and one Psychiatric Nurse Practitioner (0.6%). Out of 158 respondents, 88.6% reported that they were not fluent in Spanish and 11.4% were fluent in Spanish.

Table 3

Demographic Characteristics of Respondents

Variables	N	Percentage
Highest Degree Earned		
Baccalaureate	22	13.8
Masters	104	65.4
PhD, MD or DO	33	20.8
Profession		
Primary physicians	12	7.5
Psychologists	15	9.4
Social workers	60	37.7
Counselors	45	28.3
Nurse practitioners	14	8.8
Physician assistants	11	6.9
Psychiatrists	2	1.3

(table continues)

Table 3 (continued)

Variables	N	Percentage
Ethnicity		
Non-Hispanic White	144	91.7
Hispanic	6	3.8
Asian/Pacific Islander	1	0.6
African American	2	1.3
Other	4	2.5
Work Environments		
Public/School	10	6.3
Public/nonschool	9	5.7
Private not-for-profit	31	19.5
Private for-profit	75	47.2
State	22	13.8
Municipal	2	1.3
Combination of settings	10	6.3
Service Setting		
Rural	18	11.8
Urban	108	71.1
Both	22	14.5

table continues

Table 3 (continued)

Variables	N	Percentage
Service Setting (continued)		
Statewide	2	1.3
Other	2	1.3
County of Workplace		
Ada	116	73.4
Canyon	26	16.5
Both	133	8.2
Fluency in Spanish		
Fluent	18	11.4
Not fluent	140	88.6

Note. Totals and percentages add to more than 159 and 100% because respondents were instructed to check all that applied. Also, some totals do not equal 159 due to missing data. Some percentages may not add up to 100% due to rounding.

Hispanic Patient Profile

Over half of the respondents reported that mood (72.0%), anxiety (68.0%), adjustment (64.0%) disorders, and substance abuse (63.2%) were the most common diagnoses of Hispanic patients in their care (Figure 1).

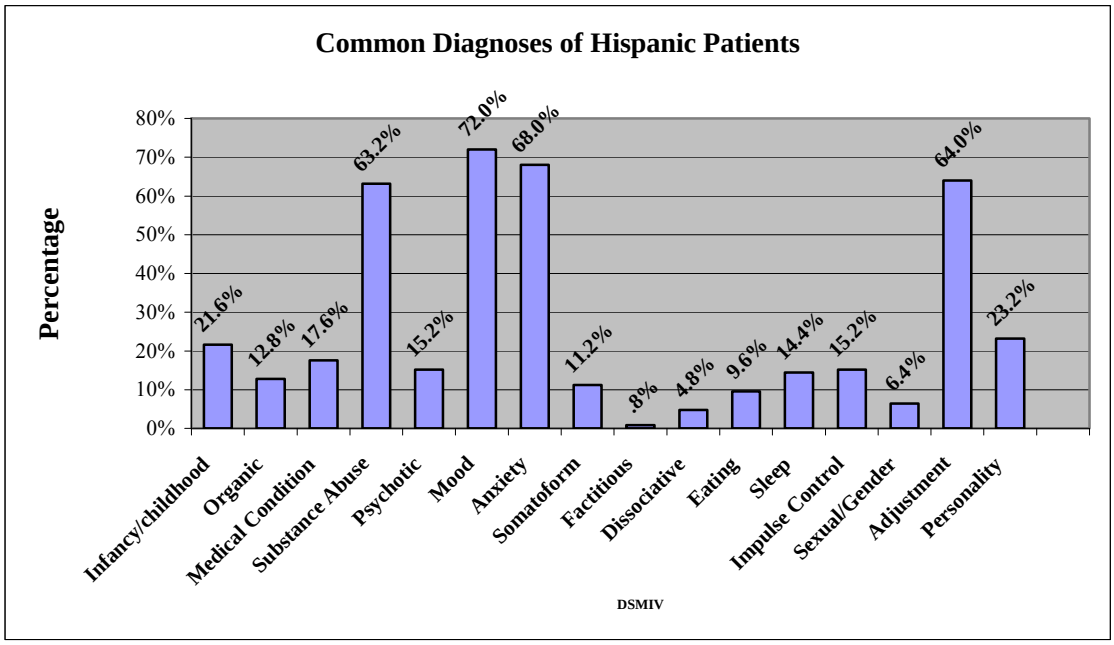

Figure 1. Common Disorders of Hispanic Patients

Note. Percentages add to more than 100% because respondents were instructed to check all that applied.

Measuring Cultural Awareness

Providers were asked to rate the importance of cultural factors in assessing the mental health status of their Latino patients. As illustrated in Figure 2, over 90% of the respondents believed that cultural factors are important during the assessment phase. No one reported that cultural factors were unimportant.

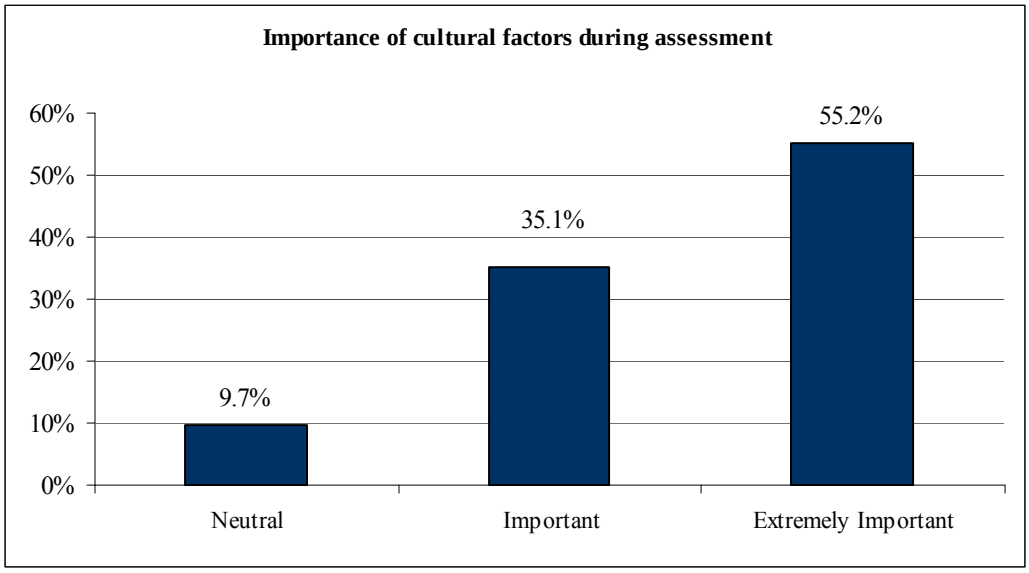

Figure 2. Provider rating of importance of cultural factors during assessment

When providers were asked about their perception of acculturation's influence on mental health status, the majority (61.1%) of respondents believed that acculturation does influence mental health (Figure 3). Providers were then asked to rate their perception of success in determining the level of acculturation during the diagnoses/assessment phase

of treatment. Thirty-nine percent rated themselves not successful in assessing acculturation level, as is illustrated in Figure 4.

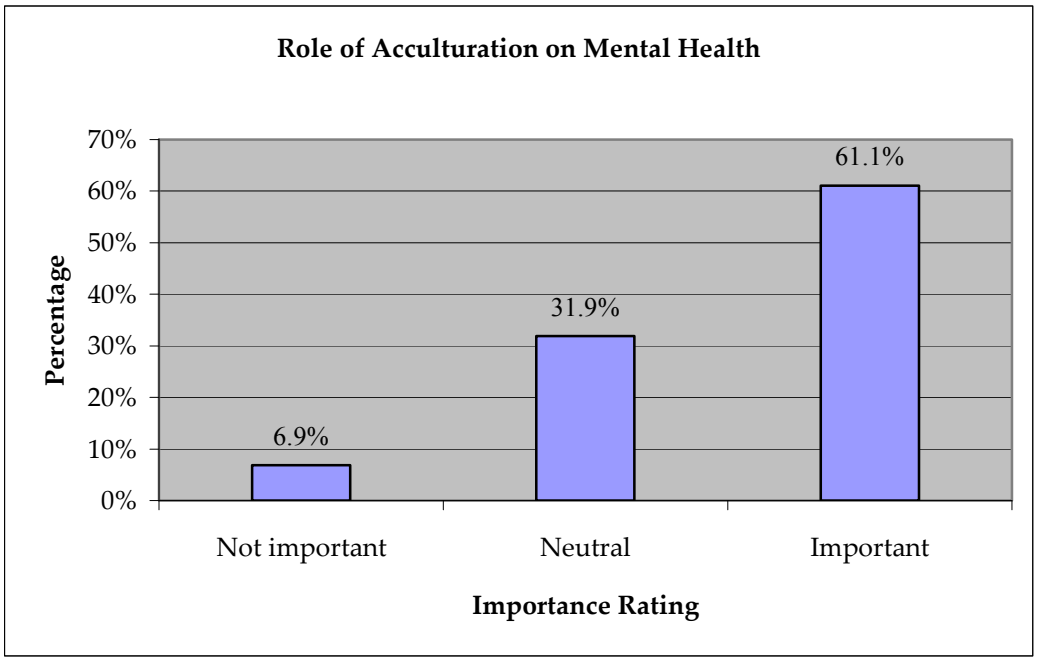

Figure 3. Provider rating on influence of acculturation on mental health

Note. Percentages do not add up to 100% due to rounding.

