Latino Health in North Carolina

To The Editor:

In your May/June 2003 issue, you focused on Latino health in North Carolina—a subject in need of attention. The issue did not mention domestic violence and I wanted to share some information with you and your readers about this serious problem. The following paragraph is an excerpt from a client's story (with names changed). It paints a picture of the issues battered Latinas face.

> *"I remember once when I was three or four months pregnant with my second child, he beat me. I was crying and begging him not to hit me, but he kept on and his mom and step-dad did nothing. After he beat me, he left the house like he always does. When I asked his mom to call the ambulance she said she was not going to get her son, José, in trouble. His mother threatened to call immigration and said she would keep my son, José, Jr., because I would be taken back to Mexico."*

Numerous organizations, such as the American Medical Association, the American Nurses Association and the Joint Commission for the Accreditation on Healthcare Organizations, endorse addressing domestic violence through the healthcare system. Domestic violence has serious physical and mental health consequences and healthcare visits may be among the few opportunities for isolated victims to receive the support they need. However, in accessing the healthcare system, battered Latinas face multiple barriers in North Carolina. In general, the Latino population faces greater challenge accessing the healthcare system due to language barriers, cultural differences, immigration status and a lack of awareness of services. For Latinas who are victims of domestic violence, these barriers are increased by the isolation that is endemic to being a domestic violence victim. To further complicate matters, other common tactics by abusers such as threats of deportation, use of children and economic abuse hinder the ability of battered Latinas to access services.

"Language barriers first and foremost result in deterring a victim from obtaining necessary assistance."

Language barriers first and foremost result in deterring a victim from obtaining necessary assistance. Although linguistically accessible healthcare services should be provided by recipients of federal funding pursuant to Title VI of the Civil Rights Act of 1964, few such services exist. Several of our clients have feared getting medical help on their own because they are monolingual and were used to relying on the abuser for interpretation. One battered Latina client told us "[h]e was the only person who helped me in situations where I needed to communicate, and in this situation I could not rely on him." Even if the battered Latina is actually able to get to a healthcare provider, if the batterer acts as the interpreter, the information given health workers may be skewed.

Since not all Latinas in North Carolina are US Citizens, immigration status is also a barrier for many battered Latinas. Some immigrants are not eligible for Medicaid or Medicare except in life threatening emergencies, thereby limiting their access to healthcare. Domestic violence victims may choose to avoid receiving healthcare because they do not know how they can pay for such services and fear reprisals from the abuser. Furthermore, it is not uncommon that abusers will threaten an undocumented victim that a phone call to 911 for emergency services will result in her deportation and removal of children from her custody. Finally, cultural differences create an additional barrier for battered Latinas to access relevant services, although defining cultural differences can be a tricky enterprise. We know that cultural differences operate on both ends of the system. Healthcare providers may lack culturally competent staff. From the perspective of battered Latinas, they may be surprised to learn that they may be eligible for services. Many of our clients, for example, are unaware that they can receive mental health counseling as victims of domestic violence. One client informed us that in her home country, there were no services available for "women who are abused by their husbands." Many women, therefore, do not attempt to obtain assistance due to a lack of familiarity with the system especially since it may be quite distinct from the system in their home country.

Taken all together, the power and control dynamics inherent in a domestic violence situation further aggravate the cultural

isolation created by language barriers, cultural differences, and immigration status. These dynamics create special difficulty for battered Latinas in accessing medical assistance.

Special Laws Applicable to Battered Latinas Who Are Immigrants

There are certain laws that offer battered immigrant Latinas some assistance from the extreme isolation created by their situation. The Violence Against Women Act (VAWA) can help certain battered immigrants obtain lawful immigration status and employment authorization—both crucial to a victim's ability to survive independently.[1] If an undocumented immigrant is married to a Legal Permanent Resident or to a US Citizen, she may have remedies under VAWA. Normally, the undocumented immigrant would get immigration status through the traditional family-based immigration process, where the spouse with legal status would control the application process. In domestic violence situations, the abusive spouse often exploits the family-based immigration process by refusing to apply for lawful status in order to exert further control. VAWA was passed to remedy the traditional family-based immigration process so that the victim herself could apply for legal immigration status by filing a Self-Petition.

The VAWA Self-Petition process not only allows victims to obtain lawful immigration status, but it also may make some battered immigrants eligible for important federally-funded benefits, such as Medicaid.[2] Battered immigrants can qualify for federally-funded benefits it they have filed a VAWA Self-Petition and can show a substantial connection between the abuse and the need for the benefit. The victim is required to show: (1) a prima facie determination or an approval of a VAWA Self-Petition or a Family-Based Petition; (2) battery or extreme mental cruelty; (3) a substantial connection between the abuse and the need for the benefit; and (4) that she no longer resides in the same household as the abuser. Children of VAWA Self-Petitioners will also be eligible. Many of our clients have been able to show a substantial connection between the need for medical attention or mental health counseling and the effects of the abuse.[3] Unfortunately, not all VAWA Self-Petitioners will automatically be eligible for Medicaid since they are still subject to the complicated restrictions facing non-US Citizens who apply for federally-funded benefits.[4] This exception, however, at least places VAWA Self-Petitioners on the same footing with Lawful Permanent Residents in terms of accessing federally-funded benefits.

