Centro de Estudios Puertorriqueños
Hunter College (CUNY)
POLICY REPORT | VOLUME 1 | NO. 4 | FALL 2007

The State of Latino Health and Mental Health

Gregory Acevedo, Ph.D., Fordham University
Manny J. González, Ph.D., Hunter College, CUNY
Victoria Santiago, Ph.D., Hunter College, CUNY
Carlos Vargas-Ramos, Ph.D., Hunter College, CUNY

The New York Latino Research and Resources Network (NYLARNet), is a consortium which brings together the combined expertise of U.S. Latino Studies scholars and other professionals to work on specific research projects in four target areas: Health, Education, Immigration, and Politics and Public Policy. NYLARNet was intiatiated by a partnership between the the Center for Latino, Latin American and Caribbean Studies (CELAC) at the University at Albany, SUNY, the Center for Puerto Rican Studies (Centro) at Hunter College, CUNY, and the Institute for Urban Minority Education (IUME) at Teacher's College, Columbia University.

The production of this policy brief was funded by the New York Latino Research Network (NYLARNet) sponsored by NY State Assemblyman Peter Rivera, Chair of the Puerto Rican/Hispanic Legislative Task Force.

Centro de Estudios Puertorriqueños
Hunter College (CUNY)
695 Park Avenue, Room E-1429
New York, New York 10065
212.772.5686
www.centropr.org

The State of Latino Health and Mental Health

Gregory Acevedo, Ph.D.
Assistant Professor
Fordham University
Graduate School of Social Service

Manny J. González, Ph.D.
Associate Professor
Hunter College
School of Social Work
City University of New York

Victoria Santiago, Ph.D.
Centro de Estudios Puertorriqueños
Hunter College
City University of New York

Carlos Vargas-Ramos, Ph.D.
Centro de Estudios Puertorriqueños
Hunter College
City University of New York

INTRODUCTION

Health conditions among Hispanics in the United States at the dawn of the 21st century are troubling.[1] Latinos/as in the United States are a growing population faced with dire health conditions and uneven access to services. This report provides an overview of Latino/a health status and concerns. Hispanics are more likely than non-Hispanic whites within the same age cohort to report being in fair or poor health, indicating a need for health services. There is substantial evidence that Hispanics' health care needs are largely unmet. Latinos/as encounter several barriers to health care access: lack of health insurance, transportation, and child care; underutilization of preventive health services; and limited availability of linguistic and culturally competent services. The high poverty rates among Hispanics, even for full-time workers, aggravate this situation.

The Centro de Estudios Puertorriqueños/Hunter College and Fordham University Graduate School of Social Service collaborated on this report to review the health and mental health status of Latinos/as. This analysis integrates national and local statistics from published reports and scholarly articles to explore: 1) methodological issues with health research and health care; 2) contextual factors affecting health status; 3) the major causes of national mortality for Latino/a populations; 4) New York City (NYC) prevalence data for diabetes and obesity to contextualize the gravity of this health care situation; and 5) key considerations on the mental health of Hispanics. Finally, we offer recommendations for further research and programmatic interventions to promote the increased well-being of the Hispanic population in the United States.[2]

METHODOLOGY ISSUES AND THE "HISPANIC PARADOX"

The population represented by the labels "Hispanic" or "Latino" varies in national origin, immigration status, place of residence, and socioeconomic status (SES). Although challenging, generalizing about the state of Hispanic health is a legitimate and on-going task in academia, public policy, and public discourse.

Despite the need for health research and policy making that specifically addresses the health of Latino/as, until fairly recently, most health research has been conducted on the non-Hispanic white male population. Non-Hispanic white males have been the basis for baseline patterns of morbidity and mortality and our understanding of health behaviors, knowledge, and attitudes.[4] As part of the recent emphasis in public health and policy on "health disparities," health research has increasingly focused on between-group differences in the prevalence of morbidity and mortality, as well as access to, and utilization of,

health services.[5] There has been a major shift in health research away from focusing on individuals to "population-based medicine," which recognizes that not all groups exhibit the same health profiles and focuses on investigating differences in health outcomes. Although the shift towards the study of between-group differences has been constructive for health research, this focus should not lose sight of the reality of substantial in-group differences among "Hispanics." As a pan-ethnicity, understanding Latinos/as requires a nuanced view that accounts for differences between the various subgroups that make up Hispanicity, such as Puerto Ricans and Mexicans. In addition, research must also account for differences within these subgroups, such as racial and ethnic diversity, immigration status, and rural and urban residence.

While behavioral, social, environmental, physiological, and genetic factors affect health outcomes, socioeconomic status (SES) is a powerful determinant of health.[6] Research into the impact of SES on health outcomes has identified a "SES-Health Gradient:" a consistent inverse relationship between SES and morbidity and mortality. This has been observed whether SES is measured using education, income, or occupational status. In light of the economic vulnerability of Hispanics and the barriers to health care access and utilization they encounter, the relationship between SES and health has important implications for Latino/a health research that need to be taken into account in research, treatment and prevention of disease.

Overall, these trends in health research underscore the need for developing Latino/a-based measures and models of health that might be used in creating policies and programs aimed at Hispanics. There is a wide range of factors that must be considered when establishing a profile of Hispanic health in the United States.

The "Hispanic Paradox"

An important consideration when interpreting the health status of Latinos/a populations is the "Hispanic Paradox," which has been the subject of much study and debate in healthcare research.[7] Latino/as exhibit an epidemiological paradox: In spite of high risk factors, in the aggregate Hispanics have lower age-adjusted mortality rates than other racial or ethnic groups for many primary causes of death (e.g., infant mortality, heart disease, certain cancers, stroke, chronic obstructive pulmonary disease, pneumonia and influenza, and suicide).[8] Yet, this paradox is not exhibited for other types of mortality. Compared to other racial and ethnic groups, Latino/a death rates have been higher for diabetes, HIV, homicide and legal intervention, and chronic liver disease and cirrhosis.[9]

However, one must be cautious when interpreting the significance of this epidemiological paradox. The primary factor affecting the dynamics of the Hispanic paradox is immigration. Among Latinos/as, it is immigrants who exhibit this favorable but unexpected health status, and even among the Hispanic immigrant population, the paradox is not universal, and depends on conditions in their home region/locality in their nation of origin. In addition, the longer they reside within the United States Hispanic immigrants exhibit a poorer health status. The evidence suggests that many Hispanic immigrants arrive in the United States healthier than the average native-born resident and that their health declines over time with continued residence and acculturation. This aspect of the Hispanic paradox should temper the public concern and debate regarding the burden or "cost" rendered to the U.S. health system by uninsured Hispanic immigrants.

