



# HARVARD JOURNAL OF HISPANIC POLICY

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## Health and the Latino Community

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### Feature Interviews

The State of Latino Health  
Antonia Novello M.D., M.P.H.  
Commissioner of Health, New York state  
*Mayra De La Garza, Nereyda Salinas*

Creating a Space for Latino Leadership in Health  
Elena Rios M.D., M.P.H.  
President, National Hispanic Medical Association  
*Mayra De La Garza, Nereyda Salinas*

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### Feature Articles

The Uninsured: A Call to Action for all Latinos  
*Olveen Carrasquillo M.D., M.P.H., Oxiris Barbot M.D.*

Addressing the Mental Health Needs of Latino Youth  
with Emotional and Behavioral Disorders: Practical  
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Congressional Hispanic Caucus Health Report  
on Hispanic Health in the United States  
*Office of Representative Ciro Rodriguez,  
Chair, Congressional Hispanic Caucus  
Health Task Force*

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Latino Health Facts and Sources

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## *Editors' Remarks*

Despite the debate surrounding President Clinton's failed universal health coverage plan and the current health care debate between the presidential candidates, Vice President Al Gore and Governor George W. Bush, the health needs of Latinos have not received the appropriate amount of attention. Latinos will become the largest minority group in 2010 and will comprise one fourth of the nation's population in 2050. In some states, Latinos are already the majority. It behooves grassroots organizations, health professionals, policymakers, and our public leaders to seriously address the health issues affecting Latinos.

We offer this year's *Harvard Journal of Hispanic Policy* as a tool to those who seek to improve the health conditions of Latinos in the United States. We hope this contribution will illuminate Latino communities' health conditions and suggest possible solutions to improve access to and utilization of culturally competent health care. This volume reflects expertise from legislators, providers, and academics and speaks to Latino health issues at the state, national, and grassroots level. It is our hopes that the nation will treat health care as a human right and not a privilege.

Our featured interviews are with two leaders who have dedicated their lives to the betterment of Latino health. Antonia Novello M.D., M.P.H., commissioner of health for New York state and former (and first woman and Latina) surgeon general of the United States, discusses the current state of Latino health in New York. She describes her efforts to eliminate obstacles to care and preventive medicine in New York, giving particular attention to the care of asthma, diabetes, and HIV/AIDS. Elena Rios M.D., M.P.H., president of the National Hispanic Medical Association (NHMA), discusses her organization's role in promoting Latino leadership in health policy and efforts to promote strategic health programs across the nation that address Latino health care needs. The experience and commitment of both interviewees provide much insight. We thank them for their participation and their determination to continue to break barriers.

Olveen Carasquillo and Oxiris Barbot's article provides us with a recent review on health insurance coverage for Mexicans, Cubans, and Puerto Ricans from the March supplement of the Current Population Survey 1999. They point out that more than one third of Latinos lack health insurance — the most

important determinant to access to the health care system — and thus call upon all Latinos to advocate for universal health care coverage.

J. Manuel Casas and others review the inequalities that exist for Latino and other minority youth in obtaining mental health services. They outline trends and themes present in previous research on this topic, and highlight key policy-related elements to consider when serving Latino youth and their families.

We close our featured articles with the Congressional Hispanic Caucus (CHC) Report, “Hispanic Health in the United States.” It is based on hearings held by the CHC during Hispanic Health Awareness Week 1999 and the report prepared by the office of Representative Ciro Rodriguez, chair of the CHC Health Task Force that was released in April 2000. It discusses HIV/AIDS, diabetes, mental health, and substance abuse in the Latino community at a national level and describes CHC policy recommendations and current efforts to address unmet health needs of Latinos.

We conclude with a fact sheet and resource page that we hope will stimulate further interest in this topic and assist future research endeavors.

The editors would like to thank the *HJHP* student board members for their contributions and coordinated efforts. Their contributions and efforts are too many to mention and at times required roles other than what was initially expected. Their time spent is a testament to their dedication to the journal’s mission.

The journal and our other activities would not exist without the continued financial and institutional support of Dean Joseph McCarthy. We are also grateful to the multiple John F. Kennedy School of Government staff who provided logistical assistance throughout the year, especially during our mid-year office move. Professor Richard Parker’s editing experience and insight produced invaluable advice and direction during our critical moments. The editors appreciate his guidance and moral support. We would also like to thank the Kennedy School Student Government for their yearly assistance. The staffs of the *Asian American Policy Review* and the *Harvard Journal of African American Public Policy* are thanked for their moral support.

When we embarked on our expedition to analyze health in the Latino community, we received precious advice and mentoring from Richard Valdez, the associate director of the UCLA Chicano Studies Research Center, associate professor of public health at the UCLA School of Public Health, and senior researcher of health policy at the RAND Corporation. He is a highly esteemed and respected health care policy expert who helped us collect manuscripts from specialists in Latino health and navigated us through the selection process. His unselfish dedication to improving Latinos’ access and utilization to health resources is inspirational.

We are appreciative to Myrna Pérez for her copyediting. As a former *HJHP* editor from 1996 to 1997 (volume 10) and volume 11’s proofreader, her extensive experience and institutional memory assisted the journal through its final stages.

We give many thanks to Mel Suarez who volunteered countless hours in the summer of 1999 creating a specialized subscription database.



We would like to thank the members of our Executive Advisory Board and Andres Jimenez, our editorial advisory board chair for their wisdom and annual contributions. James Carr was instrumental in our efforts to promote the journal at the NHMA's annual meeting in Washington, DC. Grace Flores-Hughes, our executive advisory board chairperson, provided a much-needed computer and printer for our office. We appreciate their commitment.

Finally, we would like to thank the many individuals and institutions that subscribe to and read the journal. With support from our readers, we are able to further create a space for dialogue and promote solutions to furthering the Latino community's economic, social, and political empowerment.

Raúl Ruiz M.D. '01/ MPP '01  
Publishing Editor in Chief

Maurilio León MPP '01  
Managing Editor in Chief



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## *The State of Latino Health*

**Interview with Antonia Novello, M.D., M.P.H.  
Commissioner of Health, New York state**

*Dr. Antonia Coello Novello was the first woman and the first Hispanic surgeon general of the United States, serving in the Bush Administration. She was UNICEF representative for health and nutrition from 1993 to 1996, advising the executive director on issues of women, children, and youth. Currently she is New York state health commissioner, overseeing one of the nation's largest public health agencies and is responsible for a \$27 billion budget.*

*Novello, a board-certified pediatrician, is a clinical professor of pediatrics at the Georgetown University School of Medicine and the Uniformed Services University of the Health Sciences. She is also an adjunct professor of pediatrics and communicable diseases at the University of Michigan and an adjunct professor of international health at the Johns Hopkins School of Public Health.*

*Born in Fajardo, Puerto Rico, Novello earned her undergraduate and medical degrees from the University of Puerto Rico. She received a master's degree in public health from Johns Hopkins University and holds more than 30 honorary doctoral degrees.*

*Mayra De La Garza and Nereyda Salinas of the HJHP interviewed Commissioner Novello on May 4, 2000.*

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### **HJHP**

Thank you for agreeing to speak with us today regarding the health status of Latinos in the United States.

### **Novello**

Thank you for inviting me. Before answering any questions, however, I want to clarify that I will be speaking mostly from the perspective of New York state since I am no longer as familiar with the national perspective as when I was surgeon general. I will try to make general answers, but when it comes to data, the data I am familiar with is that from New York state.

**HJHP**

That's fine. What do you consider the three most important health issues facing Latinos in the United States today?

**Novello**

It is very difficult to answer that question in a way that is fair to all. It is best if we start with some numbers. I think it's important to realize that the Latino population can no longer be considered the minority. We are the emerging majority in the year 2000 and I think it's extremely important that people realize that. My worry, however, is that as people mention the emergence of us, we not forget the importance of health and education. We will have the largest number of people, but not the largest group of people that can really affect change unless we get healthy and educated.

When I look at some of the statistics of Latinos, I am concerned that we are not talking about the reality, but only continue to talk about the dream. One must not keep the other one out. We have to be realistic first. I have read that by the year 2004, we are going to be 25 percent of the population of the nation, which is really 8 percent more than we previously thought.

One has to remember that in spite of this increase, 38 percent of us have no health insurance, and of these, 29 percent are children. Another aspect of the uninsured is that many people who have no health insurance do work. Even though we are the largest minority that is employed, we still do not work for the companies/employers that give us the insurance that we deserve, and/or they only give it to the primary worker, not to the entire family. On top of that, when we look at the median income of Latinos, it is no more than \$26,000. When you compare this to about \$39,000 for whites and about \$25,000 for African Americans, we are 1.5 times more than the \$17,000 poverty line.

We absolutely need to get health insurance if we are going to be healthy or we need to be able to participate in the labor force that provides the benefits that we deserve. In the absence of that, health becomes a commodity that we have to be sure gets supplied. When I see this, I am very cognizant of the uninsured levels in New York City. This is why we have to look at education. It helps explain some of the differences.

The HACU (Hispanic Association of Colleges and Universities) data shows that only 57 percent of Latinos have finished high school and one out of 11 have finished college. In the presence of this data, we must make sure that we make education a reality for the future. You have to be educated to make it whether you are young or old. This worries me because other data have shown that it sometimes takes Latinos as much as 12 years to finish a bachelor's degree.

I am concerned that if we don't pay attention to this reality, we might never stop being the manual labor of our cities. We must unite health and education. Even if it is a slow process, it has to begin today. I know that there are at least 23 or 26 districts that have recently been drawn where elections, starting with this one, will be decided by the Hispanic vote. If that's the case, we must use some of our emotion, but more than anything, we must rely on facts to get

elected politicians to make a difference in our lives regarding those two very important issues.

### ***HJHP***

Other than the issue of the uninsured, are there other health issues that you consider important when discussing the Hispanic community?

### **Novello**

Yes, from the perspective of looking at New York. I find that New York is a microcosm of the world, not to mention of Hispanics. I see multiple problems but there are three that I am constantly battling. The first is asthma, the second diabetes, and the third HIV/AIDS — not to mention all the others that we could get into. When I look at those three, it seems that if left unattended, they could diminish our population — either by chronic illness or disability or by absenteeism to school, which indirectly perpetuates the cycle of poverty.

Regarding asthma, one of the things that really concerns me is that it is a chronic illness among Hispanics. Yet we tend to make it sound so easy that no one really places much importance on it. When I look at New York and national studies, they show that children between the ages of 0 and 14 are the most susceptible. About 22,000 hospitalizations happen here in New York state for asthma alone. When you look at the number of related hospitalizations secondary to asthma, they are four times higher among children who live in poverty areas of the state than those that live in areas of economic gain.

When I see that asthma in Hispanics is about 15 percent more prevalent among adults — compared to African Americans at 9 percent — I am concerned that asthma is tied to neighborhood, poverty, lack of health insurance, and the pessimism that sometimes happens in our communities. East Harlem and the South Bronx in particular have the highest asthma hospitalizations. I mean 19 discharges per 1000 persons. That's a lot, and what's more, 59 percent of children in those two places miss school at least five days per month due to asthma. When you look into other issues, 69 percent of the children have had at least one emergency room visit and at least 21 percent of these children were hospitalized at least once. My greatest concern is that 59 percent of them are missing five days of school every month.

What I'm trying to do is establish a close watch of hospital rooms and clinics to see how the children are being treated. For that we have renewed dialogue around this subject that I think helps the community as well because it makes them aware of the seriousness of the problem.

Also we have received money for asthma, in particular. We used this money to make sure families know exactly how to manage asthma cases and know what services are available in the community to achieve comprehensive care. I find that most of the time, people live with asthma and say, "there's nothing I can do except when it gets really bad. Then I'll go to the emergency room."

### ***HJHP***

Prevention doesn't seem a priority for many people.

**Novello**

You are right and it's very sad. What we've done is to make sure that through the Child Health Plus program, we include all medications, prescriptions, doctor's visits, and hospital care to cover children with asthma. This is crucial because it has given parents great peace of mind. Recently, the governor also signed legislation that allows schools to give permission to children who are diagnosed with asthma to use their prescribed inhalers during the school day.

**HJHP**

They weren't allowed to use inhalers in school before?

**Novello**

No. Now they can. Also, in some of the centers during asthma season, the school nurse goes to the hospital in the area so that he/she can be there waiting when a child arrives having an asthma attack. The parents don't have to be absent from work while the child gets treated. We gave about \$400,000 to make sure we get community-based coalitions to design strategy that is pertinent to the community to reduce the burden of asthma.

**HJHP**

In this way, you're involving the family and the community.

**Novello**

Exactly. The communities draft what they need since they know their neighborhood best. Just as important, we are making the community hospital the place where the nurse visits a sick child. We are also making sure that the school-based health centers have a nurse sent from the community hospital. I want a familiar nurse to be the face that the child meets when he/she gets sick either in an emergency room or in the school-based clinic, rather than having a child see a sick or dying emergency room patient. That certainly wouldn't help their asthma.

**HJHP**

So when a child gets sick, instead of being sent from the school directly to the hospital, the child is sent to the school-based clinic where a nurse from the hospital is awaiting them. And if the child does need to go to the hospital, the school nurse goes to meet the child there in case it is troublesome for the child's parent to make it.

**Novello**

Absolutely. We make sure that during asthma season, some of the hospitals are sending a nurse to the school-based clinic where the child, allowing treatment right in the school. If the child needs to go to the hospital, the nurse that is already affiliated with the hospital and whom the child already knows, accompanies the child to the hospital. That's one thing we are doing very strongly — school-based centers where we offer a comprehensive health

package rather than having kids leave the school to go to the hospital for treatment.

***HJHP***

So a third grader who gets an asthma attack can stay in the school and get treated?

**Novello**

Yes, the child can stay in the school-based clinic in the school.

***HJHP***

How many of these school-based clinics are there?

**Novello**

There are 163 school-based clinics in the state. We're planning to turn these into true centers for health.

***HJHP***

So not every school has them?

**Novello**

There are 163 in the state and about 33 percent of the children served are on Medicaid. Many of those children are Latino children. Therefore, in terms of asthma prevention and treatment, we are trying. It is a difficult disease. When I look at the statistics, I can tell you that we are doing more than we ever thought. The governor, in the State of the State address, made it my goal to decrease hospitalization of asthma rates by 50 percent or more. That is quite challenging but we are serious about diminishing asthma rates.

***HJHP***

That's quite a goal. But as you said earlier, it affects many other areas of life, especially education.

**Novello**

I am concerned about the children affected by asthma. If 15 percent is the statistic in our neighborhoods and all of these children live in what's called "the asthma corridor," I think that poverty has a lot to do with it. When I see the rate of school absenteeism, I am concerned that the cycle will not be broken. I am petrified that if we do not make an impact, it will only perpetuate itself.

The situation with diabetes is very similar. Thousands of people are affected but they only go to the hospital when their disease has caused blindness, amputation, or kidney failure. We need to learn prevention long before we have to go to the hospital to be cured. It seems to me that about one half of the people with diabetes go undiagnosed. By the time they go to the hospital, they have a complication that could have been prevented. When I look at the state, there are about 1.2 million people with diabetes and about half of them are

undiagnosed. When I look at Latinos, we have increased our rate of diabetes during the last 20 years. Today, 8 percent of all adult Latinos have been diagnosed with diabetes in comparison with 5 percent in the white population.

What concerns me is that until recently, Type II diabetes, the adult onset diabetes, was rarely seen in people less than 40 years of age. Now I see one or two children diagnosed with Type II adult, onset diabetes every week in New York. I think it has a lot to do with diet. Obesity seems to be the most important predictor of this childhood Type II diabetes. I believe it is increasing among Latino children between the ages of 12 and 15 who are obese.

**HJHP**

Children between the age of 12 and 15 are developing the adult diabetes that has rarely been seen in people under 40?

**Novello**

Yes and I really wonder if it's diet. I see one or two cases a week, when before we never diagnosed it under the age of 40. I find that when you look into our neighborhoods, you see that fast food restaurants are only a block away from all our homes. I am concerned that somewhere along the way, with the "super-sizing" concept, we double the food and double the amount of caloric intake that we need.

This is not a criticism against fast food, but when you say "super size it," for 29 cents you increase your caloric intake from 680 calories to 1340. Somewhere in the long term, we might get ourselves in trouble for 29 cents. Another study shows that children use french fries as the individual vegetable of the day. Between the ages of 13 and 18, 40 percent of the intake of vegetables comes from french fries or chips. I'm concerned that somewhere along the way, by the way we eat, we might be causing ourselves more preventive illness by not being cognizant of the facts.

To complicate the situation, when we get home we watch TV and therefore we are inactive, the complications continue. Furthermore, parents are working to survive and have less time to supervise the eating habits of the children. Also, children are drinking more soda than ever before. The last statistic I saw was 44 gallons per year in 1992. In 1972, only 27 gallons per year were being drunk per child.

**HJHP**

There is a link between obesity and diabetes?

**Novello**

Yes.

**HJHP**

Therefore all of these things that are linked to obesity are indirectly linked to diabetes?



**Novello**

Yes. We start looking directly at the cause and find that most of the ones who were diagnosed had issues of obesity. I cannot blame things that I do not know, but I have noticed that many fast food restaurants are in our neighborhoods. And if they are there, we all enjoy them. I myself enjoy them. The point is, be cognizant that “super-sizing” your meal because you are hungry is also “super-sizing” your caloric intake. That’s OK here or there but not several times a day. Your choices have consequences that in the long run can lead to amputation, blindness, or kidney trouble. It’s just good prevention. Good information that we can use to prevent illness is part of the issue. We have to be self-advocates. We are no longer just in the curing phase of medicine; we must be good at preventing illness.

**HJHP**

Are there any steps that are currently being taken to inform people about diabetes?

**Novello**

We now have 14 regional community colleges that provide self-management and conduct education events. We get the at-risk population and give them the professional education they need. I think this is crucial. Find them, teach them, and then make sure that they help themselves to manage their illness. I think we do very well with the Diabetes Centers for Excellence. We have three in the state. In selected communities, whether there are socioeconomic, cultural, or limited language issues, we make sure we have interventions and more than anything, once we diagnose the illness, we ensure that the managed care groups in the community also take care of them. It’s a tight strategy of finding, diagnosing, and treating. That is crucial because, as we have discussed, about one half of the population with diabetes have not yet been diagnosed.

**HJHP**

Are these education efforts?

**Novello**

Yes. There is lots of education out there to enable us to try to find the people that are infected by diabetes. In the near future, I hope by the latter part of the summer and beginning of the fall, we’re going to do a massive New York screening with all hospitals for the things that are hurting people — HIV/AIDS, diabetes, asthma, or high blood pressure, for example. This way, people at least know where they stand with the many diseases that are out there. We need to remove the fear people have — fear from a lack of insurance and fear of the INS. I don’t think health has anything to do with politics — it is a right. We have to find the disease so that we can treat them. We have to make it available. If Mohammed cannot go to the mountain, we have to make

it so that the mountain comes to Mohammed. We are going to create a screening where people do not have to fear going to the hospital.

### **HJHP**

During this period of screening, people can come in for free?

