

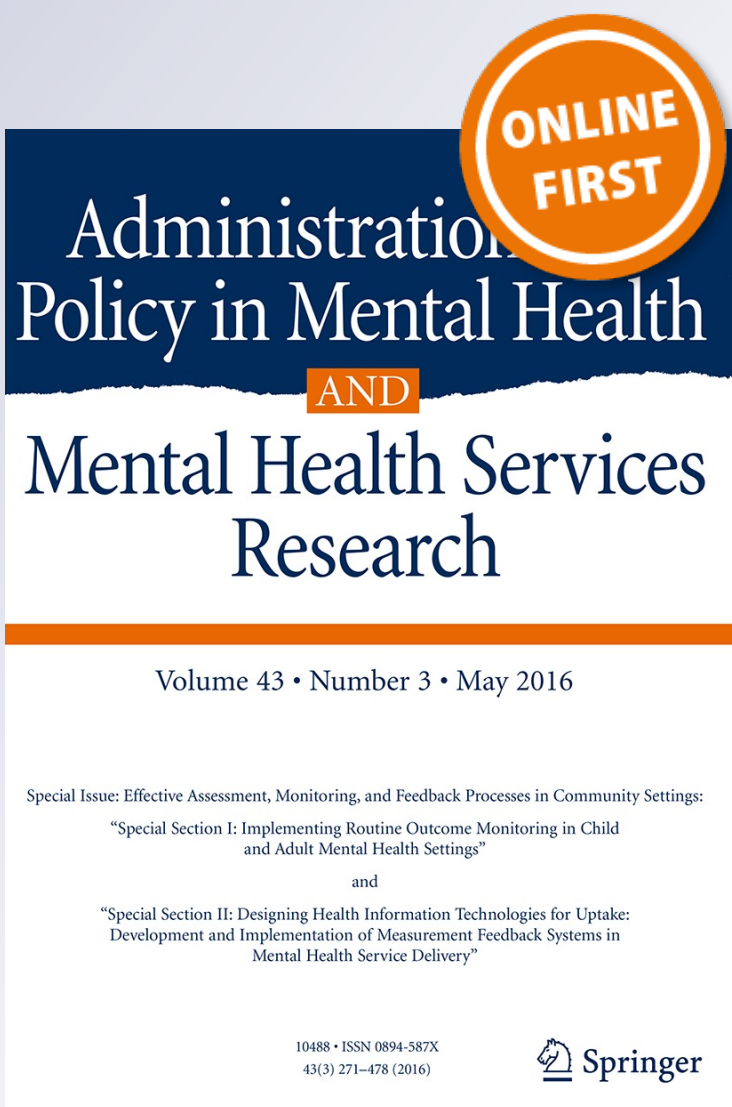
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The Healthcare Needs of Latinos with Serious Mental Illness and the Potential of Peer Navigators

Patrick W. Corrigan¹ · Alessandra Torres¹ · Juana L. Lara¹ · Lindsay Sheehan¹ · Jonathon E. Larson¹

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Abstract Latinos with serious mental illness get sick and die much younger than other adults. In this paper, we review findings of a community based participatory research project meant to identify important healthcare needs, barriers to these needs, solutions to the barriers, and the promise of peer navigators as a solution. Findings from focus groups reflected general concerns of people with mental illness (e.g., insurance, engagement, accessibility) and Latinos with serious mental illness (e.g., immigration, language, and family). Feedback and analyses especially focused on the potential of peer navigators. Implications of these findings for integrated care of Latinos with serious mental illness are discussed.

Keywords Latino · Serious mental illness · Peer navigators

Introduction

People with disabling psychiatric disorders show high rates of co-occurring physical illnesses that are often further disabling or may lead to death (Druss et al. 2011; World Health Organization 2005). Serious mental illness is defined here as

people with psychiatric disorders (e.g., schizophrenia, major affective disorders, personality disorders) who are unable to work or live independently because of the disabilities that result from these disorders. The National Association of State Mental Healthcare Providers (NASMHPD 2005, 2006) identified physical and behavioral health co-morbidities in this population among its key priorities. The healthcare needs of people with serious mental illness are exacerbated by ethnic health disparities (Ezell et al. 2013). Latinos with serious mental illness show significant health problems compared to the European American population in general (Sundquist 1993) and the European American population with serious mental illness (Alegria et al. 2011; Cabassa et al. 2014; Folsom et al. 2007). Nationally, 37 % of Latinos are uninsured and Latino children are among the least likely to be insured, regardless of citizenship (Brown et al. 2000; Kaiser Commission on Medicaid and the Uninsured 2000). This disparity is equally noticeable for Latinos with serious mental illness compared to European Americans with serious mental illness (Alexandre et al. 2009; Blanco et al. 2007; Sorkin et al. 2009).