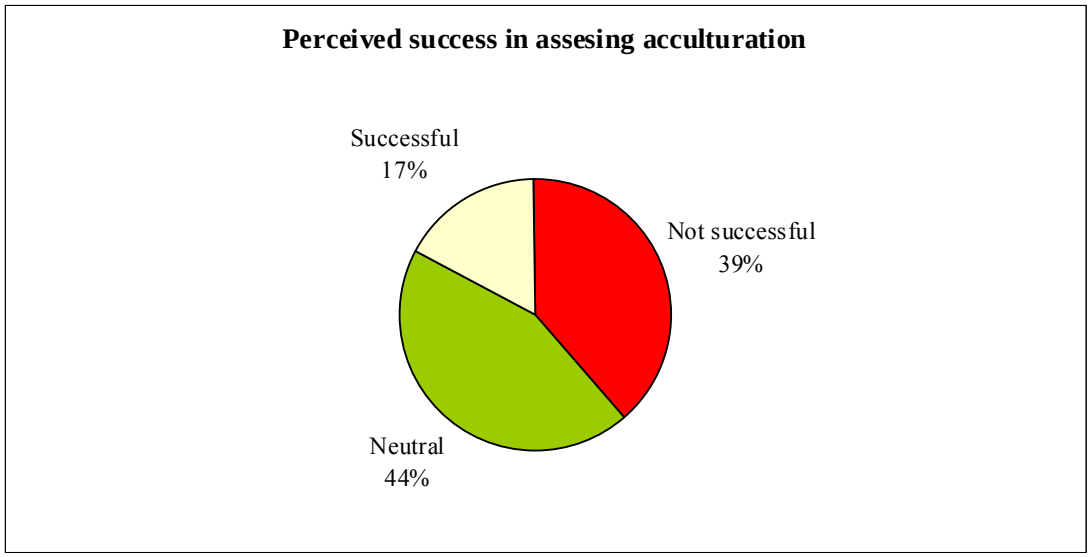

Figure 4. Perceptions of success in assessing acculturation

The Hispanic Concept Awareness Scale (HCAS) was developed to assess familiarity with Hispanic cultural terminology having to do with their understanding of health and receiving health care services. Five survey items on five cultural terms were combined into a scale that ranged from a score of zero to 20. Of the 152 that responded to this question set, 85 individuals indicated that they had little to no familiarity with the cultural concepts, *susto*, *confianza*, *tristeza*, *fatalismo* and *personalismo* (Figure 5). Out a possible score of 20, the mean score for the HCAS was 4.6 (SD=5.77).

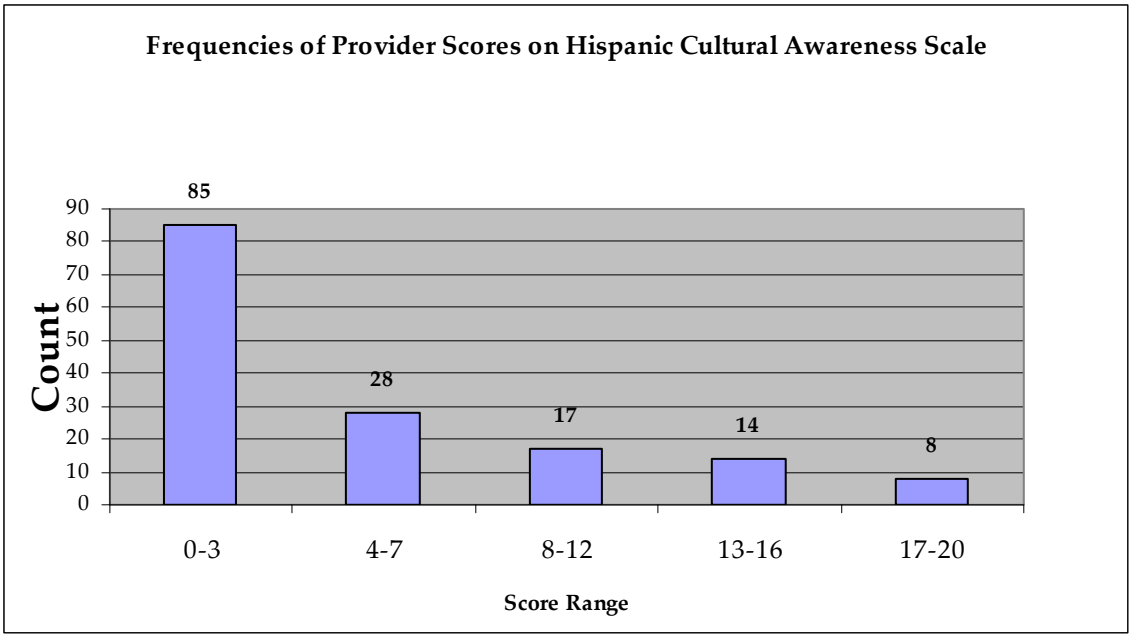

Figure 5. Frequency distribution of providers' scores on Cultural Competence Awareness Scale

The scale had good internal consistency, with a Cronbach's alpha coefficient of 0.94. Scales with fewer than 10 items commonly have low scores. Strong reliability is demonstrated in a score above 0.7. The high score, particularly with such a small number of items, suggests that this scale might be an appropriate measurement to help assess cultural competence, or at least familiarity with the terminology.

A non-parametric test was conducted to identify any demographic variables that might be associated with scores from the HCAS. No demographic variables were identified as being statistically significantly associated. A Mann-Whitney U test revealed a significant difference between Spanish speakers (MD = 14, n = 18) and non-Spanish

speaking providers (MD = 1, n = 134) in their knowledge of cultural concepts ($U = 130$, $z = -6.34$, $p < 0.01$).

