Contextual Factors at Work in the Physical Health of People with Serious Mental Illness

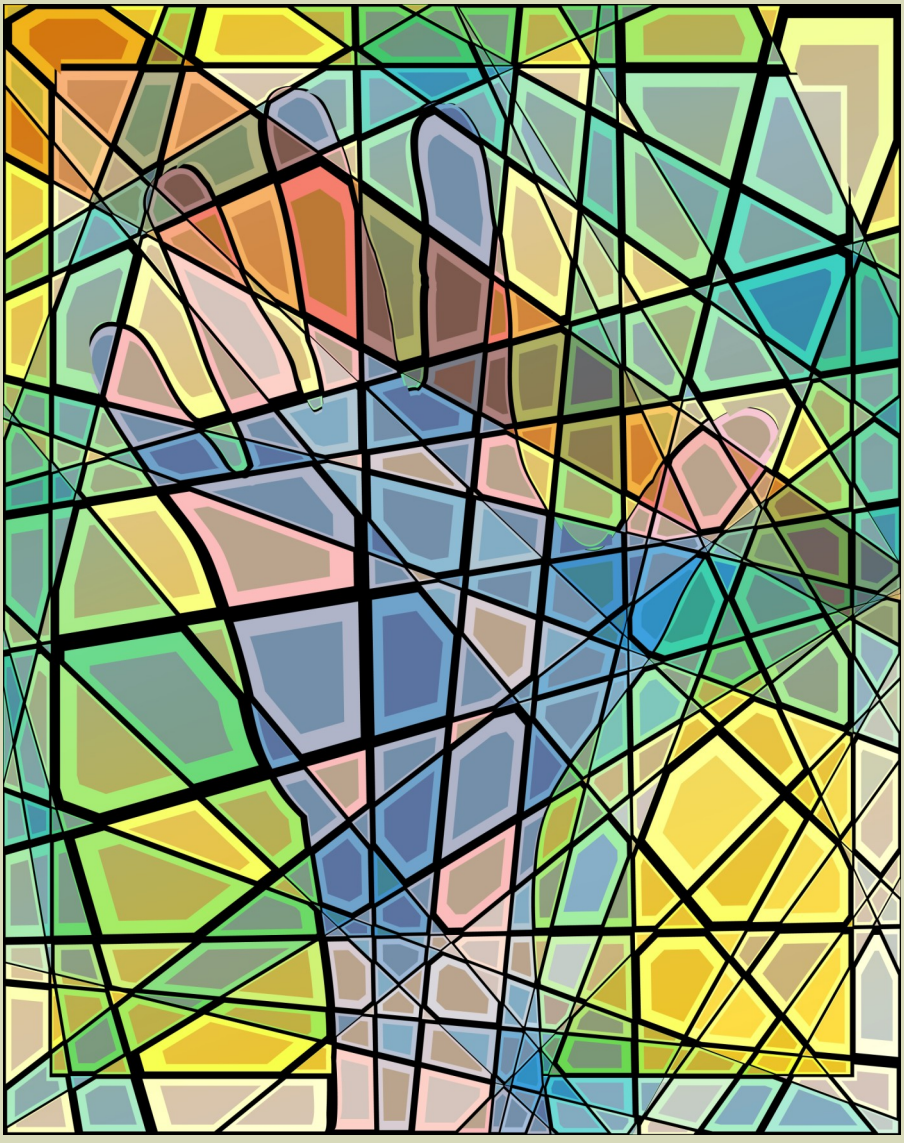

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Culture and the social environment are contextual factors that play a substantial role in the physical health and medical care of people with serious mental illness (SMI; e.g., schizophrenia, bipolar disorder). In this report, we examine how these contextual factors influence two critical aspects of the physical health of people with SMI: (1) consumer-provider interactions in the medical encounter and (2) consumers' interactions with their physical environment.

How do contextual factors influence consumer-provider interactions?

