

# Mental Health

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Essential information for decision-makers

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## SPECIAL REPORT: WORKFORCE ISSUES

### Agency, system staffs achieving progress with minority clients

It's no secret that the behavioral health care system historically has underserved or inappropriately served racial and ethnic minorities.

As a 2001 supplement to the U.S. Surgeon General's report on mental health and a more recent Institute of Medicine (IOM) report have detailed, racial and ethnic minorities have less access to mental health services. They are less likely to receive needed services. Those who are in treatment often receive a poorer quality of care. And minorities are underrepresented in mental health research.

The stakes of continuing to ignore such trends are high. Health care inequities, unless corrected, will only grow, alienating even more the

groups that now shoulder a disproportionately high burden of disability from behavioral health disorders. Meanwhile, money and other resources will be squandered as long as mental health care for minorities remains inferior.

"We will continue to have larger and larger health disparities because the population is becoming more and more diverse," says Arthur C. Evans, Ph.D., deputy commissioner of the Connecticut Department of Mental Health and Addiction Services (DMHAS). "Increasing disparities mean our dollars — tax or other health care spending — are not being spent in the best way possible."

The move toward increasing the

cultural competence of the behavioral health workforce has been slow. But there are signs of change — program by program, center by center, system by system — to incorporate policies, skills and attitudes that more effectively meet the treatment and psychosocial needs of people of diverse racial and ethnic backgrounds, values and beliefs.

The latest national conference in the field to address cultural competence was last month's Santa Fe Summit on Behavioral Health, held by the American College of Mental Health Administration (ACMHA).

Richard H. Dougherty, Ph.D.,

(See *Cultural competency*, page 2)

### This Week

As part of this week's special "Workforce Issue," our lead story examines cultural competency initiatives occurring in three states: Connecticut, New York and Pennsylvania. Details on these programs, two of which are private and one that involves a state agency, appear on pages 2 to 5.

In addition, our second lead story on the challenges of rural health recruiting examines initiatives in three states: Minnesota, North Dakota and Arizona. Details on these efforts appear on page 7.

Also, a story examining the shortage of nurses in behavioral health and strategies to recruit nurses appears on pages 5 and 6.

### Rural agencies struggle to find new approaches to attract staff

Consider the characteristics of the mental health system that serves a quarter of the nation's population — rural residents:

- In an era of specialized services, rural mental health relies heavily on primary medical care and social services.
- It is predominantly publicly funded.
- Because it lacks a critical mass of patients, it can't achieve certain economies of scale and is inefficient.
- State-of-the-art services, such as assertive community treatment, are rare, as are consumer and family advocacy.

Those characteristics long have created serious problems for rural Americans with mental health needs. They enter care later in their illness and with more disabling symptoms than their urban peers. And they require more intensive and expensive treatment.

In turn, this means serious challenges for the professionals trying to serve rural Americans.

Jobs in rural settings don't pay as well as their urban counterparts. Employees have fewer opportunities for job mentoring or advancement. Professionals are more isolated, responsible for reaching huge numbers

(See *Rural needs*, page 6)

(Cultural competency, from page 1)

chairman of the Santa Fe Summit and president of the consulting firm Dougherty Management Associates, Inc., in Lexington, Mass., says the topic was timely because the federal Center for Mental Health Services (CMHS) is reviewing its focus on cultural competence, as part of an overall effort by U.S. Department of Health and Human Services (HHS).

In interviews with *MHW*, experts said the experiences of African-Americans, Latinos, Asians, Native Americans and other minorities both in trying to access behavioral health care and with treatment itself are poorly understood.

Ronald W. Manderscheid, Ph.D., chief of the Survey and Analysis Branch at CMHS, and his colleagues have reviewed the two major studies that have tried to assess racial disparities in mental illness and service delivery. They also have studied the availability of services and their use by minorities, based on data from federally funded state hospitals and community mental health centers.

Results are equivocal. Manderscheid and his colleagues conclude that more study is needed to understand the prevalence of mental health and substance abuse disorders among minorities and the cultural beliefs that influence their interaction with the system of care.

Until that occurs, many in the field caution against striving to match rates of accessing care and treatment outcomes across various ethnic and racial groups.

