

Looking Beyond Clinical Care

in Hispanic & Latino Communities

How to incorporate community asset mapping into community-initiated care

New England (HHS Region 1)
PTTC Prevention Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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New England PTTC

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Christina is the Assistant Director and Co-Founder of Centro de Ayuda y Esperanza Latina, a community-based organization headquartered in New Bedford, Massachusetts that focuses on supporting Hispanic and Latino communities in Massachusetts, Connecticut, Florida, and the Dominican Republic. Prior to entering this role, she served the National Hispanic & Latino Prevention Technology Transfer Center (PTTC) as a Program Specialist. Christina has experience in behavioral health prevention at the local, state, and national levels. Christina is currently a PhD candidate in Health Sciences with a concentration in Trauma-Informed Care. She also holds a Master's degree in Public Health and Graduate Certificates in Epidemiology and Global Health. Christina believes in the importance of building resilient and thriving communities that can see and move beyond the systems that have oppressed them. Christina lives in Southeastern Massachusetts where she spends as much time as possible with her family, and often travels to the Dominican Republic to work on trauma-informed community development projects that are very close to her heart.

Language Matters

Words have power

Please note that this guide uses specific terms as it relates to Hispanic and Latino communities. While many people have self-identified using a variety of terms, including Hispanic, Latino, Latine, Latinx, Chicano, etc., this guide will use the term "Hispanic and Latino communities." As people from Hispanic and Latino communities do not look one particular way, we invite others to also support members of their community to self-identify in the way that best fits them on a personal level.



Land Acknowledgement

The New England PTTC acknowledges that we are all on the traditional lands of native people. In Augusta, Maine, the PTTC works from the ancestral lands of the Abenaki People, part of the Wabanaki Confederacy. We have a responsibility to acknowledge our Indigenous connections and the histories of Indigenous land dispossession. We encourage you to learn more about the stewards of the land you live and work on by working with your native neighbors, and by visiting https://native-land.ca/

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Overview

This is a how-to guide for community-based organizations and community leaders looking to improve their impact on behavioral health issues in Hispanic & Latino communities. This is meant to provide organizations and leaders with background and tangible ideas for engaging communities in asset mapping & community-based behavioral health initiatives. The Hispanic & Latino community is very diverse & has a variety of needs. As such, it is always important to involve the community voice in this work rather than relying on any one resource.



Introduction

Substance misuse is an issue that impacts all communities, regardless of race/ethnicity, culture, country of origin, or geographical location. Often a coping strategy, it is impossible to discuss substance misuse without also discussing trauma and mental health. These issues do not occur in a vacuum, and they often impact other areas of health and wellness, including physical health and productivity.

Unfortunately, not all communities have equal access to care, with many communities forced to rely only on community-based services to address their needs. Barriers are often complex and go beyond the number of providers available. Personal, sociocultural, and systemic barriers to care exist, requiring new and innovative approaches to prevention, intervention, treatment, and recovery.

Keeping in mind these realities, this how-to guide aims to provide tools that can be used to build more connected and supportive communities so that all individuals, regardless of the specific barriers they face, can access services and programs that will help them to thrive in all aspects of life.

Social Drivers of Behavioral Health

In healthcare and public health, there is a model known as the Social Determinants of Health that identifies a variety of factors seemingly unrelated to physical health that impact health outcomes. Similarly, there is a model known as the Social Drivers of Behavioral Health (also known as the Social Determinants of Mental Health or Social Drivers of Mental Health). This model identifies nine (9) factors that are considered drivers of poor behavioral health outcomes and risk of behavioral health issues among communities in the United States. These factors are:

- Under employment and/or unemployment
- Food insecurity
- Poor access to and/or poor quality of health care
- Low education and/or educational inequality
- Poverty, low income, and/or income inequality
- Poor neighborhoods and built environments
- Social exclusion and/or social isolation
- Housing instability
- Adverse early life experiences (trauma/ACES)