Three cultural norms shape the clinical encounter from the consumer's perspective: (1) a tendency to avoid overt disagreements during medical visits, (2) mistrust of medical institutions, and (3) cultural variation in body image. At the provider level, three cultural norms shape the clinical encounter: (1) mental health providers' ambivalence about intervening in consumers' physical health care, (2) primary care providers' misattribution of physical symptoms to mental disorders, and (3) providers' stigmatization of people with SMI.

Summary of Practice Recommendations:

- Motivational and engagement interventions (e.g., Right Question Project, motivational interviewing) can help consumers be more proactive and involved during the medical visit.

- Ongoing provider training about racism, bias, and community engagement is necessary to address consumers' mistrust of medical institutions.

- Health care interventions for people with SMI should take into account cultural variations in body image by discouraging thinness as a treatment goal and focusing instead on improving consumers' physical health and wellness.

- Providers should be cross-trained to work in integrated models of care to reduce misattribution of physical symptoms to mental disorders by primary care providers and lack of familiarity of mental health clinicians with medical care.

How do contextual factors shape consumers' interactions with their physical environments?

Cultural and social forces influence consumers' interaction with their environments, particularly with respect to dietary habits and engagement in physical activity. Consumers' food

environments in their neighborhoods and in the programs they visit, as well as social norms associated with traditional foods and diets, shape consumers' dietary habits and may contribute to their risk for obesity and other chronic medical conditions. For many consumers, the combination of internal factors (e.g. motivation, preferences, symptoms) and external factors (build-environment, social support) influences their involvement in regular physical activity.

Summary of Practice Recommendations:

- Attention to consumers' food environments is central to improving consumers' diets and physical health.

- Health and wellness programs should help raise consumers' awareness that their culturally traditional foods can be prepared in a healthy manner without compromising taste.

- Structured physical activity programs should be fun, culturally meaningful, enable consumers to socialize with peers, and go beyond raising consumers' knowledge about the benefits of physical activity by including structured exercise activities (e.g., walking groups, dancing).

Our goal with this report is to initiate a dialogue about the importance of contextual factors in the planning, development, and implementation of interventions and programs aimed at improving the health of people with SMI.

I. INTRODUCTION

In this report, we examine the role that culture and the social environment play in the physical health and medical care of people with serious mental illness (SMI; e.g., schizophrenia, bipolar disorder). A person's physical health is shaped not only by individual-level factors, such as inherited biological propensities, but also by his/her engagement with social-level factors, such as cultural norms (e.g., about weight), learned behaviors (e.g., about physical activity), and interactions with the human-built environment (e.g., availability of affordable food). Physical health and health care are therefore strongly influenced by cultural and social-environmental factors (1). We refer to these two factors as ***contextual*** elements that affect health and healthcare utilization. This report focuses specifically on two aspects of this influence on the health of people with SMI: (1) consumer-provider interactions in the medical encounter, and (2) consumers' interactions with their environments. Our intent is to initiate a dialogue about the importance of considering contextual factors in the planning, development, and implementation of interventions and programs aimed at improving the health of people with SMI.

The delivery of culturally competent and contextually grounded health promotion programs and medical services can help reduce the elevated morbidity and mortality associated with physical illnesses among people with SMI. These elevations are most pronounced among underserved racial and ethnic groups with SMI, who face higher rates of obesity and chronic illness as well as lower rates of health care utilization and poorer quality of care than majority White individuals with SMI (2-7). There is mounting evidence that incorporating cultural and contextual factors into health interventions results in significantly improved outcomes (8-12).

Despite this evidence, the lack of attention to these factors in health and wellness interventions and programs for people with SMI is striking (13). Most quality-enhancement approaches focus mainly on structural factors (e.g., co-location of services), which though essential (14), must incorporate contextual elements to ensure successful transportability to real-world settings, particularly those serving underserved racial and ethnic groups with SMI. As shown in the health promotion literature, interventions that ignore contextual factors may lack relevance, acceptability, effectiveness, and sustainability (15). This report focuses on several contextual factors we have found in our own research (see Appendix A) and in a review of the literature that affect the delivery of physical health care to individuals with SMI in the public mental health sector.