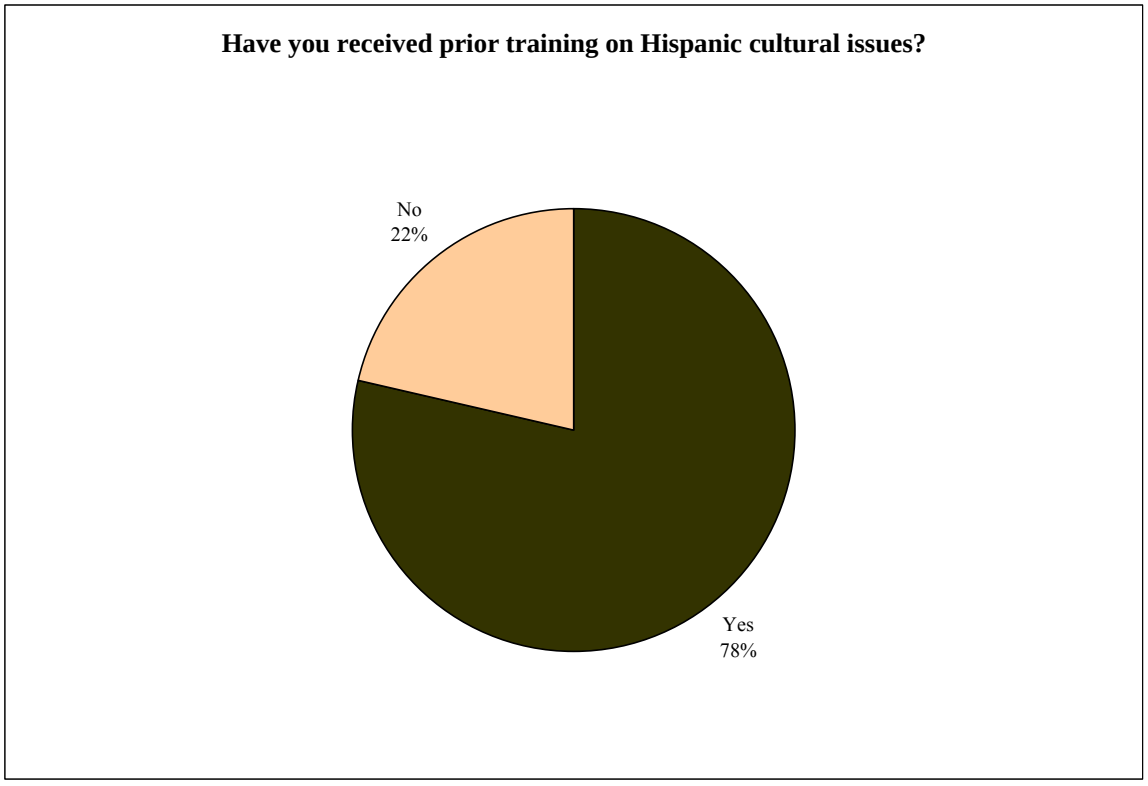

Figure 6. Prior training on cultural issues

Of the 158 respondents who answered a question about whether they had received prior training on Hispanic cultural issues, 78.5% indicated yes and 21.5% reported no (Figure 6). As Figure 7 illustrates, of the 78.5% that reported having prior training on cultural issues, approximately 62% had received cultural training while attending university or graduate school. The majority (96.4%) had training while employed, from

workshops or in-service. A small group (8.8%) reported receiving "other training." Open-ended responses describing other sources of training reported travel, literature, and knowledge gained from work experience.

Figure 7. Prior training experiences on cultural issues.

Note. Percentages added to more than100% because respondents were instructed to check all that applied.

Providers were asked to their perceptions about the types of barriers Hispanics encountered in receiving adequate mental health care. Of the 157 that responded, 98% believed that Hispanics face barriers that hinder their ability to receive quality mental health care (Figure 8).

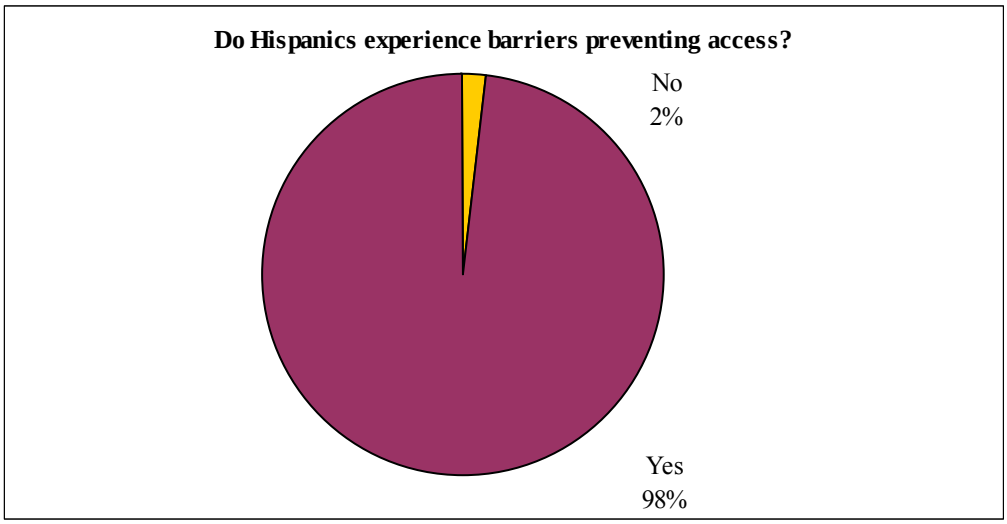

Figure 8. Hispanic barriers to accessing mental health care

Providers indicated five factors hindering the ability of Hispanics to receive adequate mental health care (Figure 9). These included: transportation (91.4%); financial issues (83.4%); the lack of knowledge of available resources (82.8%); stigma (74.8%); and language (66.9%).

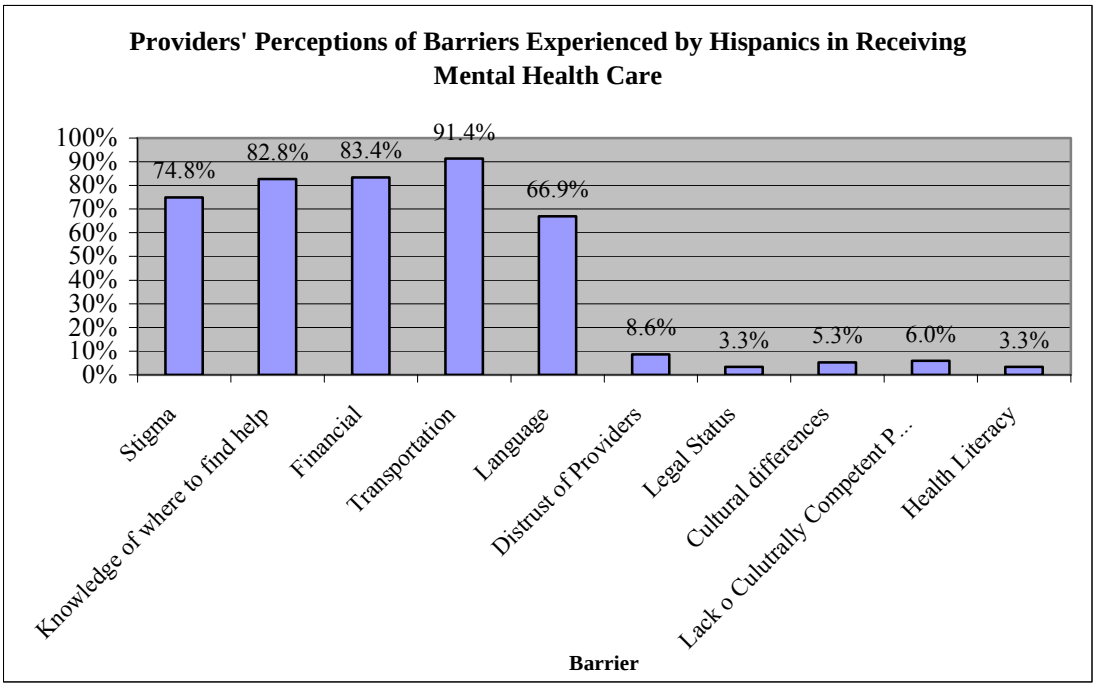

Figure 9. Providers' perceptions on the different barriers encountered by Hispanics Note. Percentages added to more than 100% because respondents were instructed to check all that applied.

Measuring Culturally Competent Behaviors: Confidence Rating

Providers were asked to rate their perceived cultural competence, as measured by their perceived satisfaction and comfort in delivering care to Hispanics. The measures of satisfaction and comfort were combined into the Confidence Rating Scale (CRS). Out of a possible score of 24, the mean score for the CRS was 12.3 (SD= 5.3). Of the 139 respondents who answered all six questions in this subscale, 43% rated themselves as not confident. Only 11% were rated as confident, and no one was rated very confident

(Figure 10). The Confidence Rating had good internal consistency, with a Cronbach alpha coefficient of 0.90.