Finally, it is essential that immigrant status and Hispanicity not be conflated; the majority of Latinos/as in the United States (three-fifths) are native-born. Granted, a substantial number of native-born Hispanics are children of immigrants, thus making the dynamics of immigration relevant for most Latino/a families and households.

CONTEXTUAL FACTORS AFFECTING HEALTH STATUS

Social and Physical Environments

Latinos/as tend to live and work in social and physical environments that are detrimental to health. Hispanics often work in conditions that are hazardous, such as demolition work in the building trades. Compounding this risk is the higher likelihood of Latinos/as to work in positions that are informal (i.e., "off-the-books") and therefore less likely to benefit from the enforcement of health and safety protections. This is evident in the overrepresenation of Latinos/as among those who die of unintended injuries (see Table 1). Hispanics frequently reside in communities rife with outdoor pollution and substandard housing.[10] Concerns about Latino/a exposure to pollution have become part of the debate over "environmental racism": the tendency for toxic industries (e.g., trash-to-steam plants) to be located in racial minority neighborhoods that lack the political clout to wage effective "not-in-my-backyard" political strategies. Outdoor pollution and indoor housing conditions (e.g., lead piping and paint, mold, mildew, dust, and pest infestation) have been linked to escalated rates of such diseases as asthma among Hispanics, especially Puerto Ricans.[11] Resources that may help counter some of these risks, such as access to green spaces and recreational/exercise facilities, are less available to Latinos/as.

An additional social and physical environmental concern is the high-need neighborhoods in which many Hispanics reside. These neighborhoods tend to suffer from epidemic-like rates of crime, gun violence, gang activity, and selling of illegal drugs. Such neighborhoods are prevalent in urban areas characterized by poverty and physical and social isolation, and are often associated with vulnerable and ineffective social institutions, atrophied local labor markets, failing schools, and distressed families.[12] These conditions increase the likelihood of such outcomes as homicides and substance addiction, and it is evident in the morbidity data where Latinos/as are overrepresented (see Table 1). Improving labor market conditions that Latinos/as experience would positively influence their health status. Better wages, benefits, and work environments would enable Hispanics to afford health insurance, minimize risk factors (e.g., work-related injuries and stress) and increase protective factors such as preventive care. Related to these goals should be improvement of the quality of education and training that Latinos/as receive.[13]

Resources are needed to promote Latino/a community social and economic development. Better schools, housing stock, green spaces and recreational areas, transportation, and child-care services within many Hispanic communities would do much to alleviate diseases such as asthma, obesity, and depression, as well as glaring social problems such as gang violence and drug-selling activity.

Healthcare Access and Utilization

Negative health conditions for Latinos/as are compounded by the barriers in access to health care they confront. For example, Hispanic children are substantially more likely than non-Hispanic children to lack health insurance, access to a primary care physician, and to be inadequately immunized. Access to health services is critical to health development across the lifespan, from the prenatal stage to the later years of adulthood. Barriers to health care include: the costs of care; lack of insurance coverage; limited availability of services (especially those that are delivered by linguistically and culturally competent providers); and undocumented status.

The lack of health insurance is a major determinant of health outcomes and is a national concern affecting nearly 46 million individuals (almost 15% of the total population) in 2004[14] and exacerbates disparities in access and health status.[15] Those with health insurance are more likely to receive the care needed to manage chronic conditions, treatment for acute conditions, and preventive health services.

Recent figures estimate almost 40% of Latinos/as in the United States lack any public or private health insurance.[16] Employment-based health insurance (EBHI) is the primary source of health insurance for the nonelderly population and Latino/a workers have lower rates of EBHI

than other racial and ethnic groups and the rate has actually declined since 1990. Hispanics are more likely to work for an employer that does not offer any health care coverage. This difference in the "offer" rate (the percentage of employees whose employers offer EBHI,) explains much of the disparity between Hispanics and non-Hispanic white employees, rather than eligibility criteria for benefits.

Hispanic workers disproportionately exhibit characteristics associated with low rates of EBHI. These include: lower educational attainment; youth, working full-time but for less than the full year; employment in a small firm, or in low-coverage industries and occupations; and having lower earnings and family incomes. In addition, citizenship and immigration status strongly affect the probability of working for an employer that does not offer health benefits. Even when EBHI is offered there are differences in the "take-up" rate (the percentage who accept EBHI offered by their employers when they are eligible) between Hispanics and non-Hispanics. More Hispanics than non-Hispanic whites declined the offer of EBHI due to high premiums.

Systematic disadvantages experienced by Hispanics in the labor market are detrimental to their overall health regardless of education and occupational levels.[17] Given the growth rate of the Latino/a population and its expanding share of the working-age population, access to health insurance is a major public policy concern.

MORTALITY

Major Causes of Death Among Latinos and Latinas Nationally

According to data collected by the National Center for Health Statistics, the leading causes of death for Hispanics are largely the same as those for other residents of the United States.[18] However, the proportions and the structure of these causes of death differ, sometimes significantly, from those that end the life of other people across the country (see Table 1).