II. CULTURE SHAPES CONSUMER-PROVIDER INTERACTIONS IN MULTIPLE WAYS

The cultures of consumers and providers intersect during the medical encounter (16, 17). These personal cultures include their interactions as individuals from particular cultural backgrounds as well as the effect of the clinician's specific perspectives and functions within a broader "culture of biomedicine" (16).

A. Consumer-level effects

From the consumers' perspective, we have identified three salient cultural norms that shape the clinical encounter: (1) avoidance of overt disagreement, (2) mistrust, and (3) the consumer's body image.

1. *Avoidance of Overt Disagreement.*

For some cultural groups, social norms dictate that people should respect and not overtly question the recommendations of authority figures, such as doctors. This leads some consumers to prefer a doctor-centered approach in which the physician is more directive and the consumer more passive during the medical encounter (18). Then, after the encounter, the consumer exerts his/her autonomy by deciding whether or not to follow the provider's instructions. In several of our studies examining the physical health of diverse consumers with SMI, we have found that this deference to authority during the medical encounter may inadvertently undermine consumers' involvement in the medical visit, such as by leading them not to ask questions or voice concerns about their illness and treatment regimens (19), particularly when the provider is someone the consumer does not know or trust. Avoidance of overt disagreement and deference to authority can have negative repercussions, particularly in adhering to medical treatments, and may contribute to communication problems with clinicians. It can also lead providers to misinterpret patients' behaviors and motivations and result in providers labeling patients as defensive, passive, and not interested in engaging in medical care.

> *"If it was my social worker or psychiatrist I'll be comfortable enough. . . I would say something . . . but someone else I might, just, you know, leave it alone and disagree internally"*
>
> Hispanic Consumer

Practice Recommendations:

- The use of culturally and linguistically appropriate health education tools (e.g., culturally tailored patient education materials) can help improve consumers' health knowledge and participation in the medical encounter (20). For example, health-related *fotonovelas* use posed photographs, simple text bubbles, and soap opera narratives to engage Hispanics consumers, enhance their knowledge about

specific medical conditions (e.g., diabetes) and healthy lifestyle changes, and model active interactions with their medical providers (21-24).

- Consumers need to be more active during their medical visits. The Right Question Project, an intervention derived from practice-based evidence developed with racially and ethnically diverse consumer groups , train consumers to ask questions and be more engaged during the medical encounter using three 45-minute sessions with a care manager (25).

- Clinicians can also use playback techniques and approaches derived from motivational interviewing to engage consumers in a more active role during the medical visit. These approaches facilitate open discussion of treatment options, concerns, and expectations and can help re-negotiate consumers' cultural norms that are detrimental to their health (19, 26).

2. Mistrust.

Consumers' mistrust of medical institutions and medical providers is another challenge that impacts consumer-provider interactions. This mistrust emanates from the legacy of racism, past exploitations by the medical establishment (e.g., Tuskegee experiments), and personal experiences with low-quality medical care in some community hospitals and medical clinics (27). We have found that

> *"I've been to doctors like that, they don't really care about your health at all… I get what I need to get from them and that's it; you don't disrespect me, I won't disrespect you, I out-fox the fox!"*
>
> African American Consumer

mistrust directly impacts provider-consumer interactions by restricting consumers' willingness to questions doctors' advice during the medical encounter in order to avoid mistreatment. It also results in consumers entering the medical encounter in a defensive stance due to high levels of suspicion. In all, consumers' mistrust erodes their confidence in doctors and other medical professionals and can result in their disengagement from care.

Practice Recommendations:

- Trainings and workshops can raise providers' awareness of how racism and bias can diminish the possibility of a therapeutic alliance and result in consumers' reticence to share or receive medical information.

- Providers can use techniques derived from the Cultural Formulation model to explore consumers' explanatory models of illness, treatment preferences, and past treatment and help-seeking experiences in order to understand consumers' world view (28, 29). The Cultural Formulation is a systematized approach to assessing cultural factors in a clinical encounter that was included in DSM-IV and is being operationalized further for DSM-5 (30).

- The use of community health workers can reduce consumers' mistrust of medical institutions because they help consumers engage in medical care and improve health outcomes among racial and ethnic minority groups (31, 32).

