Published in final edited form as:
Qual Health Res. 2014 August ; 24(8): 1126–1137. doi:10.1177/1049732314541681.

Contextual Factors in the Health of People With Serious Mental Illness

Leopoldo J. Cabassa[1], **Elizabeth Siantz**[2], **Andel Nicasio**[3], **Peter Guarnaccia**[4], and **Roberto Lewis-Fernández**[1]

[1]Columbia University, New York, New York, USA

[2]University of Southern California, Los Angeles, California, USA

[3]New York State Psychiatric Institute, New York, New York, USA

[4]Rutgers, The State University of New Jersey, New Brunswick, New Jersey, USA

Abstract

People living with serious mental illness (SMI) have shorter life expectancies than the general population. We examined how contextual factors influence the physical health of this population. We conducted interviews, focus groups, and participant observations with stakeholders from six behavioral health organizations. We found that consumers' avoidance of overt disagreement during medical visits, their mistrust of medical institutions, and cultural variations in body image influenced the clinical encounter. Mental health providers' ambivalence about intervening in consumers' physical health, primary care providers' misattribution of physical symptoms to mental disorders, and providers' stigmatization of consumers shaped clinical encounters. Consumers' diets were shaped by food environments and social norms associated with traditional diets. Internal and external factors impacted consumers' physical activity. In this article, we illustrate the importance of considering contextual factors in the development and implementation of interventions aimed at improving the physical health of people with SMI.

Keywords

culture / cultural competence; health and well-being; mental health and illness; research; qualitative

A person's physical health is shaped not only by individual-level factors such as inherited biological propensities, but also by sociocultural-level factors, such as cultural norms, learned behaviors, and interactions with the human-built environment. Physical health and

---

Corresponding Author: Leopoldo J. Cabassa, Columbia University School of Social Work, 1255 Amsterdam Ave., New York, NY 10027, USA. ljc2139@columbia.edu.

Authors' Note
An earlier version of this article was presented at the 2010 American Public Health Association annual meeting in Denver, Colorado, and as a report from the New York State Center of Excellence for Cultural Competence at the New York State Psychiatric Institute in 2012.

Declaration of Conflicting Interests
The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

health care are, therefore, strongly influenced by the broader ecology that surrounds the individual (Caprio et al., 2008). We refer to this broader ecology as contextual elements that affect physical health; that is, elements that move beyond an individual-level approach and consider how a person's health and his or her search and use of medical services is shaped by and embedded in the interactions of social, cultural, and environmental factors (Diez Roux, 2012). In this qualitative study, we examined how contextual elements were at work in the physical health and medical care of people with serious mental illness (SMI; e.g., schizophrenia, bipolar disorders). Our intent is to initiate a dialogue about the importance of considering contextual factors in the planning, development, and implementation of interventions and policies aimed at improving the physical health of people with SMI.

People living with SMI in the United States have shorter life expectancies compared to the general population because of preventable medical conditions and poor medical care (Druss, Zhao, Von Esenwein, Morrato, & Marcus, 22011; Parks, Svendsen, Singer, & Foti, 2006). These issues might be worst among historically underserved racial and ethnic groups with SMI, who face higher rates of obesity and chronic illness, lower rates of health care utilization, and poorer quality of care than non-Hispanic Whites with SMI (Druss et al., 2012; Hellerstein et al., 2007; McEvoy et al., 2005; Nasrallah et al., 2006). The delivery of culturally competent and contextually grounded health-promotion programs and medical care can help reduce the elevated morbidity and mortality associated with physical illnesses among people with SMI.

There is mounting evidence that incorporating cultural and contextual factors into health interventions results in improvement in health and health care outcomes (Glazier, Bajcar, Kennie, & Willson, 2006; Han et al., 2009; Hawthorne, Robles, Cannings-John, & Edwards, 2010). Despite this evidence, the lack of attention to these factors in health and wellness interventions for people with SMI is striking. For example, Cabassa, Ezell, and Lewis-Fernández (2010) found, in a systematic literature review of 23 healthy lifestyle intervention studies between 1980 and 2010 for people with SMI, a dramatic underrepresentation of racial and ethnic minorities in these studies and only one study that adapted the intervention to an ethnic minority group.

Furthermore, the focus of most quality-of-care enhancement approaches aimed at improving the health of people with SMI has been on addressing structural barriers to care, such as improving care coordination, colocating medical services within mental health clinics, and facilitating referrals and navigation between mental health and primary care (Druss, 2007). Although attention to structural barriers is important, health interventions must also incorporate contextual elements to ensure successful transportability to real-world settings, particularly those serving racial and ethnic groups with SMI. As shown in the health-promotion literature, interventions that ignore contextual factors known to influence health (e.g., stigma, discrimination, food environments) might lack relevance, acceptability, effectiveness, and sustainability (Castro, Barrera, & Martinez, 2004).

In this article, we examine how contextual factors play a role in the physical health of people with SMI in two areas: consumer–provider interactions in the medical encounter and consumers' interactions with their environment. Sociocultural differences between providers and consumers often influence the medical encounter, impacting the quality of medical care. Consumers' health is also impacted by the built environment and the social norms that shape dietary practices and engagement in physical activity. Attention to these two areas is critical for identifying modifiable contextual factors that can inform health interventions and policies for vulnerable populations.

Methods

Sample

Our study took place between 2008 and 2010 in six behavioral health organizations located in three northern Manhattan communities in New York City; the areas have high concentrations of racial, ethnic, and linguistic diversity. Our sampling and recruitment methods are described elsewhere (Ezell, Siantz, & Cabassa, 2013) and are summarized here. We used a purposive sampling method to obtain a sample of organizations that offered a range of mental health services and received different funding streams (e.g., public, not-for-profit). We selected six community-based behavioral health organizations: one housing agency, one community-based mental health clinic, one publicly funded community mental health center, one clubhouse program, and two hospital-based outpatient mental health clinics; all participated in the study.