Social Drivers of Behavioral Health

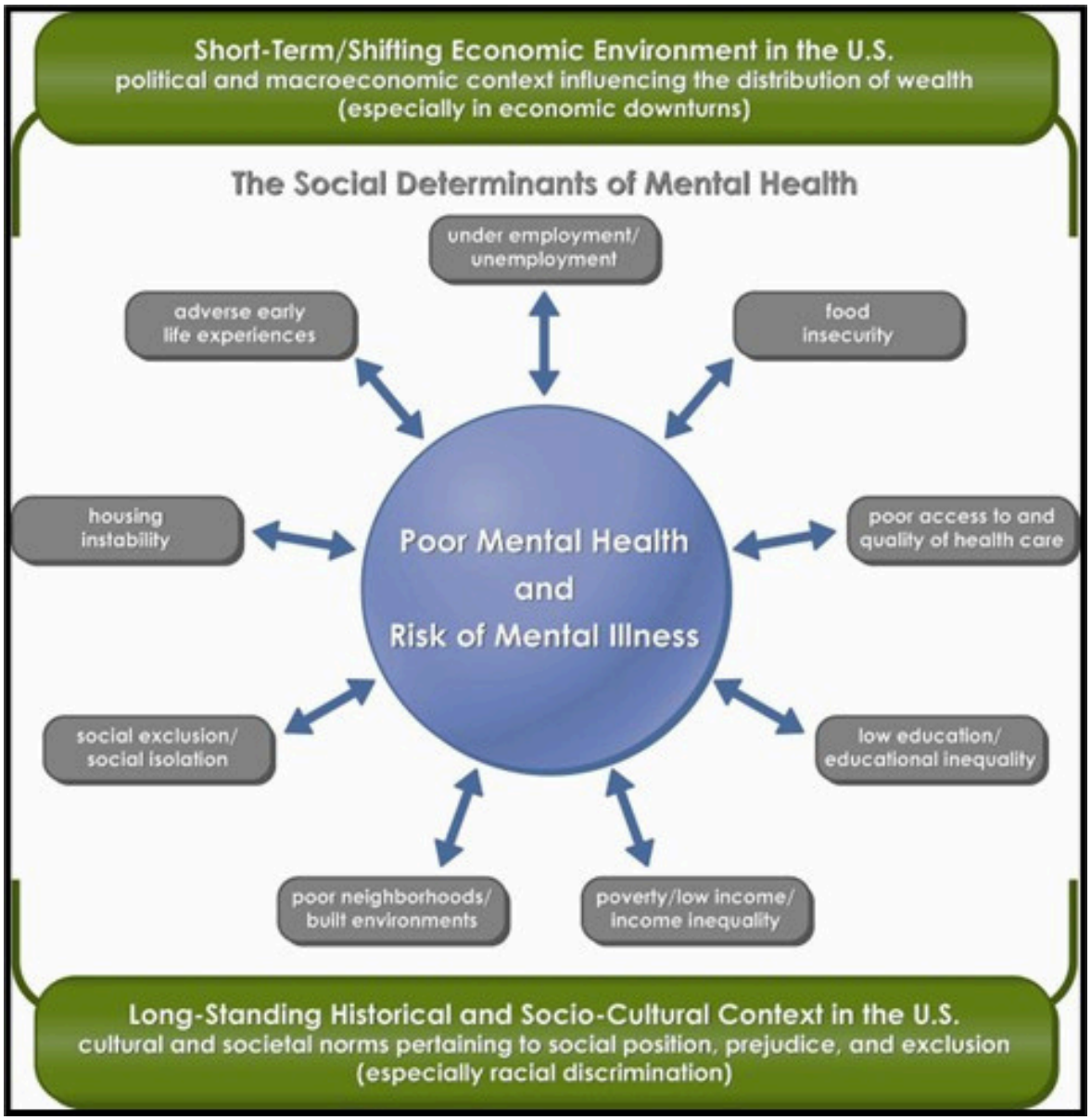


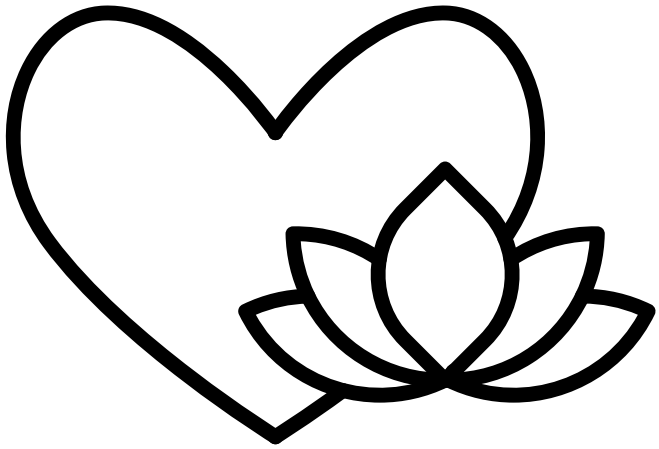
Figure 1. Social Determinants of Mental Health. MHA

Social Drivers of Behavioral Health

Focusing solely on mental health keeps people from achieving optimal wellness. When individuals lack aspects of wellness, coping mechanisms are often utilized to address these needs. In some cases, maladaptive coping strategies are used, increasing their risk for behavioral health issues, including substance misuse.

For wellness to be achieved, the following areas must be addressed:

- Social Wellness
- Occupational Wellness
- Environmental Wellness
- Intellectual Wellness
- Spiritual Wellness
- Emotional Wellness
- Physical Wellness
- Financial Wellness



Social Drivers of Behavioral Health

Clinical care, at best, only focuses on emotional wellness. This creates a significant gap, especially among individuals with limited protective factors and resilience. For this reason, it is necessary to consider the role of behavioral health-adjacent services. [1]



Figure 2. Dimensions of Wellness. UNH

Looking at Behavioral Health-Adjacent Services

Behavioral health-adjacent services are any services related to the Social Drivers of Behavioral Health. Due to the overlaps between the Social Drivers of Behavioral Health and the Dimensions of Wellness, it is expected that some of these services will also improve overall wellness and reduce gaps to optimal living. Below are some examples of behavioral-health adjacent services that fill needs outside of behavioral health.

Examples of Behavioral-Health Adjacent Services

Employment

- Community-based training programs
- Supportive employment programs
- Youth internship programs

Food Insecurity

- Food Pantries
- Soup Kitchens

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Looking at Behavioral Health-Adjacent Services

Access to Healthcare

