



mfp  
**MINORITY**  
FELLOWSHIP PROGRAM

**Celebrating Diversity in Nursing**



**Assessment  
Report**  
1974–2000

A program funded by the Substance Abuse and Mental Health Services Administration at the American Nurses Association.

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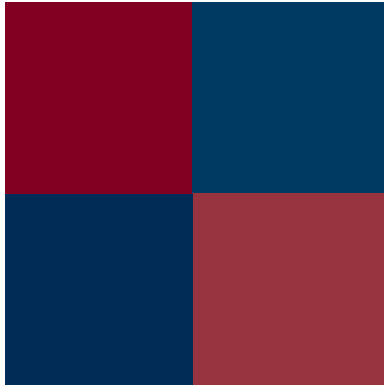


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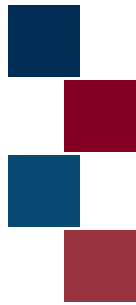
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# Assessment Report

1974–2000



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# Preface

**H**ealthy People 2010, the national health promotion and disease prevention initiative from the U.S. Department of Health and Human Services (USHHS), was designed to achieve two overarching goals: one, to help individuals of all ages increase life expectancy and improve their quality of life; and two, to eliminate health disparities among different segments of the American population. The mission of the American Nurses Association (ANA)—to work for improvement in the quality of health care and in the availability of health care services for all people—reflects these goals.<sup>1</sup> The ANA recognizes that prejudice, discrimination, and racism in American society have adversely affected minority populations, the health care system in general, and the profession of nursing. The ANA is committed to working toward the eradication of prejudice, discrimination, and racism in the profession of nursing, in the organizations in which nurses work, and among all others who provide health services. The ANA is further committed to working toward egalitarianism and the promotion of justice in access and delivery of health care to all people.<sup>2</sup>

Cultural assumptions are evident in all facets of the health care field and pervade educational systems, research programs, practice, policy promulgation, and leadership styles. These assumptions translate into perceptions about patients' cultural practices, their health beliefs and behaviors, and their definitions of health and illness, help-seeking steps, and other health-related phenomena.

Educating a culturally diverse group of nurses will help to ensure that all of this nation's citizens receive culturally appropriate, relevant, and competent care. Nursing's academic leaders already recognize the strong connection between a culturally diverse nursing work force and the nation's ability to provide quality patient care (Sullivan Commission, 2004; National Academies, 2003, 2004). In addition, greater diversity among the nation's nursing work force will strengthen cultural competence among care providers, will enhance patients' participation in their own health care, and will help to eliminate health disparities that have persisted within ethnic minority populations for centuries.

This outcome is more likely to occur if ethnic minority nurses share leadership and decision-making with their Caucasian colleagues in matters of education, practice,

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1. American Nurses Association mission statement at: [www.ana.org/about/mission1.htm](http://www.ana.org/about/mission1.htm)

2. Nursing World/Reading Room: Position Statement: Discrimination and Racism in Health Care at <http://nursingworld.org/readroom/position/ethics/etdisrac.htm>

public health policy analyses, and research. For almost 30 years, the Minority Fellowship Program (MFP; originally known as the Ethnic Minority Fellowship Program) has been instrumental in ensuring that ethnic minority nurses have access to opportunities that will secure their rightful places in nursing leadership and decision-making.

Today, the Substance Abuse and Mental Health Services Administration (SAMHSA) within the USHHS is the federal funding agency for the MFP. SAMHSA and the ANA remain committed to facilitating the entry of ethnic minority, doctorally prepared nurses into substance abuse and mental health disorders prevention and treatment careers. These nurses will be prepared to become leaders in education, practice, public health policy, and research related to substance abuse and mental health disorders. One of their main goals is to provide quality services to ethnic minority populations who bear the heaviest burdens associated with these disorders.

The ANA and the MFP proudly present the *Minority Fellowship Program Assessment Report, 1974-2000* in consultation with SAMHSA, its Center for Mental Health Services, and the National Institute of Mental Health. The Health Resources and Services Administration, Division of Nursing, has contributed to the creation of the report through financial support.

The ANA and the MFP are grateful for the leadership that has nurtured and supported this initiative for nearly 30 years. The contributions of these individuals are self-evident. We hope that this report will galvanize the MFP stakeholders' commitment to the mission and goals of SAMHSA, the MFP, and the ANA, and that they will join our untiring efforts to make our great nation a healthy and prosperous country for all people.

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# Introduction

## Minority Fellowship Program

### *Background*

Healthy People 2010 is firmly dedicated to the principle that—regardless of age, gender, race or ethnicity, income, education, geographic location, disability, or sexual orientation—every person in every community across the nation deserves equal access to comprehensive, culturally competent, community-based health care.<sup>3</sup> Eliminating health disparities is one of two primary goals set by the U.S. Department of Health and Human Services’ (USHHS) *Healthy People 2010: A Systematic Approach to Health Improvement* initiative, second only to the program’s first goal of increasing quality and years of healthy life. “Although the diversity of the American population may be one of the Nation’s greatest assets, it also represents a range of health improvement challenges,” the program plan continues.<sup>4</sup>

In the mental health field, among many others, the resources traditionally available did not meet the health care needs, especially mental health needs, of all Americans. The problem was so acute that, in the early 1970s, the Center for Minority Health and the National Institute of Mental Health (NIMH) became concerned about the lack of mental health professionals who could provide culturally competent care to an increasing racial/ethnic and culturally diverse population, with ever-expanding needs for mental health services and research. While it was believed that ethnic and minority mental health providers and researchers could best address many of the problems faced by these various populations, only a small number of these professionals were in place.

In 1973, the Center invited the American Sociological Association (ASA) to submit a grant proposal to support doctoral-level training and ethnic and racial minority sociologists. In 1974, NIMH awarded the ASA a small training grant for the purpose of supporting doctoral education for ethnic minority researchers and clinicians.

Shortly thereafter, invitations to submit training proposals were extended to the other core mental health professions of nursing (American Nurses Association/ANA), psychiatry (American Psychiatric Association), psychology (American Psychological Association), and social work (Council of Social Work

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3. [www.health.gov/healthypeople](http://www.health.gov/healthypeople)

4. Ibid.

Education). Each organization responded with enthusiasm, and thus began the most consistent, focused, and effective national program to train ethnic minority providers and researchers in substance abuse and mental health disorders.<sup>5</sup>

The Ethnic Minority Fellows—nurses, psychiatrists, psychologists, sociologists, and social workers—now function as leaders in administration, consultation, education, practice, public policy, and research. They provide initiatives and leadership in five areas—education, practice, public health policy, research, and administration—in public and private mental health agencies and other organizations to develop, implement, and evaluate services for persons, families, and communities of ethnic minorities and all other citizens (USHHS, 1994). They also function in academic institutions, where they teach and conduct research.

### *The Minority Fellowship Program Today*

Today, the Minority Fellowship Program (MFP) of the ANA provides living testament to the success of the NIMH initiatives. For almost three decades, the MFP has been engaged in the challenge of reshaping the profile of nurse leaders in academics, practice, public health policy, and research. The efforts of the MFP have resulted in an increase in the number of ethnic minority nurses who have expertise in substance abuse and psychiatric and mental health nursing. MFP Fellows with earned doctorates help to demonstrate the program's success in increasing the needed diversity across the fields of the profession.

Fellows of the MFP have contributed to nursing's body of knowledge—both theoretical and empirical—about the distinct needs of ethnic minority populations and to the much-needed dialogue about nursing's role in providing culturally competent and linguistically appropriate health care services.

Currently, some of the program graduates work as clinicians, serving in high-risk urban and rural areas and providing care to children and families who are victims of violence and substance abuse. Others provide direct care to individuals with mental illness who reside in a variety of settings, including crisis stabilization units, long-term care facilities, and community-based homes. Still others work in community clinics and outreach programs and are often the critical link between primary care and substance abuse and mental health services for less-privileged patients and their families.

A significant number of the Fellows are employed in academic settings, where they teach, practice, generate public health policy, and conduct research. These Fellows generate research on ethnic minority mental health service utilization, research that aids professionals in their efforts to provide effective and culturally relevant care to individuals and their families. Their findings and recommendations help reduce health care disparities, lessen the cost of health care, minimize the impact of the stigma of mental illness and substance abuse in some communities, and improve the nation's overall health status.

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5. [www.emfp.org/about/who.htm](http://www.emfp.org/about/who.htm)

The mission of the MFP is to develop ethnic minority nurses who are recognized for excellence in creating, transmitting, and utilizing knowledge and skills to improve the health of people in local and global communities. The Mission Statement summarizes the goals of the program and indicates the areas where success has already been achieved. The program's intention is to increase the number of PhD-prepared nurses from underrepresented ethnic minority groups who will:

- Conduct research about substance abuse and mental health disorders prevention and treatment within minority populations, across all age groups and in a variety of settings;
- Assume leadership roles in the initiation of scientific investigations and service utilization phenomena that occur among ethnic minority populations;
- Expand and contribute to the evidence-based practice of substance abuse and mental health disorders prevention and treatment among ethnic minority populations throughout the lifespan; and
- Function as leaders and members of interdisciplinary research, public health policy, and direct-service care teams with the objective of improving the overall health status of ethnic minority populations.

### *Importance of the Minority Fellowship Program*

The MFP is both unique and successful in several ways. First, it is a national program, not based at a particular institution. It is located at the headquarters of the sponsoring professional organization, the ANA, in Silver Spring, Maryland. The ANA offers support, visibility, and legitimacy to the program.

Second, the MFP model promotes collaboration among the core mental health disciplines, thus being able to benefit from the best insights of all of its participants. This multidisciplinary collaboration in turn permits myriad opportunities for professional networking, with each group making unique contributions and benefiting from the contributions of others.

Third, the MFP was originally supported by the NIMH and is currently funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the USHHS. These two federal agencies have invested in a diverse nursing work force with the intent of reducing mortality and morbidity and enhancing well-being among all people, including ethnic minority populations.

### *Looking to the Future*

In the coming years, the aging of the American population will create a greater burden for all health professionals. The overall American work force is also becoming more diverse. Ethnic populations are more heterogeneous, each with its own set of cultural values, folkways, and mores.

In addition, despite advances in the fields of substance abuse and mental health, the health care needs of ethnic minority populations have grown alarmingly, as a quick review of the literature demonstrates (see, for example, Clayton and Byrd, 2001; Compton and others, 2000; Gary, 2005; Gary and Yarandi, 2004; Gary and others, 2003; Johnson and others, 2004; Robbins and others, 2001; Rollman and others, 2002; Schneider and others, 2002; Snowden and Cheung, 1990; Son and others, 1997; Stump and others, 1997). These publications serve as a call to action for strengthening and expanding existing programs. With the growth of ethnic minority communities and their need for mental health services, one of this nation's highest priorities must be ameliorating despair and suffering through bold, innovative programs created through the contributions of well-educated ethnic minority nurses.

