

CONFERENCE REPORT

SOCIAL WORKERS MAKING A DIFFERENCE

**BEST PRACTICES WITH CHILDREN WITH ASTHMA
AND FAMILIES
IN URBAN COMMUNITIES**

JUNE 2000

A Collaboration of the

**New York City Chapter
National Association of Social Workers**

and

**New York City Department of Health and Mental Hygiene Childhood Asthma
Initiative**

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Acknowledgments

The Social Work and Asthma Conference, and the publication of this Report would not have been possible without the hard work of many individuals and the organizational support of the New York City Department of Health and Mental Hygiene, the New York City Chapter of the National Association of Social Workers, and those of child and family serving agencies that are listed in the appendix. The Conference was supported in part by a grant from the United Way of New York City, and space provided by the Hunter College School of Health Sciences.

We are especially appreciative to members of the Planning Committee: Terry Mizrahi, Alma J. Carten, Mindy Lieberman, Elyse Einhorn, Melissa Saperstein, Bill LeGette, Valerie Marriott, Jill Gerson, Gerald Beallor, Suzy Edelstein, Mona L. Martin, Karen Gooden and from NYC Health Department – Lisa Watson and Joslyn Levy. The Committee performed a variety of tasks and played key roles in the planning and implementation of the Conference and in the preparation of this publication. The workshop moderators and presenters also included in the appendix played a central role in the success of the Conference. We are especially appreciative to the workshop presenters for editing initial transcriptions of their presentations and for giving permission to include them in this publication.

A number of individuals worked in the background. Joslyn Levy Conference Organizer, Lisa Watson, then Director of NYC DOH Asthma Initiative Training Unit, and interns who had the formidable tasks of transcribing audio tapes of approximately seven hours from a full days Conference of concurrent workshops.

Appreciation is expressed to these and the many other individuals who contributed to the success of the Conference. Although held two years ago, the information contained in this report of the Conference Proceedings remains highly relevant and useful for the management of the health care of children with asthma.

Executive Summary

Background and Purpose

This report presents the proceedings of *Social Workers Making A Difference: Best Practices With Children With Asthma and Families in Urban Communities*. The Asthma Conference was undertaken in partnership with the New York City Chapter of the National Association of Social Workers and the New York City Department of Health and Mental Hygiene, Childhood Asthma Initiative. Several community based agencies joined with us in planning the conference. The names of these agencies and their staff representatives are listed in the appendices to the report.

The Conference was held in June 2000 and attended by more than 300 health and human services staff representing agencies from all boroughs who were working directly or indirectly with children with asthma with asthma and their families. The Conference was unique in that the presenters were an interdisciplinary mix of health and human services practitioners, all of whom were currently working with children with asthma and their families. All had extensive experiences in many practice settings including schools, hospitals and other health care facilities, advocacy organizations and community-based agencies. Presenter profiles and organizational affiliations are listed in the appendices.

Changes have occurred since the time of the Conference, However, the information contained in the Report remains highly relevant and useful for managing the health care of children with asthma in urban communities and for preventing asthma, especially in low-income communities. Some of those who played key roles in the Conference are no longer in the positions they held at the time of the Conference. Dr. Alma J. Carten, whose remarks are included in the Opening Plenary section of the report supported the Chapter's involvement in the project from the beginning. She ended her term as Chapter President in June 2002. Dr. Neal Cohen, and Louise Cohen, who played central roles in crafting the city's Childhood Asthma Initiative are no longer in their respective positions at the NYC Department of Health and Mental Hygiene's Childhood Asthma Initiative. Their remarks are also included in the Opening Plenary Section of the report. Some of the presenters have moved on to new positions; we have noted that in the appendices when this information was available.

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Asthma is the leading chronic illness among children across the nation. In New York City, asthma is the number one cause of hospitalization for children 0-14 years old. Although there is no cure, recent advances in the knowledge, diagnosis, and treatment of asthma means that the disease can now be effectively controlled and managed. With appropriate medical, self, and family management, children with asthma can live normal lives with little restrictions in play and school activities. Community-based solutions and advocacy to prevent the escalation of asthma also played an important part in this Conference.

In 1997, the New York City Health Department of Health and Mental Hygiene launched the Childhood Asthma Initiative as a comprehensive public health approach to improve health, educational and social outcomes for children with asthma and their families. Early pilot projects targeted city neighborhoods where asthma hospitalization rates were especially high: East and Central Harlem in Manhattan, Hunts Points and Morrisania sections of the South Bronx and Bedford Stuyvesant in Brooklyn.

In implementing the program it became apparent to the NYC Health Department and Mental Hygiene that these efforts required a strong social work presence. Subsequently, staff reached out to the New York City Chapter of the National Association of Social workers, the city's largest professional social work association, for assistance. A committee was established comprised of representatives from the NYC Chapter, Health Care Policy and Practice Network, the Family and Children Committee, the NYC Department of Health, and community based agencies, to begin planning for a jointly sponsored Conference. The planning committee was especially interested in reaching front line workers in community-based agency located in communities where asthma hospitalization rates were highest. The Committee established two primary goals for the conference 1)To create a forum for disseminating information about advances in the knowledge, treatment and management of care for children with asthma, focusing on new service models found to be highly effective in serving children with asthma in urban areas, and 2)To illuminate the critical role and contribution of social work in the prevention, assessment, treatment and management of children with asthma and their families.

Social Work Contributions to Asthma Prevention and Management

Asthma is a respiratory illness that makes breathing difficult because of the narrowing of the bronchial tubes causing lung tissues to swell, spasms in the surrounding bronchial tubes, and the accumulation of mucus in the air passage. These occurrences are triggered by allergens and lead to symptoms of tightness in the chest, wheezing, coughing and difficulty in breathing.

Asthma is not a psychosomatic illness, nor is it caused by emotional problems. There are, however, psychosocial, environmental and economic dimensions to asthma that undoubtedly account for high hospitalization rates in the city's poorest neighborhoods. Difficulties in breathing associated with an asthma episode can generate fear and anxiety in children, and their families. In addition, excessive school absences and frequent emergency room visits can contribute to development of an emotional overlay. Therefore, it is understandable that psychological problems can develop for children whose asthma is not managed well.

It is the multidimensional nature of asthma and the need for a preventive approach that provide a rationale for social work expertise and skills in the assessment, treatment and management of the illness. In urban settings, social work expertise is especially relevant because environmental triggers are exacerbated by social conditions of the urban environment, long the targets of social work interventions and advocacy efforts.

The presentations included in this report address asthma as a multidimensional illness requiring the interdisciplinary expertise of professionals and participation of families and communities. These presentations also highlight the contributions of social work with its person-in-environment approach to the management of children and families. The disease calls for multi-level interventions – clinical, policy, and community.

Summary of Conference Workshops

Social Workers Making a Difference

The National Cooperative Inner City Asthma Study, funded by the National Institute of Health, identified strategies effective for the delivery of health care services to inner city children. Many of these strategies were integrated into the service model developed at Mt Sinai Hospital serving inner city children for many years in a Pediatric Pulmonary Health Care Team. Both projects illustrate the important role and contribution of social workers as key members of the health care team.

Psychosocial Dimensions of Asthma

The mental health of children with asthma is often compromised by violence and other social problems in the home, school and community. Some children may have a dual diagnosis of asthma and mental health problems, requiring that they take both psychotropic and asthma medications. Asthma is not caused by stress or emotional problems but can be exacerbated by the presence of these problems. Workshop presenters discussed the mental health needs of children with asthma, how to reduce stressful situations for them in the home and school, and special issues related to managing health care for children with both asthma and mental health problems for which they are receiving medication.

Cultural Competency

The presenters addressed a variety of cross cultural and diversity issues illustrating how culture and health beliefs influence the use of health services and underscore the need for culturally competent practice in the assessment and management of health care for children with asthma. Populations focussed on include Chinese, Latinos, Africans and African Americans.

Asthma in the Home

Many asthma triggers are found in the home environment where children and parents spend the greatest portion of their time. Some of these are within the control of the family, and others are not because they are exacerbated by housing conditions that fail to meet standards established in the New York City Housing Code. Workshop presenters provide

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information about common triggers found in the home and how parents can be helped to create in-home plans that reduce exposures to triggers and prevent asthma episodes. They also provide an overview of the mechanism for bringing legal actions against landlords who are in violation of city housing protection laws.

Community Organizing

The workshop presenters describe three projects illustrating large scale organizing initiatives designed to address systemic, institutional and structural conditions that contribute to high asthma prevalence in some neighborhoods such as Central and East Harlem. They demonstrate the role and contributions of professional organizers and leaders in building successful advocacy coalitions to change policies and coordinate programs.

Case Study Panel

The plenary panel session used a composite, typical case that provided opportunities for the application of information covered in the workshop presentations. Panelists illustrate how social workers practicing in the school, hospital and community based preventive service agency contribute to the successful management of health care needs for children with asthma and their families.

Promoting Best Practices

Taken together these presentations contain a wealth of information for promoting best practices for children with asthma and their families living in urban communities. Many of the strategies and models discussed in the report can be easily replicated.

The New York City Childhood Asthma Initiative is now operating programs based on a public health model in all boroughs. Social workers are important members of the health care team providing direct services to children with asthma and their families, as well as developing and coordinating services for them and advocating for policies and programs to prevent and minimize the asthma epidemic.

The appendices to the report contain useful resource information including how to contact the workshop presenters, hotline and contact numbers, websites for needed services and other information.

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Opening Plenary

Opening Remarks

**Dr. Alma J. Carten, President
New York City Chapter
National Association of Social Workers**

It is a my pleasure to welcome you to this important conference planned and undertaken in collaboration with the New York City Chapter of the National Association of Social Workers and the New York City Department of Health, Childhood Asthma Initiative. With nearly 10,000 members, the Chapter is the largest professional association of social workers in New York City. The Chapter engages in a number of projects designed to advocate policy changes and best practices with many client groups. The Chapter's Health Care Policy and Practice Network, and Children and Families Committee have taken the lead in addressing policy and practice issues related to health care affecting children and families. Members of these committees also played a major role in planning this all day conference. However, we know that social workers practicing in many fields of practice, in public or private agencies, are highly likely to be involved with families impacted by asthma. Therefore, the Chapter is especially pleased to work with the Department of Health on this important initiative.

Many of those in the audience represented community-based agencies, as well as staff from the Administration for Children's Services. Community based-agencies are at the front line, and have a long-term commitment to improving the coordination and availability of services at the community neighborhood level to under-served populations. We also know that many families coping with asthma are known to the Administration for Children's Services. They often come to the attention of ACS because of allegations of medical or educational neglect, as a result of not coping well with the effects of the illness on their children. Many social workers are in a position to identify symptomatic children early. Early diagnosis means that children will have early access to preventive services that can improve health, educational and social outcomes for them and their families. They are also aware of the complex nature of the problems families confront. Some social workers may be working with families that have one, two, or three children and perhaps an adult caretaker who are all asthmatic. Their lives are more than likely already characterized by a series of

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crises. The situation for some may be worsened as a result of limited access to health and human services because of recent limitations in health and welfare benefits, or because of lack of education on how to access services, resources and to advocate for their child(ren).

Without appropriate care, asthma is a difficult illness for both children and adults. The illness can be especially difficult for children because play, excitement and exercise are the essence of childhood. For children living in urban communities, the illness is exacerbated because of environmental pollution that too frequently is a companion of urban life. And for those living in the city's poorest neighborhoods, there are additional challenges because their environments are contaminated by additional layers of preventable pollutants created by poverty and social neglect. Perhaps, it is in the lives of these children that the full impact of the illness is felt in all of its dimensions - physical, psychosocial, social and economic. It is the multidimensional nature of the illness that makes it imperative to have a social work presence on asthma health care teams.

Social work's person in environment approach make our profession especially well suited for providing direct services to families, designing outreach strategies, and advocating policy development in areas such as environmental protection, hazardous waste disposal, sanitation, housing regulations and other preventive measures that contribute to the control of the disease. These activities ensure that the act of breathing is a life sustaining and not a life-threatening act as it has become for some children living in the city's poorest neighborhoods. Social workers and other health care professionals must also work together to advocate universal health coverage that guarantees all families access to appropriate medical and psychosocial care, including preventive services, case management and the most effective medications and other remedies.

Social work has traditionally been the anchor profession in health and human service agencies serving children and families. We gladly accept the challenge that this conference establishes to increase social work presence as a viable member of the interdisciplinary health care team and as a leader in the prevention and management of asthma. We see this as a first step in an ongoing partnership with the Department of Health.

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Neal L. Cohen, M.D.

Commissioner, New York City Department of Health

We at the Department of Health are delighted to be working with the New York City Chapter of the National Association of Social Workers and other community partners in this important health care issue for the for New York City's children.

Controlling and reducing the effects of asthma on New York City children is a major priority of the Department of Health. Asthma is the number one cause of children being hospitalized, and a leading cause of school absences. We know a good deal about how to keep children with asthma healthy. And how to help them lead normal lives, play and attend school as their peers. Before 1997, however, the City did not have a comprehensive plan in place for addressing asthma and other community health problems having devastating impact on city neighborhoods.

Community Health Works was established as a new division of the Department to oversee the design and implementation of a coordinated public health approach to the problem. It was established to support the development of programs that focus on health promotion and prevention, by forging community partnerships, focusing on policy changes as well as direct services, and promoting linkages among health care providers, community based agencies and other community partners. The Staff is multidisciplinary with expertise in community organizing, health planning, program development, epidemiology, and preventive medicine. The division designed and launched the Childhood Asthma initiative. You will be hearing more about the initiative from the Director, Louis Cohen.

The New York City Childhood Asthma Initiative is an excellent example of this integrated preventive approach, where community agencies, city agencies, health care providers among others have joined together to confront a health problem that no single organization can successfully address alone. The public health approach to asthma promoted by the Department is simple and straightforward. We know that effective asthma programs must involve individuals and their doctors. But this is not enough. There is the need for supportive policies, as well as programs that are available in communities that are easily accessible to families. This means new approaches. These new approaches include strategies such as; community health workers who visit homes and help families understand

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the child's medications, and when and how to use them; working with property owners in an effort to reduce asthma triggers in homes resulting from poorly maintained buildings; building partnerships with community schools to ensure children have access to their medications during the school day; and working with neighborhood pharmacists to make sure they maintain an adequate supply of asthma equipment.

There is evidence that this public health approach is effective. For example, data from the Statewide Planning and Research Cooperative System (SPARCS) indicates that between 1997 and 1999 asthma hospitalization rates fell 13.5% citywide. The greatest reductions, 25.6% were reported for the Bronx. This means that hospitalization rates for children between the ages of 0-14 years living in the borough fell from 16.6% per 1,000 children in 1997 to 12.3% in 1999. These changes may be a reflection of many factors or combination of factors that includes the Department's new asthma initiatives initiated in 1997. We at the Department of Health find these changes very encouraging. We know that to sustain these changes over the long term will require the bringing together of many stakeholders in community partnerships. It is important for us to continue to work to ensure programs are coordinated, services are integrated, that we identify problems early and work together to find solutions.

Louise Cohen, M.P.H.

New York City Department of Health, Director, Childhood Asthma Initiative

A good deal has been accomplished since the Childhood Asthma Initiative was launched in 1997. We are now involved in many new and exciting projects providing support to community and clinical asthma projects across the city. We have entered into partnerships with many community agencies, collaborated with many city agencies, and sponsored professional development and continuing education, like today's all day conference. We have also launched a broad based public education campaign and provided case management services to hundreds of children and their families in the Bronx. These case management services more than likely account for the encouraging decline in asthma hospitalization rates that we are beginning to see in the Bronx. I would like to tell you more about this program, and what has been accomplished. But first let me give you an overview of the Childhood Asthma Initiative, what we hope to accomplish, and some of the activities we are engaged in an effort to improve outcomes through this new public health approach to asthma referred to by Dr. Neal Cohen.