Being Latino per se may additionally compound problems of serious mental illness and physical illness (Cabassa et al. 2014; Lara et al. 2005). Language differences (Bauer et al. 2010; Kim et al. 2011) and lower levels of education (Osinaga et al. 2007; Xu 2011) prevent many Latinos from engaging in treatment (Diaz 2002). Concerns related to US Immigrations and Customs Enforcement (ICE) for those with undocumented residency status make some Latinos suspicious of institutions (Shattell et al. 2008; Sullivan and Rehm 2005). The influence of extended family networks often differs with the majority culture to which much of the healthcare system conforms (Cardoso and Thompson 2010; Guarnaccia and Parra 1996; Magaña et al. 2007; Mulvaney-Day et al. 2007). Religious norms that are often at odds with American healthcare models (Jurkowski et al.

The Latino Health Disparities Consumer Research Team included Jaime Esquivel, Mavis Linda Lehmann, Patricia Munoz, Judith Ortiz, Marilyn Perez-Aviles, Timoteo Rodriguez, Nelson Santiago, and Reverend Rudy Suarez.

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2010; Murguía et al. 2003). Latinos are a heterogeneous; health perspectives of Mexicans living in the US, for example, are likely to differ from Puerto Ricans or Cubans in the US. Heterogeneity may influence solutions to health care concerns of this Latinos with serious mental illness.

Findings from a mixed methods, community based participatory research (CBPR) project with African Americans examined health care problems and solutions to enhance integrated care for African Americans who were homeless with serious mental illness (Corrigan et al. 2015). An important solution emerging from this work was peer navigators; African Americans in recovery hired to help peers navigate the complex healthcare system (Corrigan et al. 2014). These findings were used to develop a peer navigator program which was shown to have significant benefit for the physical and mental health, as well as recovery and quality of life, of participants randomized to the program versus treatment as usual.

We used insights from the African American project to conduct a mixed methods study examining healthcare concerns of Latinos with serious mental illness. In this paper, we summarize findings from the initial qualitative step of the fuller mixed methods research project. The purpose of the qualitative arm was to inductively identify healthcare problems and solutions to the problem. Given potential benefits of peer navigators (PNs), the qualitative arm was especially focused on participant views of PNs as well as perspectives on skills that might enhance PN services. The project was conducted as CBPR, an approach to science that believes research on any group is best done when professional researchers form partnerships with that group: i.e., Latinos with serious mental illness (Minkler and Wallerstein 2008). As partners, co-investigators with lived experience have shared leadership roles in all elements of research design and implementation: defining research questions and subsequent hypotheses, developing interventions meant to reflect hypotheses, describing measures and designs that will test interventions, conducting statistical analyses to make sense of data collected per design, and interpreting findings leading to recommendations with public health significance. CBPR is especially relevant to health disparities research when seeking to understand concerns and solutions of groups that are traditionally disenfranchised or otherwise alienated from systems meant to healthcare to their group.

Methods

This project was conducted in Chicago focusing on several specific Latino neighborhoods including Pilsen, Little Village, Humboldt Park, and Rogers Park. Latinos comprise about 28.9 % of the city's population with Mexicans

being largest subgroup (74.8 %), followed by Puerto Ricans (13.4 %), Cubans (11.2 %), Central Americans (4.2 %), South Americans (4.8 %), and others (1.3 %) (United States Census Bureau 2014). A CBPR team was convened at start-up to guide the project. Via flyers and word-of-mouth, a call was put out for Latinos with serious mental illness to join a research team charged with understanding and affecting the health of peers in their community. Prospective team members were further informed that participation in CBPR would require 2-h meetings, varied by week for up to 3 years. Nineteen people responded; each was interviewed by project coordinators and seven individuals were selected to serve on the CBPR team. Selection was based partially on participants understanding of the CBPR task and willingness to commit to project timeline. In addition, the team was selected based on diversity. All CBPR team members were Latinos; however, members were selected for further diversity: gender (57 % female), age, history of various physical illnesses (especially HIV–AIDS), substance abuse, and/or involvement with the criminal justice system.