### Connecticut system: Key elements

- Focus on changing staff behaviors, not staff attitudes
- Provider agency staffs must file cultural competence plans
- Policy staff open to ideas that aren't fully tested

"That's not the goal," Dougherty says. "The goal is finding the spot where people have equal opportunity to access services and where there is equality and fairness and justice in the way those services are delivered."

What follows are snapshots of three approaches to integrating those qualities into the practices and attitudes of the behavioral health workforce.

### The Connecticut Department of Mental Health and Addiction Services

Much can be said about training health care professionals in sensitivity toward people of different backgrounds. But Connecticut's mental health leaders believe that that approach alone isn't enough to bring about systemic change.

"My view is we have to make a much stronger connection between what that training is and what the outcomes are," Evans says. "We wanted to move from the emphasis being on cultural competence *per se* to: How does cultural competence help us improve our service delivery?"

Put another way: "We're not focusing on changing attitudes," says Wayne F. Dailey, Ph.D., senior policy adviser with DMHAS. "We're trying to change the behavior of the people in our system, and the thinking is [that] the attitude changes will follow."

State officials started building on existing cultural competence efforts — including some 18,000 hours of staff training in the last three years — in a way that would accomplish the goal of improved service delivery by emphasizing treatment outcomes.

What has ensued is a multi-dimensional, multi-level, data-driven approach that demands changes in clinical interactions, program characteristics and policies at the systems level. The state's mental health system comprises 3,600 employees, 15 local mental health authorities and two hospitals, and contracts with 250 private, nonprofit agencies.

The culturally competent system of care that Connecticut is striving for involves simultaneous initiatives and many different partners, including academic institutions and community

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groups. It promotes consumer and community empowerment and outreach. It is grounded in evidence-based practices, but has expanded the scope to include practices that are evidence-supported, -informed and -suggested.

"The evidence-based approach is important; we don't want to minimize its importance," says Dailey. "But it's too narrow to properly inform how we go about policy development. We're recognizing other forms and levels of evidence to provide a greater richness to how we're going to evolve policy."

The goals are embodied in the Health Disparities Initiative, which came together last year. Its components include creating a forum or "think tank" for examining the link between cultural competence and inequities in mental health and substance abuse treatment.

The initiative also establishes partnerships with academic institutions and community groups to research cultural-specific programs to see what factors improve outcomes; identify important cultural concerns in shaping policy; and test and analyze the information, along with reviewing data sets and research to shape the best practices.

"We're constantly thinking about the policy implications and adjusting what we're doing to respond to what we're learning," says Dailey.

The state has spent nearly \$13 million in the last five years, mostly from competitive federal grants, to enhance cultural-specific services.

The state requires federally and state-funded behavioral health agencies to have cultural competence plans, and most have complied. "It's part of the woodwork at this point," Evans says.

Indeed, the goal is to weave the changes into the mental health system's policy fabric to withstand the vagaries of changes in state

leadership, says Dailey.

It's too early to say how the effort is working. Evans points to a few situations where improvements have been noticed. For example, the state's Latino population had high rates of heroin use, but low rates of admission to treatment programs. The number of Latinos in substance abuse treatment has doubled over the last four to five years, Evans says.

State officials learned in the late 1990s that more African-Americans were not receiving the newest generation of antipsychotic medications as compared to similarly diagnosed whites. That disparity has since disappeared, Dailey said.

Whether the gains occurred because of the cultural competence efforts is unclear; no formal studies have been done. But Evans suspects that at the very least the state's efforts have raised awareness.

### The Bridge Mental Health Program, Chinatown, New York City

Teddy Chen describes four middle-aged Chinese women in New York City whose husbands each

#### Chinatown health center: Key elements

- Mental health team works in tandem with primary care doctors
- Staff offers visitors a safe haven from stigma
- Treatment team educates Chinese-Americans on mental illness

died suddenly, leaving them to negotiate language barriers and unfamiliar bureaucracies while raising young children in a strange country.

Each woman persevered on her own as best she could — until the strain undermined her physical health. Only after she collapsed did she visit the Charles B. Wang Community Health Center in Manhattan's Chinatown district, seeking care

from a primary care doctor.

Because the Wang center also has a mental health component, the Bridge Mental Health Program, clinic professionals were able to identify the source of the women's conditions, which were more closely tied to their psychological health than their physical health, says Chen, director of the Bridge program.

