Latinos in Mental Health: Barriers impacted amidst the COVID-19 Pandemic and their Potential Improvements

Adely Martinez

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David La Fazia

Gino Aisenberg

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Abstract

Latinos in Mental Health: Barriers Impacting Amidst the COVID-19 Pandemic and their Potential Improvements

Adely Martinez

Chair of the Supervisory Committee:

Dr. David La Fazia

Department of Social Work

The study aims to understand how the COVID-19 pandemic has impacted Latino's access to mental health services. The qualitative exploratory study outreach was completed among social media platforms, non-profit institutions, and educational institutions across eastern, central, and western Washington areas. A total of 8 Latino identifying adults that were in the process of receiving mental health services, or, currently utilizing mental health services during COVID-19 were interviewed. The interviewees acknowledged their understanding of the mental health system. To acknowledge their understanding semi-structured interviews were conducted. These involved the use of visual images and questions around what may exist at individual and institutional levels while navigating mental health services. Participants were able to supply recommendations on how they would like to see the mental health system improved. Major findings suggested that barriers are elevated when accessing services on a multitude of levels: macro, mezzo, and micro. Findings confirmed that telehealth mental services in the United States are not readily accessible for the Latino community. Participants recommended institutional, community, and accessibility changes.

Introduction

The U.S Latino population was at 50.7 million in 2010 and as of 2019 it reached a 60.6 million (Bustamante, Lopez, Krogstad, 2020). Latinos are estimated to account for 18.5% of the US population (Census, 2019). In 33 states, Latinos account for 58% of the population; in the remaining, they account for 7% (Rosentiel, 2011). Health insurance, health care costs, ability to communicate (language), legal status, discrimination, and transportation have made accessibility for mental health services difficult for the Latino community (Cristancho, Garces, Peters, Mueller, 2008). Barriers are already known to exist on micro and institutional levels for the Latino community when accessing mental health services. On a micro-level therapist have been known to have biases towards Latinos (Hansen et.al, 2006). On an institutional level, racial and ethnic disparities persist through language barriers, lack of disseminating services, and lack of culturally relevant mental health service providers.

The onset of the COVID-19 pandemic "has spotlighted racial and ethnic disparities when accessing behavioral health care" (SAMHSA, 2020). While many racial groups have been impacted, the focus of this study is the Latino community, and how they have been impacted receiving mental health services during the COVID-19 pandemic. It is important to recognize the added-on layers and barriers Latinos are experiencing while utilizing services during the pandemic. In this study, utilization is defined as the ability of a Latino effectively being able to navigate the mental health services when onboarding services (paperwork, insurance, finding appropriate institution), and when they are utilizing services they have been placed within. Utilization of mental health services becomes a possibility when looking at Latino accessibility.

Accessibility equates to one's ability to complete the task they are trying to achieve without encountering a barrier or issue (Duggin, 2016).

Literature review

The U.S. Department of Health and Human Services defines mental health as emotional, psychological, and social well-being (2020). In the Latino community, there is a trend of underutilization of mental health services (Hansen et. al, 2006). Latino individuals feel that mainstream mental health services cannot adequately address their specific needs, and that non-Latino therapists may be insensitive to their psychosocial needs (Hansen et.al, 2006).

For mental health service providers to adequately support the mental health needs of the Latino community, it is important to understand the difficulties experienced by Latino clients when attempting to or when receiving mental health services.

Latinos navigating mental health

Approximately 34% of Latinos access mental health compared to the U.S. average of 45% (NAMI, n.d). Mental health is valuable to address due to Latinos limited access to mental health services. It has been found that US mainstream services focus on long-term goals, and Latinos prefer services that are focused on the issue they're currently experiencing (Hansen, Kouyoumdjian, Zamboanga, 2006).

Cultural sensitivity is also important to consider when providing Latinos with mental health services. Cultural sensitivity equates to the integration of removing racial barriers and ethnic barriers (McGregor, Belton, Allyson, Henry, Tracey, Wrenn, Glenda, Holden, Kisha, 2019). Racial and ethnic barriers involve physical, and cultural identities that influence the Latinos beliefs, and practices in their life, racial, and, ethnic practices may affect their access or use of mental health services (ASA, n.d.). Being able to integrate cultural sensitivity involves

five things that can be remembered through the acronym CRASH: C, consider culture; R, show respect; A, assess and affirm differences; S, show sensitivity and self-awareness; H, and do it all with humility (McGregor, Belton et. Al, 2019).

Overall, institutions that provide integrated care include a combination of primary care, and behavioral healthcare services (McGregor, Belton et. al, 2019). Research has shown that the integration of health care services has been beneficial for racial/ethnic minorities in reducing behavioral health disparities (McGregor, Belton et. al, 2019). Another study found it valuable for informal language metaphors based on the regional area that the Latino is located within helped ameliorate translation of symptoms and diagnosis utilized in the mainstream services (Magana, 2019). For example, depression translates over as *nervios* (translation: nerves) for some in the Latino community (Magana, 2019).

Even though clinicians may be the designated individual to provide mental health-related services, even they can lack the ability to comprehend the Latino culture when providing services (Hansen et.al, 2006). A suitable implementation of culturally sensitive services involves 8 cross-cultural factors (Furman, Negi, Iwamoto, Rowan, Shukraft, Gragg, 2009). Harper and Lanz (1994), found that cross cultural skills are needed for culturally competent social work practice. Harper and Lanz (1994), identified a total of 8 cross cultural factors: respecting a client's worldview, bearing hope, effective helping agent, abiding by techniques that empower clients, and enabling them to feel control over their lives (Furman, Negi, Iwamoto, Rowan, Shukraft, Gragg, 2009). A meta-analytic study reveals CSI's (culturally sensitive interventions), interventions that focus on a target population's culture, have a turnout of beneficial outcomes around external behaviors, and physical outcomes (Hodge Jackson Vaughn, 2010). Further,

CSI's play a role in addressing health disparities among populations that are large (Hodge Jackson Vaughn,2010).

Disparities in accessing health care: mental health

In a study comparing Latino adults and non-Latino Whites with similar mental health problems found that Latinos underutilize mental health services (Cabassa, Zayas, Hansen, 2006). For example, Latinos, diagnosed with a mental health issue under the Diagnostic and Statistical Manual of Mental Disorders (DSM) within a six-month period of diagnosis were less likely to visit a mental health specialist when compared to their White counterparts (Cabassa, Zayas et. al, 2006). Some disparities that occur when accessing mental health begin with Latino individuals having low acculturation levels. Acculturation can be defined as a minority, in this case Latinos, being able to conform and follow cultural practices of the dominant culture which for this study would be white, westernized culture (Berry, 2017). Research has found that Latinos were less likely to use mental health services than Latinos with high acculturation levels; 13.4% to 4.0% (Cabassa, Zayes et. al, 2006). The findings suggest there is a lack of using the proper language translation, obtaining all-inclusive psychosocial history, a proper mental status examination, and any other use of relevant information diagnosing the patient (Hansen et. al, 2006). Lastly, Latino individuals may not approach mental health services due to a lack of mental health institutions disseminating services that are available to address one's mental health needs (Hansen, et.al, 2006).