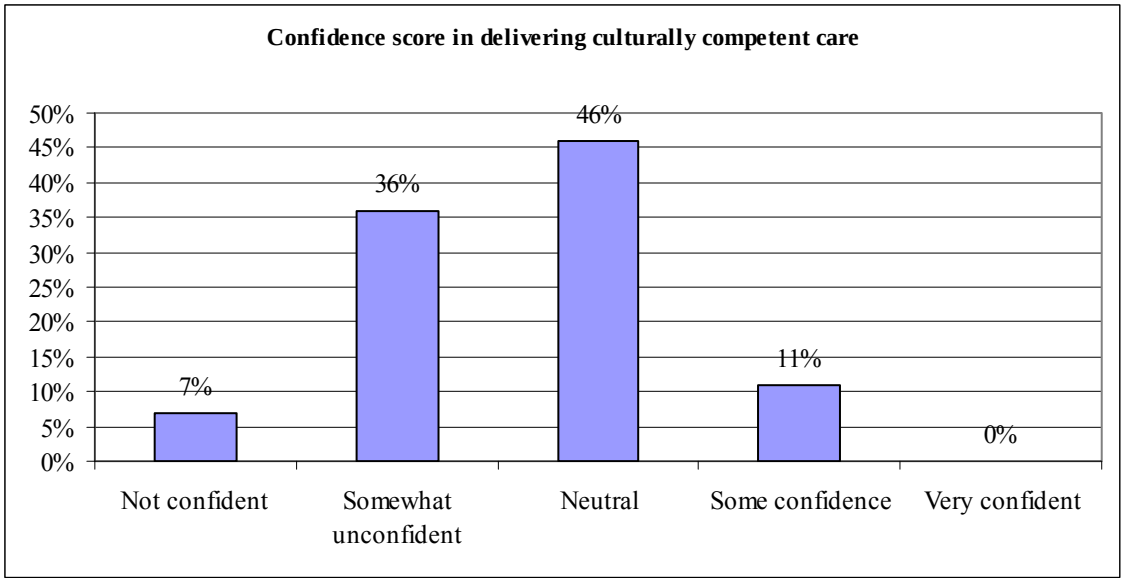

Figure 10. Confidence Rating Scale (CRS)

The relationship between familiarity with Hispanic cultural concepts (HCAS) and perceived cultural competence (CRS) was investigated using the Pearson product-moment correlation coefficient. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity, and homoscedasticity. There was a moderate positive correlation between the two variables, $r = 0.41$, $n = 139$, $p < 0.01$, with high scores from the Hispanic Concept Awareness Scale associated with high scores from the Confidence Rating Scale.

Measuring Culturally Competent Behaviors: Language Issues

In the assessment of language services, individuals responded to a question asking whether or not they were fluent in Spanish. Of these, 137 (89%) self-reported that they were not fluent in Spanish (Figure 11). When a follow-up question was asked about the availability of staff members that were fluent in Spanish, 59% reported having staff fluent in Spanish available and 41% did not have fluent staff. When these were combined, approximately 64% of those who responded to our survey were able provide some Spanish language assistance to clients.

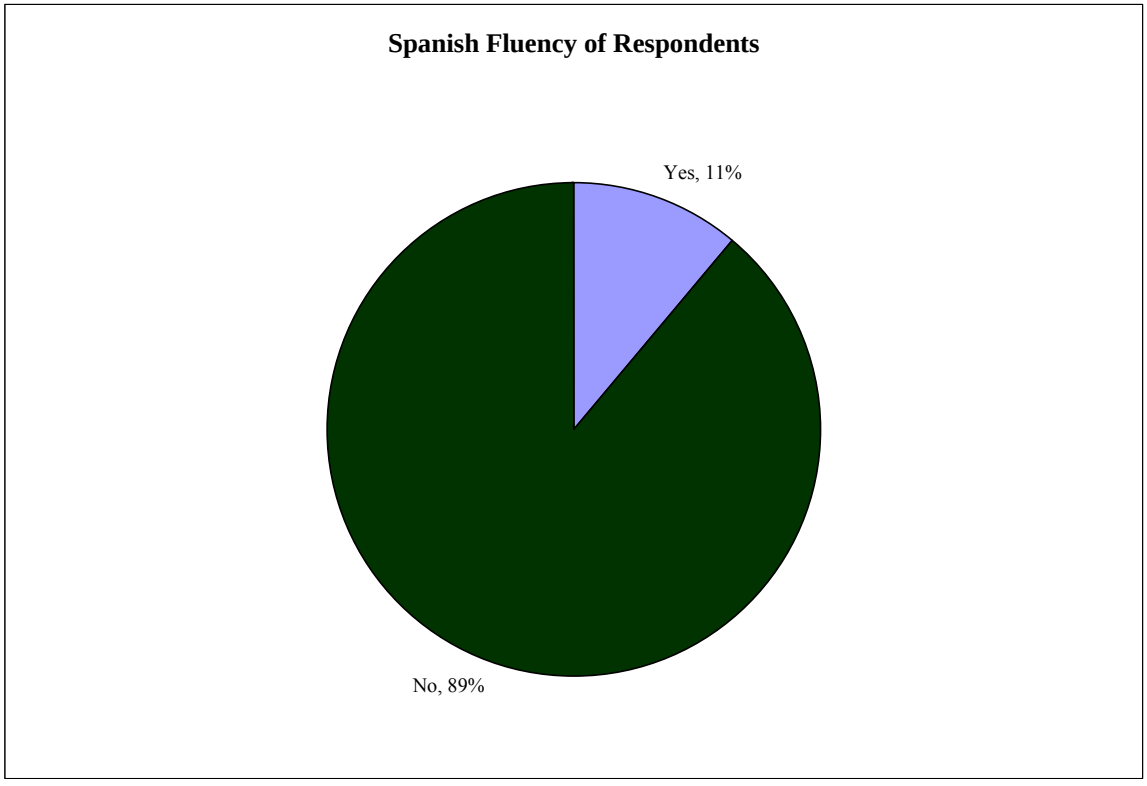

Figure 11. Spanish fluency of providers

Interpreter Usage

Interpreters were used by 58% of providers who were not fluent in Spanish. Of the 77 respondents, of which 74 were not fluent, 55% reported that they used a professional interpreter often or the majority of the time when they needed assistance with Spanish-speaking patients. Slightly over 25% of non-Spanish speaking providers reported never or rarely using a professional interpreter.

The IIUS measured inappropriate usage of family, friends, and strangers as interpreters. A high score meant that providers rarely or never used non-professional interpreters. Out of a possible score of 20, the mean score of the 68 respondents who answered each question on the scale was 16.0 (SD= 3.3). Ninety-three percent reported rarely or never informal interpreters. Sixty-four percent reported never using any non-professional interpreters (Figure 12).

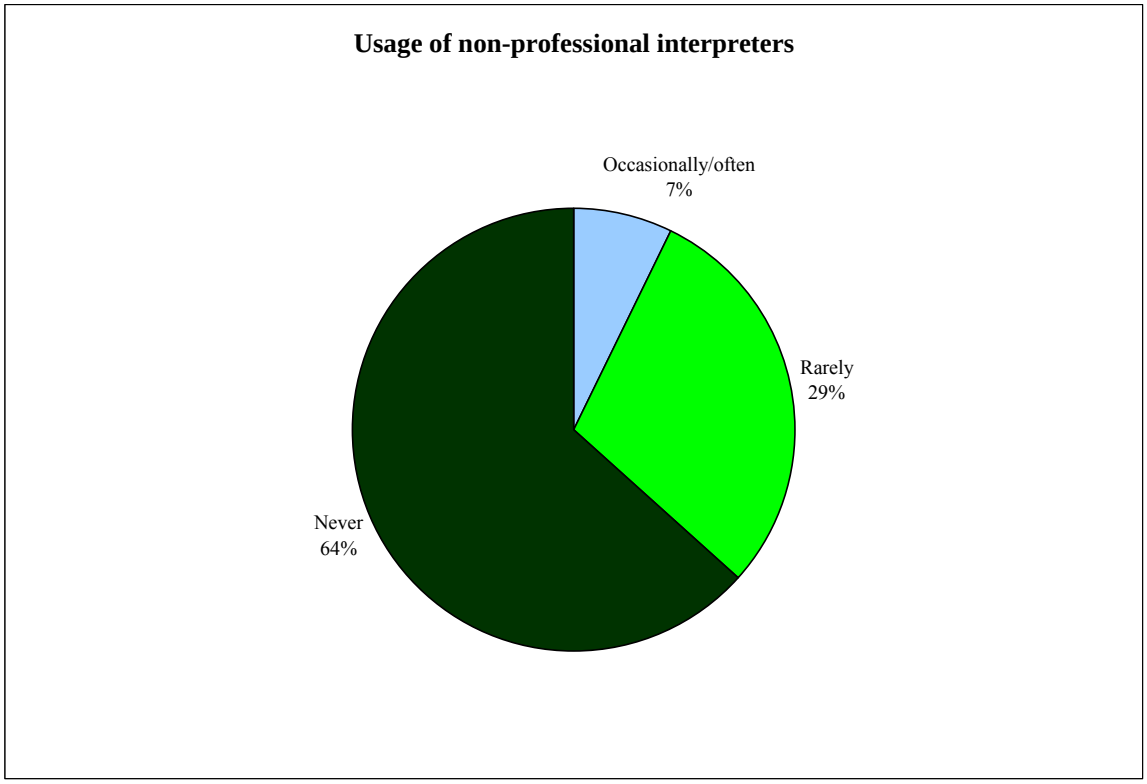

Figure 12. Use of non-professional interpreters

A Chi-square test for independence was performed to explore the association between provider fluency and the presence of fluent staff. No significant association was indicated, χ^2 (1, n = 154) = 1.25, $p > .05$, phi = 0.11. Interpreters were used by 58% of providers who were not fluent in Spanish. A Chi-Square test for independence indicated a strong association between interpreter usage and provider fluency, χ^2 (1, n = 156) = 12.21, $p < 0.01$, phi = .30.