Integrating mental health and physical health services as the Wang center does is key to providing culturally competent care to Chinatown residents, Chen believes. He has his doubts about how well these women might have dealt with their depression in a more typical health care setting, one with no links between mental and physical health.

That's because Asian-Americans are less likely than whites, African-Americans and Hispanic-Americans to seek mental health care. "With respect to treatment-seeking behavior, Asian-Americans are distinguished by extremely low levels at which specialty treatment is sought for mental health problems," according to the Surgeon General's report.

Reasons include stigma, loss of face over mental health problems, limited English proficiency, different cultural explanations for the problems, and an inability to find culturally competent services.

Chen particularly singles out stigma and the tendency among Asian-Americans to express mental distress in terms of physical suffering, called somatization.

At the Wang center, where Mandarin, Cantonese and several other dialects are spoken, officials understood both the culture-bound syndromes and the need to provide sanctuary against discrimination practiced by the larger society; the solution was to integrate mental and physical health services. "Really, it's just common sense," Chen says.

His small mental health team consists of a full-time psychiatrist, a very

part-time child psychiatrist and three social workers. The team provides assessment, treatment and referral services.

The mental health team also supports the work of the clinic's primary care doctors by helping them to recognize symptoms and otherwise be more aware of and sensitive to mental health issues in patients. And the team reaches out to New York's Chinese-American community, offering opportunities for education on mental illness.

The Wang health center, located just blocks from the site of the demolished World Trade Center towers, has seen a steady increase in use of the Bridge program since Sept. 11, 2001. In the six months from January to June of 1999, the program logged 230 patients totaling 681 visits. During the same period in 2002, 359 patients accounted for 1,439 visits to the program, Chen said.

Recognized as a model by the federal Health Resources and Services Administration (HRSA), the Bridge program has taught Chen the importance of asking, when looking at how people use or don't use services: "Is the problem with the patient or with the system? If they don't feel comfortable when they come to you, how do you expect to help them?"

### Community Connections for Families in Allegheny County, Pa.

What's unique about the Hill District Community Connections for Families isn't necessarily the kind of case management services it provides. It's who provides them and where.

The program — one of five "systems-of-care" programs in the county designed to keep children with emotional disorders from needing residential settings or ending up in jail — operates in a rented apartment in a public housing project in the Pittsburgh area. Its four employees largely came on board according to a community-hiring model, which gives

preference to candidates who are from or live in the community.

"The beauty is the individuals who work out of the site are from that community, they grew up in that community and some are in recovery in that community," says Jerome H. Hanley, Ph.D., director of the Office of Children's Policy and Cultural Competency with the Center for Innovation in Public Mental Health in South Carolina. The center is a joint project of the state's Department of Mental Health and the University of South Carolina School of Medicine.

### Allegheny County program: Key elements

- Program staff hired from the community
- Once hired, they work in neighborhoods, not downtown
- Each worksite designs its own mission and values

Hanley, who has assisted the Allegheny County program, is a long-time advocate of what he calls "intra-community-based services." He holds out the program as a national urban model, the height of cultural competence, which he describes as "a breathing, living activity that is meeting everyone's needs."

"Mental health professionals tend to get far too attached to their offices," Hanley says. Locating services in the neighborhood helps reduce the stigma associated with seeking mental health care. No sign is needed on the door because everyone knows the program is there. And people who drop in are not necessarily mental health consumers, since the office may coordinate social and recreational activities.

Hiring people from the neighborhood as employees, and providing training where needed, enhances trust between provider and client, increasing chances that the children and families will remain engaged in services and treatment, program supporters argue.

The Allegheny County program, through its five neighborhood sites, helps children ages 6 to 14 who are diagnosed with emotional disorders and who come in contact with more than one social system, such as schools, jails, mental health and child welfare. At each site, a supervisor, two service coordinators and a family support specialist connect services and advocate for the children and their families. Each program designs its own mission and core values.

The program "takes the decision-making powers away from the downtown office buildings and puts them in the hands of these communities and neighborhoods," says Fred Fowler, manager of behavioral health special projects with the Allegheny County Department of Human Services' Office of Behavioral Health.

Hanley thinks of the result as infusing other systems — such as public safety, transportation, even sanitation — into the mental health system. For example, during the last Christmas holidays, a difficult time for many and especially for low-income people, two sites sought to avert crises by assessing their families for risk. One site decided to make deposits to the power company so no family would lose electricity during the holidays. Another site started an account at a grocery store for families to access if they ran out of food.