COVID-19 Disparities. The United States has more confirmed deaths from coronavirus 2019 (COVID-19) than any other country in the world" (Summers-Gabr, p. S222, 2020). Since June 7th, 2021, there has been a total of 3.7 million deaths from COVID-19 in the United States(Elflien, 2021). The Latino community specifically has had a 34.4% death rate as of May

26th, 2021, totaling 107,105 Latino deaths. (Despres, 2021). According to the CDC data from June 2nd, 2021, Latinos currently comprise 28.8% of COVID-19 cases in the United States, second only to Whites (50.1%) (Despres,).

Many low-income minority individuals are frontline workers who are performing essential services. Therefore, putting themselves at risk of contracting the virus because their jobs involve close contact with the public (Smedley, 2020). In addition there is deep economic anxiety relative to job loss which is disproportionately among people of color (Smedley, 2020). This leaves them with no other choice than, working or putting oneself or one's family at risk (Smedley, 2020). Overall, this means that social, structural, geographical, and economic factors that were already barriers when accessing health services are now amplified (Smedley, 2020)

While issues accessing resources or basic needs have become much more difficult as a result of COVID-19, the United States government has tried to bridge some of the barriers that come with accessing mental health by implementing telehealth (Summers-Gabr, 2020). Many limitations come with providing telehealth; for one, this means that individuals must have access to the internet, secondly, the capacity to pay for such services, and lastly, own the appropriate devices to utilize telecommunication (Summers-Gabr, 2020).

The Federal Communications Commission (FCC) issued a policy stating telecommunicating services would not be terminated, or late fees charged for 60 days, and that they would provide surrounding hotspot services, as well as technological gear through libraries and schools (Summers-Gabr, 2020). The Coronavirus aid, relief, and economic security act (CARES Act) allowed for $100 million to be provided to the USDA for the Reconnect Program, providing internet services to rural areas (Summers-Gabr, 2020). The CARES Act is a 2.2 trillion economic stimulus bill passed by the 116th U.S congress, and signed into law by the

president on March 27th, 2020 (Pramuk, 2020). The CARES Act allotted $200 million towards telehealth which hospitals and other healthcare centers could use towards their patients (i.e., purchasing communication devices) (Summers-Gabar, 2020). Despite the changes, there are several limitations, for one, $100 million is not enough to provide nationwide access to the internet. There must be $80 billion invested (Sumers-Gabar, 2020). Secondly, the $200 million invested in the healthcare centers assumes that patients already have access and are just in need of the telecommunication device (Summers -Gabar, 2020). Lastly, the changes made with the available funding are not known to be a hundred percent sustainable causing uncertainty (Summers-Gabar, 2020). The uncertainty of the sustainability of the funding can be for numerous reasons the biggest one being that funding does not determine the accessibility of one's telehealth use. In conjunction, uncertainty of funding creates a limited time of being able to utilize telehealth. The funding itself also assumes that telehealth is made accessible by simply allocating money to access broadband services. Funding provides access to the device required; it does not take into consideration the knowledge needed to set up a broadband connection. Along with navigating this barrier, it also does not consider the knowledge needed with navigating and using the device past connecting it to the internet (i.e., ability to navigate telehealth sites, Zoom, Webex, Skype, etc.). Many Latinos lack access to the internet or access to healthcare from institutions that offer telehealth, while others may be lacking technology and have limited ability to speak with English-speaking providers (Sukumaran, 2020).

Another study revealed the use of digital content curation as a public health tool to bring awareness to Latinos on social health messages surrounding knowledge on COVID-19. These tools can be used in schools for students experiencing trauma, and how their voices can be used to bring about health equity through social media platforms, blog posts, peer models, digital

voicing campaigns, etc. (Despres, Aguilar, McAlister, Ramirez, 2020). These public health tools provided were evaluated over 42 weeks. Findings suggested user increase tripled compared to 2019 users (Despres, et. al, 2020). While website use has increased, this does not signify that Latino's knowledge of health has increased.

Before COVD-19, Latinos, underutilized mental health services due to socioeconomic, and cultural barriers (Rastogi et.al, 2012). For Latinos, negative mental health experiences involve language barriers, discrimination, or poor treatment impacting the utilization of services (Rastogi et.al, 2012). When examining language barriers, paperwork required to receive services and seeking services is the primary difficulty in utilizing mental health care services (Rastogi et. al, 2012). Along with this barrier, it is important to recognize that there are only 5% of physicians in the United States that identify as Latino (AAMC, 2021). The assumption that can be made that these are the few physicians in the country that would be able to provide cultural and bilingual services. Another factor that plays into Latinos utilizing mental health services is the lack of insurance; 32% to 37% of Latinos are without health insurance compared to 16% of all Americans (Rastogi et.al), 2012). Knowing that insurance was a barrier before COVID-19, it can be expected only to increase as Latino's ability to access face to face support is now remote. Latinos seeking mental health services must have access to a phone, and have knowledge of what numbers or websites should be accessed for support around acquiring, or utilizing insurance.

Considering the existing barriers to healthcare for Latinos because of social determinants of health (social factors that play into one's ability to utilize health services), it is plausible that the COVID-19 pandemic places the mental health of Latinos at higher vulnerability (SAMHSA, 2020). Data from the U.S Census Bureau states that 63% of Latinos experienced "not being able to stop or control worrying" another poll reveals that over 20% of Latinos suffering increased

anxiety due to the virus and lockdown (McCormack, 2020, paras. 7—10). Sixteen percent of Latinos report suffering from increased stress because of COVID-19 experiences (McCormack, 2020). COVID-19 has caused some health services to be virtual, or in other words telehealth (SAMSHA, 2020). This means meeting with a provider went from face-to-face interaction to meeting over a phone call, or possibly a video call. Telehealth implies that while other barriers like transportation, and location may be eliminated, other barriers are brought to light for Latinos; this would include internet access or phone access to communicate with providers and receive services remotely over the electronic device (phone, tablet, laptop, etc.). While it is very common for many people to have cellular devices that does not eliminate the cost. COVID-19 has caused a lot of economic loss – resulting in being able to pay for electronic devices that could be eliminated out of their budget. Even if they can economically maintain these devices, many Latino communities may not have regular access to the internet, providing an extra layer of difficulty when participating in telehealth services (SAMHSA,2020). Data from the Pew Research Center show that Latinos use technology at similar rates to other groups in the USA (79%, Latinos compared with 82% for the White) (Silva, Perez, Añez, Paris, 2020). Despite this finding, multiple factors might make the transition to telehealth stressful, such as living situations that include insufficient space, or privacy at home, and restricted access to internet data, Wi-Fi, or a large enough viewing screen (Silva et. Al, 2020).