## Assessment Report

### *Purpose*

The purpose of this report is to assemble current and historical information about the MFP Fellows, assess the program, and create a document that will inform NIMH and SAMHSA regarding the promulgation of policies and support for models that emphasize leadership development. Specifically, the Division of Nursing requested that three components be included in the report:

- A compilation of information on program participants from 1974 through 2000, including demographic data, and other fellowship-related variables.
- A description of the MFP's role in facilitating the attainment of doctoral degrees among the Fellows. This includes a summary of the history of the MFP, the methods used to recruit and retain ethnic minority nurse Fellows, a statement about the financial and social support needed to implement the program, and vignettes of several Fellows that indicate the significance of the MFP in assisting them in their career development.
- Recommendations for the development of academia-based ethnic minority nurse leaders in the future.

The organization and methodology of the report are described in the following paragraphs.

### *Assessment Report Organization and Methodology*

#### *Organization*

This document is divided into eight sections. Section 1 provides the context of this report by discussing the concepts and definitions of race, ethnicity, culture, and mental health. Section 2 offers a thumbnail sketch of the current nursing work force and highlights the percentages of ethnic minority nurses and selected characteristics of this group. Section 3 provides an historical perspective of the MFP. Section 4 describes the various programs—doctoral and post-doctoral, pre- and post-doctoral enhancement, and funding for nurses at other educational

levels—that have been funded for the MFP, as well as some of the leaders who implemented them. Section 5 details the personal characteristics of the research and clinical Fellows. Section 6 presents the personal stories of eight Fellows, as well as the results of interviews with six others. Recruitment and retention are the focus of Section 7. Section 8 outlines some of the program’s future plans, and concludes with recommendations for the development of ethnic minority nurse leaders.

## Methodology

This report was designed to describe the MFP Fellows’ characteristics and achievements over a quarter of a century, from 1974 through 2000. Data were collected through surveys, interviews, and the Internet. Several ANA resources, including its library records and statistical database about the Fellows, were used to conduct statistical analyses of numerous variables. Descriptive statistics, including summary measures (means and standard deviations, minimum and maximum) and frequency distributions (bar and pie charts) were used to describe the demographic characteristics of the Fellows and other selected national nursing data. The Statistical Analysis System (SAS, Version 8.2) was used for data analyses and for scientific report writing. In addition, Statistical Program for Social Sciences (SPSS, Version 11.5; SPSS, Inc., 2001) and Microsoft Excel 2002 (Version 10) were used to illustrate the charts and graphs.

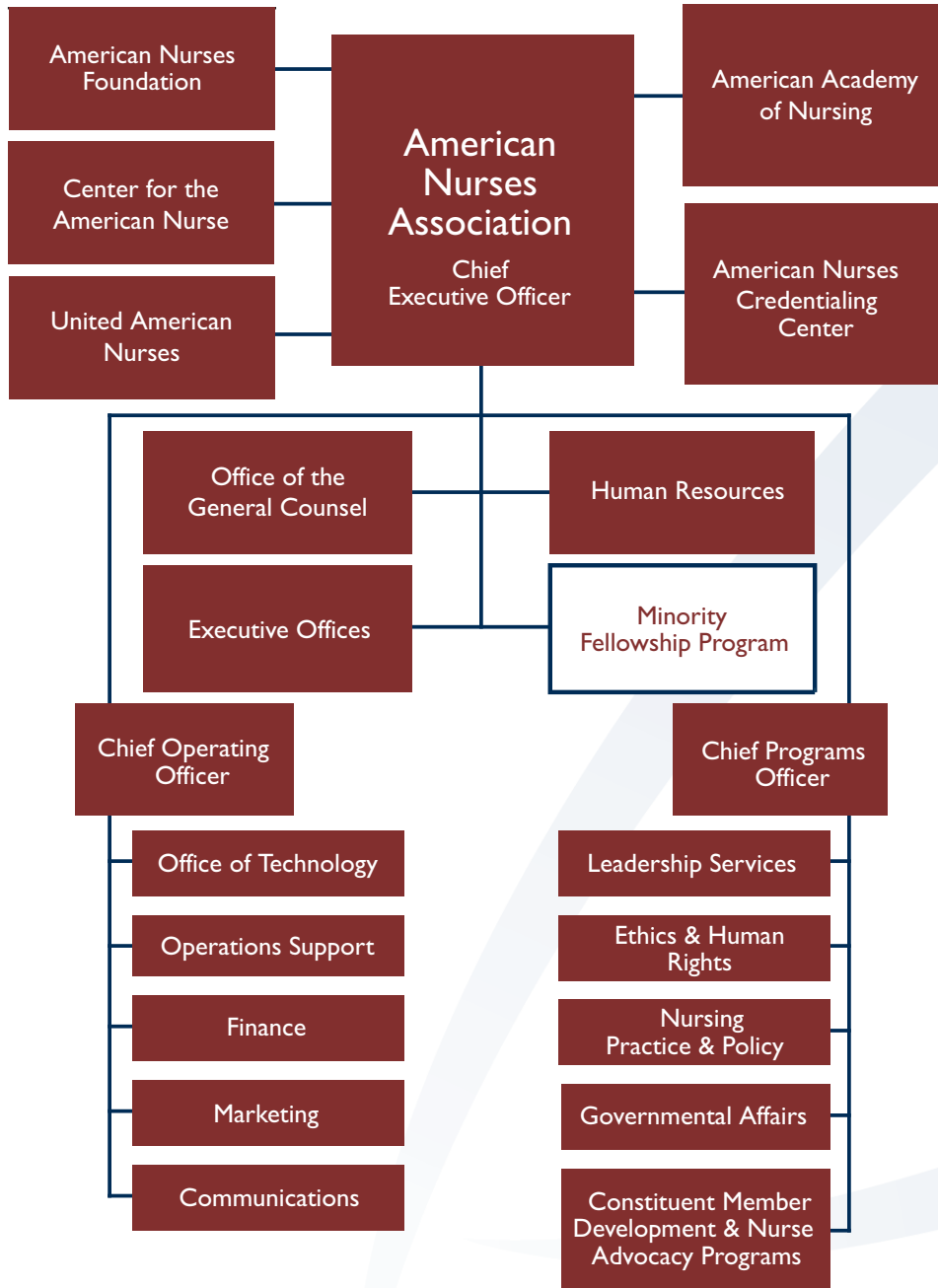
## Limitations

The data for this report were extracted from surveys, interviews, and the files of the MFP office at the ANA. Because of the long period of time over which information was gathered, some data are missing. Other limitations include inconsistencies in questionnaire design and shifts in focus, which made it more difficult to collect data for some variables. Also, not all survey instruments were returned. Follow-up with the Fellows was not always completed because of incorrect contact information or scheduling difficulties. Nevertheless, the database is being updated, and a supplemental report is being planned for the year 2008, at which time we expect many of these limitations to have been corrected.

## *Contextual Structure: The MFP Within the ANA*

The position of the MFP within the ANA has remained virtually unchanged over the three decades of its existence. The director of the MFP is a member of the executive leadership team, with a direct line of communication to the chief executive officer and all of the executive members of the ANA (as shown in Chart 1). This administrative structure helps to provide visibility for the program and facilitates the attainment of its goals and objectives. Moreover, the placement of the MFP within the leadership and executive levels of the organization provides additional opportunities for the program directors to fine-tune their leadership and management skills while providing the necessary oversight for the program (Harper, 2003; Stierle, 2003a, 2003b).

**Chart 1. American Nurses Association Organization Chart, Showing Location of the Minority Fellowship Program**



Source: Office of the Chief Executive Officer, Linda Stierle, American Nurses Association, Washington, D.C., 2006.



# Ethnic Minorities: Concepts and Definitions, Overview, and Mental Health

## Concepts and Definitions

A discussion of commonly used concepts and definitions should help the reader to better understand the use of the terms *race*, *ethnicity*, *culture*, and *minority*. Each of these designations has social and political meanings that help shape opportunities, perceptions, and behaviors among people in this nation and the world (Carnegie, 2000; Gary, 1991; Griffith, 1996; Mezzich and others, 1996; Shelder and others, 1993).

### *Race*

The concept of race has traditionally referred to biological phenomena, categorizing human beings according to physical characteristics such as skin color, hair texture, or the shape of the eyes, nose, face, or lips. But categorizing people on the basis of physiological characteristics has very limited usefulness: the Bushmen in the Southern African region, for example, have epicanthic eye folds similar to those of the Asian population (Owens and King, 1999; USHHS, 1996, 2001a). In fact, there is evidence that there may be more variability within a “racial group” than across groups (Anderson and Nickerson, 2005; Ossorio and Duster, 2005; Rowe, 2005; Shields and others, 2005).

The concept of race, however, does have social and political significance. When race is used as a social concept, it becomes a force for determining which groups are considered superior and who has access to power and resources. In health care, race is one factor that helps illuminate the mental health needs of ethnic minority groups in our society; it also figures in discussions of health service utilization (Clayton and Byrd, 2001; Gary, 1991; Gary and Kavanagh, 1991; Schwartz, 2001; USHHS, 1996, 2001a). Because the concept of race has not been clearly defined from either a biological or a social point of view, its use in research is problematic. The elusiveness of the concept interferes with both research and theory promulgation in substance abuse and psychiatric nursing and other fields of inquiry. The numerous meanings and nuances attributed to race continue to provoke confusion, invite controversy, and limit research design and theory development (Yee and others, 1993).

## Ethnicity

Ethnicity is a term used to describe common heritages, behaviors, values, perceptions, and folklore of a particular people. Music, language, food preferences, rituals, celebrations, and health beliefs and practices are typically explained by this concept. As used in this society, the concepts of race and ethnicity have some common characteristics, but there are important differences as well. The term *Asian American*, for example, can refer to individuals from more than 30 countries, and *Arab American* can include people from more than 25 countries. Yet the inhabitants of these countries have distinct heritages, customs, languages, food, music, clothing preferences, and so forth. Hispanic Americans are categorized as an ethnicity, not a racial group, but they include representatives of numerous groups, including Cubans, Guatemalans, Mexicans, Puerto Ricans, Peruvians, Ecuadorians, and many others in the Caribbean and South and Central America. Some Hispanic Americans are of African descent, while others, particularly those of Latin American heritage, are of Native American descent (USHHS, 1996, 2001a; Schwartz, 2001).