The mission of the city's Childhood Asthma Initiative is to reduce illness and death from childhood asthma in New York City. We endeavor to do that by engaging in a number of activities. These include strengthening the ability of families, schools, communities, health care institutions and city agencies to control and prevent asthma; building on existing research, educational and clinical efforts resulting in a coordinated and comprehensive effort to understand, treat, and prevent asthma in New York City; and developing linkages among health facilities, schools and city agencies. Important goals are to reduce hospitalizations throughout New York city, while paying special attention to high risk populations and neighborhoods. Since the Initiative was established, we have engaged in a number of activities to improve family management of asthma, promote state of the art medical care, control asthma by reducing asthma triggers in the home and school, monitor and track the number of people with asthma and increase community awareness about asthma.

The South Bronx and Hunts Point Childhood Health Promotion Initiative incorporates these strategies. We believe the initiative is making a very real difference in the lives of asthmatic children and their families. The initiative was started in 1997. We began

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by building partnerships among medical providers and social service agencies, helping families by providing case management services, and working with neighborhood schools. The program was enormously successful and serves as the model for five community based asthma programs currently in operation in all boroughs. We attribute much of the success of the program to its grassroots beginning, which brought several community groups together. Case management was integral to the approach taken by the program. Community health outreach workers worked closely with individual families providing many services that included asthma education, help with monitoring symptoms and use of the Asthma Action Plan. Families are taught how to make home assessments that help them understand what triggers a child's asthma, and how these can be prevented.

We are planning other projects based on an integrated public health approach that we believe will have an impact on childhood asthma. You will be hearing about a new effort that is underway to link the many asthma efforts and initiatives in New York. The New York City Asthma Partnership will bring individuals and organizations together to share resources and information to develop policy initiatives that we at the Childhood Asthma Initiative are confident will ultimately reverse the asthma epidemic in New York.

WORKSHOP PRESENTATIONS

SOCIAL WORKERS MAKING A DIFFERENCE: FROM RESEARCH TO PRACTICE

Workshop Overview

The presenters discuss two specialized programs for the development and delivery of health care services to children with asthma in urban areas. The National Cooperative Inner City Asthma Study, funded by the National Institute of Health, identified strategies effective for the delivery of health care services to inner city children. Many of these strategies were integrated into the service model developed at Mt Sinai Hospital Pediatric Pulmonary Health Care Team. Both projects illustrate the important role and contribution of social work.

The National Cooperative Inner-City Asthma Study

Presenter: Melissa Saperstein, MSW

The National Cooperative Inner City Asthma study was undertaken to learn more about best practices in the care and management of the treatment of children with asthma living in inner city areas where rates of asthma are especially high. The study also examined the unique contribution that social work could make on the health care team.

The study was carried out in two phases: Phase one involved the identification of eight hospitals for special funding that would serve as the sites for the programs. Two of the sites selected were in New York City, Mt. Sinai and Albert Einstein School of Medicine. Study participants included children between the ages of 4-9 years who were diagnosed with asthma, and their families. Phase one drew heavily on the use of home visiting to enable us to study factors in the children's home environments and to learn more about the social dimensions of the illness.

Four study areas were identified in Phase One of the study. These included access to care, psychosocial components, adherence and environmental factors. A number of professional disciplines were considered to implement the intervention—nurses, physicians, and health care educators. However, given the four study areas, it was decided that social work would be best suited because of its person-in-environment approach.

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Two groups were used in each of the selected sites. One group had a social worker; the other did not. This allowed us compare differences in outcomes between the two groups. We learned that social workers made a real difference in promoting more positive health outcomes for children. Paraphrasing from the study manual: ‘social workers were found to be uniquely qualified to assess and understand the complexity of the social environments of inner-city families and the implication of these for the management and treatment of children diagnosed with asthma.’

We discovered early, that the knowledge of families participating in the study was incredibly high. What they lacked were skills for making effective use of that knowledge. Therefore, we wanted to help families learn how to use this knowledge in the effective management of their children’s disease. In addition to the primary goal of the study - to improve health outcomes for inner city children with asthma - asthma treatment and asthma management, improving communication skills with health care professionals were established as important secondary goals. The social worker played a central role in the achievement of these goals.

The role of the social worker

All of the social workers participating in the study held the MSW degree. They were referred to as “asthma counselors” instead of social workers. We used this title because we wanted to convey that they had specialized expertise in asthma. The social workers/asthma counselors received extensive and comprehensive training conducted by physicians and other health care professionals. Social workers, of course, are not authorized to prescribe medications. They do however, play an important role in interpreting the effects of the medication to parents, and helping parents understand and manage their children’s medication. Therefore, the training included content on medication and asthma management. The role of the social worker was multifaceted and included client empowerment, linking families to other community service providers for essential services, and advocacy. Social workers were also responsible for educating families about asthma, but this was not a predominant aspect of their role. The primary role involved providing supportive counseling to families around asthma, as well as making mental health referrals, and school advocacy.

Next, I would like to talk about the study approach or method. The program was designed

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so that there was uniformity across all programs sites. This was important to ensure we were measuring the effects of interventions that were using comparable service strategies.

Study Approach

The study was implemented over one year. The service strategies included adult and children groups, individual sessions and telephone contacts. In addition to direct client contacts, the program also provided essential concrete services. These included exterminator services with special applications for children with asthma to prevent allergic reactions. We also provided mattress and pillow case covers, because there is a correlation between dust mite exposure, allergies and asthma. And, if the families requested this or were willing, we also referred them to smoking cessation programs when these programs were available.

A total of sixty families participated in each of the sites. And, as noted earlier, one group was assigned a social worker and the other was not. Three of the participating hospitals had Spanish speaking participants and social workers. This enabled us to have a “sub-study” and an opportunity to examine the implications of culture for asthma management among Spanish-speaking families.

Beginning sessions with the adult groups included a description of the study, purpose and goals and expectations. Content related to asthma included sessions on communication with physicians that addressed issues such as how to describe symptoms, and explanations of the effects of medications on the asthma patient. We also discussed problem-solving strategies and behaviors that were effective for the management and coping of asthma. There was content on environmental triggers, and other conditions that contribute to or prevent asthma attacks. And, of course, sessions devoted to a variety of issues related to medications. There were also opportunities for participants to raise other topics of interest and concern.

Topics covered in the children’s groups were somewhat similar but offered at age appropriate levels. We used the video “Roxy to the Rescue” to help children learn strategies for preventing asthma attacks. The video is available in English and Spanish. The children love it, which makes it a wonderful educational and fun tool. The Asthma Counselors also used the video with parents as an effective educational tool.

The individual sessions provided an opportunity to follow up and clarify issues

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introduced in group that were unique or problematic for individual families. The groups also provided an opportunity to address what had been identified in the assessment process as their specialized needs or risks.

Now I would like to elaborate with some examples of the four study areas:

Adherence—This is related to children taking their medication while in school. We chose to use the term adherence instead of compliance to avoid communicating an adversarial relationship between participating families and health care providers. We knew that the families were not intentionally disregarding the medical plan established for them, but there were reasons for non-adherence. If we could find out what these were, we could then offer the kind of services that removed these barriers and made adherence more likely.

Let me give you two examples of barriers that may prevent a family from adhering to the doctor's health care plan. Often preventive medications are prescribed to be taken three times a day, morning, noon and night. It may be difficult for school aged children to take the noon medication when they are in school because there may not be a nurse on premise, or children may be embarrassed if their peers see them taking medication. Since there is some flexibility in taking preventive medicines, if a social worker/asthma counselor was involved, the parent can be encouraged to talk with the doctor about taking the noon medication at another time. That's a very simple solution that will enable the child to take the medicine three times a day. Another example, with steroids, families may be hesitant to use these because of perceived negative side effects. In reality, inhaled steroids are quite different from oral steroids. So in educating parents about how to communicate with physicians, we help them know what questions to ask the doctor about the effects and difference between inhaled and oral steroids.

Environmental triggers – Some of the more common environmental triggers, are smoking, mildew, dust, mold, roaches, rats and pets [see Asthma in the Home Workshop]. Children residing in inner city neighborhoods are at greater risk for many of these because of high poverty rates and exposure to social problems associated with poverty. And as social workers we know that behavioral change occurs slowly, and some behaviors we see may be related to “survival needs” of the families. We recognize this, and would never expect a family to get rid of family pet, because we know that many have a cat because of problems

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with mice. But we might ask the parent to keep the pet out of the child's room, and off his or her bed. And, we might help in getting the extermination services they need to control mice and rodents; some may even be more willing to find a new home for a pet.

Deteriorating and substandard housing and poor upkeep by landlords contribute to environmental triggers of mold and mildew--the result of leaks and faulty plumbing. We address these conditions by providing extermination services. Social workers are engaged in direct advocacy and other activities that support client empowerment in an effort to ensure that landlords are in compliance with standards established in city housing codes.

Access to care -- Most of the families participating in the study did have medical insurance. While insurance was not an access barrier, the study revealed other barriers. For example, restricted clinic hours prevented parents who worked during the day from using preventive health care services. There were language and cultural barriers related to both client and physician. English was not always the primary language of clients or physicians, which posed many communication barriers. Transportation was another barrier. Our program attempted to address all of these—identifying health providers open on the weekends and evening, providing translation, and interpreting the possible implications of culture on the use of health care services to physicians as appropriate.

Family related problems – We also found that families were coping with additional problems including addiction, children with special health problems, developmental delays, poor parent/child relationships, and poor parenting skills. All these could serve as barriers to care. In these situations, the role of the social worker was especially important. Social workers provided supportive counseling and made referrals for mental health services, and other specialized services that helped stabilize the family.

In summary, study findings indicated that this enhanced service delivery model did result in improved health outcomes for children with asthma and their families. It is possible to replicate this project. However, to do so requires the willingness to invest the additional resources necessary. This research study resulted in many positive outcomes, but there is a price tag. I believe we should be willing to make that investment for our children. I am optimistic that we will do this, because our children are worth it. The cost of asthma treatment is already too high and this study demonstrates that this front-end investment can

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reduce the cost of asthma treatment in the long term.

The Mt. Sinai Program

Laudy Rodriquez, MSW

Mt. Sinai Hospital has had an interdisciplinary pediatric pulmonary medical team for some time. We drew on the experiences of this team in the development and implementation of a specialized program for asthmatic children at the Hospital. Mt. Sinai is located on the Upper East Side of Manhattan and serves a large number of children with asthma in the East Harlem Community. This is a community with high poverty rates, and many families are coping with the effects of social problems that are endemic to urban areas nationally that have a high correlation with asthma. Trends like high rates of asthma-related Emergency Room visits, long lengths of hospital stays for children with asthma, and high readmission rates--prompted interests on the part of the hospital administration to develop and implement a special program for this patient population.

The program implemented at Mt. Sinai Hospital drew on the experiences of the **pediatric pulmonary medical team** that had been serving this population for many years, and integrated many of the strategies that Melissa discussed. I will try not to repeat these. Primary goals of the program were to identify and intervene early with the families, conduct a comprehensive assessment of conditions that were contributing factors, reduce length of hospital stay and reduce visits to the Emergency Room. We also wanted to improve the coordination of services and continuity of care for families in outpatient and inpatient care.

The Asthma Team

The program was started in 1997. The team consisted of a nurse coordinator, social worker, and nurse practitioner. **The nurse coordinator** ensured that inpatient and outpatient services were well-coordinated and integrated. The nurse monitored implementation of the asthma plan, which included the use of medication. Community education is an important component of the program. The nurse coordinator arranged for the team to make community presentations and made sure the nurses on the floor were educated about asthma. **The social worker** was called on to address psychosocial issues and to help families obtain needed social services. Homeless families, for example, may need special assistance because shelter conditions can trigger asthma attacks. Unfortunately, similar conditions in public housing also can serve as asthma triggers. As team social worker, I typically complete a psychosocial

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assessment to identify what the families needs are, and to determine if there are barriers that may interfere with the management of the child's treatment plan. **The nurse practitioner** has a good deal of medical expertise, and is the team member with the most extensive knowledge about the medical aspects of asthma. She is capable of answering questions, educating the public on the medical aspects of the disease, medication, and usually accompanies other team members on home visits to give families the information they need in these areas.

Patient empowerment was a central component of the work. This included mobilizing community resources at the macro level. And at the micro level, this involved helping families learn how to communicate with doctors-- language for explaining symptoms and letting the doctor know when treatment was working or not working for their child.

Another goal of the program was to reduce hospital admissions and the length of hospital stay when inpatient care was necessary. We wanted to keep kids healthy and out of the hospital, and reduce the number of days of in patient care. We also wanted to reduce school absences, which is a big issue for children with asthma. We developed a risk assessment tool that was used each time a child comes to the hospital. This helped identify families who are the heaviest service users, and those who are having difficulty adhering to their medical plan.

The Hospital also uses an **Interdisciplinary Chronic Care Protocol (ICCP)**. This protocol establishes national guidelines for managing the care of children with asthma. We find this very useful for the hospital because it ensures that all required treatment is provided in a timely manner. Also it calls for the integration of services provided by various members of the health care team -- doctors, nurses and social workers.

Health care screenings help us to determine which families are high or low risk. If they are low risk, this does not mean that we do not offer services or asthma education but it enables us to set priorities. For high-risk families, we will be in there right away, calling them to make sure they have everything they need.

In my role as social worker, I often work with patients who are depressed, or who may have interpersonal, behavioral, or moderate to severe mental health problems. Many patients also come needing help with housing. I often intervene with landlords, as well as help parents complete necessary forms for disability and other benefits. I also spend a good

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deal of time working with community schools, advocating for the family and helping them to advocate for themselves to avoid disruptions in the school and educational experience for children, which is a primary goal of the program.

One of the new developments we are currently working on is intensive case management service for families assessed to be at high risk. We are following twenty patients very closely. This means that we maintain frequent contact with them after discharge. We routinely ask questions that let us know how they are doing. When we find there is a need for immediate intervention, we mobilize to take the necessary action.

We are very pleased that this service approach was successful in achieving program goals. For example, when the program began in 1997, length of hospital stay was 3-4 days. Now that is down to 2.6 days. There is a decrease in hospital admissions. Patients who were coming into the Emergency Room on a monthly basis, may not be seen for three or more months. We also made many important inroads on working on the environmental conditions that contributed to poor outcomes and served as barriers to health care management for children with asthma. That is a long-term endeavor and we are still working on these.

PSYCHOSOCIAL COMPONENTS OF ASTHMA:

WHAT SOCIAL WORKERS NEED TO KNOW

Workshop Overview

The mental health of children with asthma is often compromised by violence in the home, school and community, and other social problems endemic to urban areas. Some children have diagnosed mental health problems and take both psychiatric and asthma medications. Asthma is not caused by stress or emotional problems but can be exacerbated by the presence of these problems. Workshop presenters discuss mental health needs of children with asthma, how to reduce stressful situations for them in the home and school, and special issues related to managing health care for children diagnosed with both asthma and mental health conditions for which they are receiving medication.

Sarah Hobson Martin, MSW,
Mount Sinai Pediatric School Health Program,
Working with the Asthmatic child in school

With asthmatic children, some of the symptoms or warning signs of an asthma episode are physical, such as headache, stomachache, increased heart rate, tiredness, or sweating. Others are emotional, such as anxiety, depression, lack of energy, or sadness. These warning signs let us know that we need to do something to reduce the level of stress that can contribute to these symptoms. For children with asthma uncontrolled stress can stimulate nerves that cause muscles in the airways to tighten. This may cause fear, which then causes hyperventilation, which can then bring on an asthma episode. I want to make it very clear that stress itself doesn't cause asthma. It triggers the body to respond in a way that can bring on an asthma attack and that's why helping children with asthma keep stress under control is so important.

The role of the school social worker is to help children manage stressful situations that occur in school. Some of the stressors experienced by children with asthma in school are feelings of difference, being teased for carrying a pump around or for having to go to the nurse on a regular basis, and missing recess or gym. Children recently discharged from the hospital and who are told to "take it easy" for a week may be conflicted. They desire to be

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active with peers, but fear that this may bring about another episode.

