Latinos are one of the fastest growing segments of the older population and are known to have a high prevalence of depression, as well as a greater likelihood of risk factors for this condition such as poor comorbid physical health, distressed economic circumstances, and social isolation that leads to a de facto homebound status. Thus, long-term care providers are likely to encounter increasing numbers of older Latinos suffering from depression in both community and institutional settings. This article discusses current empirical and conceptual studies on mental health issues facing older Latinos, as well as outreach, clinical practice, and policy recommendations for working with this population.

Keywords: Hispanics; stigma; mental health services; service barriers

Meeting the Mental Health Needs of Elderly Latinos Affected by Depression: Implications for Outreach and Service Provision

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Latinos, or persons of Hispanic origin, are one of the fastest growing minority groups in the United States, and will constitute the largest such group in the early part of the twenty-first century (Pollard, 1993). Latinos are not homogenous, with considerable diversity in national origin, birthplace and immigration patterns, language use, and race (Cantor & Brennan, 2000). The largest Latino group consists of Mexican Americans (48%), followed by Cuban Americans (18%), Puerto Ricans (11%), Central and South Americans (8%), and 15% classified as "other." There will be approximately 8 million older Latinos in the United States by 2050 (Angel & Hogan, 1991). The focus of this article is mental health among the Latino older population, specifically, the identification and treatment of depression and risk factors that may precipitate or exacerbate this condition, such as social isolation and de facto homebound status due to cultural differences, caregiving responsibilities, poor health, and low utilization of mental health services.

Depression as an illness among older adults is highly significant, given its prevalence and its overwhelming association with increased morbidity and mortality (Chew-Graham, Baldwin, & Burns, 2004; U. S. Department of Health and Human Services, 1999). Older persons with mental disorders such as depression use more institutional long-term care (Parker, 2004). Further, depression in long-term home health care clients is likely to be misdiagnosed or undiagnosed, with indications that upwards of 16% of this population may have major depression (Brown, Bruce, et al., 2004; Brown, McAvay et al., 2003; Raue et al., 2003).

Major depressive disorder is defined as one or more episodes characterized by symptoms of depressed mood, loss of interest or pleasure in activities, significant weight loss or gain, sleep disorders, fatigue, psychomotor agitation or retardation, sense of worthlessness, and thoughts of suicide or death, along with other criteria related to duration, and so forth. Although the likelihood of a diagnosis of major depressive disorder decreases with age, older adults are at greater risk for clinically significant depressive symptomatology affecting anywhere from 10% to 20% of community-dwelling older adults, and anywhere from 17% to 35% of this group in primary care settings (U. S. Department of Health and Human Services, 1999).

In one national study, Latinos had a 44% increased risk for major depression relative to non-Hispanic Whites.

Prevalence of Depression Among Older Latinos

Whereas some studies have not found racial/ethnic differences in the prevalence of depression (Crystal, Sambamoorthi, Walkup, & Akincingil, 2003), others find Latinos at greater risk. In one national study, Latinos had a 44% increased risk for major depression relative to non-Hispanic Whites (Dunlop, Song, Lyons, Manheim, & Chang, 2003). Elderly Latinos are also more likely to have clinically significant depressive symptoms compared with non-Hispanic Whites (i.e., 30% to 44% and 22%, respectively; Falcon & Tucker, 2000). Differences in the prevalence of depression also

exist among Latinos based on national origin (Falcon & Tucker, 2000). Puerto Ricans are at greater risk for depression compared to Mexican Americans or Cuban Americans (Guarnaccia, Martinez, & Acosta, 2002).

Risk Factors for Depression

Sociodemographic and Economic Risk. Female gender has been associated with greater risk of depression among older Hispanics in some studies (Chiriboga, Black, Aranda, & Markides, 2002; Falcon & Tucker, 2000; Moscicki, Locke, Rae, & Boyd, 1989). However, the most consistent findings are that both older and younger Latinos are at greater risk of depression due to poverty and lack of economic resources (Aranda, Lee, & Wilson, 2001; Chiriboga, Black, Aranda, & Markides, 2002; Falcon & Tucker, 2000; Moscicki, Locke, Rae, & Boyd, 1989; Ostir, Eschbach, Markides, & Goodwin, 2003; Robison et al., 2003). Among older Latinos nationwide, approximately 23% report incomes near or below U. S. government poverty guidelines (Cantor & Brennan, 2000).

