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Enhancing the Effectiveness of Assertive Community Treatment for People of Color: Practice & Theory

by

Laura E. Escobar-Ratliff

A Banded Dissertation in Partial Fulfillment
Of the Requirement for the Degree
Doctor of Social Work

Saint Catherine University | University of Saint
Thomas School of Social Work

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Abstract

Disparities in mental health treatment have been well documented over the last 30 years. Assertive Community Treatment (ACT) is poised to be able to address these disparities for people experiencing severe mental illness if we ground practice (i.e., ACT) in theory (i.e., ecological perspective of social work). The ecological perspective pushes social workers and other practitioners to be critically aware of the complexities of humanity and be expansive in our outlook and approach to practice.

Product One was a systematic review focused on primary research that assessed the outcomes of the effectiveness of ACT with people of color who are experiencing severe mental illness. The purpose of conducting a systematic review was to establish a foundation of quality research that assessed the outcomes of ACT. From that body of knowledge, the question of ACT's effectiveness with people of color was then explored.

Product two was a conceptual paper that explored grounding ACT theoretically in the ecological perspective of social work to enhance its effectiveness in working with people of color. Grounding ACT services in the ecological perspective will enhance ACT teams' ability to provide care that meets the needs of *all* consumers, including consumers of color. The professional standards of holism, sensitivity to diversity, and strengths were used to analyze ACT services and the ecological perspective.

Product three explored the concepts of intersectionality, cultural humility, and power to operationalize the ecological perspective in practice. Practitioners who understand and operationalize these key concepts in their work are more aware and attentive to the concepts of adaptability, habitat and niche, life course, power, stress, and resilience. This enhanced

understanding aids practitioners in being attentive to the complexities of human dynamics that are impacted by race, ethnicity, and culture.

To effectively treat people experiencing severe mental illness, implications of their illness *and* identity must be considered. Inattentiveness to these factors will result in practitioners being less effective. Providing ACT services from an ecological perspective provides mental health practitioners with a framework for understanding *and* being critically aware of the consumer's unique lens and life experiences. This enables practitioners to be effective in addressing the needs of *all* consumers, including consumers of color.

Dedication

It takes a village to survive a doctoral program and this dissertation is dedicated to my beautiful and vast village. To my husband, Robbi Ratliff, who has unconditionally supported, encouraged, challenged, and loved me throughout my doctoral journey. To my daughter, Carmen Lynn Ratliff, you are my inspiration to always do better and be better. Wise beyond your six years, you supported study time and reminded mommy of play time; you bring balance to my life. To my parents, Geanine and Donoso Escobar, you are living examples of what it means to be humble, fierce, wise, and compassionate. This journey would not have been possible without your love, support, and example. To my amazing family - Roberto Escobar, Melissa Escobar, Shannon Johnson, Jenny Padgett, Tonny Ratliff, and Nicole George - your readiness to help care for Carmen Lynn over the last three years made this journey doable for Robbi and I and made it FUN for Carmen. To my dear friend and mentor Erlene Grise-Owens, there are not enough words to thank you. You are an inspiration for socially just social workers and social work educators. To my dear friend Mindy Eaves, we jumped in to the deep end together and now we are climbing out on the other-side together. I was honored to be on this journey with you my friend. To all my friends and family that encouraged and supported me I thank you. Finally, to my consumers. Thank you for sharing your lives with me. Thank you for trusting me to accompany you on your recovery journey. I continue to commit to enhancing my knowledge and skills as directed by you. You are the expert and I am the student, learning *from* you and *with* you always.

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Enhancing the Effectiveness of Assertive Community Treatment with People of Color: Practice & Theory

Research affirming the disparities in mental health treatment for people of color compared to their white counterparts has been well documented over the last 30 years (Acevedo et al., 2012; Acevedo et al., 2015; Cuéllar & Paniagua, 2000; Culture, race, and ethnicity, 2001; Miranda, Cook, & McGuire, 2007; Padgett, Patrick, Burns, & Schlesinger, 1994; U.S. Department of Health and Human Services [USDHHS], 2013). People of color encounter disparities of access, quality, and availability of mental health services (Culture, race, and ethnicity, 2001; Fiscella, Franks, Doescher, & Saver, 2002). Miranda et al. (2007) found African-Americans and Hispanics received less mental health services than their white counterparts. Padgett et al. (1994) had similar finding in their study conducted in 1983. However, Padgett et al. (1994) went a step further in their analysis and identified "cultural or attitudinal factors" (p. 222), among others, as factors in the disparities. According to Giliberti (2016), the CEO of National Alliance on Mental Illness (NAMI), African Americans and Latinos use mental health services at approximately one half the rate of Caucasian Americans and Asian Americans utilize services at one third the rate of Caucasians. Giliberti (2016) cites "racism, homophobia or other conscious or unconscious biases, lack of access to services in the community, lack of cultural competence in service delivery [and] stigma" (para 4) as some of the reasons for disparity. Giliberti (2016) advocates for various strategies to address these disparities, including "vigorous outreach *beyond clinical walls*," increased flexibility, and alternative treatment options.

People who experience severe mental illness need comprehensive treatment due to having higher rates of: chronic health needs, institutionalization (i.e., hospitalization and/or incarceration), homelessness, and premature mortality (NAMI, 2018; NIMH, 2017; Liu et al., 2017). Assertive Community Treatment (ACT) is an evidence-based practice for people with

severe mental illness “who are most at -risk of homelessness, psychiatric crisis and hospitalization, and involvement in the criminal justice system” (Case Western Reserve University, n.d., para 1). ACT has been studied extensively across the world and demonstrated positive outcomes. ACT’s approach to care for people with severe mental illness, in particular people of color, will be explored and analyzed in this dissertation.

ACT is a multidisciplinary community-based team that provides intensive treatment and psychosocial rehabilitation services in vivo (Galon, Wineman, & Grande, 2012; Stein & Santos, 1998; Yang et al., 2005). Core aspects of ACT are frequent and intensive contacts, small caseloads, and assertive outreach, all of which include case management, pharmacologic treatment, primary health care, housing services, vocational services, substance use treatment, and socialization (Galon et al., 2012; Horvitz-Lennon, Zhou, Normand, Alegria, & Thompson, 2011). This approach to care enables ACT teams to work with consumers to address health and wellness from a micro level (e.g., medication adherence, skill building, individual health, etc.), a mezzo level (e.g., social engagement, employment, social health, etc.), and a macro level (e.g., collaborating with hospitals and the criminal justice system, advocacy, socio-political health, etc.).

Mental health is not simply about biology and psychology. Cuéllar and Paniagua (2000) assert that education, economics, social structure, religion, and politics are inextricably linked. People who experience severe mental illness have complex needs and barriers. Add additional barriers that one faces as a person of color in our society, then the needs and barriers are exacerbated and compounded. Due to these complexities, treatment and recovery approaches need to be holistic, meaning that the individual and one’s environmental needs must be addressed. ACT offers a holistic, recovery based, person centered approach to treatment. A

significant amount of research confirming the effectiveness of ACT in working with people with severe mental illness most at risk for incarceration or hospitalization has been conducted (e.g., Manuel et al., 2013; Morrissey, Domino, & Cuddeback, 2013; Phillips et al., 2001). However, research into the effectiveness of ACT when controlling for race and/or ethnicity has not been fully explored.

This banded dissertation focused on *enhancing* the effectiveness of ACT in working with people of color. The dissertation utilized three products: (1) a *systematic review* of the literature on the effectiveness of ACT with people of color; (2) a *conceptual paper* focused on grounding ACT in the ecological perspective of social work practice; and (3) a *conceptual paper* that discussed three key concepts to operationalize the ecological perspective in practice (i.e., ACT). To aid in framing the three products of this banded dissertation, the conceptual framework guiding this scholarship is explored.

Conceptual Framework

The ecological perspective is the conceptual framework that guided this banded dissertation. In social work practice theories guide our understanding of the person and the environment, how a person operates in daily life, and how practitioners combat oppression and empower (Forte, 2014). The ecological perspective provides an orientation for understanding people, their environment, and the nature of their transactions/their relationship (Ecological Perspective, 2003; Gitterman & Germain, 2008; Gitterman & Germain, 2013). In the ecological perspective, *one* is trying to cope with and improve one's *level of fit* in the environment by trying to adapt to the environment (Gitterman & Germain, 2008). This theory recognizes people have the capability to take action in the coping and improving process, while recognizing that there are factors beyond individual control, will, and desire that impact the outcome. Gitterman and

Germain (2008) described the environment as the physical and social settings within one's cultural context. Environments can support or harm growth and functioning due to "the conflict between different groups competing for resources" (Forte, 2014, p. 135). As a result, attention must be given to the impact of power within the environment; the relationship and the power within the relationship is multi-directional, recursive, and transactional (Forte, 2014; Gitterman & Germain, 2008; Gitterman & Germain, 2013). Key concepts of the ecological perspective as delineated by Gitterman and Germain (2013) - adaptability; habitat and niche; life course; power, powerlessness, and pollution; life stressors, stress, and coping; and resilience – aid practitioners in understanding the multi-directional, recursive, and transactional relationship between the individual and the individual's environment.

The ecological perspective pushes social workers and other practitioners to remember the complexities of humanity and to be expansive in our outlook and approach to practice. An expansive practice approach dismantles normative paradigms and develops frameworks that are responsive to one's unique needs (E. Grise-Owens, personal communication). The ecological perspective provides a framework for understanding the complexities of human dynamics and expanding practice approaches to effectively work with people of color.

Summary of Banded Dissertation Products

Enhancing the effectiveness of Assertive Community Treatment in working with people of color was the focus of this banded dissertation. The banded dissertation requires Doctor of Social Work Candidates to complete three scholarship products that are connected conceptually through theory, problem/topic, or population, and discuss the relationship between products to their leadership as social work practitioners. The three products developed were: a systematic review and two conceptual papers.

Product One, the systematic review, focused on primary research that assessed the outcomes of the effectiveness of ACT for people of color who are experiencing a severe mental illness. The purpose of conducting a systematic review was to establish a foundation of quality research that assessed the outcomes of ACT. A cursory review of the literature revealed the rigor of some studies were questionable (e.g., Morrissey, et al., 2013). ACT is an evidence-based practice for adults with severe mental illness who have had multiple hospitalizations in the last two years (Case Western Reserve University, n.d.; Ky. Rev. Stat. Ann. § 210.005(1), 2012). However, some research assessing this evidence-based practice was doing so with populations who do not meet criteria for ACT as an intervention. In other words, studies were assessing the efficacy of ACT as an evidence-based treatment when it was not being delivered for the population with which it was intended. The systematic review produced a quality body of knowledge that looked at the efficacy of ACT as an evidence-based practice for its intended target population. From that body of knowledge, the question of ACT's effectiveness with people of color was then explored.

The first conceptual paper, Product Two, explored grounding Assertive Community Treatment theoretically in the ecological perspective of social work to enhance its effectiveness in working with people of color. People who experience severe mental illness have complex needs and barriers. Add additional barriers that one faces as a person of color in our society, then needs and barriers are compounded. Due to these complexities, treatment and recovery approaches need to be holistic. ACT's multilevel approach to treatment – working with the whole consumer to address health and wellness from a micro, mezzo, and macro level of practice – is the initial step to treating the whole consumer, but it is not enough. Grounding interventions (i.e., ACT services) in the ecological perspective will enhance ACT teams' ability to provide

care that meets the needs of *all* consumers, including consumers of color. This conceptual paper analyzed ACT services and the ecological perspective from the lenses of the professional standard of holism, professional standard of sensitivity to diversity, and professional standard of strengths.

The second conceptual paper, Product Three, explored the concepts of intersectionality, cultural humility, and power to operationalize the ecological perspective in practice. Racial disparities in mental health services are widespread and have a significant impact on those effected. Recent history has seen a growth in the awareness among mental health providers and researchers about the impact of culture on treatment. As such, mental health providers need to move away from an inclusive practice approach (i.e., bringing one in to existing paradigms) to an expansive practice approach (i.e., dismantling normative paradigms and focusing on one's unique needs). The conceptual ideas of intersectionality, cultural humility, and power aid practitioners in operationalizing the ecological perspective. Practitioners who understand and operationalize cultural humility, intersectionality, and power in their work are more aware and attentive to the concepts of adaptability; habitat and niche; life course; power, powerlessness, and pollution; life stressors, stress, coping; and resilience. This enhanced understanding aids practitioners in being attentive to the complexities of human dynamics that are impacted by race, ethnicity, and culture.