### **Novello**

Yes. On that particular day, the hospitals and I have worked out a deal. We will screen people and then when and if they find a disease, assign them to the managed care that is in their neighborhood. Here in New York, we also have Medicaid-managed care that is excellent. At least 13 counties already have it. We expect 1.4 million people will be in managed care by the end of phase II. The beauty about managed care here is that we have a wonderful cure and prevention team. In the city and in the rest of the state, information is delivered to people in a language that they understand. Every pamphlet is in English, Spanish, Haitian Creole, Chinese, Russian, Arabic, and Yiddish. It is important that you understand why it is that health insurance is important, and where to find it.

We have exemption rules for those who have too far of a distance to travel or too hard of a language to understand. The beauty is that through AT&T, we have 140 languages that can be translated. We have 29 people who can speak your language, face to face. We are very sensitive to the cultural aspects of health care. I always believe if you're going to give me something, don't make me beg. I truly believe that health care must be the five A's: available, affordable, accessible, accountable, and affable. Otherwise, it's just a wonderful protocol that doesn't get used. This year, the governor has given me \$1.7 million for outreach. This is crucial. Once you find the statistics, you always find people who can make change. But with emotion alone, you are at a disadvantage. We must have facts. This is why in this job at least, after doing the health agenda for Hispanics in 1993, I find that for the first time I am able to act upon the things that for the last seven years have not moved beyond the agenda. The agenda for New York is becoming the microcosm agenda — of the 18.5 million people in New York, we have 2.5 million who are Hispanics. If I can make a dent in the lives of these people, then somehow I can make a dent in the lives of all Hispanics nationwide.

The other thing that worries me with Latinos is HIV/AIDS. Still, almost 20 years after the first cases of this epidemic were found, we tend to think, "it's an issue that doesn't touch me." The sad part is that here in New York, I'm getting to people by making them realize that minorities are being affected by HIV/AIDS. The sad part is that here in New York, we have 19 percent of the AIDS cases in the United States. When you look at the group, 21 percent of the New Yorkers who live with AIDS are over the age of 50. This means that we have to start targeting the message to the adolescents and to the older people. If they continue to survive longer in the presence of triple therapy, that means that they are not exempted from being responsible. Remember, the largest proportion of the over-50 group with HIV/AIDS infected in the New

York population are African Americans (43 percent) and Hispanics (25 percent).

A large part of the problem is the injection drug users who make up about 33 percent of the HIV population. If that's the case, one good strategy is the IV Drug Use Needle Exchange Programs we have in New York. There are 12 of them. Each depends on the involvement of the community and the Department of Health, which looks at these in a very positive light. In a way I think this is very good. You cannot deny that if there is so much drug abuse that drug users comprise 33 percent of HIV patients, we have to do something. Those 12 centers make me feel comfortable that at least we are trying to take care of the problem as it needs to be taken care of.

### ***HJHP***

Were these needle exchange programs the same ones that became very controversial at the national level?

### **Novello**

Yes, but at this stage of the game in New York, you cannot just shy away from controversy. Being a microcosm, you have every problem and every group. And if you pay your taxes, you must take care of the rest of the public that pays taxes. One of the things that still worries me is that in New York, the leading cause of death for Hispanics between the ages of 30 and 59 is HIV/AIDS. When you talk about HIV-positive births, 28 percent of them are Hispanic women.

### ***HJHP***

Is that the leading percentage for that category?

### **Novello**

This is 28 percent for Hispanic women. I'm not sure exactly what it is at a national level or comparison-wise. But on top of these negatives, I can tell you positives. Death rates of HIV/AIDS infected people are diminishing in New York; we see this in infected people now living beyond the age of 50.

The beauty is that in this state, no child can be diagnosed in the nursery with HIV and go home without being told that he/she is positive. Since 1997, children diagnosed with HIV get tied immediately to health care and 99 percent of them already have health care by the time they leave the nursery. This is crucial to survival. The rates show that survival increases by 8 percent for these children. We are saving children's lives. At any other time, they would have gone home and in the second year they would have gotten sick and died because they did not know they were infected.

Another thing we are doing is partner notification. This should start in the late part of the summer. What this means is that we have a way to address the issue of how many people are infected. We can make sure we know who is infected and can help them. We make sure that in partner notification, the patient/doctor relationship is never broken, the confidentiality is sacred, and if

there is any fear of domestic violence by doing the report, the report will not be done. We must make sure that in the quest of counting people to make good plans for prevention, we do not destroy the things that are working, including the patient/doctor relationship and the confidentiality of a group of people that, even in the presence of ADA 1997, did suffer discrimination, especially in our communities.

Among all the programs, we have about \$2 billion and we do things that are unique in the HIV/AIDS field, including \$13 million used to prevent HIV in adolescents — one of the groups that is being affected. We have \$13 million to do prevention and primary care with them.

More than anything, we have a program called Permanency Planning that allows mothers to die in peace because we have found a place for their children to live once they are gone. The child's custody can be put into foster or family care. We make living arrangements for children of HIV parents so the parents can die in peace. At this stage of the game, we are waiting to see how much money is allocated in the new budget for the program. In the past it has been at about \$3 million to help the parents plan.

Another policy we have which I think is great is a program called ADAP (and ADAP plus) that serves about 20,000 uninsured people in the state of New York. Of these, 6,000 are HIV-infected Hispanics (or an equivalent of 30 percent of the people we serve). We give them medication, anti-retroviral therapy, treatments for opportunistic infections, and we pay for their medical care in clinics and hospitals and by private doctors. We also provide nutritional services. That is unique to New York. Even more importantly, we do home care.

### ***HJHP***

How does that work?

### **Novello**

We have 375 uninsured people each year. Thirty percent are Hispanics. We have a new program that should begin this summer that relates to special needs programs where mental health is part of the equation. This is unbelievable — the first program in the nation. This is a Medicaid, managed care plus plan, specifically to provide health care to New Yorkers with HIV. The managed care is individualized for the needs of the patient with HIV and includes a mental health component.

Between AIDS, diabetes, asthma, and finding insurance for people, the governor recently created two programs for 2001: "Healthy New York" and "Family Health Plus." Family Health Plus is a program that extends the benefits of Child Health Plus, the latter an outstanding program that serves 460,000 children enrolled in a system of care that covers everything from hospitalization to drug treatment, alcohol treatment, and mental treatment up to the age of 19. It covers dental services, mental health services, drug abuse treatment, alcohol abuse treatment hospitalization, immunizations, and medications. No other program in the land has it. It is a state of New York program with matching funds from the federal government. As long as you are a fami-

ly of four and making \$34,000 or below, you pay nothing. Above that, you pay a premium between \$9 and \$15. Because the system of care is so good, 6,200 families pay \$110 per month to be in Child Health Plus.

The governor decided already that by 2001, under Families Care Plus, families of children covered under Child Care Plus will have the ability to come to the same clinics as the children. This includes people without children. There was always the stipulation that you have to have children to be covered by the state. Not anymore. If your salary is \$8,200, you will also be able to participate as a single person.

The other project, Healthy New York, will cover 400,000 people in small businesses by providing a package that can be bought by individuals or their employer. It covers them for catastrophes between \$30,000 and \$100,000. When you realize that this will cover 1 million people who have never had insurance, you realize that many will be Latinos.

Between finding insurance, taking care of asthma, taking care of people with HIV, and school-based clinics, I want to create comprehensive health care coverage for everybody. But more than anything, I think we have to look at teenage pregnancies and how we are going to take care of this situation. Last year, there were 50,000 teenage pregnancies in the state and 14,000 of those were to Latinas.

### ***HJHP***

Don't Latinas have the highest percentage of teenage births across the country?

### **Novello**

We do. Latinas have the highest teen birth rate among the major racial/ethnic groups. In New York it was 14,000 out of 50,000. At this moment we have a large abstinence campaign called Not Me, Not Now. It's working. We also have another program called the Community-based Adolescent Pregnancy Program that provides services to 100,000 teenagers in 50 zip codes that are known to have high-risk teenage pregnancy. While we promote abstinence and the delay of early sexual activity, we also make sure we acknowledge that 54 percent of teens are sexually active by the time they finish high school. We are providing teenagers with skills as well as alternatives. If they are going to get involved in sexual activity, they should have access to comprehensive reproductive health services so we can protect them from HIV, STDs, and pregnancy. And for those that lose school-based clinics because of age, we have about 63 family planning agencies in 224 sites. Of the clients visiting these clinics, 29 percent are adolescents and of the rest, 89 percent had family incomes 1.5 times below the poverty line.

### ***HJHP***

So you are really focusing on the prevention angle with adolescents as well?

**Novello**

Absolutely, and everything is also in Spanish and English. In 1999, we served about 72,000 patients that were Hispanics — one-quarter of the population. We are starting to make many advances with Hispanics. When one is surgeon general of the country, one serves the entire country. When one is commissioner of health of New York, one serves every New Yorker. However, when some of the people are in need of insurance coverage, attention, language sensitivity, and a caring pattern, somewhere along the way, they have to benefit from having a Hispanic commissioner.

***HJHP***

Anything you foresee becoming a major issue?

**Novello**

The thing we have to start looking into is maternal mortality. Although the highest maternal mortality rate in this state happens to be African American, I believe we have to look at maternal mortality across the state as something we should be able to remedy. We are not sure why the rates are where they are. Is it lack of prenatal care, services, access, or knowledge? Or, is it fear of immigration? I don't know, so I am holding town hall meetings. People tell me their needs and I approach them from a perspective of how do I help you at least link with the systems we have to offer. I think the most important thing is that we should not be devoid of the same health opportunities everyone else has. There are certain diseases that are ours because they are killing us. The research agenda has to be planned according to the needs of the community and the importance of health insurance is crucial as a first step.

In the absence of this aligned research agenda, remember that we are a big enough population that we should be able to ask for what we need in the next elections with facts and data. If we are not healthy, then it is not OK to be the largest group, the largest emerging minority. If we are not educated, we will forever perpetuate the cycle of poverty. Therefore, are we the minority that stays behind to be the manual labor force? I do not think that should be the case by the year 2040.

We have an economic power that will translate, if I remember correctly, by the year 2010 into \$1 trillion. So if we invest in the land, we should be able to get a good response to our investment. At least for now, in terms of health care and education, if the nation cannot solve the issue with universal health care then the state where we live should be able to provide a high standard until it becomes national.

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## *Creating a Space for Latino Leadership in Health*

**Interview with Elena Rios M.D., M.P.H.  
President, National Hispanic Medical Association**

*The National Hispanic Medical Association (NHMA) was established in 1994. It is a nonprofit organization representing licensed Hispanic physicians in the United States. The mission of the NHMA is to improve the health of Hispanics and also to advance the careers of Hispanic physicians.*

*For many years, California has had an extensive network of Hispanics in health professions — medical students, doctors, and undergraduate students who are majoring in pre-medical studies. In the 1960s, there was the National Chicano Health Organization, developed to bring students together that were interested in health careers. They lost funding and in the 1970s, students went back to their home states and started their own organizations. In California, they started La Raza Medical Student Association. In Texas, they started the Texas Association of Mexican American Medical Students. In the Northeast, they started the Boricua Health Organization.*

*Elena Rios is the current president of NHMA and discussed with us the organization's creation and goals.*

*Mayra De La Garza and Nereyda Salinas of the HJHP interviewed her on April 23, 2000.*

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### **HJHP**

Can you tell us about your involvement with NHMA and how its creation came about?

### **Rios**

In the early 1980s, we formed an organization in California — the Chicano Latino Medical Student Association. The La Raza Organization had pretty much become dominated by doctors and the medical students still wanted to have a medical student organization. Through that organization, we ended up meeting medical students from Texas, Chicago, and New York. By the time I

graduated from medical school in 1987, we had met leaders from different medical student organizations. I became an adviser to the first national group of Hispanic medical students after I finished medical school. It's now called the National Network of Latin American Medical Students.

There's an organization in Chicago now — the Midwest Latino Medical Students Association. There is another group out in Miami called the Hispanic American Medical Student Association. They also joined this national network so there's five different regional organizations that make up the national network. The members of all these organizations are medical students. I was working on this as an adviser to medical schools admissions offices from New Jersey, Chicago, and Davis.

We were the advisers to these groups of medical schools, helping them get together. In 1989 and 1990, we had a few meetings. In California, we not only had medical student organizations but we also started medical organizations for doctors. There had been one started in the early 1980s, but it didn't work. The one that started in 1987 was the Chicano Latino Medical Association of California (CMAC). They took the name of the medical student group. In 1991, the surgeon general, Antonia Novello, had her first TODOS Conference. That brought together Hispanic experts in health care for the first time at the national level. It put out a report, but she was on her way out. It was in September of 1991 and five regional meetings in 1992 followed the conference. The report wasn't written until 1993 when all the regional meetings happened. I was invited as president of CMAC. Then in California, CMAC started having statewide conferences with the medical students. We were beginning to become more networked nationally, as an organization.

In college I learned the importance of power in an organization. I realized you have to start the organization to have that kind of leverage. You have to have a group of people of similar ideology — people who see the importance of getting involved within the system and in working our way into the system to help change things for our community.

While receiving my degree in health planning and policy analysis, I became interested in public policy. During that time, I worked for a health planning agency in San Jose. I recognized that the advisory boards put together by these health planning agencies planned how to spread out money within a county, through the hospitals and doctors. HMOs were just starting, but the idea was that there would be planning, that people would come to a table, and we would negotiate. But the people at the table were all doctors and hospital administrators. That's when I decided to go back to medical school and finish my pre-med requirements. I figured I would have more credibility in the health system regarding the decisions that were being made at a higher level, with a medical degree.

I went to medical school in 1982. By the time I started medical school, there were 21 Chicanos in my class in UCLA. All of them had been presidents of undergraduate clubs in California. California had 25 Chicano pre-med clubs.

That's when I realized we have this incredible resource of doctors out there



who are interested, who have had experience, and who know the responsibilities and the role of being a leader at the local level. Forming this national medical student group and coming to Washington for the surgeon general's conference opened the door to a network. That was incredible. It was a national network of other Hispanics interested in health care, but there was no medical organization that was talking about policy changes.

In January of 1993, I started working at the White House for the Health Care Reform Task Force as outreach coordinator. In the spring of 1993, I was in charge of getting people to attend about two dozen meetings. I started calling Hispanic doctors around the country, asking, "Do you know anybody that would want to come to Washington? Do you have anyone that is interested in policy who has a story to tell to the White House?" People were amazed. They'd never been asked before.

We began meeting and decided that we needed to start our own network. This was the beginning of a new administration at the federal level. They were looking for people that were going to be nominated to top jobs. We nominated people and we worked with others.

### ***HJHP***

This was the first time that there was any kind of national network institutionalized for Hispanic doctors?

### **Rios**

Yes, as far as policy efforts were concerned. By the end of the year, President Clinton held a press conference and had 10 medical organizations on stage with him. We were one of them. That's when we created the name, National Hispanic Medical Association. The core group of doctors that eventually became the board of directors formed the bylaws and incorporated the organization in July of 1994. There were several minority meetings with health professionals that the White House convened to get support. We were the doctors that represented Hispanic doctors.

The NHMA has really just taken off during the last year with full-time staff. We started the organization with bylaws, with the board of directors, and with the mission statement. The real purpose was to provide a resource for the administration, but also for other national entities to find Hispanic doctors. We created our own resume bank. If we found out about meetings, or notices about meetings, we would find someone to be at the meetings. We got funding to put together an advisory committee of about 30 doctors. And we decided to have an advisory committee based on the cities of the country where we wanted to connect our central office with cities around the country where doctors were.

### ***HJHP***

What cities were these?

**Rios**

The second grant we got was for five regional meetings from September 1995 until June of 1996 in Chicago, Los Angeles, San Antonio, New York, and Miami. We had a second meeting of the advisory committee to review the recommendations and the comments from the five regions of the country. There was great enthusiasm for this organization that there should be an umbrella group that would lead the efforts on policy development for Hispanic health. That allowed doctors to get involved in the policy debate. That promoted the idea of getting doctors involved.

**HJHP**

At this point, is the organization part of the government or its own nonprofit?

**Rios**

No, it never started off as a government initiative. I happened to be working at the White House and the doctors that came to the White House were interested in starting a mechanism for us to provide resumes. So, we incorporated our organization as a nonprofit in July of 1994. We got funding as a separate nonprofit to have an advisory committee. Our board had strategic planning meetings with a consultant and we got an office. We did mailings and we started our communication system and database with the doctors that submitted to our database and resume bank. We started our first advisory committee meeting in 1995 then we went around the country to five regional meetings in 1995 and 1996. In September of 1996, we had our second advisory committee meeting that put together the areas of emphasis that we wanted to focus on in policy. That was access to health care, and that time, the hot debate was on Medicaid.

Now it's the uninsured, meaning access to health care. The issue is medical education. We wanted to continue to get more doctors — more Hispanics — into medical schools. We saw the importance of getting involved in medical education and also faculty development and curriculum development, which is what cultural competence is all about now.

We asked for funding from the government. The agency that gave us the original funding was headed by a Hispanic who worked with me at the White House, Dr. Ciro Sumaya. He's key because he's the one who also saw the importance of this. He became the administrator of the Health Resources and Services Administration (HRSA). To this day, most of our funding has come from that agency. We went back to Sumaya and his staff for help. It was suggested to us that we start a national conference. Our first was in 1997.

**HJHP**

What were your objectives for trying to have the national conference?

**Rios**

To bring together Hispanic physicians from around the country. To share knowledge of federal initiatives that would impact Hispanic health, and share

knowledge about successful clinical practices with Hispanic patients. To network with other physicians. We had very few government speakers at the first conference. Most of the speakers were from our advisory committee. We wanted to get other doctors to come together.

I think Sumaya and probably the other speaker from the government was Dr. Jo Ivey Boufford. She's been there since the beginning too because I had discussed the organization with her. The conference was probably attended by 150 people. This last year, more than 500 people registered.

The network has been growing and the enthusiasm from doctors and medical students has been incredible. We had about 186 medical students from 35 medical schools at this conference. Doctors came from all over the country. We had much more presence and recognition from the federal government, from the surgeon general to the director of the Office of Minority Health.

### ***HJHP***

Does the conference have a particular theme every year?

### **Rios**

Yes. This year it was "Eliminating Health Disparities for Hispanics: A Call to Action." Everybody heard about the administration's Eliminating Health Disparities Initiative. But we also had sessions dealing with what are cultural values and assets from our own families and communities that need to be a part of any strategies to improve health for Latinos.

We also had the president of the Commonwealth Fund, Karen Davis, present on the importance of their data. They did a national survey to show that Hispanics are the largest group without insurance. She challenged the organization. We were given a lot of challenges about how this organization needs to get more involved with these issues. We challenged the doctors there to get more involved in their own local communities when they go back home — to be actively involved in promoting change at whatever level they're at. A lot of these doctors are directors of committees in hospitals, or they're working with local community organizations of other professionals and businesspeople. Health care just doesn't come up. We need to be spokespersons for health care, to be understood as a major issue just like education or business, or whatever other issues people are bringing up at the community level.

