Culturally Competent Mental Health Care

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The information is based on interim findings from the first four years of a five-year demonstration project. Final results of the evaluation will be available Fall 2001 upon completion of the project and data analysis.

Introduction

The Culturally Competent Integrated Mental Health HIV Care Program consists of several elements—first, an HIV mental health team integrated with primary care at a community health clinic on 161st Street in the South Bronx. The team is comprised of a psychiatrist working half time and social workers trained as psychotherapists. The concept of integration includes (a) the creation of a multidisciplinary treatment plan; (b) writing in a common chart to facilitate communication; (c) regular multidisciplinary treatment team meetings and (d) continual interdisciplinary communication regarding patients.

Second is the provision of culturally responsive care, which involves training providers in cultural issues. Project components were selected to erode barriers to care for clients, who were mostly persons of color with histories of substance abuse or the sexual partners of substance users. Finally, the last element is a program of psycho-educational seminars, attempting to attract persons who would not avail themselves of traditional mental health services.

In the clinic, the program is called the Wellness Track/Camino al Bienestar.

Introduction

Location

Services

Provider Team

Study Sample

Lessons Learned
- Lesson #1: Medical systems and patients respond differently.
- Lesson #2: Work around unforseen barriers.
- Lesson #3: Pyscho-educational seminars were ineffective.
- Lesson #4: Cultural responsiveness must be consciously and continuously articulated.
- Lesson #5: Follow Patient Advisory Board (PAB) suggestions with direct action.
- Lesson #6: Be flexible in the face of change.

Montefiore Project Chronology

Futher Information and Technical Assistance

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While some other SPNS projects and experimenters have tested new models adapted to the needs of these persons, there has been little acceptance of these innovations by dominant systems. The Montefiore project hoped to provide mental health services that were culturally responsive to persons of color, in contexts that did not shame or stigmatize.

Location

The project operates within Montefiore Medical Group, a network of primary care sites operated by Montefiore Medical Center. The treatment clinic is the Comprehensive Health Care Center (161st Street/ MMG) in the South Central Bronx. For project evaluation purposes the two comparison clinics are the Comprehensive Family Care Center (Morris Park/ MMG) and the Family Health Center/ MMG.