Discussion

Until the story of the hunt is told by the lion, the tale of the hunt will always glorify the hunter (an Ewe-Mina, peoples from Benin, Ghana, and Togo, proverb). Until the story of the hunt (e.g., the experience) is told *and* understood from the consumer, the tale of the hunt (e.g., experience) will always privilege the lens of the hunter (e.g., the practitioner).

Understanding human dynamics is complicated; an individual's identity is shaped by "individual characteristics, family dynamics, historical factors, and social and political contexts" (Daniel Tatum, 2000, p.9). Factor in implication for people who are experiencing mental health issues, then these complexities are compounded. In order to provide treatment for people experiencing mental health needs, one must consider the implications of their illness *and* their individual identity.

Over the last 20 plus years, the United States has seen the population of people of color double (Lum, 2011). One's race and/or ethnicity impacts one's culture. Culture (2003) is defined as "the customs, habits, skills, technology, arts, values, ideology, science, and religious and political behavior of a group of people in a specific time period" (p. 105). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) overtly cautions providers to be cognizant of cultural issues when assessing consumers, stating that "mental disorders are defined in relation to cultural, social, and familial norms and values" (p. 14). Tolerance for symptoms and/or behaviors may vary based on cultural influence; adaptability, awareness, coping strategies, and support systems may also vary (APA, 2013; Murphy & Dillon, 2015). Additionally, one must consider education, economics, social structure, religion, and politics. All of these factors can impact a consumer's ability to seek and engage in treatment, hence impacting consumer satisfaction with treatment and their perspective on the effectiveness of services. Inattentiveness to these factors by treatment providers will result in providers being less effective and potentially ethnocentric in their treatment approach (Cuéllar & Paniagua, 2000; Lum, 2011).

Due to the comprehensive (i.e., micro, mezzo, and macro) in vivo approach of ACT, this practice is poised to more effective in working with people of color. However, implementing

ACT services without overt attention to the person:environment from an ecological perspective hinders the effectiveness of the services due to the complexities and intricacies of one's culture.

In the last five to ten years there has been a growing movement in mental health services to approach treatment from a person-centered care model. A person-centered care model is a strengths-based approach to treatment that focuses on the individual as a whole (e.g., all aspects of wellness) *and* supports the individual in connecting/re-engaging with one's community to obtain life goals (Adams & Grieder, 2011). Albeit a newer movement within mental health services, this person-centered approach to care is a start and embedded philosophically within the ecological framework. If providers are focused on being person-centered then their lens of understanding a person's needs, wants, abilities, challenges, etc. is through the lens of the person being served. However, this is not enough. Critical attention must be given to the person:environment relationship and the relational impact at *all* levels of care. Without overtly grounding practice in this critical consciousness, the imbalance and power dynamics will be overlooked due to unconscious and systemic racism (Giliberti, 2016; Padgett et al., 1994).

Limiting one's focus to an individual's illness results in missing the holistic needs of the individual and the impact of one's environment on health and wellness. The sociopolitical environment that our country is currently in *is* having an impact on people experiencing mental health issues. If providers do not consider the impact of environment on the needs of consumers, then providers will perpetuate harm by not addressing all the stressors and systemic barriers impacting their consumer's stability.

Practicing from an ecological perspective provides mental health practitioners with a framework for understanding one's life from the unique lens and experience of the consumer. Practitioners who understand and operationalize cultural humility, intersectionality, and power in

their work are more aware and attentive to the concepts of adaptability; habitat and niche; life course; power, powerlessness, and pollution; life stressors, stress, coping; and resilience, making them more effective in addressing the holistic needs of the consumer.

Implications for Social Work Education

Social work practitioners work with those in greatest need who have experienced oppression and marginalization throughout their lives. It is an ethical imperative that we value the dignity and human worth of *everyone* we serve. It is essential that social work educators challenge students to understand how their world-view impacts practice and teach students to be *expansive* practitioners who are culturally humble. In order to do this, social work educators must infuse intersectionality, privilege, oppression, cultural humility, and social justice in *all* courses taught. It is vital that social work students, future social workers, understand this complexity. Students must understand the complexities of the questions: *who am I; how does "who I am" impact how, and if, I see you and who you are?* Students must be taught to constantly question whose lens is being used to engage, assess, intervene, and/or evaluate. Doing so ensures that we are challenging our own assumptions and focusing on the consumer.

We must keep the focus on the consumer's perspective and needs. We cannot pigeon hole the understanding of our consumers to a simple demographic variable, but rather look for the intersection of the consumer's various cultural contexts (Roysircar & Pignatiello, 2011). Teaching students how to pragmatically embed practice in the ecological perspective allows us train future social workers to be expansive practitioners.

In order to be a socially just social worker who practices in an expansive and culturally humble manner, one must recognize the social construction of race and other social identities, as

well as the discrimination and oppression that occurs at all levels – personal, institutional, and cultural (Bundy-Fazioli, Quijano, & Baber, 2013; Lee, Blythe, & Goforth, 2009). Simultaneously, students must learn to confront and work through interpersonal and intrapersonal conflicts about their "role, status, and participation in an oppressive system" (Lee, Blythe, & Goforth, 2009, p. 123). Engagement in social work practice begin with an interview, regardless of what level of practice (i.e., micro, mezzo, or macro), social workers engage with another person or persons (Petracchi & Collins, 2006). As such, social work student must learn to put theory into practice. In-depth discussions and reflections about social justice, intersectionality, privilege, oppression, cultural humility, etc. and their implications on practice must be understood cognitively *and* pragmatically in practice.

Implications for Future Research

Additional research is needed to further explore how theoretical knowledge becomes substantive skill execution. This banded dissertation found limited research assessing the efficacy of ACT for people of color. Assuming an evidence-based practice, such as ACT, is effective for a population without controlling for differences is fallacious.

The National Association of Social Work (2007, as cited by Lum) charges providers to support "diverse cultural groups who are advocating on their own behalf" (p. 21). The complexities and intricacies of one's culture directly impacts the effectiveness of services for people of color. It is incumbent upon us, as providers and researchers, to engage consumers directly when assessing the effectiveness of services. Doing so keeps services person centered, holistically focused (e.g., person:environment), and culturally expansive. Direct consumer feedback will inherently account for one's cultural needs, which will inform and improve practice.

Conclusion

In 1999 the Surgeon General of the United States, Dr. David Satcher, released a report affirming the disparities in mental health treatment for people of color and asserting that *ALL* people needed access to quality, effective, and affordable care (Culture, race and ethnicity, 2001; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1999). Dr. Satcher stated,

> The failure to address these inequities is being played out in human and economic terms across the nation – on our streets, in homeless shelters, public health institutions, prisons, and jails. . . we need to embrace the nation's diversity in the conduct of research, in education, and training of our mental health service providers, and in the delivery of services. (Culture, race and ethnicity, 2001)

Dr. Satcher's statement holds true today. We *must* do better.

ACT is poised to do better, if we ground practice in theory, more specifically in the ecological perspective of social work practice. ACT, as a practice, engages in vigorous outreach beyond clinical walls, which is what Giliberti challenges is needed to serve people of color who are experiencing severe mental illness. Grounding practitioners' skills, theoretically and pragmatically, in the ecological perspective readies them to be expansive practitioners who are critically conscious of the complexities of human dynamics (e.g., individual characteristics, family dynamics, historical factors, and social and political contexts). Being able to understand and operationalize cultural humility, intersectionality, and power enables practitioners to address the needs of *all* consumers, including consumers of color.

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Assertive Community Treatment: Efficacy as an Evidenced Based Practice

Laura E. Escobar-Ratliff

St. Catherine University – University of St. Thomas

Abstract

One in five people are impacted by mental health in the United States. The prevalence among adults by race is comparable. Despite proportionate rates of impact, people of color access services at a lower rate than their white counterparts and encounter additional life barriers. Assertive Community Treatment (ACT) is an evidenced-based practice for people with severe mental illness who are most at risk for hospitalization and/or incarceration. ACT has been studied extensively across the world. The number of studies that delineate effectiveness based on race and ethnicity is unclear. This systematic review synthesizes published literature assessing the effectiveness of ACT among people of color.

Keywords: assertive community treatment, severe mental illness, evidenced-based practice, systematic review

Assertive Community Treatment: Efficacy as an Evidenced Based Practice

The Center for Behavioral Health Statistics and Quality (2015) estimates that one in five people are impacted by mental health issues. In 2014, the most recent data available, 20.2 million adults faced challenges with substance use and 50.5% of them had a co-occurring mental illness (Center for Behavioral Health Statistics and Quality, 2015). When narrowing the population of people with mental illness to look specifically at people with *severe mental illness,* the percentage drops to 11.3, which is 2.3 million of the 20.2 million adults grappling with substance use (Center for Behavioral Health Statistics and Quality, 2015).

Severe mental illness is defined by the federal government as a disorder (mental, behavioral, or emotional) which results in functional impairment (i.e., interfering with or limiting one or more major life activities) that has been diagnosed within the past year (Center for Behavioral Health Statistics and Quality, 2015). The Commonwealth of Kentucky narrows the definition further by specifying that clinically significant symptoms must have persisted for a period of at least two years or the individual must have been hospitalized for mental illness more than once in the last two years (Ky. Rev. Stat. Ann. § 210.005(1), 2012). People who meet the criteria delineated will experience a high level of need. As such, it is imperative the services being provided to meet this need are effective for *all* people. Consequently, this raises the question of the effectiveness of assertive community treatment for people of color (e.g., racial and ethnic minorities) who experience severe mental illness.

The prevalence of mental illness among adults by race is: 16.3% Hispanic, 19.3% White, 18.6% Black, 13.9% Asian, and 28.3% American Indian/Alaska Native (NAMI, 2015). People impacted by mental health and substance use issues face many challenges such as homelessness, unemployment, and incarceration (Glaze & James, 2006; National Association of State Mental

Health, 2006; U.S. Department of Housing and Urban Development, 2011.). *People of color* with these same illnesses encounter additional barriers including "less access to treatment; less likely to receive treatment; poorer quality of care; higher levels of stigma; culturally insensitive health care system; racism, bias, homophobia, or discrimination in treatment settings; language barriers; lower rates of health insurance" (NAMI, 2015). People of color combat more complex needs and barriers to services, which beseeches the question of how effective Assertive Community Treatment is in addressing the needs and barriers for *people of color* experiencing severe mental illness. Additionally, how culturally inclusive/expansive are these services?

Successful engagement and treatment of persons diagnosed with severe mental illness requires a holistic perspective acknowledging the multifaceted cultural and contextual issues faced by each individual. In other words, engagement and treatment must be attentive to the needs of a person based on both their severe mental illness *and* their racial and/or ethnic identity. Assertive Community Treatment (ACT) is a multidisciplinary community-based team that provides intensive treatment and psychosocial rehabilitation services in vivo (Galon, Wineman, & Grande, 2012; Stein & Santos, 1998; Yang et al., 2005). Core aspects of ACT are frequent and intensive contacts, small caseloads, and assertive outreach, all of which include case management, pharmacologic treatment, primary health care, housing services, vocational services, substance abuse treatment, and socialization (Galon et al., 2012; Horvitz-Lennon, Zhou, Normand, Alegria, & Thompson, 2011). This approach to care enables ACT teams to work with consumers to address health and wellness from a micro level (e.g., medication adherence, skill building, individual health), a mezzo level (e.g., social engagement, employment, social health), and a macro level (e.g., collaborating with hospitals and the criminal justice system, advocacy, socio-political health).

Research Aims

Over the last 30 years, research affirming the disparities in mental health treatment for people of color compared to their white counterparts has been well documented (Acevedo et al., 2012; Acevedo et al., 2015; Cuéllar & Paniagua, 2000; Culture, race, and ethnicity, 2001; Miranda, Cook, & McGuire, 2007; Padgett, Patrick, Burns, & Schlesinger, 1994; U.S. Department of Health and Human Services [USDHHS], 2013). In 1999, U.S. Surgeon General David Satcher, MD, PhD released a report affirming the disparities in mental health treatment for people of color and asserting that *ALL* people needed access to quality, effective, and affordable care. Dr. Satcher (1999, as cited by Culture, Race, and Ethnicity, 2001) stated:

> The failure to address these inequities is being played out in human and economic terms across the nation – on our streets, in homeless shelters, public health institutions, prisons, and jails. . . we need to embrace the nation's diversity in the conduct of research, in education, and training of our mental health service providers, and in the delivery of services. (p. 626)

Dr. Satcher's statement holds true today. One's race and/or ethnicity impacts one's culture. Culture impacts the way people communicate, cope, identify symptoms, express symptoms, and/or access services (American Psychiatric Association [APA], 2013; Culture, Race and Ethnicity, 2001).