COVID-19: Mental Health of Latinos. The American Psychiatric Association reports that Latinos have experienced changes because of COVID-19. A few of these experiences involve anxiety from an inability to follow through with stay-at-home protocol recommendations that protect them from COVID-19 pandemic; grief from the loss of friends and family members, separation from friends, and family; difficulty communicating especially those that required

hospitalization and struggled to speak to health care workers as a result of language barriers (American Psychiatric Association, n.d.). Changes persist as Latinos were unable to access tech that allowed work, school, and social interaction; emotional stress from living situations and locating care for children out of school; the financial stress of healthcare costs, job loss, and lastly ongoing difficulties accessing health care services (American Psychiatric Association, n.d.). These are just a few examples of how stress for the Latino community is inflated as a result of social determinants of health. The inflation of barriers can cause an increase in mental health issues for a Latino who was already experiencing mental health difficulties

Gaps and limitations. Based on the review of the literature, there are multiple limitations and gaps. Methodological limitations include, the limits in the way researchers are specifically measuring Latinos' use of telehealth, their lack of use, barriers or accessibility of telehealth concerning mental health. Gaps occurred through limited qualitative findings that exist surrounding Latino clients, and their personal experience in mental health and how this has changed amidst COVID-19. Similarly, there is a lack of knowledge on how telehealth training is being implemented to support Latinos in the context of COVID-19. Lack of knowledge exists upon how mental health services provide culturally humble services remotely. Lastly, while one institution has utilized digital content curation as a public health tool to increase health equity, there is a lack of knowledge on how this is beneficial, as only online usage was measured, rather than knowledge increase from site users. Overall, the experience of Latinos utilizing mental health services has not been brought to light during the pandemic.

Final assessment. Research findings conclude that some practitioners are lacking experience when implementing mental health services for the Latino community. There is a lack of perspective from Latino clients and how they would like to be provided services under the

context of mental health. Along with these issues, there are also structural inequalities that further prevent access to mental health care as well as access to other forms of care.

Specifically, during COVID-19 because of limitations placed as a result of social distancing measures to protect infection of COVID-19, there were underlying disparities in health care access, and in health care outcomes (Belmonte, 2020). To understand the effects and outcomes that have impacted Latinos' access to mental healthcare services more research is needed around current Latino clients' personal experiences when navigating the mental health care services and how the quality of services can be improved during a pandemic.

Methods

The exploratory qualitative study examined how the COVID-19 pandemic has impacted Latinos' access to mental health services. One-on-one semi-structured interviews were conducted with a total of eight Latino adults. Latino adults were found through various platforms (social media, nonprofit institutions, and student groups). Interviews explored barriers that have been intensified due to the COVID-19 pandemic. Furthermore, the study allowed for Latinos to propose potential solutions to these barriers. In order to reveal these findings, a thematic analysis was conducted. All study materials and procedures were approved by the Institutional Review Board of the University of Washington.

Recruitment

Materials used for recruitment consisted of flyers both in English and Spanish; similarly, the general outreach message attached separately above the flyer was both in English and Spanish. The flyer consisted of the title of the project, contact information and three brief questions: whether they were Latino, if they had received or were trying to receive mental health services, and lastly if they were interested in voicing their experiences. Lastly, a direct phone

number was provided so that potential participants could contact the primary investigator for further information. The generalized outreach statement attached above the flyer stated the principal investigator's name and provided general background information on the identity of the investigator, and the purpose of the study. Recruitment was completed via Facebook, Instagram, LinkedIn, student groups at the University of Washington, and finally through two Latino-serving nonprofit institutions. Recruitment was conducted around the eastern, central Washington, and Seattle area, but the study was open to any Latino located in the United States. Any individuals that were interested in participating could contact the primary investigator via direct message on social media platforms or through the email, and phone number provided on the outreach statement. Once participants contacted the primary investigator, further screening was conducted to find out if they were Latino, and whether they were utilizing or had utilized mental health services. In addition, they were provided copies of the consent form by email or text depending on their preference. The consent form detailed the purpose, benefits, risks of the study, rights of participants, and specifically stated that they could remove themselves from the study at any point during or after the interview was conducted.

Sample

The study consisted of a purposive sample of Latino adults receiving, or having attempted to receive mental health services during the COVID-19 pandemic. To verify that participants met study eligibility criteria, recruitment material clearly stated that participants would be asked to speak about mental health. Participants were interviewed if they met the following criteria: identified as Latino/a, were 18 years or older, had been receiving mental health services during the COVID-19 pandemic, or were in the process of onboarding to receive services during the COVID-19 pandemic. In this context, onboarding services implied that

participants had contacted a mental health institution/institutions, or at the point of receiving a general intake from a mental health institution. Once individuals contacted the primary investigator, they were first provided a more in-depth summary of the study purpose. Following explanation of the study, interested participants were provided with a screening questionnaire to ensure eligibility. The questionnaire consisted of three questions, asking if the participant identified as Latino/a, were 18 years of age or older, and had currently received, or had been attempting to receive mental health services. If they had answered yes to all three questions, participants were asked if they would like to move forward with scheduling an interview time and date. A total of 12 participants were screened; but as a result of ineligibility or no response to the screening, the sample consisted of only 8 participants. All participants spoke English except for one who spoke English but primarily spoke in Spanish. All participants were female. To ensure confidentiality of participants, further demographic information was not collected.

Participants were excluded if they did not identify as Latino, were under the age of 18 years, and had not received, or attempted to receive any mental health services during the pandemic.

Data Collection. Semi-structured interviews were conducted via Zoom on a HIPPA compliant University of Washington account. Video calls maintained the participants' privacy, and also prevented any potential COVID-19 infection between the participant and the primary investigator. At the start of the interview, the purpose of the study and the benefits participants may acquire in engaging with the study were verbally stated. In addition, the guidelines stated on the consent form were provided. Participants were then asked if they understood their rights, and if they would give verbal consent to be part of the study. This method of requesting verbal consent was approved by the Institutional Review Board. Once the consent process was

completed, the primary investigator began recording the interview. Participants were notified through a pop-up box on their electronic device that the session was being recorded. The notification allowed for the participant to confirm permission for the video call to be recorded.