Moreover, there are certain federally-funded benefits that are available to all battered Latinas regardless of immigration status, since many battered Latinas are otherwise ineligible to file a VAWA Self-Petition. Some federally-funded benefits that are especially relevant to the health and safety of victims are: emergency Medicaid, crisis counseling and intervention programs, public health assistance for immunizations, treatment of symptoms of communicable diseases, violence and abuse prevention, medical and public health services and mental health, disability or substance abuse assistance necessary to protect life or safety.[5] Finally, battered Latinas, regardless of immigration status, have the right to access important criminal and civil court remedies necessary to protect their health and safety.

Suggestions for Healthcare Providers

Healthcare providers can take steps to increase battered Latinas' access to the healthcare system and to identify and assist victims. Common recommendations for increasing access for the Latino population generally are to offer bicultural and bilingual services and to conduct community education and outreach about available services. To serve battered Latinas as well, providers should be trained about the issues that are particular to battered Latinas, including the extreme isolation aggravated by their domestic violence situation and legal options for battered immigrants. Having some understanding of these issues is significant because it will shape how healthcare practitioners understand and choose to pursue treatment.

Healthcare providers should also have an adequate referral system in place for when they encounter a battered Latina who needs assistance. A good starting point is to establish contact with the local domestic violence program. Many programs are increasingly facing populations of battered Latinas and are learning about the special intricacies in assisting this population. Several of the programs within the state have also made a special effort to hire someone on their staff who is bilingual and/or bicultural; however, only a minority of the programs has bilingual staff. In addition, it is important to connect with the other local community-based organizations that serve Latinos. Many of them, particularly in communities where the domestic violence program does not have bilingual staff, serve as a de facto domestic violence program for Latinas.

Finally, a couple of statewide coalitions have worked on issues facing battered immigrants. These coalitions bring together individuals from a variety of backgrounds, including law, social work, public policy, law enforcement, and academics, in order to facilitate cooperation and the exchange of knowledge about the barriers faced by battered Latinas. Project Esperanza focused on issues relating to battered Latinas across the state. For more information, please contact the Coalition for Family Peace in Siler City, North Carolina: (919) 742-7320. There is also a larger statewide coalition called the NC Network on Behalf of Battered Immigrant Women, which addresses issues facing battered refugee and immigrant women generally. To subscribe to their list serve, please e-mail NCNetworkforBIWsubscribe@yahoogroups.com.

These coalitions would welcome the participation of healthcare practitioners who could bring to the table their unique perspective on this very important issue.

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REFERENCES

1 Violence Against Women Act of 1994, Pub. L. No. 103-322, 108 Stat. 1902, subsequently amended, Victims of Trafficking and Violence Prevention Act of 2000, 114 Stat. 1464, Pub. L. No. 106-386 (2000). There is also a more limited immigration remedy for victims of crime (U Visa) that could aid domestic violence victims who are otherwise ineligible for VAWA.

2 8 U.S.C. § 1641(c). This same provision applies to other federally-funded benefits such as Work First, Food Stamps, Public Housing and Section 8 Assistance.

3 Despite federal law, our battered Latina clients were being told by the local divisions of the Department of Health and Human Services that they were ineligible for Medicaid and other federally-funded benefits. Only with persistent advocacy on a case-by-case basis were we able to get our clients access to Medicaid and other benefits. In 2003, the Department of Health and Human Services modified their manuals to reflect federal law with more specific guidance to their workers. See "Citizen/Alien Requirements: Battered Alien (Violence Against Women Act)," Family & Children's Medicaid Manual, MA-3330, Section VI; "Immigrant Access to Benefits," DMA Administrative Letter, No. 19-03 (April 1, 2003). Similar clarification was made in the Manuals for Work First and Food Stamps.

4 All Lawful Permanent Residents who entered after August 22, 1996, for example, are subject to a five-year bar for Medicaid benefits. There is no exception from this requirement for battered immigrants. Other such restrictions were enacted by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105, and the Immigration Reform and Immigration Responsibility Act of 1996, Pub. L. No. 104-208, 110 Stat. 3009.

5 8 U.S.C. § 1611; 66 Fed. Reg. 3613 (January 16, 2001), A.G. Order No. 2353-2001, Final Specification of Community Programs Necessary for Protection of Life and Safety Under Welfare Reform Legislation. Federally-funded community health centers which provide primary and preventative healthcare serve all people regardless of immigration status or ability to pay. Mental health centers do not have restrictions on who can receive services based on immigration status; however, individual centers may have funding restrictions that are linked to immigration status.