Children may act out by refusing to take their medication in school, and they may even deny that they have asthma. This year I had to intervene in a situation involving two second graders scheduled to come to the nurse's office during their lunch periods for medications. One was receiving medication for an attention deficient disorder, the other for asthma. I discovered that the children were teasing each other. The child taking Ritalin was telling the asthmatic child he was taking "poison gas," and this asthmatic child was telling the other that he was taking his "crazy pill." I was able to sit down with the children and their parents to resolve the situation. This is a good illustration of a natural tendency of all children to tease those who they see as different.

Another part of my job as a school based social worker is to help children with asthma learn positive ways of coping with stress. Dancing, reading, art work, exercise, taking a nap, or taking a bath are all coping techniques that I encourage children to use. Some parents who live in the inner city are uncomfortable about their kids playing outside because of violence. At times I counsel parents around negative coping behaviors engaged in by adults that create stress for children. It is important for adults to endeavor to minimize stress for children, and help them identify and relieve stress.

When children have an opportunity to talk about what they are feeling, stress is reduced. When feeling pressures ourselves, we know that sometimes we don't need someone to solve the problem for us, but just need some one to listen and give us an opportunity to vent. School social workers must pay attention to this since some kids will come looking for us because they need someone to talk to. I always help children problem solve around these issues and to come up with a plan about what to do. Also there may be a need just to comfort them during the school day when parents are not around to do this.

Working with parents

We find that parents who lack information about asthma have a tendency to be overly protective of their children. Common examples of this are parents who come into school and sit with their child throughout the entire lunch period to make sure they don't run around. They will not allow their child to take gym, participate in extra-curricular activities or go on

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class trips. These behaviors lets us know that there is a need to reach out to the parent, to give them factual information about the illness, and to help them understand that with proper management of their health plan, asthma will not prevent their child from living a normal life.

Parent education is a very important role of a school social worker. You need to make sure that parents communicate with their health provider on what the child's limitations really are, so that they can have the most normal life possible. Children who experience frequent hospitalizations or visits to the Emergency Room miss many school days. This can have an impact on academic performance and cause them to miss out on extra-curricular activities that are important for their socialization. A *New York Times*, article on May 21, 2000 reported findings of a National Institute of Health study that asthma is the number one medical reason for school absence in the United States. And those numbers are probably even higher in some New York City community districts such as East Harlem, Central Harlem and Washington Heights.

Finally, I do not recommend home instructions for an asthmatic student. A lot of parents are beginning to request home instruction for students with asthma. Parents who make these requests may be overprotective and anxious, and this may be more a reflection of their feelings than what is best for the child. At times this may be realistic because of safety concerns in the school environment. Those of us who work at the district office or even on school-based support teams need to get connected to support systems. We also need to connect with school staff to create school environments where **all** children can feel safe. Community support groups are available for parents of children who have asthma. These groups can help ally their anxiety and help them realize that their children can lead normal lives.

Working with school personnel

Every year as school social worker, I am responsible, along with the nurse practitioner and medical assistant, to provide asthma education to teachers and school personnel as a part of the School District's staff development program. The training gives teachers information about the medical dimensions of asthma, and how to identify a child that might be having an acute asthma attack. It also provides information that helps teachers

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understand how stress can influence the social adjustment and academic performance of the asthmatic child. In conducting the training, I encourage teachers to reach out to families when they know there is an asthmatic child in their class to make sure that child has the most normal educational experience possible.

Training also helps teachers learn techniques for conducting stress-reducing activities like visualization and breathing exercises with children. I've taught teachers to use these in the classrooms before citywide tests with all of the children, because they become so anxious they are almost in tears before these tests begin. When children with asthma feel that an episode may be coming, teachers can walk the child through these exercises, asking them to close their eyes and visualize relaxing scenes.

Asthma support groups can also be used for children in school. We developed a curriculum in 1995 that targeted 5th and 6th grade students. It provided asthma education around medication, how to cope with stress, and how asthma affects the body. Groups are good because children are naturally social, so it reduces the feeling of difference. It allows staff to reach more children, since it is almost impossible to see all students individually because the numbers are so large.

Work with Community Agencies: It is important to know what community resources are available because we need to know where to refer families to get the services they need, especially for more serious mental health problems for children and adults, and for children with developmental problems. It is important for the school social worker to complete a comprehensive assessment. This becomes the basis for a treatment plan that identifies the various services child and family need. Social workers also should know about health care plans and insurance coverage of families, especially if they have mental health coverage. I have so many families that come back to me who were referred by another social worker to an agency that doesn't take their insurance. With managed care, mental health visits are limited. Families need to know all of this early on. If they know what to expect, they are less likely to become discouraged and more stressed. Because families typically receive services from many agencies, case management conferences scheduled on a regular basis that bring key staff people together who are seeing the family members is also a good practice. This ensures that providers are working to achieve complementary goals, and that the family

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understands the different roles of these agencies.

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Gwendolyn Florant, CSW,

Program Director, Harlem Center

Steinway Child & Family Services, Inc.

I am the Program Director at the Harlem Center of Steinway Child and Family Services. We are a mental health community-based agency. I will be talking about mental health issues confronted by children with asthma. According to the American Lung Association, an estimated 4.8 million children under the age of 18 are diagnosed with asthma. And there are many more that have not been identified.

Asthma prevalence rates are quite high in Central Harlem, the catchment area served by my program. Asthma may only be one of the problems of children who are seen in our agency. A child may be referred because of an attention deficient disorder, behavior problems, conduct disorder, adjustment problems, or depression. Then we discover at intake that another child, a sibling or another member of the family, is also asthmatic.

We conduct a comprehensive psychosocial at intake for all children. This includes a family history, a medical history of the child, and educational history. We also look at conditions in the environment that contribute to the family's problems. This enables us to develop a treatment plan that addresses the multiple factors that impact the family and child. At our agency we try to do a holistic total package. We believe in incorporating the mind, the body, and the spirit.

Many children are coming in with emotional and behavioral problems because of stressful situations in the home. domestic violence, and physical and verbal abuse are not uncommon problems for the families that we see. Many of our referrals are of children who are being reunited with birth families after being in foster care for a number of years.

Foster care: The reunification of children with their birth families is a desirable child welfare goal. Nonetheless, this can be stressful for the child and family. If the child has had a long stay in foster care, and has been in the same foster home, he/she will experience feelings of separation and loss even though returning to the birth parent. If the child is asthmatic he or she may be leaving a foster parent who is well educated about management of the illness, and the birth mother will need to learn how to take on that role. Older children

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may have some feelings about taking medication if a parent is a recovering addict. We see many children who have been in foster care and are dealing with stressful situations that can trigger asthma because of associated feelings of anxiety, frustration, sadness, and anger.

Sexual Abuse: Most children in the child welfare system have been neglected and not physically abused. We do, however, see children in our program who have been victims of sexual abuse. The perpetrator may have been a family member, or a non-relative. Our first responsibility is to ensure that the child is not at risk of further abuse. We work closely with the Administration for Children's Services to make sure that the child is safe and no longer at risk. Even when the child is not in imminent danger but has this as a part of their experience, post-traumatic stress disorder may be an issue for them. We have to be aware of this when working with children with asthma who have experienced physical or sexual abuse. These children can have very complex mental health needs that are exacerbated by asthma.

Violence and loss: Many children are fearful of going outside to play because of gangs. To me it is understandable why children will feel stressed if they are in fear that they will be beaten up whenever they leave their homes. Unfortunately, for some children, triggers can sometimes be simply related to going outside and having to deal with stressors in their neighborhoods and communities. We are also dealing with children who have experienced multiple losses and emotional trauma. There has been a decline in incidents of random violence and drive by shootings. But gun violence continues to be a reality for the community. This brings a lot of fear, anticipatory anxiety, and feelings of insecurity. Also, many children have lost parents and close relatives to HIV/AIDS. In light of this, there are very real reasons for some children to feel stressed. We always complete comprehensive assessments of the family and neighborhood to identify potential sources of stress, look for symptoms of stress in children, and provide services that help them reduce and cope with these situations.

Family and community-centered approach: It is important for mental health providers to look at the family as a system. It is also important to look at larger systems that impact on the family; the neighborhood, the schools, and other vital community organizations. You cannot work exclusively with the child. They are dependent on adults, and look to adults to provide emotionally nurturing experiences for them. This is why my program, as a matter of

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policy, works with the parent or guardian who is responsible for the care of the child. We think of asthma as a family disease because all family members must make accommodations.

It is important to talk with parents to gain information that can help us understand why and when the child's asthma attacks are occurring. Regular physical examinations are important to rule out medical causes. Talking with the parents helps us to identify situations in the home that may be creating anxiety and stress that can trigger the asthma. We talk openly with the family about problems like domestic violence and sexual abuse. Mental health workers know that these problems can be treated like family secrets because of tremendous feelings of guilt and self blame. We don't want the family member or the caregiver to feel they are being blamed. So we try to create an environment of trust to make sure we are working in partnership with parents. We should also remember that parents themselves are often feeling overwhelmed and stressed out, and it may be necessary to provide respite services for them to minimize these feelings.

Stress-reducing techniques: We use many relaxation techniques that include relaxation music. We also encourage clients to use breathing techniques so that they can create feelings of calm for themselves, and learn what works for them in reducing stress levels. We help the children use journals so that they can keep a record of all that happens to them during the day, and then begin to identify what situations and emotions trigger the asthma attack for them. We will give them a little pad and ask them to record everything that happened to them that day. Then we can talk about this with them and try to figure out what may have been responsible for bringing on the asthma episode. We bring this information to the child's primary therapist who uses it to develop an individualized clinical treatment plan.

Jonathan A. Slater, MD

Director, Pediatric Psychiatry Consultation-Liaison Service

Babies and Children's Hospital, New York Presbyterian Hospital

I work and run the Consultation-Liaison Service, which is a service that does consulting to medically and surgically ill in-patients and out-patients. The Liaison aspect of my function has to do with trying to bridge the gap between different sub-specialty services, as well as between social work and psychology and other disciplines. This is a very fitting

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place to come and speak to an audience composed of many social workers with an interest in the psychosocial aspects of asthma. I think social workers, psychologists, psychiatrists and other colleagues in pediatrics share a responsibility of working together to treat an illness that has so many different components

What I will try to do is help you learn how to think about using medications, how to think about your patients who are on medications, and how these might interact with medications that the pediatrician is prescribing if they are also on psychiatric medications.

Psychopharmacology

First a brief review about what's known about psychopathology in children with asthma. In general, what we see in terms of emotional problems in children with asthma is that they tend to have more depression than children with certain other chronic medical conditions. If a child with asthma does have depression or anxiety, it significantly increases the asthma morbidity. The incidence of psychopathology, of having an emotional disorder in asthmatic patients, ranges from anywhere from 30-63%. Relative to anxiety, parents may actually be more anxious and report greater anxiety than the children themselves. When you interview a family, parent and child, it is very important to try to look at where the symptoms are occurring. Anxious parents in particular may report their children as being more anxious than they really are. They may in effect be reporting their own anxiety indirectly. Mothers of asthmatic patients tend to have higher rates of depression than others.

Severe asthmatics seem to have more behavioral problems. There have been studies looking at children who are ADHD and also have asthma. Their family members have higher rates of anxiety disorders. Family members of adolescents with asthma have higher rates of affective disorders, depression for example and antisocial or substance abuse, than other families who don't have sick children. The literature on anxiety disorders is conflicting on this point. But generally, children with asthma who have psychosocial problems require more medication, especially corticosteroids, and these are among the more serious medications in terms of side effects. These children have greater number of emergency room and urgent office visits, a greater number of hospitalizations and longer hospitalizations. Overall they exhibit poorer compliance with their medication and actually more frequently die of asthma.

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I underscore the need for a very good intake on these patients so that you can isolate particular psychosocial or emotional problems in the child or the family. And target those, in addition to the asthma treatment. Danny Pine, up at Columbia University, studied anxious kids from the point of how they breathe. When you study them in a laboratory, anxious children breathe a lot differently than normal children. Now without going through all the particulars, their breathing patterns are a lot different, and, in fact, they're a lot more sensitive to a carbon dioxide challenge. This is specifically seen in children who have separation anxiety, and to a lesser degree, in general anxiety disorder. And it may be why a child, for example, in a plane or in an elevator where there is a higher ambient concentration of carbon dioxide, may have more somatic symptoms of anxiety. And this may be also why children who are anxious become more predisposed to having an asthma attack.

Earlier today, we heard about breathing exercises. We use very similar exercises up at Columbia, teaching children self-hypnotic exercises and deep breathing exercises, in which we train children to breathe. Danny Pine does this predominately with anxious kids, and we do it with asthmatics. There are identifiable physiological differences in how anxious children breathe that are inherited. There are genetic differences.

Medications and Drug Interactions

Drug interactions are fairly complicated to understand so I am going to try to make it easily understandable by picking a metaphor that I think everyone can relate to. How many people here drive into Manhattan or take public transportation into the city? Well a person entering the city in a car or a train is like a drug entering the body. You have to get into the city, you've got to move around the city, and then if you live outside of the city, you've got to get out of the city. And while you're in the city, you may do a variety of different things while you are there. Now you can have problems at very single level. You can get tied up at the GW bridge, you can get tied up at the West Side Highway, you can be stuck in a traffic jam on 59th Street, and then when you are leaving, you can be stuck in traffic there too. Similarly, drugs are handled that way. They get into the body, they are distributed in the body, they are metabolized in the body and then they are eliminated from the body, usually through metabolism by the liver or the kidneys, when they excreted from them in the urine. So anything that can affect how a drug is absorbed, distributed, metabolized or eliminated,

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will affect how much drug there is in the body. If you have a lot of people coming into the city for the marathon, they can't get out of the city. You have a lot more people in the city that day and they are going to take a longer time to get out. And you are going to have consequent problems from having all those additional people.

Similarly with drugs, you have drugs in the body that can't get out of the body because the kidney function is affected or some other drug is competing with that drug for its metabolism. You are going to have much more drug around. The analogy in the body is that you have a side effect from the drug. Like you have a side effect from sitting in traffic. So the way drugs interact with one another occurs on different levels. One is different drugs compete for a place to get into the body, like too many cars on the West Side Highway. Or drugs compete for the way they're metabolized. You are trying to get into a restaurant and there's a big line outside or you're trying to get out of the city and there are way too many people there because there's competition from other cars; same thing with other drugs.

Now there are different kinds of drug interactions, one, at what we call the receptor level. Drugs enter the body and the way they interact with cells is that they bind onto something on the cell called the receptor, and then changes take place and the drug exerts its effect. The same way you know you come to the city, you go into a restaurant and you eat some food. There is an interaction there and if something affects that, you similarly have effects on the drug in the body, something happens to the receptor. One drug acts on a receptor and another drug acts on the same receptor, you can have competition, and one drug might not be able to get to the receptor, and again has lower activity because in order to act, the drug has to hit the receptor.

There are idiosyncratic drug interactions too. The combination of Demerol and a monoamine oxidase inhibitor (MAOI), an antidepressant, can be lethal. And then the last kind of interaction is kind of an additive type of interaction. You give one drug such as, Valproic acid (Depakote)I, which is used to treat manic depression. Valproic Acid can cause a tremor. If you give another drug like Albuterol for asthma, which can also cause a tremor, along with Depakote, you could get more of a tremor. When you try to sift through the material on this, you look in the PDR (Physicians' Desk Reference). This lists every single possible thing that could ever happen to you when you take a medicine. This is usually very

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frightening to parents. And I think that you have to keep that in mind when you look in the PDR.

When my patient is on Ritalin or Prozac, and he is also being given Albuterol or Prednisone, do I have to worry about that? You go to the Internet. You type in the name of your favorite medicine or a list of medicines, and you click and it will spit out for you whether or not there is a known interaction between the drugs you entered. Very easy to do; it's what I do; it's what pharmacists do. It's certainly not absolutely complete however, because there may not have been published literature on using those two drugs together. So certainly there is that possibility with a new drug. You know for example, Singulair, a newer drug that is used for asthma certainly hasn't been tried with every single psychiatric medicine. So there might not be literature or data on combining it with a particular medication. You can't be 100% sure there won't be some interaction you don't know about. And a lot of times the side profiles of drugs come out after their release.