## Culture

Culture is a broad concept that involves shared meanings among a group of people, meanings that are learned ways of thinking and acquired world views. Culture is dynamic and constantly being modified. It is influenced by beliefs and behaviors, as individuals come to terms with their environments, which in turn are ever changing. Cultural ties extend beyond race and ethnicity and can include, for example, being Southern Baptist, or Catholic, or Muslim, or “gay” (homosexual), or a New Yorker. Culture also refers to the shared values, knowledge base, and expected behaviors that are evident among a group of professionals—first-grade teachers, social workers, psychiatric nurses, lawyers, and stockbrokers, to name a few examples. Even psychiatric and mental health nurses can be said to have their own culture. Nurse specialists in substance abuse services could claim a different type of culture.

In the United States, the dominant culture is fashioned by the beliefs, behaviors, norms, and values of Caucasians, European Americans with a Judeo-Christian perspective. Despite changing demographics, the basic institutions in America are governed and influenced by Western thought and culture. The prevailing culture dictates the clinical and research milieu within which all ethnic minority people are educated, practice as professionals, and receive their health care. It is also evident in all aspects of substance abuse and mental health care, including the roles and functions of nurses, their approach to patient care, basic principles of therapeutic communications, administration and interpretation of the mental status examination, and the use of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR™) (APA, 2000; USHHS, 1996, 2001a; Gary and Kavanagh, 1991; Grosel and others, 2000).



## Minority

The U.S. government created the term “minority” to describe a population group with fewer members than the “majority” Caucasian group. The term may suggest a controlling role for the majority group and, to some, may be perceived as implying exclusion and restricted opportunities. But “minority” groups consist of a heterogeneous mix of people representing different ethnic, racial, and cultural groups. These groups have a range of migration histories and have experienced various levels of acceptance, acculturation, and assimilation in this society (Coll and Garriod, 2000).

In the United States, members of minority groups often encounter barriers in accessing essential resources such as education and health care (Coll and Garriod, 2000; USHHS, 1996, 2001a; Rogler and others, 1991).

Four designated ethnic minority groups make their homes in the United States: African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans (USHHS, 1996, 2001a). A brief description of these groups is presented in the following paragraphs, along with a description of their geographical concentrations in the United States.

In this report, the terms *Black* and *African American* are used to indicate the same group; likewise, *White* and *Caucasian* are used synonymously. The term *American Indians* includes Alaska Natives as well. The term *Asian American* includes Asian Americans and Pacific Islanders.

## An Overview of Ethnic Minority Groups in America

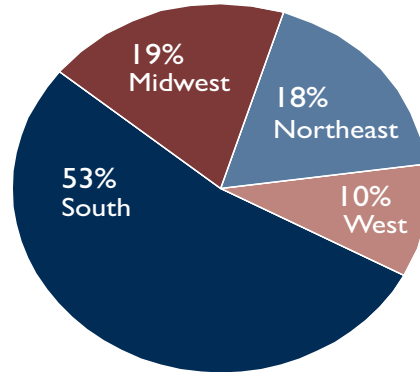
### *African Americans*

African Americans share a unique and extensive history whose impact is still felt in contemporary American society. Their history of slavery and their centuries of legal segregation have lingering implications for the economic, social, political, educational, and health status of this group. African Americans are a culturally diverse population, including individuals from the Caribbean, Africa, and other regions throughout the world. About 6% of African Americans are foreign-born.

During the early decades of the 20th century, African Americans migrated to northern regions of the United States in search of better jobs, education, and health care. Despite that exodus, a greater proportion of Blacks has lived and continues to reside in the South, the section of the country where the majority of slaves lived and worked. Currently, about 53% of all African Americans live in the South; 37% live in the Northeast and the Midwest, typically in large metropolitan areas; and 10% live in the western part of the United States (see Figure 1) (U.S. Census Bureau, 2001a; USHHS, 2001a).

**Figure 1. African American Population by Region: 2000**

Source: U.S. Department of Health and Human Services (2001a). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report to the Surgeon General*. Rockville, MD: USHHS, Public Health Service, Office of the Surgeon General, p. 55.



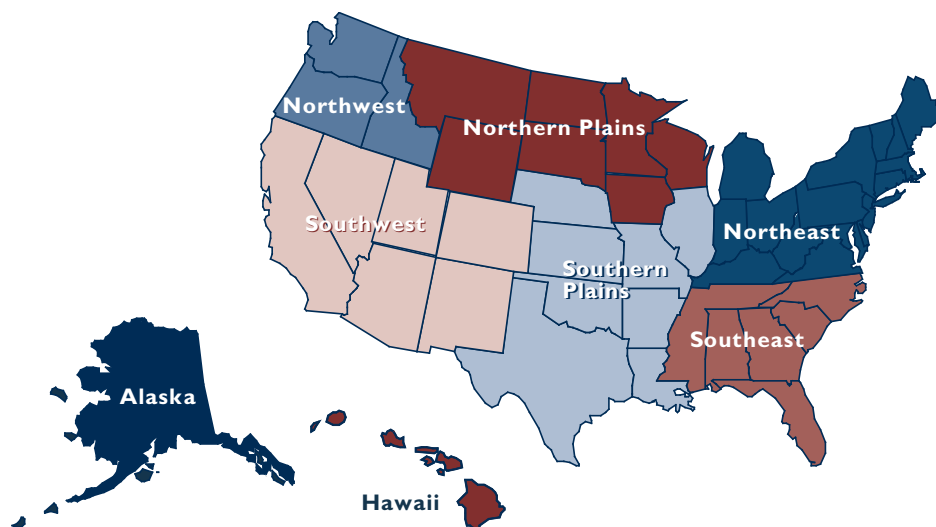
## *American Indians and Alaska Natives*

At one time, American Indians and Alaska Natives (e.g., Indians, Eskimos, and Aleuts) were autonomous and self-governing people. This changed when they came into contact with Western Europeans and Russians. Now they live on reservations, in rural areas, and in the cities, and constitute about 4.1 million, or approximately 1.5% of the total American population. The U.S. government officially recognizes 561 different American Indian and Alaska Native tribes; in addition, there are numerous tribes that have not yet been officially recognized. In all, these populations speak more than 200 indigenous languages (USHHS, 1996, 2001a; U.S. Census Bureau, 2001a).

American Indians live primarily in the western parts of the United States; 42% reside in rural areas. The states with the largest American Indian populations are California, Arizona, New Mexico, South Dakota, Alaska, and Montana. Some American Indians live on reservations and trust lands, but their numbers are steadily declining.

Alaska Natives are also a diverse population. There are more than 200 Native communities in the state of Alaska, with many different cultural norms and expectations, and numerous languages. Since the 1970s, many communities have had self-governing organizations, and tribal courts and councils continue to emerge as governing structures. Unlike American Indians, Alaska Natives were not initially relegated to reservations; the first reservations for Alaska Natives were created in 1891. After oil deposits were discovered, the U.S. Congress passed the Alaska Native Claims Settlement Act, which allowed Alaska Natives to organize into regional and village corporations. They also gained control over more than 44 million acres of land, but at the cost of waiving their claims to many other ancestral lands. Figure 2 shows the areas of the nation where American Indians and Alaska Natives reside. The referenced web site provides more detailed information about the people in these regions, their cultures, and their contributions to American society.

Figure 2. American Indian and Alaska Native Populations by Region



Source: American Indian Heritage Foundation (2003). <http://www.indians.org>. (See also CDC, 2003, <http://www.cdc.gov/omh/Populations/AIAN/AIAN.htm>.) Other excellent information can be found at <http://www.nmai.si.edu>, the web site of the National Museum of the American Indian, which offers a wealth of information about the history of Native Americans. This reference is provided here because of its symbolic significance in the history of this nation's first citizens.

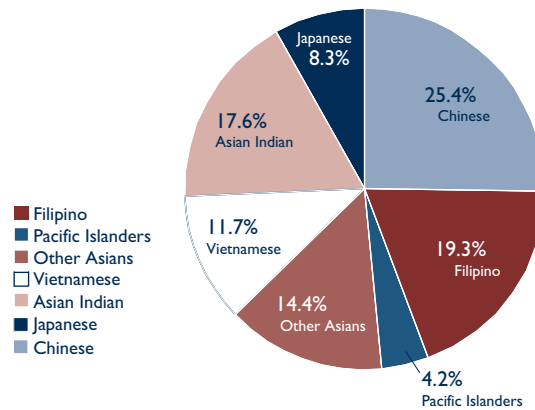
### *Asian Americans and Pacific Islanders*

During the period between 1990 and 2000, people who identified themselves as Asian American, Native Hawaiian, or Other Pacific Islanders increased 44%, reflecting the presence of about 10 million Asians and approximately 350,000 Native Hawaiian or Other Pacific Islanders in the nation. Asian Americans and Pacific Islanders are rapidly increasing in the United States. From 1980 to 1990, this population grew 95%, from 3.7% of the U.S. population to 7.2% (this increase reflects both immigration and live births). It is a diverse group, representing more than 43 different ethnic groups and more than 100 languages and dialects. Figure 3 depicts the distribution of Asian American and Pacific Islander populations by subgroups in 2000 in the United States (U.S. Census Bureau, 2000a; USHHS, 2001a; Spratley and others, 2000).

Pacific Islanders are not immigrants; they are descendents of the original inhabitants of their own land, which was claimed by the United States. Their history parallels that of the American Indians and the Alaska Natives in that their lives changed dramatically after the European explorers “discovered” them and their lands. Other Pacific Islanders include, for example, Hawaiians, Guamanians, Samoans, and Marshall Islanders. An examination of the geographical distribution of Asian Americans and Pacific Islanders reveals that they reside primarily in the West (54%), followed by the Northeast (18%), the South (17%), and the Midwest

**Figure 3. Percent Distribution of Asian American Population by Subgroup: 2000**

Source: U.S. Department of Health and Human Services (2001a). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report to the Surgeon General*. Rockville, MD: USHHS, Public Health Service, Office of the Surgeon General, p. 108.



(11%). Significantly, about 75% of all Pacific Islanders live in two states, Hawaii and California (USHHS, 2001a; U.S. Census Bureau, 2000a).

### *Hispanic Americans*

Hispanic Americans comprise a group of diverse populations having common bonds of language and culture but distinct experiences and histories. They represent individuals with ancestral bonds linked to Africa, Asia, Europe, North America, and Latin America. They have experienced tremendous growth over the past decade, and by 2050, the numbers of Hispanic Americans will approach 100 million people, or about one-fourth of the total American population (USHHS, 1996, 2001a; U.S. Census Bureau, 2000a). In America, Hispanic populations (see Figure 4) are composed of Mexicans (the largest group); Puerto Ricans and Cubans; Latin Americans; and Central Americans (from El Salvador, Guatemala, and Nicaragua), the newest group to become residents of the United States, arriving here during the 1980s and the 1990s (U.S. Census Bureau, 1996, 1999a, 2000b; USHHS, 2001a).