Within each organization, we used a multistakeholder approach by recruiting administrators, clinicians, consumers, and family members. Administrators were key informants and facilitated the recruitment of clinicians, consumers, community primary care physicians, and community leaders. Two to 3 administrators were recruited from each site. To recruit clinicians, research staff conducted presentations at staff meetings. Administrators also distributed invitation letters to all clinicians at their organization, informing them that they might be contacted to participate in a study and were free to opt out if they wished not to be contacted by the research team. Between 3 and 4 clinicians were interviewed from each site. Clinicians were asked to nominate consumers who would be interested in being interviewed.

Between 4 and 10 consumers were interviewed or participated in focus groups at each site. Consumers who were interviewed nominated a family member or friend who would be interested in talking about their experiences with mental and physical health services in the community, and their experiences caring for a person with SMI. Between 1 and 2 relatives and/or friends were interviewed at each site. Last, community primary care physicians and community/faith-based leaders were selected based on recommendations from administrators and clinicians. The appropriate institutional review boards reviewed and approved all study procedures. All participants provided written informed consent.

Data Collection

We collected demographic surveys from all participants. We conducted semistructured qualitative interviews with administrators, clinicians, consumers, relatives/friends, primary care physicians, and community/faith-based leaders. To supplement individual interviews, we conducted consumer focus groups. We used interview and focus group guides with similar open-ended questions and follow-up probes to examine (a) consumers' physical health needs; (b) availability and use of medical services; (c) influence of culture and social factors on diet, exercise, general health, and medical services; (d) relationship between consumers and providers; (e) providers' cultural competence; and (f) barriers to medical care. We conducted roundtable discussions that included consumers, clinicians, and researchers to inform the initial development of interview and focus group guides.

Our team modified the interview and focus group questions throughout the project based on the emergence of new themes and data saturation. Interviews with consumers, family members, clinicians, and administrators took place in community mental health clinics or at researchers' offices. Interviews with community and faith-based leaders were conducted at mutually agreeable community locations. We conducted all interviews in English or Spanish. Each interview lasted approximately 60 minutes, was audiotaped, professionally transcribed, and analyzed in the original language.

To supplement interviews and focus groups, trained research assistants conducted participant observations at five of the six organizations. One organization refused participant observations because of confidentiality and privacy concerns for their clients. Observation settings included health-promotion programs at the facilities, clinic-wide meetings, and assertive community treatment meetings with consumers. Research assistants recorded all observations in field notes and focused their observations on staff interactions pertaining to the delivery of care to consumers, interactions between consumers and providers regarding treatment for mental and physical illness, and consumer interactions with each other in the context of health programming.

Analytical Strategy

We used frequencies, percentages, and means to describe sample characteristics. We used open-coding procedures and the constant comparative method derived from grounded theory to analyze our qualitative data (Strauss & Corbin, 1998). Three team members independently reviewed a random cross-section of our qualitative data and open-coded these data to generate coding categories. We used NVivo computer software to develop a coding tree and to test-run this coding structure with a small sample of our qualitative data to refine the codes, add new ones, and train our main coder (Fraser, 2000). We considered our codebook a living document that was revised throughout the project. Examples of codes generated from this process included consumer–provider interactions, body image, stigma, and mistrust.

To ensure consistency and reliability of the application of codes, the first author met regularly with the coder to discuss code application and emergence of new themes. We used constant comparative methods to deepen our understanding of the data across cases and the different stakeholder groups (e.g., administrators, mental health clinicians, consumers) who participated in the study (Strauss & Corbin, 1998). Throughout this process, we generated queries and reports in NVivo (Fraser, 2000) on major codes to identify discernible patterns in our data and developed analytical memos describing the emergence of new categories and subcategories within and between codes.

During weekly analytical meetings and a 2-day retreat, we met to organize and discuss emerging themes. From these discussions, we identified a set of contextual factors that impacted the physical health and medical care of people with SMI in two critical areas: consumer–provider interactions in the medical encounter and consumers' interactions with their environments. See Table 1 for a summary of the themes and subthemes identified. We used the following strategies to ensure the trustworthiness and rigor of our analysis: consultation with qualitative experts, peer debriefing sessions, development of an audit trail, and member-checking presentations at participating organizations (Padgett, 1998).

Results

Sample Characteristics

Twenty-one administrators, 25 mental health clinicians, and 66 consumers participated in the study (see Supplemental Table S1, available online at qhr.sagepub.com/supplemental). Administrators were mostly non-Hispanic White women, bilingual (English and Spanish), and either psychiatrists or psychologists. Mental health clinicians were mostly Hispanic or non-Hispanic White women, bilingual, and either social workers, psychiatrists, or psychologists. Approximately half of consumers were women or foreign-born; most were Hispanic or African American and had 12 years or less of formal education. We also interviewed 8 relatives or friends, largely women, who were Hispanic or African American. Five primary care physicians were interviewed; most were women and bilingual. Six community or faith-based leaders were interviewed, who were largely men, foreign-born, and either African American or Hispanic.

Contextual Factors

We found that contextual factors impacted the physical health and medical care of people with SMI in two areas: consumer–provider interactions in the medical encounter and consumers' interactions with their environment, particularly around dietary practices and engagement in physical activity.

Context shapes consumer–provider interactions—From the consumers' perspectives we identified three salient socio-cultural norms that shape the clinical encounter: (a) avoidance of overt disagreement, (b) mistrust, and (c) consumers' body image.