Experiences with Hispanic Clients

As indicated in Table 4, the majority of respondents (66.9%) reported that Hispanics made up 10% or less of their annual case load. Of that, 13.4% reported having zero Hispanic patients that year. In addition, 91.1% of the providers had a 30% or less proportion of Hispanic patients. As Figure 13 illustrates, 38.2% of respondents reported having 16 or more years experience with Hispanic clientele. Almost half of the respondents reported having worked with Hispanic clients 10 years or less.

Table 4

Annual Percentage of Hispanic Clients

Annual percentage of Hispanic clients	Percent of Respondents
0%	13.4%
1 to 10%	53.5%
11% to 20%	15.9%
21% to 30%	8.3%
31% to 40%	3.2%
41% to 50%	4.5%
51% to 60%	0%
61% to 70%	0%

table continues

Table 4 (continued)

Annual percentage of Hispanic clients	Percent of Respondents
81% to 90%	0%
91% to 100%	.6%

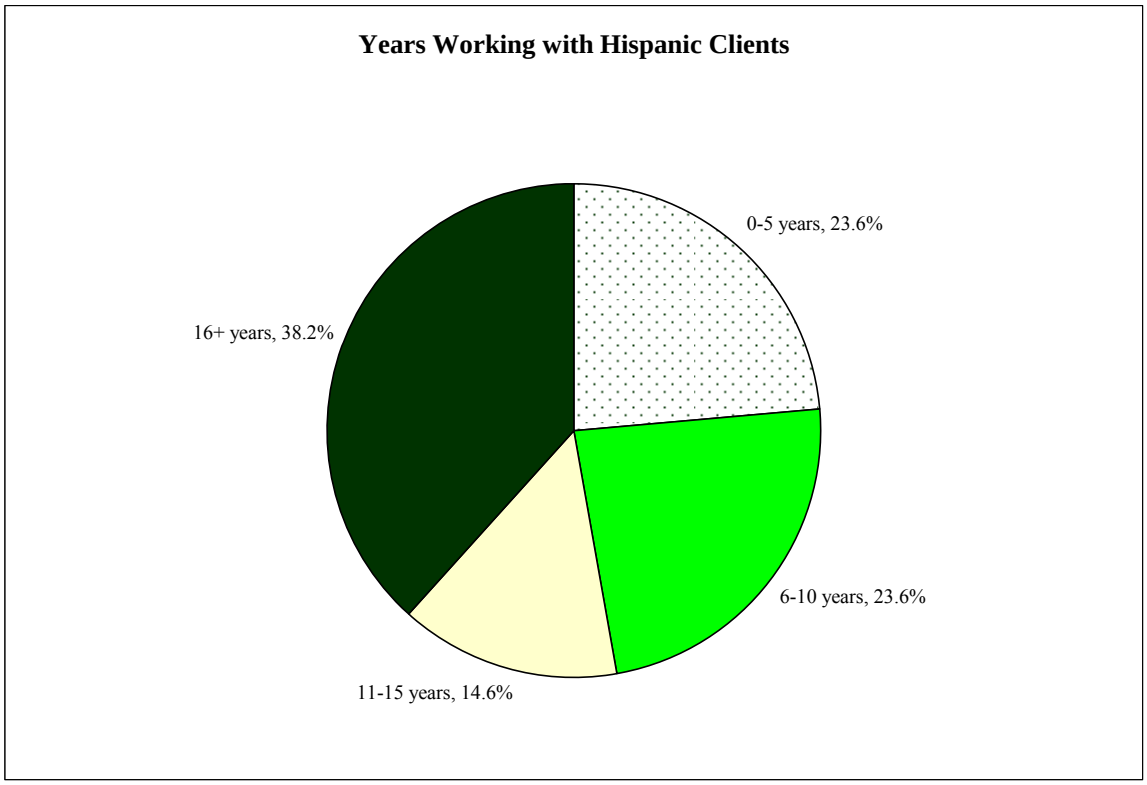

Figure 13. Years experience with Hispanic patients/clients

Measuring Cultural Competence: Sensitivity

To assess the level of cultural sensitivity, providers were asked attitudinal questions about their need for training, Hispanics' receptivity to therapy, and to report barriers that prevent mental health providers from delivering culturally competent care to Hispanics. Of the 154 that rated their need for training on cultural issues, 69.5% indicated a need for training, 24.7% were neutral, and 5.8% reported not needing any training (Figure 14). A chi-square test for independence was preformed to determine whether there was an association between perceived need for training and prior training experience. The test indicated no significant association, χ^2 (2, n = 152) = 2.78, p >.05.

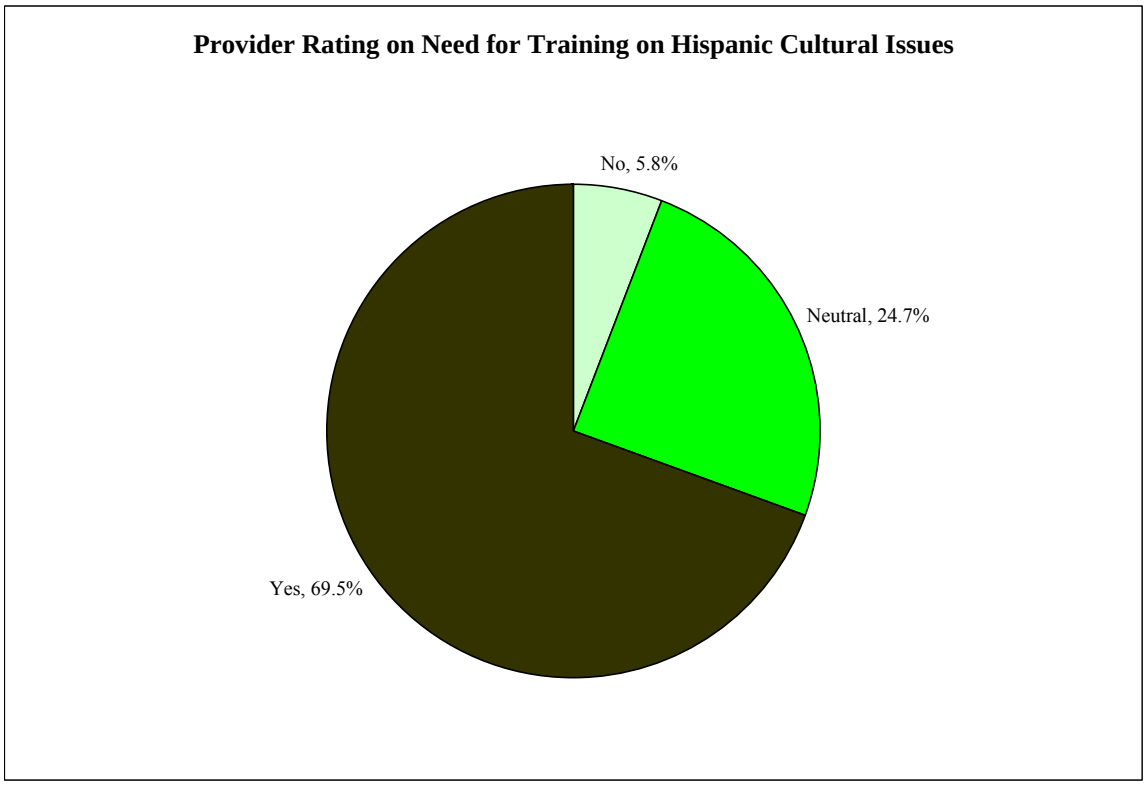

Figure 14. Provider rating of need for training on cultural issues

Cultural sensitivity was also measured by exploring how the respondents perceived provider specific barriers. As Figure 15 illustrates, 96.8% of providers indicated that they encounter barriers that limit their ability to provide culturally relevant care to Hispanics. Only 3.2% reported that providers do not encounter barriers.