Hispanic Americans are located primarily in the Southwest (60%), making their homes in California, Arizona, New Mexico, Colorado, and Texas, with about one-half of all Hispanic Americans living in two states, California and Texas (U.S. Census Bureau, 1996, 1999a, 2000b; USHHS, 1996, 2001a).

## **Ethnic Minorities as Participants in Mental Health Research**

Research suggests that health care systems should be socioculturally competent and strive to provide the type of care necessary to promote positive mental health outcomes for the specific population being served (Lillie-Blanton and Correa-Alfaro, 1995). Research on access to health care and service utilization has

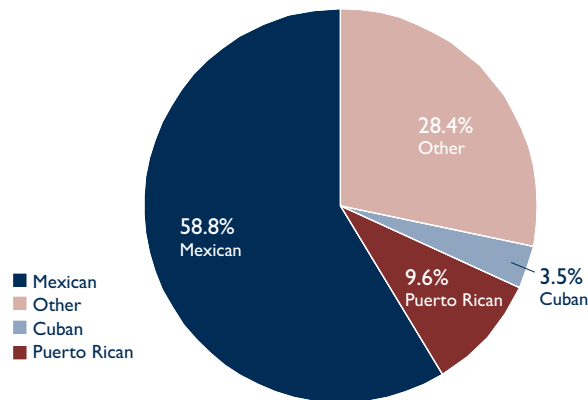
frequently documented disparities in mental health care as experienced by ethnic minority populations when compared with their Caucasian counterparts. Ethnic minorities: (1) have less access to, and availability of, mental health services; (2) are less likely to receive needed mental health services; (3) often receive a poorer quality of mental health care in treatment; and (4) are underrepresented in mental health research (USHHS, 2001b).

Part of these discrepancies in mental health care are doubtless due to the lower income levels of minorities vis-à-vis those of Caucasians, as noted in Table 1.

These data indicate that White Americans have a higher per capita income than any of the ethnic minority groups, followed by Asian Americans, who earn about \$3,000 per year less than Caucasians. African Americans reported a per capita income of \$14,397, about \$2,776 more than Hispanic Americans. Economic data for American Indians and Alaska Natives were not included in this table, though it can be safely assumed that their income is lower than that of Caucasians. Low

**Figure 4. Percent Distribution of Hispanic American Population by Subgroup: 2000**

Source: U.S. Department of Health and Human Services (2001a). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report to the Surgeon General*. Rockville, MD: USHHS, Public Health Service, Office of the Surgeon General, p. 129.



**Table 1. Per Capita Income by Ethnicity in 1999**

Source: U.S. Department of Health and Human Services (2001a). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report to the Surgeon General*. Rockville, MD: USHHS, Public Health Service, Office of the Surgeon General, p. 39. (See also U.S. Census Bureau, 1999b, 2000a, 2000c.)

	Per Capita Incomes
African American	\$14,397
Alaska Natives	Not Available
Asian American	\$21,134
American Indian	Not Available
Hispanic American	\$11,621
White American	\$24,109

economic status has a deleterious impact on health status and spins its own web of social and political complexities (USHHS, 1996, 2001a). In general, the poor do poorly (Lynch and others, 1997; Link and others, 1999; Lipsky and others, 2006).

## *Psychiatric Diagnoses and Culture*

When considering the validity of a psychiatric diagnosis, the importance of the patient's culture, race, and ethnicity cannot be overstated. In Western society, health care is based on scientific evidence and is driven by the necessity of an accurate diagnosis and the proper classification of the disorder. Diagnoses help to determine the course of treatment, the type of care needed, and the patient's prognosis. Moreover, culture and ethnicity should be important factors in making a diagnosis, planning a course of treatment, and determining the patient's prognosis. Patterns of behavioral expressions, signs (observable phenomena), and clustering of symptoms (patient-reported experiences and histories), all of which are related to distress, dysfunction, and disability, are the cornerstones of the diagnostic process. When there is impairment in one or more of the four domains—home, work, school, or the community—a disability is considered evident (APA, 1994, 2000; Rogler, 1996; Van-Ryn, 2002; National Academies, 2003).

The following three components of a diagnosis are directly influenced by race, ethnicity, and culture:

- the patient's oral history about the disease process, including his or her description of the nature, intensity, and duration of symptoms;
- data obtained from the assessments, procedures, and psychiatric review, including the mental status examination; and
- the clinician's observations and impressions of the patient's manifest behavior when in treatment.

The final but critical components are the clinician's determination that the clinical data do or do not meet the criteria for a particular disorder, as stated in the DSM-IV-TR™ (APA, 2000), and the determination of whether the patient's condition impairs his or her functioning at home, school, or work, or as a member of a community (APA, 1994, 2000; National Academies, 2003).

Despite the use of standard criteria, this process holds the potential for faulty communication or misinterpretation of the observed and self-reported experiences of the condition. Race, ethnicity, and culture are powerful influences in the entire treatment process.

Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV-TR™ classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, beliefs, or experiences that are particular to the individual's culture. Applying personality

disorder criteria across cultural settings may be especially difficult because of the wide cultural variation in concepts of self, styles of communication, and coping mechanisms (APA, 1994, 2000).

Mental health professionals acknowledge the influence of culture and ethnicity on the shaping and defining of mental health and illness in every society in the world. Culture and ethnicity help to shape symptom formation and manifestation, whether and when the person or a family member seeks professional help, and the course of the disorder. These factors are not yet clearly understood and are not always given adequate attention in clinical practice and research. For example, terms such as “anxious” or “depressed” are not in the vocabularies of some American Indian and Alaska Native cultures (Manson and others, 1985).

### *Ethnic Minority Populations and Clinical Trials in Mental Health Research*

Involvement of ethnic minority people in clinical trials and other types of research is one method of unraveling differences in cultural beliefs and behaviors among ethnic minority groups. Regarding the participation of ethnic minority individuals in clinical trials, research suggests that these populations have been underserved and mostly absent from samples that were used to determine critical clinical practice guidelines and evidence-based treatment protocols for mental disorders. The USHHS *Report to the Surgeon General* indicated that during the previous two decades, about 10,000 people were included in randomized clinical trials designed to evaluate the efficacy of treatments developed for bipolar disorder, schizophrenia, major depression, attention deficit/hyperactivity disorder (ADHD), and other conditions (USHHS, 2001a, 2001b).

As indicated in Table 2, almost 54% (4,991) of the subjects were classified as White, Black, Hispanic American, American Indian, Asian American, and Other. There were 11.24% Black, about 2% Hispanic American, 0.0% American Indian, 0.22% Asian American, and 13.14% Other in the sample. These data indicate that some of the ethnic/minority groups were underrepresented in the clinical trials that formed the basis of Table 2.

### *Mental Health Research and Application to Practice*

The lag between research and practice is a well-known phenomenon, with the practitioners’ lack of knowledge regarding recent research studies being one of the most troublesome concerns. In some instances, there is an abiding sense of uneasiness related to costs associated with implementing empirical findings in mental health systems of care. This uneasiness has increased in recent years and is related to the transformation of health and mental health care, which is now delivered through health maintenance organizations and other similar structures.

For ethnic minorities, however, the plot thickens: controlled clinical trials, the bedrock for the development of professional practice guidelines or evidence-based

**Table 2. Clinical Trials: Ethnic Analyses for Evidence-Based Treatment Guidelines**

Studies	Total Number of Participants	Number of Participants for Which Ethnicity is Reported							Total Number of Ethnic-Specific Analyses Conducted
		N (% of Total Sample)	White	Black	Hispanic American	Indian American	Asian American	Other	
Bipolar Disorder	921	305 (33%)	234	32	0	0	0	39	0
Schizophrenia	2,813	2,044 (73%)	1,314	376	44	0	5	305	0
Major Depression	3,860	1,841 (48%)	1,571	27	0	0	2	241	0
ADHD	1,672	801 (48%)	545	126	55	0	4	71	0
<b>Total</b>	<b>9,266</b>	<b>4,991 (54%)</b>	<b>3,664</b>	<b>561</b>	<b>99</b>	<b>0</b>	<b>11</b>	<b>656</b>	<b>0</b>

Source: U.S. Department of Health and Human Services (2001a). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report to the Surgeon General*. Rockville, MD: USHHS, Public Health Service, Office of the Surgeon General, p. 35.

data as related to treatment outcomes for specific disorders, are embedded in the findings of these types of studies. However, as a rule, few ethnic minority persons were included in the trials, and not one study analyzed the efficacy of treatment by ethnicity or race, as indicated in Table 2. Yet, these clinical trial studies were used to guide scientific decision-making about treatment, outcomes, prognosis, and future research (USHHS, 2001a; Grosel and others, 2000; Mezzich and others, 1996; National Institutes of Health [NIH], 1998).

This problem must be addressed. The Minority Fellowship Program is one mechanism through which this disturbing pattern can be interrupted; over time, the program will enable a larger percentage of ethnic minority professionals to conduct research, provide consultation and critique for existing research, and challenge some traditional assumptions that are based on unintentional ethnocentric thinking. For more information on recent clinical trials on psychiatric disorders, see: [www.nimh.nih.gov/studies/index/cfm](http://www.nimh.nih.gov/studies/index/cfm).



# 21st Century Realities: The Nursing Work Force

**N**ursing is the nation's largest health professional work force. It serves a multitude of health needs, in a variety of settings, over the lifespan of clients. Because a culturally diverse work force is essential for addressing the health and mental health needs of all of the population, it would be useful to present essential statistics about the current work force and discuss mechanisms that could help to reshape and diversify the nursing work force of the future into one that would more accurately reflect the population that it serves. It must not be forgotten that the ethnic minority percentage of the U.S. population continues to grow. The ethnic minority population also maintains a greater disease burden, has less positive treatment outcomes, experiences more disabilities, and has a shorter life expectancy than does its Caucasian counterpart (USHHS, 1996, 2000a, 2000b, 2001a; National Advisory Council on Nurse Education and Practice, 2000; Schneider and others, 2002; Van-Ryn, 2002; Mayberry and others, 2002; LaVeist and others, 2000; Kulis and others, 2002; LaFromboise and Howard-Pitney, 1995; Lillie-Blanton and Hoffman, 1995; Oppenheimer and Shultz, 1999; Olin, 1999; Ostrove and Feldman, 1999; Pachter, 1994). According to the National Advisory Council on Nurse Education and Practice, increasing the number of ethnic minority nurses is a major mechanism for improving the health and mental health status of ethnic minority populations (Mayberry and others, 2002; Drentea and Goldner, 2006; Lipsky and others, 2006; Ferris and others, 2006).