- Community engagement is a necessary step to address health disparities (33) . The creation of collaborative partnerships between mental health providers, consumers, community members, administrators, researchers, and community leaders can help reduce mistrust of medical institutions among underserved consumers and communities.

3. Body Image Varies Culturally.

The development of a person's body image occurs in a cultural and social context, and racial and ethnic groups may differ in their shared understanding of body ideals, size, and beauty. Past studies, including the ones conducted by our center, have found that for Hispanics and African Americans, particularly women, a fuller body image is considered a sign of good health, while thinness tends to be equated with being ill (34, 35). These cultural differences have important consequences when it comes to helping people with SMI manage the weight gain commonly associated with second-generation antipsychotic medications and unhealthy dietary habits. Interventions that do not account for cultural variations in body image may be perceived by consumers as insensitive, resulting in their disengagement from care (36).

> *"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."*
>
> Primary Care Provider

Practice Recommendations:

- Health care interventions for people with SMI should discourage thinness as a treatment goal and instead focus on improving consumers' general physical health and wellness.

- Self-management programs for people with chronic medical conditions that increase consumers' self-efficacy have been linked to positive health outcomes and lower health care costs (37-39). These promising programs need to be tested among diverse consumers with SMI.

- Providers can also inquire about consumers' views of their ideal body image in the context of good health and use this information to help consumers formulate concrete action plans around specific health behaviors (e.g., drinking water instead of sugary drinks).

B. Provider-level effects

Just as much as consumers, providers bring their own personal and professional cultural identity into the medical encounter. We identified several cultural norms at the provider level that shape the clinical encounter: (1) ambivalence about delivery physical health care, (2) misattribution of physical symptoms to mental disorders, and (3) stigmatization.

1. Ambivalence About Delivering Physical Health Care. A widespread barrier to integrating physical health services in mental health settings is mental health clinicians' ambivalence toward managing the physical health of their consumers (14, 40, 41). The discomfort emanates from professional boundary issues regarding the role that mental health clinicians should play in helping consumers with their physical health needs. These perceived boundaries are basic to the culture of biomedicine, which separates physical from mental health care, and assigns certain goals, responsibilities, and procedures to each medical specialty, including concerns about liability and basic competence (16). This pragmatic separation stems from a historical divide in Western biomedical culture between the body and the psyche, arising in ancient Mediterranean medicine, as opposed to a more holistic approach followed in other world medical traditions (16). This cultural separation translates into limited education and training, particularly in preventive medicine and in the management of common chronic diseases (e.g., diabetes, hypertension) even among the psychiatrists in our studies, which in turn contribute to mental health clinicians' ambivalence about physical health care.

> *"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."*
>
> Psychiatrist

However, we have observed a tipping-point phenomenon in our research. When mental health clinicians encounter consumers with acute, life-threatening medical illnesses, professional boundary issues are set aside, enabling mental health providers to step outside their usual roles and intervene. Increasingly we have noticed that the growing attention to the physical health of people with SMI in the media and professional organizations, and the implementation of new initiatives and mandates (e.g., New York State Office of Mental Health Cardiometabolic Program) seem to be shifting mental health clinicians' views regarding their roles and responsibilities in managing the physical health of consumers. Some clinicians are beginning to accept these new responsibilities and to incorporate them into their practice.

Practice recommendations:

- Training mental health providers and providing institutional supports to use existing protocols and guidelines for monitoring and managing the physical health needs of consumers with SMI can help clarify providers' roles and responsibilities (42).

- Learning collaboratives can also be formed across New York State to help mental health providers and agency administrators learn how to implement best practices to screen, monitor, and manage the physical health needs of people with SMI (43).

- A one-size-fits-all solution for improving the medical care of people with psychiatric disabilities is not appropriate. Organizations should carefully adapt different models of care (e.g. a health care manager program, co-located care) to their own needs, the capacities of their consumer population, and resources (14). Successful models of care move beyond screening and monitoring and include specific guidelines for management and treatment.