Health and Disability. Poor health and functional disability have been identified as major risk factors for depression among older Latinos and older adults in general (Aranda, Lee, & Wilson, 2001; Burnette, 1999; Chiriboga et al., 2002; Falcon & Tucker, 2000; Robison et al., 2003; U. S. Department of Health and Human Services, 1999; Villa & Aranda, 2000). In addition, older Latinos tend to have worse physical health and greater functional disability than non-Hispanics, even when other factors are controlled (Berkman & Gurland, 1993; Falcon & Tucker, 2000; Shetterly, Baxter, Morgenstern, Grigsby, & Hamman, 1998).

Social and Cultural Risks. Depression among Latinos is related to more recent immigration or lack of familiarity with the Anglo culture (Escalante, del Rincon, & Mulrow, 2000; Robison et al., 2003), but this does not hold true in all cases (Guarnaccia et al., 2002; Falcon & Tucker, 2000; Moscicki et al., 1989). Pre-immigration exposure to political violence also predicts depression among Latinos (Eisenman, Gelberg, Liu, & Shapiro, 2003), as does social isolation and caregiving responsibilities (Aranda et al., 2001; Robison et al., 2003). For example, married older Latinos are 2.5 times less likely to be depressed than unmarried Latinos (Falcon & Tucker, 2000). With regard to caregiving, older Latinos caring for grandchildren are approximately twice as likely to be depressed as those without such responsibilities (Burnette, 1999). However, caregiving responsibilities of older Latinos also involve other elderly (e.g., spouses, parents, or other relatives), and this type of caregiving is also associated with greater risk for depression among Latinos compared to other groups (Covinsky et al., 2003). Furthermore, neuropsychiatric symptoms among care recipients exacerbate such risk (Hinton, Haan, Geller, & Mungas, 2003).

BARRIERS TO IDENTIFICATION AND TREATMENT OF DEPRESSION

Depression may present in primary care settings as one or many physical symptoms (e.g., insomnia, loss of appetite). In one study of low-income Latino primary care patients, 47% had clinically significant depressive symptoms and, of these, only 44% were identified as depressed by their physician (Chung et al., 2003). Additionally, many Latinos report mental distress in terms of *nervios* (i.e., nerves) instead of using diagnostic categories, such as depressed or anxious, which are familiar to mental health professionals (Guarnaccia, Lewis-Fernandez, & Marano, 2003; Jenkins, 1988). This catch-all word for mental health issues diffuses the stigma while permitting tolerant inclusion of the person within the family and home (Jenkins, 1988), in line with the family-centered nature of Latino cultural values and preferences to seek help within the immediate family (Cantor & Brennan, 2000; Simoni & Perez, 1995).

Stigma is a major obstacle in the treatment of physical and mental illness. It can be defined as a set of negative stereotypes associated with life circumstances that lead individuals to devalue themselves and potentially elicit negative behavior on the part of others, for example, avoidance or discrimination (U. S. Department of Health and Human Services, 1999). Most stigmatization around mental illness stems from a fear of violence, namely, that the person with mental illness is likely to harm others. In response to such social stigma, many older adults with mental illness fail to seek treatment, even though this perception is largely unfounded.

Because of stigma it is common for older Latino adults to accept treatment only under the condition of strict confidentiality from family members, including spouses and children.

Stigma is so pervasive that it affects not only the self-esteem of persons with mental illness but also that of family members. Because of stigma it is common for older Latino adults to accept treatment only under the condition of strict confidentiality from family members, including spouses and children. This originates in part from the belief among some Latino cultures that depression is a path to *volviendose loca/o* (going crazy) or, in some Latino cultures, someone with depression is perceived as a *bruja/o* (witch) due to a typically disheveled appearance. Furthermore, compared to other groups, Latinos, along with Asians, are more likely to perceive persons with mental illness as dangerous (Whaley, 1997).