Culture (2003) is defined as "the customs, habits, skills, technology, arts, values, ideology, science, and religious and political behavior of a group of people in a specific time period" (p. 105). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; APA, 2013) overtly cautions providers to be cognizant of cultural issues when assessing clients, stating that "mental disorders are defined in relation to cultural, social, and familial norms and

values" (p. 14). Additionally, tolerance for symptoms and/or behaviors may vary based on cultural influences; adaptability, awareness, coping strategies, and support systems may also vary (APA, 2013; Murphy & Dillon, 2015). Cuéllar and Paniagua (2000) go further in asserting mental health is not simply about biology and psychology. They assert education, economics, social structure, religion, and politics are all inextricably linked to mental health. All of these factors can impact a client's ability to seek and engage in treatment, thereby impacting client satisfaction and perspective on the effectiveness of services. Additionally, inattentiveness to these factors by treatment providers will result in providers being less effective and potentially ethnocentric in their treatment approach (Cuéllar & Paniagua, 2000; Lum, 2011).

As a modality of treatment, ACT has been studied extensively across the world with mixed results (Burns, 2010; Killapsy et al., 2006). These studies have primarily been quantitative studies assessing intervention strategies, impact on inpatient hospitalization, forensic versus non-forensic clients, and homelessness (e.g., Beach et al., 2013; Horvitz-Lennon et al., 2011; Manuel et al., 2013; Morrissey, Domino, & Cuddeback, 2013;). Some studies have looked specifically at disparities among people of color (e.g., Galon et al., 2012; Yang et al., 2005), but the number of studies that delineate effectiveness of ACT based on race and ethnicity is unclear. The purpose of this study was to conduct a systematic review to address the following research question: *How effective are Assertive Community Treatment services for people of color who struggle with severe mental illness and are most at risk of homelessness and/or incarceration?*

Method

The methodology for this systematic review follows the work of Boland, Cherry, and Dickson (2014). These authors are part of a collaborative group of researchers linked to the Liverpool Reviews and Implementation Group (LRiG), whose primary focus is systematic

reviews that evaluate clinical and cost-effective evidence. These researchers draw upon the Cochrane Collaboration, Campbell Collaboration, and the National Institute for Health and Care Excellence (NICE) guidelines for treatment and clinical practice in the United Kingdom (Boland, Cherry & Dickson, 2014).

Literature Search and Retrieval Process

The electronic databases used in this review were: Criminal Justice Abstracts Full-text, Academic Search Premier, PsycINFO (PsycNet), Social Work Abstracts, SocINDEX with Full Text, PubMed, Health Reference Center Academic, and ClinicalTrials.gov. Zotero, a bibliographic manager, was utilized to track and store articles identified as potential citations.

Searching for articles about *Assertive Community Treatment* in each of these databases resulted in 2,592 potential studies. Research on the efficacy of mental health services with people of color began approximately 30 years ago, therefore the inclusion dates chosen were 1985 through 2017. The search was narrowed utilizing keywords combined with the Boolean "and", searches conducted were "Assertive Community Treatment" AND: *people of color, minorities, marginalized groups, racial minorities, ethnic minorities, diversity, outcomes, demographics, race, and culture.* Results were narrowed to only include peer reviewed journals. Each of these additional parameters decreased the potential studies to 1,585. Once duplicated articles were removed (n=31), 1554 potential citations remained to be screened with the inclusion criteria.

Inclusion criteria and study quality assessment

Cherry and Dickson (2014) recommend utilizing a PICO table in developing the inclusion criteria for systematic reviews. The PICO table is a delineation of: population, intervention,

comparator, and outcome (Cherry & Dickson, 2014, p. 28). This study utilized the PICO technique to determine inclusion (See Table 1). The author independently reviewed titles and abstracts retrieved through the search process and assessed if inclusion criteria were sufficiently met. Once this was affirmed, the full article was retrieved when possible. The relevance of each study was assessed according to criteria identified in Table 1. Studies that did not meet the criteria delineated in the screening and assessment tool were excluded. All excluded studies, reason for exclusion, and their bibliographic detail were listed in Table 2.

Results

Quantity of Research Available

The screening and selection tool was applied to 1,554 potentially relevant publications in phase one. Once titles and abstracts were assessed, 1,517 studies were excluded, leaving 37 potentially relevant publications. The full texts of these 37 articles were obtained. Phase two applied the screening and selection tool to full-text papers which resulted in 34 studies being excluded: three did not match the target population, seven did not examine the appropriate intervention, 15 did not examine appropriate comparators, four did not match the outcomes, and five full-text articles could not be obtained. As a result, three citations were included in the systematic review (See Figure 1).

Quality of Research

Three studies met the inclusion criteria; each were prospective and retrospective cohort studies. These studies were assessed for quality, exploring rigor and relevance, via the Critical Appraisal Skills Programme (CASP) Cohort Study appraisal tool. CASP (2013) is part of Better Value Healthcare. CASP's philosophy is to share knowledge and understanding while operating

in nonhierarchical, multidisciplinary, problem-based approaches. A summary of the Quality CASP results are delineated in Table 3. See Table 4 for a complete quality assessment of each study.

Data Extraction and Synthesis

A data extraction guide was developed for this study after consulting and adapting tools from four sources: University of Wisconsin Ebling Library Systematic Reviews, a Guide: Data Extraction; George Washington University Himmelfarb Health Sciences Library, Systematic reviews: Home; National Center for Biotechnology information, Appendix 12 Data Extraction Forms for Qualitative Studies, and Boland et al. (2014). Data extracted included *study characteristics, participant characteristics,* and *study results*. The Data Extraction Form, found on Table 5, was utilized to extract data from each of the selected articles. A summary of the abstracted information for each study is found on Table 6, which provides the "raw data" for the analysis and synthesis of findings.

Discussion

This study embarked on the systematic review with an awareness of a dearth in the literature regarding the effectiveness of ACT services with people of color. Application of the inclusion criteria, to the results of the database searches, yielded three papers for inclusion in this review. Despite the awareness of the scarce literature in this area, the small number of studies were surprising.

Each of the three studies assessed the *effectiveness* of ACT from a different lens and each identified different outcomes and results (See Table 6). As such, there is no clear answer to the research question: *How effective are Assertive Community Treatment services with people of*

color who struggle with severe mental illness and are most at risk of homelessness and/or incarceration? This unanswered question reiterates Dr. Satcher's (1999, as cited by Culture, Race, and Ethnicity, 2001) call to "embrace the nation's diversity in the conduct of *research* [emphasis added], in education, and training of our mental health service providers, and in the delivery of services" (p. 626).

Strengths in the review process included the comprehensive search strategy that was executed to maximize the identification of appropriate studies. The effectiveness and appropriateness of the inclusion criteria was reinforced, when author experienced duplication of studies after searching the majority of databases. Once the final included studies were identified, each study selected was assessed for quality via the CASP Cohort Quality Appraisal Tool. Despite these strengths, a limitation of the review process was the independent work of the author. The author utilized a uniformed data extraction form for each study, however the extracted data was not cross-checked.

Two of the three studies reviewed identified ACT as being effective with people of color, however, due to the varied points of focus in each of the studies, it would be premature to generalize this assertion. The results of the analysis of the three included studies does indicate potential effectiveness of ACT for people of color and illustrates the need for additional research.

Currently there is insufficient evidence to determine if ACT services are effective with people of color who experience severe mental illness. What the review has illuminated is the vast amount of data available across the United States, via ACCESS, which could be reanalyzed to examine the research question: *How effective are Assertive Community Treatment services with people of color who struggle with severe mental illness and are most at risk of homelessness*

and/or incarceration? Additionally, newer studies should be executed that overtly consider the impact of race and ethnicity in assessing the effectiveness of ACT.

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Table 1

Screening and Selection Tool: "Assertive Community Treatment" + People of Color

Review Question: *How effective are Assertive Community Treatment services with people of color who struggle with severe mental illness and are most at risk of homelessness and/or incarceration?*

Inclusion Criteria (based on PICOS):

Population = adults with severe mental illness most at risk for homelessness and/or incarceration?
Intervention = assertive community treatment
Comparator = people of color receiving ACT + Caucasians receiving ACT
Outcomes = effectiveness of ACT for people of color + effectiveness of ACT delineated by race and/or ethnicity
Study design = not specified

Criteria	Include	Exclude
Patient population	Adults with severe mental illness most at risk for homelessness and/or incarceration	Adults with severe mental illness who are stable, not at risk for homelessness and/or incarceration
Interventions	Assertive community treatment	Interventions that are not assertive community treatment Interventions that do not follow the fidelity of assertive community treatment.
Comparators	Intervention + People of color Intervention + People who are Caucasian	Intervention only
Outcomes	Impact of intervention delineated by race and/or ethnicity	Impact of intervention *not* delineated by race and/or ethnicity
Study design	Not specified	Not specified
Overall decision	*Included*	*Excluded*
Notes	Publication date 1985 – 2017	Before 1985

Table 2

Excluded Studies: Rationale and Bibliography

Inappropriate Population
Chow, Wendy, Lisa Andermann, Harleen Bedi, and Samuel Law. "Assessment of Caregiver Experiences and Psychoeducational Needs of Chinese Families for Patients with Chronic Mental Illnesses: A Pilot Study." *University of Toronto Medical Journal* 92, no. 3 (May 2015): 66–7
Clarke, Gregory, Heidi Herinckx, Ronald Kinney, Robert Paulson, David Cutler, Karen Lewis, and Evie Oxman. "Psychiatric Hospitalizations, Arrests, Emergency Room Visits, and Homelessness of Clients with Serious and Persistent Mental Illness: Findings from a Randomized Trial of Two ACT Programs vs. Usual Care." *Mental Health Services Research* 2, no. 3 (September 2000): 155–64. doi:10.1023/A:1010141826867.
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Figure 1

Flowchart of literature retrieval process

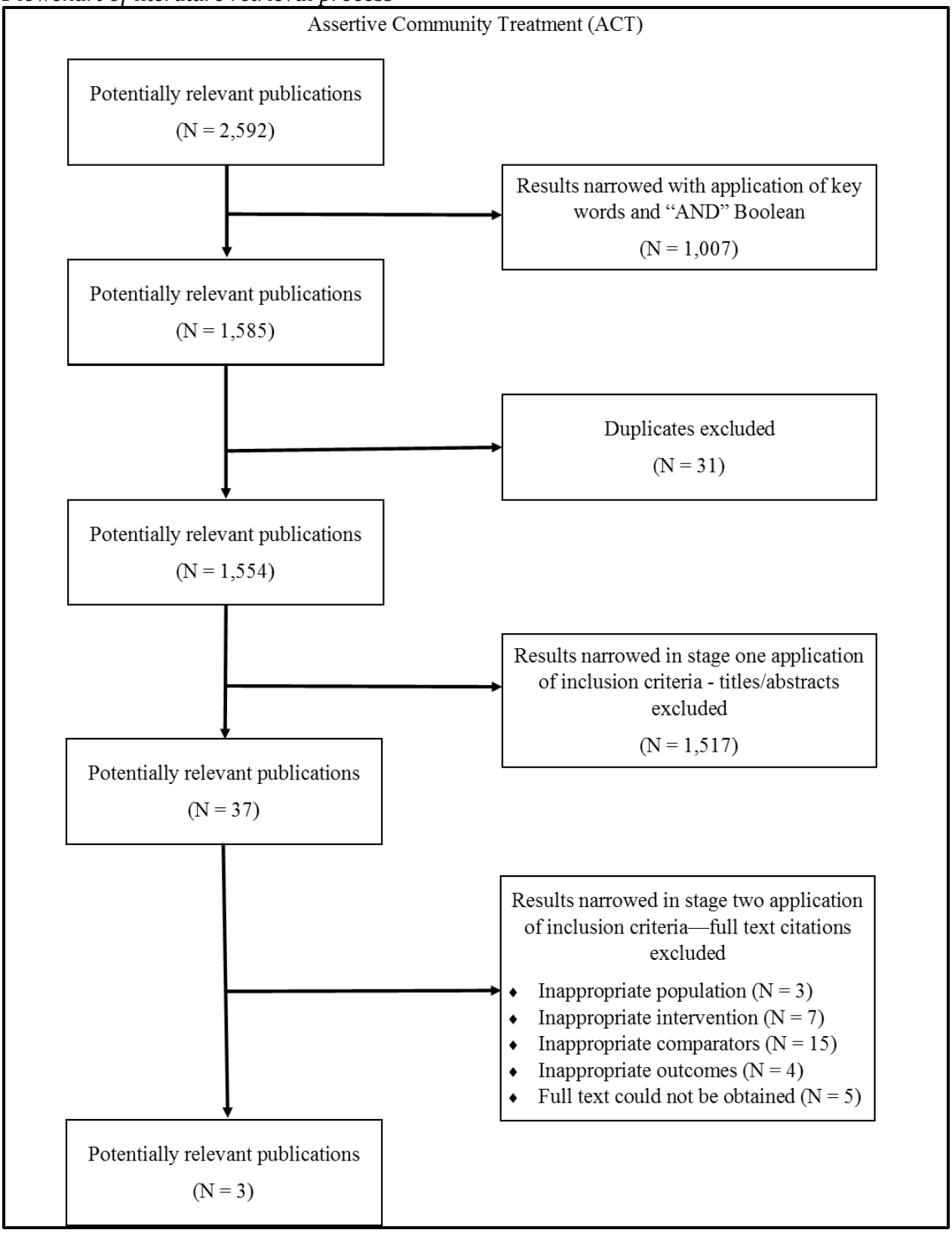

Table 3

Results of Articles Reviewed: CASP Cohort Appraisal Tool Summary

Study	Are the results of the study valid?	Are the results of the study clear?	Will the results help locally?
Brugha, Taub, Smith, Morgan, Hill, Meltzer . . . Wright. (2012)	Yes	Yes	No
Chow, Shiida, Shiida, Hirosue, Law, Leszcz, Sadavoy. (2011)	No	Yes	Unsure
Horvitz-Lennon, Zhou, Normand, Alegria, & Thomspon. (2011)	Yes	Yes	Yes