You can't be completely sure, but certainly a social worker or a family member/parents can go to the Internet. Of course the Internet can be very overwhelming, but if you know where to look, you can be very good at identifying potential problems. And I think the more people that are looking and asking questions the better. It is important to try to figure out if you have a potential interaction between an asthma medication and a psychiatric medication.

For example, I'll cite a study later where certain types of anti-depressive tricyclic anti-depressants were used with asthma patients. And tricyclic anti-depressants can sometimes raise your heart rate. There was a concern that patients who were studied with asthma on tricyclic anti-depressants, had elevated heart rates. Well it was found that even before the anti-depressant was added, there were elevated heart rates just on asthma medication, and actually when the anti-depressant were added there was really not more of an increase. If you can, you try to use objective measures. You take a kid's pulse, or you have the nurse take the kid's pulse or the blood pressure. What I usually try to do with more subjective measures: Does the kid feel jittery? Have them keep a diary. You know every day. He can use a simple rating scale, you can say 0-3, 0 is no anxiety, 1 is a little, 2 is medium, 3 is a lot. And you can chart it in relation to medication and see if this from a

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medication or is it not.

There could be reports of symptoms in kids that they have on a day to day basis, because of all the stressors that were previously mentioned, that really have nothing to do with the medication. And before you think, “Oh, the child is more anxious because he is on Albuterol or Prednisone,” for example, take a look at what is going on in a child’s life. When did the symptom begin? Did it predate the medication, for example? If he didn’t take the medication one day, did he have the symptom, etc. And what we often do with medications in order to really be sure, is not to make too many changes at once. You don’t raise the Albuterol and Prednisone, and add the Prozac, at the same time on a child, because if you have a side effect, you won’t know what caused it. Similarly, if you think you do have a problem, you reduce the dose of one medication or you discontinue one medication for a couple days and see if the symptom gets better.

We have kids on immunosuppressant regimens sometimes who get organ transplants who smoke cigarettes or marijuana, and the enzymes of the liver get induced and the drug levels drop. The kids have organ rejection. So asking kids things like marijuana, cigarette smoking are important, not to find out all the bad things they are doing to hurt their body, but because, from a medical standpoint, it can greatly effect how drugs are metabolized.

Now the most common emotional symptoms or the most serious symptoms we see relate to systemic steroids, i.e. steroids taken by mouth, or intravenous steroids. This happens when a child is really ill and comes to the hospital and gets Solumedrol intravenously. Those are the most common routes that are going to cause emotional symptoms. Inhaled steroids don’t get systemic levels as high as steroids that are taken by mouth or IV, so you don’t get as many emotional side effects; steroids can cause anxiety, restlessness, and significant mood swings, including depression and actual psychosis. You can get very severe side effects from steroids. You usually see these symptoms on higher doses of steroids or during the phase in which steroid dosages are being raised or steroids lowered.

Steroids on the other hand, are one of the mainstays for very serious asthma and can be quite effective, so I don’t want to leave you with the idea that kids shouldn’t be on steroids. I am just pointing out to you that children can sometimes react to steroids in an

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adverse way and sometimes if they need to be on steroids, but are having significant emotional symptoms, we will co-treat them with medicines that will control the anxiety or the mood swings. And then when they come off the steroids, we take them off the psychiatric medicine. That is a very common thing we would do if the child needed steroids and developed serious emotional symptoms when on them, but truly benefitted from the steroids.

Now there's also been some recent research showing that actually steroids can impair memory. So I think we generally try as best possible not to manage kids on oral steroids chronically. In some cases children may take more steroids because of psychosocial issues and because of noncompliance. They don't take their other asthma medications regularly and, then they have a really bad episode, and need to come to the hospital. Perhaps, in some cases, if they were taking their inhalers all along, they would never be in the hospital and put on steroids in the first place. So this is where the kind of grass roots level work has to come in. All of you are in the trenches with these kids, trying to get them to take their medicines on time and to identify problems in the family that might influence compliance. There are some medications which shouldn't be used in children with asthma, primarily the older anti-psychotics, like Thorazine. During acute asthma attacks they shouldn't be given because they are very sedating and they affect how you breathe. Propranolol, which is a beta-blocker used for high blood pressure, is occasionally used in kids who have explosive attacks of anger. They shouldn't be taking it because it can cause constriction of the airways.

Now there is not a lot of literature on using psychiatric medications and asthma. In one study looking at the cardiac side effects of psychiatric medication in patients with asthma, tachycardia (increased heart rate) was examined. At baseline (before psychiatric medication was introduced), 42.5% of the children had increased heart rates on asthma medication, and it went up about 10% when they were given Tricyclic anti-depressants, or TCA's. A third of them at baseline had high blood pressure and then it went up a little bit on the anti-depressant treatment. The other symptoms that were experienced were dry mouth, sedation and things like that. We don't really use Tricyclics much anymore. We use newer medicines like Prozac and Zoloft and Paxil, the so-called serotonin re-uptake inhibitors, or "SSRI's." These medications affect heart rate and blood pressure minimally.

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Now what psychiatric medications do we commonly use in asthma? Acutely, we use Benzodiazepines, such as lorazepam (Ativan), diazepam (Valium), and midazolam (Versed). They don't particularly interact with asthma medications. They tend to be well tolerated. In a very acute panicky asthma patient, we might use a benzodiazepam acutely for anxiety. For more chronic symptoms, we might use SSRI's. None of these medications have particular bad interactions with asthma medications, but you might occasionally see additive interactions meaning such as a tremor on Prozac. For example, if you have Prozac added to Albuterol, the tremor might become worse.

What I am trying to teach you all is just an approach to understanding medications and asthma medications and how to understand how drugs that your clients are on might interact with one another. And I think above all, there are sources of information for you to consult if you have a question, the Internet, the pharmacy, the physician, or asking the parent.

The last thing I'll leave you with is the importance of asking parents if the children are taking any other herbal types of medications or any alternative treatments for asthma. More and more we are realizing that there are drug interactions with herbs, such as pharmacological effects on metabolism that occur with say St. John's Wort, with licorice root, or with ginkgo biloba, for example. All these things that patients are taking can really interact with other medications, and they may cause systemic side effects themselves. You could get Hepatitis and kidney problems. Although something's natural and grows in the ground, it can still have pharmacological activities or can interact with a drug or affect the body in an adverse way. A survey in our oncology clinic was recently done at Columbia. It was found that 70% of the parents were giving their children alternative drugs without telling the physicians. A lot of times they are embarrassed to tell you that. They feel you're going to be upset with them or they feel like it's silly. I think alternative remedies can be absolutely terrific and work quite well, but we clinicians have to ask before most parents will tell us.

CULTURAL COMPETENCE

Workshop Overview

The presenters address a variety of cross-cultural and diversity issues illustrating how culture and health beliefs influence use of health services. They discuss the role of social workers in advocating for culturally competent health care services and practices for all ethnic and racial groups, especially disempowered and marginalized groups. Special populations discussed are Chinese, Latinos, Africans and African Americans.

Bakary Tamdia, Bilingual counselor

African Services Committee Inc.

African Culture

Cultural competence is more than language translation. Let me begin with an example from my work to illustrate. I was translating for a nurse who wanted me to ask the patient if she had received genetic counseling because she was married to her cousin. I made two observations from this exchange. First, genetic counseling meant little to this uneducated woman. Second, the nurse was making a culturally biased assumption that there were problems because the patient was married to her cousin. She did not know that marriage among cousins is common in the African culture. My mother and father are cousins. I am here and quite healthy. Translators are often used with non-English speaking clients, but translation is not as simple as just translating the words verbatim. Being part of the African culture allowed me to fully understand the meaning of that situation for the patient, and the inappropriateness of the nurse's expectations.

I want to share some information with you so that you will have the knowledge to work effectively with African people. Africa is a continent of more than fifty countries, comprised of many ethnic groups that speak many dialects. There is much in-group diversity, and you may find more than one hundred different languages within some countries. Besides the influence of Islam and Christianity, African society and culture has been greatly impacted by colonization and cold war structural adjustment policies. These factors make the social dimension of asthma treatment very important.

I will focus on three areas in my discussion, decision-making, communication and

preventive medicine.

Decision-making

Decision-making is important because decisions must always be made in medical treatment. In African culture, decision-making doesn't work the same as in the United States, especially when it comes to women. American women can make their own decisions, and do not need authorization from anyone else to make decisions for them. But in the African culture, there is a question of power relationship in the families. As I noted, there is much in-group diversity among Africans. Some African immigrants are from societies organized around a patriarchal structure, which means that women will not have decision-making power in the family. When working with an African woman in the U.S. who appears tense if asked to sign a consent form, should not be interpreted as a refusal or a rejection of the treatment, but rather as a reflection of her culture. Women do not make decisions independently of their husbands. Unmarried women look to their brothers, fathers or other males in the family to make decisions for her. Similarly, younger brothers will look to their older brothers for authorization.

Well-intentioned providers often will try to change and reshape the African woman's decision-making behavior. But this can have an opposite effect, creating problems and conflicts within the patient's family by undermining the authority position of the male. That is why it is very important to avoid assumptions that can result in culturally incompetent practices that are not beneficial to the client or provider. If there is no positive change in service outcomes, it may mean that the goal you are trying to accomplish doesn't make sense to that patient. Therefore, it is important to set goals in consultation with the patient to ensure that they are consistent with the norms and traditions of the patient's culture.

Communication

A growing number of African immigrants arrive in the US who do not speak English. We at African Services have been providing medical interpretation services to hospitals throughout New York City. Americans tend to think that everyone speaks English. This is a Eurocentric assumption that is not supported by the reality of life in the United States. Education levels of patient must also taken into consideration. Even among those who speak English, it is necessary to be aware of the individual's educational level. If you assume that

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your patients are capable of understanding all that you are explaining to them, especially complex medical terms and conditions, negative consequences may occur. That was exactly what happened in the case example I gave at the beginning of my talk. The woman to whom the nurse was speaking was uneducated. Therefore, a complex concept like genetic counseling had little meaning to her.

Preventive Medicine

We know that when it comes to asthma, the prevention aspect is crucial. However, in Africa, especially in poor countries, people are dealing with issues of day-to-day survival. Consequently, preventive health care is given a low level of priority. Colonization, exploitation, structural adjustments and the misuse of national resources by corrupt political leaders, have had dire consequences for the medical infrastructures and the availability of trained medical personnel. Let's take a look at a hypothetical small African country. Because of these conditions, the monthly operating budget for the health department of such a country may be less than \$10,000. How can it afford to focus on preventive health care with a such a small budget and while facing pressing life and death health care issues? Mozambique is a very real example of this. There are approximately 2 million land mines buried in the soil in Mozambique. The presence of these land mines has resulted in more than 80,000 amputees among the population. The cost of removing just one of these mines is \$300-\$1000. When you add the burden of international debt to all of these problems, you can understand why preventive health care is given low priority.

In conclusion, cultural competence is more than simple translation. When the health care professional is a member of the same community as the patient, this increases understanding of the patient's perception of his/her environment, world view and interests. But more often than not, social service and medical providers do not work exclusively in their own communities, but provide services to clients whose customs, values, and culture are different from their own. This obligates all of us to learn more about culture and how this influences health care practices to avoid being at a disadvantage to our patients. The provider can become a barrier to the client receiving the services they need if they do not have this understanding. I hope that my sharing of this information will be useful to those workers providing health services to African immigrant patients. Let me leave you with a

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quote from Sir William Osler, that highlights the cultural dimension in medical treatment. “It’s much more important to know what sort of patient has the disease, than what sort of disease the patient has.”

**Betty Cheng, MSW, Flushing Primary Care Center,
Charles Wang Community Health Center - Chinatown Health Clinic.
The Chinese Community**

I’ve been working in health care for more than 15 years, mainly with the Chinese population. Because I am bilingual, I have translated for patients numerous times. But nobody ever asked me if I did a good job or how my translation was. I think that I did a good job, and did the best I possibly could, but I didn’t really have any special training. I learned on my own. First, I had to learn the medical terminology in English. As a social worker working in a health care setting, you need to learn that anyway. But at the same time, I also had to learn it in Chinese. The patients would never ask about your training or competence because they are so grateful that you are helping them. It is the same with the providers -- they are grateful because you are doing them a favor. I don’t think that it’s good for other staff members to feel you are doing them a favor. When that happens, questions about competence are sometimes ignored. Unfortunately, this has been happening in most of the hospital settings nowadays since few hospitals have designated staff members who are bilingual and responsible for doing translation. Often patients understand English but do not understand the medical terminology, the diagnosis, and treatment because their level of understanding of the English language is not that advanced. Language barriers cause many problems, but I do believe a translation service is a good starting point for non-English speaking patients to receive good health care.

The Chinese immigration experience

As social workers and health care professionals, we understand the impact of psychosocial issues on the illness. For immigrant groups, psychosocial issues may be very different from those of American born patients. China is very large, and not all immigrants are from China. Like Africa and Africans, as we have just heard, the Asian population is quite diverse, speaking many different dialects, with different cultural norms and traditions. They may come from China, South East Asia or from South America. Therefore, the

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experiences of Asian people may be quite different among these different groups.

I am not an expert in Chinese culture, and consider myself to be acculturated because I came here at the age of eighteen. Nonetheless, I will draw from my own personal as well as my professional experiences in working with Chinese immigrants. I want to share a little bit about the cultural beliefs, values, traditions, and immigration experience of Chinese immigrants that may have some impact on asthma management of our children.

Chinese people have been in the United States since the 1800's. Mass immigration began after the Immigration Exclusion Act was lifted in 1965. According to the 1990 US census, there were about 240,000 Chinese in the New York City. According to NYC Department of City Planning Statistics, China, includes The Mainland, Hong Kong and Taiwan. It has been the third largest source of immigrants to the city since the early 1970's. In the period of 1995-1996 alone, more than 23,000 Chinese immigrants came to the city. The majority settled in Manhattan (about 41%), Queens (about 30%), and in Brooklyn (about 25%). Because Chinese immigrants came from so many parts of the world, cultural beliefs and socioeconomic backgrounds vary. Some are rich business people; some are highly educated trained and skilled professionals. But many of the families seen in social agencies are from lower socioeconomic groups. They speak different dialects and have unique cultural experiences.

Values

In general, Chinese and other Asians value hard work, respect their elderly and respect authority. Proper conduct and attitudes are stressed according to one's position in the family or in the society. On a personal note, when I went back to work in the Chinese community, it was somewhat strange working with the professionals and the community. Although I came from China, I was from Hong Kong, which was somewhat Westernized at the time. I had to learn the proper business behaviors that are accepted in the community.

Family orientation

The emphasis is on mutual interdependence and family responsibility for individual members. Family life is hierarchical; parents are usually decision-makers and the decisions are made in an authoritative manner with little room for discussion. The family core

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relationship is between the parent and children, whereas in American the core relationship is between the husband and wife. Loving affection is expressed through actions more than through words. Although I never heard my parents say, “I love you,” I knew they would ensure my physical safety and comfort, that there was enough to eat, and all of my basic needs would be met. Chinese and many other Asian groups communicate in an indirect and roundabout manner, suppressing critical comments and emotions. For example, they will not say directly, “I think you are wrong,” but they will communicate this in many indirect forms. It may be necessary for you to figure out the meaning for yourself.

Children are highly valued in Chinese families. If you want to create change, such as a reduction in smoking or the use of incense, one way is to frame the suggestion in the context of what is best for the children. You may get a better response that way. We have to be respectful of family beliefs and not really tell them not to use certain things when we really don't understand the effectiveness of, for example, Chinese herbal medicines.

Health beliefs

We believe in balanced nutritional diets according to the principal of *Yin* and *Yan*. *Yin* means feminine and *Yan* means masculine. In fact they are so-called life forces and mean anything that is opposite, but complimentary to each other. A delicate balance of *yin* and *yan* leads to good health and an imbalance leads to illnesses. The Chinese classify the foods that we eat as having the property of *yin* (cold) and *yan* (hot). This does not refer to the idea of temperature. The *yin* are usually green leaves and vegetables, and *yan* are usually fried and spicy. However, many Chinese do believe in the value of prevention and health maintenance by balancing their food intake according to the principal of *yin* and *yan*. Some of the people who come from southern provinces of China believe in drinking a lot of specially made soups with herbs and herbal tea to maintain harmony of the body functions.