- Community-based health screenings and preventive care
- Federally Qualified Community Health Centers

Education

- Adult Basic Education programs
- English as a Second Language programs
- Free youth tutoring

Economic Development

- Business planning services
- Financial management classes

Housing and Homelessness Prevention

- Emergency case management programs
- Supportive housing programs

Social Services

- Case management services
- Systems navigation support
- Linkages to care

Child & Family Support

- Parenting classes
- Parent support groups

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Coordination Across Sectors

How can we build supportive systems rather than silos of care?

There are many possibilities when it comes to breaking down barriers that exist in service delivery. The needs and structures in each community are different, and all options may not be feasible or desirable in all communities. Some potential solutions may include:

- Service provider networks to address complex needs of communities that do not fit neatly into any one system
- Establishing strong referral procedures between agencies
- Community-led initiatives that prioritize the community voice and lived experiences
- Processes to identify gaps in care and implementation of working groups to determine and work towards solutions
- Spaces where community members can safely voice their concerns with current systems of care and work with leadership to identify solutions

The Role of Community-Initiated Care

One potential solution to breaking silos and entering into a more integrated model of care across sectors is by developing and implemented a community-initiated care model.

What is Community-Initiated Care?

Community-initiated care is an integrated care model that empowers communities to address behavioral health and well-being by equipping community members with the knowledge and skills to support those living in their communities.