Barriers to Service

Even after depression has been diagnosed, Latinos are less likely than persons in other groups to seek and continue treatment. For

example, among Medicare beneficiaries Latinos are approximately only half as likely as others to receive treatment for depression and are the least likely to be treated using psychotherapy (Crystal et al., 2003). Further, this lower treatment rate is not related to diagnostic disparities between groups, but may reflect lower treatment compliance overall among Latinos (Lasser, Himmelstein, Woolhandler, McCormick, & Bor, 2002; Padgett, Patrick, Burns, & Schlesinger, 1994), and non-compliance with use of antidepressive medications (Miranda & Cooper, 2004). Stigma concerning mental illness also predicts treatment non-compliance among Latinos (Sirey, Bruce, Alexopoulos, Perlick, Friedman, & Meyers, 2001; Sirey, Bruce, Alexopoulos, Perlick, Raue, et al., 2001).

Stigma among Latino older adults with depression is exacerbated by discrimination from health care providers based on race/ethnicity. A recent survey found that 15% of Latinos believed that a health provider judged them unfairly or treated them with disrespect because of their ethnic background as compared with 1% of non-Hispanic Whites (Brown, Cohen, Johnson, & Smailes, 1999). Another study found that 28% of Latinos believed that a health care provider treated them badly because of their race/ethnicity in comparison with 5% of Whites (U. S. Department of Health and Human Services, 2001). In terms of alternative resources, Latinos may pursue traditional forms of healing (i.e., folk remedies/healers) in tandem with seeking mainstream services (Thompson, 2002). They may also seek emotional support from their families rather than outsiders, in line with Latino cultural values (Cantor & Brennan, 2000; Simoni & Perez, 1995).

CASE EXAMPLES

The following cases illustrate some of the issues older Latinos face as they age in locations that are far from their homelands and cope with physical and mental health problems.

The Case of Mrs. R.

Mrs. R. is a 68-year-old woman who was born and raised in Peru, and had three living siblings who were still there. She grew up experiencing domestic violence resulting in feelings of sadness, fear, and shyness. At age 20, Mrs. R. eloped with her boyfriend over her parents' objections, but divorced two years later because her husband was abusive. Mrs. R. remarried a few years later, had five children, and moved to the US. However, her second husband was also abusive and a womanizer, so they separated. Mrs. R. raised her children alone, receiving financial help from her brothers in Peru along with public assistance. She never worked because she felt she could not leave her children alone, she lacked skills, and did not speak English. Of her five children, three lived in New York and two in the Midwest. Her children were very involved with her and kept in touch daily. She felt proud of them; however, she reported that all their marriages had ended in divorce. Mrs. R. reported that she felt very close to her children and constantly worried about them, especially if a day went by without a call. She attended church at least once a month, and stated that it helped her to cope with worries about her children.

She attended a senior citizens' center on a regular basis because she received free breakfast and could talk to other seniors, but when she felt depressed it was difficult to go there. Mrs. R. had a boyfriend whom she met at the center. She mentioned that she got easily irritated with him when he failed to pay attention to her needs. The relationship was conflictive because he was jealous of the time she spent with her children, and because she lacked sexual appetite. She considered the relationship to be stressful and considered breaking it off, but hesitated because they had cared for each other when sick.

Mrs. R.'s primary care physician referred her for assessment and treatment for depression. Her medical records showed that she had had a hysterectomy 15 years ago and surgery for breast cancer 2 years prior, in addition to asthma and hypothyroidism. She was taking medications for these conditions, but denied using illegal drugs or alcohol. A year and a half ago, she had also been referred for treatment of depression, but attended only three appointments and did not accept therapeutic services. She explained that on the present occasion she was more interested in treatment because her symptoms were more consistent, namely, crying almost daily for no specific reason, having decreased appetite and losing 11 pounds in the past 3 months, and constantly feeling "nervous." Mrs. R. reported that her current depression symptoms were exacerbated 2 years ago when she was first diagnosed with breast cancer. At the intake psychiatric evaluation, she screened positive for moderate depression on the Beck depression inventory, and received DSM-IV diagnoses of recurrent major depressive disorder and moderate psychosocial stressors due to conflict with family and her current boyfriend.

Mrs. R. reported that she had always been a loner and withdraws when she is feeling sad. She perceived herself to be a "useless old lady," and thought she was unable to do much for others; this self-concept prevented her from socializing with family members. She also avoided social events with her children because she felt left out due to the language barrier. Mrs. R. also felt pulled in two directions because her children live in the US and her siblings in Peru.

As her emotional state deteriorated, she was finally motivated to seek treatment for her depression.