TABLE 1 **Leading cause of death in US, 2003**

All Persons		% Death	Hispanic or Latino	% Latino Death
...	All causes	100.00	All causes	100.00
1.....	Diseases of heart	27.98	Diseases of heart	23.19
2.....	Malignant neoplasms	22.75	Malignant neoplasms	19.73
3.....	Cerebrovascular diseases	6.44	Unintentional injuries	8.54
4.....	Chronic lower respiratory diseases	5.16	Cerebrovascular diseases	5.46
5.....	Unintentional injuries	4.46	Diabetes mellitus	5.06
6.....	Diabetes mellitus	3.03	Chronic liver disease and cirrhosis	2.77
7.....	Influenza and pneumonia	2.66	Homicide	2.75
8.....	Alzheimer's disease	2.59	Chronic lower respiratory diseases	2.60
9.....	Nephritis, nephrotic syndrome and nephrosis	1.73	Influenza and pneumonia	2.42
10.....	Septicemia	1.39	Certain conditions originating in the perinatal period	2.15

Heart disease and cancer are the two leading causes of death in the United States and for Latinos/as. While these diseases accounted for more than 50% of the causes of death in the country, they accounted for less than 43% of Latino/a deaths in 2003 (the last year for which data are available). The proportion of deaths for cerebrovascular disease, chronic lower respiratory diseases, influenza, and pneumonia was lower among Latinos/as than among the population as a whole. Moreover, other leading causes of death among the general population (e.g., Alzheimer's disease; nephritis, nephritic syndrome and nephrosis; and septicemia) did not register as leading causes among Hispanics. On the other hand, factors such as chronic liver disease and cirrhosis, homicide, and certain conditions surrounding births, which are not leading causes of death among the population as a whole, ended life for higher proportions of Latinos/as. Furthermore, Hispanics suffered greater mortality from factors such as unintentional injuries and diabetes mellitus than the population as a whole.

TABLE 2 Leading cause of death for Males in US, 2003

All Males	% Male Death	Hispanic or Latino Males	% Latino Male Death
... All causes	100.00	All causes	100.00
1..... Diseases of heart	27.96	Diseases of heart	21.83
2..... Malignant neoplasms	23.96	Malignant neoplasms	18.60
3..... Unintentional injuries	5.87	Unintentional injuries	11.60
4..... Cerebrovascular diseases	5.11	Cerebrovascular diseases	4.51
5..... Chronic lower respiratory diseases	5.05	Diabetes mellitus	4.37
6..... Diabetes mellitus	2.95	Homicide	4.12
7..... Influenza and pneumonia	2.39	Chronic liver disease and cirrhosis	3.50
8..... Suicide	2.10	Suicide	2.51
9..... Nephritis, nephrotic syndrome and nephrosis	1.70	Chronic lower respiratory diseases	2.49
10..... Alzheimer's disease	1.53	Human immunodeficiency virus (HIV) disease	2.15

These patterns are replicated when mortality rates are broken down by sex. Heart disease, cancer, unintentional injuries, and cerebrovascular disease are leading causes of death for the overall male population as well as Latino males (See Table 2). However, the combined death rates from heart disease, cancer (malignant neoplasms) and stroke (cerebrovascular disease) are markedly higher in the overall male population (57%) than among Latino males (45%), and twice as many Latinos (12%) are likely to die from unintentional injuries as is the case for all males (6%). Influenza and pneumonia, kidney conditions, and Alzheimer's disease are among the top 10 leading causes of death for all males, but not for Latino males overall. On the other hand, homicide, liver disease and cirrhosis, and HIV register as leading killers of Latino males, whereas this is not the case for males overall.

TABLE 3 **Leading cause of death for Females in US, 2003**

Cause of death		% Female Death	Hispanic Females or Latinas	% Latina Death
...	All causes	100.00	All causes	100.00
1.....	Diseases of heart	28.00	Diseases of heart	24.92
2.....	Malignant neoplasms	21.58	Malignant neoplasms	21.15
3.....	Cerebrovascular diseases	7.72	Cerebrovascular diseases	6.66
4.....	Chronic lower respiratory diseases	5.27	Diabetes mellitus	5.94
5.....	Alzheimer's disease	3.62	Unintentional injuries	4.67
6.....	Diabetes mellitus	3.11	Influenza and pneumonia	2.82
7.....	Unintentional injuries	3.11	Chronic lower respiratory diseases	2.74
8.....	Influenza and pneumonia	2.92	Alzheimer's disease	2.23
9.....	Nephritis, nephrotic syndrome and nephrosis	1.76	Certain conditions originating in the perinatal period	2.17
10.....	Septicemia	1.53	Nephritis, nephrotic syndrome and nephrosis	2.04

Among women in general and Latinas in particular, the difference in rates for the top three killers (heart disease, cancer, and cerebrovascular disease) is narrower (See Table 3). These three factors result in the death of 57% of all women in the country and 53% of Latinas. Yet, the proportion of death among Latinas as a result of influenza and pneumonia, or chronic lower respiratory disease, or Alzheimer's disease is lower than that for the population as a whole. Septicemia, is not a leading cause of death among Latinas, as it is for the population as a whole. Certain conditions surrounding births however, are a leading cause of death for Hispanic women compared to women in general.

Thus far our focus has been on national-level incidences of mortality. Next, we contextualize these dynamics locally, focusing on obesity and diabetes in New York City. We do so because this is the population we serve most directly and because New York City is remarkable for the scale, diversity, and long-standing nature of its Hispanic population. Finally, the local context demonstrates the need to pay attention to between-group differences.

NEW YORK CITY PATTERNS

Obesity and diabetes are critical health problems for many New Yorkers and their incidence are closely monitored by the New York State Department of Health and the New York City Department of Health and Mental Hygiene (NYCDHMH). The NYCDHMH reports that "one in six New York City adults is obese and in neighborhoods such as Central and East Harlem, the South Bronx, East New York, Flatbush-Canarsie-Flatlands, Bedford Stuyvesant-Crown Heights, and Williamsburg-Bushwick, one in four adults is obese."[19]

Diabetes is a serious problem for Latino/as at the national level, and in New York City it is a significant health issue.[20] The Public Health

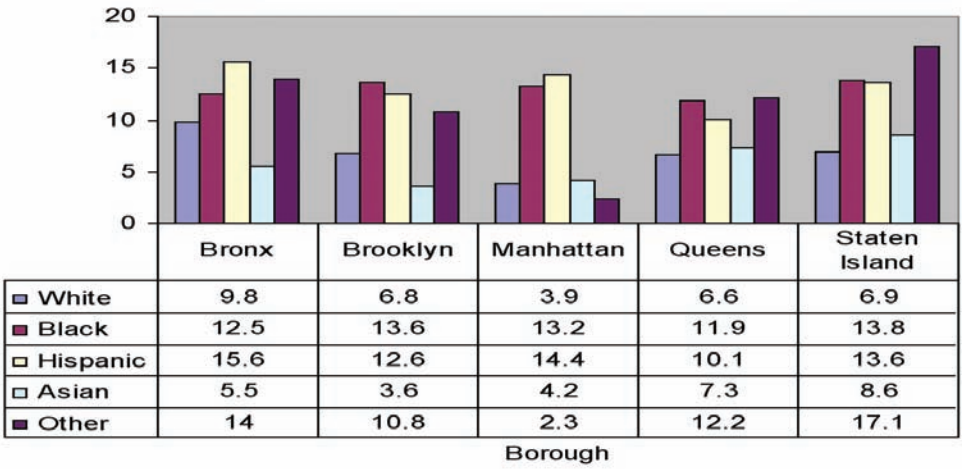
Association of New York City reports that "the diabetes type 2 epidemic and the associated rise in obesity and physical inactivity threaten public health, social justice, economic productivity, and the capacity of the city's hospitals and social services to respond to the city's health needs." They also note that:

- "Diabetes is the leading cause of hospitalization and death. The diabetes rate is one of the few increasing causes of death in NYC."
- "Diabetes worsens other health conditions. Those with the disease have 2–6 times greater the risk of death from heart problems than persons without diabetes."
- "In the past 8 years, diabetes has doubled among adults in NYC and the disparities between blacks, Latinos and Whites are widening the already large gaps in health among these groups."

Figures 1–4 review diabetes and obesity prevalence in 2004 for New York City. Obesity is highlighted because it is a major risk factor for diabetes, as well coronary and cerebrovascular diseases.

FIGURE 1

Diabetes Rates by Borough and Ethnicity

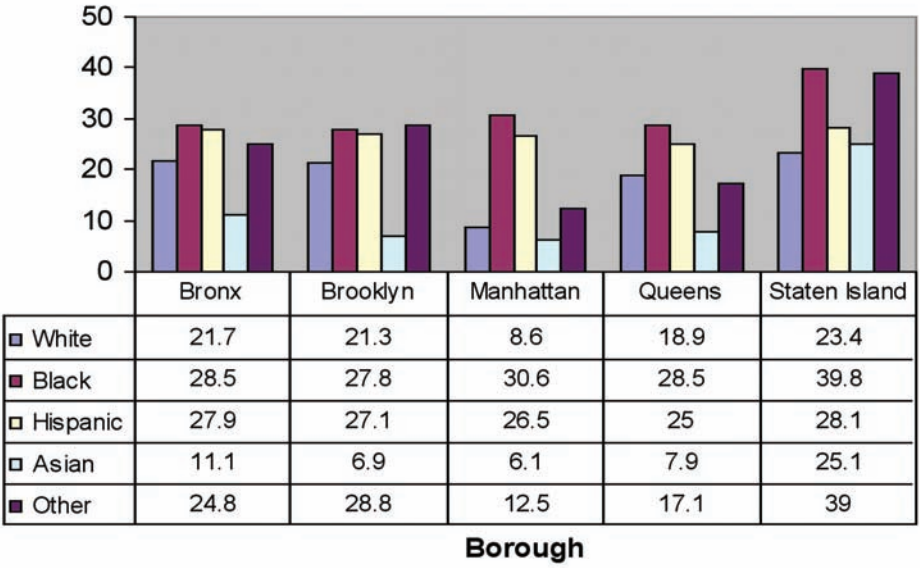


	Bronx	Brooklyn	Manhattan	Queens	Staten Island
White	9.8	6.8	3.9	6.6	6.9
Black	12.5	13.6	13.2	11.9	13.8
Hispanic	15.6	12.6	14.4	10.1	13.6
Asian	5.5	3.6	4.2	7.3	8.6
Other	14	10.8	2.3	12.2	17.1

Borough

Figure 1 describes diabetes prevalence rates by ethnicity and borough for the NYC respondents "who were ever told they have diabetes." The diabetes rate is the highest (15.6%) for Hispanics in the Bronx, followed by (14.4%) for Hispanics in Manhattan. This rate is almost four times higher than the rate of (3.9%) for White Manhattanites. For Brooklyn, the diabetes rate for Hispanics at (12.6%) is slightly lower than the diabetes rate (13.6%) for Black New Yorkers as is the case for Hispanics in Queens whose rate (10.1%) is lower than the rate for Blacks (11.9%). It should be noted that percentages for Staten Island provide unreliable estimates of prevalence due to small sample sizes.

FIGURE 2 **Obesity Rates by Borough and Ethnicity**



	Bronx	Brooklyn	Manhattan	Queens	Staten Island
White	21.7	21.3	8.6	18.9	23.4
Black	28.5	27.8	30.6	28.5	39.8
Hispanic	27.9	27.1	26.5	25	28.1
Asian	11.1	6.9	6.1	7.9	25.1
Other	24.8	28.8	12.5	17.1	39

Figure 2 provides obesity rates by ethnicity and borough for the NYC population. The obesity rate for Hispanics is at least 25% in Brooklyn (27.1%), Manhattan (26.5%), and Queens (25%), while the Bronx and Staten Island register the highest obesity rates in NYC at 27.9% and 28.1% respectively.

FIGURE 3 **Diabetes Rates by Ethnicity and Gender in NYC 2004**

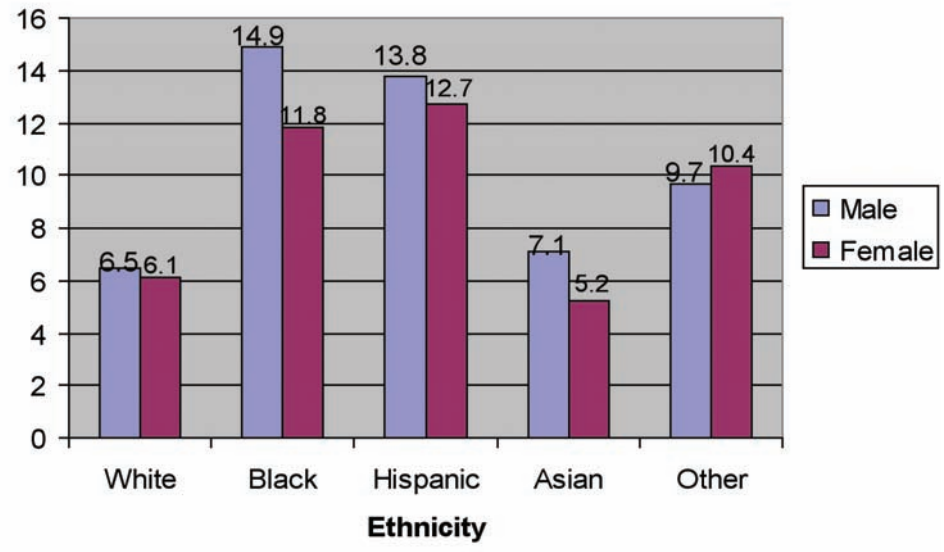


Figure 3 illustrates diabetes prevalence rates by ethnicity and gender for the NYC respondents "who were ever told they have diabetes." The rate for Hispanic males was 13.8%; the second highest rate after Black

males (14.9%) and double the White male rate of 6.5 %. Among women, the Hispanic female diabetes rate (12.7%) is the highest; slightly higher than the Black female rate of 11.8% and more than twice the White female rate (6.1%).