Avoidance of overt disagreement—In individual interviews and focus groups, some African American and Hispanic consumers reported that social norms dictate that people should respect and not overtly question the recommendations of authority figures, such as doctors. This deference to authority during the encounter might inadvertently undermine consumers' involvement in the medical visit, such as by asking questions or voicing concerns about their illness and treatment regimens, particularly when the provider is someone the consumer does not know or trust. For instance, when asked whether she would disagree with her physician, a Hispanic consumer replied, "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" (Consumer [C], interview [I]).

This external deference to authority was also noted by a primary care provider in our study as being more prevalent among Hispanic consumers, and expressed as “yessing” during the medical encounter; that is, agreeing with the doctor even when the patient does not understand or is uncertain about how to follow the doctor’s instructions:

> Definitely in the Latino populations, they say, yes, yes, yes. They are probably not following through. You know, like if you ask them to mirror back what you said, you are not necessarily always getting … an understanding. I think a great example is a patient that I gave an inhaler to that had a little capsule that you had to put inside the inhaler … and so he was using it in his nose instead of as an inhaler. (Primary Care Provider [PCP], I)

Mistrust—In individual interviews and focus groups, consumers reported that mistrust of medical institutions and medical providers was a serious challenge that negatively impacted their interactions with providers. Mistrust seemed to impact provider–consumer interactions by restricting consumers’ willingness to question the doctor’s advice during the medical encounter to avoid mistreatment, as exemplified by the reaction of an African American woman when asked if she would disagree with her physician:

> I feel like it would be a waste of time. A lot of doctors are headstrong and they feel like they are the smartest people in the world anyways. I personally wouldn’t do it. I have seen how some of the doctors act, and if you don’t agree with some of the stuff then they will start mistreating you. (C, focus group [FG])

Mistrust also results in consumers entering the medical encounter in a defensive stance because of high levels of suspicion, as described by an African American man:

> 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! (C, I)

Body image varies culturally—Consumers, friends, and relatives described cultural norms that favored a fuller body image as a sign of good health, particularly among Hispanic and African American women: “When I was young I would complain about my skinny legs, because in Santo Domingo people with plump legs were the beautiful people” (Hispanic C, FG). These cultural differences have important consequences for helping people with SMI manage the weight gain commonly associated with second-generation antipsychotic medications or unhealthy lifestyle. As illustrated by the comments of a Hispanic primary care provider, inattention to cultural norms associated with body image can inadvertently create resistance to losing weight:

> 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. (PCP, I)

We also identified several sociocultural norms at the provider level that shaped the clinical encounter: (a) ambivalence about delivering physical health care, (b) misattribution of physical symptoms to mental disorders, and (c) stigmatization.

Ambivalence about delivering physical health care—Just as much as consumers, providers bring their own personal and professional culture into the medical encounter. Providers' ambivalence toward managing the physical health of consumers can result in serious barriers to the integration of physical and mental health services, as illustrated by the comments of a social worker:

> Having the therapists step outside of their role and get actively involved in the … nitty-gritty [small details] of their health care … I just think it is not right, in my own hesitation. … I wouldn't want to be the one staring over their shoulder, seeing if they lost or gained a pound. (Social Worker [SW], I)

This discomfort originated from professional boundary issues regarding the role mental health clinicians should play in helping consumers with their physical health needs. Limited education and training, particularly in preventive medicine and in the management of common chronic diseases (e.g., diabetes), even among the psychiatrists in our study, contributed to mental health clinicians' ambivalence about physical health care, as exemplified by this comment from a psychiatrist: "But I'm not really monitoring them because I'm not up to date with the latest, you know, antihypertensives and the best regimen for diabetes. I want them to get the best care possible, so I try to refer them out" (Psychiatrist [P], I). However, we observed a tipping-point phenomenon. When mental health clinicians encountered a consumer with an acute, life-threatening medical condition, and felt that the person's need was overpowering, professional boundary issues were set aside and mental health providers were willing to step outside their usual role and intervene:

> I think the milder cases … we probably need to do a better job. But the serious cases, we really work hard to help. A great example is … four or five years ago, one of our psychotic patients needed a heart transplant, and he was very low on the list because he was psychotic, and we really advocated for him. (P, I)

Misattribution of physical symptoms to a mental disorder—Providers' bias shaped by their medical training and inexperience working with people with SMI can negatively impact consumer–provider interactions. This results in the commonly held view expressed by primary care physicians and mental health clinicians in our study that unraveling the physical health needs of consumers constitutes a difficult "jigsaw puzzle." A common sentiment described by mental health clinicians and relatives of consumers was that consumers' health concerns were often misinterpreted by primary care providers as delusions instead of as real medical conditions. In the words of a family member, "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 [people] think they [the patients] are delusional" (Family Member [FM], I).

Mental health clinicians and relatives in our study repeatedly 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." This leads physicians to question the reliability of the medical information they obtain from consumers with SMI. Both primary care providers and mental health clinicians noted that working with these consumers requires skill in untangling the physical from the mental, as illustrated by the following example from an experienced nurse practitioner:

> I had a client that four days after I met him kept telling me he had beach balls behind his leg, and I didn't know what that meant, but I did know that he had told me … he was a diabetic and he wasn't taking his medications. So when I took him to our own ER [emergency room] … one of the nurses said, "Is this part of his delusion?" Yes, there is a delusional system but there's also this very weird subjective experience, and his description was quite odd. It ended up he was actually admitted and had a heart condition. (Nurse Practitioner [NP], I)

Stigmatization—The combination of stigma toward mental illness and mistrust because of racism and other factors contributed to consumers entering the medical encounter resigned to the inevitability of receiving poor medical care. As summarized by an administrator, this resignation might contribute to developing fatalistic attitudes that are exacerbated by experiences with racial discrimination and result in patients giving up and disengaging from medical care.