2. Misattribution of Physical Symptoms to Mental Disorder. Providers' biases, shaped by their medical training and their inexperience working with people with SMI, can negatively impact consumer-provider interactions. This results in the commonly held view expressed by many primary care physicians and mental health clinicians in our studies that unraveling the physical health needs of consumers constitutes a difficult "jigsaw puzzle." A common sentiment expressed by mental health clinicians, consumers, and their family members is that consumers' health concerns are often misinterpreted by primary care providers as delusions instead of real medical conditions. Mental health clinicians and family members frequently mentioned that consumers with SMI are often perceived by primary care physicians as "not the greatest historians," and that their medical presentations "jump from one symptom to another."

> *"People don't listen to the mentally ill. They don't. That's a huge problem . . . If somebody with a mental illness says I have a headache, they think they are delusional."*
>
> Family Member

This leads physicians to question the reliability of the medical information they provide. Both primary care providers and mental health clinicians noted that working with people with SMI consumers requires skills in untangling the physical from the mental.

Practice Recommendations:

- Improving collaboration and coordination of care between primary care and mental health providers can help reduce the misattribution of physical symptoms to mental disorders by facilitating communication and sharing of important medical information.

- Training of primary care providers (e.g., physicians, nurses) should include rotations alongside mental health professionals in community mental health clinics to gain clinical experience treating people with SMI and how to work across systems of care.

- Medical and other professional schools that train primary care and mental health providers should invest in training programs that prepare the next generation of practitioners to work in integrated models of care, particularly in interdisciplinary treatment teams, and to understand the clinical, organizational, and legal complexities of delivering medical and mental health care.

3. Stigmatization.

Stigmatization from providers and community members is a culturally patterned attitude that hampers consumers' involvement in the medical encounter (44). The combination of stigma toward mental illness and mistrust due to racism contributes to consumers entering the medical encounter resigned to the inevitability of receiving poor medical care. Administrators, mental health clinicians, family members, and community leaders we interviewed report how medical providers tend to view consumers with SMI as dangerous and unmanageable and how the presence of a serious mental disorder evokes fear and resistance toward consumers with SMI. Stigma resulted in consumers often being "dismissed and shunned" by health care providers. Because of the existing level of stigmatization, some clinicians felt that working with SMI consumers is a specialized skill that few primary care providers possess. Primary care providers also acknowledged the limited training they received in professional school for working with people with SMI. Clinicians, including primary care providers, believed that stigmatization and stereotypes regarding consumers with SMI cause medical providers not to be receptive to, and in some cases ignore, the physical health concerns of patients with SMI. This results in poor-quality medical care.

> *"There is a certain fatalism that comes with being stigmatized by the system…that gets compounded if you have racial discrimination, people just kind of give up and take for granted certain kinds of neglect."*
>
> Administrator

Practice Recommendations:

- Anti-stigma training should be disseminated to primary care and other health care providers working with consumers with SMI. For example, the National Alliance on Mental Illness provides training for providers throughout New York State and 21 other states. Such anti-stigma strategies and campaigns are needed in primary care settings.

- Anti-stigma programs should provide people with the opportunity to interact with consumers since positive social contact with a person with mental illness reduces stigma (45).

- Case managers or peer health workers can reduce stigma by accompanying consumers to their medical appointment in order to advocate for their care and reduce miscommunication between consumers and their medical providers.

III. CULTURE SHAPES CONSUMERS' INTERACTIONS WITH THEIR PHYSICAL ENVIRONMENTS.

Culture is at play in how people interact with their physical environments. In this section, we illustrate how cultural and social forces influence consumers' health behaviors around dietary practices and engagement in physical activity. We focus on these two areas as they are highly linked to the chronic illnesses that disproportionally impact people with SMI.

1. Consumers' Food Environments.

Food carries cultural meaning and embodies cultural identity. What we eat is shaped by who we are and where we come from. People place different values on foods and dietary practices based on their cultural background and heritage. In addition, their knowledge about healthy food tends to be locally bound to what is available in their regions of origin, and may be difficult to transfer to a new setting after migration. But these values, understandings, and practices are not static; they are influenced by socioeconomic forces, nutritional marketing, and social norms (46).