Team members were paid \$25 per hour plus travel expenses. The CBPR team was led by a health services researcher with lived experiences in mental illness (JL) and a Latina working in public health (AT). The CBPR team also included a service provider from a local community health center. He was Latino and was included as an active member to provide immediate feedback to the team regarding feasibility of its proposals related to the service community (JE) (e.g., CBPR team says: “Let’s require all neighborhood clinics to stay open until midnight.” Service provider’s response: “No, that won’t work because clinics do not have staff for those hours”).

Defining the Problem and Possible Solutions: CBPR Consensus Work and Qualitative Interview

The CBPR team began with preliminary work: consensually agreeing about the nature of healthcare problems for Latino Chicagoans with serious mental illness followed by possible plans to address these problems. The team concurred that peer navigators may benefit Latinos with serious mental illness. Preliminary work on problems and solutions was necessary for development of an interview guide that engaged focus groups of community members. The interview guide was developed over a 2-month period with multiple iterations of research questions to represent the breadth of concerns about health within a manageable list of questions. The interview guide addressed four areas relevant to the goals of this paper.

1. What are the healthcare needs of Latinos with mental illness in Chicago?

2. What are the barriers for Latinos with mental illness meeting these needs?
3. What are possible solutions to these barriers?
4. How might peer navigators be good solutions?

The CBPR team agreed that focus groups should comprise key stakeholders to address these questions. The team defined key stakeholders as people with lived experience: Latinos currently challenged by mental illness and struggling with physical illness. The CBPR team thought key stakeholders should be expanded to others whose perspectives would increase our appreciation of health problem and possible solutions: providers of healthcare, advocacy and community services, and family members. The CBPR team decided focus groups should be heterogeneous including both people with lived experience and providers in the same group. Groups were scheduled at various days/times and locations (e.g., Monday afternoon, Saturday morning) to be convenient to the varied availabilities of all. To recruit people with lived experience, each of the seven CBPR team members distributed 25 flyers throughout Latino neighborhoods with specific focus on community health centers, homeless shelters, food pantries, shopping areas, bus stops, and social media. Flyers included a 24-h contact number and participants were screened until focus groups were filled. The CBPR team generated a list of provider names recruit to focus groups. All that were invited and agreed to participate received \$25 dollar along with commuting pay.

Focus groups were conducted by two bilingual research assistants (AT and JL) after being trained by the project PI who conducted focus groups for the mixed methods African American study (Corrigan et al. 2015). Groups were about 90 min in length with 6–10 participants and conducted in either Spanish or English depending on participant preference. Notes were taken by one of the group leaders and made into transcripts. Focus group transcripts that were written in Spanish were translated to English for a common data set by the two research assistants. Transcripts were then analyzed using Lofland and Lofland's (1984) systematic filing system and Berg's themes-to-concepts paradigm (Berg 2004) which allowed us to combine similar themes into categorical frameworks. First, research assistants reviewed all responses for each question identifying category labels that summarize key concepts. Two research assistants not involved in the initial sorting process were asked to code concepts into corresponding categories. We utilized GraphPad software to complete Cohen's kappa coefficient to measure inter-rater agreement between research assistants ($k = 0.95$). Qualitative findings were then reviewed with the CBPR team to obtain consensus about the themes of key responses to focus

group questions. The project was fully approved by the IRB at the Illinois Institute of Technology.

Results

Thirty-six people were recruited and completed focus groups. Another five completed key informant interviews that were conducted on providers who were too busy to attend scheduled focus groups. The overall sample was 63.4 % female ($n = 26$); we did not code for specific Latino ethnicity. Stakeholders differed by group with 53.6 % ($n = 22$) self-reporting as consumers of mental health services and people with lived experience, 26.8 % ($n = 11$) being service providers, 9.8 % ($n = 4$) being at large community members, and 9.8 % ($n = 4$) being family members of consumers. Summary of key themes and corresponding items are reviewed in Table 1. These results are summarized by aims of the project: healthcare needs, barriers to meeting needs, solutions to barriers, and peer navigators as possible solution. Information in Table 1 was reviewed with the CBPR team from which further elaboration of specific ideas were developed. Items consensually identified by the CBPR team as a priority were determined and are flagged in the Table 1. Special emphasis was given to items that may specifically concern Latinos living in the United States.

