

Culturally Competent Physical Health Care for People with Serious Mental Illness

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Public Health Crisis among People with Serious Mental Illness (SMI)

- ▶ People with SMI are dying on average 25 years earlier than the general population largely due to:
 - Preventable medical conditions (e.g., cardiovascular diseases, diabetes)
 - Modifiable risk factors (e.g., smoking, obesity, sedentary lifestyle)
 - Medication side effects (e.g. weight gain and metabolic alterations)
 - Poor quality medical care

Parks, et al., 2006; American Diabetes Association et al., 2004; Institute of Medicine, 2006

Racial/Ethnic Health and Health Care Disparities in the SMI Population

- ▶ There is growing evidence that minorities with SMI are at higher risk than Whites with SMI to suffer from:
 - Obesity
 - Metabolic syndrome
 - Diabetes
 - Cardiovascular diseases
- ▶ Racial/ethnic minorities with psychiatric disorders are at higher risk to receive poor quality care and lack of guideline-concordant medical care

Cabassa et al., in preparation; Hellerstein et al., 2007; Kato et al., 2004; McEvoy et al., 2005, Parks et al, 2006, Druss 2007, Nasrallah et al.,2006, Mauer & Druss, 2009

Gaps in research and practice

- ▶ Little is known about the provision of culturally competent medical care to racial and ethnic minorities with SMI
- ▶ In recognition of this gap, we conducted a qualitative study to help inform the development and provision of culturally competent models of care that integrate physical health services in behavioral health settings for people with SMI

Study Aims

- ▶ To identify systemic and socio-cultural barriers and facilitators to the integration of physical health services in behavioral health settings
- ▶ To develop recommendations for culturally competent service integration

Sampling

- ▶ Purposive sample of six community-based mental health organizations in Northern Manhattan that:
 - Serve large numbers of racially and ethnically diverse individuals with SMI
 - Provide different mental health services (e.g., outpatient, day treatment, housing, ACT)
 - Receive different funding streams (e.g., public, private)

Qualitative Methods

- ▶ Multi-stakeholder approach (consumers, family members, clinicians, administrators, community and faith-based leaders)
- ▶ 97 in-depth interviews, 5 consumer focus groups and 32 hours of participant observations at community sites
- ▶ Reviewed organizations' documents (mission statements, intake forms, brochures)
- ▶ Analytical Strategy: coding, consensus, co-occurrence, and comparison, an analytical strategy rooted in grounded theory

Results: Sample Characteristics

Administrators (n=21)

- ▶ Average age (n=20) = 49 years
- ▶ Females = 57%
- ▶ Bilingual = 32%
- ▶ Race/Ethnicity:
 - Whites = 71%
 - Hispanics = 14%
 - Black/African-Americans = 10%
- ▶ Profession (n = 17)
 - Psychiatrist = 38%
 - Social Worker = 19%
 - Psychologist = 29%
 - Nurse = 5%
 - Other = 10%

Clinicians (n=25)

- ▶ Average age = 45 years
- ▶ Females = 80%
- ▶ Bilingual = 60%
- ▶ Race/Ethnicity:
 - Whites = 36%
 - Hispanics = 40%
 - Black/African-Americans = 16%
- ▶ Profession (n = 18)
 - Psychiatrist = 28%
 - Social Worker = 39%
 - Psychologist = 22%
 - Nurse = 6%
 - Other = 11%

Results: Sample Characteristics

Consumers (n= 66)