Interview procedures. The principal investigator conducted a one-on-one interview with each participant. The interview consisted of visual content and a questionnaire. The visual content consisted of a collage of photos (See Appendix A). The images chosen were based on similar photos utilized in photovoice studies focused on expressing barriers to receiving mental health (Quinlan, 2017) and mental health issues (Eisenberg Family Depression Center). All images were arranged on a document and used as a rating scale, which allowed each participant to choose one image from the compilation of images to describe how they felt about the mental health system. The rating scale had three rows of a total of nine images that portrayed different ways other individuals had described mental health. Overall, the rating scale varied from positive ways to view mental health and negative ways. When looking at the scale from top to bottom, the first row represented negative experiences with mental health. The second row of photos addressed positive experiences with mental health, and the final row depicted a mix of both negative and positive. Research has shown that conversations surrounding mental health are difficult for one to speak upon. This is a result of societies negativity reflected upon mental illness, procuring a stigma onto individual's thoughts and views on mental illness causing issues on an institutional level (employment discrimination) (Casados, 2017). The images allowed the participant to prepare for conversation around mental health. The second purpose of the images was to collect content spoken by the participant as they elaborated on why, and how the image described mental health specifically within the context of COVID-19.

The questionnaire consisted of two separate sections (See Appendix B). The first section consisted of barriers, and positive and negative experiences in mental health. The second part of the questionnaire consisted of the participants' personal input on how they would like to see the mental health system improved. These interviews provided an understanding of institutional barriers, community barriers, and personal barriers that can also be referenced as Macro, Mezzo Micro. To gain an overall understanding of these three categories the Bronfenbrenner's ecological system model was used in the creation of the questions and during the interview process. Bronfenbrenner's ecological system consists of, micro, mezzo, and macro. Micro allows for significant qualities to be identified in one's own immediate environment, mezzo allows for linkages and processes taking place between two or more settings to be discovered, while macro allowed for the identification of the patterns that exits between micro, mezzo, and macro that provided a broader social context (Härkönen, 2007). Asking participants, the barriers they have experienced allowed for one to understand what personal issues arise within their environment when accessing services on a micro level, and reflect onto current macro issues. Asking participants about both positive and negative experiences allowed the participants to put into context what is going on in the mezzo environment (relationship between participant and mental health institution). Lastly, asking participants for their recommendations bridge the gaps of what is needed to minimize macro issues which then reflect positively onto Latinos personal experiences within a micro and mezzo system.

At the start of the interview participants were asked to carefully examine and take their time in choosing a photo that best described their experience with the mental health system. After choosing their photo they were asked to elaborate further, and were asked follow-up questions to clarify how this was related to COVID-19. Once the images were discussed the conversation

transitioned into the following questions, centered around participants negative, and positive experiences with mental health during COVID-19. After discussing their experiences, they were asked how they would label their overall experience based on a multiple-choice question of three options. Again, once choosing their option, they were asked follow-up questions to further elaborate on why they had chosen this description. The interview concluded with asking participants on how they would like to see the system improved. Overall, interviews were completed between twenty to thirty minutes.

Qualitative Analysis. Content and thematic analysis was performed on the recorded video sessions. Areas of focus reviewed direct quotes made towards the photo caption, negative barriers, and provided solutions. To minimize bias in analysis, a multitude of sources was used to establish credibility. Sources utilized included personal review of video content (visual and auditory), guidance and support from the Center for Social Science Research (CSSR), and the final method of analysis included two software's, Otter Ai and Atlas ti.

Coding. The first step to analysis involved creating a codebook based on both themes and content that had emerged from the first several reviews of the interviews (auditory and visual). Coding was completed by personal review of each video conducted by the investigator. This first review involved jotting down immediate and recurring themes. The second time the videos were reviewed was by reviewing solely the audio portion, again, immediate themes that were apparent were written down. Following this completion, all video content was uploaded onto Otter Ai where the verbal content was transcribed. In order to ensure accuracy of the transcription, every video was manually corrected by being proofread and listened to for any mistakes that the software made. After transcription both content that was jotted down from reading, listening, and transcribing the interviews were categorized onto an excel sheet and color

coded based on whether they were a micro (an individual barrier), mezzo (a community barrier), macro (a structural barrier), or an improvement. As a result of this coding process a total of 59 codes emerged.

Software. To use and analyze all data collected from codebook and interview transcriptions within Atlas ti software, a CSSR consultant was utilized. The CSSR consultant reviewed small samples of the data from interviews, and provided step by step support on how Atlas ti software could be utilized for data analysis. The first process in using the consultant involved creating a codebook to which they reviewed. The following processes involved the consultant providing references to different analytical methods Atlas ti could provide. After the consultant provided a tutorial on the tool, the primary investigator applied the recommended tool to the data procured in the study. Following the consultant reviewed samples of the analyzed data to grasp an idea of what the content signified. After reviewing the content of the data the consultant provided the following steps of analyzation. The process of review and analytical tool recommendations was iterated seven times.

A total of 8 documents transcribed by Otter Ai were uploaded onto Atlas ti along with the excel sheet where the codebook was located. Each document was read through and all phrases or quotes that coincided with the previously determined codes were correlated to their designated code. Each code had between 1 to 4 quotes or phrases assigned. After reviewing this data networks emerged. Networks involve further categorizing codes onto a blank document of their own, once placed onto the document correlations can be found. Once all codes and their respective phrases were placed onto a network further connections and causations can be found between all codes. A total of 12 networks were discovered, but only ten were used for results as some were not applicable to designated findings. As each network was placed onto their

respective categories further analysis was done to connect and discover salient themes. Once connections were made between each individual network, description of the findings were documented through a detailed comment within each network.

Results

Using methods of repetitive review of the data (visual, and auditory) along with the use of software and direct input from a consultant allowed for a greater understanding of the micro, mezzo, and macro experiences Latinos have encountered when accessing mental healthcare. Furthermore, their communications revealed potential improvements, and solutions towards improving remote services that are interpolated with COVID-19

Barriers When Accessing Mental Health Services

Macro

When looking at barriers from a macro scale we find these are things that occur on an institutional level. When analyzing data, it became clear that when Latinos were accessing mental health services amidst the COVID-19 pandemic two themes emerged, insurance coverage, and extensive onboarding. Under these two major themes, a total of seven sub themes were found: service denial, telehealth coverage, unawareness, lack of advertisement, medical terminology, telehealth unavailability, and lacking providers.