Healthcare Needs

Healthcare priorities that emerged from the focus groups include mental health services, preventive medicine, and dentistry. The CBPR team especially endorsed the need for mental health and substance abuse services for Latinos with serious mental illness with special focus on alcohol abuse services. The CBPR team agreed that preventive services are needed, especially as related to illnesses that result from obesity such as diabetes. The CBPR team identified two other issues not specific to healthcare but still clearly relevant to health: domestic violence and housing. "For a lot of families, when dad comes home drinking during the day, and it is seen as something normal." Participants noted this kind of behavior could lead to violence with spouses or children sometimes becoming injured. Substance abuse and violence were also associated with homelessness. Latinos with mental illness living on the streets or in shelters seemed to report more health challenges. The focus groups rounded out the discussion with statements of concern about maternal and childcare; reproductive and sexual health; and allergy and asthma.

Table 1 Common themes that emerged in qualitative interviews related to healthcare needs, barriers, and solutions of Latinos with serious mental illness

Healthcare needs

Mental health (9) (CBPRTEAM)

Depression

Anxiety

Counseling services (1) (CBPRTEAM)

Therapy (different types ex. Art) (1)

Substance abuse (8) (CBPRTEAM)

Alcohol abuse (4) (CBPRTEAM)

Substance drug abuse (1)

Preventive screenings/services (7) (CBPRTEAM)

Dental (4)

HIV (2)

Reproductive and Sexual health (1)

Obesity related illnesses (ex. hypertension, diabetes, etc.) (2) (CBPRTEAM)

Domestic violence (1) (CBPRTEAM)

Maternal and child care (1)

Allergy needs (1)

Asthma needs (1)

Vision (2)

Housing services (2) (CBPRTEAM)

Physical therapy (1)

Barriers to healthcare needs

Immigration—(undocumented status)

Fear (13) (CBPRTEAM)

No insurance (7)

Financial constraints (4)

Difference in generation (acculturation) of immigrants (3)

Language barrier (3)

Need of familiarity (2)

Unstable lifestyle/engagement (due to non-residency here, job changes day to day) (2)

Stigma (18) (CBPRTEAM)

Individual (7)

Social stigma (8)

Men stigma (machismo) (5)

Old stigma (religion) (3)

Avoidance of care (11)

Not a priority—only if necessary (emergency) (4)

Time restrictions within jobs (4)

Financial constraints (3)

Fear of finding additional health problems/results (2)

Lack of awareness/identifying of an illness (12)

Denial (4) (CBPRTEAM)

Downplayed by others (2) (CBPRTEAM)

Not identifying an illness (7)

Substitute with home remedies (2)

Lack of bilingual services (10) (CBPRTEAM)

Limited options due to lack of bilingual services (1)

Resources not in Spanish (3)

Translators do not explain just translate (3)

- Lost in translation (assistance with family members/children) (2)
 - Embarrassed of English (verbal) level (1)
 - Not understanding (audio), embarrassed to clarify (3)
 - Lack of understanding Latino culture: Machismo (2) (CBPRTEAM)
 - Lack of understanding Latino culture: family/home—'Familismo' (3)
 - Lack of understanding of Latino culture: cultural religious beliefs (6)
 - Lack of understanding medical terminology—(English/Spanish)(5)
 - Lack of free or sliding scale costs for low income/no insurance (4)
 - Women barriers to healthcare services (specific) (4)
 - Need of childcare services for smaller children
 - Need of transportation
 - Limited financial resources
 - Low literacy (4) (CBPRTEAM)
 - Difference in generation and/or acculturation
 - Mistrust of healthcare (4)
 - Misdiagnosis (1)
 - Miscommunication (2) (CBPRTEAM)
 - Bad experience (2)
 - Lack of familiarity (1)
 - Limited knowledge or no access to resources (6)
 - Culturally accepted 'illness' (3)
 - 'Nervios'
 - Lack of transportation (3)
 - Criminal history (1)
 - Unable to continue treatment (2)
 - Ethnic assumption (1)
 - Solutions to healthcare barriers
 - Provide insurance (information) (11)
 - Know medicaid and county care insurance coverage (2)
 - Know insurance marketplace—options (6)
 - Know insurance plan (individual) coverage (3)
 - Incorporate family to services (10) (CBPRTEAM)
 - Recommend and connect to resources (17) (CBPRTEAM)
 - Provide early awareness (9)
 - Increase community outreach/networking (14)
 - Religious and educational institutions
 - Provide bilingual/bicultural services (8) (CBPRTEAM)
 - Explain services not just translate
 - Ability to collaborate low understanding
 - Awareness of different dialects
 - Culturally responsive
 - Provide user-friendly medical terminology—simplify (English/Spanish) (3)
 - Gather pre-immigration information (differences in acculturation) (5)
 - Where the patient comes from (ethnic origin)
 - Rural versus urban; small versus large community
 - Occupation
 - Generation of immigrant
 - Level of family support (here vs. back home)
 - Create awareness of Stigma (Individual, Social, Men (Machismo), Old Stigma (religion) (7) (CBPRTEAM)
 - Acceptance of illness (2)
 - Provide peers (from the community)/mentors (3)
-

