THE LATINO GERIATRIC MENTAL HEALTH WORKGROUP OF NEW YORK CITY

MEETING THE MENTAL HEALTH NEEDS OF LATINO ELDERS

A Report Prepared by Michael B. Friedman
On behalf of the Latino Geriatric Mental Health Workgroup
December 2006

Older adults from minority cultures who have mental health problems face an array of issues above and beyond the usual geriatric mental health problems. These include issues of language, cultural understanding, workforce shortages, eligibility for services, insurance coverage, and more.

The Latino population should be of particular concern because its elderly population 60 and over is projected to quadruple over the next quarter century from 2.7 million to 10.4 million nationwide. It will be the largest population of minority elderly by 2030. As a result the number of Latino older adults with mental illnesses in the United States will grow from approximately 500,000 in 2000 to approximate 2.1 million in 2030. In New York State the expected growth is from 57,000 to over 150,000.[1]

Concern about the lack of readiness to meeting the mental health needs of Latino elders led The Association of Hispanic Mental Health Professionals, The Geriatric Mental Health Alliance of New York, the NYC Department for the Aging, and the NYC Department of Health and Mental Hygiene to organize The Latino Geriatric Mental Health Workgroup of New York City.

In the spring of 2006, the Workgroup convened a meeting attended by nearly 100 people, who shared an array of suggestions about how to improve services for this population. (A list of the organizations that participated is attached.)

Their suggestions focused on seven major areas—(1) language, (2) cultural competence, (3) workforce development, (4) outreach and education, (5) home and community-based services, (6) family support, (6) best practices, and (7) limited service capacity.

Their recommendations follow.

Language: A large proportion of Latino elders are not proficient in English, and even those who are often can only communicate their innermost experiences in Spanish or Portuguese. Unfortunately, most mental health professionals are not fluent in these languages. As a result, non-professional staff or even family members are frequently called upon to translate. This obviously is not conducive to personal privacy, accurate diagnosis, or sensitive treatment. The system needs more bi-lingual mental health professionals and, in the meantime, needs more interpreters who are trained to translate in the context of mental health service delivery.

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[1] These estimates assume that the prevalence of mental illness is the same among Latinos as among the general population. There are a number of studies that suggest that it may be higher among Latinos.

Cultural Competence: Even professionals who speak Spanish or Portuguese are often unfamiliar with the diverse cultures of Latino elderly, which vary considerably depending on country of origin. More bi-cultural providers are needed. But since it is unlikely that there will be enough mental health professionals of Latino origin in the foreseeable future, training and organizational change to build cultural competence are critical. This should include more effective engagement of Latino elders as well as more accurate diagnosis and more sensitive treatment. In addition, culturally competent organizations need to confront issues of organizational leadership and governance to assure promotional opportunities for bi-cultural staff and that Latinos participate on the governing bodies of the organizations that serve them.

Workforce Development: Given the need for bi-lingual/bi-cultural mental health professionals, it is clear that there need to be major efforts to attract Latinos to the field of geriatric mental health. This could include mentoring of college and graduate students, scholarships, loan forgiveness, salary differentials, etc. There is also a need to influence the curricula of professional schools, which tend to offer very limited education regarding geriatric mental health. And for those already in the field there is a vast need to build cultural competence.

In addition, because Latino elders with mental health problems are also served in the aging and health systems, there is a need to build clinical competence among health providers—such as primary care physicians, specialists, and home health workers, etc.—and among those who work in senior centers, NORCs, and elder case management.

Finally, over the next quarter century older adults will become a larger and larger portion of the American population while working age adults become a smaller proportion. This arouses concerns of a major workforce shortage. We believe, however, that older adults themselves can fill the growing need for people to provide assistance to disabled older adults—if roles are developed for able Latino elders that would enable them to help Latino elders who need assistance. This could include respite, friendly visiting, home health, care and case management, and more.