This case illustrates how older Latinos often fall through cracks in the system due to a combination of language barriers and resistance to treatment. If Mrs. R. had remained engaged with her mental health provider at the time of her first referral, her depressive symptoms might have been kept in check, or at least prevented from becoming worse.

The Case of Mrs. L.

Mrs. L. is a 75-year-old Puerto Rican widow with a history of chronic major depression and general anxiety disorder, in addition to a number of severe illnesses, including Parkinson's disease, asthma, and diabetes. She has had multiple family stressors including the loss of her husband by suicide 25 years ago, the death of one son 5 years ago, a 38-year-old daughter with breast cancer, and the

diagnosis of her 53-year-old son, with whom she lives, with Parkinson's disease. She used a wheelchair and had been homebound for 5 years. Thus, with the exception of her son, she was socially isolated. Mrs. L. had had an extreme emotional reaction to the September 11th attacks, which she witnessed from her apartment. This was the first time a primary care physician referred Mrs. L. to a mental health clinic, where she was diagnosed with anxiety and depression.

Mrs. L. was hesitant about seeking help from the mental health clinic because of the social stigma, namely, *verguanza* (shame) and fear that her neighbors and relatives would perceive her as *loca* (crazy). After confronting her feelings, Mrs. L. had great difficulty getting to the clinic with her wheelchair and needed special transportation. Despite waiting a long time for a Spanish-speaking therapist, she still felt misunderstood when one became available, and this problem was exacerbated when her services were terminated on three consecutive occasions during a one-year period because she missed two consecutive appointments due to her poor health. Mrs. L. felt resentment and frustration attempting to access mental health services, stated that she no longer had the energy to confront the overwhelming barriers, and felt it was better if she remained at home. Traditional outreach failed to bring her back for treatment.

The only time Mrs. L. expressed satisfaction with services from the mental health clinic was when she was finally helped by a Spanish-speaking social worker who was able to make home visits and was attentive to her basic needs (e.g., arranging for home care). She stated that no one had ever enabled her to share as much about her emotional needs and sense of loss as this social worker. Mrs. L. related that this was the only time she had ever talked about her husband's suicide, which otherwise remained an unspoken subject within her family. She expressed two ways in which this culturally competent social worker was able to assist her as others had not: she felt respected and that her needs were addressed. Thus, through mental health services given in a culturally competent manner, by the meeting of basic needs resulting from her homebound status, and by providing a safe space in which she could share her emotional pain without fear of stigmatization, Mrs. L. was finally able to access the mental health services she needed.

PROVIDING OUTREACH TO THE OUT-OF-REACH

Service-resistant populations often comprise a significant segment of caseloads for mental health and social service professionals. Below, we describe a community-based outreach model that was successful in a community of elderly Latinos for whom other outreach modalities were ineffective. This initiative was conducted in a primarily Hispanic section of New York City, and serves as an outreach model that is both non-traditional and culturally sensitive.

Project Population

The project population consisted of 18 elderly Latinos who were homebound for a variety of reasons. Many had a history of employment but were currently receiving public assistance due to medical and financial needs. All but two had been born outside the U S, spoke Spanish, and had limited education beyond the ninth grade. All had been married and had between three and four children with extended families. As a whole, they had strong religious beliefs and church affiliations. Members of this group lived within a 39-block radius. These Latinos shared a need for some kind of case management intervention to coordinate their resources or mental health services. However, they were deemed to be *molestoso* (very hard to get along with) and generally not responsive to neighbors' help, or "charity."

Initial assessments for mental health services or community supports were attempted by telephone as well as "street contact" through neighbors, clergy, and local merchants. At this juncture service-resistant individuals are frequently lost from the system as a result of burgeoning staff caseloads within community programs and safety concerns about visiting client homes in public housing facilities. Assessment revealed that some of these individuals did not leave their apartments, even to buy food, and many had stopped attending religious services. Initial attempts to contact these families directly or through relatives over many weeks were unsuccessful.

Proactive Outreach Methods

After failing to make contact using traditional outreach, we began a more proactive approach. Eventually we were successful through persistent in-person visits, many conducted through a closed door. Some of these visits were initially very brief. Conversations were in Spanish, the client's first language, and the social worker was knowledgeable about the cultural norms of this population. The involvement of third parties such as family or non-kin that would embarrass clients was avoided.