Insurance coverage was a prominent factor identified by the participants as a barrier. Insurance for several participants is understood as having limitations in the way one can use it for mental health services or impedes the ability for one to use the services. One participant claimed they were not sure if their medical state insurance was only covering “five visits,” another participant found that they weren’t sure what their health insurance “covered,” and lastly one participant found their coverage had not expanded and they were still left with the same

options they had been offered prior to COVD-19. This participant had demonstrated the options available for mental health providers had not changed. When they had come to discover that their options had not changed, they felt as though they were not being provided adequate support towards their mental health needs. Overall, these feelings resulted in an indirect denial of mental health services during the COVID-19 pandemic. This denial was not because the patient did not want to address their mental health needs, but rather, a feeling of not wanting to approach previous providers that had failed to meet their mental health needs.

Insurance coverage was also a result of service denial. In this case it wasn't that Latinos didn't want mental health services; but rather, a result of their insurance not providing "telehealth coverage". It was also discovered that insurance providers had a sense of unawareness on how to provide appropriate referral information for mental health services. One participant stated, 'My insurance gave me three numbers to call in the community and two of them weren't even correct…causing miscommunications between those systems'. In this case, the participant was referring to their insurance provider; and the clinic's inability to coincide, making it difficult for them to understand appropriate options for their mental health needs. This signifies that Latinos could spend an inordinate amount of time looking for mental health services only to be denied because it is not covered by their insurance provider; The miscommunication can not only cause a delay in receiving services, but also contributes to a lack of awareness in whom Latinos should be approaching for referrals, even if located within their insurance network.

When Latino participants were able to successfully move past the barriers of using their insurance, they found that there was an extensive onboarding process. In this case, the onboarding process included; the requirement of documentation and insurance information to

begin mental health services. As one Latino participant stated, when they provided their therapist the insurance information, the therapists required that they receive an "approval or authorization number" from their insurance provider. After a significant amount of phone calls between the insurance provider and the participant, the participant was finally able to speak to someone with knowledge of what they needed to do in order to be referred to the appropriate number to call for authorization of mental health services. The circuitous nature of the insurance process caused a delay in the participant receiving services due to all the necessary steps required to be taken by the Latino participant; The completion of these steps became even more difficult when insurance providers themselves were not aware of the authorization required to begin mental health services.

Factors outside of insurance barriers included lack of advertisement and medical terminology. Lack of advertisement is the inability to provide comprehensive flyers or outreach material that provide in-depth information of what type of services mental health institutions are providing, and how this may be beneficial to the Latino community. Medical terminology represents medical terms used that Latino patients are unaware of therefore making it harder to begin mental health services. One participant found that lack of advertisement was a result of insufficient disclosure on what was "readily available". Specifically for this participant they were not aware of the specific details on what type of mental health services were being offered, for how long, and for what price. From another perspective, one participant, who identified English as their second language, found that medical terminology used when seeking mental health services was difficult, making it so that they wouldn't be able to understand the rules about insurance or what is involved in therapy.

Mezzo

When looking at the mezzo level, these are barriers that occur within one's community. This study involves looking directly at the mental health institutions that participants interacted with during the pandemic. The participants were directly asked to relay experiences they had with the mental health institution. As a result, two themes emerged, lack of culture, and telehealth unavailability. From these two themes, a total of nine sub themes emerged:, transitioning gap, homogeneous providers, service diversity, invalidation, discontinutity, lack of support, lack of privacy, policy disclosure, and lacking providers.

When examining culture (Latino's beliefs around mental health) it was discovered that the participants experienced a cultural barrier with their therapist when relaying experiences, that reflected mainly on their providers being homogeneous. For participants in this case homogeneous providers were those that identified as "white" providers.

Two participants discussed issues that arose for them with homogeneous providers, service diversity, and invalidation. Participants found a lack of service diversity, specifically mental health services. One participant found difficulty in "trying to find like, an actual, person, or a program that, could help identify, with my specific issues in terms of my background.". When one participant was able to move past their homogeneous providers, there was a lack of invalidation which reflected in a participant feeling unsatisfied. The participant stated, "I seek mental health for validation, I guess, like, my problems are valid, so going out, and not really feeling as satisfied like I thought I would be, and obviously, one session isn't going to clear all my problems, but I feel, at least like I have somewhere to start would be much more satisfying". On the same topic participants found there was a lack of support from mental health institutions, as one participant stated, "I was able to find a program…, but I never heard back". Even when

participants are seeking help the institutions themselves didn't do their part in providing support for Latinos to onboard onto services.

For one participant there was a transition from in-person services to telehealth services causing discontinuity of care. Discontinuity signifies an interruption of services as a result of the therapist's practices. One participant stated, "I never realized until we went virtually that I would use markers in her office when I was processing or thinking through something, like she had this one pillow that has those sequins that like you can move back and forth, and when I was having a hard time verbalizing something I would rub it". For another participant moving from different telehealth services to a more affordable set of services meant a long service gap that lasted from 'October' through 'November' so about a month and a half' waiting period from one provider to the next.

Within a telehealth space, there was a lack of privacy and policy disclosure. Lack of disclosing confidentiality in a telehealth meeting made Latinos feel as though they weren't free to fully disclose information during each session making one Latina participant, "cautious... taking away some of the aspects I was used to receiving before". This ties into the therapist's failure to disclose policy procedures involving confidentiality in order to or create a safe space for the client to disclose personal information as they would be advised in face-to-face interaction. This left one participant without the ability to consent to the services making them feel as if there was never "a point where we're like, okay, you can like feel free to share even though this is remote this is still a safe space".

Telehealth unavailability also emerged from the data. Telehealth unavailability was not a result of insurances not providing coverage, but rather mental health institutions themselves eliminating the possibility of telehealth service. For one participant in particular the provider

that they had already built a relationship with before COVID-19 minimized all services upon the onset of the pandemic. The participant stated, "una vez tube una cita con la doctora y la tubimos como over the phone. y duro como 3 minutos la cita, nada mas me dijo que si estaba bien y le digo si estoy bien, y dice aucoupas medicina y okay y ya fue todo"[1]. The phone call was essentially just to continue prescribing medication rather than providing telehealth service to potentially review medication effects, benefits, etc. When looking at providers, one Latino client seeking services during the pandemic experienced difficulty finding providers of color. The participant found that these providers were mainly 'white', and likely would not seem to 'understand me… as a daughter of immigrants or even just like a person of color'.

Barriers Preventing Latinos from accessing Mental Health Services: Micro

Micro barriers involved direct interactions that clients have experienced on a personal level with the mental health system. A total of four themes emerged: privacy restriction, language, unfamiliarity, and directionality.