NHMA was also provided with an opportunity to start writing programs. The Office of Minority Health gave us a cooperative agreement. It partners with organizations. We had an advisory committee meeting that put together ideas for the focus of our programs. In order to have staff, you have to have programs to pay for staff. So we decided we would focus on leadership development because that really is what we are trying to do. Our resource is ourselves.

It's medical students that are going to be the future doctors and it's current doctors that are interested in national change efforts — whether it's in the private sector or the public sector. We wanted to develop leadership — formal

leadership training programs. We now have three leadership development programs. Two of them have been funded in the last year.

### **HJHP**

Are these government funded or foundation funded?

### **Rios**

They're government funded because like I said, we got a cooperative agreement from the Office of Minority Health.

The major leadership program is called the National Hispanic Medical Association Leadership Fellowship Program. It's in conjunction with the Wagner Graduate School of Public Service of New York University. Again, it's Jo Ivey Boufford, the dean of that school. She left the Department of Health and Human Services in 1997. We're working with her and her faculty, and we've developed a program. It's a one-year program for 20 mid-career doctors who are interested in high-level, public service careers.

### **HJHP**

If there is a change in administration with the elections coming up, do you see the funding continuing for NHMA? Do you think there will still be commitment even if there's a Republican president?

### **Rios**

Yes. The United States is about to become the second largest Spanish-speaking country in the world. Hispanics have the largest number of uninsured in the country. Hispanic physicians need to be supported in order to help with a health system that doesn't recognize the importance of giving health care to everybody as a right.

The federal government in this country, has used minority doctors and minority admissions committee funding for 30 years as a method to help increase access to the minority communities. Our society's thinking in health care is that minority people need minority doctors. Let's provide incentive support for health professionals to take care of the underserved communities in the country.

We're just laying the groundwork. We're just building the organization with support that was given to us just because of the network we have. Our money basically comes from the leadership development program we have. For example, at New York University, the Wagner School of Public Service is our subcontractor. They do most of the work. We have a medical student mentorship program in Texas with the University of Texas Health Science Center, San Antonio. They're also our subcontractor. I still don't have the staff here.

The medical student mentorship program was supposed to go the second year to Massachusetts General Hospital in Boston. It hasn't happened. They had some problems with their office. Our third year event program will go to California — probably southern California. Our subcontractors are Stanford Medical School, which has the Hispanic Center of Excellence, and the

Cornell Medical School, which has a minority, a multicultural, and minority health office run by one of our advisory committee members. Our advisory committee is a network of people that we're using to develop our programs.

***HJHP***

That's great. Sounds like you are really mobilizing all the existing organizations that are already there.

**Rios**

At the conference this year, we started a council of presidents. We gave awards and had 10 presidents of Hispanic medical societies. There are actually about 30 Hispanic medical societies around the country.

***HJHP***

What would you call the three most critical issues that NHMA has to address?

**Rios**

The first one is insurance. There are 44 million uninsured Americans and the Hispanic group has the largest percentage.

***HJHP***

Does this differ from the national percentage?

***HJHP***

I think the numbers for uninsured people under 65 are 37 percent for Hispanics, 24 percent for African Americans, and about 14 percent for whites. When you're 65, you get into Medicare. For everybody under 65, almost two out of five Hispanics in the whole country doesn't have health insurance. Not having health insurance is one of the major reasons why people do not go to a doctor. Or, they wait until they're really, really sick to get a medical exam.

***HJHP***

Why do you think this exists within the Latino population?

**Rios**

There are a lot of reasons. Health insurance in the country is tied to employment. A lot of Hispanics work for small businesses that can't afford insurance or work part-time and don't get benefits. Or they have insurance as an option to purchase and they don't have the money to buy it. Also, a large number of immigrants don't understand the concept of insurance. Why would you want to pay money a month for something you don't think you're going to ever need?

In all Latin America countries, and for that matter most of the countries in the world, there is no insurance. It's a nationalized health system. Everybody has it. You don't have to pay for it. The Latino immigrants coming to this country don't understand the concept. Then we have our own culture and fam-

ilies that pass on traditional healing and health care practices so people don't understand the need to go to a physician or to get immunizations. So, there are lots of reasons. I think we're going to be doing a project this year on Hispanics. Part of what we'd like to do is to develop strategies.

**HJHP**

Are there any types of strategies right now that are increasing awareness of the problem?

**Rios**

Yes. The major effort right now is the new Children's Health Insurance Program, the CHIP program. In this country, in the 1960s we started Medicare for the elderly. We started Medicaid for the blind, disabled, and poor. CHIP is the latest national effort. It's from the federal government but it's given like the Medicaid program — a state-run program. States have options on how to run the program, whether it's through their government like Medicaid, or they can run the CHIP program in the private sector as a separate business.

**HJHP**

Each state has the option?

**Rios**

Yes, each state has the option. Then there are some combined states. It just started two years ago. There's been an estimated of 10 million uninsured children that are eligible for CHIP, which is fantastic. But, there is a horribly low-level of enrollment. The majority of children in our country that are eligible are Hispanic, so there has been an effort by the states to get more outreach and education to the Hispanic communities.

Since the program started, there has been a much lower number of children enrolled than expected, or than hoped for. The federal government also dealt with what's called the "public charge issue." They found out one of the major reasons why Hispanics weren't enrolling their children was because they were afraid of deportation.

**HJHP**

That makes sense.

**Rios**

The CHIP program is now trying to get the word out to the Hispanic community that it's not a public charge. Which means you don't have to be a citizen to enroll in the program.

**HJHP**

CHIP is under what department?

**Rios**

CHIP is under the Department of Health and Human Services (HHS). It's being run out of the Health Care Financing Administration (HCFA), which runs Medicare and Medicaid. This is the third tier of a national effort to help decrease the number of uninsured. It'll help the Latino community very much.

So that's one problem. The other issue is not having enough Hispanic doctors and health professionals and increasing their numbers because of the demise of affirmative action in California and Texas, which are the two states with the largest number of Hispanic students. We need new strategies to encourage students to become academically able to compete to get into medical school and other health profession schools. We need more nurses and dentists — the whole thing. We've only been able to get up to about 5 percent. Five percent of all the doctors in the country are Hispanics.

**HJHP**

Has there been a decrease?

**Rios**

Yes. There's been a large decrease since the changes in affirmative action, especially in California. In Texas, they passed a law to allow the top 10 percent of every public high school class to automatically get a seat in the University of Texas college system. It has affected a lot of Hispanic students in all these high schools. They're going to get into college.

**HJHP**

Is affirmative action in Texas also affecting the public medical schools?

**Rios**

Yes, but not as much as California. The medical schools in Texas have been working on it in a more strategic way. They've had better outcomes. Both states had a major blow with the change in their affirmative action, but Texas got on the ball faster.

**HJHP**

What kind of strategies did they use?

**Rios**

The admissions committee in the medical schools are interviewing students and asking them questions about their background and their cultural heritage — their sense of commitment and their sense of leadership to the Latino community.

**HJHP**

In Texas?

**Rios**

And in California, too. As an organization, NHMA thinks it is very important to get more Latino families out there to understand the importance of academics, math and science, to get their children to become health professionals.

The other thing is that within medical and health professional education, they have this whole idea of cultural competence. This whole health system needs to have cultural competence because there's never going to be enough Hispanic doctors for the Hispanic community in the country. We're about to become the largest minority group in the country in the next four years, and the United States is going to be the second largest Spanish-speaking country in the world. We think that the whole health system needs to have cultural competence standards. They've begun to be written already at different levels. The Office of Minority Health has cultural competence standards that we've written comments on, that we've supported. A group of us went to review the national boards on cultural competence. We helped to provide questions for the accreditation committee for all the medical schools across the country.

**HJHP**

When will medical students be exposed to this?

**Rios**

At all levels.

**HJHP**

Will it be part of a course? Will it be something integrated throughout the curriculum?

**Rios**

Yes, it will be integrated throughout the curriculum. Well, we would like it to be integrated throughout the curriculum. You need to learn how to interview, how to communicate, and how to work with patients from different cultural backgrounds. It's a multicultural effort. For Hispanic patients, we want the mainstream doctors of tomorrow, when they're in medical school training, to be trained in clinics where there are Hispanic families, or in neighborhoods where there are Hispanic families so they can see and understand a little bit more about where they're coming from — their lifestyles, their stresses, their daily routine. When they learn about diseases, they learn about diseases that affect Hispanics and how they affect the Hispanic family and household. It's not just about one person. When they learn about how families cope with diseases, they also have to understand the belief system and the values of the families or of the Latino patients.

It's teaching the mainstream medical students about minority patients, but not just stereotypes — really trying to help teach more than stereotypes. It is teaching values and belief systems and the dynamics within the Hispanic family so that they can better treat them.

Then there's linguistic competence. There should be interpreters, language



services, and signs in the language of the target population in different parts of the country. This is true for Asians, as well. The Asian community has more than 500 languages. That whole stream of thought is called cultural competence. We think that is very key.

***HJHP***

Are there any kinds of strategies currently being implemented? Not that NHMA is particularly doing, but strategies being pushed forward on a national level?

**Rios**

Yes. The accreditation body for medical schools is called the Liaison Committee for Medical Education (LCME). It has already approved cultural competence standards for all medical schools. The national board for doctors around the country to get licensed, the United States Medical Licensing Examination, did have a review of its exams. They had a review and they're asking for questions to be included about minorities. I coordinated that review. We took doctors from different Asian, Native American, black, and Hispanic communities to review the exam. The Office of Minority Health, which is from HHS, developed standards for the whole health system. They were out for public comment until April 30. The first draft standards were actually published for public comment. HCFA put out standards for cultural competency for all businesses in the country that get contracts for Medicaid or Medicare. Clinics, HMOs, doctors, and hospitals all have to go along with these cultural competence standards. They're pretty flexible. This is the first generation of these types of standards. There's not a whole lot of evaluation yet. There's no research. That's the next step.

***HJHP***

Is there anything in place from HCFA to try to put that as the next step?

**Rios**

I don't know. I have to call and talk to them. I'm sure there will be.

***HJHP***

Have you heard of anyone else taking those next steps, maybe at the conferences? Anyone that seems to be at the forefront?

**Rios**

HCFA. The Substance Abuse Mental Health Services Agency (SAMSA) also put out cultural competence books and information for their grantees. The grantees are drug treatment centers and mental health rehabilitation centers. They have cultural competence standards that they put together. They had a Hispanic summit just a few weeks ago talking about what they're going to do during the next five years. One of their biggest complaints was that nobody

has taken their standards and run with it. They haven't been able to institutionalize them. HCFA has and HRSA has community clinics around the country.

They also have put together cultural competence meetings, discussions, and training for their clinic directors on how to be more culturally competent. They haven't made it mandatory, however. HRSA is also the agency with the money that goes to the medical schools, the nursing schools, and the dental schools. They have cultural competence in their grants, as a priority. So it has been in the government. I know that the foundations are also interested in the whole issue. But they're interested more in the next step, which is, let's see what works. We want to evaluate. We want to do research and show what works and what doesn't work. We want to know what cultural competence really means.

It's really cutting edge right now. All of this is new. I think it's because of a realization that diversity in this country is happening so fast. By the year 2050, one out of every four Americans is going to be Hispanic. The country is trying to get ready for a change in the population of the country. And it's not just Hispanics. There'll be more Asians and more Native Americans. We'll be the biggest group, however, and it's the diversity of the Hispanics that they're really focusing on. This is what cultural competence is really becoming more of a focus.

### **HJHP**

Looking out into the future, do you see any problems that aren't on the radar screen yet but may potentially happen for the Latino community?

### **Rios**

Lack of leadership.

### **HJHP**

Could you say a little more about that? At all levels? Overall?

### **Rios**

National levels. We really need to think strategically about future leaders. We need to find and identify them. When the United States has one out of four Americans being Hispanic and the country still run by non-Hispanics, that's a tragedy. After the conference, we met with media. We had a Hispanic health media breakfast series. We're having it with the Congressional Hispanic Caucus. Our first one was in Los Angeles with the chair of the Congressional Hispanic Caucus, Lucille Roybal-Allard. We had top-level management like the vice-presidents, general managers, and news directors of ABC-TV, NBC-TV, CBS-TV, FOX-TV, Univision, and Telemundo. Then we invited the *Los Angeles Times* and *La Opinion*. We went to San Antonio about a week later in March and had a meeting with the management of the same stations; all the TV stations; *La Prensa*, their Spanish newspaper; and the *San Antonio Express News*, their daily newspaper. We're going to have a third one in New York with Congressman Serrano. The one in San Antonio was with

Congressman *Ciro Rodriguez*, chair of the Congressional Hispanic Caucus Health Task Force. In both meetings we found out that there was an incredible interest in having Hispanic doctors be spokespersons for health on TV and in the newspapers. They never thought about it before. They didn't know where to find Hispanic doctors that had that expertise or talent to be on TV. NBC requested us for a Hispanic anchor in San Antonio. That's incredible to have those opportunities to build name recognition — a person that the public will become familiar with. That's leadership development for the future.

There are so many departments where Hispanics need to be in leadership positions. There are very few Hispanic doctors that are in leadership positions. There are very few Hispanics period. It's not just doctors — it's Hispanic leaders in general. We need to have more Hispanics in leadership positions in public and private sectors, in government, in media, on corporations boards of directors, and on foundations boards of directors. I'm on one pharmaceutical company's Hispanic advisory board and I think that's probably the only drug company that has a Hispanic advisory board right now. I know of two others that are interested in developing Hispanic advisory committees.

### *HJHP*

It seems like some of these initiatives don't even occur to companies until they see another entity doing it.

### **Rios**

Right. That is a future opportunity that's going to take us further and help move our agendas further if we have the opportunity to be at the table at the top levels of national corporations and government agencies. It's here that decision-making takes place, where budgets are decided, and where funding is distributed.

### *HJHP*

Right. Would the presence of a bottleneck at the entrance to 13th grade hinder the entire development process of those leaders?

### **Rios**

You need people to work at all levels. You need educators to work with K through 12. You need Head Start people to work with the Head Start program to encourage Hispanic kids at the Head Start level and to motivate and mentor them about how they can be whatever they want to be. Then when they get into kindergarten, or K through 12, they have to work on their math and science and/or their art. You need people at every level.

I think that there needs to be a more strategic effort by Hispanics in leadership positions right now to replace themselves. Hispanic leaders should start identifying younger Hispanics that are going to be promoted and supported as top-level leaders in the future. They're out there right now. With our NHMA leadership fellowship program, that's what we're doing.

**HJHP**

In terms of getting people to listen to these messages, are there any tactics that have been proven more effective with the Latino community than with just the general population? Or are there things that are effective with the general population — information tactics or awareness strategies — that you find just don't work with the Latino population?

**Rios**

No, I don't know. That's another whole new area that's just starting. It's this idea of prevention. Up until now, our society has looked at health care as a sickness system or illness system. You only go to the doctor when you're sick. You don't get messages on TV or anything about the importance of nutrition and jogging and not smoking. You didn't get that until this generation. In terms of Latinos and a targeted message to the Latino community, you don't see the Latino media doing anything on health care. It's not there yet. It's just starting. There is a government program called Healthy People 2010.

**HJHP**

I haven't heard of that.

**Rios**

The World Health Organization in the 1980s started the Healthy People Program. The program declared that all people should be healthy by the year 2000. It started in the 1980s. They decided to start it as a graduated approach — Healthy People every 10 years. Healthy People 1990, Health People 2000. Now we're in Healthy People 2010.

Every government of the world that belongs to the World Health Organization agreed to start getting their governments, in our case it's the state governments, to start collecting data to show the trends on certain measurable objectives such as people with diabetes or cancer. Up until now, the Healthy People objectives in the United States were a double standard: one goal for white people and a lower goal for minority Americans. Nobody ever expected minorities to be as healthy as the general public.

**HJHP**

So they were keeping track on two separate books?

**Rios**

Two levels. Take mammograms, for example. The goals for Healthy People 2000 were that 90 percent of white women would have mammograms. For Latinos and blacks, 70 percent of women would get mammograms.

**HJHP**

Really?

**Rios**

Yes. This is how discriminatory everything is in society. When you ask if there's going to be new efforts for educating Hispanics, the answer is yes. The whole government has realized that they've been having this double standard just in the idea of prevention and getting messages out and getting more people to behave healthier. The whole effort with Healthy People 2010 is now all on the same standard, the same level, and the same goals, which is fantastic. The other thing they did was to say, we want to focus our efforts for the next 10 years. This is what the Eliminating Health Disparities Initiative was all about with six major areas: heart disease because it's the number one killer of Americans; cancer number two; HIV/AIDS, which is a big, big problem for minorities, especially Latinos and blacks; diabetes; immunizations for children and adults; and infant mortality. They also added mental health. All people with diseases have mental health issues, too. That's very optimistic that the country is going to pay more attention to minority health because of these major initiatives.

**HJHP**

You say this because they are finally putting everyone on an equal basis?

**Rios**

Yes. Getting back to your question about the administration and the change in the administration, whether the President becomes Gore or Bush: for minority health care, I think that there is more opportunity now to have leadership on both Republican and Democratic sides to pay attention to minority health. There have been more studies in the literature. There've been more discussions in Congress. There've been more discussions with HHS. Certainly the White House had promoted race and health as important. President Clinton started this initiative that HHS is carrying out. As our society becomes diverse, society will demand that their special needs be paid attention to. There's a lot of work ahead. The NHMA is about getting individual doctors to become more involved in policy, other organizations must be supported to become better at providing research, information, and medical school curriculum regarding Hispanics.



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## ***The Uninsured: A Call to Action for all Latinos***

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**“The United States remains the only industrialized nation that has never settled on a social policy that, however policymakers choose to accomplish it, offers a basic set of health care benefits to all residents....certainly a regrettable failure in a nation blessed with so many resources.” — JK Iglehart**

### **Introduction**

The Universal Declaration of Human Rights, adopted with the assent of the United States, states that “everyone has the right to... health and well being of his family, including ... medical care... and the right to security in the event of ... sickness [or] disability” (Universal Declaration of Human Rights 1948).

More recently, the Tavistock Group's ethical code for all health care workers asserts, "Health care is a human right. The aim of health care delivery is to...provide access to appropriate health services to all persons regardless of their ability to pay" (Benetar 1999). Yet, unlike all other developed nations, the United States does not assure that every resident has health insurance. In 1998, 44.3 million Americans — 16.4 percent of the population — lacked health insurance coverage (Campbell 1999). In addition, due to decreasing rates of private insurance and, more recently, decreasing Medicaid coverage, from 1989 to 1997, the number of uninsured Americans increased by 10.1 million (Carrasquillo 1999a).

Previous studies have shown that persons living in poor families, young adults, and racial and ethnic minorities are most likely to lack health insurance coverage (Carrasquillo 1999a, Kuttner 1999). For example, in 1998, 32.3 percent of persons living below the poverty level lacked insurance versus 8.3 percent of those living in households earning more than \$75,000 per year (Campbell 1999). It has also been known for at least a decade that Latinos are much more likely to lack insurance than other racial/ethnic groups (Trevino 1991). In this paper we review the most recent data on health insurance coverage among Latinos and provide data on Latino subgroups and immigrants.