FIGURE 4 **Obesity Rates by Ethnicity and Gender in NYC 2004**

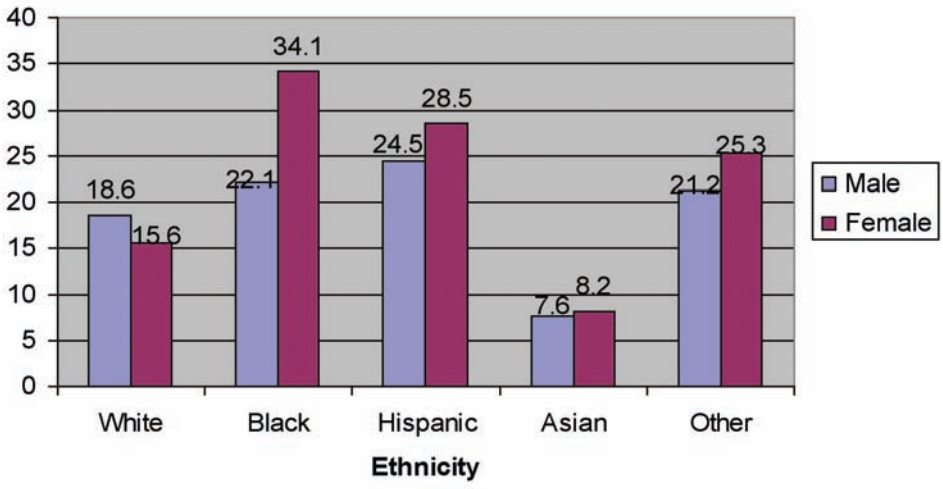


Figure 4 presents obesity rates by ethnicity and gender for the NYC population. The rate for Hispanic females was 28.5%; only the rate for Black females (34.1%) was higher. The Hispanic male obesity rate (24.5%) is the highest for males among all ethnic groups.
Thus far we have presented a profile of the physical health of Hispanics. No portrait of the overall well-being of the population would be complete without an analysis of the mental health of Latinos/as their access and utilization of mental health services.

MENTAL HEALTH AMONG HISPANICS

As with the case of general health services the underutilization of mental health services by Hispanics has been well documented in the literature. Hispanics encounter numerous obstacles that prevent them from successfully navigating the mental health system. These obstacles include language barriers, lack of health insurance, affordable mental health services, limited access to bilingual and bicultural mental healthcare providers, and lack of information on accessing mental health services. Research suggests that this is further compounded by higher rates of mental health disorders among Hispanics.[22] Kessler et al. and Malgady and Rogler have noted that Hispanics, in comparison to other ethnic groups and non-Hispanic Whites, exhibit higher prevalence rates of major depression, other mood disorders, and cognitive impairments.[23] Hispanics represent

a growing population in disproportionate need of mental health services.

Based on Guarnaccia and colleagues review of three national survey mental health studies—the Hispanic Health and Nutrition Examination Survey [HHANES],[24] the Los Angeles site of the National Institute of Mental Health Epidemiologic Catchment Area Program [ECA],[25] and the Mexican American Prevalence and Services Study [MAPSS Study][26] —important statements about the mental health status of Hispanics in the United States may be made.[27] Table 4 summarizes the rates of psychiatric disorder across three national studies on Hispanic mental health, and includes the rates for mental health disorders among Puerto Ricans living in Puerto Rico.[28] The findings of the Puerto Rico Island Study appear to indicate that Puerto Ricans living in Puerto Rico have similar rates of mental health disorders when compared to mainland United States residents of diverse ethnic and socioeconomic backgrounds.[29]

TABLE 4 **Rates of Psychiatric Disorders Across Major Studies of Latino Mental Health**

DIAGNOSIS	**LA-ECA** Mexican Americans (n=1243)	**Island Study** Puerto Ricans (n=1513)	**HHANES** Mariel Cubans (n=452)	**MAPSS** Mexican Immigrants (n=3012)
Major Depression	3.0%	3.0%	8.3%	9.0%
Panic Disorder	1.0%	1.1%	4.3%	1.7%
Phobia	7.3%	6.3%	15.6%	7.4%
Alcohol	5.3%	2.7%	6.0%	3.3%

SOURCE: Guarnaccia, P., Martinez, I. & Acosta, H. (2005). Mental health in the Hispanic immigrant community: An overview. In M.J. González & G. González-Ramos, *Mental Health Care for New Hispanic immigrants: Innovative Approaches in Contemporary Clinical Practice* (pp. 21–46). New York: Haworth Press.

Predicated on the findings of the Hispanic Health and Nutrition Examination Survey, Guarnaccia and colleagues noted that, in comparison to Cubans and Mexican Americans, Puerto Ricans had higher rates of both symptoms of depression and depression cases, and a greater prevalence of Major Depression Episode (a major mental health disorder). In their analysis of the National Latino and Asian American Study [NLAAS], Alegria et al. also observed that Puerto Ricans had the highest overall lifetime and past-year prevalence rates of psychiatric disorders (e.g., depressive disorders, anxiety disorders, substance use disorders, and overall psychiatric disorders) compared to Cubans, Mexicans, and other Hispanics.[30] A perceived sense of discrimination and low socioeconomic attainment may be two factors that negatively affect the psychological status of Puerto Ricans.[31] Review of the National Latino and Asian American Study suggests that overall psychiatric disorder prevalence rates are

higher among Hispanics who had migrated to the United States before the age of 13 years or after the age of 34 years than among those who had migrated at other ages.[32]

The findings of the Los Angeles ECA Study show that in comparing U.S.-born Mexican Americans to immigrants from Mexico, U.S.-born populations had higher rates of mental health disorders.[33] This finding parallels the central thesis of the literature on acculturation and mental health: acculturation to the norms and mores of the United States increases the risk of substance abuse and psychiatric disorders.[34] The Mexican American Prevalence and Services Study [MAPPS] provides empirical support for the notion that the process of acculturation negatively affects the mental health outcomes of Hispanics in the United States.[35] Guarnaccia and colleagues et al. observed that the most important finding of the MAPSS Study was that as Mexican immigrants acculturate to societal conditions in the United States their mental health worsens.