Note. CASP = Critical Appraisal Skills Programme

Table 4

Results of Articles Reviewed: CASP Cohort Appraisal Tool – Full Report

	Are the Results of the Study Valid?											
	Screening Questions						Detailed Questions					
	Addressed a focused issue			Recruitment of cohort acceptable			Exposure accurately measured to minimize bias			Outcome accurately measured to minimize bias		
Study	Yes	Can't Tell	No	Yes	Can't Tell	No	Yes	Can't Tell	No	Yes	Can't Tell	No
Brugha 2012	X			X			X			X		
Chow 2011	X			X				X				X
Horvitz-Lennon 2011	X			X			X			X		

	Detailed Questions											
	Confounding factors identified			Design accounted confounding factors			Follow up of subjects complete enough			Follow up of subjects long enough		
Study	Yes	Can't Tell	No	Yes	Can't Tell	No	Yes	Can't Tell	No	Yes	Can't Tell	No
Brugha 2012	X			X					X			X
Chow 2011			X			X			X			X
Horvitz-Lennon 2011	X			X			X			X		

	What are the Results?			Will the Results Help Locally?					
	Results believable			Results applicable to local population			Results fit with other evidence		
Study	Yes	Can't Tell	No	Yes	Can't Tell	No	Yes	Can't Tell	No
Brugha 2012			X			X			X
Chow 2011		X			X			X	
Horvitz-Lennon 2011	X			X			X		

Table 5

Data Extraction Form – Full Text Review

Reference:			
Study Characteristics			
Study Design:			
Purpose / Aim:			
Intervention:			
Study Population:			
Sample:			
Sample size			
Factors influencing selection			
Appropriate sample	*Yes*	*No*	*Unclear*
Setting:			
Data collection:			
Method used			
Adequately described & rigorously conducted	*Yes*	*No*	*Unclear*
Follow up:			
Key Findings:			
Study Sponsorship:			
Duration of Study:			
Ethical Standards:			
Ethical approval	*Yes*	*No*	*Unclear*

Informed consent	*Yes*	*No*	*Unclear*
Ethical issues addressed	*Yes*	*No*	*Unclear*
Confidentiality maintained	*Yes*	*No*	*Unclear*

Participant Characteristics (Clients)

Mean Age:

Gender:

Race/Ethnicity:

History of homelessness:

History of hospitalization:

History of incarceration:

Diagnosis:

Other:

Participant Characteristics (Team)

Months in operation:

Urbanicity:

Staffing:

Caseloads:

Fidelity Rating:

Other:

Study Results

Primary Outcomes:

Secondary Outcomes:

Quality Score:

Adjustment for confounding variables: *Yes* *No* *Unclear*

Duration of study:

Data analysis:

How analyzed

Adequate description *Yes* *No* *Unclear*

Adequate evidenced to provide support to analysis *Yes* *No* *Unclear*

Set in context / finding and relevant theory:

Results:

Other

Evaluative Summary:

Researcher's potential bias:

Reflexivity:

Generalizability:

Implications for policy:

Implications for practice:

Additional bibliography or links to other references:

Table 6

Summary of study characteristics, participant characteristics, and study results.

Study	Study Characteristics	
Brugha (2012) England	Design: Two-stage design Purpose: *Primary aim*, to identify predictors of success in assertive outreach. *Secondary aim*, examine effects on secondary outcomes with attention to validity of findings for people who are black and ethnic minorities. Intervention: Assertive outreach Setting: England, 1% rural, and eight geographical regions	Sample: *Stage One*, 100 of 186 "stand-alone" AO teams (stratified sample). Systematic sampling from teams which had been sorted by stratum. Resulted in list of 94 teams. *Stage Two*, a systematic sample of 12 clients from each team list with stratification for black and ethnic minority clients. Resulted in list of 1096 clients. Data collection: *Team data* drawn from linked TSO study. Assessments made via interviews with team leaders and review of other data sources. Interviews used Team Organisation Questionnaire (TOQ). The Dartmouth Assertive Community Treatment Scale (DACTS) measured fidelity to ACT. International Classification of Mental Health Care (ICMHC) assessed team's ability to provide a range of interventions and level of expertise. *Participant data* gathered was retrospective data and collected from case files and medical records. Prospective data on hospital admissions were collected over nine months following client sampling. Characteristics of those lost in the prospective study were noted from the retrospective data.
Chow (2011) Canada & Japan	Design: Secondary data analysis, comparison of cohorts (Mount Sinai and KUINA) Purpose:	Sample: *Mount Sinai ACT*, first 66 patients admitted to program ➢ Outcomes were based on comparisons of data for one year before admission to aCT and one year after admission.

	Compared Mount Sinai ACT and the KUINA Center ACT for fidelity to ACT guidelines and principles and populations served to determine whether the successful outcomes of Mount Sinai ACT could be reproduced in a Japanese setting. Intervention: Assertive Community Treatment Setting: Mount Sinai ACT, located in Toronto, Canada; has 100% government funding KUINA Center ACT, located 100km from Tokyo, Japan; 90% government funding (half is from the prefecture level and half from the municipality level) and 10% is from fees charged to clients. Fees are similar to fees for general medical care; government assistance available depending on income. KUINA Center does not turn clients away for financial reasons.	*KUINA ACT*, first 40 patients admitted to program ➢ Outcomes were based on compassion of data for six months before admission and six months after admission Note: Different time periods used by teams were chosen on the basis of availability of complete data sets at the time of the study. Data Collection: Data collected between 2002 and 2005 *Charted intake forms,* client demographic profiles *Dartmouth Assertive Community Treatment Scale (DACTS),* ACT fidelity scale *Family standard questionnaire,* client satisfaction *Chart review,* patient clinical profiles *Brief Psychiatric Rating Scale (BPRS) & Chart Review,* outcomes over the study period
Horvitz-Lennon (2011) United States	Design: Secondary data analysis, reanalyzed data collected from the Access to Community Care and Effective Services and Support (ACCESS) program. Conducted a disparities analyses of baseline and longitudinal utilization data collected. Encouragement design, used to evaluate the effectiveness of a systems integration intervention among participants receiving ACT Purpose:	Sample: Secondary data collected by ACCESS study ➢ Focused on black, Latino, and white participants Participants receiving ACT for 12 months at 18 sites located in nine metropolitan areas Data Collection: Investigated equity effects by conducting baseline and longitudinal utilization data collected for ACCESS study participants ➢ Focused on black, Latino, and white participants

	To determine whether receipt of ACT is associated with a reduction in service use disparities for black and Latino adults with severe mental illness who also experience homelessness.	➢ Baseline, three months, and 12 months *Outcome variable,* use of outpatient psychiatric services *Explanatory variables,* self-reported black, Latino, or non-Latino white race or ethnicity *Primary multivariate model,* included age, sex, marital status four measure of mental health need, a measure of general health need, and two measures of social need. *Addiction Severity Index,* composite psychiatric score *Diagnostic Interview Schedule* and *Psychiatric Epidemiology Research Interview Schedule,* measured psychotic symptoms *Dichotomous variables:* chronic homelessness, chronic unemployment, and substance use disorder

Study	Participant Characteristics	
Brugha (2012) England	Client Description: *Gender* 34% Female; 66% Male *Ethnicity:* 18% Other; 82% White British *History of homelessness* 16% Yes; 84% No *Diagnostic grouping* 9% Other; 91% Psychosis *History of drugs/alcohol abuse* 44% Yes; 56% No *History of violence* 43% Yes; 57% No *History of hospitalization* *Number of admissions 10 years prior to AO* 9% None 26% One or two 24% Three or four 15% Five or six 8% Seven or eight 17% Nine or above	Team Description: *Months in operation* 16% 0-12 32% 13-24 21% 25-36 31% more than 36 *Urbanicity* 11% Rural 66% Suburban 23% Urban *Staffing (mean)* 8.8 Whole time equivalents *Caseloads (mean per team)* 40.5

	Age (mean) 36.4 years	
Chow (2011) Canada & Japan	Mount Sinai Client Description: *Gender* 71% Male *Ethnicity:* 46% Chinese 18% Tamil 14% Vietnamese 10% Caribbean 12% Other *Diagnostic grouping* 75% Schizophrenia 18% Schizoaffective disorder 6% Bipolar disorder 2% Co-occurring substance use disorder *Age at illness onset (mean)* 22 years KUINA Client Description: *Gender* 80% Male *Ethnicity:* 100% Japanese *Diagnostic grouping* 80% Schizophrenia 5% Schizoaffective disorder 5% Bipolar disorder 5% Depression 5% Co-occurring substance use disorder *Age at illness onset (mean)* 24.8 years	Mount Sinai ACT Team, DACTS results: *Human resources* Score: 55 out of 55 *Organizational Boundaries* Score 35 out of 35 *Nature of services* Score 40 out of 50 *Summary Score* Total: 129 out of 140 KUINA ACT Team, DACTS results: *Human resources* Score: 36 out of 55 *Organizational Boundaries* Score 34 out of 35 *Nature of services* Score 37 out of 50 *Summary Score* Total: 109 out of 140
Horvitz-Lennon (2011) United States	Client Description 6,829 homeless adults with severe mental illness 3,394 Black 381 Latinos 3,054 Non-Latino white	Team Description Metropolitan areas Fidelity varied among study sites ➢ Generally comparable scores earned by real-world ACT programs All sites provided outreach, medication management, and assistance with housing and entitlements; most also provided counseling and employment assistance

Study	Study Results
Brugha (2012) England	Outcome(s): *Primary outcome,* nights in hospital in the first year was positively associated with nights in hospital two years before AO. *Secondary outcome,* hospital admissions beginning in the first year of AO were progressively associated with total admissions in the ten years before AO. ➢ 23% more admissions in the first year for clients with a history of violence than those without ➢ 19% fewer admissions of black and ethnic minority clients in the first year than of white British clients Nights in hospital in the third year of AO were positively associated with the proportion of nights in hospital in the two years before AO Data Analysis: *Linear regression modeling,* analyzed proportion of time spent in the hospital with other continuous outcome measures *Unconditional logistic regression*, used for specialist psychological interventions and other secondary outcomes. *STATA survey facilities,* used to reflect the stratification and over-sampling inherent in the sampling designed. *Confounding factors*: age at acceptance, gender, ethnicity, living situation, accommodation, diagnostic grouping, number of hospital admissions in 10 years prior to AO, and histories of homelessness, violence, and drugs/alcohol abuse. Results: Team characteristics of AO services do not predict individual use of inpatient care. Team characteristics of AO services do predict individual use of psychological interventions Service are effective in preventing loss of contact with clients Joint management appears to increase inpatient care on compulsory orders by 12% for clients from ethnic minorities.
Chow (2011) Canada & Japan	Outcome(s): *Mount Sinai ACT clients:* Hospital days, 78% reduction Total admissions, 57% reduction BPRS scores decreased from 57 to 45 Client “satisfied” and “very satisfied”, 91% Family “satisfied” and “very satisfied”, 100% *KUINA ACT clients:* Hospital days, 72% reduction