### **Methodology**

We analyzed data from the March supplement to the 1999 Current Population Survey (CPS). The CPS is a Census Bureau survey of non-institutionalized population of the United States covering approximately 60,000 households and 160,000 persons (Moore 2000). Each March, the survey asks a detailed series of questions about health insurance coverage during the previous year. Accordingly, we present data for health insurance coverage for 1998.

Data on race and ethnicity is based on self-reported information. We considered persons to be Hispanic/Latino if they identified themselves as such. Those respondents who did not consider themselves Hispanic were classified as either non-Hispanic whites (NHW) or blacks based on their self-reported race. Persons of other race/ethnicity are not included in this analysis.

We considered persons insured if they reported any health insurance coverage during the previous year, either public or private. Persons were considered as having public insurance coverage if they reported receiving Medicare, Medicaid, military associated insurance, or various other state sponsored programs. Persons who had insurance from a current or former employer were considered as having employer-provided insurance. However, these two categories are not mutually exclusive. For example, persons who received Medicare as well as supplemental coverage from a former employer or those who received Medicaid and then became employed and obtained employer insurance in 1998 were considered as having both types of coverage.

Population estimates were derived using weights provided by the Census Bureau to agree with independent estimates of the population and account for factors such as under-coverage and non-interview of households (Moore



2000). When interpreting our results, it should be kept in mind that all of our reported percentages are based on extrapolations to the U.S. population from the surveyed population. There is a certain magnitude of error associated with each of our reported percentages. In general, the smaller the population is, the larger the standard error is. For example, a 50 percent estimate involving the entire 31 million Hispanics living in the United States would have a standard error of less than 1 percent. For mainland Puerto Ricans whose population in 1998 was estimated at 3 million, the standard error of such a percentage would be about 3 percent. However, among the estimated 460,000 Dominicans who were not U.S. citizens in 1988, the standard error would be about 7 percent. Due to large standard errors, the Census Bureau does not recommend summary measures on populations smaller than 75,000 (Moore 2000). Therefore, we do not present any percentages for such small populations.

### Results

In 1998, 35 percent of all Hispanics living in the United States did not have health coverage. In contrast, 22 percent of blacks and only 12 percent of NHW lacked insurance. Furthermore, while blacks and Hispanics made up only 24 percent of the U.S. population, in 1998 they accounted for 44 percent of the uninsured population. As we show (Table 1) for each age and income group, Hispanics were much more likely to lack insurance than NHW. Even among families with incomes greater than \$50,000, 19 percent of Hispanics were uninsured as compared to only 6 percent of NHW.

Analysis by type of insurance (Table 2) shows that the reason most Hispanics lacked health coverage is due to much lower rates of employer-provided insurance. Only 43 percent of Latinos had such coverage versus 69 percent of NHW. Due to their lower incomes, Hispanics were more likely to receive Medicaid coverage but among persons with family incomes less than 150 percent of the federal poverty level (FPL), rates of Medicaid coverage were similar between Hispanics and NHW at 32 percent and 26 percent respectively.

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*Analysis by type of insurance (Table 2) shows that the reason most Hispanics lacked health coverage is due to much lower rates of employer-provided insurance.*

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We also examined health coverage among the Hispanic sub-groups that were specifically identified by the CPS, namely Latinos of Mexican, Cuban, and Puerto Rican origin. In this sub-group analysis, we found that both Puerto Ricans and Cubans were more likely to lack health insurance than NHW at 20 percent and 17 percent respectively (Table 1). However, Hispanics of Mexican origin were the most likely not to have insurance with 38 percent lacking cov-

erage in 1998. Among these subgroups, children of Mexican origin were also most likely not to have coverage with 32 percent of Mexican children being uninsured versus 16 percent and 15 percent of Cuban and Puerto Rican children respectively and 11 percent of NHW children. In Table 2 we show that while Cubans were more likely than Mexicans to receive employer insurance, Mexicans and Puerto Ricans had similar rates of employer-provided coverage. However, both Cubans and Puerto Ricans were much more likely to receive government coverage than Mexicans and thus had a lower proportion uninsured. In fact, due to their older age, 19 percent of Cubans received Medicare benefits and, as a result of lower incomes, 29 percent of Puerto Ricans received Medicaid. In addition, more than half of Puerto Ricans in families with incomes less than 150 percent of FPL had Medicaid coverage as compared with only 30 percent of such Mexicans.

We also examined data among Hispanic immigrants who are not U.S. citizens. Not surprisingly, these Latinos were the largest percentage of uninsured persons. We found that 57 percent of the 1.1 million Latino children who were not U.S. citizens in 1998 lacked health coverage. In addition, despite the perception that Medicare provides universal coverage for all elderly, 12 percent of the 370,000 Latino non-citizen elders were uninsured (Table 1). Analysis by source of coverage found that only 30 percent of Latino immigrants who are not U.S. citizens had coverage from their employers and among all groups examined, they were the least likely to receive government insurance. In fact, contrary to anti-immigrant rhetoric, among persons in families with incomes less than 150 percent of the FPL only 16 percent of non-citizen Latino immigrants had Medicaid versus 26 percent of NHW and 44 percent of blacks.

Among the non-citizen immigrants from Latin American countries who were surveyed in sufficient numbers to allow for extrapolation, we found that immigrants from Central America and Mexico had the highest proportion of uninsured, including 64 percent of Salvadorians, 64 percent of Guatemalans, and 60 percent of Mexican immigrants. Latino immigrants from the Caribbean were more likely to receive government insurance and thus had a slightly lower proportion of uninsured persons. For example, 28 percent of non-citizens from the Dominican Republic received Medicaid and 32 percent of non-citizen Cubans received Medicare and/or Medicaid and thus a slightly lower proportion of these immigrants lacked insurance; 40 percent of Dominican; and 27 percent of non-citizen Cubans were uninsured in 1998.

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*We found that 57 percent of the 1.1 million Latino children who were not U.S. citizens in 1998 lacked health coverage.*

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Lastly, in Table 5 we present previously published data (Carrasquillo 1999, Hellander 1994) and combine it with our current 1998 data to examine trends in health insurance coverage among Latinos. We found that due to their high non-insurance rate as well as rapid population growth, Hispanics who make

up 11 percent of the population accounted for 39 percent of the increase in uninsured population from 1989 to 1998. We also found the largest absolute increase in the number of uninsured children occurred among Latinos. During this 10-year period, the number of uninsured Latino children increased by 1.2 million versus an increase of only 0.5 million for NHW children.

### Discussion

In our analyses, we found that Latinos are three times as likely as NHW to lack insurance coverage. Those disparities in health coverage between Hispanics and NHW persist among all age and income groups. In fact, blacks and Hispanics — who make up less than one-quarter of the U.S. population — made up more than half of the uninsured. We also found that despite the unprecedented economic prosperity of the last decade, the number of Hispanics without insurance increased by 62 percent while the number of NHW lacking insurance only increased by 20 percent.

Low rates of coverage among Hispanics are primarily due to having the principal wage earner(s) for the family being employed in occupations that do not provide health insurance (Carrasquillo 1999b, Fronstin 1997). In fact, more than 80 percent of uninsured Hispanics live in a family where at least one person is employed (Quinn 2000). A recent survey among working adults by the Commonwealth Fund found that despite Hispanics' high rate of participation in the workforce, they were much less likely than blacks or NHW to work for an employer who provided health coverage (Quinn 2000). Even when such coverage was offered, Hispanics were less likely than blacks or NHW to qualify for insurance due to either being part-time workers or not having worked sufficiently long enough at the occupation to receive benefits (Quinn 2000). In the survey, 75 percent of the working adult Hispanics who did not have health coverage were uninsured because their employer did not provide coverage or because they did not qualify for benefits. Only 8 percent had declined coverage due to cost concerns and less than 1 percent declined coverage because they did not feel it was important (Quinn 2000).

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*For various reasons including lack of other employment opportunities and undocumented status, many Hispanic immigrants, particularly recent arrivals, work in low paying occupations that do not provide health insurance.*

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Differences in type of employment also account for the variations in coverage rates among Hispanic sub-groups. For example, among working males, Cubans are most likely to have employer-provided coverage and Mexicans least likely to have such coverage (Fronstin 1997). As we had shown in a prior analysis using 1997 data (Carrasquillo in press), our current analysis demonstrates the important effect of citizenship status on coverage. More than half

of all Latino immigrants who are not U.S. citizens lack health insurance. For various reasons, including lack of other employment opportunities and undocumented status, many Hispanic immigrants, particularly recent arrivals, work in low paying occupations that do not provide health insurance. Many of these work in so-called "off the book" occupations such as migrant farmers, domestic helpers, and nannies and receive no fringe benefits (Rumbaut 1997).

Lack of coverage among Hispanics is very disturbing, as many studies have shown health insurance to be the most important determinant of access to the health care system. The absence of health insurance has been associated with difficulties accessing the health care system, having unmet medical needs, and lacking a regular source of care (Berk 1995, Kogan 1995, Donelan 1996, Schoen 1997). The uninsured are less likely to obtain preventive services such as mammograms and pap smears (Himmelstein 1995) and have higher preventable hospitalization rates (Weisman 1992) and adjusted mortality rates (Hadley 1991, Franks 1993). Among Latinos, health insurance rather than language, residency, income, or ethnicity, has been found to be the most important determinant of access (Hubell 1991, Halfton 1997, Schur 1999, Lewis-Epsetein 1991, Trevino 1996). Uninsured Latinos are less likely to rate their health as excellent or very good (Trevino 1991), and among Latino immigrants who seek care but lack insurance, many have serious illnesses with a high likelihood of long-term disability (Akin 1989).

Certain caveats apply to our findings. First, although the CPS asks respondents about insurance coverage during the previous year, some believe that these percentages reflect estimates rather than coverage for all 12 months (Swartz 1986). However, longitudinal studies have shown that Hispanics are also more likely to have spells without insurance and that such spells are longer among Hispanics. In a three-year period from 1993 to 1996, 50 percent of all Hispanics had at least one month without insurance versus 25 percent of NHW (Bennefield 1998). These spells lasted an average of 7.4 months for Hispanics versus 4.5 months for NHW (Bennefield 1998). In addition, 10 percent of Hispanics were uninsured all 36 months versus only 3 percent of NHW (Swartz 1990).

Secondly, there are many other important factors related to access to care. Having health insurance alone will not assure access to health care. Some of these others factors which are important barriers to access include geographic location, access to public transportation, and having a telephone. Cultural barriers are also important including language and cultural beliefs — highlighting the need for culturally competent providers. However, as noted previously many studies have clearly shown that health insurance remains the single most important determinant of access to the health care system.

### **Implications and Conclusions**

**“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” — Rev. Martin Luther King**

In 1993, President Clinton's attempt to provide universal coverage for all Americans was met with fierce resistance and was ultimately defeated. Since then, there has been a paradigm shift in the way health insurance reform is viewed. Rather than accepting health insurance as a basic right and providing coverage for all persons, most attempts at health reform have centered on the provision of improved access to health insurance coverage to certain groups assuming they meet specific, and at times onerous, requirements. Thus, it is not surprising that attempts at incremental reform were met with limited success. For example, in 1996, the Health Insurance and Portability Act was enacted, designed to assist workers who lose employment in continuing to receive health insurance coverage. However, persons could be charged exorbitant rates to receive such coverage and thus the act has had a negligible impact (Pear 1998).

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*Until health insurance is viewed as a basic human right and not as a privilege that one must earn, it is doubtful if any incremental program will help the one-third of Latino children and almost two-thirds of non-citizen Latino immigrant children who currently lack insurance.*

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Most recently, the widely supported Child Health Plus legislation was enacted. However, problems with implementation was widely acknowledged (Pear 1999, Andrulis 1999). While federal officials recently announced that more than two million children have been enrolled. In many instances, these were children previously covered under other state plans or Medicaid (Pear 1999) and thus, the number of uninsured Latino children continues to rise steeply. Unlike health insurance, most people and policymakers in this country view public education as a basic right of all children. Thus enrolling a child in school does not require filling out a 30-page form, calculating all percentages to several significant figures, presenting several months worth of pay-stubs or providing proof of citizenship. Yet, these are barriers that exist in some state Child Health Plus programs. Until health insurance is viewed as a basic human right and not as a privilege that one must earn, it is doubtful if any incremental program will help the one-third of Latino children and almost two-thirds of non-citizen Latino immigrant children who currently lack insurance.

Unfortunately, most politicians continue to advocate for either incremental reforms (Clinton-Gore Press Release 2000) or initiatives based on tax rebates (Wakin 2000) rather than for a system which guarantees health insurance for all persons living in this country. Such lack of support for universal coverage among political leaders is surprising given that it enjoys widespread support among the general population and professional organizations. More than 80 percent of Americans believe that health care, like education and social security, is a right and not a privilege (Yankelovich 1995). In addition, six major

medical organizations — the American Medical Association, the American College of Physicians, the American Academy of Family Physicians, the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American College of Surgeons — have recently all joined together to support universal coverage and make this a major issue in the 2000 presidential campaign (American College of Physicians 1999). In addition, one of the stated objectives in *Healthy People 2010* is to “increase the proportion of persons with health insurance to 100 percent” (Office of Disease Prevention and Health Promotion 2000).

Despite widespread public support, even among Latino political leaders, advocacy for universal health insurance and increasing health insurance coverage among Hispanics is often not perceived as health priority. For example, at the 1999 Congressional Hispanic Caucus Institute Issues Conference, the major health issues identified for discussion were diabetes, mental health/substance abuse, and HIV/AIDS (Congressional Hispanic Caucus Institute 1999). Similarly, at a recent presentation by representatives of the Congressional Black Caucus, universal health coverage was not identified as one of their eight major health priorities (Martin 1999). It should be noted that both groups have correctly identified important health problems in our communities and members of both Caucuses are actively spearheading initiatives to decrease ethnic and racial disparities in health. Rather, it seems that these political leaders are not being made sufficiently aware of the scope of the uninsured problem and its implications. In fact, partly as a result of advocacy efforts by the National Hispanic Medical Association, the Latino congressional representatives will be holding hearings this summer to address the issue uninsured Latinos.

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*In addition, governmental efforts at incremental reforms that fail to view universal coverage as a basic human right have had little impact on the rising number of uninsured Latinos.*

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In conclusion, more than one-third of Hispanics do not have health insurance coverage. Blacks and Hispanics currently make up almost half of the uninsured population in the United States. During the past decade, the number of uninsured Latinos has risen much more rapidly than any other racial/ethnic group. Lack of insurance among Hispanics is largely due to lack of employer coverage. Despite the unprecedented economic expansion over the last 10 years, the private sector is not meeting the health insurance needs of Hispanics. In addition, governmental efforts at incremental reforms that fail to view universal coverage as a basic human right have had little impact on the rising number of uninsured Latinos. Hispanic health care workers must ensure that policymakers espouse universal health coverage as a key health priority in their effort to reduce racial and ethnic disparities in health.

**Table 1. Percent of Uninsured Persons by Race/Ethnicity**

	<b>Hispanics</b> n=32 million	<b>Blacks</b> n=34 million	<b>NHW</b> n=193 million	<b>Hispanic subgroups by ethnic origin or immigrant status</b>			
				<b>Mexican</b> n=21 million	<b>Puerto Rican</b> n=3 million	<b>Cuban</b> n=1.4 million	<b>Non-Citizens</b> n=9 million
<b>Total Uninsured</b>	35%	22%	12%	38%	20%	17%	56%
<b>Age</b>							
<18	30%	20%	11%	32%	15%	16%	57%
18-39	45%	30%	18%	49%	29%	20%	60%
40-64	34%	21%	12%	37%	18%	24%	54%
>64	5%	1%	<1%	5%	3%	2%	13%
<b>Family Income</b>							
<\$25,000	42%	27%	18%	46%	24%	22%	62%
\$25-\$50,000	35%	19%	13%	37%	17%	23%	52%
>\$50,000	19%	12%	6%	20%	11%	7%	36%

**Table 2. Types of Insurance Coverage by Race/Ethnicity**

	Hispanic subgroups by ethnic origin or immigrant status						
	Hispanics	Blacks	NHW	Mexican	Puerto Rican	Cuban	Non-Citizens
<b>Employer Provided<sup>1</sup></b>	43%	50%	69%	41%	45%	51%	30%
<b>Government Insurance</b>	23%	33%	23%	22%	29%	27%	13%
Medicaid <sup>2</sup>	18%	22%	7%	17%	29%	13%	11%
Medicare <sup>2</sup>	6%	11%	15%	5%	9%	19%	5%
Medicaid <sup>3</sup>	32%	44%	26%	30%	54%	30%	16%
(<150 percent of FPL)							

<sup>1</sup> Employer insurance and government insurance are not mutually exclusive.

<sup>2</sup> Medicaid and Medicare are not mutually exclusive.

<sup>3</sup> Percentage of persons with family incomes less than 150 percent of the federal poverty level who receive Medicaid



Table 3. Trends in number uninsured (in thousands) by race/ethnicity

	1989	1992	1993 <sup>1</sup>	1994 <sup>2</sup>	1995	1996	1997	1998	Absolute Increase of Uninsured between 1989-1998	percent Increase in Uninsured
<b>All adults</b>										
Hispanics	6,900	8,400	7,700	8,100	9,500	10,000	10,500	11,200	4,300	62%
Blacks	5,800	6,600	6,800	6,600	6,900	7,200	7,100	7,500	1,700	29%
NHW	19,100	21,800	22,700	22,200	22,000	22,100	23,100	22,900	3,800	20%
<b>Children age &lt;18</b>										
Hispanics	2,100	1,900	2,300	2,400	2,800	3,100	3,100	3,300	1,200	57%
Blacks	1,700	1,500	1,700	1,900	2,000	2,100	2,100	2,100	400	24%
NHW	4,300	4,500	4,900	5,000	5,000	4,800	4,900	4,800	500	12%

<sup>1</sup> Implementation of 1990 Census weights may account for a portion of the increase in number uninsured from 1992 to 1993.

<sup>2</sup> Health insurance questions were redesigned to reduce underreporting of private health insurance

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## ***Addressing the Mental Health Needs of Latino Youth with Emotional and Behavioral Disorders: Practical Perspectives and Policy Implications***

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### Introduction

During the past 25 years, the United States has undergone a transformation in the composition of its population. By the year 2050, it is estimated that the largest proportional increase of population will occur in states with sizable Latino populations (Hernandez, Isaacs, Nesman, and Burns 1998; Singh 1998; Sue, Bingham, Posché-Burke, and Vasquez 1999). For the youth of America, the future is actually occurring right now. Racial or ethnic minority youth make up 45 percent of all students. In some states like California, they already outnumber white students (California Department of Education 1999; Sue et al. 1999). As this population transformation occurs, it increases the importance of adapting child and family-serving agencies to meet the needs of the increasing Latino population. This is even more critical because race, ethnicity, as well as associated constructs such as nativity, acculturation levels, socioeconomic conditions, and demographic environments (Aneshensel and Sucoff 1996) influence mental health outcomes. An appreciation of these factors contributes to the understanding of who develops emotional and behavioral disorders, how and where they are diagnosed and treated, and the effectiveness of interventions in improving the quality of life of minorities (Abe-Kim and Takeuchi 1996; Ruiz 1993; Takeuchi, Bui, and Kim 1993; Takeuchi, Sue, and Yeh 1995). In this context, attending to the mental health needs of Latino youths is a critical aspect in meeting their general growth and development needs (Nuttal, Sanchez, Osorio, Nuttal, and Varvogli 1996).