## Ethnic Minority Population Distribution of Nurses

In this section, selected characteristics of the nation's nursing work force as it currently exists are shown. First, the percentage of the population of each U.S. ethnic minority group is shown, along with that of the Caucasian population, in Figure 5.<sup>6</sup> By way of comparison, Figure 6 shows the percentage distribution of registered nurses (RNs) among these same groups.

Figure 6 reveals that the RN population of the United States remains predominantly White: they comprise 86.6% of the RN work force, about seven

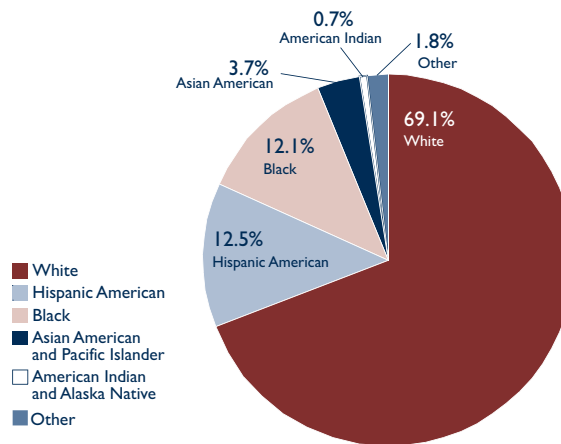
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6. It should be noted that much of the available data on American Indians and Alaska Natives do not always adequately distinguish one group from the other, and often combine the two. Therefore, while some of the data in this section are noted as pertaining only to American Indians, they should be considered to include Alaska Natives as well. In addition, this is also often the case with Asian Americans and Pacific Islanders.

times the size of the ethnic minority RN population. African American nurses constitute about 4.9% of the nursing work force, or some 133,041 individuals (Spratley and others, 2000). Asian Americans and Pacific Islanders make up 3.7%, or 93,415 of the RN population, and Hispanic Americans comprise 2.0% of the RN populace, though they consist of 12.5% of the total national population. American Indian and Alaska Native individuals are minimally represented in the profession, with about 0.5%, or 13,040 of the nation's professional nurses. Individuals who acknowledge themselves as having identities in two or more racial groups include 1.2% of the population, or 32,536 individuals (Spratley and others, 2000).<sup>7</sup>

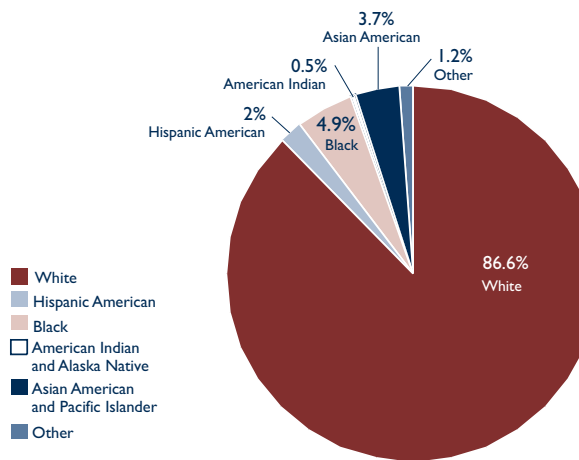
**Figure 5. Percentage Distribution of U.S. Population by Ethnic Minority Background, March 2000**

Source: Spratley, E., Johnson, A., Sochalski, J., Fritz, M. and Spencer, W. (2000). *The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses*. Rockville, MD: USHHS, p. 9.



**Figure 6. Percentage Distribution of RNs by Ethnic Minority Background, March 2000**

Source: Spratley, E., Johnson, A., Sochalski, J., Fritz, M. and Spencer, W. (2000). *The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses*. Rockville, MD: USHHS, p. 9.



7. These data reflect the new practice promulgated by the Office of Management and Budget that queries the nurse about whether his or her ethnic status is Hispanic/Latino; then it asks the respondent to identify all races that best describe him or her. It therefore reports data on an additional category: non-Hispanic RNs reporting two or more races which, in this survey, yielded a total number of 32,536, or 1.2% of the total RN population (Spratley and others, 2000; USHHS, 2001a).

The percentage distribution of RNs in the Other group is less than the percentage distribution in the general population. In general, except for Asian Americans, the percentage distribution of RNs in all ethnic minority groups is less than the percentage distribution in the general population (Spratley and others, 2000).

A more incisive review of demographic patterns should illustrate further the need for a more culturally diverse professional nurse work force. Over a period of two decades between the mid-1970s and the mid-1990s, the number of RNs in the United States having a license to practice increased by more than 1 million; between 1996 and 2000, the RN population grew at a rate of 1.3% each year, indicating a slower increase than in previous years. Moreover, the nursing work force is aging, with an average age in 1996 of 44.3, compared with data from the year 2000 that revealed an average age of 45.5 years.<sup>8</sup> The majority of the nursing work force (n=2,694,540) continues to be female, with 5.4% of the population (n=146,902) being male.

## Educational Preparation of the Nation's Registered Nurse Work Force

The majority of current RNs—40%—received their education at institutions granting associate degrees (they number 1,087,602, out of the total nursing work force of 2,694,540). About 30% of the nurses attended diploma degree programs, and another 30% enrolled in baccalaureate degree programs. Over the past 5 years, however, 55% of the RNs graduated from associate degree programs, and 38% were graduates of baccalaureate programs. A smaller number, 6%, completed diploma programs. Of the nurses who earned an advanced degree, the majority (53.2%) completed a bachelor's as their first degree (Spratley and others, 2000).

An examination of Figure 7 will show how ethnic minority RNs compare in regard to advanced degrees. Blacks (11.4%) and the nurses categorized as Other (12.6%) were more likely to have achieved master's and doctoral degrees. More than 10% of White nurses have attained master's or doctoral degrees.

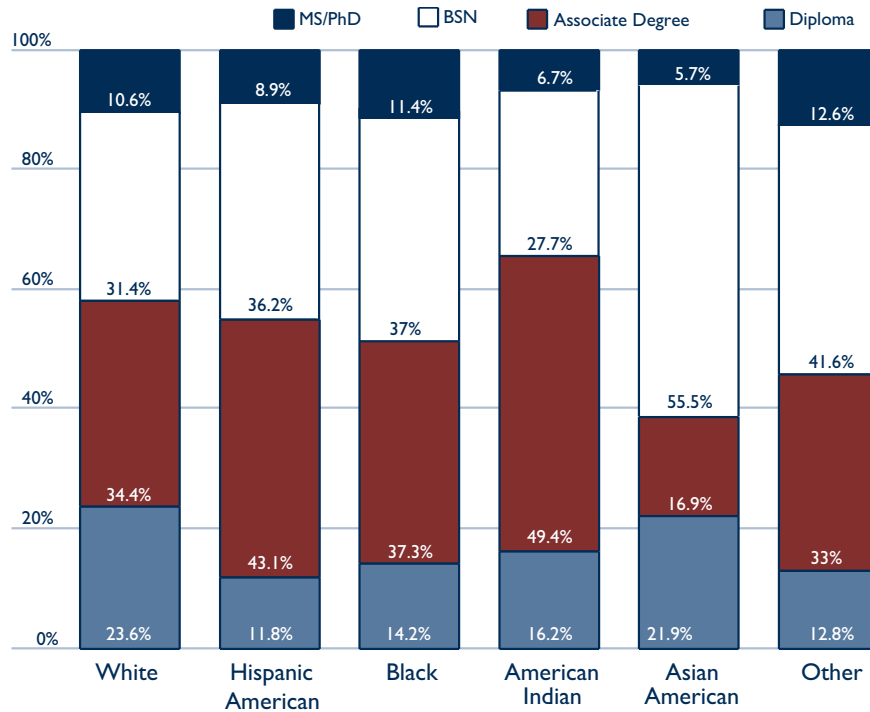
Hispanic Americans, American Indians, and Alaska Natives have acquired fewer master's and doctoral degrees. However, the lowest percentage of nurses with master's and doctoral degrees were Asian Americans.

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8. Recent statistics indicate that percentages of other essential health care providers are diminishing as well. Dentists, for example, are likely to be in short supply in the near future. In the year 2004, more dentists left their practices because of death or retirement than graduated from dental school. This trend is expected to continue as the professional work force ages and dies (Size, 2003).

Large numbers of African American, American Indian, and Alaska Native nurses will soon retire from the nursing work force. One-third of all African American nurses are 50 years of age or older. The average age of American Indian and Alaska Native nurses is about 49. Conversely, Hispanic American, Asian American, and Pacific Islander nurses, in general, are younger, with an average age of 41 years (National Advisory Council on Nurse Education and Practice, 2000).

**Figure 7. Percentage Distribution of RNs in Each Ethnic Minority Group by Education, March 2000**



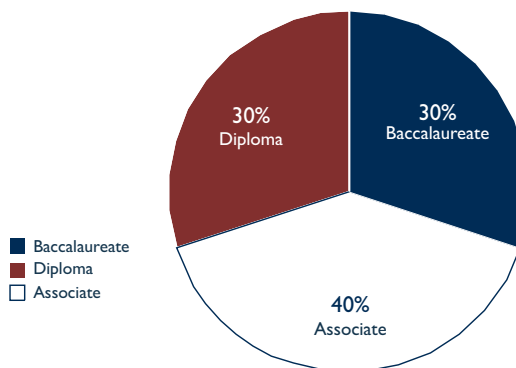
Source: Spratley, E., Johnson, A., Sochalski, J., Fritz, M. and Spencer, W. (2000). *The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses*. Rockville, MD: USHHS, p. 18.

An examination of data regarding initial nursing education demonstrated that equal percentages of nurses (30%) attained diploma and baccalaureate degrees (see Figure 8). However, about 40% of active RNs obtained their initial education in associate degree programs. The data in this figure clearly indicate that the greatest number of the nation’s nursing work force receive their initial exposure to the discipline while matriculating in associate degree programs, and an even split exists between diploma and baccalaureate programs.

As noted above, the majority (53%) of RNs who earned master’s and doctoral degrees received their first-level preparation in baccalaureate programs. That is to say, nurses who graduated from baccalaureate programs were more likely to matriculate in graduate schools and attain advanced degrees. These data are important for ethnic minority populations, because most of these students are more likely to enroll in associate degree programs. These 2-year programs, typically located in community colleges, produce the highest numbers of graduates across all ethnic groups except Asian Americans and those in the Other category. Their Caucasian nurse counterparts report their highest numbers of graduates in the associate degree category as well.