Services

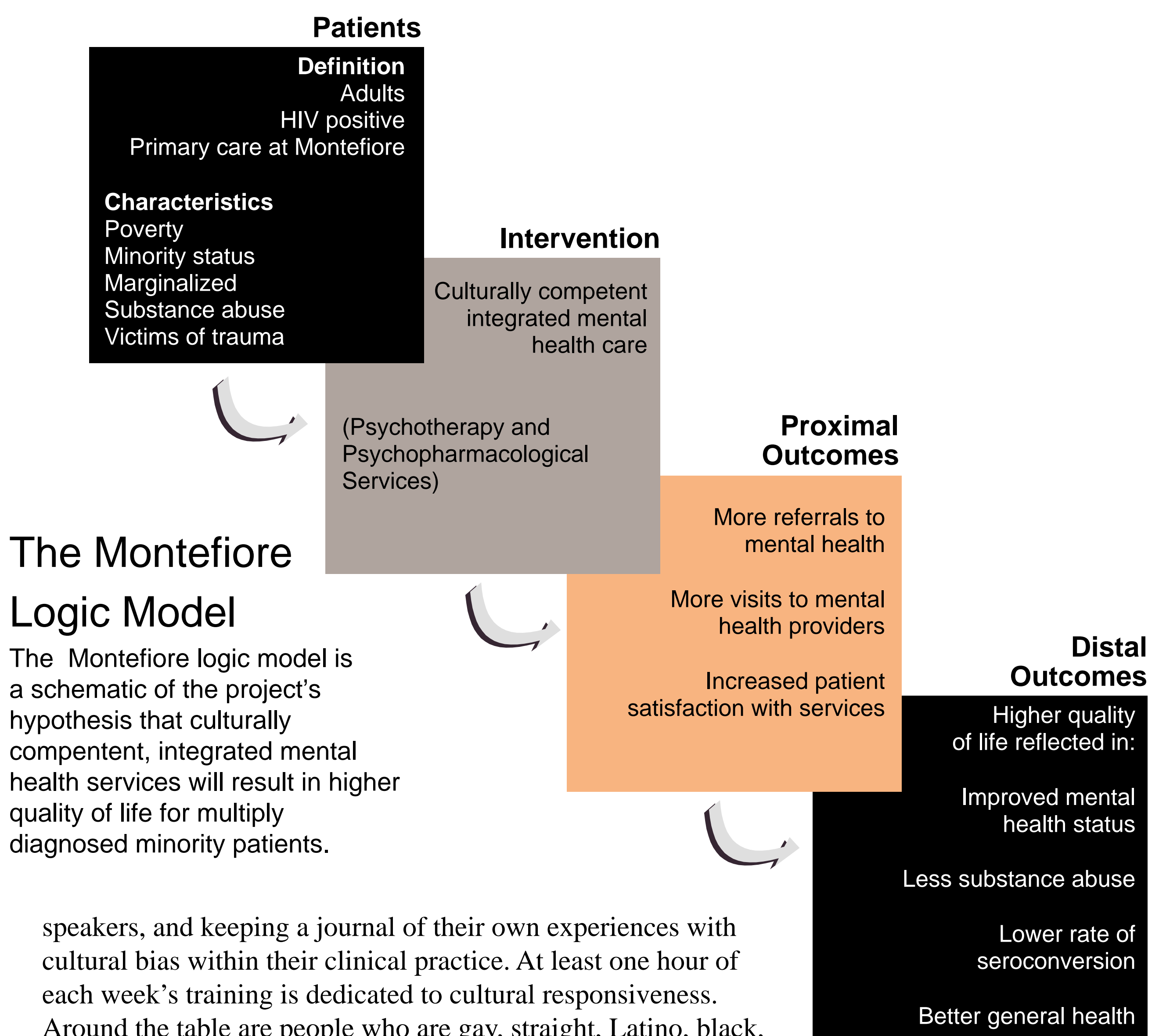
The program provides services to persons of color in the Bronx, New York, the northernmost borough of New York City. The program addresses the needs of this population as reflected in the demographic statistics of the state and the effect of HIV/ AIDS. Seventy-seven percent of the 1.2 million citizens of the Bronx are persons of color and the per capita income is $10,514. The cumulative adult AIDS case rate was 2,274/ 100,000 in year 2000. That HIV/AIDS has become a condition with a majority of persons of color strongly argues for the need to test a model of care to meet the explicit needs of African-American and Latino communities.

The Wellness Track/Camino al Bienestar Program has several components. First, psychiatric and psychotherapy services always attempt to be culturally appropriate and non-stigmatizing. Montefiore's patients face a variety of barriers—linguistic, cultural, economic—which the program seeks to address through the provision of client-centered, culturally sensitive services in both English and Spanish.

Second, a series of seminars is open to all clinic patients. Seminars consist of psycho-educational meetings meant to introduce information to patients in a nonthreatening, nontraditional manner and to serve as a gateway to enrollment in SPNS mental health services for the hard-to-reach patients and/or those who underutilize mental health services. These weekly seminars are conducted in both English and Spanish; topics have included "Secret Keeping in the Family" and "Substance Use and Prevention Relapse."

Third, the Patient Advisory Board (PAB) meets regularly and provides an opportunity for patients to comment on the workshop/series program and to designate topics they believe are of interest to the larger HIV/AIDS patient community. Meetings serve as a forum for patients to voice concerns about the general functioning of the clinic. Views are shared on cultural issues and their impact on medical and mental health care.

Cultural responsiveness is a major feature of this program's intervention. The mental health workers, together with the research team, regularly take part in training meant to sensitize them to cultural issues within a clinical context. Training includes reading articles and participating in discussions, sharing cultural vignettes, attending presentations by guest



The Montefiore Logic Model

The Montefiore logic model is a schematic of the project's hypothesis that culturally compentent, integrated mental health services will result in higher quality of life for multiply diagnosed minority patients.

speakers, and keeping a journal of their own experiences with cultural bias within their clinical practice. At least one hour of each week's training is dedicated to cultural responsiveness. Around the table are people who are gay, straight, Latino, black, white, male and female. Through these activities, providers continually increase their knowledge of cultural issues and foster the experiential element of cultural awareness.