A primary problem for children and adolescents of color is that they are underserved by many public and private sector mental health systems within the United States (Bui and Takeuchi 1992; Hough, Landsverk, Karno, and Burnam 1987). Additionally, even when services are provided, individuals from diverse racial/ethnic minority cultures are more frequently misdiagnosed than are white Americans (Hoernicke, Kallam, and Tablada 1994). Some reasons for these misdiagnoses include problems of language, cultural nuances, and at times, clinician biases (Pumariega and Cross, 1997; Singh, 1998). Until the publication of the DSM-IV (American Psychiatric Association, 1994), clinicians did not have the benefit of cultural formulation guidelines for psychiatric diagnosis. Previously, mental health disorders were isolated and treated from a very limited internal perspective. In doing so, the total person as a product of and a participant in a social-cultural environment was all but ignored (Sue, Bingham, Posché-Burke, and Vasquez, 1999).

From the onset, it is important to point out that underutilization of the mental health system by minority populations is *not* a function of experiencing

fewer and less intense mental health-related problems (Hough et al 1987; Pumariega and Vance 1999). Minority clients said economic difficulties and lack of or inadequate insurance were the biggest barriers to accessing health care services, which were followed by other system barriers such as lack of child care, time conflicts, and language barriers (Marin, Marin, Padilla, and De la Rocha 1983). In short, minority individuals express the need for and willingness to seek mental health services, but contextual factors act as barriers to their reaching needed services. For Latino youths and families in particular, contextual factors, such as language, communication difficulties, and cultural beliefs can discourage individuals from seeking mental health services. For example, a Latino youth with serious emotional disturbance — a circumstance that requires staff with high levels of cultural sensitivity and the ability to communicate effectively in highly emotionally situations — is more likely to be assessed in a language not his or her own (Isaacs-Shockley, Cross, Bazron, Dennis, and Benjamin 1996) and, in turn, be provided with culturally inappropriate or unacceptable services.

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*In short, minority individuals express the need for and willingness to seek mental health services, but contextual factors act as barriers to their reaching services.*

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### Trends and Themes in Previous Research

The importance of addressing the influence of culture on mental health was emphasized in the 1999 *United States Surgeon General's Report on Mental Health*, which states:

A number of central concepts and guiding assumptions underpin our current understanding of children's mental health and illness. These have variously been defined by different investigators, but by and large these tenets are based on the premise that psychopathology in childhood arises from the complex multilayered interactions of specific characteristics of the child (including biological, psychological, and genetic factors), his or her environment (including parent, sibling, and family relations, peer and neighborhood factors, school, and *community factors, and the larger sociocultural context*), and the specific manner in which these factors interact with and shape each other over the course of development (p. 127). [*Italics added*]

Research relative to the provision of mental health services to racial or ethnic minority children and their families has emphasized the importance of these sociocultural factors:

- descriptions of psychosocial and environmental factors that put racial or

- ethnic minority persons at risk for experiencing mental health problems (e.g., Rogler, Malgady, Constantino, and Blumenthal 1987);
- epidemiological perspectives of the prevalence of specific psychologically based problems in ethnic minority populations (e.g., Casas 1985);
  - documentation of the types of interventions and service-provider characteristics that are more complementary to culturally rooted expectations (e.g., Atkinson and Lowe 1995);
  - examination of the effectiveness of traditional mental health interventions and approaches (e.g., Keefe and Casas 1980); and
  - identification of factors that impact the provision and utilization of services such as predisposing factors: cultural values inherent in ethnic minority individuals that predispose them to seek out alternative sources of help); enabling factors: financial resources, availability of ethnic-specific mental health services); and disabling factors: inattention to sociocultural variables that are relevant to or impact the client, lack of bilingual counselors, lack of ethnically similar counselors, reliance on Western-oriented counseling theories and strategies, lack of culturally sensitive/knowledgeable counselors (e.g., Knitzer 1982; Ponterotto and Casas 1991; Ponterotto, Casas, Suzuki, and Alexander 1995).

Abe-Kim and Takeuchi (1996) identified themes and issues that ethnic minorities face in the mental health system. They reported that ethnic minorities in the United States might:

- experience a disproportionate burden of health illnesses and disease compared to white Americans;
- encounter the greatest number of barriers to accessing health and mental health services;
- have the fewest financial resources to obtain appropriate services and are subsequently overrepresented in the number of Americans who are uninsured or underinsured; and
- experience lower quality of care when they do receive health and mental health services.

Furthermore, other research has found that in addition to the problem of under utilization service, minority youth, when provided with mental health treatment, are often served in more restrictive out-of-home centers or juvenile probation settings (Pumariega and Vance 1999). In one investigation, African Americans and white Americans in these facilities were referred for mental health evaluations in a juvenile justice system at a higher rate than Latino youth, even though Latinos comprised more than 50 percent of the detained population (Wordes, Bynum and Corley 1994). This points to the misperception of fewer mental health symptoms among Latino youth — a situation that has also been found in teachers' rating of Latino student's behaviors related to attention deficit disorders (Dominquez de Ramirez and Shapiro 1998; McDermott and Spencer 1997).



### Addressing Service Inequities

Given the shortcomings of traditional mental health services for minority youths, various policy-oriented task forces have been convened to promote possible solutions. For example, the Council for Children with Behavior Disorders (CCBD) established the Committee on Ethnic and Multicultural Concerns in 1982 (Bullock 1999). They urged professionals to undertake efforts to ensure that the following goals are achieved:

- removal, from special programs, all culturally different students who are not truly exhibiting emotional and/or behavioral disorders, but rather are displaying culturally based behavior (e.g., withdrawing from certain social interactions);
- provision of respectful and culturally appropriate educational and treatment services to culturally different students who do not have emotional or behavioral disorders;
- implementation of culturally and linguistically competent assessment procedures;
- recruitment of culturally diverse professionals;
- provision of pre-service and in-service training in modifications of practice that better address the characteristics of culturally different students with emotional and/or behavioral disorders;
- creation of welcoming institutional atmospheres in which culturally different students with emotional and/or behavioral disorders feel valued, respected, and physically and psychologically safe; and
- enhancement of the cultural knowledge base of professionals, clients/students, and the public at large.

A significant amount of research provides evidence that addressing and attaining the policy objectives established by the CCBD Committee on Ethnic and Multicultural Concerns can result in positive developmental and mental health outcomes for minority youths. More specifically, when systematic efforts are made to serve minority youth, studies have found that ethnic and language matching between client and mental health professional are associated with a decrease in dropout rate and an increase in utilization of services by ethnic minorities (Takeuchi, Uehara, and Maramba 1999). Although this research has begun the process of understanding how to better serve ethnic minorities, extant culturally sensitive models have focused almost extensively on adult populations and research of the micro-counseling process (i.e., counselor characteristics, acculturation).

The importance of addressing cultural competence in mental health services was emphasized at the first Multicultural Conference coordinated in January 1999 by the American Psychological Association (APA). Among the notable topics that were broadly addressed and discussed by the participants were:

- the impact of biases on scientific pursuits as they relate to ethnic minority groups;
- issues and challenges inherent in the teaching of multiculturalism and diversity;
- the implications of multiracial/biracial identity relative to education, training, and practice;
- the development of strategies for multicultural organizational change, political action, and advocacy for multicultural changes; and
- the implications of individual, professional, and organizational multicultural competence on research, education training, and practice.

Of particular importance to the thrust of this article is that the topic of the unique needs of minority youth in general, and those with serious emotional and behavioral disorders in particular, were all but ignored by the APA conference participants (Sue et al. 1999). What is lacking, even among professionals interested in multicultural issues, is the specific implementation of research programs, policy initiatives, and service programs that tackle the issues and diverse needs of culturally diverse youths and in particular those with serious emotional and/or behavioral disorders.

### **Purpose of Article**

Given the need to better understand and serve Latino youths with serious emotional and behavioral disorders, the basic guiding philosophy, values, and principles inherent in a system of care are first presented. This discussion underscores the reasons why a system of care may be an effective means to address the needs of Latino youths. The values and principles that cut across racial/ethnic and cultural boundaries and are relevant to *all* children are then identified. More detailed attention is subsequently directed to those key elements of a system of care that are most important and relevant to Latino youths and families. In addition, relative to these key systems of care elements, discussion is focused on policy implications that must be addressed in order to enhance the ability of these elements to increase the probability of realizing positive mental health outcomes for Latino youths with serious emotional disturbance and their families. In this discussion, we draw extensively on the experiences of staff and researchers working since 1994 on the Santa Barbara County systems of care initiative, Multiagency Integrated System of Care (MISC).

### **Systems of Care: A Promising Mental Health Service Model for Latino Youths**

#### ***Systems of Care Philosophy***

The systems of care mental health service model has received much attention at both state and federal levels in part because it promotes the delivery of culturally sensitive and effective services for minority youths and their families.

Public policy has supported the development of systems of care by distributing grants nationally through the Center for Mental Health Services (CMHS) and private foundations (Pumariega and Vance 1999). Stroul and Friedman (1986, 1996) envisioned systems of care as emphasizing comprehensive and individualized services provided within the least restrictive environment, full participation of the families involved, and coordination among all agencies and programs serving children and adolescents. The systems of care concept, therefore, represents not just a network of coordinated services, but rather encompasses a philosophy about how services should be delivered to youths and their families.

The philosophy upon which the broader system of care movement was developed is predicated upon specific core values, which call for developing service systems that are child-centered, family-focused, community-based, and culturally competent. In addition, the concept of systems of care extends beyond a continuum of services (Stroul 1993). It also includes specific mechanisms, structures, and processes necessary to ensure that services for youths are provided in a coordinated, cohesive, and comprehensive manner, such as through interagency case review, case management, and system-level coordination of services. In particular, the system of care's guiding principles state that, "children with emotional disturbance should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs" (Stroul 1996, p. 6).

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**Table 1**

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**Core Values for the System of Care**

- The system of care should be child-centered.
- The system of care should be community-based.
- The system of care should be culturally competent.

**Guiding Principles for the System of Care**

- Children with emotional disturbance should have access to a comprehensive array of services.
- Children with emotional disturbance should receive individualized services.
- Children with emotional disturbance should receive services within the least restrictive environment.
- The families and surrogate families of children with emotional disturbance should be full participants in all aspects of service delivery.
- Children with emotional disturbance should receive services that are integrated.
- Children with emotional disturbance should be provided with case management.
- Early identification and intervention for children with emotional problems should be promoted.

- Children with emotional disturbance should be ensured smooth transition to services across the life span.
- The rights of children with emotional disturbance should be protected.
- Children with emotional disturbance should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics.

Adapted from Stroul and Friedman (1986, 1996).

### ***Santa Barbara County Multiagency Integrated System of Care (MISC)***

The Santa Barbara County MISC, for example, is one of more than 40 sites nationwide that have received federal grants from CMHS to develop and evaluate a system of care for youth with serious emotional and behavioral disorders and their families. MISC coordinates services among family members, the Department of Alcohol, Drug and Mental Health Services; the Probation Department; the Department of Social Services; the Public Health Department; nonprofit organizations; and public schools, in order to provide a research-driven, family-focused, comprehensive continuum of community-based services, which is consistent with Stroul and Friedman's (1986, 1996) system of care principles. Staff from each of these partner agencies is co-located at one of three sites that offer one-stop services to families. The continuum of services includes: assessment, intensive case management, home- and school-based services, after hours and weekend crisis response, individual/group/family therapy, and medication treatment. MISC provides services with the goals of helping youth to:

- reside with families
- live in safety
- achieve success in school
- abide by the law
- develop supportive relationships with others
- maintain physical health

MISC specifically includes a training initiative to increase the cultural competence of all staff. The need for culturally competent services in Santa Barbara's MISC is clearly shown by the fact that more than 50 percent of all youths are from racial or ethnic minority backgrounds. Between 1994 and 1999, 45 percent of all youths served by MISC were Latino.

### ***How Does the System of Care Model Offer a Viable Mechanism for Serving Latino Youths and their Families?***

The recent *United States Surgeon General's Report on Mental Health* recognizes the need for children's services to draw upon natural support systems, "A key to the success of mental health programs is how well they use and are connected with established, accepted, [and] credible community supports. The more this is the case, the less likely that families will view such help as threat-

ening and as carrying stigma; this is particularly true for families who are members of racial and ethnicity minority groups” (p. 186). The elements that give the system of care model the potential to address the needs of Latino youth and their families is attention to comprehensive and coordinated treatment approaches, focus on intensive case-management, and commitment to cultural competency in the provision of services (Boles III and Curtin-Boles 1996). System of care’s emphasis on working with family members as partners and experts in the provision of care is in concert with the family-based support mechanisms characterizing many Latino families. More specifically, this model is based on the premise that it can help all clients, and in particular racial or ethnic minority clients, maintain the necessary balance between managing external stresses and the intrapsychic reactions they face due to the nature of their illness, difficult socioeconomic conditions, and a sometimes unresponsive or inadequate mental health or educational system.

### **Systems of Care Core Values and Guiding Principles and Policy Implications**

As shown in Table 1, system of care programs share a set of core values and guiding principles that distinguish them from traditional mental health service systems. As will be made evident, these core values and principles also have the potential to provide more appropriate and effective mental health services to Latino children with serious emotional disturbances and their families in ways that draws upon their cultural strengths. As noted above, certain values and principles cut across racial/ethnic and cultural boundaries and are subsequently relevant to all children. These include the following system of care elements: services should be child-centered; services should be integrated; services should be coordinated by a case manager; the rights of children should be protected; and services should be provided without regard to race, religion, national origin, sex, physical disability, or other characteristics. Given their generic nature, these elements are not addressed in this section; instead, attention is directed to those key elements of a system of care that we believe are most important and relevant to Latino youths and families, which include:

- services should be community-based;
- services should be culturally competent;
- children should have access to a comprehensive array of services;
- children should receive individualized services;
- services should be provided within the least restrictive environment;
- families and surrogate families of children should be full participants in all aspects of service delivery; and
- early identification and intervention for children should be promoted; and children should be ensured smooth transition to services across the life span.

To this end, we provide a brief summary of each element (for the sake of brevity, when possible, elements that share common attributes are combined) and then selectively highlight key policy issues that need to be addressed by communities that are seeking to successfully implement systems of care with Latino families.

### *Systems of Care Should be Community-Based*

#### *Summary*

In order to ensure that the needs of the community are effectively met, systems of care should be community-based. In addition, not only should such systems adequately reflect and address the needs identified by the community, but the systems should do so in a manner that is congruent with the beliefs and values that are an integral part of the community. Efforts should be directed towards getting grass root community members (including parents whose children are receiving services) involved in the decision-making and policy-setting activities of a system of care (e.g., advisory boards, commissions, or hiring committees).

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*In order to ensure that the needs of the community are effectively met, systems of care should be community-based.*

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#### *Policy Considerations*

In order to ensure that the community is amply represented in making decisions and setting policy, the written goals and objectives of the respective boards and commissions that oversee or fund a system of care must clearly stipulate the inclusion of community persons. Whenever possible, the process by which such persons are appointed or elected should be addressed with some detail. Because elected officials make many relevant appointments, it behooves the Latino community to ensure that they have a voice in the care of their children by exerting their right to vote. In making appointments, every effort should be made to get "new faces" on the advisory boards that represent a good cross-section of the community (e.g., socioeconomic level, diversity with respect to length of residency in the United States, acculturation level, and varying levels of education). To ensure ongoing active participation, boards and commissions should meet at times when the greatest number of community partners can attend and in locations that are within easy reach of the community. In many low-income Latino communities, a history of participation in governing bodies is nonexistent. Should this be the case, efforts should be directed by the system of care towards developing a concerted outreach process to identify potential participants. Such efforts should include the training of participants to help them understand the role that they are being asked to execute. A pairing of "old-timers" with "new faces" might help to expedite this training process.

### *Systems of Care Should be Culturally Competent*

#### *Summary*

The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the population served. "Cultural competence" is a concept that should drive changes in the way system of care services can be designed and implemented. To make appropriate changes, systems first need to assess cultural and professional attitudes, values and beliefs that underscore the services they presently provide, and then take appropriate steps to ensure that such values, and beliefs are compatible with the populations that they are seeking to serve (Ponterotto and Casas 1991). These efforts may require fundamental changes in existing structures, policies, and priorities (Casas 1985).

#### *Policy Considerations*

It should be noted that the concept of cultural competence is often addressed in broad and generic terms that are difficult to assess and measure if and when attained. Cognizant of this fact, the comments contained in this section — while reflective of the literature on systems of care — are largely based on six years of experience implementing a system of care that serves more Latino youths than any other racial/ethnic group. Consequently, attention is directed to specific and pragmatic issues and recommendations that need to be addressed from the perspective of planning, training, and implementation.

In interviews with Head Start clinicians, a number of issues that impact a system of care's ability to be culturally competent with Hispanics were discussed. One clinician noted that having MediCal pay for counseling services, utilizing bilingual counselors and care coordinators, and providing transportation are all ways to more competently serve this population. However, some problems exist in service delivery. Specifically, there is an alarmingly low number of Latino counselors and physicians (Bui and Takeuchi 1992) and many mental health care professionals are not familiar with certain sociocultural issues that are pertinent to effectively work with Hispanic families. For example, it is erroneous to assume that English speaking Hispanic families have Euro-American values. What some may see as racial/ethnic/culturally-related issues really are a reflection of socioeconomic conditions [what Oscar Lewis (1966) referred to as the "culture of poverty"]. These clinicians also outlined practical policy suggestions for developing a culturally competent system of care. They stated that bicultural (not just bilingual) individuals should be represented to a greater degree in the direct service staff.

In order for a system of care to be culturally competent it is necessary that issues and recommendations identified above be accepted and implemented at all levels (e.g., clerical staff, administrative staff, service providers, and clinicians). To ensure such implementation, it behooves policymakers to make it blatantly clear that cultural competency is a vital and integral part of a system of care. The importance of cultural competency must be imbued throughout all the documents that focus on the values and principles that guide a system of care (vision and mission statement, goals, objectives, strategies, and stan-

dards). Suffice it to say that if cultural competency is to become synonymous with systems of care, attention to such competency cannot be relegated as an "after thought" paragraph contained in such documents. Finally, to ensure that all employees are adept at implementing and maintaining a culturally competent system on an ongoing basis, it is necessary for systems of care to establish ongoing and required training classes that focus on cultural competency. An emphasis is given to "ongoing" in order to differentiate the one-time, cure-all approach that has characterized previous efforts. Classes that focus on cultural competency should be given at regular intervals and consistently updated to ensure that the most recent information and effective approaches are presented. From a policy perspective, in order to ensure such consistency, systems of care should create a permanent position and office that focuses solely on matters related to cultural competency.