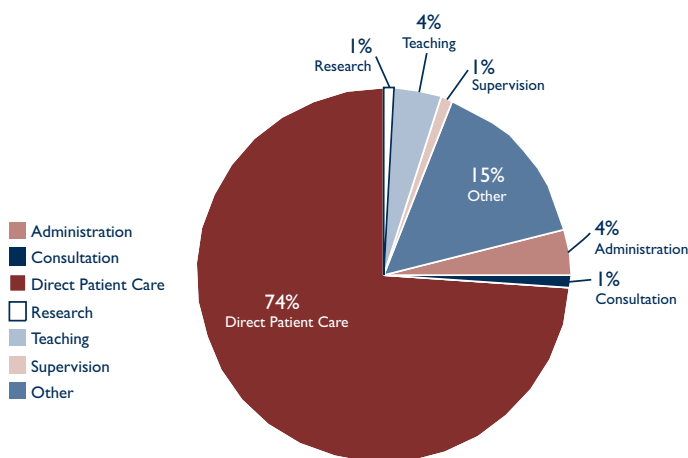
**Figure 8. Percentage Distribution of RNs by Initial Education**

Source: Spratley, E., Johnson, A., Sochalski, J., Fritz, M. and Spencer, W. (2000). *The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses*. Rockville, MD: USHHS, p. 19.



**Figure 9. Percentage Distribution of RN Employment in Hospitals, March 2000**

Source: Spratley, E., Johnson, A., Sochalski, J., Fritz, M. and Spencer, W. (2000). *The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses*. Rockville, MD: USHHS, p. 23.



## Employment of Registered Nurses

Employment settings for nurses have not changed significantly over the years. In general, nurses have been employed in direct care settings such as hospitals, clinics, home health settings, etc.; this trend continues into the 21st century.

Figure 9 indicates that 74% of the RNs who are employed in hospitals are involved in direct care, while 15% are engaged in other nursing functions. The third-highest employment functions for nurses were in teaching (4%) and administration (4%). Significantly, RNs employed as researchers, supervisors, and consultants comprise only 1% of the total in each of these categories. The Minority Fellowship Program staff and Advisory Committee are cognizant of this fact and aim to increase the percentage of nurses who are active in research programs, a variety of health care systems, and academic institutions, as well as other settings.

Concluding this section is Table 3, which depicts RN employment by gender, race, and ethnicity at three time periods: November 1984, March 1996, and March 2000.

The data provide some insight into the numbers, percentages, and increases in the gender and race/ethnicity categories over this period of time. The number of males increased about 2.1% over a 12-year period (1984-1996), but over the next 4 years (1996-2000) it increased only about 0.5%. The percentage of females in the profession decreased slightly over the three reporting periods. Regarding race/ethnicity, White nurses showed a slight decrease, from 89.5% to 89.1%, and then a more substantial shift downward over the last 4 years, from 89.1% in 1996 to 85.9% in 2000. They still remain the predominant majority of RNs in the United States, however.

In 1984, Blacks made up 4.5% of the RN population, but 12 years later, the percentage of Black RNs had declined to 4.3%. By 2000, the percentage of Black RNs had shown a slight gain, to 5.1%. In 1984, 3% of the RNs in the United States were classified as Asian; their percentage of RNs increased slightly to 3.7% in 1996 and 3.8% in 2000. Hispanic Americans constituted 1.6% of the RN population in 1984, with slight gains over the subsequent reporting periods. In the year 2000, 2.2% of RNs were classified as Hispanic Americans. American Indians and Alaska Natives showed gains in the 12-year period, but they remained constant during the 1996 to 2000 time span. The total population of Native Hawaiian and Pacific Islander nurses was nearly 6,000 in 2000.

**Table 3. RNs Employed in Nursing by Gender, Race, and Ethnicity for 1984, 1996, and 2000**

<b>Gender, Race/Ethnicity</b>	<b>November 1984</b>	<b>March 1996</b>	<b>March 2000</b>
Total	1,485,725 (100%)	2,115,815 (100%)	2,201,813 (100%)
<b>Gender</b>			
Male	49,658 (3.3%)	113,683 (5.4%)	129,118 (5.9%)
Female	1,436,067 (96.7%)	2,001,399 (94.6%)	2,072,695 (94.1%)
Unknown Gender	0 (0.0%)	1,840 (0.1%)	0 (0.0%)
<b>Race/Ethnicity</b>			
White (Non-Hispanic)	1,329,118 (89.5%)	1,885,532 (89.1%)	1,890,708 (85.9%)
Black (Non-Hispanic)	67,175 (4.5%)	91,157 (4.3%)	113,362 (5.1%)
Asian American	44,813 (3.0%)	79,152 (3.7%)	82,716 (3.8%)
Hispanic American	23,390 (1.6%)	35,804 (1.7%)	47,763 (2.2%)
American Indian and Alaska Native	4,996 (0.3%)	10,510 (0.5%)	11,356 (0.5%)
Native Hawaiian and Pacific Islander	NA	NA	5,725 (0.3%)
Two or more races	NA	NA	26,998 (1.2%)
Not known	16,233 (1.1%)	13,661 (0.6%)	23,185 (1.1%)

Source: Adapted from USHHS, Health Resources and Services Administration, *United States Health Personnel Factbook*. June 2003.



# Historical Perspectives on the Minority Fellowship Program

## Three Critical Periods and Their Influence on the MFP

The Ethnic Minority Fellowship Program (EMFP; now known as MFP) was established to educate minority substance abuse and mental health professionals in the four core disciplines: nursing, psychiatry, psychology, and social work. Three time periods are useful in conceptualizing the development of psychiatric and mental health nursing as it relates to the MFP: 1974-1981, 1982-1989, and 1990-2000. Some of the critical factors that influenced the outcomes across the three times periods include:

- changes in the specialties of psychiatric/mental health nursing, neuroscientific nursing, and behavioral health nursing;
- the availability of doctoral programs in psychiatric/mental and behavioral health nursing, as well as substance abuse prevention and treatment; and
- the identification of eligible ethnic minority applicants who met federal, MFP, and university doctoral program criteria (Porter, 2000; Serlin, 1998).

### *Period One: 1974–1981*

Between the mid-1970s and the early 1980s, nursing curricula changed in structure and content, shifting from distinct domains of knowledge to a more integrated approach. Nurse educators and clinicians posited that all nurses needed to be proficient in the basic knowledge and skills of psychiatric nursing and be able to function in various settings. The nomenclature changed from psychiatric nursing to mental health nursing and, later, to psychosocial nursing. This shift, evident in the 1980s, dominated the specialty. While this orientation was useful in expanding the theoretical perspectives of mental health nursing, it was not accompanied by a concurrent increase in the training required to provide care for psychiatric populations. In general, students did not have adequate opportunity to study in-depth theoretical psychiatric nursing or to gain an understanding of the comprehensive management of individuals experiencing the burden of mental disorders (Porter, 2000; Serlin, 1998), including its chronic and acute phases.

Finding an EMFP applicant with a background in psychiatric and mental health nursing was a daunting task (ANA, 2003). Most of the nurse graduates were

alumni of hospital-based schools of nursing. Many among the growing population of associate degree nursing graduates did not elect to continue their education and, therefore, they did not receive bachelor's or master's degrees. This situation limited the potential for expanding the EMFP cadre of nurses who would be interested in careers in psychiatric and mental health nursing. Even fewer opportunities were available for nurses who wanted to pursue a career in substance abuse disorders prevention and treatment.

One pathway by which ethnic minority nurses, primarily African Americans, attained their education was by attending Historically Black Colleges and Universities (HBCUs). The curricula at these institutions had evolved, and reflected many of the same trends that were evident throughout the discipline and in the majority (predominantly Caucasian) schools of nursing. But, unlike the predominantly Caucasian universities, the HBCUs typically did not have master's programs. Even today, few HBCUs have master's programs, and even fewer of them have master's programs with substance abuse and psychiatric and mental health nursing curricula (Carnegie, 2000).

Currently, 11 HBCUs have accredited master's programs, most with a focus in Family and Community Health Nursing. Three HBCUs offer a master's degree in psychiatric nursing (Bessent, 2003a; Hammond, 2003; Davis, 2003). Two HBCUs have doctoral programs: Hampton University, Hampton, Virginia, and Southern University, Baton Rouge, Louisiana (Hendricks, 2003; Hammond, 2003). Some Hispanic Americans and Asian Americans, matriculating in Hispanic- and Asian-serving institutions, receive master's degrees in psychiatric and mental health nursing. There are even fewer American Indians and Alaska Natives with master's degrees in this specialty (Porter, 2000; Serlin, 1996, 1998).

Over the past 25 years, the National Institute of Mental Health (NIMH) has addressed this concern by widening educational opportunities for advanced study. The Registered Nurse Fellowship Program was one such medium. To address the shortage of master's-level ethnic minority nurses in psychiatric nursing, the NIMH's Center of Minority Group Mental Health Programs awarded the ANA financial support to enable 10 ethnic minority nurses to attain their doctoral degrees. The program, which was funded from 1974 to 1981, recruited nurses who were not master's-prepared in psychiatric nursing. The program focused on students who demonstrated a commitment to research; in some instances, they pursued a course of study in education, psychology, sociology, anthropology, and related areas (Gonzalez, 2003).

These graduates were expected to establish research programs in academic institutions, but that was no easy task. Numerous barriers had to be overcome. For example, at the time this program was implemented, limited infrastructures for research existed in schools of nursing; most schools had only a small number of research programs and a tiny cadre of faculty who were involved in research. This condition continued until 1985, when the U.S. Congress established the National Center for Nursing Research (since 1993, the National Institute of Nursing Research) as a component of the National Institutes of Health within the USHHS (Porter, 2000; Serlin, 1996). In addition to ethnic minority individuals'



participation in such research, a small number of Caucasian faculty members pursued mental health and mental illness research that was highly relevant to ethnic minority populations. For examples of the earlier Fellows' research, see Bessent (1983).

Another difficulty faced by some ethnic minority faculty was the expectation on the part of some of the Caucasian faculty members regarding the ethnic minority faculty's commitment to ethnic minority students, causes, and communities. Ethnic minority faculty often felt burdened with roles in recruiting, counseling, tutoring, mentoring, and mitigating the problems experienced by ethnic minority students. The ethnic minority faculty were more likely to serve on committees, task forces, and special initiatives, and to represent the school in community events. These activities consumed additional faculty time, but were not perceived as the types of commitments that would aid in the members' pursuit of promotion and tenure. Tensions were more likely to occur between academic requirements and service-related commitments. Ethnic minority faculty, who were typically not involved in administration or decision-making, nevertheless were frequently called upon to address specific issues that had arisen regarding the ethnic minority students and community. The implicit messages that were communicated by the majority faculty and administration to the ethnic minority faculty regarding their expected commitments to ethnic minority students and causes could produce conflict. Ultimately, the ethnic minority faculty members were in danger of being faulted for failing to meet basic criteria for tenure and promotion, and their careers in academic institutions risked being aborted (Porter, 2000; Serlin, 1996, 1998).