Increase information on mental health conditions and symptoms (3) (CBPRTEAM)

Increase free or sliding scale services (3)

Ensure confidentiality; (provide client/patient rights) (7)

Provide cognitive behavior techniques (1)

Change the approach to services (focus to general) (4)

Provide transportation (2) (CBPRTEAM)

Provide central place for Latinos (1)

Peer navigators as solutions

Communication skills (12) (CBPRTEAM)

Be social (3)

Learn to listen (4)

Able to communicate with doctors (1)

Be aware of body language (2)

Need of disclosure (share their story) (8)

Stability—Level of Recovery (6)

Knowledge of mental illness and symptoms (8)

Knowledge of medical conditions (5)

Empathy (7) (CBPRTEAM)

Knowledge of substance abuse (4) (CBPRTEAM)

Self-awareness quality (5)

Bilingual (3)

Provide boundaries between PN and client (4) (CBPRTEAM)

Need of common background (3)

Matched based on recovery (2)

Matched by personal experience (2)

Age (2)

Gender (2)

Care coordination training skills (7) (CBPRTEAM)

Able to provide group environments (3)

Coaching services (5)

Recovery process (2)

Coaching to become independent (3)

Appointment/referral process (5)

Provide support/educational workshops & trainings (5) (CBPRTEAM)

Provide model of cultural sensitivity to organizations (2) (CBPRTEAM)

Be flexible (1)

Cons of PN (5)

Not all Hispanic/Latinos relate

Assumptions on ethnicity (1)

Literal versus integrating

Need of compensation and benefits

Not to impose own values

Be aware of responsibility load

Items that were endorsed by the CBPR team at the post-evaluation discussion are marked as CBPRTEAM

If women are pregnant, it can be cultural to have them stay home. Sometimes you'd think you'd have post birth depression but it can be something else.

Barriers to These Needs

The focus group and CBPR team recognized a single health care barrier specific to Latinos: immigration. Focus group participants and the CBPR team worried that engaging in healthcare services might result in undocumented Latinos being remanded to the U.S. ICE and possibly deported. "Undocumented immigrants don't seek help... because they don't want to get deported." They also thought Latinos seem to endorse a special stigma to the pursuit of healthcare in general and mental healthcare in particular.

A lot of people accept it like, 'no, that's not me,' and try to tell you that they don't have anything. There's a stigma.

For men, this manifests itself as machismo, the expectation that real men do not need these kinds of services. In addition, Latinos involved in Christian Churches might believe healthcare services are not needed in light of the church. The ministry and god will watch over them. Further undermining health needs of people who are undocumented include absence of insurance benefits, language difficulties, and mental health systems that are foreign to Latino expectations.

If they do have translators, they are not educated to explain. They are no help, like they don't know medical terms, like if she tells me she fainted and was bleeding I will just say, 'oh, she feels weak.' I will translate in my format, so medical terms.

Lack of awareness of illness was viewed as a major concern, a problem that is not specific to Latinos.

Fear if they find something you don't want to find out. Like this person had cancer and didn't want to go to the doctor out of fear and when he finally went it was too late.

People are often unable to identify an illness or deny symptoms that reflect it. As a result, they avoid treatment services. Time restrictions due to jobs can impede care seeking as do financial constraints. This combines to lead to a general mistrust of the healthcare system, especially mental healthcare services.