Administrators, mental health clinicians, relatives, and faith-based leaders also reported how medical providers tended to view consumers with SMI as dangerous and unmanageable, and how the presence of a serious mental disorder evoked fear and resistance to seeing consumers with SMI. These stigmatizing attitudes 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 have developed. Primary care providers also acknowledged the limited training they received in professional education concerning working clinically with people with SMI. When asked to describe how medical services for people with SMI could be improved, one primary care physician responded,

> I don't think that … physicians, in their training, receive a lot of that exposure. So when you are out there, you are sort of like making mistakes as you go along and offending people because you really were never trained on how to approach these issues. (PCP, I)

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 to ignore, the physical health concerns of patients with SMI. This results in poor quality medical care.

Context shapes consumers' interactions with their environment—We found that sociocultural forces shape consumers' dietary habits and their engagement in physical activity. These two areas are related to the chronic illnesses that disproportionally impact people with SMI.

Consumers' food environments—There is increasing evidence that dietary choices are limited in low-income, urban, minority communities by the high cost of fresh fruits and vegetables and the availability and convenience of fast food (Kaufman & Karpati, 2007;

Kumanyika, 2008). As exemplified by the comments of an African American woman, limited income places serious constraints on consumers' dietary choices:

> 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. (C, FG)

Administrators, mental health clinicians, and primary care providers also voiced concerns about the food environment in consumers' communities, citing that the abundance, affordability, and convenience of fast food makes it easier for consumers to eat an unhealthy diet than to purchase fresh fruits and vegetables and cook their own meals on a regular basis.

Because most consumers in our study were on a fixed income, our participant observations revealed that the food served for lunch at day treatment programs became an important part of consumers' diets. However, providers of these programs lamented the low quality of the food served for lunch, admitting that some of the food was high in fat and sodium. Consumers had mixed reactions to the food served at clinics; some described the food as overly starchy and unhealthy, whereas others described the food as healthy and were grateful for the free meal.

Agency staff described how budget limitations had a negative impact on the healthfulness of lunch. At one site, the food served for lunch was purchased at local grocery stores in the neighborhood, limiting the options of available food on a limited budget. We also observed that this site also had a snack bar where consumers were able to purchase snacks; most were high in sodium, sugar, or fat. The money raised at the snack bar went toward kitchen expenses, including groceries. In all, these comments and observations provide a glimpse of consumers' food environments and their dietary choices.

Social norms associated with dietary practices—Social norms also shape dietary practices and consumers' motivation to engage in healthy lifestyles. When we asked Hispanic and African American consumers why racial and ethnic minorities have higher rates of obesity, cardiovascular disease, and diabetes, the consensus was that low-income minority people "live unhealthy lives" because they eat unhealthy foods, or "don't know how to eat." These sentiments were best captured by the comments of a Hispanic woman:

> 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 there'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. (C, I)

Consumers acknowledged how difficult it is to change their dietary habits, with some feeling a sense of helplessness. According to a Hispanic woman,

> My doctor complains a lot about my soda intake. I drink a lot of Pepsi and a lot of Coke; I have to; I'm addicted to Coca-Cola or Pepsi … which is bad, and that's why I look so heavy. (C, I)

There was also a perception that culturally meaningful foods are unhealthy. Mental health clinicians, primary care providers, and Hispanic consumers discussed rice—a food full of cultural meaning for Hispanics—as a bad food choice. According to one Hispanic consumer, "We lead very unhealthy lives; very. I mean, with the Spanish, you know with all that rice and beans and all that seasoning" (C, FG). This perception that traditional foods are unhealthy was also supported by an African American faith-based leader:

> Like, how do we educate ourselves to cook collard greens differently? And not smother pork chops … to know that we don't have to have fried chicken and cornbread and green beans, we don't have to have all of this at a meeting at noon on a Saturday. (Faith-Based Leader [FBL], I)

This self-blame and sense of limited self-efficacy are likely to limit consumers' motivation to engage in lifestyle changes.

Social context influences consumers' engagement in physical activity—When asked in individual interviews and focus groups to discuss physical activity, consumers were aware of the importance of exercise for their health, particularly for weight management, but differed in their engagement in daily physical activity. 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 activity; exercise was not part of their daily routine. In the words of one Hispanic woman, "I don't like to exercise, not even when I was younger. … Now I'm old I don't, I don't exercise" (C, FG). Not having access to safe environments, such as parks or pedestrian walkways, deterred many consumers we interviewed from engaging in regular physical activity, as expressed by a Hispanic woman: "I don't feel comfortable walking alone in the streets. … I get very nervous; it's not safe" (C, I).

Many other consumers listed walking as their preferred and most common physical activity. Some valued engaging in physical activity because they felt it benefited their physical and mental health. These same consumers reported that they tried to walk every day, but that it was difficult to sustain this routine because of bad weather, pain in their extremities, or lack of motivation because of their symptoms (e.g., depressed mood). Consumers frequently listed housecleaning as exercise, even though this does not constitute aerobic activity that yields cardiovascular benefit. Most consumers expressed interest in the exercise groups offered by their mental health clinic, particularly those that offered an opportunity for cultural expression (e.g., salsa dancing classes) and other activities that promoted weight loss and healthy lifestyle.

Discussion

In this article we have illustrated how contextual factors can shape the physical health and medical care of people with SMI. We found that consumers' avoidance of overt disagreement in medical visits, mistrust of medical institutions, and cultural norms that favored a fuller body image were factors that influenced consumers’ interactions with their providers during the medical encounter. At the provider level, we found that mental health clinicians’ ambivalence about delivering physical health care, primary care physicians’ misattribution of physical health concerns to mental disorders, and health care providers’ stigmatization toward people with SMI influenced their interactions with consumers during medical visits. We also uncovered that consumers’ food environments, their social norms associated with dietary practices, and their social context were factors that influenced their dietary habits and engagement in physical activity.