Often, interpersonal contact was established by setting up situational dynamics in which clients were the hosts and the social worker was a visitor accepting hospitality. This approach respected clients and preserved their dignity by acknowledging their dominion over their homes. Vital information was often shared through *bochinchen* (gossip) between the client and social worker. Rapport was established through sharing of the client's culture and folklore.

With some of the individuals involved in this outreach, meetings were first held in a participant's apartment, but as more and more people from the community showed up for these meetings, the group eventually moved downstairs to the community room in the basement of the building. A son-in-law, the superintendent of the building, took care of setting up the space, including borrowing chairs from the local funeral home. New people continued to come each week, as a network was built based on cultural commonality and shared interests, such as holiday celebrations and personal achievements, as well as disappointments and complaints. These interactions strengthened motivations of these persons toward helping each other and themselves, creating a supportive network of individuals in the surrounding community, and bolstering their sense of self-worth and self-esteem.

In summary, this proactive outreach consisted of: (a) assessments through direct person-to-person contact between social service workers and clients in their homes in the clients' preferred language without translators; (b) building rapport between the provider and client based on culturally appropriate common knowledge and experiences; (c) involvement of family, non-kin, and community resources as necessary, appropriate, *and* if desired or accepted by the client; (d) creation of client networks sharing a common language and culture, and dealing with similar challenges; and (e) maintenance of contact over an extended period of time.

Psychosocial Issues and Program Participation

The common features in psychosocial assessments of these older Latinos were isolation, depression, anger, fear, and resistance. They also presented a wide range of chronic medical problems that were exacerbated by lack of timely care resulting from resistance to available services and isolation. Some were just getting by with limited informal and formal social supports. Others were clinically depressed and had a hard time focusing on important issues. Still others were more aware but angry about their situations. However, as these clients regained their self-respect, they became willing participants in an ongoing group therapeutic process. They joined a telephone network using a call circle established at a fixed time each week through which they could share their common experiences and complaints. The latter frequently involved dealing with "the system," which became their demonized common adversary. Each individual's strengths (e.g., knitting, cooking) were revealed and emphasized as the basis of interpersonal sharing. These strengths became the foundation for further interactions such as visits, craft projects, and participation in community events like bake sales.

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The positive outcomes achieved with this model for effective, proactive outreach emphasized client strengths rather than problems, and addressed needs in a culturally and linguistically competent manner. Rebuilding dignity and self-respect empowered clients toward self-sufficiency and the use of community resources. Such innovative outreach proved to be an effective modality for combating their persistent neglect of chronic health problems, reducing the need for expensive crisis intervention, and establishing a link with community-based providers.

EVIDENCE-BASED PRACTICE FOR DEPRESSED LATINO ELDERLY

Despite the difficulties in providing outreach to older homebound Latinos, blaming patients for their lack of engagement and resistance to treatment does not justify under-serving these men and women. Consequently, there is a need for culturally specific approaches to the problem of mental illness for the Hispanic elderly. However, there is a significant lack of research and knowledge concerning older Hispanics' access to mental health services, their service retention, and the provision of high quality care for depression.

The drive toward accountability and quality in mental health care revealed by evidence-based practice research over the last 10 years has yet to include fully the study of depression in older Latinos. Evidence-based practices have not been designed for Hispanics or other minorities, but have been standardized on majority populations. In fact, only recently have government-funded and -regulated studies of psychoactive medications required tracking and analysis of the ethnic identity of research participants. Therefore, the evidence-based practices that have demonstrated efficacy in majority populations must be re-examined for Hispanics.

However, despite the lack of empirical data, the provision of culturally competent services should improve access for underserved ethnic minority groups such as Latinos. The Federal Office of Minority Health has recommended culturally and linguistically appropriate health care services (U. S. Department of Health and Human Services, 2004). These guidelines include the provision of care compatible with specific health beliefs and preferred language, as well as the development of strategic plans and collection of ethnic, cultural, and linguistic data from target populations. Additionally, mandated ethnic data collection in studies regulated by the government will help to develop evidence-based strategies for the Latino elderly.