Total admissions, 57% reduction
BPRS scores decreased from 58 to 47
Client "satisfied" and "very satisfied", 95%
Family "satisfied" and "very satisfied", 90%

Data Analysis:
Data for each team, in each of the five domains, was compared

Results:
Comparison of DACTS scores indicates that both teams conformed to the basic ACT model.
Demographic characteristics were similar in both groups, with the following exceptions:

- KUINA ACT clients, more likely to live with family; Mount Sinai ACT clients, more likely to live in boarding homes
- 16% of Mount Sinai clients live with their families versus 60% of KUINA ACT
- Mount Sinai ACT clients, divergent ethnically and linguistically versus homogeneity of KUINA ACT clients

Mount Sinai ACT clients, mean reduction in

- Mean reduction in:
  - hospital days was 78%
  - hospital admission was 57%
  - number of clients with at least one admission was 56%
- BPRS scores decreased -12

KUINA ACT client,

- Mean reduction in
  - hospital days was 72%
  - hospital admission was 57%
  - number of clients with at least one admission was 50%
- BPRS scores decreased -12

Favorable clinical outcomes suggest that ACT is effective in diverse ethnocultural settings and homogeneous ethnocultural settings.
An adequate social welfare system and availability of other community resources are crucial in ACT development

Horvitz-Lennon (2011) United States

Outcome(s)
Rates of attrition at three- and 12-month time points:

- Latinos had the highest rates, 23% and 30%
- Blacks had the lowest rates, 12% and 17%
- Whites were 17% and 22%

Groups differed on all variables included in the multivariate model

- Except for medical burden

Whites scored lowest across the four mental health variables, indicated better mental health

Whites had lowest level of social need, chronic homelessness, and chronic unemployment
Latinos, highest degree of geographic clustering
Reported no outpatient psychiatric visits at all three time points:

- 18% if blacks
- 28% of Latinos
- 21% of whites

Data Analysis:
Zero-inflated Poisson (ZIP) regressions, used to model highly right-skewed service use data
Regressions, used to assess racial and ethnic disparities at baseline and during the course of the 12 month intervention
Encouragement design, used to evaluate the effectiveness of a systems integration intervention
Participants divided into cohorts: (1) blacks and whites and (2) Latinos and whites

- Same whites were used in each cohort

Cohorts analyzed separately

- ZIP distribution used in lieu of standard Poisson distribution
    - Modeled probability of use and intensity of use

Models adjusted for confounding factors
Computed odds rations (ORs) and rate rations (RRs)

Results:
Study found mixed evidence of the equity effects of ACT
Receipt of ACT, associated with an equitable increase in the probability of use of outpatient psychiatric services for all racial and ethnic groups
Study found disparities-narrowing effect did not extend to Latinos

Assertive Community Treatment & Ecological Perspective: Grounding Practice in Theory

Laura E. Escobar-Ratliff

St. Catherine University – University of St. Thomas

Abstract

People who experience severe mental illness and/or co-occurring substance use have complex needs and barriers; add additional barriers that one faces as a person of color in our society, the needs and barriers are exacerbated and compounded. Due to these complexities, treatment and recovery approaches need to be holistic. Assertive Community Treatment (ACT) is an evidence-based practice for people with severe mental illness at risk of institutionalization. ACT works with the whole consumer to address health and wellness from a micro, mezzo, and macro level of practice. This multilevel approach to treatment is the beginning steps to treating the whole consumer. Grounding interventions (i.e., ACT services) in the ecological perspective will enhance ACT teams in providing care that meets the needs of all consumers, including consumers of color. This conceptual paper explores ACT services and the ecological perspective, both are analyzed from the lenses of the professional standard of holism, professional standard of sensitivity to diversity, and professional standard of strengths.

Keywords: assertive community treatment, ecological perspective, severe mental illness, evidenced-based practice, holism, diversity, strengths

Assertive Community Treatment & Ecological Perspective: Grounding Practice in Theory

Understanding human dynamics is complicated; an individual's identity is shaped by "individual characteristics, family dynamics, historical factors, and social and political contexts" (Daniel Tatum, 2000, p. 9). Factor in implications for people who are experiencing mental health and/or co-occurring substance use issues, then these complexities are compounded. In order to provide treatment for people facing mental health and/or co-occurring substance use needs, one must consider the implications of their illness *and* their individual identity.

The Center for Behavioral Health Statistics and Quality (2015) estimates that one in five people struggle with mental health. In 2014, the most recent data available, 20.2 million adults struggled with substance use and 50.5% of them had a co-occurring mental illness (Center for Behavioral Health Statistics and Quality, 2015). The prevalence of mental illness among adults by race is: 16.3% Hispanic, 19.3% White, 18.6% Black, 13.9% Asian, and 28.3% American Indian/Alaska Native (NAMI, 2015).

People experiencing mental health and/or co-occurring substance use issues face many challenges such as homelessness, unemployment, and incarceration (Glaze & James, 2006; National Association of State Mental Health, 2006; U.S. Department of Housing and Urban Development, 2011.). *People of color* impacted by mental health and/or co-occurring substance use issues face additional challenges, such as "less access to treatment; less likely to receive treatment; poorer quality of care; higher levels of stigma; culturally insensitive health care system; racism, bias, homophobia, or discrimination in treatment settings; language barriers; lower rates of health insurance" (NAMI, 2015). Over the last 15 to 20 years, research acknowledging the disparities in treatment for people of color compared to their white

counterparts has been on the rise (Acevedo et al., 2012; Acevedo et al., 2015; U.S. Department of Health and Human Services [USDHHS], 2013).

People who experience severe mental illness and/or co-occurring substance use have complex needs and barriers; add additional barriers that one faces as a person of color in our society, then the needs and barriers are exacerbated and compounded. Due to these complexities, treatment and recovery approaches need to be holistic. Assertive Community Treatment (ACT) is an evidence-based practice for people with severe mental illness "who are most at-risk of homelessness, psychiatric crisis and hospitalization, and involvement in the criminal justice system" (Case Western Reserve University, n.d., para 1). ACT offers a holistic, recovery based, person centered approach to treatment. ACT is a multidisciplinary team that works with the whole consumer to address health and wellness from a micro level (e.g., medication adherence, skill building, individual health, etc.), a mezzo level (e.g., social engagement, employment, social health, etc.), and a macro level (e.g., collaborating with hospitals and the criminal justice system, advocacy, socio-political health, etc.).

To best serve people experiencing such complex needs in a holistic manner, practitioners need to both understand the interventions (i.e., evidence-based practice of ACT) *and* be able to ground their practice in theory. The ecological perspective in social work practice arose from the recognition of the complexities of our society. Mental health and/or co-occurring substance use issues in the United States are no exception; they are pervasive and complex. The ecological perspective, it's application to working with people of color experiencing severe mental illness, and assertive community treatment are explored. Application of the ecological perspective is analyzed from the lenses of *professional standard of holism, professional standard of sensitivity to diversity,* and *professional standard of strengths.*

Ecological Perspective

Ecologists were among the first system thinkers (Gitterman & Germain, 2013). The ecological perspective provides an orientation for understanding people, their environment, and the nature of their transactions/their relationship (Ecological Perspective, 2003; Gitterman & Germain, 2008; Gitterman & Germain, 2013). It emphasizes the *reciprocity* of person-environment exchanges (Gitterman & Germain, 2013). Carel Bailey Germain is one of the exemplar theorists for the ecological perspective in social work practice. Her life events are indicative of the key assumptions delineated and emphasized in the ecological perspective. A brief overview of Germain's life is discussed, the historical development of ecological perspective and social work practice is explored, and assumptions, key concepts, and major propositions are delineated.

Exemplar Theorist: Carel Bailey Germain

Carel Bailey Germain was born in 1916 in San Francisco, CA. As a young girl, she was an active member of the Camp Fire Girls and as a young adult she received her Bachelor of Arts in economics from the University of California at Berkeley (Hartman, 2008; Smith College, 1922-1998). Bailey married in 1941 and later gave birth to twin girls (Smith College, 1922-1998). She went on to receive her master's in social work and later her doctorate in social work from Columbia University (Hartman, 2008; Smith College, 1922-1998). Early in her professional career, Dr. Germain worked as the Assistant Director of Social Work in the Department of Psychiatry at the University of Maryland School of Medicine and taught in the School of Social Work.

Dr. Germain is known as a scholar, educator, writer, theoretician, and naturalist (Germain, Carel Baily, 1995; Hartman, 2008; Smith College, 1922-1998). One can reflect upon Dr. Germain's life experiences and surmise how these experiences impacted her commitment, passion, and vision in bringing, and adapting, the ecological perspective to social work practice. The ideals of a naturalist were instilled at a young age through Germain's experiences as a Camp Fire Girl. The Camp Fire Girls organization was established by progressive reformers and was the leading girls' organization in the United States until the 1930s (Helgren, 2014). It afforded young girls the opportunity to learn about careers, outdoor activities, and civic life; they had a unique spiritual connectivity to American Indian imagery that was fostered by the founders, instilling the importance of "tending the family *and* [emphasis added] community hearth" (Helgren, 2014, para 2). A former Camp Fire Girl described the program as one that encouraged "strength, compassion, and wisdom . . . [while] allowing the girls to recognize the importance of self-respect, service to their community and country, and openness to diversity in others and the environment as a whole" (Nonchalant mom, 2009, para 4).

Dr. Germain's early foundation in the natural environment/nature, coupled with initial training in economics, would lend itself to interest and skill development in learning to systematize a more comprehensive understanding of how things work. Economics (n.d.), as a social science is chiefly concerned with the "description and analysis of the production, distribution, and consumption of goods and services" (para 1). Germain's early education positioned her to critically think about systems, their interplay, and applicability in a variety of arenas. To then become the mother of twin daughters, life further affords the opportunity to explore and analyze the interaction of systems – person:environment. Her daughters were biologically the *same,* yet based on socialization, environment, personality, etc. they no doubt

were unique. As such, this would contribute to a fundamental understanding that all things being "theoretically equal" were not and can manifest very differently.

Being the Assistant Director of a Psychiatric Department exposed Germain to people and thinking that was linear, causal, and cookie cutter; especially during this time period. This would challenge her foundational learning and through her masters and later doctoral training, Germain would be able to deconstruct and reconstruct her own thinking about life, it's interactions, and how they impact individuals and society.

Historical Development

A framework conceptualizing the reciprocity of person and environment exchanges was needed in social work practice. Informally there was a recognition of this reciprocal relationship. This informal awareness was impacted by various historical events and early social work done through Charity Organization Societies and Settlement Houses. Historical events such as the industrial revolution, migration of African Americans from the south to the north, westward migration, immigration from Europe, Asia, and Latin America, and escalating numbers of orphans were some of the major historical events impacting the "status quo" of healthy living and illustrating the need for the ecological perspective (Gitterman & Germain, 2008). Contemporary societal events reinforce the need for this perspective. Events such as the abuse of economic and political power, corporate abuse, manipulation of stock market prices, private and government led pollution of areas populated by marginalized groups, institutional racism and sexism, etc. (Gitterman & Germain, 2008). These multifaceted issues cannot be resolved with a simple diagnosis or linear fix. Such issues require one to look systemically at causalities as transactions between the person and the environment.

Assumptions: Person:Environment

In the ecological perspective, a *person* is trying to cope with and improve one's *level of fit* in the environment by trying to adapt to the environment (Gitterman & Germain, 2008). The perspective assumes people have the capability to act in the coping and improving process, ***and*** recognizes there are factors beyond individual control, will, and desire that impact the outcome. An individual is influenced by one's own habitat, niche, and life course, as such *adaptability* is impacted by a combination of complex factors beyond individual choice, will, and/or desire.

Gitterman and Germain (2008) describe the *environment* as "physical and social settings within a cultural context" (Habitat and Niche section, para. 1). According to the ecological model, environments can support or harm growth and functioning. This help or hindrance is due to "the conflict between different groups competing for resources" (Forte, 2014, p. 135). As a result of this conflict, attention must be given to the impact of power within the environment.

A core assumption of the ecological perspective is the *relationship* and the power within the relationship is multi-directional, recursive, and transactional (Forte, 2014; Gitterman & Germain, 2008; Gitterman & Germain, 2013). The relationship, the transactions between the person and environment is in the middle of the individualism-collectivism continuum. This relationship is further illustrated by the key concepts and their relationships.