The cultures of consumers and providers intersect during the medical encounter (Good, 1994; Katz & Alegria, 2009). These cultures include their interactions as individuals from particular cultural backgrounds as well as the effect of clinicians’ specific perspectives and functions within a broader culture of biomedicine (Good). Our findings indicate that physical health services need to respect and engage consumers’ views, values, cultural norms, preferences, and needs in a way that reduces mistrust and stigma, and results in open negotiation of existing and desired health-related behaviors and goals. Culturally appropriate strategies are needed to improve consumers’ engagement in health and wellness activities, including consumers’ participation in the medical encounter.

Because enhancing consumers’ awareness and knowledge of health issues is the first step to increasing their participation in medical visits, the use of culturally and linguistically appropriate health education tools can help improve consumers’ health knowledge (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). Our findings suggest that consumers should also be encouraged to become more active participants during their medical visit by coming prepared with a list of questions to ask their physician and being better informed about their physical health issues. For instance, the Right Question Project, an intervention derived from practice-based evidence, helps train consumers to do this using three, 45-minute sessions with a care manager (Alegria et al., 2008). The Project has been developed with a mixed racial/ethnic consumer sample and can easily be adapted to physical health topics.

Physical health programs in mental health settings must also be sensitive to consumers’ body image, dietary practices, and food environment, and their views of and motivations to engage in physical activity. For example, medical and lifestyle interventions for people with SMI (e.g., weight management classes) should discourage thinness as a treatment goal and instead focus on improving consumers’ general physical health and enhancing their self-efficacy for achieving a healthy lifestyle. 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 (Chodosh et al., 2005; Druss, Zhao, et al., 2010). These should be assessed for cultural fit with various consumer communities. 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, such as drinking water or diet sodas instead of beverages with high concentrations of sugar.

We also found that providers bring their own personal and professional cultural identity into the medical encounter. These professional boundaries are integral 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 (Good, 1994). Consistent with our findings, professional boundaries can produce uncertainty among mental health clinicians regarding their role and responsibilities in helping consumers with SMI with their physical health issues (Kilbourne, Greenwald, Bauer, Charns, & Yano, 2012; Wheeler et al., 2010).

To reduce the ambivalence that many mental health providers feel about delivering physical health services to people with SMI, clinicians must receive training on existing practice guidelines for monitoring and managing common physical conditions among people with SMI (Marder et al., 2004), and must have the resources and infrastructure to implement these guidelines into practice. For example, health care management interventions can help clarify providers' roles and responsibilities by systematizing the monitoring, coordination, and management of the physical health needs of consumers with SMI (Druss, von Esenwein, et al., 2010). However, 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 and programs for integrating health and mental health services (e.g., health care manager interventions, co-located care programs) to their own needs, consumer populations' capacities, and resources (Druss, 2007). Effective models incorporate screening and monitoring and include specific guidelines for management and treatment.

Moreover, improving the collaboration and coordination of care between primary care and mental health providers can help reduce the misattribution of physical symptoms to mental disorders that we found in the study by facilitating the communication and sharing of important medical information. Training of primary care providers (e.g., physicians, nurses, social workers) should include rotations to work alongside mental health professionals in community mental health clinics to gain clinical experience treating people with SMI and learn how to work across systems of care. Medical and other professional schools (e.g., social work programs) 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 gaining expertise on how to work within interdisciplinary treatment teams and understand the clinical, organizational, and legal complexities of delivering medical and mental health care.

Our finding regarding the stigmatization that people with SMI face from health care providers is consistent with previous studies and indicates that this is a serious barrier that could result in consumers underutilizing and disengaging from medical care (Borba et al., 2012; Thornicroft, 2006). To tackle this stigmatization, antistigma trainings need to be disseminated to primary and other health care providers working with consumers with SMI. For instance, the National Alliance on Mental Illness (NAMI) provides training for providers (e.g., NAMI Provider Education Program) throughout the United States. Antistigma programs should educate providers about the lives of people with SMI, discuss recovery principles and values, and provide them with the opportunity to interact with consumers, because positive social contact with a person with mental illness reduces stigma (Corrigan, 2012). The use of community health workers can also reduce stigma and consumers' mistrust of medical institutions because they help consumers engage in medical care and improve health outcomes among racial and ethnic minority groups (Ayala, Vaz, Earp, Elder, & Cherrington, 2010)

We also found that context influences consumers' dietary habits and their engagement in physical activity. Food carries cultural meaning and embodies cultural identity; what we eat is shaped by who we are and where we come from. But these values, understandings, and practices are not static; they are influenced by socioeconomic forces, nutritional marketing, and social norms (Farley & Cohen, 2005). Attention to consumers' food environments is central to improving their diet and health. Addressing consumer attitudes regarding food consumption and providing behavioral skills might not be sufficient, by themselves, to sustain dietary improvements if consumers' local social worlds are not supportive of these changes (Kumanyika, 2008).

Many organizations for people with SMI serve lunch as part of their programs. Lunchtime can be used to model healthy eating habits and a healthy food environment through a balanced diet. Partnering with nutritionists could 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 using a simple three-color scheme (red = unhealthy, yellow = less healthy, green = healthy) to communicate the nutritional value of different foods sold at a hospital cafeteria significantly improved the sale of healthier items, particularly beverages (Thorndike, Sonnenberg, Riis, Barraclough, & Levey, 2012). Similar approaches can be used in behavioral health organizations.

Self-blame for leading an "unhealthy life" and the sense of limited self-efficacy to change observed in many of the consumers in our study can partly be attributed to the socioeconomic forces that limit their dietary choices. However, these findings also suggest that racial and ethnic minority consumers might internalize 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. Explicit consumerism and targeted food marketing to minority communities could contribute to the internalization of self-blame by supporting the view that traditional foods are less valuable compared to modern, dominant-culture dietary options, such as fast foods.