Although many questions remain unanswered, goals for treatment of depression among Latinos are the same as for non-Latinos: decreasing symptoms, reducing risk of relapse/recurrence, increasing quality of life, improving mental health status, and lowering health care costs and mortality rates. Systematic reviews of geriatric mental health interventions confirm that treating depression in the elderly works, although these treatments may not be available for all of those in need (Bartels et al., 2004; Draper, 2000; Schulberg et al., 2001; Sorenson, Pinquart, & Duberstein, 2002; Unutzer et al., 2001).

Psychiatric and Psychological Treatment

The most extensive source of evidence-based research in the treatment of elderly depression concerns antidepressants. Hundreds of studies have confirmed the efficacy of these drugs to prevent and relieve signs and symptoms of depression. There have been reports that Hispanics have shown lower adherence to treatment than other ethnic groups due to a combination of drug side effects, poor information, and other barriers to care. Furthermore, language discordance between patient and psychiatrist is a frequent cause of

failed compliance with antidepressant treatment among Hispanics. There are no significant evidence-based studies regarding antidepressant use among elderly Latinos (Sleath, Rubin, & Houston, 2001), but the newer antidepressants may soon prove to be safe and effective in conjunction with culturally and linguistically appropriate services for this population (Skaer, Sclar, Robison, & Galin, 2000). Response to treatment in elderly patients often takes longer compared to younger patients, and may require 6 to 12 weeks of therapy. Lack of medication compliance, a common situation among older patients, is the most frequent cause of poor response. However, a poor response among compliant patients can be addressed through trials with alternative medications.

Because of coexistent medical comorbidities, careful consideration is required to choose a safe medication, taking into account these conditions and potential negative interactions with other medications. In addition, the side-effect profiles and idiosyncratic genetic differences among Hispanics require further research (Burroughs, Maxey, & Levy, 2002). Other psychiatric medications might be required to treat psychiatric symptoms coexistent with depression, such as anxiety, psychosis, insomnia, and dementia. Therefore, access to the full currently existent pharmacopoeia is essential for treatment of these conditions.

Culturally and linguistically competent psychotherapy is likely to enhance medication compliance; provide additional cognitive, behavioral, and psychosocial skills to deal with depression; and prevent relapses. Although there are still no identified best practices in this population, the literature suggests that cognitive behavioral therapy (CBT), which is aimed at the development of cognitive and behavioral coping skills, reduces dropout rates in treatment of depression among Hispanics when associated with antidepressant medication use (Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Wells et al., 2004).

In rare cases that do not respond to psychotherapy and psychopharmacological treatment, or when antidepressant drugs are medically contraindicated, electroconvulsive therapy (ECT) has been shown to be effective and safe in the treatment of depression in older adults. Further study is needed to address response and risks among Hispanics treated with ECT, and to test treatment strategies (e.g., maintenance ECT, maintenance antidepressants post-ECT). Finally, peer or self-help groups and faith-based services for older people with depression are related to improved outcomes, and may be more acceptable to older people than are clinical mental health services.

Integrated Mental Health in Primary Care

There are insufficient numbers of geriatric mental health clinics with competent professionals available to deal with the large numbers affected by depression. It is estimated that two-thirds of older Hispanic depressed individuals do not receive the psychiatric treatment that they need. Thus, it is imperative that a mental health component be integrated into the primary care practice. Despite the current lack of evidenced-based research of this promising practice for Latinos, several ongoing studies are expected to identify optimal models for integrating mental health in primary care for older individuals. For example, the use of case management improves retention and may improve outcomes for Hispanics with depression (Miranda et al., 2003).

Long-Term Community Mental Health Treatment for Latino Elderly

A range of models is currently under study involving long-term treatment of this population (Washington Institute for Mental Illness Research and Training, 2003). One NIMH program is the Helping Older People with Severe Mental Illness Experience Success (HOPES) study, based on teaching skills needed for community participation and health care management. Enhanced services in HOPES include monitoring nursing care, facilitating preventive and primary medical care, and psychoeducation. Another evidence-based practice study is the Psychogeriatric Assessment and Treatment in City Planning (PATCH) serving older adults in public housing. PATCH utilizes a mobile treatment model to target older adults in need of mental health care. Psychiatric staff provides education to public employees who are in contact with residents, and a psychiatrist makes home visits and develops ongoing treatment plans (e.g., psychotherapy, medication, service linkages, etc.). Although a number of promising models are being developed, none focus specifically on the Latino population. But these data do include the ethnicity of participants and may serve to improve clinical practice in the Latino community.