Hispanic groups who have entered the United States as refugees (e.g., Cubans) also experience significant mental health problems. Portes, Kyle, and Eaton found that Cubans who came to the United States during the Mariel era exhibit higher levels of phobia, major depression, and alcohol disorders compared to Mexican Americans and Puerto Ricans.[36] The mental health outcomes of Hispanic refugee groups must be diagnostically assessed within a socio-political-economic context. For example, in describing the family reunification issues that may affect the mental health functioning of Cuban Marielitos and *balseros* (rafters), González, Lopez, and Ko noted that Marielitos often struggled in their adaptation to U.S. life as a result of cognitive dissonance in comprehending the political-economic principles of capitalism and the structure of a democratic government.[37]

Understanding Hispanic mental health requires accounting for political, economic, and social conditions in the United States, but also necessitates that attention be focused on cultural factors among Latinos/as that affect mental health outcomes. It is necessary to educate mental health professionals about delivery of care to patients from different cultures in the United States. Sociocultural differences between clinicians and patients may influence healthcare communication and clinical decision-making. When these differences are not explored or understood within the clinical encounter, the results may lead to poor mental health and utilization outcomes. There is a lack of research on best practices for mental health treatment of Hispanics. Models of mental health treatment should incorporate and mirror the values of many Hispanic subgroups, including *respeto* (respect), *personalismo* (personalism) and *familismo* (the centrality of the family).[38]

The Institute of Medicine's recommendation to increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals is derived from evidence of the benefits of having a more diverse pool of practitioners delivering care.[39] It has been shown that minority clinicians are more likely than their nonminority colleagues to treat patients from minority backgrounds. It has also been found that, when there is concordance of race and ethnicity, patients are more likely to be satisfied and to adhere to treatment recommendations. Guarnaccia and colleagues et al. noted that ethnic matching (i.e., having Hispanic patients see Hispanic mental health practitioners) has been shown to be effective in aspects of mental health treatment and for some Hispanic groups.[40] This effect has mostly been studied with Mexican Americans in Los Angeles, but the finding has implications for the mental health treatment of other Hispanic groups.

In addition, one must consider not only the quality of mental health services, but also their physical accessibility. Seeking care in more naturalistic settings, such as through primary care centers, generally makes sense for many Hispanics, given the close association between the body and the mind in the Hispanic culture.[41] Hispanics have long been recognized to have a holistic understanding of health; even the language reflects the close ties between body and the mind. For example, *Estar sano* (to be healthy) usually denotes both health and mental health, without the split that can exist between the two in the delivery of services within the U.S.

There is one final aspect to consider in profiling the mental health of Hispanics: although we have an understanding of the mental health needs of the three largest Hispanic populations in the United States (i.e., Mexicans, Puerto Ricans, and Cubans), the study of emerging Hispanic subgroups (e.g., Dominicans, South Americans, and Central Americans) should be a high priority for behavioral and social scientists. The numbers of these Hispanic groups have expanded greatly during the past two decades, but there has been little or no research on their specific mental health outcomes. The need for psychiatric and epidemiological studies about new Hispanic immigrants, as well as services for them, is urgent.

HEALTH RECOMMENDATIONS

Based on our analysis of Hispanic health and mental health, we have generated a set of recommendations for policies targeting the health and mental health needs of Latinos/as and promoting their overall well-being. Aside from these specific recommendations, we call for more disaggregated data collection about Hispanic subgroups.

1. The most obvious policy priority is to increase Latino/a healthcare access and utilization. Instituting a national health care system that would guarantee health insurance coverage for all residents of the United States would have the most immediate and significant effect.
2. The most pragmatic policy would be increased government subsidies and coverage under such existing programs as Medicaid and state Children's Health Insurance Programs.
3. It is important to recognize that despite the immigration status of undocumented Hispanic immigrants, the majority do contribute to federal, state, and local taxes, and that there is a need for "safe havens" for hospitals to offer the undocumented preventive, acute, and chronic health care services, given their ineligibility for many services.
4. Another policy priority is to improve social and physical conditions in Hispanic neighborhoods. Federal, state, and local government can do so through: a) continued funding for participatory community research on the effects of and links between nutrition, obesity, and diabetes;[42] b) promoting accessible fresh food and the creation of organic farmers markets and community gardens; c) promoting green spaces and green belts between industrial blocks and residential zones, and the rerouting of traffic; and d) supporting the development of food cooperatives in all neighborhoods.
5. Expand efforts to regulate the inclusion of nutritious food in *bodegas* and grocery stores.
6. Increase the availability of safe and accessible exercise facilities.
7. In order to improve Latino/a access and utilization of health services, the linguistic and cultural competence of many agencies and organizations needs to be improved. One of the most practical goals would be to increase the numbers of linguistically and culturally competent Latino/a physicians and other health service providers.

MENTAL HEALTH RECOMMENDATIONS

1. Promote quality and cultural competence in mental health services by physically situating services in more naturalistic settings, such as in primary care centers.
2. Support more research on best practices for mental health treatment of Hispanics, and the creation of models of mental health treatment that incorporate and mirror the values of Hispanic subgroups.
3. Educate and train mental health professionals about delivery of care to patients from different Hispanic cultures in the United States.
4. Promote understanding among mental health professionals of the holistic association between the body and the mind in the Hispanic culture.
5. Increase the proportion of Hispanic health professionals.