*Children with Emotional Disturbances Should have Access to an Individualized and Comprehensive Service Plan*

*Summary*

Children with emotional disturbances should have access to an individualized and comprehensive service that addresses the child's physical, emotional, social, and educational needs. Inherent in this principle is a strong emphasis placed on unconditional care and wraparound services for youths and families (Katz-Leavy, Lourie, Stroul, and Zeigler-Dendy 1992). It should be noted that a commitment to unconditional care often breaks the cycle of rejection that many of these troubled youths have previously experienced (Burchard 1988).

Comprehensive and individualized wraparound services draw upon all available treatment-focused resources for youths and their families — formal and informal, traditional and nontraditional (enlisting family members or friends as "service providers"). This broad range of treatments has been termed a "continuum of care" (Stroul and Friedman 1986) and is considered to be an essential aspect of a system of care. The continuum of care is intended to deliver needed services on an individualized basis and in a coordinated manner, using case management and interdisciplinary teams to integrate treatment programs and to facilitate transition between services (Bickman 1996). Burchard (1988) states that the underlying foundation of wraparound services is to identify those children who are the most severely emotionally disturbed and "wrap" services around them to facilitate their adjustment in the mainstream. The process of individualizing services entails a thorough, ecological assessment, completed by the case manager and interagency team (psychologist, social worker, probation officer, public health nurse, school personnel, and family members) that identifies strengths and needs of youths and families in all life domains. This precedes and facilitates the development of a comprehensive individualized service plan — or wraparound plan — which reflects the specific needs and strengths of the youths and family (Clarke, Schaefer, Burchard, and Welkowitz 1992). The implementation of wraparound plans, if properly done, has the potential of helping many Latino families that find themselves with a multiplicity of problems and challenges. With respect



to youths themselves, Rosen and colleagues (1994) examined youths' perceptions of wraparound service plans and found that they were generally satisfied with their care and their satisfaction was related to their sense of involvement in services and their perceptions about the unconditional nature of their care.

### *Policy Considerations*

Wraparound service plans entail an ecological assessment that takes into consideration the strengths and needs of the youths and families in all life domains; therefore, it is necessary to consider how "presenting problems" are associated with sociocultural variables, including but not limited to, race, ethnicity, culture, language, socioeconomic level, and living conditions. Giving consideration to such variables may require that universities and service-providing institutions reconceptualize the type of training that is provided to mental health professionals. Dealing solely with intrapsychic or externalizing issues is not enough to help children with emotional and behavioral disorders. Youths and their families need to be provided with services that expediently address all needs that impact the prevailing disorder(s) within the family's personal sociocultural context.

If a wraparound plan is to be appropriately and successfully implemented, it is important that the family be treated as an equal partner in the formulation of interventions. Here again, there is a need to establish policy that clearly stipulates the equitable involvement of families. Professionals need to be reminded, especially in reference to Latino families, that the real experts on the presenting problems are the families and that the most successful outcomes for targeted children are those in which the family is involved in the context of the community. To ensure consistency, the development and implementation of wraparound plans may require ongoing training. This is especially important if there is regular staff turnover. From past experience, it appears that the implementation of wraparound meetings can be greatly facilitated if the interagency teams are collocated in one place. This also helps families in need get help at one place, at one time, rather than having to go from agency to agency in order to get their diverse needs met. A collocation of agencies requires that the respective service agencies come to the table and reformulate service policies from a collaborative interagency perspective. Unfortunately, many agencies are entrenched in doing business within their own isolated and familiar safety zone. Consequently, if reformulation is to become a reality, it requires that the Latino community, through its leaders, take the initiative to implement collocation.

### *Children Should be Served in the Least Restrictive Environment*

#### *Summary*

A major structural component of systems of care is the development of broad continuums of community-based services for youths with emotional disturbances and their families. Recent research in children's mental health has increased awareness of the need to move beyond a client-versus-system focus in cultural competence and to look at the roles that communities play in their

responses to systems of care (Gutierrez-Mayka and Contreras-Neira 1998). Many communities have designed innovative services such as intensive non-residential and residential components that better address the needs of the youths and families that they serve in a less restrictive manner (Stroul 1993). Such systems of care have been able to serve the needs of the youths and families within their home communities rather than sending youths to out-of-home or out-of-county placements.

As indicated above, reducing the use of restrictive-treatment environments and out-of-home placements is a critical goal of system development (Stroul and Friedman 1996). There has been a clear historical pattern of overutilization of costly and restrictive inpatient and residential treatment settings for youths with emotional and behavioral disturbances (Sondheimer, Schoenwald, and Rowland 1994). Creating a wide array of services that are intensive and community-based allows communities to divert many youths from restrictive environments to services within their own communities, or better yet, within their own homes. Addressing this fact, Gutierrez-Mayka and Contreras-Neira (1998) suggest three culturally competent strategies for engaging minority communities in reform efforts that result in serving youths in a less restrictive environment:

- using an ethnographic and ecological approach to learning about the community and the cultural norms by which its members behave;
- developing and/or nurturing an attitude that is open, receptive, respectful, and unbiased toward engaging in partnerships with the community; and
- facilitating an environment that encourages the willingness of professional outsiders to come into the community as learners and facilitators rather than as teachers and overseers.

The effectiveness of the Alaska Youth Initiative (Burchard 1988), a project in which individualized care was used to return children from out-of-state, residential programs illustrate the potential success of using these strategies. After approximately two years of individualized care, a majority of the children and adolescents who were initially in out-of-state residential treatment programs were finally placed successfully in less-restrictive programs within their home state of Alaska (Burchard and Clarke 1990). Such positive placement-related outcomes for youths and families are the espoused major goals of a system of care.

### *Policy Considerations*

Given the positive outcomes that are associated with treating children in their communities using less restrictive approaches, mental health and social service administrators should collect and provide substantive data to relevant commissions, county boards of supervisors, and state departments of health that underscore the cost-effectiveness that can be realized as a result of using such approaches. These governing bodies could, in turn, develop policies and procedures as well as provide resources to facilitate the implementation of

such approaches. While one would expect that most families would want to keep children in need of treatment close to home, if not in the home itself, the incentives for wanting this may differ for Latino families. Policymakers should take these differences into consideration. For one thing, if the children are monolingual Spanish-speaking and are placed out of home and community, there is a high probability that the setting into which they are sent may not have Spanish-speaking professionals and/or support staff. Finding themselves linguistically isolated could very likely create stressful situations that could impede their treatment progress. The same could be said for those children who identify strongly with their Latino culture. Would the setting to which they are sent be sensitive to and respectful of their ethnic and cultural identity? For many Latino children the existence of an extended family (e.g., uncles, aunts, grandparents, cousins, padrinos, madrinas) is an important and viable resiliency resource for maintaining or improving their well-being. Again, depriving these children of such a resource could negatively impact their well-being.

### *Families are Full Participants in all Aspects of Service Delivery*

#### *Summary*

Research has demonstrated that family involvement is critical to successful outcomes for children. System of care efforts recognize the valuable resources that families can bring to service delivery (Ronnau 1995). The principle of family participation focuses on the system's responsiveness to families and family members' authentic involvement in service delivery and planning demonstrated by: respect for families; recognition of family strengths; involvement of families in setting priorities; and centering service delivery on the holistic, ecological needs of families. In addition, systems of care intend to empower families to be flexible to their changing needs, utilize informal support networks, and be culturally competent in their delivery of services to family members.

#### *Policy Considerations*

This is a very important principle that cannot be ignored due to the importance ascribed to more traditional values held by many Latino families. Addressing it, however, is also a very challenging task because Latino families that adhere to their "traditional culture" are apt to put full responsibility in the hands of the so-called experts ("ellos son los que saben que hacer"). However, from a pragmatic perspective, "los que saben que hacer" are truly the family members. Given this fact, policymakers must develop guidelines that underwrite the fact that reimbursements for services provided by state and or federal departments can only be made if and when family members are involved in the development of the service plan. To verify that appropriate and relevant family involvement occurs may require that state and county policymakers establish a policy-focused department that could develop the mechanism by which relevant family involvement would be monitored and rated. To

emphasize the importance of family involvement, the availability of future funding for the targeted project could be contingent on such ratings.

In the meantime, to accomplish such initiatives, it may be necessary to implement policies that facilitate the inclusion of family members in the therapeutic planning process. To this end, it might help if Latino clients, especially those new to this country, are put in contact with Latino service providers who give them a culturally appropriate and relevant explanation of what they are going to encounter as they seek help for their child. In addition, the procedures and "rituals" that are followed in the initial sessions may focus less on paper work (getting insurance information) and administering a series of diagnostic instruments and more on establishing a stronger caring and respectful bond between caregivers and family. Taking extra time during the initial assessment period helps the families to be more comfortable answering personal questions. It is also crucial that all assessment instruments be translated into the Spanish dialect of the respective community and eventually be validated for use in the community.

### *Children Receive Early Identification and Intervention*

#### *Summary*

The need for increased early identification is evident in much of the recent literature. Both epidemiological studies and clinical impressions suggest that the number and intensity of behavior problems in young children are increasing (Wright and Leonhardt 1998). In addition, Stallard (1993) reported a behavior problem prevalence of 10 percent in three-year-old children using parent reports. There have been few reports on the prevalence of behavior problems in infants and toddlers, but one study suggests that three out of 100 children younger than three years old had emotional problems and needed help (Luk, Leung, Bacon-Shone, and Leih-Mak 1991). In addition, few studies have followed infants and preschool children longitudinally; yet the accumulating body of evidence suggests that a significant number of young children with emotional and behavioral problems continue to have difficulties during their school-age years and later (Wright and Leonhardt 1998). Finally, most developmental models of emotional and behavioral disorders emphasize the importance of preschool factors such as a child temperament and parental care and supervision in the latter development of conduct disorders (Loeber and Farrington 1998).

#### *Policy Considerations*

During the 1990s, numerous systems of care for children and adolescents with emotional and behavioral disorders were initiated. However, as significant as this reform has been, these efforts have focused primarily on the needs of older children and adolescents. The needs of younger children have been largely ignored, especially for those from birth to six years and their families (Knitzer 1996). In fact, the majority of the population younger than six years of age who are in need of mental health services receive no services at all. To effectively intervene with young children, service providers must deal with

their numerous developmental issues within a broader ecological context emphasizing a cultural framework (Wright and Leonhardt 1998). Both developmental and cultural competencies are crucial for service providers' effective assessments and interventions with young children and their families. However, there is a paucity of well-trained clinicians available to provide services. In addition, there has been little consideration of or planning for training children's mental health professionals in system of care development efforts (Wright and Leonhardt 1998).

An analysis of the historical perspective of health and social services for young children has revealed that they tended to be fragmented and often lacking in depth and comprehensiveness (Wright and Leonhardt 1998). For example, Head Start, which was established in the 1960s, provides early intervention services to children from disadvantaged socioeconomic backgrounds as a means of improving their chances for success in school. Parent education programs burgeoned in the 1970s, and the 1980s brought new knowledge of children's school and social success. In the 1980s and 1990s, new understandings regarding the capacities of infants developed along with information regarding the critical importance of the first weeks and months of children's lives (Bowlby 1989). This has led to an increased emphasis on early parent-child interactions and growth of programs aimed at parents and their young children.

Implicit in these professional trends is a clear message for system of care service providers and policymakers. Developmental competence is an essential skill when working with young children and their families (Wright and Leonhardt 1998) and programs must be designed to develop such a skill. Professionals must consider multi-system involvement just as they do with older children. Focusing attention to both environmental and biological factors impacting the lives of young children may result in less psychological and educational impairment, hence lowering public and private costs. The importance of designing early childhood mental health partnerships is imperative, particularly ones that are sensitive to service needs at different developmental stages. This is especially true with respect to Latino children in need of services who are prone to enter the mental system later in life through the probation department rather than directly through the mental health department (Casas, Wood, Alvarez, Furlong, Warholic, and Walton 1998). For these children, early intervention could help prevent the development of more serious emotional and behavioral problems later in life.

### *Children are Ensured a Smooth Transition of Services Across Their Life Span*

#### *Summary*

While the transition from high school to adulthood for youth without disabilities has been extensively researched (Raffe 1988), few studies have focused on youth with emotional and behavioral disorders (EBDs). However, the poor outcomes for these youth are well documented and include high dropout and unemployment rates, lack of ability to function independently in adulthood,

and high incidence of illegal activities and/or high-risk behaviors (Neel, Meadows, Levine, and Edgar 1988). Many youth with EBD disrupt or sever their ties with mental health services as they transition to adulthood. Many agencies and systems disagree with one another regarding eligibility criteria for this population once they become adults. The best-implemented service plan for a child or adolescent has the potential to be for naught if transition issues related to school (to postsecondary education), work (from work-skills programs to actual employment), and mental health services (from family-focused systems of care to adult services) are not planned for at an early age and carefully monitored.

### *Policy Considerations*

For certain Latinos, making transitions from one service level to another may be quite traumatic. This would be especially true for those Latino children who, over their life history, may have been forced to make transitions that were not under their control and they may not have understood. Such transitions could include the following: having to immigrate to this country because of political reasons, entering and living in this country under great stress because of lack of immigration documents, having to consistently move for economical reasons from one geographical region to another, having to develop the means to communicate and navigate one's self in different and often alienated worlds, and finally, having to understand and master the transitional variables that comprise one's identity as a Latino and as a so-called "American." Mental health and social service professionals within a system of care need to be trained and supervised to ensure that factors such as these are taken into consideration in helping Latino clients make transitions across their life span.

### **Conclusion**

Children and adolescents of color are often underserved or inappropriately served by public and private sector mental health agencies in the United States. A service delivery model, referred to as systems of care, has been proposed as a promising way to expand and improve mental health services to all children and adolescents who have serious emotional disorders. Because the system of care paradigm emphasizes cultural competence in service delivery, it also provides a promising mechanism that can assume the responsibility of meeting the mental health needs of Latino youths and their families. This article addressed the inequalities that exist for Latino and other minority youth in obtaining mental health services, outlined trends and themes present in previous research on this topic, and highlighted key policy-related elements of systems of care to consider when serving Latino youth and their families. In this discussion, we drew extensively on the experience of staff and researchers working in the Santa Barbara County Multiagency Integrated System of Care (MISC), a collaboration among family members, health and safety net agencies, schools and community-based organizations. MISC is one of more than

40 sites nationwide which received a federal grant from the Center for Mental Health Services to develop and evaluate a MISC. Between 1994 and 1999, the MISC program was implemented and has proven to be a system of care that looks promising. However, there are several policy-related issues that need to be continuously addressed as noted above (staff training, assessment instruments, and parent involvement). The Santa Barbara service community has embraced the system of care principles so strongly, especially in reference to its ability to better serve Latino children and families, that this model and the service system it has spawned are now completely self-funded using Medicaid and other revenue sources. Readers who want to access additional information about Santa Barbara County's system of care program can obtain more detailed information at the following Web address: <http://education.ucsb.edu/~sbmisc/>.

### Authors' Note

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## ***Congressional Hispanic Caucus Report on Hispanic Health in the United States***

### **Congressional Hispanic Caucus**

*The Congressional Hispanic Caucus (CHC)<sup>1</sup> is an informal group of 18 members of Congress of Hispanic descent. The caucus is dedicated to voicing and advancing, through the legislative process, issues affecting Hispanic Americans in the United States and the insular areas. The CHC was founded in December 1976 as a legislative service organization of the U.S. House of Representatives. Today, the caucus is organized as a congressional member organization, governed under the rules of Congress and comprised solely of members of the United States Congress. Although every issue that affects the quality of life of Americans is of concern to the caucus, certain national and international issues have a particular impact on the Hispanic community. The function of the caucus is to serve as a forum for the Hispanic members of Congress to coalesce around a collective legislative agenda. In addition to covering legislative action, the group also monitors executive and judicial policies that affect Hispanics. Task forces permit members to draw on their particular expertise and interests in pursuing the legislative agenda of the caucus. This report, on the status of Hispanic health, is based on hearings held by the CHC during Hispanic Health Awareness Week 1999. It was prepared by the Office of Representative Ciro Rodriguez, chair, CHC Health Task Force<sup>2</sup> and released in April 2000. To obtain a copy of the written testimonies submitted to the Congressional Hispanic Caucus during Hispanic Health Awareness Week, log onto [www.house.gov/rodriguez/](http://www.house.gov/rodriguez/) or call 202-225-1640.*

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### **Executive Summary**

Despite the notable progress our nation has made in the overall health of our population, serious disparities persist in the burden of illness and death experienced by minorities compared to the U.S. population as a whole. In order to educate policymakers about the health needs of the Hispanic community, the CHC hosted Hispanic Health Awareness Week in September of 1999. During that week, members held a series of hearings on the status and specific needs

of the Hispanic community in the areas of diabetes, HIV/AIDS, and mental health and substance abuse. The purpose of the hearings was to gather information from the community and educate colleagues on Capitol Hill about the unique health needs of the Hispanic community. Public health advocates and other experts from the medical community presented research and information on these topics and offered a series of recommendations. The three hearings produced common themes regarding health care to the Latino community.

These major themes include:

- *Access to Health Care*  
Hispanics constituted 35.3 percent of the total uninsured population amounting to approximately 15.6 million people.
- *Funding Needs*  
Funding for existing and new programs on prevention, education, and direct services should be directed towards community-based organizations that serve the Latino community.
- *Culturally Competent Information*  
Most written and verbal information that reaches Latinos is not understandable or culturally appropriate. This prevents many Latinos from receiving adequate care and from making educated decisions about their well being.
- *Representation of Latino Health Care Professionals*  
A lack of adequate representation of Latinos in the health professions hinders care. Steps must be taken by the public and private sectors to increase opportunities for Latinos to enter into health professions.
- *Data Collection*  
The U.S. Department of Health and Human Services and other federal agencies have failed to adequately collect data for Hispanics and other minority groups to determine health outcomes.

### **Highlights From the Testimony Provided During Hispanic Health Awareness Week**

#### ***Diabetes***

##### ***Findings***

Type II diabetes<sup>3</sup> accounts for 90 percent to 95 percent of diabetes cases nationwide and it is the most common form in the Latino community. Six percent of Hispanics in the United States and Puerto Rico have been diagnosed with Type II diabetes. In the Hispanic community, Type II diabetes occurs at a rate approximately twice that in the non-Hispanic Caucasian population. It is estimated that another 6 percent have undiagnosed diabetes.

Latinos face numerous barriers to adequate care: lack of diabetes education; poor diet due to the unavailability and lack of affordability of important vegetables, legumes and fruits; and lack of exercise, due to scarce safe and community-based exercise facilities. Controlling the risk factors of diabetes can prevent the development of diabetes in many genetically susceptible indi-

viduals. Addressing environmental risk factors like diet, weight, and physical activity can significantly impact the development of diabetes.