In addition, oversimplified messages from health professionals about what constitutes healthy eating that include only North American food examples could inadvertently communicate a rejection of traditional foods. To address these issues, health and wellness programs can include modules that raise consumer awareness that their traditional foods can be prepared in a healthy manner without compromising taste, particularly when cooked with fresh produce and lean meats. These modules can include recipes for preparing healthy traditional foods and help consumers practice portion control.

Finally, improving consumer motivation for and engagement in regular physical activity is a critical goal for recovery-oriented mental health programs. Given that a sedentary lifestyle is a major risk factor for chronic illnesses that disproportionally impact people with SMI, physical health services in mental health settings should provide opportunities for consumers to engage in regular physical activity (Bartels & Desilets, 2012). A recent report suggests that the most successful physical activity programs go beyond education and encouragement by incorporating extensive exercise activities and integrating fitness measures (e.g., 6-minute walk test) to monitor consumer progress (Bartels & Desilets).

Exercise is not only good for the body but also for the mind, because it can help improve depression, self-esteem, and social isolation (Richardson et al., 2005). Our findings indicate that structured physical activity programs should be fun, culturally meaningful, and provide consumers an opportunity to socialize with their peers. Wellness programs should clarify for consumers the difference between housework- and work-related activity (e.g., bending, carrying) and aerobic exercise with cardiovascular benefits. Providers can help consumers set concrete physical activity goals, such as walking for 30 minutes three times a week.

The study results must be interpreted in light of several limitations. This study was conducted in one large urban area in the northeastern United States, thus limiting its generalizability to other urban areas in the United States. As noted earlier, most consumers were African American or Hispanic (predominantly Dominicans and Puerto Ricans); thus, results might not portray the health care experiences of other U.S. racial and ethnic minorities with SMI. Future studies are needed to examine the health care experiences of other racial and ethnic minority consumers 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 United States (Alakeson, Frank, & Katz, 2010; Smith & Sederer, 2009), it is imperative that contextual factors are considered in the planning, development, and implementation of these service innovations. It is also important that efforts to improve the physical health of people with SMI move beyond medical interventions to consider environmental approaches and strategies that can help facilitate their access to and consumption of healthier foods and increase their engagement in regular physical activity. Considerable work in these areas is still needed to address the physical health care disparities faced by people with SMI. A focus on contextual factors that blends efforts to improve provider and consumer behaviors with attention to the social and environmental determinants of health will result in a more comprehensive approach to enhance the physical health of people with SMI, one that is responsive to the needs, preferences, and realities of consumers from all cultural backgrounds.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

We thank the research team from the New York State Center of Excellence for Cultural Competence at the New York State Psychiatric Institute for their work on this project and all the organizations that participated in the study. We also thank Benjamin Druss for his comments and feedback on an earlier version of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: A grant from the New York State Office of Mental Health to the New York State Center of Excellence for Cultural Competence at the New York State Psychiatric Institute (Cabassa, Nicasio, Siantz, and Lewis-Fernández) supported this work. Grants were also received from the National Institutes of Health, including L60 MD001850-03 (Cabassa), K01 MH091108 (Cabassa), R25 MH080916 (Cabassa), and R01 MH77226 (Lewis-Fernández). The content of this article is solely the responsibility of the authors and does not represent the official views of the National Institutes of Health.

References

Alakeson V, Frank RG, Katz RE. Specialty care medical homes for people with severe, persistent mental disorders. Health Affairs. 2010; 29(5):867–873. DOI: 10.1377/hlthaff.2010.0080 [PubMed: 20439873]

Alegria M, Polo A, Gao S, Santana L, Rothstein D, Jimenez A, Normand SL. Evaluation of a patient activation and empowerment intervention in mental health care. Medical Care. 2008; 46(3):247–256. DOI: 10.1097/MLR.0b013e318158af52 [PubMed: 18388839]

Ayala GX, Vaz L, Earp JA, Elder JP, Cherrington A. Outcome effectiveness of the lay health advisor model among Latinos in the United States: An examination by role. Health Education Research. 2010; 25(5):815–840. DOI: 10.1093/her/cyq035 [PubMed: 20603384]

Bartels, S.; Desilets, R. Health promotion programs for people with serious mental illness. Washington, DC: SAMHSA-HSRA Center for Integrated Health Solutions; 2012.

Borba CP, Depadilla L, McCarty FA, von Esenwein SA, Druss BG, Sterk CE. A qualitative study examining the perceived barriers and facilitators to medical healthcare services among women with a serious mental illness. Women's Health Issues. 2012; 22(2):e217–e224. DOI: 10.1016/j.whi.2011.10.001 [PubMed: 22172651]

Cabassa LJ, Ezell J, Lewis-Fernández R. Lifestyle interventions for adults with serious mental illness: A systematic literature review. Psychiatric Services. 2010; 61:774–782. DOI: 10.1176/appi.ps.61.8.774 [PubMed: 20675835]

Caprio S, Daniels SR, Drewnowski A, Kaufman FR, Palinkas LA, Rosenbloom AL, Schwimmer JB. Influence of race, ethnicity, and culture on childhood obesity: Implications for prevention and treatment. Obesity (Silver Spring). 2008; 16(12):2566–2577. DOI: 10.1038/oby.2008.398 [PubMed: 19279654]

Castro FG, Barrera M Jr, Martinez CR Jr. The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. Prevention Science. 2004; 5(1):41–45. DOI: 10.1023/B:PREV.0000013980.12412.cd [PubMed: 15058911]

Chodosh J, Morton SC, Mojica W, Maglione M, Suttorp MJ, Hilton L, Shekelle P. Meta-analysis: Chronic disease self-management programs for older adults. Annals of Internal Medicine. 2005; 143(6):427–438. DOI: 10.7326/0003-4819-143-6-200509200-00007 [PubMed: 16172441]

Corrigan PW. Where is the evidence supporting public service announcements to eliminate mental illness stigma? Psychiatric Services. 2012; 63(1):79–82. DOI: 10.1176/appi.ps.201100460 [PubMed: 22227764]

Diez Roux AV. Conceptual approaches to the study of health disparities. Annual Review of Public Health. 2012; 33:41–58. DOI: 10.1146/annurev-publhealth-031811-124534

Druss BG. Improving medical care for persons with serious mental illness: Challenges and solutions. Journal Clinical Psychiatry. 2007; 68(Suppl 4):40–44.