Key Concepts and Major Propositions

Gitterman & Germain (2013) delineate several key concepts to the ecological perspective: adaptability; habitat and niche; life course, power, powerlessness, and pollution; life stressor, stress, coping; and resilience. One's *adaptability* is one's "level of fit" (Gitterman & Germain, 2013) with one's environment. One's adaptability impacts development, health, and

social functioning (Gitterman & Germain, 2008; Gitterman & Germain, 2013). Individuals strive for a good fit, hence adapted, however this fit is impacted by habitat and niche; life course; power, powerlessness and pollution; life stressor, stress, coping; and resilience.

Gitterman & Germain (2013) assert the nature of social and physical environments is determined by the concepts of *habitat and niche*. They go on to delineate examples of habitat which include geographical boundaries, residential dwellings, physical resources, and communal amenities. Niche is one's status within the habitat (Gitterman & Germain, 2008; Gitterman & Germain, 2013). One's niche is impacted by societal *power* - the political, social, and economic structures in one's habitat (Gitterman & Germain, 2008). These structures (i.e., political, social, and economic) have a direct impact on one's niche; impacting whether a person's niche (i.e., status) is growth-supporting or stigmatizing. One's habitat and niche have a direct impact on adaptability.

Life course is an individual's "unique pathway of development" (Gitterman & Germain, 2008, Life Course section, para. 1) which is impacted by one's environment and varied life experiences. There is no single, linear, static life course that people must take, rather there are individual experiences that one encounters throughout life which impact life trajectory. One's life course is impacted by *social time*, which is "the timing of individual, family, and community transitions and life events influenced by changing biological, economic, social, demographic, and cultural factors" (Gitterman & Germain, 2013, Ecological Concepts section, para 5). Furthermore, it is important to recognize that individuals are not simple and static in identity and experience; rather they are a complex *intersection* of identities (Yamada, Werkmeister Rozas, & Cross-Denny, 2015). These identities are influenced by and reciprocally impacted by one's habitat and niche; this in turn impacts life experiences and one's standing in society.

The impact and exchange of *life stressors, stress, and coping* are influenced by the "characteristics of the person and the operations of the environment" (Gitterman & Germain, 2013, Ecological Concepts section, para 6). One's habitat and niche, life course, and social time impacts one's stressors, which in turn impacts one's adaptability. One's stress is impacted by the ability to navigate, individually and/or with resources, life stressors. As such, one's environmental and personal resources impact one's ability to cope with said stress (Gitterman & Germain, 2008). Life stressors and stress can also be mitigated by resilience.

Resilience is one of the newer concepts in the ecological perspective. Gitterman and Germain (2008) are careful to delineate that resilience is more than individual attributes, but rather "complex person:environment transactions" (Resilience and Protective Factors section, para. 1). As such, when thinking about resilience one must consider the individual and the collective; one must consider biological, psychological, and/or environmental processes (Gitterman & Germain, 2008). One's habitat and niche, life course, and access to *power* can contribute to a person's resilience.

Analysis: ACT & Ecological Perspective

Assertive Community Treatment is an evidenced-based practice for people with severe mental illness, most of whom are also experiencing substance use issues. Mental health and substance use needs can negatively impact one's family, employment, education, housing, physical health, and social relationships. Additionally, such struggles can result in legal problems, social isolation, homelessness, and death (Drake, Mueser, Brunette, & McHugo, 2004; Mueser & Gingerich, 2013). To successfully work with people struggling with such complex and multifaceted issues, one must work with them in a holistic manner that is grounded in understanding the person:environment (e.g., ecological perspective). Professional standards of

holism, sensitivity to diversity, and strengths are utilized to analyze the application of ACT and the ecological perspective.

Professional Standard of Holism

Holism is defined as "the idea that the properties of a system can't be determined or explained by its component parts alone" (Forte, 2014, p. 264). To meet the standard of holism, the theoretical knowledge must focus on the "physical, cognitive, emotional, behavioral, and spiritual dimensions of the person" (Forte, 2014, p. 265). This does not mean that components themselves cannot be analyzed, they can, but the analysis cannot lose sight of the whole (Forte, 2014).

The structure of an ACT team and the service provisions embedded in the practice meet the standard of holism. ACT teams are interdisciplinary teams that include: a team lead, therapist, substance use specialist, vocational specialist, case manager, prescriber, nurse, and consumer (i.e., person with lived mental health and/or substance use experiences). Fundamental services provided by an ACT team include in vivo mental health and addiction treatment, vocational support, financial services, transportation, and community integration (i.e., community resources, social supports, etc.) (Lamberti, 2004; Tschopp, Berven & Chan, 2011).

The ecological perspective meets the standard of holism. Even though key concepts can be delineated and identified, they are transactional in nature as discussed previously, each key concept impacting and impacted by the other. Grounding ACT as a practice in the ecological perspective would enhance practitioners' awareness and overt attention of the person:environment and implications for direct practice. Operating from a holistic perspective innately readies one to be sensitive to diversity.

Professional Standard of Sensitivity to Diversity

Forte (2014) delineates human differences as the intersection of: age, class, color, culture, disability, ethnicity, gender, gender identity and expression, geographic location, immigration status, political ideology, race, religion, sex and sexual orientation, and other social identities. Theoretical frameworks, and practices embedded in frameworks, that affirm differences are more likely to develop culturally sensitive interventions (Forte, 2014).

ACT as an evidence-based practiced has been extensively researched for outcomes on effectiveness for persons experiencing: severe mental illness, co-occurring substance use, criminal justice involvement, and/or homelessness. Some research has been done assessing the effectiveness for ACT with minority populations (e.g., Galon et al., 2012; Yang et al., 2005), but the number of studies that delineate effectiveness of ACT based on race and ethnicity is unclear. The service provisions of ACT are focused on "frequent contact with consumers, attention to details of everyday living, and provision of services without time limits" (Tschopp et al., 2011, p. 408). This level of in-vivo engagement fosters the *opportunity* for enhanced attention to diverse needs.

The ecological perspective meets the standard of sensitivity to diversity. Each of the key concepts delineated are impacted by human differences. As discussed earlier, the intersection of one's age, class, ethnicity, and sexual orientation has a direct impact on one's niche, life course, life stressors, power, etc. The ecological perspective lends itself to an enhanced awareness of how difference/diversity impacts the person:environment. The high intensity of ACT services provides opportunity for enhanced attention to diverse needs, but does not necessarily do so overtly. Practitioners can engage consumers at high levels and still miss the nuances and differences based on the intersection of one's social identity. Grounding ACT services in the

ecological perspective provides a vehicle for practitioners to enhance their understanding of the importance of sensitivity to diversity. This enhanced understanding deepens practitioners understanding of consumers' needs because the key concepts of the ecological perspective (i.e., habitat and niche, life course, power, etc.) become overt aspects of assessment and understanding. Enhanced sensitivity to diverse needs innately enables practitioners to be more attentive to the whole person and better positioned to work from consumers' strengths.

Professional Standard of Strengths

Rettew and Lopez (2008, as cited by Forte, 2014) define strength as "a capacity for feeling, thinking, and behaving in a way that allows optimal functioning in the pursuit of valued outcomes" (p. 286). The rapid pace of our society and the power imbalances that permeate it reinforce a deficit perspective. As such, theoretical frameworks and practices should emphasize potentials rather than deficits; they should focus on "resources, opportunities, and strengths rather than absences, pathologies, and disorders" (Forte, 2014, p. 284). The concepts of resilience and strengths are kindred; one's strengths are a source of resilience.

ACT as an evidenced-based practice is founded on the belief that people with severe mental illness are resilient and capable of living in the community with appropriate supports. The creation of this practice challenged the assumptions that people with severe mental illness would always be hospitalized, incarcerated, and/or homeless due to the severity of their illness. As a team, providers acknowledge the deficits and challenges, but focus on building upon the consumer's strengths and motivation for change.

The ecological perspective overtly addresses the concept of resilience. Many lay people would operationalize resilience as one's ability to bounce back. However, the ecological

perspective operationalizes the concept of resilience within the person:environment frame, meaning that resilience can lay with the individual and/or within the environment. The ecological perspective meets the professional standard of strengths. Philosophically the creation of ACT as a practice recognizes the strengths of individuals with severe mental illness. However, as discussed in the previous professional standard, there is no overt attention to a strengths approach in the practice itself. There are some critics of ACT who assert the practice is coercive rather than person-centered (e.g., Angell, Mahoney, & Martinez, 2006; Tschopp et al., 2011). Being a practice that requires high engagement with persons who have high levels of need, high risk for institutionalization, and complex needs, puts providers at risk of approaching treatment in a paternalistic and controlling manner versus an empowering and strengths-based approach. To ground ACT practices in the ecological perspective enables practitioners to understand key concepts to help frame their thinking, engagements, and interventions from a strengths approach because of the overt attention and acknowledgement of the consumers' resilience.

Although ACT and the ecological perspective lend themselves to these standards, it is not without challenges. Practitioners, humans, are providing ACT services and applying the ecological perspective. As such, practitioners can be limited by their own worldview. To effectively operate from a holistic and inclusive perspective, i.e. an ecological perspective, practitioners must engage in reflective practice, challenge themselves to be culturally humble, and intentionally work with a diverse team (Chavez, 2012; Murphy & Dillon, 2015).

Conclusion

ACT has been studied over the last 30 plus years and is held up as an evidence-based practice for adults with severe mental illness who are at the highest risk for institutionalization.

This is a population who have been marginalized and discarded by society based on their illness. Add the complexity of being a person of color and this marginalization is enhanced.

Limiting one's focus to an individual's illness results in missing the holistic needs of the individual and the impact of one's environment on health and wellness. The sociopolitical environment our country is currently in *is* having an impact on people impacted by mental health and substance use. If providers do not consider the impact of environment on the needs of clients, then providers will perpetuate harm by not addressing all the stressors and systemic barriers impacting their client's stability. Operating from an ecological perspective enables providers to see *both* the components (i.e., the individual, the environment) *and* their relationship. It is through this holistic lens that providers will be better able to accompany clients and assist in making sustainable change.

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Paving the Way for Expansive Practice: Operationalizing Ecological Practice in Mental Health

Laura E. Escobar-Ratliff

St. Catherine University – University of St. Thomas

Abstract

Racial disparities in mental health services are widespread and have a significant impact on those affected. Recent history has seen a growth in the awareness among mental health providers and researchers about the impact of culture on treatment. As such mental health providers need to move away from an inclusive practice approach to an expansive practice approach: an approach which dismantles normative paradigms and develops frameworks that are responsive to one's unique needs. The ecological perspective provides a framework for understanding the complexities of human dynamics and expanding practice approaches when working with people of color. The conceptual ideas of intersectionality, cultural humility, and power aid practitioners in operationalizing the ecological perspective. Practitioners who understand and operationalize cultural humility, intersectionality, and power in their work are more aware and attentive to the concepts of adaptability, habitat and niche, life course, power, powerlessness, and pollution, life stressors, stress, coping, and resilience. Practice examples are utilized to illustrate applicability of the ecological perspective.

Paving the Way for Expansive Practice: Operationalizing Ecological Practice in Mental Health

Racial disparities in mental health services are widespread and have a significant impact on those affected. Over the last 30 years, research affirming the disparities in mental health treatment for people of color compared to their white counterparts has been well documented (e.g., Acevedo et al., 2015; Cuéllar & Paniagua, 2000; Culture, race, and ethnicity, 2001; Miranda, Cook, & McGuire, 2007). Nearly 20 years ago, in 1999, U.S. Surgeon General David Satcher, MD, PhD released a report affirming the disparities in mental health treatment for people of color and asserting that *ALL* people needed access to quality, effective, and affordable care (Culture, Race, and Ethnicity, 2001; U.S. Department of Health and Human Services, 1999). Dr. Satcher challenged the Academy and mental health service providers to engage in research, education, and training that was expansive in addressing the needs of our diverse population. He stated, "failure to address these inequities is being played out in human and economic terms across the nation – on our streets, in homeless shelters, public health institutions, prisons, and jails" (Culture, Race, and Ethnicity, 2001, p.626).

Mental health and co-morbidity with substance abuse is a highly prevalent issue in the United States. The Center for Behavioral Health Statistics and Quality (2015) reported one in five people struggle with mental health issues. The Center for Behavioral Health Statistics and Quality (2015) reported 20.2 million adults struggled with substance use and 50.5% of them had a co-occurring mental illness. Over 77% of adults experiencing mental illness are people of color (Center for Behavioral Health Statistics and Quality, 2015). One's race and/or ethnicity impacts one's culture. Culture impacts the way people communicate, identify and express symptoms, and/or access services (American Psychiatric Association [APA], 2013).