Outreach and Education: Latino elders are highly affected by stigma regarding mental illness; often they and their families are unfamiliar with concepts of mental health, and they are frequently unaware of the effectiveness of treatment. Participants in our meeting reported, however, that, when they have been able to organize outreach and mental health education efforts, they have been extremely effective in engaging Latino elders in mental health services. They noted that their ability to reach out and to provide education is very limited because funding for mental health services is provided almost only for treatment. They simply cannot afford to provide outreach and education services.

Home and Community-Based Services: Participants in our meeting also noted that many Hispanic elders with mental health problems are homebound—some because of physical disabilities, some because depression and anxiety promote isolation sometimes verging on reclusiveness, and some because they are afraid to go out in their neighborhoods.

They also noted that some Latino elders will not go to a "mental health" center for treatment but that they can be engaged in community settings such as senior centers, NORCs, houses of worship, and the like.

For these reasons, it is very important to redesign the mental health system so as to remove disincentives to providing services in the home and to make it possible to fund mental health services provided in community settings.

Family Support: The obligation of families to provide care for family members with physical and/or mental disabilities is very powerful in the Latino community. As a result, very few Latino older adults go to nursing homes. But family caregivers are vulnerable to developing anxiety, depression, and physical disorders and often neglect the stress of caregiving because of their sense of obligation. These family caregivers need such support services as affordable counseling, support groups, respite, and responsive crisis services.

Best Practices: Many of the meeting participants voiced great concern that evidence-based practices for the most part have not been tested on Latino older adults. The development of clinical and services research involving Latino populations is critical.

However, there is widespread consensus about what works best, and it seems clear that efforts to identify best practices through consensus building exercises would be quite productive.

Limited Service Capacity: Despite stigma, a great many Latino elders and their families do seek mental health services, only to be confronted with a lack of services within a reasonable distance of where they live as well as long waiting lists even outside their neighborhoods. Everyone at the meeting agreed that it is important to develop more mental health services in Latino neighborhoods and to expand the capacity of the outpatient mental health system.

Latino Geriatric Mental Health Workgroup

The Latino Geriatric Mental Health Workgroup is sponsored by The Association of Hispanic Mental Health Professionals in partnership with the Geriatric Mental Health Alliance of New York, the NYC Dept. for the Aging (DFTA), and the NYC Dept. of Health and Mental Hygiene (DOHMH). Its initial goals are to:

- Develop and advocate for recommendations on meeting the mental health needs of Latino older adults
- Promote the development of a culturally competent workforce including increasing the number of Latino professionals
- Promote the development and use of evidence-based practices specific to the Latino population.

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The workgroup is chaired by Carmen Collado who is Director of Immigrant Services and Latino/Hispanic Affairs at the Jewish Board of Family and Children Services and who represents the Association of Hispanic Mental Health Professionals.

Co-sponsoring organizations are represented by Michael Friedman, Chairman of the Geriatric Mental Health Alliance, Commissioner Edwin Mendez-Santiago from DFTA and Associate Commissioner Jorge Petit from DOHMH.

Association of Hispanic Mental Health Professionals

The A.H.M.H.P. is a not-for-profit tax-exempt (501C3) organization founded in 1983 by a multidisciplinary group of Hispanic Mental Health professionals to address serious gaps in the mental health delivery systems affecting the Hispanic Community. Our members are nurses, psychiatrists, psychologists, social workers, and other mental health professionals of Hispanic backgrounds as well as non-Hispanic Mental Health professionals interested in Hispanic issues.

Our mission is to identify the mental health needs of the Hispanic community through ongoing analysis of major concerns in public and private mental health issues, including research, education, policy, and training in the City and State of New York, and to promote alternative services that best meet the needs of the Hispanic community.

Geriatric Mental Health Alliance of New York

The Geriatric Mental Health Alliance of New York is an advocacy organization with nearly 2000 members. Its goal is to improve geriatric mental health policy and practice through changes in law, funding, regulations, and plans; through the promotion of cooperative working relationships between the mental health, health, and aging systems; through the development of local advocacy and planning groups; and through training and consultation about best practices.