Use of health services

Many seek medical treatment from the Western medical doctors as well as from the Eastern Chinese medicine practitioners. Although the Chinese believe in seeking medical care, they don't particularly value preventive care in the traditional sense of regular routine

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visits. The philosophy is: “If it is not broken, why fix it?” They believe that when one is not sick, it is not important to see the doctor and there is no need to take medications. Many parents then stop giving the medication to their children. Some of them believe that giving children more medication than they need will weaken their system. Instead, they will give their children Chinese herbal teas believed to have medicinal effects.

Chinese families of lower socio-economic status may live in substandard and overcrowded housing. Several families sharing an apartment is not uncommon among this socioeconomic group. So you may have a three bedroom apartments, occupied by 3 families. As recent immigrants, the Chinese may not have health insurance. Health care costs obviously are quite expensive, and they may have brought medications from China that they are still using. It is not unusual for them to send money home to their family in China so that they can get more when these run out.

Appointments are not required in China’s health care system. When they want to see the doctor, they just go to the doctor’s office or clinic and wait. In this country appointments are required, and if patients missed scheduled appointments they may not be seen. In order to improve health care utilization among Chinese, and continuity of care it may be important to create a walk-in system. We have to be sensitive to the cultural needs, while we maintain a standard of care.

Lastly, a translation service is a must for non-English speaking patients. Using bilingual staff from a different department to translate for patients is not fair because usually it causes extra work for that staff person without compensation. Using volunteers who are not provided adequate training impacts the quality of patient care. Let your organization know that they need to hire staff who are bilingual and bicultural, also volunteers need special training. In the long term the presence of a translator is not only beneficial for the patient, but improves staff morale, increases productivity, and creates a more cost effective program.

Communication pattern

The value of respect for authority means that many Chinese do not express their opinion or ask questions of individuals whom they perceive as the authority or who are in

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positions of authority. This tradition promotes behavioral responses that can impede communication for proper care. As I said, the Chinese tend to communicate in an indirect way. They may be asking for help, but if the health care provider is not sensitive, he/she can miss the meaning of what they are trying to say and the opportunity to understand the conditions under which they are living.

Social Circumstances and Religious beliefs

As discussed before, there are many barriers and difficulties of being in a new country. These include language barriers, economic hardships, culture norms that are not acceptable in the country of re-settlement, alienation, social isolation, and discrimination. When a child is sick with a chronic disease such as asthma, parents confronting environmental problems like these, may experience this as yet another burden. So social workers and health care providers must endeavor to help them lessen their burden.

Let me just share with you some the cultural, social, and economic factors that may impede asthma adherence and the treatment effectiveness. Many Chinese are Buddhists, although some are converting to Christianity. Even those who convert continue to place high value on ancestor worship. The ceremonial rituals of this belief include burning incense candles to signify our respect for Buddha and the ancestors. Obviously the smoke and smell can really trigger or exacerbate asthma.

Laudy Rodriguez, MSW

Mt. Sinai Hospital

The Latino Culture.

I want to talk about Latino culture and how it affects use of health services by families with asthma. I work at Mt. Sinai in East Harlem so we see many Latino patients. Working with providers and other hospital staff while trying to be sensitive to the cultural needs of the populations is a daily struggle. As social workers, an important role is client advocacy. To effectively enact the role, we must be culturally competent.

The impact of culture on use of health care services

Latino health beliefs and practices affect children's health because they influence both the ability and the willingness of the caregiver or the parent to seek professional help, and comply with the preventive or the treatment regimen. Culture is important because it shapes a person's concept of disease. There is also much in-group diversity among Latinos. When we talk about Latinos, you have to include Central Americans, South Americans, Puerto Ricans, Dominicans, and Mexicans. There are commonalities among these populations, but also many differences. I am going to talk about some of the beliefs that I have learned from patients that are in New York City that are held in common by many groups within the vast Latino culture.

Latinos tend to be very distrustful of Western medicine. In most Latin American countries the doctor is not the first place a person goes when they are ill. Usually, you go to grandma or someone in the family and use home remedies, religious articles, or spiritualism. If this fails, then they may go to the doctor. Many of our parents and grandparents grew up thinking that all medicines and drug were bad with bad side effects. I still see patients who hold on to many myths such as if they take asthma medications, they will explode, get sick or end up with heart or liver problems. They especially feel that the medications will harm their children.

Negative implication of “steroids”

Parents often associate asthma with steroids. The minute we say “inhaler” or “pump,” they think we are referring to steroids and immediately have a negative reaction.

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We have to explain to parents that inhaled steroids prescribed by their child's physician are generally safe, and encourage them to let the doctor know about negative side effects. We should not try to convince the patient or the parent what they should do in regard to their medication, but educate them about their options and especially the benefits of taking the medication. Having this kind of information can be empowering, and in the long run will enable the client to manage the medication plan themselves and reduce emergency hospital visits because of failure to take medications as prescribed.

The doctor is the medical expert and should provide this information. However, I have been in situations where the doctor becomes frustrated by the patient's anxiety about taking medications. I will often join in the conversation and invite the patients to talk about their concerns. That way, the doctor and patient can have an open dialogue. Often, the anxiety is based on myths that have been passed down through the family. When brought out, they can be openly addressed. This approach helps to dispel myths and increases the doctor's understanding of the patient.

Home remedies

Although there is no cure for asthma, a commonly held belief in the Latino culture is that it can be cured. Therefore, it is difficult to convince them that asthma is a chronic illness that must be managed over the patient's life. Home remedies are widely used by Latinos, and many patients believe that people who use these have been cured. The truth is that some of these remedies may reduce or elevate symptoms for some patients. There are many home remedies including herbal teas, chamomile, oregano, and eucalyptus. I always ask the patient to explain to me what they are taking, how they are using these, and what they believe the effect will be. Any home remedy when used in excess and prevents the patient from taking prescribed medications, can be harmful. Therefore, a good rule of thumb is to respect cultural norms that support the use of these treatments and help the patient feel comfortable in discussing these with you or the doctor. I am asthmatic and know that sometime these home remedies do provide some relief for me. Knowing this, I tell providers if the home remedies don't hurt the patient, let them take them, especially in cases where this does not interfere with necessary prescribed medications.

Naturalistic view of disease

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In the Latino community among some groups, there is a naturalistic view of the disease that includes the hot and cold theory [Not unlike the Chinese culture]. This is the belief that certain foods, herbs and medicines have either hot or cold origins or properties, and a good state of health requires a balance between hot and cold. If you have a disease classified as hot, you would eat cold foods and take cold medicine. The opposite would be true for a disease classified as cold. Asthma is classified as a cold disease. Conflicts can and do arise when there are differences between this naturalistic classification of disease and the patients formal medical regime. There is one trick that the doctors in Latino cultures have used to make patients, who believe in “hot and cold theory” feel more comfortable taking asthma medications. This is to teach the patient to “neutralize” the effects of the medications by taking something cold or hot as appropriate.

Superstitions

Superstitious views support beliefs that illness is caused by the evil eye, sorcery, and envy. Many people holding these beliefs will go to *santeros* and *espiritistas* for help when they become ill. One problem for asthmatic patients is that often, incense and candles used in these practices can be triggers to asthma episodes. Asthma in Spanish is referred to as *fatiga*, which is translated to fatigue. That carries a stigma; it implies disability.

Myths

As mentioned, a common myth is that asthma medications will cause them to explode or get sick and end up with heart or liver problems. Medications are seen as especially harmful to children. Some Latinos believe that if you have asthma and get a Chihuahua, the disease can be passed on to the dog and the patient cured. What often happens is that the dog sheds and its dander can be a trigger for asthma.

Access to Care

Access to care is an issue for many new immigrants of Latino background because of language, lack of medical insurance and if in the country illegally, of deportation. There is a large Mexican population in NYC now and we are seeing many of their children being diagnosed with asthma. Many will not use formal health care services because they fear deportation and do not know they are eligible for Child Health Plus even if they do not have

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a green card. Another problem is that because there are many informal networks and family supports, medications are often shared. For example, one member of a family might have two inhalers and they will give one to another family member. As we all know, there are many different asthma medications and different dosages given in prescribed amounts, so this could cause a big problem. It is important to ask Latino patients about that.

In conclusion, we should always talk to patients about their feelings regarding their illness and medications, we should ask what they are doing to manage the disease, keep an open mind, and try to engage them in a mutual partnership which demonstrates respect for cultural traditions and beliefs.

Sehu Jappe

**Senior Program Officer
New York City, Childhood Asthma Initiative**

The African American Community

I've been with the NY Asthma Initiative for about a month.. Prior to that, I worked with NYC DOH HIV Prevention Services for over a decade, and most recently as a Director of the Correction Community Linkage Program. In this program, we provide aftercare services to people leaving Rikers Island who are HIV positive. When I came to the Department of Health in 1986, I found great racial disparities in health outcomes among New Yorkers. African Americans have by far the poorest outcomes than any other racial group. We are at the top of the charts in every major illness. For black males, the picture is even worse. This is the case for cancer, cardiac disease, diabetes, AIDS, homicide and injury, chemical dependency, and now asthma. I find this distressing. I have come to think that the "stress" of being a black man in today's society is the biggest contributing factor for this. My experiences have also taught me the importance of looking at conditions of the larger social environment and understanding the effects of racism and discrimination on health and well being of Blacks.

Increasing racial and cultural sensitivity

It is crucial to increase awareness of the shaping social factors that impact the people that we serve so that we can be more effective and resourceful in helping them. Historically, people of African decent or American born blacks have suffered from the effects of oppression that has influenced all segments of our society, and that includes the health care system.

Home Remedies

A common thread is the use of home remedies. This may be rooted in our African heritage, where all kinds of potions, healers, shaman, and bush doctors were common practices. Although there exists a long history of conventionally trained physicians, these traditions have held on as residuals of an African heritage. They have also held on because Blacks have experienced exclusion and discrimination in the formal health care system. One has to be tolerant of this propensity for people of African heritage to self manage their health and their suspiciousness of the formal health systems. It is only then that you can attempt to move them into mainstream medicine.

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It is not untypical for African Americans, especially those with limited formal education and of lower socioeconomic status, to try many different home remedies or over the counter medications before they will relent and take prescription medications. Take asthma as an example. Asthma is the number one reason why children are hospitalized. However, the number one complaint on admission is ear infections. In black families, in particular, children have usually taken many medications, including antibiotics before they will be put on asthma medications. We do not fully understand the reason for this, but we do know that having their children on asthma medications can be overwhelming for many families whose lives tend to be crisis ridden.

The “Black Experience”

The “Black experience” is the food, music, speech patterns- a way of life that is affected by religion and much more. While there are universals in the black experience, there are also differences. All Blacks are not the same. As with the other ethnic groups discussed, there is much in-group diversity among American born blacks. For example, the speech, life styles and political views of an African American living in a southern state will be different from an urban northerner. Socioeconomic status or class, and educational level also influence one’s experiences and life style, and perception of the world. Contrary to conventional wisdom and prejudicial beliefs, African American values, attitudes, and behavior are very much family centered. I would say this is important for all Blacks. Children are important and all adults feel responsible for their care; elders are respected and extended family relationships are highly valued.

As I mentioned, blacks are suspicious of formal systems because they have experienced racism and discrimination in them. You will often find an African American client receiving public assistance who looks at the social worker as an enemy and someone who can take their children away. This perception is based on the fact, that black children are over-represented in the foster care system. But we also know that Black children are also four times more likely to live in poverty than other children, and therefore are at greater risk for exposure to conditions that place them at risk of abuse and neglect. These high poverty rates also contribute to high prevalence rates of asthma in African-American neighborhoods.

Historically, hospitals have also been considered the enemy. Because of the poor

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quality of medical treatment generally received by Blacks, some have memories of being told that hospitals are places where relatives entered never to return. And if they returned, they were sicker because it was believed they had been used for medical experimentation. There are many memories of a time when there were “White only” hospitals, and Blacks could not get services. Every black person, for example, can tell you about the case of Bessie Smith, a jazz singer who bled to death because a hospital would not admit her. There are few Blacks who do not know about the Tuskegee experiment. This project was undertaken by public health officials with the approval of the federal government. They withheld treatment from black men diagnosed with syphilis, although drugs were available at the time to treat the disease.

Community influences

It is also important for social workers to be aware of factors in the community that affect African Americans, especially those living in neighborhoods with high prevalence rates of childhood asthma. These are largely disempowered communities, with more than their share of poor environmental conditions and social problems that contribute to these high prevalence rates. This includes deteriorating housing that is poorly maintained by absentee landlords, poor sanitation services, and too many empty lots that are used to dump waste that pollute the air. Social problems such as child poverty, and community violence, create additional stresses that have implications for asthma prevalence rates. These are only a few examples of community problems that will require broad based political activism to fully address.

These communities have also been targeted for marketing products that we know are harmful to our health. For example, as other Americans are smoking less and becoming more health conscious, there has been an influx of certain products in the Black community that target youth and support behaviors that are unhealthy. These include cheap cigars and alcoholic beverages that are marketed to have a special appeal to youth. Cigarette smoking was declining among African American youth a few years back, and now it is on the rise. In the past, if a black youth had the choice between cigarettes and McDonalds, they would choose McDonalds. This is no longer the case; those who have money are choosing to spend it for cigarettes. More of these youth are unemployed and feel disengaged. This makes them

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easy targets for marketing campaigns designed to increase feelings of self esteem. These activities will increase feelings of self-esteem for the moment, but will compromise their health in the long term.

My work has been with young black males. Young men that have asthma often suffer from low self-esteem because they feel that they cannot compete with healthier men of their age group. Competitive sports are very popular for this age group, and is a way for them to excel. Therefore, some will push themselves beyond what they should as a defensive reaction. Others may deny they have the disease and refuse medical treatment. Many feel that, because they are Black, they will have a short life span, and therefore are more likely to engage in risky behaviors –“live for today because tomorrow may not come.” These are all issues that must be taken into consideration in developing and managing health care plans for our young Black males.

ASTHMA IN THE HOME:

CREATING ASTHMA FRIENDLY HOME ENVIRONMENTS

Workshop Overview

Most asthma triggers are in the home environment where children and parents spend the greatest portion of their time. Some of these are within the control of the family, others are not, exacerbated by poor housing conditions that often are in violation of the City housing code. This workshop presents information about common triggers found in the home and how parents can be helped to create in-home conditions that prevent and reduce asthma episodes. It includes an overview of the mechanism for bringing legal actions against landlords who are not compliant with City housing protection laws.

Cathy Breen, RN

Little Sisters of the Assumption

My job title is “Home Environmental Worker,” and much of what I do I consider to be social work. I will be talking with you about asthma triggers in the home and how these can be corrected or prevented. Let me begin by saying that, East Harlem, the community served by my program, has the highest asthma hospitalization rate for children in the nation. The project tries to reduce those numbers by working with families in their homes to correct conditions in the home environment. We work with families for at least one year. Our goal is to improve health outcomes for children with asthma, reduce the number of emergency room visits and school absenteeism. While we work in the home, we also know that there is a bigger picture that contributes to the high asthma rates observed in the East Harlem.

There are many triggers in the home. These include cigarette smoke, cockroaches, mice and rats, pets- especially cats and dogs because of dander, and also birds and hamsters that may be in home or in school classrooms. Other triggers are: carpeting, upholstered furniture, decorative pillows, or other furnishings commonly found in the living room that collect dust. In the bedroom, mattresses, pillows, bedding, stuffed animals can trigger an episode. And, in the bathroom and kitchen, mold and mildew are common triggers because this is where faulty plumbing and leaks are more likely to be found. This creates moist places for these molds to grow.

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Over the year that we work with the family, we listen carefully to their concerns, and make a plan with the primary caretaker, usually the mothers and the grandmothers, to correct some of the more serious problems. Parents and the children themselves are often the best detectors when it comes to identifying what triggers their asthma.