The benefits of this approach include:

- Less stress on the current overburdened behavioral health system
- Limitations of the current system are not a barrier in this model of care
- Not a replacement for clinical care
- Systemic barriers, like health insurance coverage, are no longer an issue to establishing some level of care
- Helps to develop leadership skills in the community
- Introduces community members to the field of behavioral health, as a potential career pathway

The Role of Community-Initiated Care

Key Aspects of Community-Initiated Care:

- Trains and equips community members to be a resource for others, rather than relying solely on clinical providers
- Utilizes practical evidence-based interventions that can be implemented in community-based settings
- Includes training on self-care strategies and resilience building
- Includes strong referral processes to increase access to behavioral health and social support services
- Designed to complement and expand current behavioral health services
- Helps to build trust and social connectedness
- Can support other social needs beyond behavioral health
- An environment where agencies and community can come together, engaging all aspects of the behavioral health continuum, as well as agencies addressing social drivers of behavioral health and wellness needs

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The Role of Community-Initiated Care

Goals of Community-Initiated Care:

- Improve access to behavioral health support
- Promote early intervention
- Reduce stigma and promote help-seeking behaviors
- Enhance community resilience

Community-Initiated Care is more than a program or service. It is a strategically planned network of programs, services, and partners looking to significantly impact and improve the effects of trauma, mental health, and substance use in the community they serve. This model is for those that wish to engage, involve, and mobilize the community in authentic ways, providing a space for those with different types of lived experiences to heal and make meaning of their own behavioral health journeys, while also helping others to do the same. The first step to developing your own community-initiated care model is to engage in community asset mapping.

Community Asset Mapping

How it can help communities establish Community-Initiated Care Models

What is Community Asset Mapping?

- A strength-based approach to community development
- The goal of asset mapping is to document a community's existing resources, incorporating these strengths into community development work
- The process of asset mapping can include identifying the institutions, individuals, and citizen associations existing within communities that serve as positive resources
- Typically has a specific aim or purpose associated with the community asset map
- There are different types of asset mapping, including:
  - Institutional asset mapping
  - Individual asset mapping
  - Cultural asset mapping

Community Asset Mapping

How it can help communities establish Community-Initiated Care Models

What are Some Approaches to Community Asset Mapping?

- Community Participatory Approaches
  - Community-engaged mapping
  - Observatory community walks
  - Qualitative interviews and focus groups

- Digital & Data-Driven Approaches
  - Online mapping, through the use of GIS or other mapping software
  - Database development
  - Data analysis

- Other Approaches
  - Capacity inventory
  - Community relationship mapping
  - Interest checklists

Community Asset Mapping

How it can help communities establish Community-Initiated Care Models

Community asset mapping is participatory in nature, and as such, facilitates a process **with** communities to identify and build on existing resources, strengths, and human capabilities. Some of the benefits of community asset mapping include:

- Assisting communities in regaining control over their lives and reclaiming their own agency
- Enhancing community engagement and participation
- Recognizing and foregrounding the importance of networks and relationships as assets
- Bringing community assets to the forefront
- Mobilization of assets, resources, skills, and strengths of individuals and communities
- Encouragement of leadership engagement to promote action
- Generation of community cohesion, solidarity, and collaboration

Community Asset Mapping

How it can help communities establish Community-Initiated Care Models

The Five Steps of Community Asset Mapping

1. Mapping the assets of community members, institutions, and organizations;
2. Building internal relationships among local community assets;
3. Mobilizing community assets for community building and development;
4. Developing a community vision and plan, and
5. Establishing external connections to support locally driven development

These steps rely heavily on trusting and collaborative relationships between individuals and agencies, the use of strategic planning principles to develop shared visions for community building and development, and the prioritization of community needs over personal agendas.

Community Asset Mapping

How it can help communities establish Community-Initiated Care Models

Guiding Questions

Guiding questions can be helpful in the community asset mapping process. These questions should be answered **prior to** beginning any community asset mapping activities.

- What is your aim or purpose for mapping assets?
- What outcomes do you hope to achieve with the mapping of assets?
- What is the size of the community in which you are interested in identifying assets?
- Who (individuals, organizations, stakeholders, and so on) will be involved, and are they available to participate in identifying assets?
- What is the timeframe for identifying and mapping the assets?
- What resources do you need?
- Are there any funds available for the mapping process?
- Which methods do you intend to use to map assets?