Provider Team

The project's team consists of a psychiatrist and several social workers. Members of the team provide psychotherapy in English and Spanish, and psychopharmacology. They work side by side with the medical staff and psychosocial unit and are available on-site for quick referrals, walk-in appointments as well as consultations with the primary care physicians. In addition, the team is responsible for monthly case conferences at the HIV medical team meeting. Team members work closely with the clinic HIV coordinator in fostering a psychosocial context in which to better aid the patients. Their focus is integrating mental health care to the overall HIV medical care of patients in a culturally sensitive manner.

An integrated treatment team cares for patients. The team is comprised professionals with three specialties: two physicians who specialize in HIV/AIDS care, a psychologist or social worker who provides both psychotherapy and substance treatment intervention, and case managers who attend to concrete services and entitlements issues such as housing, disability payments, and food stamps.

Added to the integrated treatment team is a patient care program that offers positive, non-stigmatizing pyscho-educational, supportive and mental health services. The program, offers culturally specific packages of mental health/ substance abuse and other psychosocial interventions that are (1) culturally valued; (2) perceived as nonstigmatizing and (3) assist patients not only with HIV-specific issues but with other social related issues, such as substance abuse, spirituality, parenting and planning their children's futures.

Study Sample

Two groups were evaluated. The first group encompassed patients who obtained services but declined to be part of a formal assessment procedure. There is limited information on this group, such as age and ethnicity, drawn from clinical records. The second group is volunteers with signed consent forms, drawn from the population HIV/AIDS adults who are active patients at three of the Montefiore Medical Centers' outpatient clinics (meaning they have kept an appointment at the clinic within the past year). They were recruited through flyers in English and Spanish distributed at the clinics and through referrals from providers. The project's research assistants carry pagers in order to allow for interviews to be conducted on a walk-in basis. Participants/subjects in the program are paid $10 for baseline interviews, $15 for first follow-up interviews and $20 for second follow-ups.
The research sample is 162 persons; most assessed three times over one year.

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Lessons Learned

Lesson #1: Medical systems and patients respond differently.

Responsive mental health care is defined as convenient, high-quality, and respectful of a patient's culture. The integration of mental health services has been successful, with psychotherapy being a fully integrated component of care at the clinic. At this time evaluation indicates that both the medical system and the patients individually responded in different ways to the program.

For example, of 543 patients eligible for referral to Wellness Track services, clinical staff referred 260 (47.8 percent) which is almost one of every two patients. The next analysis of data will indicate how well clients responded, but initial observations indicate a remarkably large response.

Lesson #2: Work around unforeseen barriers.

One of the project goals is to have patient cases discussed by the integrated team with integrated treatment plans written and included in the patients' charts. The meeting is to be attended by project staff as well as clinical medical, psychosocial, and other providers.

This objective met with substantial barriers. The major barrier was the administrations' focus on increased productivity by primary care providers, which made additional meetings

very expensive in terms of lost patient encounters. As a result, the goal of an interdisciplinary meeting to discuss patient care plans was not met. Instead, the program held one meeting per month on case discussions. The SPNS-funded providers made a substantial contribution to those meetings. Communication between project staff and other clinical staff was accomplished through this meeting, and through the patients' charts and informal corridor conferences.

Lesson #3: Pyscho-educational seminars were ineffective.

The Wellness Track psycho-educational seminar series was a good idea that was tried and substantially failed. The goal was to provide "nontraditional, culturally appropriate psycho-educational and supportive services" that would provide information and help recruit persons into mental health care.

One issue, raised almost immediately, was that if the seminars were limited to persons with HIV, attendance in a public place would disclose their status. As a result seminars were opened to all clients. At the end of each seminar attendees were asked to complete feed-back forms asking for an anonymous disclosal of status. This attempt to obtain information was unsuccessful.

Beginning at the end of year one, psycho-educational seminars were provided by the project on a weekly basis in an attempt to recruit people to mental health care. Attendance was uniformly poor (from none to five attendees and typically two-to-three) even after suggestions from the Patient Advisory Board were incorporated. Seminars were held in Spanish as well as English, refreshments were available and the scheduling was changed to determine if some time periods were more attractive than others. Topics were diversified; some targeted Latinas or women generally. After a trial period of experimentation during year three and an examination of the situation, the seminars were discontinued.