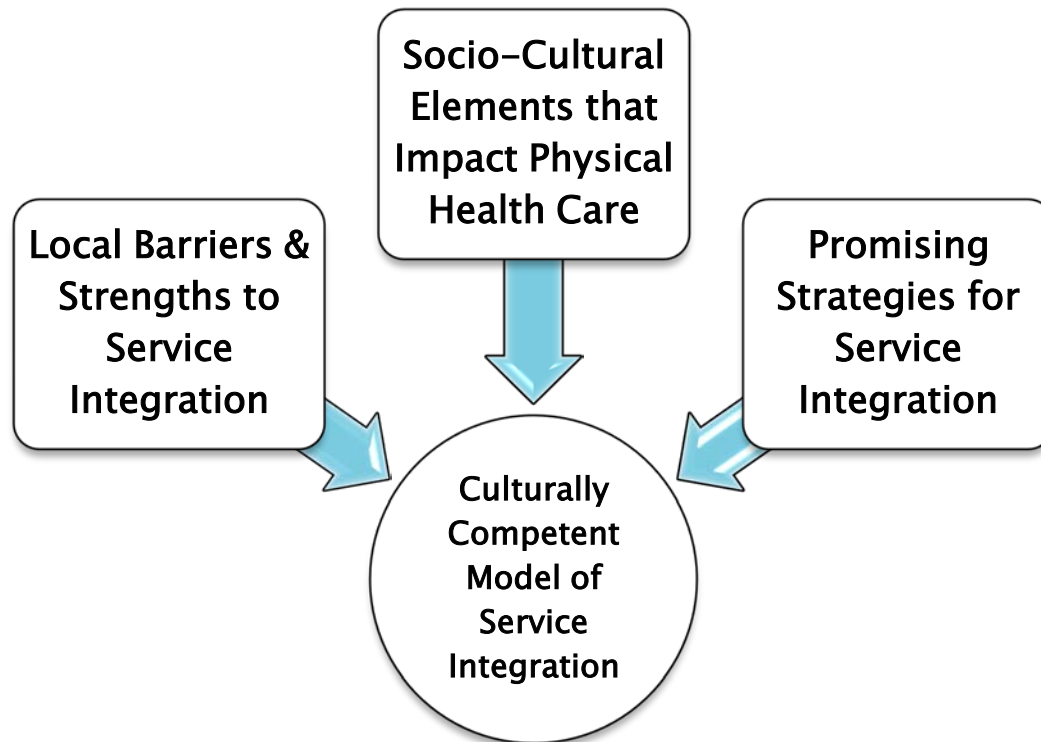
- ▶ Average age = 50 years
- ▶ Females = 56%
- ▶ Foreign born = 55%
- ▶ Single (never married) = 57%
- ▶ Spanish only speaking = 31%
- ▶ Race/ethnicity (n=65)
 - Non-Hispanic Whites = 8%
 - Hispanics = 57%
 - African Americans = 34%
- ▶ Years of Education (n=63)
 - Less than 12 yrs = 35%
 - HS Diploma/GED = 35%
- ▶ Employment Status (n=65)
 - Employed = 6%
 - Disabled = 45%
- ▶ Annual Household Income (n=54)
 - Less than \$9,999 = 59%

Study Findings

- ▶ The following results summarize the perspectives of administrators, mental health clinicians, consumers, family members, primary care physicians, and community and faith-based leaders with regard to:
 - Local barriers and strengths to integration of physical and mental health services
 - Socio-cultural factors that impact service delivery
 - Promising strategies and recommendations for service integration

Elements for the Development of a Culturally Competent Service Integration Model

- ▶ Our results summarize four key elements to the development of culturally competent service integration models



Local Barriers & Strengths to Health Service Integration for people with SMI

- ▶ Consumers, friends, relatives, mental health and physical health providers, administrators, and community and faith-based leaders identified local strengths and well documented barriers to health service integration, which we call the usual suspects
 - These barriers to health service integration impact access to and quality of medical care across multiple levels (organizations, providers, and consumers with SMI)

Existing local strengths for health service integration

- ▶ Genuine interest and concerns about the physical health needs of persons with SMI
- ▶ Collection of physical health information (e.g., medical history, annual physicals)
- ▶ Participation in physical health initiatives and research studies
- ▶ Emergence of home-grown health groups and activities (e.g., weight management groups, walking groups, yoga classes)
- ▶ Some co-located care (e.g., once a week internist)
- ▶ Local knowledge of how to access and navigate medical system, social and community services
- ▶ Some relationships with primary care clinics
- ▶ Established community trust
- ▶ Experience and expertise working with diverse communities

Local Barriers to Physical Health Care for People with SMI: The Usual Suspects

Organization

- Service fragmentation
- Reimbursement policies
- Lack of physical health infrastructure (equipment, space)
- Long wait lists for medical appointments

Provider

- Turnover
- Training
- Multiple demands
- Lack of access to medical information
- Frustration with primary care (accessibility, feedback)

Consumer

- Lack of medical insurance
- High medical cost
- Competing demands
- Transportation
- Lack of stable medical home
- Language barriers

Local Barriers to Physical Health Care for People with SMI: The Usual Suspects

- ▶ However, attention to these usual health service integration barriers is important but **NOT SUFFICIENT**
- ▶ Major socio-cultural issues that impact the delivery and quality of medical care need to be incorporated into any integration approach of physical health services in mental health settings for people with SMI

Cultural Competence

- ▶ The integration of physical health services into mental health settings in a culturally competent manner is essential in order to **optimally deliver healthcare to people with SMI**
- ▶ We define cultural competence as a dynamic web of policies, strategies, interactions, practices, skills, and norms that facilitate effective practices and services among the multiple cultures of consumers, providers, and organizations

Cross et al., 1989; Guarnaccia et al., 1996; Whitley, 2007

Cultural Competence Matters in Health Service Integration

- ▶ Ignoring socio-cultural factors can lead to consumer dissatisfaction with services, poor engagement with and adherence to treatments, poor health outcomes, and persisting racial/ethnic disparities in care
- ▶ Interventions that explicitly incorporate socio-cultural factors show promise in narrowing health inequalities among diverse populations

Lau, 2006; Fisher et al., 2007

Summary of Socio-Cultural Factors that Impact Health Integration Service in Mental Health Settings

Organizational Factors

Social context and cultural competent policies and practices

Provider Factors

- Professional boundaries
- Stigma towards people with SMI
- Bias

Provider - Consumer Interaction

- Deference to authority
- Mistrust/Racism

Consumer Factors

- Body image
- Socio-economic status & environment impact diet/exercise
- Self-blame for unhealthy lifestyle
- Family involvement

Illustrative Examples of Socio-Cultural Factors Organizational Level

Organization's Social Context Impacts Service Integration

- ▶ An organization's social context, which consists of expectations, perceptions and attitudes of its staff, determines the likelihood that an organization will adopt new technologies and practices

Glisson et. al., 2008

Illustrative Examples of Socio-Cultural Factors Organizational Level

Organization's Social Context Impacts Service Integration

- ▶ We found that when mental health organizations' cultural context conflicts with the physical health intervention approach, integration did not happen.