### *Period Two: 1982–1989*

This 7-year period brought about numerous changes in mental health care systems and in psychiatric/mental health nursing. First, psychobiology advanced in a rather rapid manner, and the scientific community witnessed shifts in five areas:

- neurotransmitter and neuronal receptors;
- psychobiology of emotions;
- brain imaging techniques;
- molecular and genetic knowledge related to psychology; and
- an intense interest in the study of the brain (Schatzberg and Nemeroff, 2003; Insel and Scolnick, 2006; Howell and others, 2001; Helmers and others, 1995; Marangell and others, 2003; Richters and others, 1995; Simeon and others, 1995; Stuart, 2001; Gary and Kavanagh, 1991; Porter, 2000; Serlin, 1998).

While these phenomenal advances were being made, to some extent, nurses continued to practice from a conceptual model that valued the psychodynamic perspective and some behavioral models. The discipline as a whole did not immediately embrace the paradigm shift to the psychobiological framework. As a result, new knowledge about psychobiology and its social and behavioral components was inadequately integrated into psychiatric nursing education and practice.

Second, other changes were occurring in practice and policy implementation. Community-based care became the preferred method of treatment, and fewer patients were retained in large state mental hospitals (Gary, 1991; Stuart, 2001; Porter, 2000; Serlin, 1998). In response to this shift, psychiatric nurse educators began to integrate knowledge related to the brain, behavior, emotions, cognition, culture, and community as essential features in psychiatric nursing. Nationwide, colleges and schools of nursing responded by developing advanced practice nursing programs, which were designed to integrate the biological, psychological, and social components of substance abuse and mental health care, with the intent of providing holistic approaches. Despite the proliferation of these academic programs, they did not produce enough nurses to satisfy the demand from clients and communities, both of which were seeking community-based services and culture-specific population care. The cultivation of new partnerships is essential for the development of ethnic minority nurses, who will function as leaders in education, practice, public policy analyses, and research (Powell and Gillis, 2004a, 2004b; Aday, 2001; Aguilar-Gaxiola and others, 2002; Alegria and others, 2003; Anderson and others, 2003; NIH, 2000).

During this period, other changes in nursing were occurring as well. For example, the number of doctoral programs in nursing increased rapidly. In 1983, there were 27 programs, but by 1987, 45 doctoral programs were operating. Their content varied, with some requiring a specialty focus; the majority of these programs, however, embodied content that concentrated on theory, philosophy, ethics, and research methods and design. Of the 45 programs, 7 offered psychiatric nursing as a specialty (NIH, 1987; Porter, 2000; Serlin, 1996). At the master's level, about 10,000-12,000 psychiatric nurses were in the pool of potential recruits into doctoral programs, indicating a prospective interest in psychiatric nursing at an advanced level. Psychiatric nurses with master's degrees were represented in smaller percentages than were nurses in other specialties, such as family and community health or adult health nursing. This trend continues into the 21st century.

Despite the small percentage of ethnic minority psychiatric nurses, and the lack of immediate resources to help in locating this nursing population, the EMFP staff was successful in recruiting ethnic minority nurses into its program. These nurses were committed to developing careers in scholarship, practice, and research. Other disciplines explored as viable options included medical sociology, clinical and educational psychology, political science, and education. As cognates or minors in these programs, psychiatric nursing theory, psychopharmacology, psychiatric epidemiology, mental health theory, psychopathology, and advanced treatment modalities (i.e., family and group theories/therapies) were frequently added to the nurses' courses of study. Their dissertation research often focused on psychiatric and mental health issues, behavioral health conditions, or psychiatric disorders. Research topics also included the prevention and treatment of substance abuse disorders. These were requirements set forth by the EMFP and the guidelines promulgated by NIMH and the Substance Abuse and Mental Health Services Administration.

An important document, the NIMH *Report of the Task Force on Nursing* (NIH, 1987), addressed the shortage of psychiatric/mental health nurses and recommended that research career awards be developed to aid in expanding the cadre of professionals in this specialty. One outcome was the availability of financial support for psychiatric/mental health nursing at the doctoral level.

### *Period Three: 1990–2000*

Further changes occurred in mental health service systems during the latter part of the 20th century. Evidence-based research on effective community-focused care increased in importance. Health services for people with acute and chronic mental illness became available without the extended hospitalization periods that were common in earlier decades. Psychotropic medications emerged as a dominant approach to treatment, and antipsychotic drugs were typically used to aid in the management of all forms of psychosis, including schizophrenia, mood disorders with psychosis, and organic disorders with psychosis (Marder, 1998). The prevention, assessment, and treatment of mental disorders in children and adolescents and their families also included pharmacologic alternatives (Raghavan and colleagues, 2005; Schireman and others, 2005). The availability of these psychopharmacologic agents brought about new thinking related to caring for individuals with mental illness. Please see Evans and colleagues (2005) for an in-depth discussion on mental health disorders in children and adolescents.

However, behavioral, environmental, cultural, and social issues remain in the continuum of care given to the clients and their families. The MFP intends to continue addressing national recommendations for more research that links service utilization to quality of care and other clinical and social indicators of patient status and treatment outcomes. Ethnic minority nurses are needed to help unravel the myriad issues involved in humane and culturally appropriate care for individuals and families in a variety of settings and throughout the life cycle.

As these dynamic changes in mental health delivery systems unfolded, other shifts were also occurring. While doctoral student enrollments were increasing, there was a 14% decline in ethnic minority enrollment in the nation's master's-level mental health/psychiatric clinical specialty programs and the mental health nurse practitioner curricula. These enrollment shifts would have a direct impact on the percentages of ethnic minority nurses who would be in the pipeline for doctoral education with a specialty in substance abuse prevention and treatment and psychiatric/mental health nursing (Porter, 2000; Serlin, 1996; NIH, 1987).

Five factors converged to create this scenario:

- The decline in ethnic minority nurses educated at the master's level minimized opportunities for doctoral studies in the specialty.
- Few doctoral programs offered specialties in substance abuse and/or psychiatric/mental health nursing, limiting the availability of theoretical and research approaches to the scientific advancement of the specialty.

- Too few colleges and schools of nursing developed concentrated programs or courses that focused on ethnic minority substance abuse and mental health disorders or evidence-based approaches to the prevention of these disorders.
- The number of faculty with federal or comparable funding to support ethnic minority health, substance abuse, and mental health issues was minimal.
- There was a scant number of ethnic minority nurses and faculty at colleges and universities.

Given this situation, MFP Fellows were forced to be creative in constructing their courses of study, identifying mentors and advisors, selecting a doctoral research committee, and developing a culturally sensitive and scientifically precise area of research study. The outcomes of their creative approaches varied. The MFP—through its formal and informal relationships with schools and colleges of nursing, former Fellows, advisory committee members, committed faculty, deans and directors, and extensive network of professional friends—has been able to identify and recruit eligible candidates for this outstanding program. However, despite best efforts, recruiting and educating nurses in master’s and doctoral-level programs is a subject for immediate and extensive discussion that must yield a definitive national plan for action; the beginning of such a plan is outlined in Section 8 of this report.

## Programmatic Responses to Creating a Diverse Nurse Work Force

### *MFP as a Long-Term Approach to Educating Nurses*

The EMFP was developed in 1973 and placed under the administrative structure of the Center for Minority Mental Health at the NIMH. It was an outgrowth of the Center’s findings that documented the scarcity of ethnic minority mental health professionals who were educated to provide care for the growing numbers of ethnic minority individuals, families, and communities.

It was evident from the demographic data that the need for human resources was increasing, and that these populations would require expertise in mental health theory and practice, as well as enhanced culture-specific knowledge and clinical care. The center’s staff also reasoned that nurses and other mental health professionals who were members of those particular groups and were well educated as researchers and clinicians could best address the needs of ethnic minority groups. The problem was that only a few ethnic minority mental health professionals were available to assume such important responsibilities (Jones, 2003).

That same year, 1973, the Center for Minority Mental Health invited the American Sociological Association to submit a grant proposal for the purpose of educating

ethnic minority sociologists at the doctoral level. This initiative was expanded to four other mental health professional groups, among which were nurses (ANA), psychiatrists (American Psychiatric Association), psychologists (American Psychological Association), and social workers (Council on Social Work Education).

At the 20th anniversary of these five ethnic minority programs, the Center for Mental Health Services (CMHS) published the *CMHS Minority Fellowship Program 20 Year Report* (USHHS, 1994), which explained the need for well-educated ethnic minority core mental health professionals:

- The multicultural composition of the U.S. population requires sensitivity to ethnic differences in mental health services.
- Culture has a specific influence on a person's definition of health and illness, methods of detection, and service use.
- Culture influences the forms of mental health treatment that are acceptable to the individual and family.
- Ethnic minority professionals are more likely to be sensitive to the cultural needs and mental health/illness factors of an ethnic minority individual, family, or community.
- Ethnic minority individuals, families, and communities carry the heaviest burdens of physical and mental diseases and are more likely to live in poverty, which exacerbates school failure, violence, substance abuse, teenage pregnancy, and numerous other undesirable physical, mental, and social conditions. Yet mental health services are deplorably lacking.
- Ethnic minority mental health professionals are front-line caregivers in their communities and have the potential to engage in leadership-related, culturally sensitive education, research, clinical practice (informal and formal teaching), and role modeling.

The ethnic minority fellowship programs were based on three superordinate objectives (*CMHS Minority Fellowship Program 20 Year Report*; USHHS, 1994):

1. Increase the pool of ethnic minority doctorally trained mental health professionals and researchers;
2. Approach its work through the respective national mental health core professional organizations; and
3. Expand research in ethnic minority mental health.

Although the EMFP began a gradual name change to the MFP in the 1990s, the five goals of the program at the ANA remain about the same:

1. To target training support to increase the pool of doctoral-level ethnic minority nurses who are committed to providing leadership in substance abuse and mental health education, practice, and research, directed toward relieving the burdens that are associated with these disorders.

2. To create a nucleus of ethnic minority nurse professionals with expertise in substance abuse and mental health disorders who are capable of addressing complex health-related disorders within a framework of cultural competency in local and global communities.
3. To collaborate with local, state, national, and international organizations and communities to increase the quality of care among ethnic minority populations.
4. To ensure that education and training are consistent with the latest scientific developments in substance abuse and mental health disorders prevention and treatment.
5. To assume leadership roles in translating science to service, reducing mortality and morbidity, and enhancing well-being among ethnic minority populations.