Privacy restrictions, in this case, were regarding the space the participant was located at during the time of their session. Specifically, in this context due to the COVID-19 pandemic meant mental health services primarily became remote which involved both the client and the therapist in their personal space on an electronic device (phone, computer, tablet, etc.). For all participants in this study, it meant a space located in their home (room, office, living area, etc.). As a result, many felt as though other residents within their homes could hear their conversation with the therapist. One participant stated, "knowing that my parents were literally like 10 feet away … caused a constant stressor… like I had to play a front" in this case playing off the fact

[1] Translation: "one time I had an appointment with the doctor and we had it like over the phone, it lasted like 3 minutes. She just asked if I was okay and if I needed medicine and that was all

that they were seeking mental health services. At the same time, because they received services within their home, they had a hard time separating home from mental health services. As one participant stated, “being in the “comfort of my own home… in my office… there’s a visual of other things I need to do, so it can be kind of distracting”. Sometimes participating in the session wasn’t because of the location, but was attributed to self-disclosure, in this case, one participant felt as though they struggled to be open in their therapeutic session online because of their legal status. The participant stated, “because of my status… it’s really hard to make sure that I am secure with the person”. In this case, security meant that they felt uncomfortable disclosing all their personal information.

Another theme was language. A participant reported their struggles in navigating mental health services were increased through language barriers. The participant stated, “The system is really difficult for people who are nonnative English speakers like myself, who wouldn’t be able to understand the rules of insurance or even how therapy works”.

Unfamiliarity caused a barrier when trying to grasp an understanding of mental health services within a telehealth environment. One participant reported, utilizing telehealth health is “different being on the phone or a screen …telehealth wasn’t a service I was used to using…It even seemed like getting help was a barrier” and now there was an added-on barrier when making services remote.

One of the final struggles Latino participants identified was directionality. Directionality came into play when there was unawareness of the first steps required to onboard mental health services. One participant reported, "Esta dificil porque no puedes acesar servicios vas a un lugar y te dicen oh, te vamos a referir a otro lugar. Luego vas a ese lugar y luego oh no no ayudas aquí

tienes que ir aquí"[2]. Another participant stated, "I didn't know where to start to be honest, so I just googled it".

Improvements

Improvements for Latinos signify ways that the mental health system can be changed, or revised to make mental health services accessible during times like the COVID-19 pandemic. For these recommendations, a total of seventeen themes emerged. Themes were further categorized into three broad categories: institutional, community, and accessibility.

Institutional

Improvements on institutional scale involve large political or systemic changes. A total of seven themes emerged when seeking to make these changes: universal health care, free clinic, clarity, transparency, de-stigmatization, affordability, and training.

On a macro scale, one participant believed the best way to improve mental health services would be to provide universal healthcare, "healthcare access for everyone and full coverage for everything". Another participant recommended having "clinics" offering some "free" mental health services to Latinos monthly.

Other participants found that improvement can be done through clarity. Clarity happens through open communication with potential clients around what mental health services are available, whom it is available to, and clarifying the process and steps needed on behalf of the Latino client to receive services. The overall starting process of receiving mental health services, 'It should be more simple" and "easier to seek someone". Similarly, another participant asked for transparency among the services being offered, "going into more detail, because sometimes it

[2] Translation: "it is difficult because you can't access services you go to one place they say, were going to refer you to another place. Then you go to that place and then oh no, you don't get help here you need to go here"

feels like, a lot of the services are advertised just because they have to be". Further improvements involved mental health agencies actively promoting services to destigmatize mental health among Latino communities. Overall, the outlook is to "break the stigma", and "becoming more open about talks about mental healt".

When directly looking at therapists employed within institutions participants are asking "the counselors themselves" could be changed by the way "they're trained".

The final recommendation was affordability. When it came to affordability this fell under two different categories for one participant, affordability to receive the "services" and "affordable medication" that can be prescribed sometimes with receiving mental health services.

Community

Community involvement increased the sense of alliance among mental health institutions. When increasing community there are a total of four themes: allyship, responsibilities, therapeutic options, and compassion.

Allyship occurs by directly "knowing that there are people (mental health professionals) that will support you" and being an "ally" that is "compassionate," and "understands without a biased lens" as well as "counselors to guide me through it". Logistically speaking the "therapist", or "business should be the ones getting the approval". "Approval" the participant recommends may be completed by the therapist or the clinic in which the services are being provided. This means the providers should be the individuals to seek insurance providers and complete the onboarding process rather than in this case the Latino client who is not aware of the necessary steps or questions to be asked to complete this crucial process required to begin receiving services.

The therapeutic option is specifically related to offering therapy in a group setting as this may make Latinos feel therapy as though it is a more communal approach "they might be more willing to" attend "instead of seeking someone individually".

Lastly, compassion involves finding the mental health professionals you first come across when beginning services displaying a sense of understanding, and sympathy "porque llegas y no te dicen buenos días no te dicen buenas tardes te dicen oh so you're suicidal"[3].

Accessibility

This category included a total of four themes: diversity, funding, tailored advertisement, and availability. Participants defined numerous characteristics surrounding diversity, professionals of different backgrounds "counselors of color, LGTBQ, and or someone with my shared experience".

Funding involves an overall allocation of money into mental health services "No hay dinero. el estado no esta poniendo suficiente dinero en mental health… y pues mientras no pase eso, no vamos a arreglar nada… un señor que miraba dice que necesita mirar 70 personas al mez, imaginate cuanto tiempo le esta dando a una[4]. Lastly when advertising mental health services available there is a need to involve "advertisement" that is "personalized. If you just target demographics … that are directed towards people of color I think they would be more inclined to attend."

The final recommendation for participants was availability. Participants stated that availability should involve therapeutic sessions that are available for Latinos who work later in the "evening", or availability of different "options" of "mental health services".

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[3] Traducción: "Llegas, y no te dicen buenos días o buenas tardes sólo dicen oh así que eres suicida"

[4] "There is not money. The state is not putting sufficient money toward mental health... and while that does not our nothing will be fixed ... one man I used to see said he needed to see 70 people a month image how much time he is giving one of his clients"

Discussion

Latino participants have revealed structural issues with mental health systems as well issues occurring amongst those mental health providers. Participants revealed difficulty beginning services, and sometimes denying the services themselves. The issue persisted throughout the COVID-19 pandemic impacting the ability to receive services. The U.S. Department of Health and Human Services Office of Minority Health reports 8.8% of Latinos age 18 and older in 2018 had received mental health services compared to non-white Latinos measuring at 18.6% (2019).

Barriers in utilization of Mental healthcare

Insurance has widely affected Latino's ability to utilize services. Five out of eight participants reported insurance as a barrier that was impeding the ability for them to make use of mental health services. As the literature reports, this reflects onto social determinants of health; insurance accessed by Latinos or not accessed causes restrictions or eliminates access to mental health services (SAMHSA, 2020). When considering insurance as a whole; for Latinos, this means that insurance directly plays a role in what mental health services and providers they can access, as well as implementing further stipulations to the amount of access they can receive, and the steps that they are required to begin in order to begin to utilize mental health services. It is also important to note mental health institution options are already designated under the insurance carrier that the Latino individual has acquired. This is rather limiting as it does not provide Latinos the autonomy to choose a location where a provider may be located which would be more suitable to their mental health needs. This can signify a variety of changes required: accessible locations, diverse providers that can identify with Latinos, and varying

treatment modalities that can take into consideration the Latino's background and the issue they present the therapist with.