> ....an integrated health care team with specific emphasis on culturally competent care, and a program of nonstigmatizing, culturally appropriate psychosocial and mental health services.

There were several hypothesized reasons for the failure of the Wellness Track Program's seminars: first, as with any group regardless of culture, there is little time for optional activities such as health seminars. Patients have many appointments both at the clinic and with various city agencies for insurance, housing and public assistance. While many patients expressed interest, they did not attend. Second, patients visit the clinic infrequently (every 3- 6 months), and perhaps did not see schedules of Wellness Track activities. A mailing to all HIV-positive clinic patients was considered but the overriding need to maintain the confidentiality of their diagnosis precluded a specialized

mailing. Compilation of a group of clients who wanted mailings became a labor-intensive and time-consuming chore. As an alternative, a table in the lobby offering information on HIV-related topics is periodically staffed by the project.

Lesson #4: Cultural responsiveness must be consciously and continuously articulated.

HIV/AIDS has tragically become part of the fabric of the inner city, yet persons of color there face health care systems that often fail to meet their cultural needs. Recent research indicates persons of color significantly underutilize medical and psychosocial HIV services. That HIV/AIDS has become a condition with a majority of person of color strongly argues for the need to test a model that offers an integrated health care team with specific emphasis on culturally competent care, and a program of non-stigmatizing, culturally appropriate psychosocial and mental health services.

Montefiore Medical Center has had the opportunity to provide mental health services to the Bronx population for years via SPNS grants. Experience and lessons learned from previous programs made it possible to enhance the provision of mental health services with this current grant. Past experience taught that much of standard mental health psychotherapy, specifically and psychiatric care based on Western European models is culturally inappropriate for persons of color. Moreover, these services provided in fairly rigid medical-model systems discourage utilization by persons whose lives are marked by poverty, lack of opportunity, the need to wrestle with unwieldy entitlement systems, encounters with law enforcement and child welfare systems, and substance abuse.

A lesson learned in previous programs was that in order to meet the explicit needs of persons of color, this SPNS project had to make cultural responsiveness a consciously major, and continuously articulated, theme of care. If cultural responsiveness were relegated to an afterthought, represented by episodic inservice programs, but a conscious major theme, then mental health care would be conducted as it has for decades, with the usual discouraging results.

The program, therefore, had the following elements:

- A team of providers, who were, in effect, self-selected because of their commitment to work in the inner city.
- Clinical team members who represented a variety of cultures and were, for the most part, bilingual in Spanish and English. Team members were white, black, Latina, gay, straight, foreign-born, U.S. born, male and female ranging in age from mid-20s to 60.
- A weekly hour of attention to cultural issues in HIV mental health care including discussions of reading from pertinent books of articles, presentations by speakers with expertise in areas of cultural competence, and discussion of cultural vignettes from actual cases at the clinic. The knowledge gained at these meetings was then shared with colleagues at the clinic through individual discussions with providers, weekly social services meetings, and monthly coordination meetings.

- A newsletter was also published by the Wellness Track at irregular intervals and distributed to clinic staff. Publication of this newsletter met some barriers from staff who said their mailboxes were often stuffed with announcements and other papers, and that they didn't often read what they had received.

Lessons learned included:

- Primary care clinic staff members, regardless of their ethnicity, tend to believe that they are already culturally knowledgeable, and are typically unwilling to set aside additional time amid their already busy day to consider these issues.
- An essential issue in cultural responsiveness is the acknowledgment of invisible monoculturalism in medical and mental health care.
- Individual providers must concern themselves with their unconscious racisms, which are often demonstrated in subtle ways with clients.
- The issue of cultural responsiveness is very radical and is viewed by some as significantly threatening.

Lesson #5: Follow Patient Advisory Board (PAB) suggestions with direct action.
Although the creation of a Patient Advisory Board seemed to be a good idea, it has been a very disappointing experience and as a result, the group was temporarily discontinued. The PAB functioned for about two years, from midway year one through midway year three. During this time it was difficult to get volunteers, but the program's social workers persevered and meetings with three to six persons occurred. Then attendance dropped off to the point that meetings were not viable. The major reason for the attrition, according to the social workers, was that nothing was done to ameliorate problems, such as poor telephone service at the clinic, which had been identified by advisory board members. After several months of providing advice that was not followed, group members stopped attending. Participants have stated that they made all the proposals/suggestions/comments they could think of and more meetings would no longer add value to the project. Due to the lack of implementation of the suggested changes, participants no longer saw the PAB as a serious forum for their voices to be heard.