Remedies

Mold and Dust: We use an all purpose solution for mold and dust. It is simple to prepare. One-part Clorox to ten-parts of water, a 10% Clorox solution. It is inexpensive, and can be used to clean virtually everything, including counter tops, sinks, floors, and walls. There are some important precautions that must be taken when this solution is used to clean mold—always use gloves when spraying the area with the Clorox solution; work an arm's length away from your head and away from yourself. Mold that is black/green in color can be highly toxic and dangerous. Do not attempt to clean it. It requires an expert to remove. When you see molds like this, call for help. It is not unusual for tenement housing and older poorly maintained buildings to contain mold that has been painted over. Since paint acts as a nutrient, the mold will continue to grow under these conditions.

Cockroaches: Cockroaches need to eat and drink to survive, so a common sense approach is to cut off their supply of food and water. Food should be covered at all times, unwashed dishes should not be left in the sink or dishwasher, and trash should be taken out daily. Garbage cans should be covered with a tight fitting lid, and plumbing kept in good repair to prevent leaks.

When cockroaches are a major problem, we do a very extensive clean up, with the help of the adult caretaker, which is usually the mother. We ask her to remove everything from cupboards in advance of our visit to the apartment. We bring a special vacuum that sucks-up everything. Unlike other vacuums that have an exhaust pipe, the HEPA vacuum does not; it keeps everything contained. After this, we clean with the Clorox solution, and then apply Combat gel. The gel should be re-applied every two to three months. The gel is expensive, but it works and you can see the results almost immediately. It is encouraging to the family when they see a reduction in cockroaches right away.

Families also have to be encouraged to maintain good housekeeping practices, and also cautioned not to use these applications where food is being prepared, or where there are

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dishes. Of course, they should always be kept out of the reach of the children. It is important to remember that a dead cockroach can be even more dangerous than a live one because it will release particles in the air as it disintegrates.

Rodents: If there are mice or rats, first find out where they're coming from and then plug up the holes. It is good to use steel wool for plugging up holes. A door sweep can be used at the bottom of the door to prevent them from coming in from the outside, or from public hallways. Some repairs are the responsibility of the landlord. We generally contact the landlord, if we have the permission of the family. We also try to contact the landlord when the parent is present. Violations are documented, and we assist the family initiate court proceedings against the landlord. [See Legal Presentation following]

Cigarette smoke: This is very difficult. It is an addiction and a difficult habit for some people to break. The nicotine patch works for some people. We have had more success in helping families reduce the number of cigarettes they smoke. If an adult member of the household is a smoker and cannot quit, we ask them to smoke outside of the apartment, open a window or go into another room and close the door. The family can ask visitors not to smoke when in the apartment, and remove all ash trays which sends a message that the apartment is a “smoke free environment.”

Pets: Pets should be kept away from the asthmatic child. Pets should not be allowed on the child’s bed, and children should also be discouraged from holding animals. If a child has a stuffed animal they are attached to, limit it to one. In general, stuffed animals should be avoided.

Temperature: Extreme temperatures should be avoided in the home, either too cold or too hot, and ventilation must always be adequate.

Solutions

Once triggers have been identified, the challenge becomes effecting change needed to maintain a household where asthma triggers are at a minimum—that may be the most difficult. The families that we work with are often struggling under many hardships and the illness only exacerbates these problems. Many are single female heads of households, and live in substandard housing, and some may be asthmatics themselves. We need to remember

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that these mothers are usually doing the best they can and should be saluted because they face tremendous obstacles in just getting through one day. Many are reluctant to pressure the landlord for fear of eviction, because they have no other place to go. Some contemplate going into the shelter system hoping they'll get a higher priority for housing. We also see mothers who are recipients of public assistance having to report to work, and must leave their children in the care of unskilled caregivers. These substitute care-givers all too often may not know how to care for an asthmatic child, and their apartments may be filled with asthma triggers. In addition, there is the stress created for the mother as she travels long distances to work worrying about her children. The children as well experience stress, because they are in new and unfamiliar surroundings.

We try to help individuals and families. This is important work and must be continued. Unfortunately, as I said earlier, there are problems in the larger environment over which the family has little or no control. We must also look beyond the band-aid approach to advocate for clean, safe, affordable housing that is maintained in keeping with city housing regulations. This must be a right for every child and family wherever they happen to live in this city.

Jennifer Levy, Esq

South Brooklyn Legal Housing Services

The South Brooklyn Legal Housing Services provides legal representation to individuals in obtaining apartment repairs, and to community-based organizations involved in tenant organizing to help groups of tenants obtain building-wide repairs.

There is a clear link between substandard housing and asthma; these conditions create the triggers that you have just heard about-- dust, excessive cold, excessive heat, poor ventilation, cockroaches, rats, mice and mold. We understand that some of these conditions are within the control of the families, but some are not. As a tenants' rights attorney, I see futile attempts on the part of tenants to get landlords to keep apartments in good repair as required by city housing law. These requests are too often ignored by non-compliant landlords, leaving the family in unsafe conditions. When there are family members with asthma these conditions can be life threatening.

I will be talking with you about the legal mechanisms available to enforce compliance with New York City Housing regulations when landlords are not responsive to tenants' requests for repairs. All New Yorkers have the right to a safe and sanitary place to live. There are a network of laws designed to protect this right, and mandate the landlord to maintain a building in good repair. The City can go after non-compliant landlords. Unfortunately, because the agency responsible for the enforcement of these laws is underfunded, or the number of complaints received is so extensive, tenants need to become active to make these laws work for them. Let me walk you through the process for doing this.

The **first step, of course, is to ask the landlord to make repairs.** This can be done on the telephone, by regular mail, or by certified mail with return receipt request. Whatever form, always keep a record of the date of the request and outcome. If this does not work the other options available to the tenant are to **complain to the New York City Housing Preservation and Development (HPD), file an HP Action, withhold the rent, take the landlord to court and ask the court to order the repairs, or make the repairs and deduct the costs from the rent.** These activities can be undertaken one at a time, or they can all be done together. For example, filing for HP Action and withholding rent can be done simultaneously. There are advantages and disadvantages to each approach.

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What most tenants do **first is complain to the NYC Housing Preservation and Development**. As I mentioned earlier, this is the city agency responsible for enforcing housing laws, or the network of laws that hold the landlord accountable for maintaining a building in good repair. All of the triggers referred to are a violation of the housing maintenance code in one way or another. Chipping paint and not keeping the public areas of the building clean are some that have not been mentioned but are also violations of the housing maintenance code. HPD has a Central Complaint number to call to report violations.

After the complaint is made, an inspector should come to visit the apartment to inspect the premises. The violations are listed, the landlord is then contacted and issued a violation notice. This notice contains a date within which the violations must be corrected. If the landlord does not comply by this date, they are fined and HPD is required to follow up. When there is inadequate enforcement or follow up from HPD, we move in to take some steps ourselves.

Even if there is no follow-up, an advantage of making the complaint is that it is now on record and in the city data base. The HUD housing inspector enters each violation in a central data base that can be accessed by all housing courts. That means that if and when you go to court on the matter, the judge can pull up all of the violations that have been entered for the apartment. The disadvantage of this tactic is that it can be a long, tedious, time consuming, and frustrating process. Also, if tenants are living in illegal apartments where violations are extensive and have not been attended to for long periods of time, then the inspector could issue an order to vacate the apartment or the entire building.

A second approach is to file what is called an HP Action. This is a tenant-initiated action that is brought to housing court. In an HP Action, the only action the court can take is to order the landlord to make repairs. It cannot order the tenant to pay rent and does not have the power to evict tenants. This is a special court that has the sole purpose of ordering landlords to make repairs. Any tenant can bring an HP Action. A tenant is defined as anyone who pays rent to the landlord. The tenant does not have to have a signed lease, and this is true for both private and city owned housing. An HP action can be filed in Manhattan at 111 Center Street, and in Brooklyn it is at 141 Livingston St. In completing the required forms, if asthma is an issue, it is important to list all of the conditions that serve as asthma

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triggers. It's good to do this because the inspector will only look at what is listed on the complaint form when they come out to inspect the premises.

There is another form that will give the first court date. This is to be signed by the judge and delivered to the landlord. Then there is a waiver form. There's a \$ 35 filing fee for filing an HP Action. However, if the tenant is at a low income level, this fee can be waived. Housing maintenance code violations are categorized as to severity. An "A" violation is the least severe, and "C," is the most severe. By law, the landlord must correct violations categorized as "C" within 24 hours. They have 3 days for correcting those categorized as "B" level violations, and 120 days for "A" violations.

On the first court date, the major action is for the landlord and the tenant to enter into what is called a "consent order." Housing problems not entered on the initial complaint can be added at this time. In our experience, judges have been pretty responsive to ordering corrections of conditions that endanger health even if these are not in violation of the housing code. We've even had success in upgrading a violation and getting the judge to order the repairs within less time.

Although a tenant may have the order, the landlord still may never show up for court and never make the repairs. This is, in fact, a fairly common occurrence. Many people will give up at this stage. However, it is important to go back to court if the repairs are not completed. The judge needs to know this, and they tend to take the landlords' disregard of orders issued by the court quite seriously. It can be discouraging, but with persistence the process can be effective.

Another tactic that some tenants use is to withhold the rent until repairs have been made. One possible outcome is that the landlord, who will be losing income, takes the tenant to court. This will give the tenant "a day in court" and the opportunity to have the apartment inspected, and a court order for repairs. It is important to hold all of the rent money withheld aside. The tenant's case is strengthened when the judge has evidence that the tenant has the ability to pay the rent, but has been holding pending repair of the violations. To succeed, the tenant must prove that the landlord has been given notice and that the violations do exist. Therefore, it is best to send notices by certified mail to have a record. Photographs and the dates these were taken, as well as explanations about the

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negative effects of these conditions on quality of life and health serve as evidence that the violations are real and dangerous. For asthma sufferers in substandard housing, this can be pretty obvious.

Disadvantages of this approach are that withheld rent can be spent, making it difficult for some to come up with a lump sum amount for retroactive payment should this be ordered by the court. Since the tenant is waiting for the landlord to initiate court proceedings, the landlord may not provide the tenant with the correct date of the court proceeding. In this case a judgment will be made against the tenant, which can be an eviction notice. The tenant is also at risk of retaliation from an angry landlord angry, who may try to force eviction. The level of risk, depends on whether the tenant is in a rent stabilized building or not and the number of apartments in the building. That may be too complicated for me to talk about now. It is important to know that there is a law on the books that the landlord cannot evict a tenant in retaliation for filing a formal housing complaint.

Finally, the tenant may opt to have the repairs done themselves, and deduct the cost of the repairs from the rent. The landlord must be given notice before this action is taken. The first notice should include a requested date for having the repairs completed. If there is no response, a second notice should be sent giving the date that the repairs will be completed by the tenant. The problem with this tactic is that some conditions are so extensive they are quite expensive and require a skilled contractor to complete. If the withheld rent does not cover these cost, some tenants may not be able to make that kind of financial outlay themselves.

This has been an overview of the process. All of these options that I outlined, probably work best in concert, and when people work together.

**COMMUNITY ORGANIZING
Workshop Overview**

The workshop presenters describe three projects illustrating large scale organizing initiatives designed to address systemic, institutional, and structural conditions that contribute to high prevalence rates of asthma in such City neighborhoods as Central and East Harlem.

Building A Community Coalition: A Case Study:

**Barbara Brenner-Director,
Community Relations, Mt. Sinai Medical Center**

I have been active in the community for the past 15 years, representing Mt. Sinai in a variety of coalition activities. I am going to talk about the experiences of the East Harlem Health Committee, a highly successful organizing project in the East Harlem community where asthma prevalence rates had reached epidemic dimensions. For example, a prevalence study conducted by the New York Academy of Medicine of two East Harlem public schools showed that 22% of the student body had a diagnosis of asthma. If we had good prevalence studies, the numbers would probably be even higher. The Academy study provided the rationale for developing a strategy for addressing a health problem of enormous magnitude for the East Harlem community.

Creating a coalition to address asthma involved bringing together many community stakeholders. Not only health professionals, social workers, social service providers and community-based organizations, but we knew it would be important to include consumers as well. It would be especially important to include parents because they live the experience of asthma day to day. Establishing the Committee was a long and sometimes difficult process.

The East Harlem Working Group was established in 1996 as an outgrowth of the East Harlem Community Health Committee. The Committee was formed in 1970 in response to the threat to close Metropolitan Hospital, which served as a catalyst for mobilizing people across many sectors to oppose the hospital closing. It was a very successful organizing effort, and prevented the closing of the hospital. A smaller group of people from this committee decided to stay together to confront institutional barriers that contributed to disparities in health outcomes for East Harlem residents. The group consisted primarily of representatives from community hospitals and community based organizations. All of us who worked in the community understood the reasons for the poor health status of

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the community, despite the presence of three hospitals, two federally funded health centers and many other medical resources, and all kinds of social service provisions in the community. It was related in part to the failure of these groups to develop a means for working together across disciplines, organizational boundaries, and special interests.

Even with all those resources, we were not sufficiently organized to address the serious health problems in the community. The lesson to learn from this is that you may have all of the resources in world at your front door, and still unable to solve a major community problem if there is no well-defined coordinated strategy for making use of these resources.

The East Harlem Health Committee emerged as an initiative to correct this, moving from an issue oriented group that met episodically to become an organized stable group. Over time a stable leadership was formed, and we became a 501(c)(3) non-profit organization with a board of directors, a structure, and with a very clear philosophy and public health mission. Our goal was to rid ourselves of all of the competitive and burdensome attitudes and turfism and see if we could gain consensus as to how problems were to be defined, and then to work together to solve them.

The Asthma Working Group

The East Harlem Health Committee took on a number of different health issues through a committee structure. The **Asthma Working Group** was established in 1996, and emerged from the **Pediatric Health Committee**. Mt. Sinai had consistently provided staff to support this effort since it was the major hospital and medical school involved with the Committee. This was both a benefit and a liability. The benefits were that we were able to draw upon the many resources of the hospital and medical school. The liability is that whenever you have a large institution, a university, a hospital, a medical school, or a large agency, there is the risk that the community agenda may be offset by competing priorities of the larger institution. I find that this is very typical for a medical school. However, although issues have come up from time to time, the Asthma Working Group has been able to work through these to form a strong asthma action agenda that has the support of the Hospital and other community institutions.

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The Asthma Working Group is made up of a true cross-section of representatives of East Harlem. It has brought everyone to the table, which I think is a true test of a coalition. When I say “everybody to the table” I mean elected officials, hospital representatives, social service providers, community health centers, housing organizations, tenant leaders, and representatives of government. Our coalition sought very clearly to bring people to the table from every sector of the community because asthma affects every sector of the community. For example, most East Harlem residents are not home owners. They either rent their apartments from the NYC Housing Authority (NYCHA), or they live in buildings that are privately owned and the landlord is NYC Housing & Preservation Development (HPD). Therefore, representatives from housing organizations, NYC government and tenant leaders needed to be involved.

In the process of undertaking the following activities, the coalition identified a number of gaps in service delivery systems and other critical issues that influence access to health services.

First, we did an inventory of how many programs and services have been created to address asthma in East Harlem. Our initial list totaled 107 separate projects. That number grew to 140 by the time of our final tally. These programs were engaged in a range of activities. Some provided services to prevent asthma, some health education, some case management, and some were involved in some sort of environmental project. We realized that a very clear function of the coalition was to find a way to conduct an analysis of these projects, and devise some sort of plan to evaluate their effectiveness, and integrate these programs to prevent duplication and improve patient utilization rates. The proliferation of agencies established to address asthma, illustrate that asthma was viewed as a health problem of some magnitude for the East Harlem community. However, we had not been able to devise a way to effectively attack the problem.

Second, we endeavored to identify the issues that were most relevant in East Harlem. There was very poor continuity between emergency rooms, primary care providers, schools and parents. There were school rules and regulations that served as barriers to treatment to children experiencing asthma episodes while in school. There was a need for parent education and support. And there was little evidence that children were being taught how to

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manage their own asthma treatment plans. We also learned that many of the health providers in the community were not using culturally competent practices and there was a lack of culturally appropriate educational materials.