"You know what? For me, it would be straying from the dynamic of the program. So I would not encourage that here. But basically I would also encourage that we monitor their medication, you know that they are taking it and see that they are taking it.... It's just like an underlying thing where we just – we are just concerned about you. It's not so much like it's a clinical program."

By a provider

Illustrative Examples of Socio-Cultural Factors Provider Level

Professional Boundaries

- ▶ Mental health providers felt a sense of ambivalence to address the physical health of their patients due to professional boundaries and lack of training

"But I'm not really monitoring them because I'm not up-to-date with the latest, you know, anti-hypertensives and the best regimen for diabetes. I want them to get the best care possible, so I try to refer them out."

By a provider

Illustrative Examples of Socio-Cultural Factors Provider Level

Professional Boundaries

- ▶ However, there is a tipping point – at which mental health providers are willing to step outside their usual role in an urgent situation.

"I think the milder cases, like I was saying; we probably need to do a better job of. But the serious cases we really work hard to help.

By a provider

Illustrative Examples of Socio-Cultural Factors Consumer Level

Body Image Varies Culturally

- ▶ For some Latina and African American women, a fuller body image is linked to good health according to providers:

"It's more difficult with a Spanish population, because the idea of being obese is healthy... they grew up with it. And they say if I don't gain weight, I'm not healthy. And that has to be dealt with."

By a provider

Illustrative Examples of Socio-Cultural Factors Consumer Level

Body Image Varies Culturally

- ▶ A Latina consumer stated:

“Cuando muy joven, tenía el complejo de que tenía las piernas flacas, y quería tener las piernas gordas porque en Santo Domingo la gente con las piernas gordas eran las bonitas. ”

“(When very young I had a complex that I had skinny legs, and I wanted to have fat legs because in Santo Domingo people with fat legs were the pretty ones).”

By a consumer

- ▶ Conflicts in cultural norms regarding body image may inadvertently create resistance to lose weight and engage in healthy lifestyle changes

Promising Strategies & Recommendations

- ▶ Integration efforts should be reflective of the organizational context and model of service delivery at each site
- ▶ Enhance consumer activation skills and health literacy by providing culturally competent health promotion and education materials
- ▶ Promote open discussion between providers and consumers of what constitutes an ideal body image in the context of good physical health
- ▶ Develop clinical strategies to improve consumers' self-efficacy to achieve healthy lifestyles and reduce self-blame

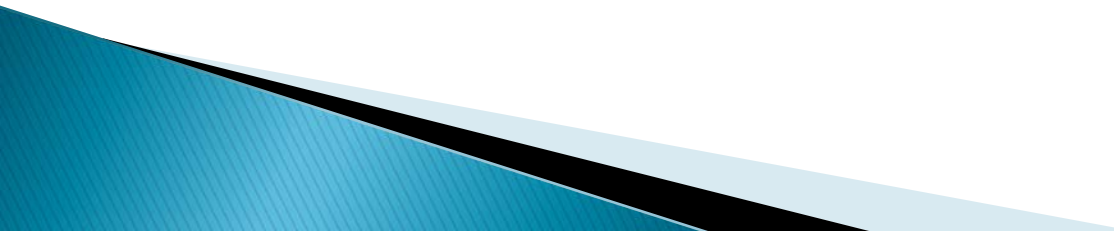
Discussion

- ▶ Attention to local system barriers, strengths and socio-cultural elements is essential to improve the physical health of racial and ethnic minorities with SMI
- ▶ Ignoring the cultural background of consumers, providers, and organizations can create an environment of mistrust, misunderstanding, and sometimes consumer self-blame
- ▶ Efforts to integrate culturally competent physical health services in mental health settings need to be adapted to:
 - consumer needs
 - provider capacity
 - organizational context
 - community resources

Conclusion

- ▶ Attention to socio-cultural factors at multiple-levels (organizational, provider, & consumer levels) is essential to tailor interventions that optimally deliver physical health care to racial/ethnic minorities with SMI
- ▶ The integration of culturally competent physical health services into mental health settings can help improve access and receipt of quality medical care for racial/ethnic minorities with SMI

Limitations

- ▶ Results may not be generalizable to all Latina/os, African Americans and other racial/ethnic minorities with SMI due to the study's purposive sampling
 - ▶ Setting was a sector in a large East Coast metropolitan area
 - ▶ Causal inferences cannot be established because this is a cross-sectional design study
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Thank you! ... ¡Gracias!

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