Once these questions are answered, involved parties can begin to come together to start the community asset mapping process. One example of how this process can be done is found in the following case study on New Bedford, Massachusetts.

Case Study

New Bedford, Massachusetts

A city of slightly more than 100,000 people located in Southeastern Massachusetts. City demographics, according to the 2023 American Community Survey data, are:

- 49.8% Male | 50.2% Female
- 24.4% Under 18
- 55.0% White
- 6.2% Black or African American
- 24.7% Hispanic or Latino
- 0.3% Native American
- 1.6% Asian
- 22.2% Multiracial

Initial review of publicly available datasets suggests that health and wellness disparities in New Bedford most greatly impact the Hispanic and Latino community. Some datasets that may be available for your community, depending on the size and location are:

- City Health Dashboard
- Public School District Profiles
- Community Health Needs Assessments
- Other Census Data Tables on income, unemployment, health insurance enrollment, etc.

Case Study

New Bedford, Massachusetts

Our agency, based on this information, defined our community of interest as the Hispanic and Latino community residing in New Bedford, Massachusetts. In 2023, we conducted the first Hispanic and Latino Behavioral Health Needs Assessment, which included findings from publicly available datasets, death record analysis, community surveys, stakeholder interviews, and Hispanic Community Forums.

Hispanic Community Forums are an event where community members are invited to share their concerns related to their experiences living in the community. Often, agency leaders and lawmakers are also present to help identify solutions to some of the issues that arise. Some of the most common concerns brought up in these forums are around housing, health, discrimination, and the lack of culturally and linguistically appropriate services across all systems.

All of this information was compiled into an assessment, but it also led us to a larger problem. This problem was transformed into the following problem statement.

Problem Statement: What are the agencies that are actually delivering culturally and linguistically appropriate services, and not just claiming to do so?

Case Study

New Bedford, Massachusetts

Once this problem statement was identified, we chose to be a little more specific and keep this problem statement specific to the area of behavioral health and behavioral health adjacent services.

We first compiled a list of all the agencies conducting work in behavioral health and behavioral health adjacent areas. In healthcare, including behavioral health, culturally and linguistically appropriate service delivery is mandated by law. In most cases, human and social services have followed suit, offering translation services at a minimum.

In order to get a more unbiased understanding of the impact of these programs and services, we began tracking our own referrals and asking clients about their own experiences with these agencies.

While we are still in this process, some potential approaches to this asset mapping may include:

- Developing a standardized rating system to promote those services that are serving the community well in terms of cultural and linguistic appropriateness
- Using the findings to discuss quality improvement with agencies who may be missing the mark

Case Study

New Bedford, Massachusetts

- Discussing ways to improve culturally and linguistically appropriate service delivery across agencies and sectors, including agency collaboration
- Identifying the areas in which the community is being served well and celebrating those successes

The aim of this project is not to shame any agency for what they may not be doing well, but to understand the ways in which collaboration can support both agencies and the community. Currently, many community members are unable to get the support they need, prolonging their suffering. In order to change this reality, it is necessary to understand and discuss the issues leading to this reality both at the community level and systems level. Nothing will change until we can be honest about what is going on.

Culturally & Linguistically Appropriate Processes, Tools, & Resources

- **Centro de Ayuda y Esperanza Latina's Latino-led Prevention Model**
  - Training slides can be found at: https://pttcnetwork.org/wp-content/uploads/2023/01/Community-led-Prevention-TA-FINAL508-kg.pdf
- The **Strategic Prevention Framework** provides a lot of information on assessment, cultural competency, and evaluation that may be helpful in your own development of community asset mapping and community-initiated care
- New England PTTC also has a **CLAS assessment tool** to determine your own organization's level of cultural competency
- **Research on Community-Initiated Care Models**
  - https://www.sciencedirect.com/science/article/abs/pii/S2212144722001211
  - https://pmc.ncbi.nlm.nih.gov/articles/PMC10579655/
- **Community Asset Mapping Toolkit**
  - https://www.cdss.ca.gov/inforesources/cdss-programs/ffpsa-part-iv/asset-mapping-strength-and-needs-assessment-toolkit