How many crises did the families have? "Zero. Not a one," Hanley says. "We're not talking about community mental health, but community development."

The county began the program with a five-year, \$3.9 million grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), with local matching requirements. The grant this fall will be extended for one more year and will include some expansion to include youths up to age 21.

The programs collectively get

high ratings from parents in areas of respecting a family's values and needs, and in coordinating services, says Sheila Bell, evaluation coordinator with Community Connections for Families within the county human services department.

Strain and stress among

caregivers of the children have decreased significantly, surveys show. And more children are completing their homework, and suspensions and detentions have dropped, Bell says.

Whether—or which elements of—the program continue after the

federal grant expires is unclear. The hope is that those involved with the program have been “opening some eyes and showing some of the more traditional providers different ways of getting better outcomes. And that’s what we’ll be looking to sustain,” Fowler says.

## Providers struggle to attract nurses to behavioral health

The nursing shortage in the United States in all health sectors has been well documented.

A recent report by the federal Bureau of Labor Statistics forecasts that over one million new nurses will be needed in the United States between 2000 and 2010, or about 100,000 per year to fill new positions and replace other nurses who are expected to leave the practice.

The U.S. Department of Health and Human Services (HHS) said the driving growth in demand for nurses includes an 18 percent increase in the overall population, a larger proportion of elderly persons and medical advances that heighten the need for nurses.

Nursing and health care officials predict the shortage will affect nurses working in behavioral health, especially because the industry has difficulty attracting nurses to begin with. New nursing graduates do not often choose behavioral health as their first entry into nursing, if at all, say officials.

According to Rachel Boersma, MS, R.N., CARN (Certified Addictions Registered Nurse), who has a private practice for patients with mental illness and substance abuse and teaches nursing at Fitchburg State College in Massachusetts, the nursing shortage poses multiple problems in the mental health and substance abuse arenas.

“For many nurses entering the field, addiction and psychiatric nursing are often second choices,” Boersma told *MHW*. “Historically,

the mentally ill and substance-abusing patients are second-class patients in the health care system. They are in some ways forgotten about or not paid attention to at all in the larger health system.”

The salary levels of nurses in behavioral health are often cited as obstacles to attracting nurses to the addictions workforce. “One issue is that salaries tend to be lower for staff nurses in addictions and psychiatry,” said Diane Snow, R.N., Ph.D., CARN, president of the International Nurses Society on Addictions (IntNSA), a professional specialty organization for nurses committed to the prevention, intervention, treatment and management of addictive disorders, including alcohol and other drug dependencies.

Snow added, however, that salary is not the only motivator. “If that’s what they [nurses in behavioral health] want to do, they’re going to do it regardless,” she told *MHW*. “Nurses in this field love their jobs and are terrific advocates for the patients they work with.”

### Recruitment and training initiatives

Nursing schools can help nurses enter the behavioral health field “by providing opportunities for nursing students and supporting their interest in these areas and not passively reinforce the stigma that exists in society,” Boersma said.

Nursing students are often discouraged by [nursing school] faculty from entering specialty areas, such as mental health, without having

first worked in the medical-surgical area, Boersma said.

Meanwhile, some hospitals and institutions are doing their part to encourage nursing students to enter the mental health arena by offering loan and scholarship opportunities as well as education and training programs.

In an effort to recruit and retain psychiatric nursing staff, the Arbour Health System (AHS), the largest private mental health and addictions system in Massachusetts, offers a special scholarship program for prospective nurses. The Arbour Health System includes five psychiatric hospitals in Massachusetts.

“The nursing shortage will be more in crisis in the next several years,” Marcia Hoch, R.N., M.S., C.S. (clinical specialist), director of nursing development at AHS, told *MHW*. “The population is aging and mental health issues are not subsiding.”

Hoch said the scholarship program provides nursing students with a “hands-on experience” in the field. “The scholarship is expressly designed to bring more nurses into the behavioral health field,” said Hoch.

According to Hoch, nurses can receive up to \$4,000 in tuition assistance in return for one-year of employment following graduation and up to \$8,000 in tuition support for two years of part-time employment at one of AHS’ psychiatric hospitals as a mental health associate/counselor.

AHS also offers a training program for new nursing graduates or for those interested in changing nursing specialties, or returning to the field