> *"If you don't have enough money . . . you buy foods that are really not good for you . . . you want to buy a bag of oranges, but a bag of oranges is not going to last that long. There are bags of potato chips . . . are going to last longer. They are cheaper. You go for what's cheaper, what's going to last longer… and you can't afford that extra expense of better foods."*
>
> African American Consumer

There is increasing evidence that dietary choices are limited in low-income minority communities by the high cost of fresh fruits and vegetables and the availability and convenience of fast food (36, 47). This is also a common concern for most consumers with SMI. Most consumers we interviewed are well aware that not all communities have the same types and quality of foods and that the racial, ethnic, and socioeconomic composition of neighborhoods contribute to these inequities. Moreover, the mental health clinicians and primary care providers in our studies also voiced concerns about the availability of affordable food options and the accessibility of fast food establishments in consumers' communities.

Since most consumers in our studies had limited income, the food served for lunch at the mental health programs they participate in their communities became an important part of consumers' diets. However, many of the providers of these programs lamented that the high fat and sodium content of the food tended to contradict the dietary recommendations they discuss with consumers, thus sending mixed messages about maintaining a healthy diet. Consumers also had mixed reactions to the food served in these programs. Some consumers described the food as overly starchy and unhealthy, particularly for those who had diabetes, while other consumers described the food as healthy and were grateful for the free meal. In all, consumers' food environments in their neighborhoods and in the programs they visit shape their dietary choices and may contribute to their risk for obesity and other chronic medical conditions. Attention to consumers' food environments is central to improving consumers' diet and physical health.

Practice Recommendations

- Several organizations are making affordable healthy food part of their health and wellness initiatives through the development of community gardens and partnerships with farmers' markets. These efforts have been popular and well received by consumers.

- Consumers living in New York City should be reminded that "Health Bucks" and food stamps can be used to buy fresh fruits and produce at farmers' markets. Consideration should be given to extending this program throughout New York State.

- Many organizations for people with SMI serve lunch as part of their programs. Lunchtime can be used as a "teachable moment" to model healthy eating habits and a healthy food environment through a balanced diet. Partnering with nutritionists may be a way to help improve food preparation at these organizations. Simple strategies for presenting and communicating the nutritional value of

different foods served and/or sold at these organizations can also be used to encourage consumers to make healthier choices. For example, a recent study found that by using a simple three-color scheme (red = unhealthy, yellow = less healthy, and green = healthy) to communicate the nutritional value of different foods sold at a hospital cafeteria significantly improved the sale of healthier items, particularly beverages (48).

2. Social Norms Associated with Dietary Practice. Social norms also shape dietary practices and consumers' motivation to engage in healthy lifestyles. When we asked Hispanics and African Americans consumers about why racial and ethnic minorities have higher rates of obesity, cardiovascular disease, and diabetes, a common reason articulated by many consumers was that low-income minority people "live unhealthy lives" because they eat unhealthy foods, or "don't know how to eat."

> *" When I see White folks, American folks . . . I notice the bottle of water in their hands all the time. You look at a Latino or African American, there's a bottle of soda or a bottle of beer, there's a bottle of all this juice with sugar . . . and here's a small percentage that takes care of their health, within the Spanish and the Afro-Americans. I think we have to be educated more, we have to be motivated more."*
>
> Hispanic Consumer

We have also encountered a perception from many providers and consumers that culturally meaningful foods are unhealthy. Mental health clinicians, primary care providers, and Hispanic consumers have discussed how rice, a food full of cultural meaning for Hispanics, is a bad food choice. This self-blame and sense of limited self-efficacy can be attributed to the socioeconomic realities mentioned above. It also signals that minority consumers may be internalizing a racist view that devalues traditional foods and practices as generally unhealthy, when in fact traditional cuisines are full of time-honored healthy food choices. Other elements of traditional diet, in moderation, are healthier than eating processed foods. Explicit consumerism and targeted food marketing to minority communities may contribute to the internalization of self-blame by supporting the view that traditional foods are less valuable and unfashionable, compared to modern, dominant culture dietary options, such as fast foods. In addition, an oversimplified message from health professionals about what constitutes healthy eating based only on North American food examples may inadvertently communicate a rejection of traditional foods to consumers.