Research into both Hispanic health and mental health must be more extensive. There is a need to study Hispanics across subgroups, their geographic contexts, immigration status, level of acculturation, and socioeconomic status. A final consideration regarding developing a health profile of Hispanics: often, data collected on Hispanics, health or otherwise, is not disaggregated. A number of national and local health agencies collect data for various Latino/a subgroups. Disaggregated data need to be collected and reported in order to fully capture and improve the health status of Latinos.

Given the growing significance of Latinos/as in the overall U.S. population, improving the state of health and mental health among Hispanics is a matter of national importance. As Brown and Yu comment, "It is not hyperbole to suggest that the future of the nation and its economy depend on the well being of Latinos."[43]

ACKNOWLEDGMENTS

The authors would like to thank Dr. Aixa Cintrón-Vélez, Senior Program Officer at the Russell Sage Foundation, Dr. Anthony De Jesús, Assistant Professor at the Hunter College School of Social Work and former Interim Director of the Center for Puerto Rican Studies, and Mr. Andrew Luecke, Assistant to the Interim Director of the Center for their contributions to the publication of this manuscript.

REFERENCES / ENDNOTES

1 In this report we follow federal Office of Management and Budget (OMB) guidelines for racial/ethnic categories, using "Hispanic" and "Latino" interchangeably.

2 The data sources include the New York City Department of Health and Mental Hygiene, the New York State Department of Health, the National Centers for Disease Control Behavioral Risk Factor Surveillance System, and the National Institutes of Health.

3 Hayes-Bautista, D. E. (2002). The Latino Health Research Agenda for the Twenty-first Century. In M. M. Suárez-Orozco & Mariela. M. Páez (Eds.) *Latinos Remaking America* (pp.215–235). Berkeley, CA: David Rockefeller Center for Latin American Studies, Berkeley, CA: University of California Press.

4 "Morbidity" refers to illness/disease and "mortality" to death.

5 Lerman-Garber, I., Villa, A. R., & Caballero, E. (2004). Diabetes and cardiovascular disease. Is there a true Hispanic paradox? *Revista de Investigación Clínica*, 56 (3), 282–296.

6 Anderson, N.B. & Armstead, C. A. (1995). Toward understanding the association of socioeconomic status and health: A new challenge for the biopsychosocial approach. *Psychosomatic Medicine* 57: 213–225.

7 Hayes-Bautista D. E. (2002); Sudano, J. & Baker, D. W. (2006). Explaining US racial/ethnic disparities in health declines and mortality in late middle age: The roles of socioeconomic status, health behaviors, and health insurance. *Social Science & Medicine*, 62 (4), 909–922.

8 For example, Hessol, N. A. & Fuentes-Afflick, E. (2005). Ethnic differences in neonatal and postneonatal mortality. *Pediatrics, 115* (1), e44–e51; Mensah, G. A., Mokdad, A. H., Ford, E. S., Greenlund, K. J. & Croft, J. B. (2005). State of disparities in cardiovascular health in the United States. *Circulation, 111*, 1233–1241; Health disparities experiences by Hispanics–United States (2004). *Morbidity & Mortality Weekly Report, 292* (19), 2330–2331; Prevalence of diabetes among Hispanics—Selected areas, 1998 2002. (2004). *Morbidity & Mortality Weekly Report, 53* (40), 941–944; Nath, S. D. (2005). Coronary heart disease risk factors among Cuban Americans. *Ethnicity & Disease, 15* (4), 607–614; Sheinfeld Gorin, S. & Heck, J. E. (2005). Cancer screening among Latino subgroups in the United States. *Preventive Medicine, 40* (5), 515–526.

9 For example, Cheung, R. C., Currie, M.A., Hui Shen, M.S., Ho, S.B., Bini, E.J. Anand, B.S., Bräu, N., & Wright, T. (2005). Chronic Hepatitis C in Latinos: Natural history, treatment eligibility, acceptance, and outcomes. *American Journal of Gastroenterology, 100* (10), 2186–2193; Lepe, R., Layden-Almer, J. E., Layden, T. J., & Colter, S. (2006). Ethnic differences in the presentation of chronic hepatitis C. *Journal of Viral Hepatitis, 13* (2), 116–120; Health disparities experiences by Hispanics – United States (2004). *Morbidity & Mortality Weekly Report, 292* (19), 2330–2331.

10 Vargas-Ramos, C. (2005). The State of Housing for Hispanics in the United States. *Centro de Estudios Puertorriqueños, Hunter College (CUNY), Policy Brief*, Volume 2, No. 1, Spring.

11 Santiago, V. (2007). Constricted Airways: Status of Asthma among Puerto Ricans and Latinos in New York State, *Centro de Estudios Puertorriqueños, Hunter College (CUNY), Policy Report*, Volume 1, No. 3, Spring.

12 Vigil, D. (2002). In Marcelo M. Suárez-Orozco & Mariela M. Páez (Eds.) *Latinos*

Remaking America (pp.97–109). Berkeley, CA: David Rockefeller Center for Latin American Studies, Berkeley, CA: University of California Press.

[13] De Jesús, A. & Vasquez, D. W. (2005) Exploring the Education Profile and Pipline for Latinos in New York State, *Centro de Estudios Puertorriqueños, Hunter College (CUNY), Policy Brief*, Volume 2, No. 2, Fall.

[14] DeNavas-Walt, C., B. D. Proctor, & C. Hill Lee (2005). U.S. Census Bureau, Current Population Reports, P60–229, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, U.S. Government Printing Office, Washington, DC.

[15] Brown, E. R. & Yu, H. (2002). Latinos' Access to Employment-based Health Insurance. In M. M. Suárez-Orozco & Mariela. M. Páez (Eds.) *Latinos Remaking America* (pp.236–253). Berkeley, CA: David Rockefeller Center for Latin American Studies, Berkeley, CA: University of California Press.

[16] Brown, E. R. & Yu, H. (2002). Latinos' Access to Employment-based Health Insurance. In M. M. Suárez-Orozco & Mariela. M. Páez (Eds.) *Latinos Remaking America* (pp.236–253). Berkeley, CA: David Rockefeller Center for Latin American Studies, Berkeley, CA: University of California Press; Latino health facts and sources. (1999/2000). *Harvard Journal of Hispanic Policy, 12,* 87–92.

[17] Brown, E. R. & Yu, H. (2002).

[18] *Health, United States, 2005*. Washington, DC: National Center for Health Statistics, 2005, Table 31.