Lessons learned include:

- Project developers and administrators should make it clear to the advisory board that their comments about nonproject issues may not receive a response.
- If project and system administrators want to communicate a message of caring and importance to the advisory groups, they must send representatives to the meetings. These representatives should be individuals who have the power to respond to complaints and concerns.

Lesson #6: Be flexible in the face of change.
During the five years of this SPNS project, the system in which it operated saw major and continual changes in the table of organization, personnel, and organizational culture.

In order to continue project staff needed to be flexible and adapt to the changes. A few changes were:

- The SPNS project was borne within a primary care network based in the inner city with a large Medicaid clientele. During the project cycle the main medical center merged with a private-practice model organization that had little inner city exposure.

- There was significant turnover of medical staff in the clinic.

- Clinic psychosocial staff changed during the project's existence. For example, a very supportive social worker died during the early phase of the project.

Montefiore Project Chronology

This chronology of implementation and development demonstrates the steps and length of time involved in developing program components. The chronology also presents the barriers project staff encountered and the process involved in overcoming them.

October 1996

- Project receives funding.

November 1996

- Received Institutional Review Board (IRB) approval.
- Montefiore Medical Center begins to consolidate the socially conscious primary care network with a private-practitioner medical group network that focuses on privately insured patients.

December 1996

- Approval of funding amount.
- Recruitment for staff begins.

April 1997

- First social worker is hired and begins working at the treatment site.

May 1997

- Second social worker is hired.
- Wellness Track intervention program officially begins.
- Evaluator pilots self-administered surveys.

June 1997

- Four part-time research assistants begin at the main site and at the control site.
- SPNS staff invites providers to nominate patients as members of Patient Advisory Board (PAB).

August 1997

• Two research assistants resign to return to school. Remaining assistants become full-time to staff each site.

• Half-time psychiatrist starts at treatment and control centers.

September 1997

• Social worker resigns.

• Wellness Track workshops begin on a weekly basis. Workshops are offered in both English and Spanish.

• Wellness Track has information table at health fair. The intervention is introduced.

• Medical director of the primary care network resigns. Director was supportive of the mental health program but the continuing administration wishes to divest itself of mental health activities. Program loses a major source of referrals as a result.

October 1997

• Evaluator resigns.

• Research assistant assumes duties of evaluator on a temporary basis.

• Replacement social worker hired. Social worker meets with administration to discuss whether SPNS staff could provide psychosocial and cultural content at staff meetings.

• First Patient Advisory Board (PAB) meeting.

November 1997

• Social worker meets individually with providers and other staff to explain services provided by and the goals of the SPNS project.

December 1997

• Presentation of Wellness Track program at social service meeting.

• HIV physician with a large caseload of patients resigns. There is a drop in referrals to Wellness Track.

• Provider questionnaires are distributed at clinics. Few are returned.

• Improvements in evaluation made by upgrading database system from Paradox 3.5 to Access. Data cleaning and codebook development.

January 1998

• Memorandum to all staff providing detailed information on Wellness Track (including staffing, services provided, eligibility criteria) and requesting staff assistance in regarding survey and nominations for the PAB.

• Presentation stressing integration of care is made to representative from 30 clinics. At conclusion, the medical facility administrator advises that referrals can be made away from the site.

- HIV physician at the control site resigns. Project loses significant number of referrals to the study because the bulk of HIV positive cases follows the physician or is referred to another clinic.
- The project's plan to have psychiatrist lead cultural discussions—a major component of the project—is rejected by the medical director because of pressure to improve physician productivity.

February 1998

- A social worker dies suddenly resulting in loss of program support and referrals.
- Flyers inviting patients to sign up for support groups are posted and given to providers.
- Search for evaluator continues.
- Research assistant is hired to work at control site.

March 1998

- HIV physician at treatment site resigns.
- HIV coordinator at another control site resigns impacting referrals and caseloads.