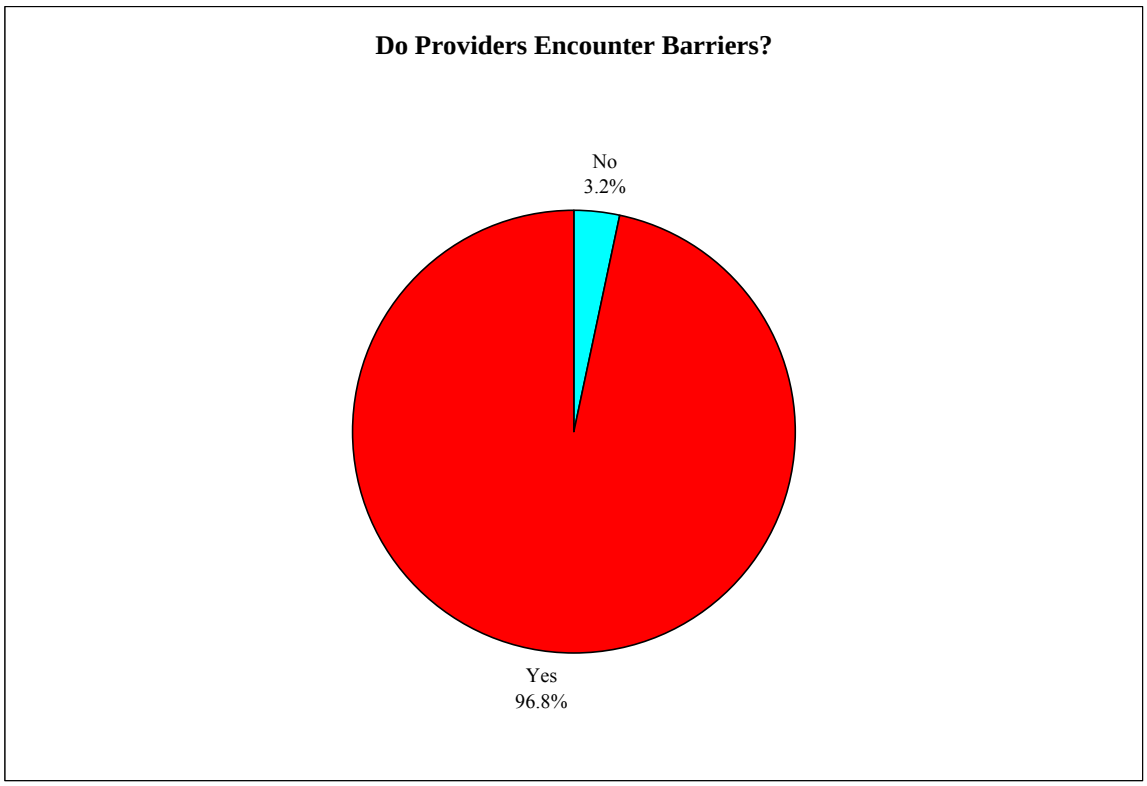

Figure 15. Providers' opinion on whether or not they experience barriers to providing care

As Table 5 illustrates, the majority of providers believed that language barriers, the lack of culturally specific knowledge and the lack of available training on cultural

issues limit their ability to provide culturally competent care. The types of barriers reported indicate a level of culturally sensitivity, for example, 95% of the respondents indicated that language barriers were a factor that keeps them from serving Hispanics appropriately. Roughly 73% of providers were sensitive to the idea that they are lacking culturally specific knowledge. More providers reported language barriers as a provider barrier than as a Hispanic client barrier. A Chi-square test indicated no significant association between reporting language as a Hispanic barrier and reporting it as a provider barrier, χ^2 (1, n = 148) = 0.47, $p > .05$

Table 5

Types of Barriers Experienced by Providers

Provider Barriers	Percentage
Language	95.3
Culturally specific knowledge	73.6
Lack of available training	56.8
Time limitations	41.9
Financial	6.8
Lack of available referrals	2.0
Differences in spiritual beliefs	4.1
Lack of outreach	2.0
Cultural insensitivity	2.0

Note. Percentages added to more than 100% because respondents were instructed to check all that applied.

Barriers and Needs: Potential Targets for Intervention

Respondents were asked to provide suggestions for further training that they felt would improve the quality of care to their Hispanic clients. Their responses were categorized into two themes: venue/mode of instruction and training topics. Of the 110 respondents that suggested types of training, 28 offered suggestions related to how the training should be delivered. Eleven (39.2%) suggested that the training be provided through workshops.

Of the 110 respondents, 69.1% suggested topics to address during training. The majority of respondents suggested basic training on cultural issues, however several provided ideas for specific topics, such as acculturation, and improving communication with the clients.

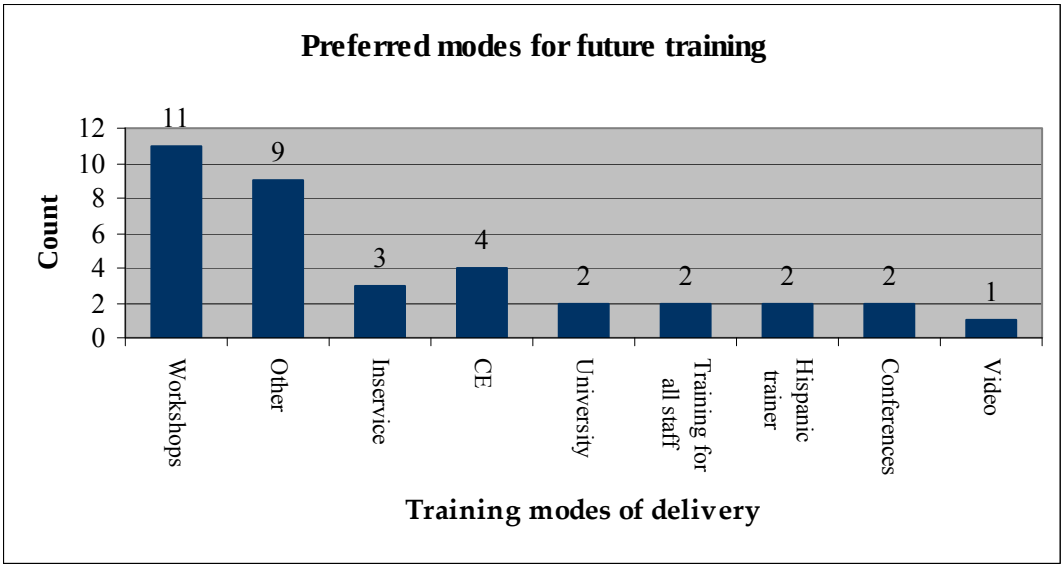

Figure 16. Preferred modes of training

Note: Totals are greater than 28 because respondents were asked to select more than one answer.

CHAPTER V: DISCUSSION

This purpose of this study was to explore the nature of mental health provision among health providers that are available to the Hispanic population in Ada and Canyon Counties in southwest Idaho. Specifically, the knowledge, attitudes and behaviors related to cultural competence were evaluated. In addition, the perceived barriers and training needs related to providing and receiving culturally competent care were assessed. In this section, the findings related to the study's purpose are discussed. Suggestions and directions for further research and for target interventions are also presented.

Provider and Client Traits

The respondents of this study were, as expected, predominantly non-Hispanic whites. The majority worked as specialists in the mental health field, and worked in urban settings in Ada County. Due to the relatively low response rate, findings from this study may not be generalizable to the provider population in Ada and Canyon Counties. Nonetheless, the study provided much needed input from providers serving the mental health needs of the Hispanic community.

The common diagnoses of substance abuse, depression, and anxiety disorders reported by providers to be common among their Hispanics were consistent with the literature. For example, anxiety disorders, depression, substance abuse is more common among second generation and third generation Hispanics and has been related to acculturation (Alegría et al., 2007; Escobar et al., 2000). Posttraumatic stress disorder

(PTSD) is categorized as an anxiety disorder and research suggests that the migration process may leave some vulnerable to PTSD. Adjustment disorders, which are behavioral disorders commonly diagnosed in children and triggered by stressful/traumatic events, were reported as common by more than half of the providers in this study.

Cultural Knowledge/Awareness

The majority of providers reported having had training on Hispanic cultural issues. Many of those providers received this training while in their current profession or during their undergraduate or graduate studies. Unfortunately, the providers were not asked to rate the quality their previous training. That information would be helpful in developing future training programs.

The majority of respondents rated culture and acculturation as important factors to consider when providing mental health care. Although providers generally thought acculturation was important, only 17% felt successful in being able to assess acculturation level. Because acculturation has been shown to negatively affect the mental health of second and third generation Hispanics, it is important for providers to have tools that enable them to assess acculturation level.