Culturally and linguistically competent psychotherapy is likely to enhance medication compliance; provide additional cognitive, behavioral, and psychosocial skills to deal with depression; and prevent relapses.

Family and Caregiver Support Interventions

Caregiver support interventions may help to address mental health issues for these older Hispanics. Such interventions may delay nursing home placement for care recipients, as well as decrease the incidence and severity of depression among caregivers (Gitlin et al., 2003; Sorensen et al., 2002). Taking this approach, the Senior Companion Program is a best-practices model that provides federal monies to organizations to expand supportive services and improve the lives of older people. This model could be particularly promising for the caregivers of elderly Latinos.

DEPRESSION AMONG OLDER LATINOS: POLICY ISSUES

Despite the high rates of depression among Latinos, utilization of available mental health services is exceedingly low, resulting from failures of engagement between providers and Latinos, and limited access and availability of clinically and culturally competent services. These problems cannot be addressed without changes to public policy in the provision of mental health services to underserved minorities.

Public Education

Increased efforts to provide public education to the Latino community, including primary care physicians, religious leaders, educators, and others who serve them, are necessary in order to address ignorance about mental illness and the nature and effectiveness of treatment. Public education efforts are also needed to address stigma around mental illness and depression.

Outreach, Home-Based, and Non-traditional Services

By and large mental health services are designed, structured, and financed on a medical model. People with illnesses are expected to come to a place where mental health services are provided by mental health professionals who rarely provide services off-site, in the community, or in people's homes. The services provided are generally a combination of verbal and medication therapy. Services designed to provide community supports of the kind that have been developed for people with serious and persistent mental illnesses are generally not available for people with depressive disorders unless they experience repeated hospitalizations. Given the culturally determined reluctance of Latinos to seek out traditional mental health services, a fundamentally new vision of services for this cultural minority needs to be developed, one that emphasizes outreach in community settings and the provision of a variety of support services that will help to engage Latinos.

Cultural and Clinical Competence

Problems of clinical and cultural competence are commonplace in the mental health system. The recent push by federal and state governments to spread the use of evidence-based services will certainly help. However, a serious push with regard to cultural competence is also needed. This calls for changes in professional education, major training initiatives, changes in organizational structure and culture, and new regulatory requirements that make licensing dependent on improvements in serving people of diverse cultures.

Expansion of Service Capacity and Workforce Development

Given the size of the currently underserved population of Latinos with depression and the rapid growth of the U. S. Hispanic population, it will not be sufficient simply to modify service models and spread clinical and cultural competence. The capacity of the mental health service system itself must increase. Similarly, there is a need for many more clinically and culturally competent mental health professionals. This will require a major effort to build interest in mental health careers among Latinos and others who have the language skills and cultural knowledge to serve Latinos effectively, as well as the expansion of education and training programs.

Clinical and Services Research

Few studies have focused on Latinos, and funding for clinical research and trials on this population is needed, including refinements in diagnosis and the development of culturally relevant variations on basic treatment techniques. Research on which types of services are effective in engagement and the value of community supports is essential to help transform the paradigm of service provision to alleviate depression among older Latinos.

Financial Help

To achieve these goals requires a variety of changes in mental health financing. Clearly an increase in funding is needed in order to expand service capacity, build clinical and cultural competence, expand the workforce, and enhance research. In addition, there will need to be a number of structural changes in mental health reimbursement, including providing parity between physical and mental health coverage in both employer-based health insurance and Medicare. This also includes the assurance of adequate reimbursement for home-based services, and the need to fund non-traditional outreach and support services. These may actually be less expensive than traditional services but are not currently reimbursable.

CONCLUSION

This article has illustrated the high prevalence and increased risk for depression of many older Latinos who are isolated in their homes and communities. It is imperative that the needs of this population be addressed in order to avoid both overburdening our current system and the excess disability and poor quality of life that result from untreated depression and other mental illnesses. Although current direction in policy and practice are promising, more must be done to assist this vulnerable segment of the elderly population.

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Acknowledgments. The authors wish to thank Thalia MacMillan, MSW, for her suggestions and assistance in preparing this manuscript.

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