Practice Recommendations

- Health and wellness programs should include modules that raise consumers' awareness that their traditional foods can be prepared in a healthy manner without compromising taste, particularly when cooked with fresh produce, whole grains, and lean meats.

- One immigrant advocacy agency affiliated with one of the organizations in our studies is preparing a cookbook for this purpose directed at Hispanic immigrants.

3. Social Context Influences Consumers' Engagement in Physical Activity. A person's social context influences their engagement in physical activity (49). Among people with SMI, time, motivation, personal preferences, social support, self-esteem, and symptomatology are factors that influence their involvement in regular physical activity (50). For immigrants from warm climates, such as most of the Latino consumers in our studies, exercise during the winter months required them to overcome additional obstacles due to lack of familiarity, motivation, and fear of illness and accident. Moreover, not having access to safe environments, such as parks or pedestrian walkways, also deterred many consumers we have interviewed from engaging in regular physical activity.

> *"When you exercise the darkness goes away, you feel good."*
>
> African American Consumer

> *"I exercise because it makes me feel better, it makes me stronger and younger … that's why I exercise."*
>
> African American Consumer

When asked to discuss physical activities, consumers in our studies have consistently reported being aware of the importance of exercise for their health, particularly for weight management, but differed in their engagement in daily physical activities. Some consumers reported that they did not like to exercise and, other than walking to catch a bus or a train or to shop, did not engage in any other physical activities. Exercise was not part of their daily routine. Other consumers frequently listed walking as their preferred exercise and valued engaging in physical activity because they felt it benefited both their physical and mental health. Consumers that reported exercising also talked about how it was difficult to sustain their exercising routine because of bad weather (i.e., raining, snow), pain in their extremities (e.g., legs), and lack of motivation due their symptoms (e.g., depressed mood). Consumers frequently listed housecleaning as exercise, even though this does not constitute aerobic activity that yields cardiovascular benefit. Across different studies conducted by our group, most consumers expressed interest in exercise groups offered by their mental health clinics (e.g., walking groups) as well as other organization-sponsored activities that promote weight loss and healthy lifestyles.

Practice Recommendations

- Structured physical activity programs should be fun, culturally meaningful, and provide consumers an opportunity to socialize with their peers. To increase consumers' engagement and retention in these programs, some of the organizations in our studies had begun to develop structured exercise programs (e.g., *salsa dancing groups*) that were culturally meaningful and social.

- Extra walking should be encouraged when possible, given that consumers show a preference for walking as a form of exercise. Some of the organizations in our studies have started walking groups which provide consumer a safe social setting in which to exercise.

- Consumers should be taught about the difference between heart-healthy aerobic exercise and housework or work-related activity (e.g., bending, carrying). Providers can also help consumers set concrete physical activity goals, such as walking up the stairs instead of taking the elevator or walking for 30 minutes three times a week.

- Some providers have become familiar with the resources in consumers' communities that promote health and wellness and make this information available to consumers, such as exercise programs available at local Parks Department offices and the YMCA.

- A recent report of the Substance Abuse and Mental Health Services Administration (51) suggests that the most successful physical activity programs go beyond education and encouragement and incorporate active and extensive exercise activities (e.g., individual or group exercise activities) and integrate fitness measures (e.g., 6-minute walk test, standardize physical activity monitoring instrument) to monitor consumers' progress.

IV. CONCLUSION

In this report, we have illustrated from our research and our review of the literature how contextual factors are at work in the physical health and medical care of people with SMI. As the impetus for the integration of physical and mental health care and the development of patient-centered medical homes continues to grow across the nation and in New York State (52, 53), it is imperative that cultural and social-environmental factors are considered in the planning, development, and implementation of these service innovations. It is also essential that efforts to improve the physical health of people with SMI move beyond medical interventions toward environmental approaches and strategies focused on improving consumers' accessibility and consumption of healthier foods and increasing their engagement in regular physical activities. Work in these areas is still needed to address the physical health disparities faced by people

Work in these areas is still needed to address the physical health disparities faced by people with SMI. The contextually informed framework presented in this report simultaneously focuses on providers' and consumers' behaviors and considers social and environmental determinants of health. This comprehensive approach can enhance the physical health of people with SMI by responding to the needs, preferences, and realities of consumers from all cultural backgrounds.