#### *Recommendations*

- Support the recommendations of the National Institutes of Health (NIH) Diabetes Research Working Group (DRWG) presented to Congress during the spring of 1999. These recommendations include identification of genes conferring disease susceptibility in Type II diabetes and obesity; identification of environmental factors that may cause a predisposition to Type II diabetes to become an overt clinical disease; and efforts to increase genetic studies in minority populations.
- Increase funding to Centers for Disease Control and Prevention (CDC) programs to support comprehensive awareness and education programs in all 50 states. Provide diabetes information and messages through prime time television viewing hours, radio stations, newspapers, posters, and billboards.

#### *HIV/AIDS*

##### *Findings*

Hispanics account for 20 percent of new AIDS cases. Of these new AIDS cases, Hispanic men account for 20 percent of all reported cases among males, Hispanic women account for 19 percent of all reported cases among females, and Hispanic children account for 22 percent of cases among all children. In 1998, Hispanic women had the second-highest rate of AIDS cases among all women. Among Hispanic women, 52 percent of AIDS cases are from heterosexual transmission and 44 percent are due to injection drug use. Young people represent half of all new infections. Hispanic youth face risk of HIV infection from engaging in unprotected sex and/or injection drug use. The two primary modes for HIV transmission in the Hispanic community are individuals who have unprotected sex and individuals who inject themselves with drugs.

Barriers that hinder the ability to fight the disease in the Latino community include: the community's unwillingness to recognize that AIDS is a problem; lack of specific research on sexual attitudes, beliefs, behaviors and practices among Hispanics; lack of research on the factors which contribute to drug use and abuse; lack of data on Latino sub-populations; lack of access to health care that is culturally competent; fear of seeking health care due to immigration status; lack of participation in clinical trials and research; cultural factors such as religion, views of homosexuality, and "established" gender roles; language differences; level of education; and limited knowledge and misconceptions about HIV/AIDS and its treatment.

The CDC's national system for HIV surveillance does not reflect the trends in the epidemic among Hispanics because currently only 33 states and jurisdictions report HIV infection cases to the CDC. For instance, California, Illinois, and Puerto Rico do not report HIV cases to the CDC, Texas reports

only pediatric cases, and New York is in the process of implementing its reporting system.

#### *Recommendations*

- Tailor public information and education campaigns to Hispanic sub-populations and take into account region and national origin. Provide direct, age-appropriate, and culturally competent HIV/AIDS education. Increased attention to youth and women should be a priority. Increase appropriations for HIV/AIDS prevention, care services, and research.

#### *Substance-Abuse and Mental Health*

##### *Findings*

Adapting to a new culture is a significant factor for mental health problems and substance abuse among Hispanics. Mexican American women are more likely to report severe depression than their non-Hispanic white or African American female peers. Between 1995 and 1997, substance abuse increased among Hispanic youth at the same time it declined for non-Hispanic white and African American youth. Those at greatest risk appear to be Hispanic girls. Hispanic girls now lead girls nationwide in rates of suicide attempts, alcohol and drug abuse, and self-reported gun possession.

##### *Recommendations*

- Support research to assess the accessibility and quality of mental health care to all Latinos, especially for groups not well represented in current published research, such as elderly Hispanics, mainland Puerto Ricans, Cuban Americans, and Central Americans. Ensure that prevention and treatment services are culturally competent and appropriate. Facilitate health and mental health access for Hispanic families through outreach in both language-appropriate and culturally competent manners.

### **Congressional Hispanic Caucus Action Plan**

The testimony received during the Hispanic Health Awareness Week hearings indicates a critical need for action at the federal level to improve research and health care delivery for Hispanics. The findings compiled from the hearings clearly portray the grim state of health care facing Hispanics. For far too long, federal resources have not been used to assess fully the health care needs of the Hispanic community nor to address the disproportionate impact diseases have on this population.

Under the leadership of Representative Lucille Roybal-Allard, CHC chair, and Representative Ciro Rodriguez, CHC Health Task Force chair, the Congressional Hispanic Caucus will evaluate the recommendations outlined by the health experts during Hispanic Health Awareness Week and develop an agenda to implement necessary changes. A major piece of this agenda will focus on ways to integrate fully the needs of the Latino community into the



programs run by the U.S. Department of Health and Human Services (HHS) and its agencies.

The CHC will continue to work with members of Congress and with the administration to eliminate health disparities in the Latino community. By eliminating the health disparities in the fastest growing population in the United States, we will help our children and improve the well-being of our country.

### **Diabetes and the Hispanic Community<sup>4</sup>**

Wednesday, September 8, 1999

The testimony presented to the Congressional Hispanic Caucus resulted in a number of findings and recommendations.

#### ***Findings***

Diabetes affects an estimated 16 million Americans and the complications of the eyes, kidney, nervous system, and heart caused by diabetes cost an estimated \$98 billion annually. It contributes heavily to heart disease, birth defects, sexual impotence, incontinence, and other serious health problems. Americans with diabetes face shortened life spans. Roughly 100,000 individuals suffer preventable acute and chronic complications such as kidney failure, blindness, and lower extremity amputations each year. The prevalence of retinopathy, which is a debilitating eye disease and a leading complication of diabetes, is 80 percent higher among Mexican Americans than among non-Hispanic whites.

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***Among Hispanics, Type II diabetes is twice as high compared to non-Hispanic whites.***

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The cause of diabetes is unknown in most instances although genetic and environmental factors appear to play a role. Type II diabetes accounts for 90 percent to 95 percent of the diabetes cases and it is the most common form seen in the Latino community. There is an increase in reports of Type II diabetes related to obesity and this has become a major public health concern. Among Hispanics, Type II diabetes is twice as high compared to non-Hispanic whites (6 percent of Hispanics in the United States and Puerto Rico have been diagnosed with diabetes and it is estimated that another 6 percent have undiagnosed diabetes). Among adult minority populations, 10.8 percent of non-Hispanic blacks, 10.6 percent of Mexican Americans, and 9.5 percent of American Indians and Alaskan Natives have diabetes. One out of every four Mexican Americans and Puerto Ricans 45 and older has diabetes. One out of three elderly Latinos has diabetes.

Factors accounting for the diabetes epidemic in the United States include: demographic changes (aging, increased growth of at-risk populations); behav-

ioral elements (improper nutrition, decreased physical activity, obesity); surveillance systems that do not completely capture the exact burden of diabetes; and the present inability to change unhealthy behaviors. Diabetes disproportionately impacts racial and ethnic minority communities because of: inadequate access to proper diabetes prevention and control programs; improper quality of care; high prevalence of diabetes resulting in more complications such as amputations; and higher critical diabetic conditions such as hyperglycemia.

Barriers to diabetes care encountered by Hispanics include: lack of diabetes education; unavailability and lack of affordability of important vegetables, legumes and fruits; and lack of exercise due to scarce safe and community-based exercise facilities. Health care is key to proper diabetes care since the disease is chronic and affects multiple systems of the body, thus requiring skilled health professionals. Controlling the risk factors of diabetes can prevent the development of diabetes in many genetically susceptible individuals. Addressing environmental risk factors like diet, weight, and physical activity can significantly minimize the development of diabetes.

Patient education is critical to reduce risk for complications. Patients can learn and practice the skills necessary to better control their blood glucose levels and receive regular check-ups. The Hispanic community's understanding of diabetes and its complications is limited. Many individuals in the community do not associate the onset of diabetes with poor nutrition, genetics, or unhealthy and sedentary lifestyles.

The American Diabetes Association's (ADA) Diabetes Assistance & Resources Program (DAR) seeks to increase awareness in the Hispanic community about the seriousness of diabetes and the importance of prevention and control. The ADA has increased its efforts to reach the Latino community and appointed Andrea Zaldivar to its board of directors.

Since the complications of diabetes affect many parts of the body, this disease is an important National Institutes of Health (NIH) research area. The NIH has a two-step peer reviewed process to identify the most promising avenues of diabetes research: an initial review by a group of non-federal scientists and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) Advisory Council.

The NIDDK has undertaken research initiatives to fight diabetes. Large-scale studies of the genetics of diabetes and the genetic susceptibility to diabetic kidney disease are forthcoming. NIDDK's efforts include the establishment of the National Task Force on Prevention and Treatment of Obesity, since obesity is a serious risk factor for Type II diabetes. In addition, NIDDK has formed the International Type II Diabetes Linkage Analysis Consortium to map genes responsible for Type II diabetes. Two clinical trials conducted by NIDDK include:

- Diabetes Prevention Program, which is designed to find out whether Type II diabetes can be delayed or prevented; and
- Study of Health Outcomes of Weight Loss (SHOW), which is designed to

study if interventions to produce sustained weight loss in obese individuals with Type II diabetes will improve health.

Since 1995, the National Diabetes Education Program (NDEP), a joint NIDDK, NIH Office of Research on Minority Health (ORMH), and CDC program, seeks to improve the treatment and outcome of people with diabetes and reduce the illness and death associated with diabetes and its complications. The media campaign "Control Your Diabetes. For Life." targets people with diabetes by informing them that close control of blood glucose levels can prevent or reduce the complications of diabetes. The message emphasizes that diabetes is serious, common, and costly, but it is also controllable. The campaign targets audiences with culturally sensitive messages designed by minority organizations. In addition, NDEP's "Lightning and Thunder" campaign targets English-speaking Latinos.

Through the Diabetes Research and Training Centers (DRTCs), the NIDDK funds research on the development of model education programs that seek to generate the most competent professional personnel, and to translate advances in the field into improved patient care. The centers are required to develop programs and/or materials directed at minority populations. One center located at the University of Chicago has had four major projects focusing on diabetes in Hispanic populations. The NIDDK also supports regular research grants studying culturally sensitive lifestyle interventions. Such a study at the University of Texas in Austin aims to develop culturally relevant, community-based interventions to improve the health of diabetic Mexican Americans and their families.

The National Diabetes Information Clearinghouse (NDIC) seeks to increase knowledge and understanding about diabetes among patients, health care professionals, and the public. Many NDIC fact sheets and pamphlets about diabetes are available in Spanish.

CDC utilizes the Behavioral Risk Factor Surveillance System (BRFSS) to assess diabetic prevalence and to provide state-specific information on diabetes prevalence, risk factors, and preventive care practices. CDC intends to expand the BRFSS's capacity to perform surveillance of diabetes in minority communities. CDC is also monitoring a trend of increasing diabetes cases among youth and has convened meetings with pediatric endocrinologists, epidemiologists, and public health professionals to address this increase.

CDC's efforts to fight the diabetes epidemic in the Latino community include: developing a national strategy to increase awareness and education; promoting early detection services about diabetes; funding state-based control programs; and building partnerships to broaden the message. CDC has initiated a five-year study to conduct research within managed care organizations that will evaluate and improve the health care and health status of people with diabetes. CDC also funds state-based diabetes control programs in all 50 states, the District of Columbia, and eight U.S.-affiliated island jurisdictions. A two-tiered funding level enables 34 states to operate core capacity-building

diabetes programs and 16 states to operate comprehensive capacity-building programs.

HHS's Diabetes Work Group, co-chaired by the CDC and NIH, has identified ways to address the gaps in what is known about diabetes and to develop strategies to eliminate the disparity.

### *Recommendations*

- Support the recommendations of NIH's DRWG presented to Congress during the spring of 1999. These research efforts include: identification of genes conferring disease susceptibility in Type II diabetes and obesity; identification of environmental factors converting predisposition to Type II diabetes into overt clinical disease; and efforts to increase genetic studies in minority populations.
- Support DRWG recommendations to tackle diabetes in racial and ethnic minority communities. These recommendations include: initiate research to develop culturally sensitive preventive and therapeutic approaches utilizing innovative communication and education techniques applicable in "real world" settings such as rural and county clinics, and urban health centers; and design and conduct studies in partnership with minority communities to better understand the cultural, familial, and other factors that influence the adoption of health promotion and change high risk behaviors.
- Increase NIH's recruitment and training of Latinos in areas related to diabetes. Promote the inclusion of Hispanics in major clinical studies to reach population-appropriate conclusions.
- Increase funding to CDC programs to support comprehensive awareness and education programs in all 50 states. Provide diabetes information and messages through prime time television viewing hours, radio stations, newspapers, posters, and billboards. Provide funding for community-based organizations and community and migrant health care centers for diabetes education and treatment programs.
- Request information from the CDC regarding the status of the recommendations produced by the National Hispanic/Latino Diabetes Initiative for Action and the University of Illinois and the Promotora Diabetes Initiatives targeting Latinos. Request that the Health Care Financing Administration (HCFA) develop standards that address quality of health care for diabetics. Request that the Food and Drug Administration (FDA) continue its "Take Time to Care" campaign to use medications effectively.

### **HIV/AIDS and the Hispanic Community<sup>5</sup>**

Thursday, September 9, 1999

Testimony presented to the Congressional Hispanic Caucus resulted in numerous findings and recommendations.

### *Findings*

Hispanics account for 20 percent of new AIDS cases. In terms of new AIDS

cases, Hispanic men account for 20 percent of reported cases among all males, Hispanic women represented 19 percent of reported cases among all females, and Hispanic children made up 22 percent of cases among all children. In 1997, AIDS was the third leading cause of death among Hispanics between the ages of 25 and 44, and the tenth for Hispanics of all ages.

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*In 1998, Hispanic women had the second-highest rate of AIDS cases among all women.*

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The AIDS rate among Hispanic men is 3.3 times greater than white men, while Hispanic women have an AIDS case rate almost 7 times higher than their white counterparts. Hispanic children have an AIDS case rate almost 5 times that of white children. Among migrant farm workers, HIV prevalence is estimated between 3 percent and 13 percent. Multiple health problems and high mobility make delivering consistent medical care to this population very difficult. The two primary modes HIV is spreading among Hispanics are: individuals who have unprotected sex (46 percent) and individuals that inject themselves with drugs (39 percent).

In 1998, Hispanic women had the second-highest rate of AIDS cases among all women. Among Hispanic women, 52 percent of AIDS cases are from heterosexual transmission and 44 percent are due to injection drug use. The fastest growing number of HIV cases is among women (23 percent of new cases). Also, young people represent half of all new infections. Hispanic youth face risk of HIV infection from engaging in unprotected sex and/or injection drug use.

Hispanic adults are almost 8 times more likely than non-Hispanics to be illiterate; therefore, traditional means of disseminating disease prevention messages and healthy lifestyle recommendations often do not reach them. Consequently, prevention is one of the challenges to halting the spread of the HIV/AIDS epidemic.

Despite the advances in AIDS drug therapies that have led to drops in AIDS deaths, ethnic and racial minorities continue to lag behind. Between 1996 and 1997, deaths due to AIDS dropped 54 percent for whites, but only 44 percent for Hispanics, and 38 percent for African Americans.

Barriers that hinder the ability to fight the disease in the Latino community include: the community's unwillingness to recognize that AIDS is a problem; lack of specific research on sexual attitudes, beliefs, behaviors, and practices among Hispanics; lack of research on the factors which contribute to drug use/abuse; lack of data on Latino sub-populations; lack of access to health care that is culturally competent; fear of seeking health care due to immigration status; lack of participation in clinical trials and research; cultural factors such as religion, views of homosexuality, "established" gender roles; language differences; level of education; and limited knowledge and misconceptions about HIV/AIDS and its treatment.

The HIV Care Services Utilization Study (HCSUS) shows that many

Hispanics learned of their HIV status later in the course of the disease and were referred into care even later. Once in care, Hispanics were less likely to receive appropriate anti-retroviral therapies. Latinos have a higher rate of concern about HIV infection than other ethnic groups and this could be utilized to educate, motivate and mobilize community members. However, even when Latinos are aware of the risk factors for HIV/AIDS, they tend not to translate these risks as affecting them personally.

The CDC's national system for HIV surveillance does not reflect the trends in the epidemic among Hispanics because currently only 33 states and jurisdictions report HIV infection cases to the CDC. For instance, California, Puerto Rico, and Illinois do not report HIV cases to the CDC, Texas reports only pediatric cases, and New York is in the process of implementing its reporting system. HIV reporting data must be used judiciously. Surrogate markers for HIV infection (rates of infection from other sexually transmitted diseases and teen pregnancy rates) should be used to project trends and to target funding.

CDC's allocation of prevention-related resources does not reflect the current epidemiological trends (support for programs targeting racial and ethnic minorities, injection drug user populations, and men who have sex with men). CDC's HIV/AIDS budget in fiscal year 1999 indicates that about 9.9 percent (\$35 million) of \$353 million is targeted specifically to Hispanics.

### *Recommendations*

- Encourage national, regional, and local leaders to increase their involvement in the fight against HIV/AIDS. Tailor public information and education campaigns to Hispanic sub-populations and take into account region and national origin. Provide direct, age-appropriate, and culturally competent education. Increase attention to youth and women.
- Develop a national initiative to encourage testing. The initiative should target high-risk population groups. Coordinate national testing campaigns with local HIV Prevention Community Planning grants so that funds are linked to local demographics of the epidemic.
- Encourage participation of minorities in the planning groups created by CDC's HIV Prevention Community Planning, which is the primary process to get federal funding for prevention activities. Direct CDC to target resources to community-based organizations (CBOs) in the Hispanic Community for HIV prevention services. Populations reached by these CBOs include: gay men, youth, women, injection drug users, and immigrant and migrant populations.
- Increase appropriations for HIV/AIDS prevention, care services, and research. Provide funding for CBOs and national minority organizations to develop culturally sensitive and appropriate materials. Strengthen the Communities of Color Initiative. Increase funding for international HIV programs and for programs that seek to deliver capacity-building assistance to HIV prevention programs and services.
- Commit resources to standardize data collection procedures and conduct

- continuous analysis and reporting of Latino data. Explore techniques such as behavior modification to prevent HIV infection.
- Support the Ryan White CARE Act. Advocate for access to care and funding for early intervention through expansion of Medicaid. Include and develop a comprehensive system approach to the care of Latinos living with HIV infection.
  - Direct the Health Resources and Services Administration (HRSA) to develop and expand initiatives aimed at training Hispanic health professionals on current HIV treatment and care. Direct HRSA to standardize and regulate the formularies used by the states to access AIDS Drug Assistance Program (ADAP). Work with the Substance Abuse and Mental Health Services Administration (SAMHSA) to increase access to substance abuse treatment for Hispanics.
  - Request a report from CDC to establish the initiatives and resources allocated to serve the Hispanic community. Request a report from CDC to delineate its plans to address the under-representation of Hispanics in prevention community planning. The plan should address the disparities in the allocation of HIV prevention resources and ensure that states are channeling resources to populations with the greatest need for prevention services.

### **Mental Health and Substance Abuse<sup>6</sup>**

Thursday, September 9, 1999

The testimony presented to the Congressional Hispanic Caucus resulted in numerous findings and recommendations.

#### ***Findings***

SAMHSA is a model agency with several programs serving the Hispanic community. It launched new efforts to provide better service to Hispanic customers including six substance abuse prevention products developed by the Hispanic community. SAMHSA sees data collection as an important component of adequate health care and provides technical assistance to states to improve the quality of the data collected as part of the Substance Abuse Prevention and Treatment Block Grant and for the Community Mental Health Services Block Grant.