Druss BG, von Esenwein SA, Compton MT, Rask KJ, Zhao L, Parker RM. A randomized trial of medical care management for community mental health settings: The Primary Care Access, Referral, and Evaluation (PCARE) study. American Journal of Psychiatry. 2010; 167(2):151–159. DOI: 10.1176/appi.ajp.2009.09050691 [PubMed: 20008945]

Druss BG, Zhao L, Cummings JR, Shim RS, Rust GS, Marcus SC. Mental comorbidity and quality of diabetes care under Medicaid: A 50-state analysis. Medical Care. 2012; 50(5):428–433. DOI: 10.1097/MLR.0b013e318245a528 [PubMed: 22228248]

Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical Care. 2011; 49(6):599–604. DOI: 10.1097/MLR.0b013e31820bf86e00005650-201106000-00011 [PubMed: 21577183]

Druss BG, Zhao L, von Esenwein SA, Bona JR, Fricks L, Jenkins-Tucker S, Lorig K. The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness. Schizophrenia Research. 2010; 118(1–3):264–270. DOI: 10.1016/j.schres.2010.01.026 [PubMed: 20185272]

Ezell JM, Siantz E, Cabassa LJ. The contours of usual care for meeting the medical needs of racially and ethnically diverse persons with serious mental illness. Journal of Health Care for the Poor and Underserved. 2013; 24(4):1552–1573. DOI: 10.1353/hpu.2013.0158 [PubMed: 24185152]

Farley, T.; Cohen, DA. Prescription for a healthy nation: A new approach to improving our lives by fixing our everyday world. Boston: Beacon Press; 2005.

Fraser, D. QSR NVivo NUD*IST Vivo reference guide. Melbourne, Australia: QSR International; 2000.

Glazier RH, Bajcar J, Kennie NR, Willson K. A systematic review of interventions to improve diabetes care in socially disadvantaged populations. Diabetes Care. 2006; 29(7):1675–1688. DOI: 10.2337/dc05-1942 [PubMed: 16801602]

Good, BJ. Medicine, rationality and experience: An anthropological perspective. Cambridge: Cambridge University Press; 1994.

Han HR, Lee JE, Kim J, Hedlin HK, Song H, Kim MT. A meta-analysis of interventions to promote mammography among ethnic minority women. Nursing Research. 2009; 58(4):246–254. DOI: 10.1097/NNR.0b013e3181ac0f7f00006199-200907000-00004 [PubMed: 19609176]

Hawthorne K, Robles Y, Cannings-John R, Edwards AG. Culturally appropriate health education for Type 2 diabetes in ethnic minority groups: A systematic and narrative review of randomized controlled trials. Diabetes Medicine. 2010; 27(6):613–623. DOI: 10.1111/j.1464-5491.2010.02954.x

Hellerstein DJ, Almeida G, Devlin MJ, Mendelsohn N, Helfand S, Dragatsi D, Capitelli L. Assessing obesity and other related health problems of mentally ill Hispanic patients in an urban outpatient setting. Psychiatric Quarterly. 2007; 78(3):171–181. DOI: 10.1007/s11126-007-9038-y [PubMed: 17417734]

Katz AM, Alegria M. The clinical encounter as local moral world: Shifts of assumptions and transformation in relational context. Social Science & Medicine. 2009; 68(7):1238–1246. DOI: 10.1016/j.socscimed.2009.01.009 [PubMed: 19201074]

Kaufman L, Karpati A. Understanding the socio-cultural roots of childhood obesity: Food practices among Latino families of Bushwick, Brooklyn. Social Science & Medicine. 2007; 64(11):2177–2188. DOI: 10.1016/j.socs-cimed.2007.02.019 [PubMed: 17383060]

Kilbourne AM, Greenwald DE, Bauer MS, Charns MP, Yano EM. Mental health provider perspectives regarding integrated medical care for patients with serious mental illness. Administration and Policy in Mental Health and Mental Health Services Research. 2012; 39(6):448–457. DOI: 10.1007/s10488-011-0365-9 [PubMed: 21735302]

Kreuter MW, Lukwago SN, Bucholtz RD, Clark EM, Sanders-Thompson V. Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. Health Education and Behavior. 2003; 30(2):133–146. DOI: 10.1177/1090198102251021 [PubMed: 12693519]

Kumanyika S. Ethnic minorities and weight control research priorities: Where are we now and where do we need to be? Preventive Medicine. 2008; 47(6):583–586. DOI: 10.1016/j.ypmed.2008.09.012 [PubMed: 18955076]

Marder SR, Essock SM, Miller AL, Buchanan RW, Casey DE, Davis JM, Shon S. Physical health monitoring of patients with schizophrenia. American Journal of Psychiatry. 2004; 161(8):1334–1349. DOI: 10.1176/appi.ajp.161.8.1334 [PubMed: 15285957]

McEvoy JP, Meyer JM, Goff DC, Nasrallah HA, Davis SM, Sullivan L, Lieberman JA. Prevalence of the metabolic syndrome in patients with schizophrenia: Baseline results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and comparison with national estimates from NHANES III. Schizophrenia Research. 2005; 80(1):19–32. DOI: 10.1016/j.schres.2005.07.014 [PubMed: 16137860]

Nasrallah HA, Meyer JM, Goff DC, McEvoy JP, Davis SM, Stroup TS, Lieberman JA. Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: Data from the CATIE schizophrenia trial sample at baseline. Schizophrenia Research. 2006; 86(1–3):15–22. DOI: 10.1016/j.schres.2006.06.026 [PubMed: 16884895]

Padgett, DK. Qualitative methods in social work research: Challenges and rewards. Thousand Oaks, CA: Sage; 1998.