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Appendix A.
Description of CECC Studies

Exploring the Integration of Physical Health Services in Behavioral Health Organizations

The aim of this qualitative study was to identify social and cultural elements in the provision and coordination of physical health services in behavioral health organizations serving African Americans and Hispanic consumers with SMI. We used a purposive sampling approach to obtain a sample of behavioral health organizations in Northern Manhattan that offered a variety of mental health treatment modalities and received different funding streams (e.g., public, non-for-profit). Six community-based behavioral health organizations participated in the study: one housing-based agency, one community-based mental health clinic, one publicly funded community mental health center, one clubhouse mental health program, and two hospital-based outpatient mental health clinics. We used a multi-stakeholder approach within each organization. Surveys were used to collect basic demographic information from all participants. We conducted in-depth, semi-structured qualitative interviews with administrators, clinicians, consumers, family members/friends, primary care physicians, and community and/or faith-based leaders. We supplemented these interviews with consumer focus groups and participant observations at five of the six organizations. We used frequencies, percentages, and means to describe sample characteristics. Grounded theory methods were employed to identify cultural and social elements that impact the physical health and health care of people with SMI and to generate practice and policy recommendations from our qualitative data.

Project Status: Completed

Publications:

Cabassa, L. J., Nicasio, A., Guarnaccia, P. & Lewis-Fernández, R. (In Preparation). How social and cultural factors influence the physical health of people with SMI.

Ezell, J., Cabassa, L. J., & Siantz, L. (In Preparation). Contours of usual care: Meeting the medical needs of diverse persons with serious mental illness.

Cabassa, L.J., Siantz, E., Nicasio, A., Guarnaccia, P.J., & Lewis-Fernández, R. (In Preparation). Contextual factors at work in the physical health of people with serious mental illness.

Health and Wellness Photovoice Project

The aim of this project was to use photovoice to engage racially and ethnically diverse consumers in informing the planning and implementation of health care interventions in two supportive housing agencies. Photovoice is a participatory method that empowers people with cameras to document their lives and promote social action. Sixteen consumers, eight at each agency, participated in six weekly sessions in which they took photographs about their physical health and wellness and discussed the meaning of these photographs in individual interviews and group discussions. We used frequencies, percentages, and means to describe sample characteristics. Pile-sorting techniques and the constant comparative method derived from grounded theory were used to analyze the visual and narrative data generated from this study.

Project Status: Completed

Publications:

Cabassa, L. J., Parcesepe, A., Nicasio, A., Baxter, E. Tsemberis S. & Lewis-Fernández, R., (In Press). Health and wellness photovoice project: Engaging consumers with serious mental illness in health care interventions. *Qualitative Health Research*

Cabassa, L. J., & Nicasio, A. (In Preparation). Picturing recovery: A photovoice exploration of recovery among people with serious mental illness in supportive housing.

Implementing Health Care Intervention for Hispanics with Serious Mental Illness

The aims of this NIMH-funded study are to use a collaborative planning approach that blends principles of community-based participatory research and intervention mapping to modify an existing health care manager intervention and to assess its feasibility and acceptability to improve the physical health of Hispanics with SMI and at risk for cardiovascular disease. This study is being conducted at a public outpatient mental health clinic in Northern Manhattan. The project uses a multiphase approach to advance from intervention planning to pilot testing. Intervention modifications and implementation plans are informed by consumer focus groups, stakeholder interviews, and input from a community advisory board. This is one of the few studies to date that illustrate how blending health-disparities research and implementation science can help reduce the disproportionate burden of medical illness in vulnerable populations.

Project Status: Ongoing

Publications:

Cabassa, L. J., Druss, B., Wang, Y., & Lewis- Fernández., R. (2011). Collaborative planning approach to inform the implementation of a health care manager intervention for Hispanics with serious mental illness: A study protocol. *Implementation Science, 6* (1), 80.