Very few providers were aware of the terms used in the HCAS: *susto, tristeza, personalismo, fatalismo,* and *confianza*. Although knowledge of those terms was strongly associated with Spanish fluency, awareness in how their Hispanic clients conceptualize mental health is essential in providing culturally competent care. Integrating curricula

that address these concepts would be a feasible approach in developing and enhancing cultural awareness.

Almost all of the respondents believed that Hispanics experience barriers in accessing mental health care. The main barriers perceived to be experienced were transportation, language barriers, a lack of knowledge on where to find services, the inability to pay for care, and stigma. Over 90% of providers reported that transportation was a barrier. Many Hispanics in southwest Idaho reside in rural areas. Because the majority of providers worked in urban settings, transportation could indeed be an issue, as Hispanics would have to leave their communities to access services. This finding, coupled with the low numbers of returned surveys from providers in rural areas, might suggest that mental health services in rural settings are lacking. Another possibility is that providers may not be aware of what barriers exist for Hispanics. The IPHMH Hispanic individual interviews that are currently being conducted are exploring barriers faced by Hispanics as well. The disparity between the providers' responses and those from the Hispanic individuals will be explored once data collection for that study is completed.

Culturally Competent Skills and Behaviors

Only 11% of respondents rated high on the Confidence Rating Scale (CRS), meaning that a small percentage of respondents perceived themselves as being culturally competent providers. Almost half did not perceive themselves as culturally competent. Because this was a cross-sectional study, this self-rating may change as more training and resources are developed and available.

A reassuring finding was that the majority of the respondents were able to provide services in Spanish. However, the quality of those services needs further investigation. Idaho has not mandated that medical interpreters be certified, although according to Sam Byrd, Director of the Center for Community Justice, the Idaho State Office of Rural and Primary Health (SORH) is currently testing a certification program (personal communication, July 5, 2009). Another reassuring finding was that providers scored high on the Informal Interpreter Utilization Scale (IIUS) meaning that very few providers reported using family members, friends or strangers in the waiting room as interpreters.

Interestingly, language was more often reported as a provider barrier than as a barrier experienced by Hispanics. A chi square test indicated that there was no association between the two. This might indicate a level of cultural sensitivity if the higher reporting of language being a provider barrier could imply that providers saw it as their responsibility to offer language services rather than a consumer responsibility to learn English.

Cultural Sensitivity

One finding of concern from this study was that a large proportion of respondents perceived that Hispanics were less receptive to therapy than non-Hispanic whites. This could indicate treatment bias because providers tend to become less invested when they perceive that their clients may not be engaged in treatment (Antshel, 2002). A qualitative study using Hispanics in focus groups reported the contrary, and found that Latinos were receptive to therapy, and preferred it to medication (New Jersey Mental Health Institute,

2003). It is promising, however, that the providers were aware of their need for training on Hispanic cultural issues. Interestingly, many identified a lack of available training on cultural issues as a barrier they experienced in effectively serving their Hispanic patients.

Providers identified several other barriers that that they perceived as preventing them from providing quality mental healthcare to Hispanics. The majority of providers reported experiencing language barriers; lacking culturally specific knowledge, and a lack of available training on building skills in cultural competence.

Potential Targets for Culturally Competent Intervention

This study indicated a number of areas that might be possible targets for future intervention development to reduce disparities in Hispanic mental health. The barriers experienced by providers and by Hispanics in need of help can be feasibly addressed. For example, to reduce Hispanic barriers, a peer specialists program could be integrated with the *promotora,* or community health worker model. Peer specialists as *promotores* can be trained as outreach workers, mental health interpreters, and educators to help Hispanics with mental health problems navigate the system and to communicate effectively with their providers. Hispanic community health workers have been found to be effective in addressing other Hispanic health issues such as diabetes prevention and family planning (Berthold, Miller, & Avila-Esparza, 2009).

Another potential intervention is the development of an interpreter program specifically for mental health care interpreters. The sensitive nature of the topics discussed when receiving mental health services and the discomfort and mistrust reported

by Hispanics that have used interpreters suggests that interpreters might need training in cultural competence as well (Farrog & Fear, 2003).

Limitations

Mail surveys are traditionally known to have low response rates (Nuetens & Rubinson, 2002). In addition, the timing of distribution was not optimal, as many school psychologists and counselors who may work with Hispanic families were unavailable during the summer when the survey was distributed. Consequently, the respondents of this survey may not be representative of the population of providers that are available to Hispanics receiving care or those who are in need of mental health care services.

An additional limitation of this study is that the questionnaire has not been validated. Due to ambiguity of cultural competence guidelines and the dearth of instruments available to test knowledge and cultural awareness specific to Hispanic mental health, a tool was created needs to undergo validity testing. It is unclear if the constructs intended to measure cultural competence actually did so and additional testing is necessary to establish validity and reliability of the tool.

Conclusions

This study provided an important starting point to researching and addressing the provision of mental health care to Hispanics in southwest Idaho. Prior to this study, there was little information available on the providers that were available to Hispanics in need of care.

Cultural knowledge, sensitivity, and culturally congruent behaviors were estimated using the Hispanic Concept Awareness Scale, the Confidence Rating Scale, and the Informal Interpreter Utilization Scale. The findings from this study indicated although providers may lack some culturally specific knowledge, they are aware of the importance of culture and how its elements influence mental health.

This study found that the individuals that responded to this study exhibited several culturally competent characteristics. For example, the majority of respondents reported having Spanish services available for their clients with limited English proficiency. Providers were also aware and sensitive to the barriers experienced by Hispanics. Moreover, respondents reported barriers that they experienced in caring for Hispanics.

Future Directions

Triangulating the findings from this study with those of the Hispanic interviews and the mental health provider key informant interviews will provide a foundation for the improvement of access and quality of care to Hispanics in need of mental health care. Programs will be researched and designed based on the findings of the Idaho Partnership for Hispanic Health's (IPHMH) community mental health needs assessment that will focus on provider training and culturally relevant mental health outreach.

In addition to providing information that will help address the mental health needs of Hispanics in southwest Idaho, three subscales measuring constructs of cultural competence in serving Hispanics were created in the implementation of this study. These

subscales, although still needing additional validation and reliability testing, could serve as potential measures for cultural competence in future studies.

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APPENDIX A

Idaho Partnership for Hispanic Health Mental Health Provider Questionnaire

Idaho Partnership for Hispanic Health Mental Health Provider Questionnaire

INSTRUCTIONS:

Please remember to base answers on your experiences in 2008. Choose your answers by checking the boxes or writing in where appropriate. Please only select one answer unless instructed to do otherwise. Once complete, place the completed survey in the postage paid envelope and drop in the mail.

DEMOGRAPHIC INFORMATION

In this section, we are requesting demographic information. Due to the make-up of Idaho's provider population, the combined answers to these questions may make an individual person identifiable. We will make every effort to protect participants' confidentiality. However, if you are uncomfortable answering any of these questions, you may leave them blank.

D1. Age? _____

D2. Gender? ☐1 Male ☐2 Female

D3. Ethnic background?

- ☐1 Non-Hispanic White
- ☐2 Hispanic
- ☐3 Asian or Pacific Islander
- ☐4 African American
- ☐5 Native American
- ☐6 Other: (please specify) _____

D4. What is your highest level of education?

- ☐1 Doctorate (include physicians with other doctorates)
- ☐2 Doctorate of Medicine or Doctorate of Osteopathy
- ☐3 Master's
- ☐4 Baccalaureate
- ☐5 Associate's Degree
- ☐6 Some college but no degree
- ☐7 High School Diploma/GED

D5. What is your professional identification?

- ☐1 Primary Medical Care (Please circle which one applies to you) Physician, Nurse Practitioner or Physician's Assistant
- ☐2 Psychologist (other than school psychologist)
- ☐3 Social Worker
- ☐4 Marriage and Family Therapist
- ☐5 Counselor
- ☐6 School Psychologist/Counselor
- ☐7 Rehabilitative Provider
- ☐8 Psychiatric Physician Assistant
- ☐9 Psychiatric Nurse Practitioner
- ☐10 Psychiatrist

D6. How many years experience do you have in your field?

- ☐1 0-5 years
- ☐2 6-10 years
- ☐3 11-15 years
- ☐4 16+ years

D7. What county is your workplace located?

- ☐1 Ada
- ☐2 Canyon
- ☐3 Both
- ☐4 Other

_____

D8. How many years in your current profession have you practiced or worked in your county?