Third, we realized that although we could focus on treatment and prevention, if we did not take the indoor/outdoor environment into consideration we would get nowhere. We decided to start with the indoor environment of families because poor housing conditions in East Harlem exacerbate asthma triggers. We were able to obtain funding from the Federal Government and the American Academy of Pediatrics to test a home environmental intervention developed as a pilot program. The pilot program was implemented by the Little Sisters of the Assumption. [See Workshop; Asthma in the Home]

The project was a culmination of coalition efforts that brought many community stake holders together to define a purpose and a problem and then get behind it to secure funding support for a program that addressed the problem. We have also made a submission to the New York City Department of Health and Mental Hygiene that we hope will be approved for \$300,000/year for two years. The money will be used to support coalition activities and a number of discrete projects. Some examples of these are extending the home intervention that has shown to be extremely successful; placing case managers at all of the community health sites; and continuing to test and implement some of the 140 projects identified in the inventory that have proven to be the most effective.

An outstanding challenge that we face is to develop strategies for improving environmental conditions that effect air quality. This will require significant legislative changes in public policy regulating activities like waste disposal and transportation to reduce exhaust fumes from trucks and buses. Our next presenter will discuss these.

**West Harlem Environmental Action, Inc. (WE ACT):
Peggy Shepard- Executive Director and Co-Founder**

Over the past 14 years, I have worked to impact public policy through community organizing and community-based participatory research partnerships. My organization, West Harlem Environmental Action, or WE ACT, is an environmental justice organization. It was created in 1988 in West Harlem as a result of community organizing around the operations of the North River Sewage Treatment Plant, which is located in the Hudson River between 138th and 145th Streets. A state park had been constructed atop the sewage plant.

I was the Democratic district leader in 1986 when community residents initially asked me to help them organize the community and work to get the City to be accountable for this facility. One of the first things that we realized was that residents were having allergic and respiratory symptoms. The children, some of whom already had asthma, were having asthma attacks more often than usual. We began to make the connection between the facility, air pollution, and asthma. By 1988, we understood our need for data and reached out to Dr. Jean Ford, now chief of pulmonary medicine, at Harlem Hospital.

Research for Organizing

We asked Dr. Ford if he observed that more hospitalizations or emergency room visits were coming from specific zip codes near certain facilities like the North River plant. After two years of conducting research, he and his colleagues published a study that indicated that hospitalizations and mortality rates in Northern Manhattan, Harlem in particular, were three to five times those of other communities in New York City. Data from this study armed us with facts to begin more substantive organizing and education of residents around the environmental health linkages. We initiated a strong advocacy campaign targeted to city and state officials around ambient air pollution concerns in Northern Manhattan, pollutants emanating from the plant and the impact on the health of residents. We spent eight years organizing around the North River Plant.

Tactics

Our long-term objective was to place the issue of environmental racism on the City's agenda and to get the plant fixed. Strategies included mobilization, litigation and strong

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advocacy. We mobilized residents. Between 100 to 200 people came out to meetings around this issue every month. We organized direct action and civil disobedience. On Martin Luther King Jr. Day in 1988, 100 residents participated in civil disobedience demonstrations. Seven of us were arrested holding up traffic during rush hour on the West Side Highway. WE ACT also pursued a legal strategy and filed a lawsuit against the city. We won a 1.1 million-dollar settlement from the lawsuit against the City with the funds being used as an environmental benefits fund for projects in West Harlem. Our advocacy resulted in Mayor Dinkins' commitment of 55 million dollars to fix the North River plant in a five-year plan that ended in 1999. Now the plant is operating more efficiently with less pollution and odors emitted into the community, though children with asthma still may not be safe playing in the park due to the emissions from the plant's stacks that are present in the park.

Connecting Issues: “Environmental Racism”

Community residents began to see that our community was being used as a dumping ground for a variety of polluting facilities and unwanted uses. We call the intentional targeting of communities of color and low income communities for this kind of citing along with the lack of environmental enforcement, “environmental racism.”

A prime symbol of environmental racism is the proliferation and expansion of diesel bus depots in Northern Manhattan neighborhoods. Out of the eight depots currently in Manhattan, six are located above 99th Street. There are two in East Harlem, one in Central Harlem, two in West Harlem and one in Washington Heights. These are neighborhoods totaling 7.4 square miles, home to 600,000 mostly African-Americans and Latinos, and home to one-third of New York City's 4,200 diesel buses. Due to ridership demand and the success of the Metrocard, many more buses are being purchased. The MTA is now purchasing or leasing parking lots all over Northern Manhattan to house these hundreds of additional buses. The buses are parked outdoors and not in a heated depot, so those parked buses have to idle all-night so the fuel does not coagulate. The outdoor parking lots have no environmental controls that will trap fine soot particles emitted by diesel buses. These fine particles exacerbate respiratory disease like asthma and lead to 20,000 premature deaths per year.

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The New York State Legislature has focused on this issue and encouraged the MTA to commit to buying more alternative fuel buses and to commit to not building additional diesel bus depots. In addition, the U.S. Environmental Protection Agency (EPA) has promulgated a new heavy duty diesel rule and a new standard for fine particles. However, the same polluted communities will continue to bear this burden over the next ten years until cleaner fuel and vehicles are finally in use and the new regulations have been fully implemented. So, we will continue to have a problem that will affect new generations of children, some of whom, studies indicate, are being born sensitized *in utero* to certain allergens that are triggers for asthma.

Housing is another critical environmental factor. We realized that the asthma belt is the lead belt. The same top ten neighborhoods for asthma are the same top ten neighborhoods for lead poisoning. Housing maintenance is a crucial and unique issue in New York City. This is because 60% to 80% of residents live in rental housing, which means they are not in control of certain aspects of their living situations. They can't control heating, which is often a key trigger for asthma in housing projects where certain lines of apartments are overheated. Tenants can't control moisture. If a toilet overflows upstairs and water seeps into the walls, mold can proliferate. Mold is a trigger for asthma and certain types of mold are highly toxic and can affect neurological function. Mold also results from moisture seeping between the bricks of building facades, which have not been pointed or well maintained. That often happens in NYC Housing Authority buildings as well as privately owned buildings. So, housing maintenance is a critical issue, but it's been very difficult to form coalitions with tenant groups on these issues. However, the New York City Coalition to End Lead Poisoning has been able to coalesce with the New York State Tenants Association. At the neighborhood level, it has been difficult to work with tenant groups because groups have a narrow agenda, few resources, small staff, if any; they feel overwhelmed to take on another issue, even an important one.

Organizing to raise awareness

In 1996, WE ACT began raising awareness around asthma. We joined forces with the Harlem Health Promotion Center, which is a Center for Disease Control-funded facility that is a project of the Columbia School of Public Health. Ruth Messenger (then Manhattan

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Borough President) agreed to declare June 1996 as *Uptown Asthma Awareness Month*. We held the first community conference in New York City on that issue. We organized a youth event called “Hoops and Home Runs for Asthma” in a schoolyard where we had physicians like Dr. Jean Ford. We distributed and demonstrated the use of asthma pumps to parents and children and trained them about asthma management. We held a briefing for media and legislators with the Director of the National Institute of Environmental Health Sciences to discuss some of the issues linking asthma and environmental exposures. That’s when we really began organizing at a neighborhood level around asthma.

We have found our partnerships with the Columbia School of Public Health to be very effective and rewarding. We have become a partner in outreach and education; we are also an integral voice in study designs; we are a partner of the Children’s Environmental Health Center at Columbia University.

At the Children’s Environmental Health Center, we are investigating the impact of environmental pollutants and the resulting exposures on pregnant women and their newborn children. Findings indicate that children are being born sensitized in the uterus to certain triggers for asthma. We are following those children and administering developmental tests at six month intervals for a period of two years. One of the published findings is the high level of exposure to pesticides by pregnant women in the study. Many of us have been reading front-page news about the use of illegal pesticides. These are serious exposures taking place indoors as well as in schools. Until recently, parents and teachers were not notified when pesticides were sprayed in schools. You might have a child very sensitive, very vulnerable, yet the parent won’t know what the child is exposed to at school. In the state legislature we have been pushing for a number of “healthy school” bills; a “neighborhood notification” bill on pesticides has recently been passed.

Finally, we have a *Healthy Child, Healthy Home* campaign that WE ACT has organized as a part of our outreach and education response at the Columbia Children’s Environmental Health Center. We have mobilized other community-based groups in Central and West Harlem and in Washington Heights to participate as advisors, and we have developed training sessions on children’s environmental health issues for the health educators employed by these CBO s. We have distributed a tip sheet to parents listing seven

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key concerns for them to address in their homes regarding pesticides, pest control, children washing their hands, and eating fruits and vegetables. I should also say that organizing is simply a tool, and not an end in itself. WE ACT's eye is on the prize of changing public policy that affects environmental health and community quality of life. To effect change in this arena, we must impact city, state and federal agency regulations, policies and guidelines. But ultimately, change starts with a mobilized, informed community participating in the decisions that affect their quality of life.

Northern Queens Health Coalition:

Mala Desai, Executive Director

I will focus my talk on what it takes to do community organizing and bring people together to get the work done. My background is working as a volunteer with South Asian women. I started that in 1992 as a volunteer. Within six months, I realized that working as a volunteer with individuals was not going to get South Asian woman anywhere as a group. So, we decided to give ourselves a structure and form an organization. That organization still exists. It is in its sixth year, but still struggling. Hopefully, this year we will have a budget of around \$40,000- our previous budget was below \$20,000. We have survived on donations, relationships and work that we have done with communities across Queens and also at a citywide level.

Building Coalitions

I am a believer in forming partnerships and collaborations. That is reflected directly in the work I do in my community. Our organization survived because we have formed collaborations with Victim Services Agency and the YWCA in Flushing to start a job placement and training project for women. Of course, when you work with women, it's never work with women alone; so now we are looking to officially revise our mission to include women and families.

Before working with the Northern Queens Health Coalition as a consultant, I had served on the board as a volunteer for almost three years. When we started working with woman and children, there were needs that woman brought to us that impacted their children, and we realized that we had to look at the bigger picture. So we worked actively with the Northern Queens Health Coalition to form a partnership to begin enrolling children in the new Child Health Plus Program. Fortunately, with the help of the Northern Queens Health Coalition office, we obtained funding in northern Queens for nine separate organizations. These programs are now underway, and we have enrolled almost 100 children in one month among the nine organizations. Working collaboratively, we are ensuring that children receive the health care that they need through the *Child Health Plus Program*.

We put together a committee to seek financial support from the NYC Department of

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Health for the Northern Queens Region to bring resources for an Asthma Initiative. Immigrant communities have very few resources to provide educational and support services for asthmatic people. The community is also disenfranchised. For example, over 30% of Queens residents are new immigrants who are voiceless and have no political leverage. Unfortunately, our project was not funded. However, one of the funded agencies is a pilot program in Queens named the Center for Children and Families. The program has become a very strong partner in our coalition. In fact, that agency is also the lead agency for the CHIP initiative. So, even though we are competitors, we can also work together for the community that desperately needs service. From this experience, we began a dialogue at the Jewish Community Relations Council again to talk about how to bring partners together who may be competitors but who need to work together to resolve a larger issue in a community.

The New York City Asthma Partnership

I am honored to serve on the Steering Committee of the New York City Asthma City Partnership, and would like to tell you about this initiative. This Partnership has provided me an opportunity to voice the concerns of a number of communities from Queens. It has also helped to create a structure that is needed citywide- one that will be inclusive, reflect diversity and that addresses different points of view. We are in the process of creating that structure with a list of priorities. To do this, we are working with a multitude of stakeholders including hospitals, community-based organizations, The Board of Education, and the Housing Department (HPD). The NYC Asthma Partnership has captured almost every stakeholder in the city that needs to be working together to not only to resolve the asthma epidemic, but also to prevent future epidemics in the City.

When we organize, it is important to set ground rules and establish a common vision. The vision must reflect and be inclusive of all the resources. I really want to specify that when we developed a vision for the Asthma Partnership, we looked at the wealth of resources that exist within that partnership, including past structures that existed. We also looked at ideology and what it was we wanted the citywide partnership to reflect.

American Lung Association:

Mindy Lieberman, Program Associate

I work at the American Lung Association in the Public Education and Outreach department. We coordinate asthma education programs on a national level. Our largest program is called **Open Airways for Schools**, which is a school-based asthma education program for third through fifth graders. We work closely with our environmental health department whose main program is called **Indoor Air Quality Tools For Schools**. These are two programs that you can advocate be brought into your school or community. Our government relations department works on a national level to lobby government officials to pass bills that will impact the outdoor and indoor air quality. On a local level, each Lung Association works with geographic communities and local elected official to initiate change.

Resources

There are three different legal tools that an individual or an organization can use to advocate better services for clients.

First, is the *Americans with Disabilities Act*. Although many people are not aware of it, asthma is covered under this Act. It is something that can be used to advocate for services if your clients aren't receiving the proper services either through their health care or through their school services. It's something that you can use with your organization to make sure those services exist for your clients.

Second, there are **two** New York State policies that are important to know about. In New York City, we are in a very unique position because asthma medication is allowed in schools. A law passed under Governor Pataki in 1998, states that a child can bring his asthma medication to school with both physician and parental authorization. One is the standard MD/parent authorization form created by the Board of Education -- the **504 form**. If your clients who have asthma are unable to bring their asthma medication to school for whatever reason, I would recommend that you research the school's policy. Private schools are under different regulations and may have their own policies. If you are working with a child who has asthma who goes to a NYC public school, it is important for you to be aware of this policy. If you live in another state, you can contact your local Lung Association to

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find out the policy of taking asthma medications to school in that state. The second NYS policy is *Access to Healthcare*. It is a policy in New York State that provides medical services for the treatment of and rehabilitation with children with disabilities; that includes medical services. There is no reason for a child to go without services. There are free clinics that provide these services. Every child is eligible and should have access to medical services.

The American Lung Association created a resource publication called “**Action on Asthma Binder.**” It includes a list of the laws passed in each state pertaining to asthma as well as guidelines for model legislation. The Binder has language that organizations can use, in collaboration with the American Lung Association, to advocate for bills to be passed.

It is very hard to make changes alone. Working in coalitions can make a difference in your community, especially when using policy as an advocacy tool. I think policy is our strongest ally and we need to really know about it in order to use it. One thing I would like to alert you to is the **resource guide** that was prepared for this conference. It is a resource guide that is comprehensive but by no means exhaustive. It includes health plans and asthma clinics; it has information on nation-wide programs; and pharmaceutical companies where you can obtain free asthma medication. This information can be used as a tool to help your clients get services. As a former direct practice social worker, I know that my resource guide was my “bible” at work. There are so many different programs and services being offered around the city and having a resource guide like this one makes searching for such services a lot easier!

Working with coalitions.

As the newest organizer in this field, it seems like a daunting task to me to start a coalition. It is easy for people to suggest that you should start organizing a group of people to make change, especially when you are so passionate about a cause. But it can be a really huge task and it sometimes just doesn’t seem feasible for a social worker sitting in an office who is trying to help his or her clients day to day. But, what we have learned today is that there are so many resources that the city has to offer and there are so many organizations and coalitions that you can join with in a partnership rather than trying to start something on your own. I am not suggesting that coalitions can’t be started, but if there is already a coalition

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that already exists that is addressing the same issues you are interested in—by all means join it. You can not only benefit from others' expertise, but you can add your own expertise to that group. I recommend using this resource guide and using the information we learned in this session to help change policy and to change ideas and to change thoughts about asthma and access to care for asthma.

The last thing I want to say is that I think this is an amazing opportunity for social workers. I think too often some social workers don't think they can make a difference in improving the quality of health care services for their clients. When we were planning this conference, we had a difficult time finding social workers who thought that they were experienced in the field of asthma. I think more social workers are "experts" than we think. Hopefully, this conference will bring attention to the fact that we can actually help our clients manage their asthma with policies, resources, comprehensive services and coalition-building. We are in a unique position to do that. As social workers, you have the power because of the work you do directly in communities. We are each other's best resources.