Solutions to Barriers

Solutions emerged at the systemic level as well as patient-to-service interactions. The CBPR team agreed with focus

group members that addressing healthcare costs and insurance is essential. This may include development of sliding scales at clinics. In part, this may require action by governments suggesting a need for advocacy. Research participants noted the complexity of costs and insurance, recommending that programs should educate and explain options. Peer navigators, discussed below, can serve a vital role in helping people to actually avail insurance programs.

Focus group participants believed services need to be culturally adapted. Most healthcare systems are not set up to include families in decisions and practice. Research participants believed parents, spouses, and adult children may play a more central role in healthcare than for the Anglo majority.

Treatment need life style changes. It is hard to do if you are the odd person, so inviting family could be helpful to make healthcare changes.

Parents and other family elders were believed to be especially important in health decision making. The church may play an important role here too.

So have the padre go door to door and talk about support groups and outreach programs and give information... When they hear from priests they (Latinos) listen a little better.

Services need to be available in Spanish. Service providers need to be sensitive to immigration and documentation issues, making sure they are fully informed of the degree to which they can keep information confidential. Providers need to be culturally sensitive and humble, recognizing exchanges that might seem strained because of differing cultural expectations. This varies not only between Latinos and other cultures but within the Latino community as well (e.g., differences in perspective of Mexicans vs. Cubans). Finally, participants noted help in pragmatic issues may be needed such as transportation or child care services.

Peer Navigators

Peer navigators are one possible solution that spans many of the recommendations from the previous section. Focus group feedback yielded information about perceived costs and benefits of peer navigators leading to recommendations for a peer navigator training program. Participants believed navigators who were not only Latino but in recovery from serious mental illness would have a special empathy for program participants. They would have a consumer's knowledge of the service system which could be helpful in navigating the health system. Peers may also have a self-awareness from which participants might learn vicariously.

Concerns about peer navigators included recognizing that Latinos are not a homogeneous class, that significant differences may exist, for example between Cubans and Mexicans. Peer navigators and their supervisors need to be mindful of the demands of the position and make sure these demands do not overwhelm their ability to cope. Finally, peer navigators need to make sure they do not allow their previous experiences to prevent navigators from understanding participant needs, instead imposing their values on people.

Given these strengths and concerns, participants made recommendations for a peer navigator training program. Some of these would apply to navigators whether they were or were not peers: communication skills, knowledge of the healthcare system, and care coordination skills. These may be especially necessary when considering age differences.

It is a different story when you got another female who is 25–30 and here you are 50 and going through menopause. You won't feel comfortable venting these things out because she won't be able to relate.

Some recommendations are specific to peers; learn how to use disclosure of peer experiences to advance the needs of participants and appropriate boundaries between navigator and participant. "I've seen similar programs like *promoterías de salud*. It works because they share their story." Shared story promotes greater intimacy. They may also offer some insight on how the Latino patient might better avail existing health systems.

Discussion

In this paper, we report on findings from a qualitative study meant to describe the healthcare needs of Latinos with serious mental illness, barriers to these needs, and solution to the barriers. Many of these findings were expected, and corresponded with other research on Latino perspectives of the healthcare system. Given its innovative nature, we especially examined the potential of peer navigators for this group. The project was conducted as a CBPR effort. One finding of the study arose anecdotally from review of the CBPR process that address lingering concerns about including people with mental illness, and corresponding social or cognitive disabilities, in CBPR. Namely, people with serious mental illness were able to engage in all phases of the CBPR process. Latinos with lived experience had central and active roles in designing the qualitative project including interview guide, group logistics, and analysis of findings.

Healthcare needs with notable priority identified by focus group participants and echoed by the CBPR team

include: mental health and substance abuse services as well as human services, while not specific to health per se, are clearly related: domestic abuse and child care services. Barriers to needs reflected concerns that reflect Latino culture as well as those common across most groups with serious mental illness. Immigration and documentation were identified as barriers to healthcare. Participants expressed stigma and beliefs common to Latino culture that might undermine healthcare needs such as machismo and the Catholic Church. More generally, participants were concerned about lack of awareness of illness that undermined seeking help for conditions. They also believe that practical considerations related to transportation and time away from job were critical barriers.