Separate from insurance it is also important to recognize how the mental health institutions themselves have also played a part in impeding Latino's ability to use mental health services. The institutions themselves are not making a clear distinction to Latinos what type of mental health services are available or being offered through their institution. As one Latina participant stated it is very valuable for them to understand exactly what is being provided rather than it being advertised to meet institutional policies.

Telehealth would be an issue regarding accessing the internet and telecommunication devices (Summers-Gabr, 2020). Latinos lack access to the internet or access to healthcare from institutions that offer telehealth, others may be lacking technology and have limited ability to speak with English-speaking providers (Sukumaran, 2020). Latinos did not report this as an issue but rather reported difficulty in the telehealth space itself. As one participant stated they had experienced unfamiliarity with face-to-face mental health services, but then being moved into telecommunication, which is another foreign modality to which the therapist never proceeded to adjust the Latino to or address the discomforts that may have occurred. Along with this issue, there was also informality as therapists did not make it of high importance to make their Latino client feel as though it was a safe space to speak freely. The informality had to do with the therapist not disclosing confidentiality that is commonly disclosed in a face-to-face meeting, other times it was a lack of verbal communication to the Latino that it was a "safe space" to disclose personal information despite the differences in location. Other times it was an issue because there wasn't a way to orient them to the different settings. Orienting a client to the environment allows for rapport to be built between the client and therapist. This lack of

orienting the Latino places them at high risk of deteriorating the client and therapist relationship and further risking early termination of services. Along with this issue, Latinos have reported that providers that can relate or identify with them are scarce, reflecting onto the literature that reports Latinos tend to underutilize mental health services (Hansen et. al, 2006). Overall, this resonates with the distrust three participants stated that they have exhibited towards the mental health system that has either made them unable to advocate for their needs during services or other times stray away from the services themselves.

Another important factor to consider among mental health institutions is the mental health providers themselves. When looking directly at the providers themselves, it is recognized that the providers mainly identify as white. Data revealed that these providers show a lack of understanding for Latinos who identify with a migrant background. This left the participant feeling unheard and invalidated, while also reflecting on the inability of therapists to practice in a culturally sensitive manner (McGregor, Belton et. al, 2019,). Cultural sensitivity for Latino's therapists is exhibited by a therapist showing interest and curiosity towards understanding cultural factors of the Latino participant and then considering the effects it plays on their current issue.

Several participants found a lack of service diversity amongst mental health services. One participant found difficulty in "trying to find an actual person, or program that could help identify, with their specific issues". A lot of the time what is happening may not directly be the therapist's fault, but the lack of service diversity that is being offered amongst their mental health services. As the literature reveals the U.S. has wide use of western practices within mental health services and the Latino community is looking for brief services (Magana, 2019,).

Separately, when looking at issues away from institutions or those located within the Latino community it is important to recognize and understand the issues Latinos are experiencing individually. Findings indicate personal issues with the telehealth process itself as there was sometimes an inability to find privacy within the space the Latino participant was located within. Literature revealed that Latinos experienced increased emotional stress from living situations. This stress may be attributed to their inability to have privacy during their telehealth services (American Psychiatric Association).

Other times Latino participants revealed language barriers when seeking to comprehend the medical terms used in mental health services. The inability to comprehend services causes negative experiences as previous literature has found (Rastogi et.al, 2012).

Overall, it is important to understand that many of the ways that Latinos can utilize mental health services are through systems that are westernized and not tailored to their care due to the fact that many times Latinos may have low acculturation levels (Berry 2017). This can further impede their ability to understand how insurance may work, whom they can seek for further support, and what services are available, or done within a mental health space, whether telehealth or face to face.

Improvements and Implications

While there has been a multitude of barriers displayed, Latino participants recommended a variety of changes to increase the benefits of their ability to utilize services. Changes recommended by participants included: institutions, community, and accessibility. Institutions involve the mental health sites that are providing the services. Community, involves individuals located within the mental health institutions. Lastly, the accessibility describes the policies and procedures set in place that allow for Latinos to receive mental health services.

Institutions should be changed by making the services affordable. This does not only include receiving mental health services, but also includes considering the drug prescriptions that sometimes are required that assist in Latinos maintaining their mental health. This means being able to implement universal healthcare that is fair for all (offer free mental health services a few days out of the month.).

Changes participants recommended on a macro scale were requiring mental health institutions professionals to take the role in engaging and onboarding participants within services, or to make it a more inviting space for Latinos to want to engage. Latinos who are not aware of the practices of mental health should not be left to completely tackle this adversity alone, a mental health institution who has experience dealing with insurances and people with mental health are better equipped to serve and guide Latino's onboarding to services.

In conjunction with building responsibility for mental health institutions, Latinos find an increasing sense of needs within the community. Participants would like allyships ‘knowing that there are people (mental health professionals) that ‘will support you'. Literature shows that Latinos are less likely to approach services due to a lack of mental health institutions disseminating services (Hansen, et.al, 2006,), so being able to bridge an allyship between a potential Latino client and individuals located within mental health institutions may bring awareness of mental health services available. This allows for the mental health institution to account for the general lack of knowledge that the Latino community has surrounding mental health services, and results in making the utilization of services simpler.

While it is important to note the changes needed for Latinos within an institution and community, it is still important to recognize that accessibility is still needed. This means providing diverse services, specifically diversifying the providers available, meaning those that

have a background with shared experiences (language and identity). This not only makes the services themselves accessible, but something that provides Latinos a sense of connection.

Overall, participants revealed important issues and needs within mental health services, but further research should be completed to reveal barriers for strictly Spanish-speaking Latinos as their experience will differ from that of bilingual Latinos who tend to have higher acculturation levels. Furthermore, research should continue to assess the stigmas that Latinos have around approaching mental health services and potential barriers that therapists may add to receiving services.

While it is important to understand a Latino's experience there is also a need to understand the complexities of being a therapist servicing the Latino community and their abilities to serve through a culturally humble lens and how it can be increased.

When specifically looking at personal barriers Latinos are experiencing outside of mental health institutions it is discovered that Latinos often have jobs that do not offer paid leave, and so being able to find appointments outside of work hours is essential, but problematic (Glynn, Farrell, 2012).