PANEL PRESENTATION

SOCIAL WORK AND ASTHMA MANAGEMENT: A CASE STUDY

Moderator: Cheryl Archbald, M.D.

Children's Aid Society

Asthma is not just as a disease, but an illness that involves medical and psychosocial components. The purpose of this panel is to use an actual case, to apply some of the information covered by members of the panel in the workshops, and illustrate how social workers in various practice settings contribute to the management of health care for an asthmatic child. All of the panelists have had extensive experiences in working with children with asthma and their families, in schools, hospitals and community-based agencies.

Sarah Hobson Martin will represent the school social worker, Laudy Rodriguez the hospital medical social worker, and Valerie Marriott, the preventive services, community-based social worker.

Case Overview

Let's begin with an overview of the case. The patient is Crystal, an 11-year-old girl who lives in the Bronx and was seen for the first time in my clinic last December. Her mother was concerned because Crystal had been having coughing episodes at night. Her coughing continued over several weeks, and was not helped by over the counter medications. She has been healthy in the past and mother does not report a history of asthma in the family. Crystal presented with symptoms of heavy breathing and wheezing. We gave her nebulizer treatments to resolve her respiratory difficulties, and decided that she could go home with medication. We taught her how to use the pump and gave her a spacer to take home. A follow-up appointment was scheduled for two weeks. Unfortunately, Crystal did not keep this appointment. It is now two months later, and she is at school in gym class playing basketball. Her symptoms begin with tightness in the chest, and she decides to sit out the rest of the game. An hour later when in math class, she is still feeling chest tightness and decides to go to the school clinic.

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Sarah, you are the school social worker, and also work in the school clinic. Crystal comes to the clinic complaining of having difficulty with her breathing. Is this common, are you seeing children like Crystal coming to the school clinic?

School Social Worker: Sarah Martin Hobson

This is very common. Medical providers do not notify the school that a child has been diagnosed with asthma. This means that unless the parent tells them, teachers and other staff will not know the child is asthmatic until they present symptoms when in school. Mt. Sinai has an on-site primary care and acute care unit in the public school, so we generally are aware if a student is asthmatic, but this is not the case in most city public schools. We are fortunate to have a medical social worker on site to provide specialized services. These include teacher education programs to help teachers recognize symptoms of an asthma episode in students-- tightness in the chest, coughing, heads on their desks for long periods, wheezing, difficulty catching their breath are some of these. Medical staff cannot treat without permission, and because of confidentiality, cannot obtain information from primary health care providers without a release signed by the child's legal guardian. The social worker secures a release of medical information, so that we can communicate with other health care providers to obtain information about the child's past health history and find out if they are on medication. The social worker also provides other services like stress management to reduce absenteeism, and helps with make-up assignments to make sure the child keeps up with home work when they do miss school. Helping children plan how to catch up with missed work can be very helpful in diminishing stress about falling behind academically. The social worker is also responsible for securing the 504 form. This is the form used by the Department of Health that authorizes students to carry their inhalers while in school, and to self-administer asthma medications.

If Crystal was a student in our school and registered in our program-- to be registered the parent must complete and sign the registration form-- all of these services would be immediately turned on for her. We would put her on a nebulizer, give her Albuterol, and monitor her progress to see if the symptoms cleared up so she could return to class. Her mom would be notified and alerted to what has happened.

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The nurse practitioner would notify the primary health care provider that Crystal had been seen in our clinic, and establish an on-going collaborative relationship with the facility.

M.D. Moderator:

What would happen if Crystal's mother didn't know that there was a school clinic, or doesn't have much interaction with her primary care provider? There is no 504 form on file, and Crystal is not registered in the school health clinic. Sarah, can you talk about what would happen to Crystal if this were the case?

School Social Worker

We would contact the parent immediately and call 911. The parent would come in and accompany the child if they are able to get to the school quickly. Otherwise a school representative would accompany the child to the emergency room and the parent would come directly to the emergency room.

M.D. Moderator:

In Crystal's situation, her breathing difficulty worsened, and she ends up in the emergency room. Crystal's mom was called from work to pick her up and take her to the emergency room. She's in the emergency room and because of the severity of her symptoms, requires multiple nebulizer treatments. The hospital staff decides to admit her. When the mother comes in, the medical team is concerned because she seems to be in denial about the severity of the child's illness and is not able to give them the name of the primary care provider. The hospital medical social worker is called in to complete a psychosocial assessment.

Laudy, can you tell us what kind of information the hospital social worker would obtain to help the medical staff gain a full picture of all of the important factors to understand in developing a medical plan for Crystal?

Medical/Hospital Social worker: Laudy Rodriguez

We know that the mother is going to be feeling considerable stress and anxiety since she has been called at work. It's important to try to calm the mother down, and it will help to give her information about the child's status. Although very ill, Crystal is receiving

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appropriate care and the medical team is working to stabilize her breathing. We will need mother's permission to administer medication, and Crystal may need steroids to improve her breathing. Parents often have myths about steroids, so I would want to get to this right away with the mother. After the mother has had an opportunity to calm down and integrate some of the information she has been given about Crystal's condition, I would begin to get more information to make a full assessment. I would begin by exploring around the medical teams' initial observations-- the mother's seeming denial of the severity of Crystal's illness, what are the possible causes of this, and why is there no primary care giver for a child with such a severe illness. Does she have health insurance? Is she relying on home remedies? Because asthma is an illness with physical and psychosocial components, the assessment would be conducted to elicit information in all of these areas.

It is always important to obtain information about home conditions, and the child's indoor environment, to make an assessment of triggers in the home. Pets, roaches, mold and mildew are common household triggers. Since this is a working mother, it is important to obtain information about household composition-- who lives in the home, are there smokers, and who is responsible for the care of the child while mother is working. If the mother is receiving public assistance, we know that she will be in a work program, and required to keep in touch with the job center.

These are some of the assessment questions that need to be explored to help us understand the situation, and make immediate plans for the child. Since asthma is a chronic disease, in planning long term goals it is important to assess social supports available to the family. The assessment helps us understand psychosocial factors, and to identify risk factors in the child's indoor and outdoor environment that may be triggers, as well as what services the family needs.

M.D. Moderator:

Community conditions like sanitation pick up, and waste disposal, effect air quality and the prevalence of asthma in certain neighborhoods. Poor housing conditions can serve as triggers in the child immediate environment -- roaches, rodents, the mold and mildew. So we would want to know about neighborhood conditions. Is she living in NYC Housing Authority or does she live in a private building? Because stress can also serve as a trigger

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when considering psychosocial issues, it is important to find out from Crystal and her mother what is going on at home. Housing problems can create considerable stress for families and create additional issues that influence psychosocial dynamics in the home. Some parents are very stressed because they are being evicted from their homes. There may be interpersonal problems among family members, problems in the marriage, disciplining children, children having school problems, etc. If we know what the problems are, the family can be referred to community-based agencies for appropriate follow-up services.

The next step is that Crystal improves and is ready for hospital discharge. Can you tell us what should be in the discharge plan for Crystal and her family, to prevent her from bouncing back and ending up in the emergency room again?

Medical/Hospital social worker

We need to make sure that the child has a primary care physician to provide medical follow up. An appointment would be made for her to see her primary care physician before leaving the hospital. It is important that communication linkages are established between the admitting hospital and the primary care physician before discharging the patient. We'll give her an asthma plan, but that doesn't necessarily mean that when she sees the doctor, the doctor is going to know this. As a policy, we like to send a letter to the primary care physician, to let them know in writing that the child has been admitted, the name of the medications prescribed, and the child's medical plan. This ensures that there is consistency in treatment and medical follow up. We would also want Crystal to be seen within a week after her discharge.

It is also important to make sure that Crystal has medical coverage. If she doesn't, I would take the mother to the Medicaid office and help her with the application forms, or to the Mt. Sinai R.E.A.P. (Resources Entitlement Advocacy Program) and apply there. Crystal's asthma medications will be quite expensive, about 70 dollars for the pumps alone. Therefore, the family will need medical coverage to pay for these. Now there is Child Health Plus in New York State, which covers children who do not qualify for Medicaid.

We received a grant to do outreach and go to homes and register children who had no

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medical coverage. In New York City, it is important to reach out to identify immigrant groups. Undocumented immigrants may not want to be identified because they fear deportation. There are high child asthma rates in some immigrant populations including Mexicans. We make a special effort to reach these children. With Child Health Plus, parents may have a co-payment of \$5 or \$10 a month.

We have our home care unit at Mt. Sinai. But I also refer to other agencies that have good asthma programs to see families after discharge. Little Sisters is one that we use for East Harlem. They go in, do the home assessment, and provide mattress covers if needed and other services when home triggers are identified. Home care is an important component of the discharge plan.

If the child is discharged on medication, it is important make sure the 504 form is completed so they are authorized to carry a pump and take medication while they are in school. Sometimes parents tell me that the kids are not allowed to carry inhalers or the MDI's. I know that some schools allow it and some don't, so it would be important to contact the school social worker to find out what the their policy is on medication.

It recently came to my attention that there are two different 504 forms. The short form authorizes the student to carry and administer their own medication. The long-form, authorizes the school nurse to assist the student. The student has a right to use either method. The districts and the schools may try to tell you no, but it is a right. There is a coordinator in the school district office who oversees the program who can be contacted to resolve any problems.

M.D. Moderator:

Valerie, as a community social worker, what would be your specific role then in Crystal's asthma management?

Community Social Worker: Valerie Marriott

First, to make a home visit and complete an assessment of Crystal's home environment. Based on that, I would advocate for Crystal's family to get exterminator services if there are roaches, and repairs for faulty plumbing if we observe mold and mildew. I would also reinforce information with the mother about triggers in the home environment.

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We would find out if the mother needs financial help with transportation to keep medical appointments, or help with child care during the hours she is working. I would also explore if it would help for Crystal to be involved with a children's support group. This will reduce feelings of difference that Crystal may feel. It helps children to know that they are not the only one affected by asthma. It is so important in the treatment and management of asthma to get the individual child to know what are trigger and what are limitations before she becomes ill.

M.D. Moderator:

What would happen if the social history reveals that Crystal lives with her mother and four other siblings in a basement apartment that is very dusty with poor ventilation? She has been waiting for months for the superintendent to fix all the black stuff that is on the walls, and there are many very leaky pipes. The mother reports that she tries to keep her place clean but there are those roaches in the apartment and up and down the hallways because her neighbors don't control their garbage. In addition, two months ago, Crystal's mother came off welfare and is now required to go to work. She started in an evening housekeeping job. She felt that she had no alternative and arranged for Crystal and her four siblings to go to a neighbor's house after school. Unfortunately, the neighbor smokes cigarettes and also has a cat. This situation sounds extreme, but is not atypical of the kinds of problems that the outreach community worker must help families solve. Can you talk about how the community social worker would handle those issues?

Community Social Worker:

There are many violations in this apartment, and since basement apartments are illegal, a priority will be to help the family find a new apartment. This won't happen overnight, so as an interim measure, a letter would be sent to the landlord, to notify them of these serious violations of housing code. If nothing happens I will file a report to the responsible housing office. I might also try to find an after school center, or a community agency for child care and after school services while mother is working. I can't ask her neighbor to stop smoking but I may ask them to smoke outside of the house. I can't ask them to get rid of the cat, but I may ask to keep the cat in a separate area from all the children, during the time that they are staying there. But the basic thing is to look for a new apartment

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for her because these conditions are substandard and endanger the health of any child, and seriously compromise the health of an asthmatic child.

M.D. Moderator:

You talked a lot about case management. What do you perceive as some of the barriers, problems and challenges to case management or to the team approach?

Medical Social Worker:

Managing the health care of children with asthma, and addressing medical needs and psychosocial needs requires cooperation from many specialized agencies, and health care disciplines. Case management is necessary for orchestrating these. There are some challenges to effective case management to avoid duplication, and to ensure that providers are working together, so that families do not fall between the cracks and rely only on emergency room treatment when the child is in crisis.

Adequate, clean affordable housing is a major barrier. It is not always possible to involve private landlords, or the NYCity housing authority for that matter. Some families may be known to the Administration for Children Services because they have been reported for medical or educational neglect. Such allegations may involve a child who is asthmatic. ACS workers have demanding caseloads, so getting the staff on board and thinking from a preventive perspective can be a challenge. Sometimes the family itself may be a challenge. They may be distrustful of formal health care providers, rely heavily on home remedies or have many interpersonal conflict among individual family members. In addition, community services are not always available at a sufficient quality and duration to meet the serious needs of families or integrated to adapt to the changing presentation of the disease.

I try to remind people involved with a case that we are doing this for the benefit of the child. It is not your child, it is not mine; but collectively we have to function as a team. Communication is important. Team members must be willing to communicate across boundaries of professional disciplines and organizations. We all have an important contribution to make. Social workers, whatever their practice setting, understand the psychosocial aspects of this disease, and all speak the same language so to speak. So,

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whether in the school, hospital or community agency, social workers can take the lead in case management, ensuring that services are integrated and that we are all working towards the same goals.

Community Social Worker:

It is important to remember that advocacy is an important component of case management. We work as advocates to individual clients to help them get the services they need. As social workers we also identify service gaps that impact large groups of clients and advocate, and work to get those services in place to close these gaps, and advocate for policy changes to make delivery systems more responsive to the needs of our clients.

M.D. Moderator:

The discussion of this case was an excellent illustration of the ways that social workers in different settings can work together in collaboration with other members of the interdisciplinary team to develop and monitor and health care plans for children with asthma and their families. Asthma management requires a continuum of care that includes prevention, treatment and aftercare services. It calls for the expertise of many health care disciplines. But clearly, this case demonstrates the importance and essential roles for social workers as members of the health care team, as advocates and as change agents.

CLOSING REMARKS

Terry Mizrahi, PhD.

Chair, New York City Chapter NASW

Health Care Policy and Practice Network

Today's conference was attended by more than three hundred social workers, health care and community workers in all city boroughs who are directly and indirectly involved in the diagnosis, treatment and management of children with asthma and their families. It has been a productive day by any measure. A major objective of the conference was to explore the roles of social worker on the health care team. We have certainly learned that social workers can and do play an important role on asthma health care management teams as well as in the broader community and policy arenas.

Another goal of the conference was to provide information to front line workers about new program approaches and services strategies that are especially effective in the treatment and management of children with asthma in urban communities. I think you will all agree that the presenters were exceptionally knowledgeable in their areas of expertise, and provided us with state of the art information. The conference package prepared by the Planning Committee contains an enormous amount of information that we hope you will find useful as reference and resource materials. I would say that the objectives of the Conference have been well achieved.

I hope you will take what you have learned today back to your agencies in your work with children and families. We should all take from this conference that we do not have to rely on trial and error approaches in working with children with asthma and their families. We have objective evidence from empirical research studies and demonstration projects to inform clinical interventions known to be effective for managing the illness, reducing hospitalization rates for children, and make it possible for children with asthma to live normal and healthy lives. Workshops on community organizing presented information about how to develop broad based strategies for influencing public policy, building community coalitions, and collecting data to support advocacy efforts.

Findings from practice and research are clear that social workers make a difference in improving outcomes for children and families in quantitative and qualitative ways. Changes

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reported in hospital admission rates in neighborhoods where these rates have been alarmingly high provide beginning evidence of the effects of the integrated public health approach to asthma. But sustained efforts will be required to maintain the downward trends of these numbers over time. We must all commit to advocating for and contributing to these outcomes. This conference has been an important and successful beginning, Members of the NASW planning committee, and the NYC Department of Health will be planning next steps. We all thank you for your participation that made this conference a success.

The Challenge of Childhood Asthma for Social Work: A Call to Action
Wednesday, June 14, 2000
Hunter College, Brookdale Health Sciences Center

List of Speakers

** = no longer at that organization

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The Challenge of Childhood Asthma

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Or for asthma resources developed by the NYC
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1-877-278-4620 or 1-877-ASTHMA-0
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