To successfully work with people experiencing mental illness, struggling with such complex and multifaceted issues, from various cultural contexts, one must work in a holistic manner. Operating from a holistic perspective innately readies one to be sensitive to diversity. Sensitivity to human diversity includes attention to the intersections of: age, class, color, culture, disability, ethnicity, gender, gender identity and expression, geographic location, immigration status, political ideology, race, religion, sex and sexual orientation, and other social identities (Forte, 2014). The ecological perspective provides an orientation for understanding people, their environment, and the nature of their transactions/their relationship (Ecological Perspective, 2003; Gitterman & Germain, 2008; Gitterman & Germain, 2013). It emphasizes the reciprocity of person-environment exchanges (Gitterman & Germain, 2013). Social workers have specialized training in the ecological perspective as this is the heart of social work practice. However, not all mental health service providers have this education. As such, it is imperative that social work practitioners lead the way in training mental health providers about the practical applicability of the ecological perspective in mental health services.

This conceptual paper delineates the disparities in mental health treatment and explicates how practice from an ecological framework best serves consumers of mental health services, and in particular consumers of color. I suggest three representative practices, grounded in the ecological perspective, and how these might inform mental health practice. These practices include cultural humility, consideration of intersectionality, and attention to power. Key concepts of the ecological perspective (i.e., adaptability, habitat and niche, life course, power, powerlessness, and pollution, life stressor, stress, coping, and resilience) are discussed. Conceptual ideas (i.e., cultural humility, intersectionality, and power), which are essential to expansive practice, are extracted from the theoretical key concepts and explored.

Training mental health providers about these conceptual ideas expands their lens for understanding people, their environment, and the nature of their relationship. This expanded lens prompts providers to develop a practice approach that addresses needs holistically. It is essential that one's practice is expansive versus inclusive. Inclusivity promotes the position that one is being *invited* in to an established paradigm, whereas, being expansive, denotes a willingness to dismantle "normative" paradigms and develop frameworks that are response to one's unique needs (E. Grise-Owens, personal communication).

Literature Review

Over three quarters of the adult population in the United States experiencing mental illness are people of color. The prevalence of mental illness among adults by race is: 16.3% Hispanic, 19.3% White, 18.6% Black, 13.9% Asian, and 28.3% American Indian/Alaska Native (NAMI, 2015). People impacted by mental health and substance use issues face many challenges such as homelessness, unemployment, and incarceration (Glaze & James, 2006; National Association of State Mental Health, 2006; U.S. Department of Housing and Urban Development, 2011.). *People of color* with these same illnesses encounter additional barriers: "less access to treatment; less likely to receive treatment; poorer quality of care; higher levels of stigma; culturally insensitive health care system; racism, bias, homophobia, or discrimination in treatment settings; language barriers; lower rates of health insurance" (NAMI, 2015, Section critical issues).

Treatment Disparities

Recent history has seen growth in the awareness among mental health providers and researchers about the impact of culture (i.e., race and ethnicity) on treatment. However, there are disparities of access, quality, and availability of mental health services for people of color (Culture, race and ethnicity, 2001; Fiscella, Franks, Doescher, & Saver, 2002). Miranda, Cook,

and McGuire (2007) measured trends in mental health disparities from 2000 until 2004 and found African-Americans and Hispanics receive less mental health services than their white counterparts. Padgett, Patrick, Burns, and Schlesinger (1994) had similar findings in their study, which was conducted in 1983. However, Padgett et al. went a step further in their analysis and identified "cultural or attitudinal factors" (p. 222), among others, as factors in the disparities. According to Giliberti (2016), the CEO of NAMI, African Americans and Latinos use mental health services at approximately one half the rate of Caucasian Americans, and Asian Americans utilize services at one third the rate of Caucasians. Giliberti (2016) cites "racism, homophobia or other conscious or unconscious biases, lack of access to services in the community, lack of cultural competence in service delivery [and] stigma" (para 4) as some of the reasons for disparity.

Culture

Culture (2003) is defined as "the customs, habits, skills, technology, arts, values, ideology, science, and religious and political behavior of a group of people in a specific time period" (p. 105). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) overtly cautions providers to be cognizant of cultural issues when assessing clients, stating that "mental disorders are defined in relation to cultural, social, and familial norms and values" (APA, 2013, p. 14). Additionally, tolerance for symptoms and/or behaviors may vary based on cultural influence; adaptability, awareness, coping strategies, and support systems may also vary (APA, 2013; Murphy & Dillon, 2015). Cuéllar and Paniagua (2000) go further in asserting that mental health is not simply about biology and psychology. They assert that education, economics, social structure, religion, and politics are inextricably linked. All of these factors can impact a client's ability to seek and engage in treatment, hence impacting client satisfaction with

treatment and their perspective on the effectiveness of services. Additionally, inattentiveness of these factors by treatment providers will result in providers being less effective and potentially ethnocentric in their treatment approach (Cuéllar & Paniagua, 2000; Lum, 2011).

Successful engagement and treatment of persons impacted by mental illness and/or co-occurring substance use requires a holistic perspective acknowledging the multifaceted cultural and contextual issues faced by each individual. In other words, engagement and treatment must be attentive to the needs of a person based on both their mental illness *and* their social identity (e.g., person:environment).

Ecological Perspective

The ecological perspective is a theory that provides an orientation for understanding people, their environment and the nature of their transactions/their relationship (Ecological Perspective, 2003; Gitterman & Germain, 2008; Gitterman & Germain, 2013).

Person:Environment

In the ecological perspective, a *person* is trying to cope with and improve one's level of fit in the environment by trying to adapt to the environment (Gitterman & Germain, 2008). The perspective assumes that people have the capability to take action in the coping and improving process, but recognizes that there are factors beyond individual control, will, and desire that impact the outcome. One is influenced by one's own habitat, niche, and life course, as such adaptability is impacted by a combination of complex factors beyond individual choice, will, and/or desire.

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A core assumption of the ecological perspective is that the *relationship* and the power within the relationship is multi-directional, recursive, and transactional (Forte, 2014; Gitterman & Germain, 2008; Gitterman & Germain, 2013). The relationship, the transactions of one and one's environment is in the middle of the individualism-collectivism continuum. This relationship is further illustrated by the key concepts of the perspective.

Key Concepts

Gitterman & Germain (2013) delineate several key concepts to the ecological perspective: adaptability; habitat and niche; life course, power, powerlessness, and pollution; life stressor, stress, coping; and resilience. One's *adaptability* (i.e., level of fit with environment) impacts one's development, health, and social functioning (Gitterman & Germain, 2008; Gitterman & Germain, 2013). Individuals strive for a good fit, hence adapted, however this fit is impacted by habitat and niche; life course; power, powerlessness and pollution; life stressor, stress, coping; and resilience.

Gitterman & Germain (2013) assert that the nature of social and physical environments is determined by the concepts of *habitat and niche*. They go on to delineate examples of habitat that include geographical boundaries, residential dwellings, physical resources, and communal amenities. Niche is one's status within the habitat (Gitterman & Germain, 2008; Gitterman & Germain, 2013). One's niche is impacted by societal *power* - the political, social, and economic

structures in one's habitat (Gitterman & Germain, 2008). These structures (i.e., political, social, and economic) have a direct impact on one's niche; impacting whether a person's niche (i.e., status) is growth-supporting or stigmatizing. One's habitat and niche have a direct impact on one's adaptability.

Life course is an individual's "unique pathway of development" (Gitterman & Germain, 2008, Life Course section, para. 1) which is impacted by one's environment and varied life experiences. There is no single, linear, static life course that people must take, rather there are individual experiences that one encounters throughout, which impact one's life trajectory. One's life course is impacted by *social time*, which is "the timing of individual, family, and community transitions and life events influenced by changing biological, economic, social, demographic, and cultural factors" (Gitterman & Germain, 2013, Ecological Concepts section, para 5). Furthermore, it is important to recognize that individuals are not simple and static in identity and experience; rather they are a complex *intersection* of identities (Yamada, Werkmeister Rozas, & Cross-Denny, 2015). These identities are influenced by and reciprocally impacted by one's habitat and niche; this in turn impacts life experiences and one's standing in society.

The impact and exchange of *life stressors, stress, and coping* are influenced by the "characteristics of the person and the operations of the environment" (Gitterman & Germain, 2013, Ecological Concepts section, para 6). One's habitat and niche, life course, and social time impacts stressors, which in turn impacts one's adaptability. Stress is impacted by one's ability to navigate, individually and/or with resources, one's life stressors. As such, one's environmental and personal resources impact one's ability to cope with said stress (Gitterman & Germain, 2008). Life stressors and stress can also be mitigated by resilience.

Resilience is more than individual attributes, but rather the transactional relationship of person and environment (Gitterman & Germain, 2008). As such, when thinking about resilience one must consider the individual and the collective; one must consider biological, psychological, and/or environmental processes (Gitterman & Germain, 2008). One's habitat and niche, life course, and access to *power* can contribute to a person's resilience.

The ecological perspective provides a framework for understanding the complexities of human dynamics and expanding practice approaches when working with people of color. The conceptual ideas of intersectionality, cultural humility, and power, in particular privilege and oppression, aid practitioners in operationalizing the ecological perspective.

Expansive Practice: Ecological Perspective and Mental Health Providers

An individual's identity is shaped by "individual characteristics, family dynamics, historical factors, and social and political contexts" (Daniel Tatum, 2000, p. 9). Over the last 20 plus years the United States has seen the population of people of color double (Lum, 2011). The complexities and intricacies of one's culture directly impacts the effectiveness of services for people of color.

To be an expansive practitioner who practices in a culturally humble manner, one must recognize the social construction of race and other social identities, as well as the discrimination and oppression that occurs at all levels – personal, institutional and cultural (Lee, Blythe, & Goforth, 2009; Bundy-Fazioli, Quijano, & Baber, 2013). Simultaneously, one must learn to confront and work through interpersonal and intrapersonal conflicts about their "role, status, and participation in an oppressive system" (Lee et al., 2009, p. 123).

A significant amount of literature has been written about the ecological perspective and the concepts of intersectionality, cultural humility, and power (e.g., privilege and oppression).

Never the less, further exploration and discussion is needed. To that end, the conceptual framework that connects the understanding of these concepts (e.g., intersectionality, cultural humility, and power) with the key concepts of the ecological perspective will result in an expanded practice lens. The subsequent section will explore these concepts and delineate their applicability with the ecological perspective. Practice examples are utilized to illustrate applicability of the ecological perspective. It should be noted that names and identifying information of consumers have been changed to protect their confidentiality.

Intersectionality

Intersectionality is the crossroads of one's individual multiple social identities (e.g., race, class, gender identity and/or expression, sexual orientation, age, physical and/or mental ability, class, etc.) (Lum, 2011; Murphy & Dillon, 2015). Intersectionality is the constellation of one's social identity which provide a person with a unique experience that may differ from those who may share one or more similar social identities, but not others as well as the nature of their experience (i.e., environment and/or relationships) (Tharp, 2012). Consider an example of three adult sisters, who are three to four years apart in age, born in Mexico and raised in the same household. All three sisters immigrated with their parents to the United States at the age of 12, eight, and four. Their commonalities include: women, immigrants, heterosexual, middle-class, and Latina. Their variance in age at time of migration has a significant impact as it impacts the intensity of their accent, their formative memories of their home country, the status of their parents' citizenship during childhood impacting accessibility to supportive resources, the intensity of feeling bi-cultural, etc. These variances impacted niche, adaptability, power, life course, and life stressors differently for each sister.

Understanding intersectionality enhances a provider's ability to understand the impact of one's habitat and niche, adaptability, power and/or powerlessness, life course, life stressors, stress and coping, and resilience. This understanding further enhances awareness of one's access to resources and/or power (Lum 2011).

Cultural Humility

There are multiple concepts and phrases embraced by social work and other helping professions such as cultural sensitivity, cultural competence, cultural awareness, etc. However, the most pragmatic term for practitioners to conceptualize and execute is cultural humility. Sensitivity and awareness are about the external ability to recognize differences whereas cultural humility promotes an *internal* and *external* awareness that directly impacts action. Murray-Garcia and Tervalon (2014) coined the term cultural humility a process that requires providers: commit to life-long learning and critical self-reflection, recognize and challenge power imbalances, and foster mutually respectful and dynamic relationships with individuals and communities. This commitment, to culturally humble practice, readies providers for an enhanced understand of an individual, the environment, and the transactional relationship of the two. Consider the example of an African American adult male who is transitioning in to the community after serving 15 years in prison. This consumer entered the prison system as an adolescent and was reared in the penitentiary. He has been reared to follow directions from people he considers to be authority figures, including treatment providers; he comes from an institutionalized culture. Extra attention is required to foster a mutually respectful relationship and address power imbalances. This consumer wants to defer to what treatment providers recommend and he struggles to recognize his power in directing his treatment.