Parks, J.; Svendsen, D.; Singer, P.; Foti, ME. Morbidity and mortality in people with serious mental illness. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Direcotors Council; 2006.

Richardson CR, Faulkner G, McDevitt J, Skrinar GS, Hutchinson DS, Piette JD. Integrating physical activity into mental health services for persons with serious mental illness. Psychiatric Services. 2005; 56(3):324–331. DOI: 10.1176/appi.ps.56.3.324 [PubMed: 15746508]

Smith TE, Sederer LI. A new kind of homelessness for individuals with serious mental illness? The need for a “mental health home. Psychiatric Services. 2009; 60(4):528–533. DOI: 10.1176/appi.ps.60.4.528 [PubMed: 19339329]

Strauss, AL.; Corbin, J. Basics of qualitative research: Techniques and procedures for developing grounded theory. 2. Thousand Oaks: Sage; 1998.

Thorndike AN, Sonnenberg L, Riis J, Barraclough S, Levey DE. A 2-phase labeling and choice architecture intervention to improve healthy food and beverages choices. American Journal of Public Health. 2012; 102(3):527–533. DOI: 10.2105/AJPH.2011.300391 [PubMed: 22390518]

Thornicroft, G. Shunned: Discrimination against people with mental illness. New York: Oxford University Press; 2006.

Wheeler AJ, Harrison J, Mohini P, Nardan J, Tsai A, Tsai E. Cardiovascular risk assessment and management in mental health clients: Whose role is it anyway? Community Mental Health Journal. 2010; 46(6):531–539. DOI: 10.1007/s10597-009-9237-0 [PubMed: 19688593]

Biographies

Leopoldo J. Cabassa, PhD, is an associate professor at the Columbia University School of Social Work and the assistant director of the New York State Center of Excellence for Cultural Competence at the New York State Psychiatric Institute, New York, New York, USA.

Elizabeth Siantz, MSW, is a doctoral student at the University of Southern California School of Social Work, Los Angeles, California, USA.

Andel Nicasio, MSED, is a doctoral student in the Department of Psychology at the University of Central Florida, Orlando, Florida, USA.

Peter Guarnaccia, PhD, is a professor in the Department of Human Ecology at Rutgers University, New Brunswick, New Jersey, USA.

Roberto Lewis-Fernández, MD, is a professor of psychiatry at Columbia University Medical Center, New York, New York, USA.

Table 1

Summary of Study Themes and Subthemes.

Themes/Subthemes	Summary of Results	Stakeholder Groups
Consumer–provider interactions in the medical encounter: Consumer level		
Avoidance of overt disagreement	Social norms dictate respect, and consumers should not overtly question doctors. Deference to authority could undermine consumers' involvement in medical visits.	Consumers, primary care providers
Mistrust	Mistrust of medical institutions restricted consumer willingness to question doctors' advice to avoid mistreatment. Mistrust can result in consumers entering the medical encounter in a defensive stance because of high levels of suspicion.	Consumers
Consumers' body image	Cultural norms favored a fuller body image as a sign of good health. Provider inattention to cultural norms associated with body image can inadvertently create resistance to losing weight.	Consumers, friends/relatives, primary care providers
Consumer–provider interactions in the medical encounter: Provider level		
Ambivalence about delivering physical health care	Mental health clinicians' ambivalence about delivering physical health care can result in barriers to the integration of physical and mental health services. Ambivalence originates from professional boundary issues and limited education and training in preventive medicine and managing chronic disease. Tipping-point phenomenon: For acute, life-threatening medical issues, professional boundary issues were set aside and mental health providers were willing to intervene.	Administrators, mental health clinicians
Misattribution of physical symptoms to mental disorders	Unraveling the physical health needs of consumers is difficult and requires skill to untangle the physical from the mental. Consumer health concerns, as related to consumer mental health conditions, are often misinterpreted by primary care providers. Physicians question the reliability of the medical information they obtain from consumers.	Primary care providers, mental health clinicians, relatives
Stigmatization	The combination of stigma and racism contributes to consumers entering the medical encounter resigned to receiving poor medical care. Medical providers view consumers with SMI as dangerous and unmanageable, evoking fear and resistance toward treating them. Lack of training and experience working with people with SMI contributes to stigmatization.	Administrators, mental health clinicians, relatives, faith-based leaders, primary care providers
Consumer interactions with their environment		
Consumers' food environments	Consumers' limited income places constraints on their dietary choices. There was a lack of available and affordable healthy food options in consumers' communities. Consumers reported easy access to fast food establishments in their communities. For some consumers, the food served in day treatment programs is an important part of their diet.	Administrators, consumers, mental health clinicians, primary care providers
Social norms associated with dietary practices	Some consumers internalized the view that low-income minority people live unhealthy lives because they eat unhealthy foods. Consumers acknowledged how difficult it is to change unhealthy dietary habits. Consumers endorsed the perception that culturally meaningful foods are unhealthy.	Consumers, mental health clinicians, primary care providers, faith- based leaders
Social context influences consumers' engagement in physical activity	Consumers are aware of the importance of exercise for their health but varied in their engagement in daily physical activity. Not having access to a safe environment deterred consumers from engaging in regular physical activity. Consumers face multiple barriers to engaging in and maintaining physical activity. Most consumers expressed interest in exercise groups offered in mental health clinics that provided opportunities for cultural expression and promoted healthy lifestyles.	Consumers