Limitations. It is important to recognize that the barriers are represented within the pacific northwest and should not be generalized to all Latinos located in the U.S. as geographical factors increase, or change the way barriers are perceived, or how improvements could be implemented. The sample size consisted of Latina women and thus does not speak to the barriers that may be experienced from a Latino male's point of view. Time limits were also restrictions towards collecting the data and analyzing the findings. Considering that the primary investigator was also Latina there may have been biases conducting the study itself and interpreting the data. Although an iterative process of analysis and use of multiple sources

(software and academic practices and support) was applied continuously as data emerged to minimize bias.

Conclusion

Findings indicate that several barriers happen within institutions that further cause issues. Issues occurred on a micro, mezzo, and macro scale. On the micro level, we find personal issues with assimilation of western culture for the Latino community occurring that make communication difficult as a result of language barriers that also contribute to one's ability to understand mental health services. On a mezzo scale, it is the services being offered and those that are providing the services that make it difficult for Latinos to maintain a longstanding relationship with receiving mental health services. Macro issues represented a need to structurally change the process required to begin receiving mental health services. While a lot of these barriers existed before COVID-19, they are now heightened by the limits of contact that Latinos can access that may have provided support. This shows that there is a lack of use of mental health services for Latinos. As a result, any research looking specifically at Latinos who do use services is especially important as it may help to explain what is being done incorrectly, correctly, and bring light to improvements that can be made as a result.

In addition to the added layer of barriers, another set of issues occurred as many mental health services became remote. This was a process that many Latino participants had no familiarity with. Important recommendations were provided by participants that systematically change the roles of mental health institutions, and provide Latinos the ability to eliminate burdens of onboarding services, or financially limiting them to mental health services of their choice. It is recommended to be more specific in regards to what mental health services can be provided for Latinos; it is also important to orient the Latino towards telehealth services as this

differs greatly from face-to-face services for a number of reasons such as different locations, lack of privacy, and unfamiliarity. This can occur by being transparent and disclosing appropriate policies as well as what mental health treatments (i.e., cognitive behavioral therapy) can be provided. In conjunction, it is also important to have a conversation early with the participant on the benefits of receiving mental health services, and how their ethnic background and cultural beliefs can be a strength rather than a barrier. In totality, the COVID-19 pandemic is an important time to have access to mental health services and for the Latino community, their inability to access these services has been impacted.

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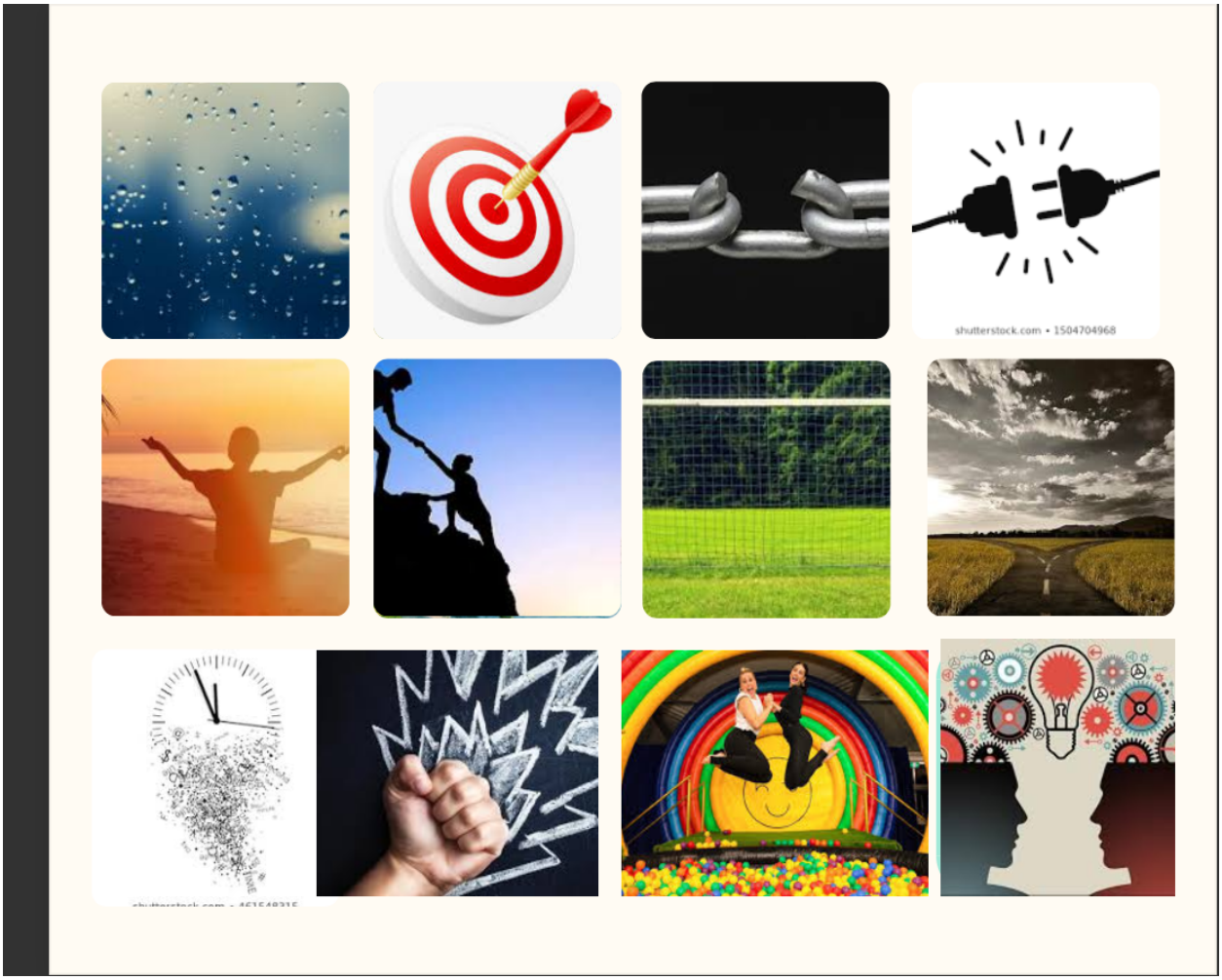
Appendix A

Rating Scale



Appendix B

Questionnaire guide

1. Can you choose a photo that describes how you navigate the mental health care system?
2. Based on the photo you chose, how would you caption this photo to describe your understanding of the way in which you have navigated the mental health system during COVID-19?
3. If you have had any, Can you explain a positive experience you have had with the mental health care system?
4. If you have had any, Can you explain a negative experience you have had with the mental health care system?
5. How has your experience been receiving mental health services with COVID -19 social distancing measures?
6. How would you describe your experience as a Latino Navigating the mental healthcare system?
    1. Negative
    2. Difficult
    3. Misunderstood
2. How would you like to see the mental health care system improved during COVID-19?