April 1998

- Project moves administratively to the Department of Psychiatry.
- HIV coordinator hired at treatment site and agrees to meet monthly to review cases with an emphasis on psychosocial and cultural issues.
- Research assistant resigns; new research assistant is hired.

May 1998

- Social workers have a second meeting with administration to review integration of Wellness Track program.
- Social workers plan distribution of cultural bulletins on a monthly basis to all clinic staff.
- Meeting with the medical group HIV director to discuss Wellness Track program in anticipation of medical director's departure.
- After seven months, the position of evaluator is filled.
- Research assistant begins part-time.
- Project data submitted to evaluators.

June 1998

- Medical Director resigns. Results in drop in number of referrals to Wellness Track program.
- Project closes registration of new HIV patients at the clinic due to insufficient number of medical providers with expertise in HIV.

July 1998

• Semi-structured interviews are piloted at the sites; instrument changes from self-administered to interview format.

• Database changes from Paradox to ACCESS and SPSS.

• After two-month delay, research assistant is placed at control site.

August 1998

• Meeting with medical providers focusing on cultural issues.

• Full-time research assistant resigns.

• Focus group for African-American males is attempted to further examine barriers to services and underutilization issues. One person of six confirmed attendees appears.

September 1998

• Group therapy begins for men and women who speak Spanish and mothers with children. Both groups are subsequently discontinued due to low attendance.

• HIV coordinators start at control sites.

October 1998

• It is determined that HIV-positive patients new to clinic are to be referred out due to staff shortage and turnover.

November 1998

• Full-time research assistant begins.

• Social workers present Wellness Track program and cultural component at Yeshiva University.

December 1998

• Staff retreat held to identify goals and objectives of intervention and evaluation.

• Staff decides to suspend the SPNS Patient Advisory Board (PAB) due to low turnout. Medical group states intention to convene a system-wide PAB program.

• Medical group begins Patient Advisory Board first meeting with seventeen participants.

January 1999

• Medical director hired.

February 1999

• Discussion with new medical director regarding the freeze on registration of HIV patients. Medical director indicates policy will change and new providers are appointed with HIV expertise.

April 1999

• One of the two therapists resigns, leaving one full-time social worker and a part-time psychiatrist.

May 1999

- Office space continues to be problematic, as the only office available is on a different floor from where the majority of the patients are treated.
- The research assistant loses his office to an intern and is unable to cover the site on a full-time basis.
- Evaluator resigns after one year.

July 1999

- New HIV coordinator begins. She dictates that all HIV positive cases are to be maintained on site and referrals to the Wellness Track intervention increase.
- Search for evaluator continues.
- Project moves to new offices.
- Project physician leaves.

September 1999

- Evaluator on another grant accepts offer to work on SPNS part time.

November 1999

- Social worker leads workshop on cultural competence and presents at the U.S. Conference on AIDS in Denver.
- Presentation made at the American Public Health Association annual meeting in Chicago.
- Consultant hired to assist in comparing old SPNS data with current SPNS data.

January 2000

- Three presentations made at the Ryan White CARE Act All-Titles Meeting in Washington, DC.

March 2000

- SPNS staff addresses the national AIDS Update Conference in San Francisco.

April 2000

- Memo sent to medical group officials informing them of the project end.

May 2000

- Presentation made at the American Psychiatric Association annual meeting in Chicago.

July 2000

- Staff written article on responding to distrust in the medical system is published by Focus: A Guide to AIDS Research and Counseling.

August 2000

- Project physicians leave.
- Clinical aspects of project end.

- Clients are referred either to a psychiatrist who serves the clinic part-time, or to other community clinics.

September 2000

- Project evaluation continues with research assistants interviewing subjects.

October 2000

- Staff members address the U.S. Conference on AIDS regarding project findings.

December 2000

- Research supervisor leaves. New statistician is hired on a part-time basis.
- Article manuscript on the SPNS project is submitted to a peer-reviewed journal.

January 2001

- Research staff begins calling project clients to determine if they availed themselves of other mental health care after project end.

Further Information and Technical Assistance

Should you wish to obtain additional information about the service delivery model developed by the Montefiore Medical Center, you are welcome to contact the project director and request technical assistance:

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