SAMHSA sponsored the development and distribution of national radio public service announcements in Spanish to help educate Latino youth and adults on the dangers of alcohol abuse. It has provided training in cultural competency among substance abuse treatment providers and sponsored a minority fellowship program to increase the pool of ethnic minority, doctoral-level mental health professionals and researchers. The agency has also sponsored increased service and prevention activities for ethnic minority individuals with mental health and substance abuse disorders.

Mexican American women are more likely to report severe depression than their non-Hispanic white or African American female peers. Fifty-three percent of Hispanic women responded to a survey that they were seriously

depressed, in comparison to 37 percent of non-Hispanic white and 47 percent of African American women. Adapting to a new culture is a significant factor for mental health problems and substance abuse among Hispanics. Recent immigrants are less likely to engage in risky activities than acculturated youth. Acculturation itself is also tied to increased rates of attempted suicides and depression among Hispanic girls, boys, and adults.

Between 1995 and 1997, substance abuse increased among Hispanic youth at the same time that it declined for non-Hispanic white and African American youth. Those at greatest risk appear to be Hispanic girls. Hispanic girls now lead girls nationwide in rates of suicide attempt, alcohol and drug abuse, and self-reported gun possession. Close to one out of every three Hispanic female high school students in 1997 had seriously considered suicide in comparison to one out of every five African American girls and one out of every four non-Hispanic white girls. Hispanic female students are almost twice as likely to have experimented with cocaine than their non-Hispanic white counterparts and more than 12 times as likely as their African American peers. However, fewer prevention or treatment services reach Hispanic girls than girls in any other racial or ethnic group. Hispanic girls are significantly less likely to have been taught about risks of HIV/AIDS in school than their African American and non-Hispanic white peers.

Little is known about whether mental health services are reaching Latino children. There is a critical lack of trained professionals who speak Spanish and this is a serious problem when it comes to evaluating the needs of bilingual children.

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*Between 1995 and 1997, substance abuse increased among Hispanic youth at the same time that it declined for non-Hispanic white and African American youth. Those at greatest risk appear to be Hispanic girls.*

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### **Recommendations**

- Set aside resource allocations to include Hispanics in all HHS programs and tailor services to the cultural needs of the Hispanic population. Put all Hispanic Caucus recommendations into the Hispanic Agenda for Action. Increase the availability and affordability of adequate health insurance for Hispanics.
- Support research to assess the accessibility and quality of mental health care to all Latinos, especially for groups not well represented in current published research, such as elderly Hispanics, mainland Puerto Ricans, Cuban Americans, and Central Americans.
- Make housing a component in addressing the mentally ill.
- Provide incentives for mental health systems of care to apply existing organizational technology to make services accessible to Latinos. Encourage



- local health agencies to include health consumers in the planning of services.
- Ensure that investigators, directors, and staff have the experience and qualifications to work with Hispanics to develop programs to recruit and train Hispanics in health professions. Hire staff that speak Spanish and are knowledgeable of Latino culture. Provide incentives for mental health systems of care to train existing practitioners and administrators to incorporate treatments that have proven effective with Latinos. Provide incentives for educational institutions to recruit and train practitioners who are able to communicate in Spanish at a professional level.
  - Continue working to increase and make available educational programs that develop medical, behavioral, and research careers for Hispanics. Provide incentives for educational institutions to carry out systemic training in treating Latinos with mental health problems. Provide incentives for the test industry to improve available tests for Latinos in general, and limited-English proficient Latinos in particular. Encourage local health agencies to partner with local health professional programs at colleges and universities to increase the pool of eligible health professionals adequately trained to work with the Hispanic community.
  - Ensure that prevention and treatment services are culturally competent and appropriate. Ensure that any public media campaign that is taking place is accompanied by culturally competent community-based prevention treatment programs.
  - Ensure health and mental health access for Hispanic families through outreach in both language-appropriate and culturally competent manners. Support new community-based models to promote positive cultural identification and adaptations among Hispanics to reduce the serious risk to Hispanic girls in particular. Provide language-appropriate and culturally sensitive programs to prevent child abuse. Support research to test cultural and linguistic translations of available evidence-based treatments so that Latinos can use them.
  - Encourage local health agencies to evaluate thoroughly the cultural and linguistic competence of their programs, management, and clinical staff. This would reduce the barriers to care and enhance accurate diagnosis and successful treatment interventions. Encourage local health agencies to sponsor cultural sensitivity seminars designed to enhance the knowledge base of administrators and direct service providers in culturally competent services in the Hispanic community.
  - Emphasize the need for performance monitoring and data that evaluate areas of success to identify effective programs. Adequate resources for these programs should be provided. Improve data collection on risk resiliency factors facing Hispanic girls and boys paying attention to Hispanic subgroups and geographic location. Support successful community-based strategies to promote resiliency among Hispanic girls and boys to strengthen Hispanic families. Support new community-based models to promote positive cultural identification and adaptation among Hispanics to

reduce the serious risk to Hispanic girls in particular. Provide child care services while parents seek treatment.

### **Acknowledgements**

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 U.S. Department of Health and Human Services, Office of the Surgeon General  
 Centers for Disease Control and Prevention, Division of Diabetes  
 National Institutes of Diabetes and Digestive and Kidney Diseases  
 Substance Abuse and Mental Health Services Administration  
 Presidential Advisory Council on HIV/AIDS  
 American Diabetes Association  
 National Hispanic Medical Association  
 National Council of La Raza  
 National Minority AIDS Council  
 National Latina/o Lesbian, Gay, Bisexual and Transgender Organization  
 National Coalition of Hispanic Health and Human Services Organizations  
 City of New York Health Policy Office

### **Endnotes**

**<sup>1</sup> The members of the Congressional Hispanic Caucus for the 106th Congress are:**

Rep. Lucille Roybal-Allard, Chair  
 Rep. Ciro D. Rodriguez, Chair, Health Task Force  
 Rep. Silvestre Reyes, 1st Vice Chair  
 Rep. Luis Gutierrez, Whip  
 Rep. Matthew Martinez  
 Rep. Solomon Ortiz  
 Rep. Jose Serrano  
 Rep. Ed Pastor  
 Rep. Xavier Becerra  
 Rep. Robert Menendez  
 Rep. Nydia Velasquez  
 Rep. Carlos Romer-Barcelo  
 Rep. Robert Underwood  
 Rep. Ruben Hinojosa  
 Rep. Loretta Sanchez  
 Rep. Charles A. Gonzalez  
 Rep. Grace Napolitano  
 Rep. Joe Baca

**<sup>2</sup> The members of the Congressional Hispanic Caucus Health Task Force are:**

Rep. Ciro D. Rodriguez, Chair  
 Rep. Robert Underwood  
 Rep. Carlos Romer-Barcelo  
 Rep. Ed Pastor

<sup>3</sup> Diabetes is a chronic disease due to insulin deficiency and/or insulin action associated with hyperglycemia. Insulin is a hormone needed to convert sugars, starches, and other food into energy essential for daily life. Type II diabetes, or non-insulin-dependent diabetes, develops when the body's cells resist insulin made by the pancreas and glucose remains in the blood stream.

<sup>4</sup> The Congressional Hispanic Caucus sponsored the "Diabetes and the Hispanic Community" hearing during Hispanic Health Awareness Week on September 8, 1999. Two sets of panelists testified before CHC Members about the impact of diabetes in the Latino community.

**Panel 1 participants included:**

Phillip Gorden, Director  
National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

Frank Vinicor, Director of the Division of Diabetes  
National Center for Chronic Disease Prevention and Health Promotion

**Panel 2 participants included:**

John Graham, Chief Executive Officer  
American Diabetes Association

Yanira Cruz Gonzalez, Policy Specialist  
National Council of La Raza

Dr. Elena Rios, President  
National Hispanic Medical Association (NHMA)

<sup>5</sup> The Congressional Hispanic Caucus (CHC) sponsored the "HIV/AIDS and the Hispanic Community" hearing during Hispanic Health Awareness Week on September 9, 1999. Two sets of panelists testified before members of the CHC about the impact of HIV/AIDS in the Latino community.

**The panel 1 participant was:**

Dr. David Satcher, United States Surgeon General

**Panel 2 participants included:**

Barbara Aranda-Naranjo, RN, Ph.D., member  
Presidential Advisory Council on HIV/AIDS  
University of the Incarnate Word, San Antonio, Texas

Martin Ornelas-Quintero, Executive Director  
National Latina/o Lesbian, Gay, Bisexual & Transgender Organization (LLEGO)

Miguelina Maldonado, Director of Government Relations  
National Minority AIDS Council (NMAC)

Ruth Roman, Policy Specialist  
National Council of La Raza (NCLR)

<sup>6</sup> The Congressional Hispanic Caucus (CHC) sponsored the "Mental Health and Substance Abuse and the Hispanic Community" hearing during Hispanic Health

Awareness Week on September 9, 1999. Two sets of panelists testified, before members of the CHC.

**The panel 1 participant was:**

Dr. Nelba Chavez, Administrator  
Substance Abuse and Mental Health Services Administration (SAMHSA)

**Panel 2 participants included:**

Dr. Jane Delgado, President  
National Coalition of Hispanic Health and Human Services Organizations  
(COSSMHO)

Dr. Rosa Gil, Special Adviser to the Mayor for Health Policy  
Office Of the Mayor of New York City

Dr. Steve Lopez, Professor  
University of California at Los Angeles

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## *Latino Health Facts and Sources*

### **Health Care Access**

- Latinos are most likely not to have health insurance in comparison to other ethnic groups. Overall, 39 percent of Latinos do not have health insurance compared to 24 percent of non-Latino African Americans and 13.8 percent non-Latino whites. The highest non-insurance rates among Latinos occur in Central and South Americans (44.3 percent) and Mexican Americans (41.6 percent).
- Latino children are three times more likely to be uninsured at 29 percent, which is more than twice the rate for Asian Americans (12 percent), whites (10 percent), and African Americans (10 percent).
- Lack of transportation and adequate child care pose serious obstacles for Latinos to access health care, regardless of insurance status.

### **Health Clinic Utilization**

- Forty-four percent of primary care clinic recipients are Latino — a rate higher than whites (35 percent), African Americans (8 percent), Asian Americans (5 percent), and other (8 percent).

### **Preventive Health Utilization**

- In California, 53 percent of Latino children were adequately immunized at two years of age in 1996, compared to 61 percent of white children, 44 percent of African American children, and 72 percent of Asian American children.
- Children who have one primary doctor have a higher rate of being adequately immunized. Lack of insurance, transportation, and time are cited as the biggest obstacles that families have when it comes to immunizing their children.

### **Cultural and Linguistic Competency**

- Spanish-speaking patients have been found to be less likely than English-speaking patients to receive sufficient preventive information or referrals

from their providers. Language barriers can result in misdiagnoses of illnesses or a physician obtaining inadequate consent from the patient.

- Spanish-speaking patients ask more questions when seen by bilingual providers.

### **Latino Physician Workforce**

- In 1993, although nearly one-third of the population in California was Latino, only 3 percent of all physicians were Latino. In comparison, 75 percent of physicians are white, 3 percent are African American, and 19 percent are Asian or of other racial/ethnic groups.
- In 1990, there were fewer Latino medical students per Latino population than in 1970.

### **AIDS**

- As of December 1996, 17,809 Latinos have been diagnosed with AIDS in California. Of all the new cases of AIDS that were diagnosed in California between 1985 and 1995, Latinos jumped from 11 percent to 24 percent of the total number, while new cases among whites declined by 25 percent.
- As of 1994, 209 Latinas diagnosed with AIDS accounted for almost 25 percent of diagnosed AIDS cases in California.

### **Diabetes**

- The American Diabetes Association estimates that close to 11 percent of Latinos in California have diabetes.
- In the nation, approximately 25 percent of Mexican Americans and Puerto Rican Americans between the ages of 45 and 74 have diabetes — twice the rate of the general population.
- Studies among Latinas show significantly higher death and complication rates during pregnancy due to the increased risk of established diabetes and of developing gestational diabetes mellitus (GDM). Women who develop GDM are at increased risk for developing diabetes after pregnancy as well.
- While 2 million or more Latinos in the United States have diabetes, only half know they have the disease.

### **Cancer**

- Leading cancer sites for Latinos are similar to those found for whites: prostate, breast, lung, colon, and rectum.
- Nationally, rates of occurrence and death due to lung cancer are lowest among Latinos. The rate of occurrence and deaths due to breast cancer in Latinas and prostate cancer in Latinos is relatively low in comparison to other ethnic groups.

- Cervical cancer rates among Latinas are higher than in any other group besides Vietnamese American women.

### **Smoking/Tobacco**

- Among Latinos, 24 percent of men and 15 percent of women smoke. Among Latino high school students, 35 percent of the boys, and 33 percent of the girls smoke.
- Six percent of Latinos and 3 percent of Latinas in high school use smokeless tobacco.

### **Births**

- Forty-five percent of all births are to Latinas, 37 percent to white mothers, 8 percent to African American mothers, and 10 percent to Asian American mothers or other ethnic backgrounds.

### **Life Expectancy**

- Among Latinos, life expectancy for males is 76.4 years and 84 years for women. Asian-Americans are the only group with higher life expectancies.

### **Offices/Centers**

Centers for Disease Control and Prevention  
1600 Clifton Road, NE  
Atlanta, GA 30333  
404-639-3311  
[www.cdc.gov](http://www.cdc.gov)

Latino Health Institute  
95 Berkeley Street  
Boston, MA 02116  
617-350-6900  
[www.lhi.org](http://www.lhi.org)

The National Alliance for Hispanic Health  
1501 16th Street, NW  
Washington, DC 20036  
202-387-5000  
[www.hispanichealth.org](http://www.hispanichealth.org)

National Hispanic Medical Association  
1700 17th Street, NW, Suite 405  
Washington, DC 20009  
202-265-4297  
[www.home.earthlink.net/~nhma](http://www.home.earthlink.net/~nhma)

National Latina/o Lesbian and Gay, Bisexual and Transgender Organization  
1612 K Street, NW, Suite 500  
Washington, DC 20006  
202-466-8240  
[www.llego.org](http://www.llego.org)

The Office of Minority Health Resource Center  
U.S. Department of Health and Human Services  
Rockwall II Building, Suite 1000  
5600 Fishers Lane  
Rockville, M.D. 20857  
800-444-6472  
[www.omhrc.gov](http://www.omhrc.gov)

Public Health Foundation  
1220 L Street, NW, Suite 350  
Washington, DC 20005  
202-898-5600  
[www.phf.org](http://www.phf.org)

### **Print Publications**

*Harvard Journal of Minority Public Health*  
Harvard School of Public Health  
677 Huntington Avenue, Kresge 1012  
Boston, MA 02115  
[www.harvardminorityhealth.com](http://www.harvardminorityhealth.com)

*Journal of Multicultural Counseling and Development*  
5999 Stevenson Avenue  
Alexandria, VA 22304  
800-347-6647  
[www.counseling.org/journals/jmcdinfo.htm](http://www.counseling.org/journals/jmcdinfo.htm)

*Journal of Rural Health*  
One West Armour Blvd., Suite 203  
Kansas City, MO 64111  
816-756-3140  
[www.nrharural.org](http://www.nrharural.org)

*La Salud Hispana Magazine*  
PO Box 1255  
Englewood Cliffs, NJ 07632  
888-887-2583  
[www.lasaludhispana.com](http://www.lasaludhispana.com)



### Latino Health Web Sites

California Latino Medical Association:

[www.latinomed.com/resources/clma.html](http://www.latinomed.com/resources/clma.html)

Center for the Study of Latino Health: [www.med.ucla.edu/cesla](http://www.med.ucla.edu/cesla)

Hispanic Dental Association: [www.hdassoc.org](http://www.hdassoc.org)

Hispanic Health Council, Inc.: [www.hispanichealth.com](http://www.hispanichealth.com)

Julian Samora Research Institute:

[www.jsri.msu.edu/RandS/research/irr/rr03.html](http://www.jsri.msu.edu/RandS/research/irr/rr03.html)

Latino Health: [www.latinohealth.org](http://www.latinohealth.org)

Latino Medicine: [www.latinomed.com/index.ncl](http://www.latinomed.com/index.ncl)

National Center for Farmworker Health: [www.ncfh.org](http://www.ncfh.org)

National Hispanic Leadership Initiative on Cancer:

[www.enaccion.bcm.tmc.edu](http://www.enaccion.bcm.tmc.edu)

National Institute of Health Hispanic:

[www.nih.gov/welcome/hispanic/index.html](http://www.nih.gov/welcome/hispanic/index.html)

National Latina Health Association: [www.clnet.ucr.edu/women/nlho](http://www.clnet.ucr.edu/women/nlho)

### Statistics sources

American Cancer Society, "Cancer Figures-1997" (1997)

American Diabetes Association, "Fact Sheet" (1997)

American Heart Association, "Biostatistical Fact Sheets" (1997)

Aranda, D. "Barriers to the Latino Community in Accessing Prenatal Care, Immunization and Diabetes Programs," Latino Coalition for a Healthy California (May 1997)

California Department of Health Services, Office of Women's Health. "Profile of Women's Health Status in California 1984-1994" (February 1997)

Latino Coalition for a Healthy California, "Ensuring Access to Health Care for Latinas in California," Latina Health Policy Project (1998)

Office of Statewide Health Planning and Development, *California Health Care Fact Book* (summer 1996)

State of California Department of Mental Health, *Race/Ethnicity of Clients Served in Local Mental Health-Fiscal Year 1989-90* (1992)

San Francisco AIDS Foundation, *A New Era For HIV/AIDS Care, Treatment and Services* (January 1997)

University of California, Health Insurance Policy Program, *State of Health Insurance in California, 1997* (1998)

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## *Call for Papers*

### *Hispanic Policy in the 21st Century*

The *Harvard Journal of Hispanic Policy* (HJHP) is currently accepting submissions for Volume 13: *Hispanic Policy in the 21st Century*, to be published in June 2001.

HJHP is a non-partisan scholarly review published by the John F. Kennedy School of Government and Harvard University. HJHP's mission is to educate and provide leadership that improves the quality of public policies affecting the Latino community and thus furthers the economic, social, and political empowerment of Hispanics.

HJHP is interested in manuscripts that emphasize the relationship between public policymaking and the economic, social, legal, and political environment affecting Latinos residing in the United States. Original research and analysis that propose innovative policy direction will be given highest publishing priority. A peer review process is used to select submissions for each year's publication. The review process is conducted through blind readings of all submissions — the author's name will not be disclosed to reviewers unless the article is selected for publishing.

#### **Submission Guidelines**

To be eligible for the editorial review, an article must satisfy the following requirements:

- Articles must be original
- Articles should be 15-25 double-spaced pages
- Articles should be formatted on any version of Microsoft Word
- Citations should be formatted according to the guidelines in the *Chicago Manual of Style*

In addition, the HJHP requests that all authors submit the following:

- A cover letter with the author's name, address, daytime phone number, and a brief biography
- Five hard copies of the article
- A copy of the article on a 3.5 IBM disk
- A 100 word abstract

#### **Please refer any inquiries to**

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