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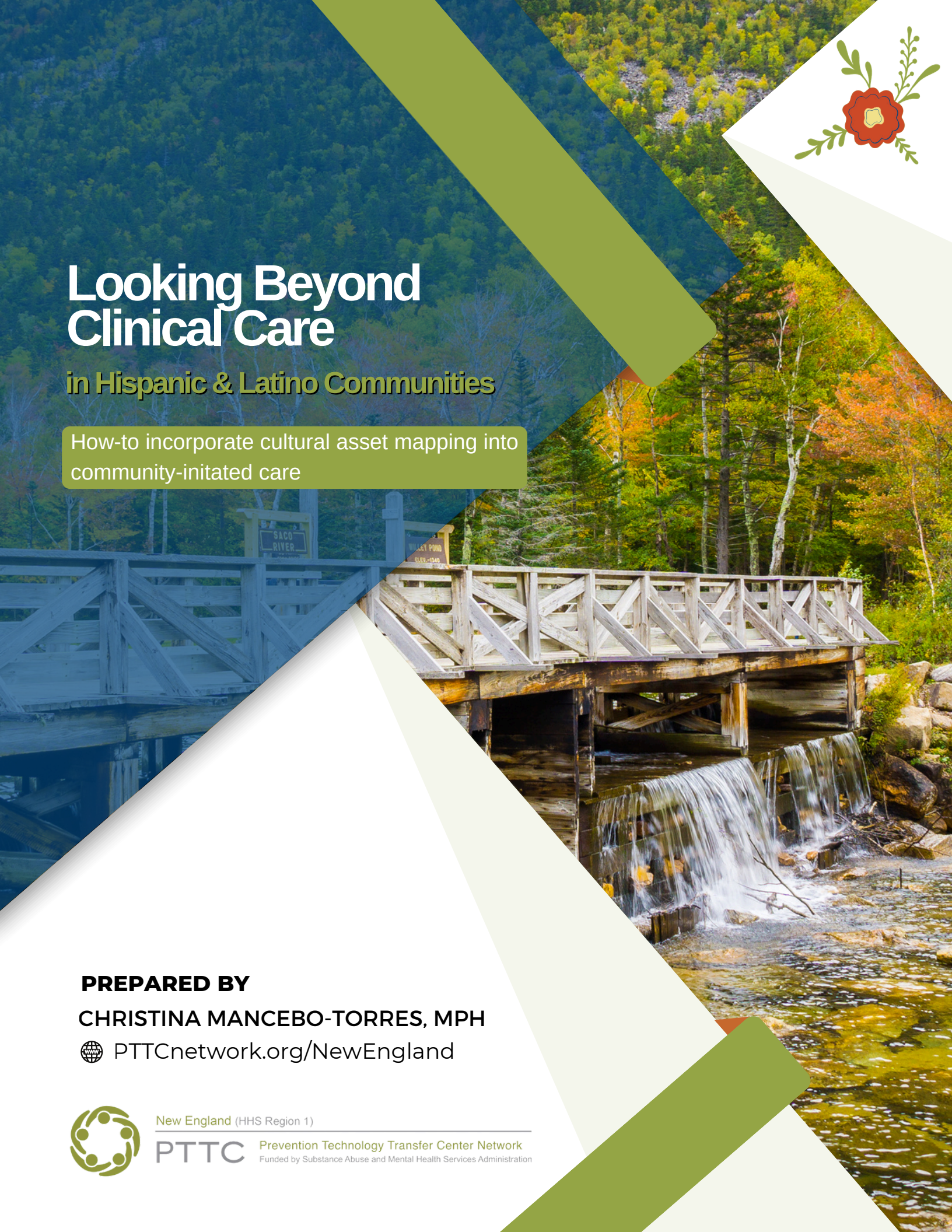

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