[19] *NYC City Vital signs*, New York City Department of Health and Mental Hygiene, July 2003, Volume 2 no 7.

[20] "More than one in eight New Yorkers (800,000 adults) now have diabetes and the city's rate is a third higher than U.S. rate" *New York City Department of Health and Mental Hygiene, 2004*.

[21] González, M.J. & González-Ramos, G. (2005). Health disparities in the Hispanic population: An overview. In M.J. González & G. González-Ramos, *Mental Health Care for New Hispanic Immigrants: Innovative Approaches in Contemporary Clinical Practice* (pp. 1–19). New York: Haworth; Rogler, L.H., Cortes, D.E., & Malgady, R.G. (1991). Acculturation and mental health status among Hispanics. American Psychologist, 46, 585–597.; Rogler, L., Malgady, R. & Rodriguez, O. (1989). *Hispanics and mental health: A framework for research*. Malabar: Robert E. Krieger Publishing Company.

[22] Guarnaccia, P., Martinez, I. & Acosta, H. (2005). Mental health in the Hispanic immigrant community: An overview. In M.J. González & G. González-Ramos, *Mental Health Care for New Hispanic Immigrants: Innovative Approaches in Contemporary Clinical Practice* (pp. 21–46). New York: Haworth; Malgady, R.G. & Constantino, G. (1998). Symptom severity in bilingual Hispanics as a function of clinician ethnicity and language of interview. *Psychological Assessment*, 10(2), 120–127.

[23] Kessler, R., McGonagle, K.A., Zhao, S. (1994). Lifetime and 12-Month Prevalence Of DSM III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey. Archives Of General Psychiatry, 51, 9–19; Malgady, R. G.,&Rogler, L. (1993). Mental health status among Puerto Ricans, Mexican Americans, and non-Hispanic whites: The case of the misbegotten hypothesis. *American Journal of Community Psychology*, 21(3), 383–395.

[24] *Plan and operation of the Hispanic and Nutrition Examination Survey 1982–1984* (1985). National Center for Health Statistics, Washington, DC: US Government Printing Office.

[25] Karno, M., Hough, R. L, Burnham, M.A., Escobar, J.I., Timbres, D.M., Santana, F. & Boyd, J. H. (1987). Lifetime prevalence of specific psychiatric disorders among Mexican Americans and Non-Hispanic Whites in Los Angeles. *Archives of General Psychiatry*, 44, 695–701.

[26] Vega, W.A., Kolody, B., Aguilar-Gaxiola, S., Alderate, E., Catalana, R. & Carveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry*, 55, 771–778.

[27] Guarnaccia, P., Martinez, I. & Acosta, H. (2005).

[28] Canino, G.J., Bravo, M., Rubio-Stipec, M., Bravo, M., Martinez, R., Sesman, M., & Guevara, L.J. (1987). The prevalence of specific psychiatric disorders in Puerto Rico. *Archives of General Psychiatry*, 44, 727–735.

[29] Guarnaccia, P., Martinez, I. & Acosta, H. (2005).

[30] Alegria, M. Mulvaney-Day, N., Torres, M., Oddo, V., Polo, A., Zhun, C. & Canino, G. (2007). Prevalence of psychiatric disorders across Latino subgroups in the United States. *American Journal of Public Health*, 97, 68–75.

[31] Oquendo, M., Elllis, S., Greenwald, S. Malone, K., Wiseman, M. & Mann, J. (2001). Ethnic and sex differeneces in suicide rates relative to major depression in the United States. *American Journal of Psychiatry*, 158, 1652–1658.

[32] Mulvaney-Day, A. M., N., Torres, M., Oddo, V., Polo, A., Zhun, C., & Canino, G. (2007). Prevalence of psychiatric disorders across Latino subgroups in the United States. *American Journal of Public Health*, 97, 68–75.

[33] Guarnaccia, P., Martinez, I. & Acosta, H. (2005).

[34] Vega, W.A., Kolody, B., & Valle, J.R. (1987). Migration and mental health: An empirical test of depression risk factors among immigrant Mexican women. *International Migration Review*, 21, 512–529.

[35] Vega, W.A., Kolody, B., Aguilar-Gaxiola, S., Alderate, E., Catalana, R. & Carveo-Anduaga, J. (1998).

[36] Portes, A., Kyle, D. & Eaton, W.W. (1992). Mental iones and help-seeking behavior among Mariel Cuban and Haitian refugees in South Florida. Journal of Health and Social Behavior, 33, 283–298.

[37] González, M.J., Lopez, J.J. & Ko, E. (2005). The Mariel and balsero Cuban immigrant experience: Family reunification sigues and treatment recommendations. In M.J. González & G. González-Ramos, *Mental Health Care for New Hispanic Immigrants: Innovative Approaches in Contemporary Clinical Practice* (pp. 141–153). New York: Haworth.

[38] González, M., & Acevedo, G. (2006). Psychological interventions with Hispanic patients: A review of selected culturally-syntonic treatment approaches. In J. Rosenberg & S. Rosenberg (Eds.) *Community Mental Health: Challenges for the 21st Century* (pp.153–165). New York, NY: Routledge.

[39] *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (2003). Institute of Medicine Washington, DC: National Academy Press.

[40] Guarnaccia, P., Martinez, I. & Acosta, H. (2005).

[41] González, M.J. & González-Ramos, G. (2005).

[42] Lipson, P. *South Bronx Environmental Health and Policy Study* (Serrano). The South Bronx study focused on the increase of environmental causes for high asthma rates for children & residents in areas where there are multiple sources of pollution.

[43] Brown, E. R. & Yu, H. (2002). Latinos' Access to Employment-based Health Insurance. In M. M. Suárez-Orozco & Mariela. M. Páez (Eds.) *Latinos Remaking America* (pp.236–253). Berkeley, CA: David Rockefeller Center for Latin American Studies, Berkeley, CA: University of California Press.

Centro de Estudios Puertorriqueños
Hunter College (CUNY)
695 Park Avenue, Room E-1429
New York, New York 10065
212.772.5686
www.centropr.org

Centro de Estudios Puertorriqueños
Hunter College (CUNY)
695 Park Avenue, Room E-1429
New York, New York 10065
212.772.5686
www.centropr.org