Mental Health Reform

To The Editor:

In several of the analyses of the State Mental Health Reform Plan published in the September/October 2003 issue of the *North Carolina Medical Journal*, veteran observers of the reform effort raised concerns about the capability of the state mental health workforce to meet the challenge. Basic elements in the Plan—conservation of resources for the most severely mentally ill, increased accountability of clinicians and communities for mental health policy, consumer involvement, transfer of service delivery to the private sector and provision of evidence-based best practices for the targeted populations—pose challenges to the clinicians in the workforce as it is currently configured. The limitation of the most expensive forms of public mental healthcare to all but the most severely ill citizens will exclude some consumers from public sector facilities where they are currently being served, requiring that they seek care in different settings. Care of the uninsured and indigent citizens who do not meet target criteria is still undetermined.

Furthermore, by downsizing public mental hospitals and shifting public funding to community-based services for severely mentally ill citizens, the Plan inherently calls for a compensatory array of primary mental health services that are characterized by easy access, quick, comprehensive response, and that use an arsenal of interventions to restore normal function and divert hospitalization or incarceration. A shift to more primary mental health services means that the traditional equation of incremental intensity of services is reversed. Consumers, whether mildly or severely mentally ill, currently have access to intensive intervention immediately through multiple portals to care. Evidence-based early intervention precedes tertiary care, a wider array of clinicians are empowered to make gate keeping decisions and service authorizations, and relationships among individuals and institutions are collegial, not hierarchical. These elements require a level of seamless integration among frontline systems (e.g., emergency departments), mid-level systems (e.g. community mental health providers, clubhouses) and tertiary systems (e.g. inpatient facilities and mental healthcare hospitals). If a commitment is made to truly change mental healthcare, this necessary configuration must be addressed honestly rather than "patching" the current system in a way that preserves existing interests. As the Plan and the Journal analysis noted, meeting the reforms in the Plan is beyond the composition and configuration of the current state workforce.

In that same issue of the Journal, Schwartz and Morrissey called for bold training and recruitment and retention initiatives to intensify clinicians' skills, while Bacon and Stallings proposed increased use of advanced practice psychiatric nurses, in particular, the psychiatric nurse practitioner (PMH-NP). We would like to focus on this one role, not as a solution to the challenges of reform, but as an exemplar of the way in which existing clinicians within the mental health system could be prepared to bring the innovative elements that were in the Plan closer to reality.

The PMH-NP, a relatively new face on the mental healthcare team in North Carolina, has proven to be a cost-effective, quality-enhancing addition to mental healthcare in other states. Currently, there are almost 3,000 registered nurses working in mental health in North Carolina—more than 300 have a master's or doctoral degree. Most of these clinicians were prepared as

PMH Clinical Nurse Specialists with advanced practice preparation in psychotherapies and primary mental healthcare, but without prescriptive authority in North Carolina. As the state mental health hospitals are downsized and consolidated, some of these experienced nurses could help meet the mental health workforce needs if they were prepared as PMN-NPs to provide the right care at all levels of acuity in these ways:

- As independent practitioners, PMH-NPs could widen the portals of immediate mental healthcare through the provision of individual, family and group psychotherapeutic interventions for less-severely mentally ill adults and children in the community and, in collaboration with a physician, prescribe and maintain psychotropic medication, thus helping to prevent progression of disorders.
- As community-based providers of care for severely mentally ill adults and children in conjunction with local managing entities (LMEs), PMH-NPs could coordinate multiple care systems and construct support systems for families and community groups who will be the primary caregivers of these citizens, and in collaboration with a physician, provide medication prescription and ongoing maintenance and education.
- As institutionally-based providers of care to severely mentally ill citizens in crisis, the PMH-NP could collaborate with physicians to manage complex physical and mental health conditions and psychiatric crises that require readjustment of psychotropic medications and alterations in care treatment plans required to maintain them once they have returned to their communities.
- As institutionally-based providers of care to medically-ill citizens, the PMH-NP, in a consult and liaison role, could collaborate with physicians to correctly identify mental health issues when appropriate, secure early intervention when appropriate and assist in correct placement in community-based treatment facilities.

Nationally, and in North Carolina, existing advanced practice nurse educational programs prepare PMH-NPs to be cost-effective, multi-skilled providers. These programs already have mechanisms such as online courses, executive formats and AHEC liaisons through which many nurses who already have psychiatric experience could be supported to return to school. Through partnerships with existing facilities, faculty can work with LMEs to place these students in preceptored experiences that will prepare them to meet the newly-evolving service roles. With additional preparation enriching their years of experience in the provision of mental healthcare, these PMH-NPs could provide cost-effective, high quality care to North Carolinians based on best-practice evidence. The model that is already in progress for nursing could be adapted by other disciplines, thus creating an exemplar of interdisciplinary care to meet the challenge of mental healthcare reform in North Carolina.

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