Providers who are attentive externally and internally are more apt to recognize this power imbalance and cultural norm of deference. Otherwise the consumer deference could be interpreted as *compliance* at best or *engagement* at worst. Providers who do not recognize the cultural implications of institutionalization run the risk of exploiting the power imbalance which privilege the providers lens while oppressing the consumers.

Power: Privilege and Oppression

It is imperative that when one is discussing the concept of privilege that there is a simultaneous discussion of oppression. One without the other further dichotomizes groups and thinking. Discussing the concepts together illuminates the complexities of the concepts as well as their transactional relationship.

Privilege is the unearned advantage one experiences due to having sociodemographic traits that align with a dominant group of people (Franks & Riedel, 2008). In other words, the benefits a person experiences are based on who one is (i.e., social identity) rather than what one has done (Tharp, 2012). Due to this alignment, the person with privilege experiences an economic or social boost afforded the dominant group while supporting the structural barriers to nondominant groups impose by prejudice. Recognizing and acknowledging the impact of privilege increases provider's ability to recognize structural barriers, intentional or unintentional contributions to barriers, and develop strategies that are more expansive of the needs of all in the communities served (Franks & Riedel, 2008).

Van Soest (2008) offers a common definition of *oppression*, which is "the domination of a powerful group-politically, economically, socially, culturally-over subordinate groups" (Section oppression defined, para 1). In other words, oppression is a process in which a person is denied benefits based on who the person is (i.e., social identity), not based on anything done or

accomplished (Tharp, 2012). Oppressive relationships are often invisible to both the parties (i.e., dominant and subordinate), but do impact the psychological makeup of both parties. This psychological makeup has a direct impact on the realities of the relationships amongst the parties (Van Soest, 2008).

Most people can identify with social identities that have experienced oppression and privilege. An African American male who is a consumer of mental health services and currently on disability was a first responder. He recounted the bias and discrimination he endured throughout his childhood and young adulthood, being told he would amount to nothing. He shared that after becoming a first responder people looked at him differently. He was no longer that black man to be feared but a first responder who helped people. He rose through the ranks to become captain. His team encountered a terrible disaster which resulted in several of the first responders under his command losing their lives. His sense of grief and guilt haunted him leading him to use alcohol to escape. Symptoms of post-traumatic stress disorder led to him leaving the first responder's department which further deteriorated his sense of self. Today he is homeless, struggling with alcoholism, struggling with trauma and depression, and struggling with a sense of failure.

A deeper understanding of the relational dynamics of privilege and oppression enhances providers ability to address the identified problem without blame, recognize and separate their own bias (i.e., personal values), it illuminates the interaction, power dynamics, between the personal and political, and addresses the systemic nature of relationships (Van Soest, 2008).

Expansive Practice in Action

Until the story of the hunt is told by the lion, the tale of the hunt will always glorify the hunter, an Ewe-Mina (peoples from Benin, Ghana, and Togo) proverb. Until the story of the

hunt (e.g., the experience) is told *and* understood from the consumer, the tale of the hunt (e.g., experience) will always privilege the lens of the hunter (e.g., the practitioner). Practicing from an ecological perspective provides mental health practitioners with a framework for understanding one's life from the unique lens and experience of the consumer. Practitioners who understand and operationalize cultural humility, intersectionality, and power in their work are more aware and attentive to the concepts of adaptability, habitat and niche, life course, power, powerlessness, and pollution, life stressors, stress, coping, and resilience.

Case Example: Ting-Ting

Ting-Ting is a Karen immigrant, who experiences schizophrenia and homelessness, speaks no English, has been hospitalized multiple times, and has no biological family in the area. The local community mental health center became involved with Ting-Ting at the behest of the local homeless shelter. She had spent months at the homeless shelter with no progress and the shelter was looking to ask her to leave due to no engagement in the shelter's supportive services.

A social worker from the community mental health center began engaging with Ting-Ting. The shelter advised the social worker that Ting-Ting arrived at the shelter on a Greyhound bus with a note paper clipped to her shirt identifying her name, that she was to be taken to this shelter, and the shelter should contact the local refugee ministry services. The social worker communicated with an advocate from the refugee ministry that advised that Ting-Ting had no known supports. The social worker recognized her ignorance of the Karen culture; therefore, she began to reach out to various immigrant organizations in the city to learn about Karen culture and resources in the city.

Intersectionality

Through consultation with various groups the social worker learned that the *intersection* of Ting-Ting's identities was a complicating factor. The number of Karen people in the world itself is small. The number in the United States, let alone this mid-size city in the U.S., was even smaller. However, Ting-Ting is not only Karen, she is Black Karen, which is a smaller population of Karen people. Black Karen people potentially face the same discrimination and oppression from non-black Karen people that Black Americans potentially face from White Americans. The Karen people are communal people and Ting-Ting is an older adult which culturally means she should be cared for by her people. In Karen culture, one's "people" are not defined by blood lineage but rather by culture, as such Karen immigrants are her people. To not be cared for by one's people is considered as being unworthy. Add the fact that Ting-Ting struggled with schizophrenia further complicated matters. Ting-Ting believed that she was awaiting execution, the police would one day come for her, and that she needed to stay so she could be executed for the bad choices she had made. As such she refused to leave the shelter and attempts to connect her to services in the past resulted in her becoming combative. Her illness and potential combative behaviors complicated the ability to connect Ting-Ting to her people because of the anti-immigrant sociopolitical environment increasing in the United States. Karen families that were found expressed desire to be supportive from a distance, there was not a willingness to take Ting-Ting into their home out of fear of bringing attention to their families and communities thereby putting the community at risk.

Cultural humility

As the social worker learned more about Ting-Ting, the Karen culture, and Ting-Ting's unique needs it became apparent that the standard practice of connecting one to services and readying one for independent living were counter indicated. In attempts to practice from a

culturally humble manner, the social worker slowed down the process of engagement and connecting to services. The social worker spent weeks visiting Ting-Ting in the homeless shelter, sometimes engaging in conversation through a translator other times sitting and being present with Ting-Ting. Slowing the process allowed the social worker to foster a mutually respectful and trusting relationship. Over time she began to ask Ting-Ting if she would like to hear about services, if Ting-Ting said no, the social worker affirmed her decision and dropped it. If Ting-Ting was open to hearing about services, then the social worker offered.

Power

Throughout her engagement with Ting-Ting the social worker attempted to model and verbalize to Ting-Ting that she had the *power* to choose, or deny, services. The social worker mirrored power dynamics in her physical engagement with Ting-Ting. If Ting-Ting sat on the floor, the social worker did too. If she sat under a table, the social worker sat under there with her. The social worker engaged Ting-Ting multiple times a week for the duration dictated by Ting-Ting. Some visits were five minutes, others were an hour, all guided by Ting-Ting.

After months of engaging Ting-Ting through mere presence, Ting-Ting began to ask questions about services and agreed to be connected to an Assertive Community Treatment (ACT) team with the social workers support. The social worker and ACT team worked closely together during the first two month of the transition. She educated the ACT team about what she had learned and had to provide repeated coaching around cultural humility and awareness of power dynamics.

Expansive Practice: Challenges

The social worker in this case example was better positioned to operate from an ecological perspective and embrace the concepts of intersectionality, cultural humility, and power in practice due to her training and education. The ACT team is an interprofessional team of therapists (social workers and psychologists), nurses, prescribers, case managers (social workers and other helping professions), community support professionals, peer support specialists, housing specialists, and employment specialists. Team members have varying educational backgrounds, levels of practice experience, and exposure to an ecological lens. Standard practice for an ACT team is to operate from a person-centered approach and wrap services around the consumer to foster recovery and assist in maintaining independent living in the community.

Intersectionality

Awareness of the intersection of Ting-Ting's social identities enhanced treatment providers' conceptualization of her life experiences and needs. As an older Karen woman, she wanted to be cared for, this normative expectation impacted how Ting-Ting engaged with younger ACT team members as opposed to older ACT team members. With older team members, her engagement was more collaborative, whereas with younger team members she wanted them to do more for her. With the support and education provided by the social worker, the team had a better understanding of these relational dynamics. The difference in engagement could have been pathologized as being manipulative as opposed to being embedded in cultural norms

Cultural humility

Working with Ting-Ting challenged the ACT team's internal and external awareness of values and norms as identified by Ting-Ting's, the ACT team as a whole, and individual team members. The ACT team values helping people to maintain independently in the community and engaging people in their recovery process. These values and norms were challenged by what Ting-Ting wanted and needed. Ting-Ting needed communal living, foods and spices that were akin to her culture, community support from her people, and support through her recovery process due to her language and mental health barriers. This required that the team become proficient in utilizing interpreters and the language line when meeting with Ting-Ting, that they humble themselves and acknowledge their limitations in understanding her culture and norms, that they learn to ask permission and clarifying questions when unsure, that they become comfortable with the unknown, that they learn to recognize the difference between culturally normative behaviors and what is related to mental health issues. The social worker was integral in helping the team navigate these various challenges.

Discussion

Social workers are poised to operate from an ecological perspective. People struggling with mental health and/or substance use issues face complex and multifaceted challenges due to the impact of their illness. Concepts of intersectionality, cultural humility, and power foster a deeper and more holistic understanding of both consumer needs in terms of services needed/received and providers' needs in terms of service delivery.

Over the years various initiatives have been promoted by SAMHSA and other leaders in behavioral health then implemented by mental health providers to address the needs of those struggling with mental health and substance use. These different initiatives include a person-centered approach to treatment, trauma informed care, and holistic care. These are all important

initiatives, however, such initiatives without enhanced understanding of these key concepts will continue to fall short of meeting the needs of consumers, in particular consumers of color.

A person-centered approach to treatment is a step in the right direction toward an ecological perspective in that treatment is driven by the consumer. If the consumer's voice and perspective is at the center, then theoretically one could surmise that environmental factors would become part of the equation. However, unless practitioners understand, embrace, and operationalize the concepts of intersectionality, cultural humility, and power then the complexities of one's ecology are missed resulting in our approach to treatment privileging the lens of the practitioners as opposed to the unique constellation of the consumer's lived experience. Training mental health providers about the concepts of intersectionality, cultural humility, and power are pragmatic ways of operationalizing the ecological perspective for those who do not have a back ground in social work.

Education, economics, social structure, religion, and politics are inextricably linked to mental health (Cúellar & Paniagua, 2000). Educating mental health providers about intersectionality, cultural humility and power enhances their ability to holistically understand, externally and internally, the needs of the consumers with whom they are working. Understanding these concepts aids providers' ability to see the uniqueness and complexity of each consumer. This enhanced understanding fosters a critical consciousness about the role of education, economics, social structure, religion, and politics. Critical consciousness then becomes a protective factor against conscious and unconscious bias, lack of cultural competence, and stigma. Additionally, it aids providers' ability to recognize the importance of being person-centered. Being person centered should not only be about autonomy and choice, but also about fully understanding the complete person. In other words, one's understanding of a consumer has

to be more than a contextual understanding of inclusivity, understanding the consumer in the provider's pre-established paradigm. Providers must expand their lens to learn and understand the consumer through the consumer's lens/paradigm.

There are challenges in working from an ecological perspective that is operationalized in an understanding of intersectionality, cultural humility, and power. Challenges include training, support, and supervision. Mental health providers receive a significant amount of training around different modalities of treatment, diagnosis, and service provisions. These trainings are often delivered in an in-service manner with little to no follow-up. Understanding and operationalizing the concepts of intersectionality, cultural humility, and power will require training, ongoing consultation, and ongoing supervision. To simply educate and expect providers to implement these concepts in practice would create a superficial and limited external understanding, which could potentially be more harmful. Ongoing training, consultation, and supervision would need to be provided by a social worker with advanced understanding of these concepts and of the ecological perspective.

Social workers are uniquely poised to lead a paradigm shift from inclusive practice to expansive practice. As the population of people of color in the United States continues to grow, so do the unique needs of consumers seeking mental health services. Our traditional approaches to mental health treatment, that fail to recognize impact of one's ecology in treatment, will fall short in addressing the needs of our consumers of mental health services, in particular consumers of color. Enhanced knowledge and understanding of intersectionality, cultural humility, and power will aid mental health providers' ability to understand the importance of person and environment. Doing so enables providers to understand and discuss strengths and barriers to adaptability, habitat and niche, life course, power, stress, and resilience as part of treatment. This

in turn promotes expansive practice that promotes a framework that is responsive to consumers' unique needs.

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