Solutions reflected Latino-specific perspectives as well as more general ideas common to people with serious mental illness. Services need to be culturally adapted including providers who are fluent in English and Spanish. Providers need to be aware of the immigration challenges of working with people who are undocumented, making sure they know the limits of confidentiality so people are not unduly exposed to ICE intervention. Programs need to be able to more fully engage family members in treatment. More general concerns include helping people understand insurance and entitlements. They may need assistance in pragmatic issues such as transportation or child care services.

Peer navigators may be one way to actualize many of these solutions. Benefits of peer navigators include a special sense of empathy and insight that result from shared, lived experience. Participants provided several suggestions for subject areas which peer navigators might learn to become more adept at their services: communication skills, knowledge of the healthcare system, and care coordination skills. These findings provide an excellent start for understanding the healthcare needs, barriers, and solutions of Latinos with serious mental illness, especially in terms of integrated care. There are varying models of integrated care that all seek to coordinate the provision of physical and mental health system in a common plan. Peer navigators may help Latinos with serious mental illness work their way through the integrated system in real time doing so over protracted time so that services for physical and mental health needs can become rooted in the person's life. These suggestions were used to develop a peer navigator program described more fully below.

Despite strengths of this study, there are concerns that need to be examined in future research. CBPR not only represents the interests and perceptions of ethnic groups, but of groups in specific locales. Hence, these findings reflect the perspective of Latinos living in Chicago. This is a strength for developing programs that strongly represent local issues. However, findings need to be replicated in

settings outside the Midwest. “Latino” in this study was presented as somewhat of a homogeneous construct, contrary to the fact that Latinos vary significantly and meaningfully by nation of origin and race. Future research needs to account for these kinds of heterogeneity.

Patient navigators have a fairly long history in medicine, first emerging to provide both instrumental assistance (offering practical and logistic guidance on doctor’s orders, medications, and therapy options in the real medical setting during real time) and interpersonal support (empathy and reflective listening when components of care became overwhelming) in the cancer clinic (Parker et al. 2010). Navigators of similar ethnic backgrounds are often viewed as more emotionally present and better listeners leading to being more trusted (Han et al. 2009; Nguyen et al. 2011). Peers—patients with past experiences with cancer—soon joined the ranks of navigators. Women with past breast cancer acting as navigators to peers led to better engagement in cancer care (Burhansstipanov et al. 2010; Burhansstipanov et al. 1998; Giese-Davis et al. 2006; Nguyen et al. 2011) Patient navigator guidelines were adapted for African Americans with mental illness who were homeless in the mixed methods CBPR study mentioned earlier.

Information from the study reported herein was used by the CBPR team to develop a peer navigator practice and procedure manual for Latinos with serious mental illness. The resulting manual was governed by several basic principles including eight basic values (e.g., accepting, empowering, recovery focused, and available), seven qualities of being part of a team (e.g., networked, accessed, informed, resourced, and supervised), and six fundamental approaches (e.g., proactive, broad focused, active listener, shared decision making, and problem focused). These led to four sets of helping skills: (1) basic helper principles; (2) skills to work with the person (such as reflective listening, goal setting, motivational interviewing, strengths model, and advocacy); (3) skills to respond to a person’s concerns (e.g., interpersonal problem solving, relapse management, harm reduction, cultural competence, and trauma informed care); and (4) role management skills (relationship boundaries, managing burnout, self-disclosure, and street smarts). Peer navigators were also informed about area resources as well as a dynamic service engine locator used by the provider agency. The PNP manual can be downloaded from www.ChicagoHealthDisparities.org for free. The CBPR team is now conducting a randomized controlled trial examining the impact of the peer navigator program for Latinos with mental illness or treatment as usual over the course of 1 year. Outcomes are not only physical and mental health, but impact on recovery and quality of life.

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Compliance with Ethical Standards

Conflict of interest Patrick W. Corrigan declares that he has no conflict of interest. Alessandra Torres declares that she has not conflicts of interest. Juana L. Lara declares that she has not conflict of interest. Jonathon E. Larson declares that he has no conflict of interest.

Disclaimer All statements in this report, including its findings and conclusions, are solely those of the authors and do not necessarily represent the views of the Patient-Centered Outcomes Research Institute (PCORI), its Board of Governors or Methodology Committee.

Ethical approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent Informed consent was obtained from all individual participants included in the study.

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