- ☐1 0-5 years
- ☐2 6-10 years
- ☐3 11-15 years
- ☐4 16+ years

D9. How many clients do you serve per year?

_____

D10. In the past year, what approximate percentage of your personal case load/clientele was Hispanic?

_____

D11. Considering the number of years you have worked in this field, how many of those years have you worked with Hispanic clients?

- ☐1 0-5 years
- ☐2 6-10 years
- ☐3 11-15 years
- ☐4 16+ years

D12. What is your work environment?

- ☐1 Public/ school
- ☐2 Public/nonschool
- ☐3 Private not-for-profit
- ☐4 Private for profit
- ☐ 5 State
- ☐6 County
- ☐7 Municipal

D13. Where do you provide services?

- ☐1 Rural
- ☐2 Urban
- ☐3 Other

II. CULTURAL AWARENESS

C1. Do you consider yourself to be fluent in Spanish (Read, write, and speak)?
☐1 Yes
☐2 No

C2. In the past year, were any members of your staff fluent in Spanish?
☐1 Yes
☐2 No

C3. In the past year, were you able to provide direct services to clients in Spanish?
☐1 Yes
☐2 No

C4A. Did you provide services to Spanish speaking clients through an interpreter?
☐1 Yes
☐ No

C4B. If you answered yes to the previous question, please rate how often the following individuals translated for your Spanish patients(If the response was no, please continue to question the next question.

		Never				Frequently
	(Circle one response for each item)					
1	Children…….……..	1	2	3	4	5
2	Spouse…….....	1	2	3	4	5
3	Other adult family members……	1	2	3	4	5
4	Friends……..…	1	2	3	4	5
5	Professional interpreter……	1	2	3	4	5
6	Stranger (e.g., someone in the…….. Waiting room)	1	2	3	4	5

C5. In your career, have you ever received training on Hispanic cultural issues?
☐1 Yes
☐2 No
If yes, please describe:

_____

C6. Please rate the extent that you are familiar with the following Hispanic cultural concepts.

		Unfamiliar				Very Familiar
	(Circle one response for each item)					
1	Fatalismo……1	2	3	4	5	
2	Confianza……1	2	3	4	5	
3	Personalismo……...1	2	3	4	5	
4	Susto……1	2	3	4	5	
5	Tristeza……1	2	3	4	5	

C7. Do you believe that there are barriers to providing quality mental health care that are unique to the Hispanic Community?

☐1 Yes
☐2 No (If no, skip the next question and proceed to question C9)

C8. If so, what types of barriers exists that you think prevent you from providing quality mental health care? (Please check all that apply)

☐ 1 Language barriers
☐ 2 Lack of culturally specific knowledge
☐ 3 Time limitations restrict training opportunities
☐ 4 Lack of available training in the area
☐ 5 Other (please fill in)

_____

C9. Do you believe that there are barriers experienced by Hispanics preventing them from receiving adequate care?

☐1 Yes
☐2 No (If no, skip the next question and proceed to question C11)

C10. If so, what types of barriers do you think they experience and prevents them from receiving adequate care?

☐1 Stigma
☐2 Lack of knowledge of services
☐3 Financial/Insurance limitations
☐4 Language
☐ 5 Transportation
☐5 Other (Please describe)

_____

C11. Please rate your general level of satisfaction in serving Hispanic clients.

		Very Unsatisfied				Very Satisfied
		(Circle one response for each item)				
☐1	Communication with clients.....	1	2	3	4	5
☐2	Meeting treatment goals…….……	1	2	3	4	5
☐3	Ability to deliver culturally Relevant care…….	1	2	3	4	5

C12. Please rate your general level of comfort when serving Hispanic clients whose first language preference is Spanish? Very Unsatisfied Very Satisfied

		(Circle one response for each item)				
☐1	Communication with clients.....	1	2	3	4	5
☐2	Meeting treatment goals……	1	2	3	4	5
☐3	Ability to deliver culturally Relevant care…….	1	2	3	4	5

C13. In completing the assessment/diagnosis of the mental status of Hispanics, to what extent do you perceive yourself as successful in determining a Hispanic client's level of acculturation/assimilation such as language usage?

Not at all				Extremely
1	2	3	4	5

C14. How does a client's level of acculturation influence his/her mental health status?

Not at all				Extremely
1	2	3	4	5

C15. How important do you think it is to take into account cultural factors in the assessment of mental health status of Hispanics?

Not at all				Extremely
1	2	3	4	5

C16. To what extent do you perceive yourself as needing more training related to the considerations of cultural factors in addressing the mental health of Hispanics?

Not at all				Extremely
1	2	3	4	5

C17. If you have received culturally focused training in the past, how was it delivered?

- ☐ None completed
- ☐ University course(s)
- ☐ In-service training
- ☐ Workshop(s)
- ☐ Other _____

C18. What type of training do you feel would improve the quality of care to Hispanic clients?

_____

III. HISPANIC MENTAL HEALTH ISSUES

H1. Using the DSM IV diagnostic categories, what were the prominent issues among Hispanic clients that you served in the past year: (Check all that apply)

- ☐ 1 Disorders usually first diagnosed in infancy, childhood or adolescence (other than mental retardation or developmental disabilities)
- ☐ 2 Delirium, dementia, and amnestic and other cognitive disorders (organic brain disorders and syndromes.
- ☐ 3 Mental disorders due to a general medical condition not elsewhere classified.
- ☐ 4 Substance-related disorders (alcohol abuse or dependency, drug abuse)
- ☐ 5 Schizophrenia and other psychotic disorders (schizophrenia or other major psychoses)
- ☐ 6 Mood disorders (affective disorders: bipolar disorder, major depression)
- ☐ 7 Anxiety disorders
- ☐ 8 Somatoform disorders

☐9 Factitious disorders
☐10 Dissociative disorders
☐11 Eating disorders
☐12 Sleep disorders
☐13 Impulse control disorders not elsewhere classified

H1 (continued). Using the DSM IV diagnostic categories, what were the prominent issues among Hispanic clients that you served in the past year: (Check all that apply)

☐14 Sexual and gender identity disorders
☐15 Adjustment disorders (adjustment, family and/or relationship, academic problems)
☐16 Personality disorders (borderline disorders, antisocial disorders)
☐17 Other conditions that may be a focus of clinical attention (other mental health problems not listed above briefly describe)

_____

H2. What mental health conditions/issues do you perceive to be more common among your Hispanic clients compared to your non-Hispanic clients?

_____

H3. What mental health conditions/issues do you perceive to be less common among your Hispanic clients compared to non-Hispanic clients?

_____

H4. Compared to the majority population, how receptive do you think Latinos are to participating in psychotherapy? (Please select one).

☐1 Less than
☐2 Same
☐3 More than

H5. Compared to the majority population, do you think there are differences in the incidence of mental health problems?

☐1 Less than
☐2 Same
☐3 More than

H6. Compared to the majority population, how involved are the families in the delivery of care of Hispanic clients?

☐1 Less than
☐2 Same
☐3 More than

Thanks for taking the time to complete this survey!

APPENDIX B

Provider Participation Letter

July 2008

Dear Provider:

The Idaho Area Health Education Center and The Idaho Partnership for Hispanic Health (IPHH) are working together to explore Hispanic mental health issues from a provider's perspective. Your experiences, perceptions, and knowledge will be used to explore mental healthcare delivery to Hispanics in southwest Idaho in order to develop and enhance culturally responsive community based mental health services.

Please invest a few minutes of your time in completing the enclosed questionnaire. Your response is extremely important!!

Your name will never be associated with your responses, and all responses will be summarized by IPHH to ensure confidentiality. A number appears on the return postage reply envelope. This number will only be used to track those forms that are returned so that we don't mail you another form as part of our follow-up efforts.

Once your questionnaire has been completed, fold and return it in the enclosed postage paid envelope by Friday, July 18, 2008. The results will be compiled by IPHH and shared with community stakeholders and area providers and will be posted at http://www2.state.id.us/icha/iphh/.

If you have any questions related to this process, please feel free to call Linda Powell at (800) 836-8064 extension 235. Thank you for your interest and assistance.

Sincerely

Nicole S. Stickney
Outreach Coordinator

APPENDIX C

Follow-up Postcard

URGENT!

Several weeks ago you should have received survey on behalf of the Idaho Partnership for Hispanic Health. We haven't received a response from you and we really need your input. Please take the time to complete and return this survey. If you need another survey call (800) 836-8064 ext. 271, leave your name and address, and another survey will be sent to you. Thank you for your time!