At several levels, the MFP is unique:

- It is a national program that is not based at any particular academic institution. Instead, it is located at the headquarters of the ANA, the national professional nursing organization. The ANA offers support, visibility, and legitimacy for the MFP.
- This model promotes and expects collaboration among the core mental health disciplines and is able to benefit from the best thinking and insights from all of the core mental health professions.
- Multidisciplinary professional networking can occur; each professional group makes unique contributions and, at the same time, benefits enormously.
- The MFP provides for a particular focus on substance abuse, HIV/AIDS, and mental health and illness.

As the MFP plans for the future, some vital issues on the horizon need to be addressed. There is an urgent need for more graduate programs in substance abuse and psychiatric/mental health nursing. In addition, the aging of the American population will present a daunting challenge to mental health professionals. At the same time, the American work force is becoming feminized and more culturally diverse. Ethnic populations are gradually becoming more heterogeneous, each with its own set of cultural values, folkways, and mores. Though the MFP has met and surpassed its goals over the past quarter-century, it will require a focused and concentrated effort to educate a sophisticated work force of nurse leaders who are doctorally prepared, can conduct research, and can function as competent educators, clinicians, and policy promulgators.



# The Minority Fellowship Program in Review

**T**hroughout its history, the foundation of the MFP has been the conviction that a diverse, superbly educated nursing work force is the most useful response to dealing with the health and mental health care needs of ethnic minority populations. The objective of the program has been to improve the delivery of substance abuse prevention and treatment as well as psychiatric mental health services to ethnic minority populations by increasing the availability of nurse leaders from ethnic minority backgrounds who were educators and scholars, clinicians, researchers, and administrators. In these positions, nurses would serve as role models, encourage the nursing community to become more responsive to the physical and mental health needs of members of various groups, and educate the next generation of nurses.

Two keys to the success of the MFP have been its generous funding and the continuing excellence of its leadership. The ongoing financial support from a variety of sources has enabled Fellows to participate in a number of activities, including doctoral and post-doctoral programs, pre-doctoral and post-doctoral enhancement programs, and initiatives for nurses at other educational levels. In the following paragraphs, these programs, their generous supporters, and the capable leaders who directed them are described.

## Past and Current Doctoral and Post-Doctoral Programs

### *National Institute of Mental Health*

Prior to the funding and leadership of the Substance Abuse and Mental Health Services Administration (SAMHSA), NIMH funded the Ethnic Minority Fellowship Program (EMFP) for more than two decades (1974-1996). In 1974, the Center for Minority Group Mental Health Programs of NIMH awarded the first grant for the “ANA Registered Nurse Fellowship Program for Ethnic/Racial Minorities,” as EMFP was initially entitled. The primary objective of this award was to increase the number of nurse researchers from ethnic minority backgrounds who had either engaged in or demonstrated an interest in conducting research on ethnic minority populations. The long-range goal was to increase the knowledge

base related to mental health among members of racial and ethnic minority groups. Nurses who were awarded this fellowship were expected to establish academic research careers, and were referred to as “Research Fellows.”

Over the years, specific criteria based on NIMH priorities were fine-tuned. Applicants for NIMH funding were expected to pursue doctoral degrees related to psychiatric and mental health nursing, with a focus on academic research in child and adolescent health issues, HIV/AIDS, the neuroscience of mental health, or psychosocial processes that contribute to an understanding of mental health and illness. The fellowship was renewable for up to 5 years.

Another primary and continuous supporter of the MFP is the ANA, which provided financial assistance to the program from 1977 to 1996. The ANA helped nurses from diverse racial and ethnic backgrounds gain access to nursing education and professional advancement; it also advocated for culturally competent health services for underserved and unserved populations. The ANA Board of Directors has reduced its direct funding to the MFP; however, it continues to support the philosophical underpinnings of such an initiative.

Over the life of the MFP, the ANA has provided the program with infrastructure. Material resources, for example, have consisted of space, equipment, and supplies. Human resources, essential for the success of the program, have been boundless: collaboration with other nurse leaders and mental health professionals within the United States and in the world, and entrée to leaders and decision-makers at the ANA, SAMHSA, NIMH, and in Congress, among others. The ANA serves as an incubator for new ideas and ideals for nursing and health care systems, and the MFP is one of its major interests.

## *Substance Abuse and Mental Health Services Administration*

After SAMHSA was established in 1992, a component of the EMFP was transferred from the NIMH to the Center for Mental Health Services within this new Agency. SAMHSA has played a critical role in sustaining the EMFP through supporting activities related to the development of nurse clinicians and researchers. In 1977, the Center for Mental Health Services at NIMH funded the EMFP to establish the Clinical Fellowship Program in Nursing for Minorities. The award offered financial support to nurses from ethnic minority backgrounds who were in clinical mental health nursing doctoral programs. The goal was to create a nucleus of racial and ethnic minority psychiatric and mental health nurses. The program would also provide consultative and administrative services to organizations that developed and implemented programs and services for individuals and families experiencing substance abuse and mental health disorders. Fellows were expected to conduct clinical research specific to the nature, prevention, and intervention of substance abuse and mental health disorders. In recent years, the research mandate has included HIV/AIDS and related diseases. For over two decades, recipients of these fellowships were referred to as “Clinical Fellows.”



Currently, the SAMHSA funds for fellowships are the only pre- and post-doctoral programs available to the ANA for its MFP initiatives. This fellowship can provide up to 5 years of financial support, but must be renewed each year.

## Past Pre- and Post-Doctoral Enhancement Programs

Along with the doctoral degree programs, the MFP has continuously sponsored and supported many enrichment activities for the Fellows. Through symposia, leadership and management training, internships, and other programs, the MFP has enabled Fellows to obtain invaluable skills. These activities broadened their academic training and enhanced their expertise in such areas as management of health care organizations, participation in political and legislative efforts, and crafting winning research proposals. Some of these enhancement activities are outlined in the following paragraphs.

### *Annual Fellows' Symposia*

The Annual Fellows' Symposia, initiated in 1976, were often held jointly with other national nursing conferences (e.g., ANA biennial convention, ANA Council of Nurse Researchers). These symposia provided opportunities for Fellows to network and exchange ideas about research and educational experiences, present their completed dissertation research, and interact with respected senior educators and administrators from across the nursing community. Of equal importance, the symposia decreased the social isolation that many Fellows experienced in their academic institutions. Such symposia provided opportunities for social affiliation, reaffirmation for their scholarly work, and the occasion for planning and critiquing their career trajectory.

### *W. K. Kellogg Foundation Leadership Projects*

From 1985 to 1991, the Kellogg Foundation funded the EMFP to provide post-doctoral leadership and management training in mental health for Research Fellows of the five MFPs. The goal of the first 3 years of this particular program was to facilitate the continued development of leadership and management skills in order to improve the contributions made by Fellows to racial and ethnic populations. The goal of the second 3 years was to introduce, discuss, and portray the management and leadership concepts and styles related to the oversight of a community-based health care organization. During the funding period, a total of 120 Fellows participated in workshops conducted by prestigious faculty, administrators, and community-based organizers with a wide range of administrative and organizational leadership skills and philosophies. Faculty who conducted these workshops represented a variety of institutions, including the University of California at Los Angeles, Florida A&M University, Hampton University, Harvard University, the University of Maryland, Wayne State University, NIMH, SAMHSA, and others.

## *Congressional Internship Program*

During the period between 1977 and 1990, congressional internships offered an exciting and valuable enhancement experience for many Fellows. Clinical and Research Fellows enjoyed opportunities to observe and participate in the national legislative process. Specific emphasis was placed on the enactment of legislation related to the nursing profession and to the mental health and illness of members of racial and ethnic groups. This national political experience enhanced Fellows' abilities to assume leadership roles in political and legislative arenas. By 1990, 37% of all Fellows had interned in congressional offices and committees, federal health regulatory agencies, or research and policy centers. Placement of Fellows in these offices afforded opportunities for them to influence and monitor legislation that affects health-related issues. They could also observe over time that their critical thinking and strategic action helped to influence long-term improvements in the nation's health systems (Bessent, 2002, 2004).

## *Research Proposal Development Program*

Another MFP enrichment program, funded by the ANA between 1994 and 1996, was designed to promote Fellows' post-doctoral research trajectories and career development. The primary purpose of the program was to foster the development of research proposals for external funding by creating mentor relationships with successful senior investigators from both minority and majority backgrounds. Its intent was to strengthen and galvanize the Fellows' commitment to research and scholarship and to help them to develop viable, funded research programs (Serlin, 1996, 1998).

## *Health Policy Research Institute*

The Agency for Health Care Policy and Research granted funds to the MFP between 1995 and 1997 to support post-doctoral training for nurses from ethnic minority backgrounds. The program provided financial support for the promotion of ethnic minority health policy research through the development of culturally appropriate and fundable research proposals for submission to funding agencies (Serlin, 1996, 1998).

Finally, the list of ways in which the MFP has supported the Fellows would not be complete without noting the infrastructure that the program has created to integrate Fellows into the health services system and academic nursing. This infrastructure was developed and is maintained through newsletters and publications about the graduates, such as *Future Nurse Researchers* (Bessent, 1979), *Nurse Researchers: Selected Abstracts* (Bessent, 1983), and *Strategies for Recruitment, Retention, and Graduation of Minority Nurses in Colleges of Nursing* (Bessent, 1997), which are distributed to the nation's schools and colleges of nursing. The infrastructure is also maintained through national conferences and interdisciplinary meetings with the program's cadre of Advisory Committee members and others across the country. Over the years, this infrastructure has

resulted in exciting academic and leadership enhancement opportunities for all pre-doctoral and post-doctoral Fellows. In recent years, the infrastructure has been expanded to include the employment of technologies such as e-mail, web sites, chat rooms, and other electronic media.

## Past Programs and Funding for Nurses at Other Educational Levels

In addition to enrolling Fellows in doctoral programs, the MFP has supported the education of nurses from racial and ethnic backgrounds at other academic levels. These efforts were undertaken in response to the fact that many ethnic minority nurses are educated at community colleges, where they receive their RN licensure but may not earn the baccalaureate degree. The steps to a baccalaureate or master's program can be costly and arduous, extending over several years. The following are examples of the program's outstanding efforts.

### *Clara Lockwood Fund*

In 1977, the ANA Board of Directors designated funds to support the graduate education of at least two American Indian and Alaska Native nurses selected by the EMFP Advisory Committee. Later, the ANA Board of Directors approved the use of the interest from this fund to help finance the graduate education of nurses from among the designated ethnic minority groups.

### *Baccalaureate Completion Scholarship Fund*

From 1983 to 1989, the EMFP administered funds committed by the ANA Board of Directors to support baccalaureate education that targeted, but was not limited to, RNs from ethnic minority backgrounds. These funds were intended to increase "access to nursing care" in medically underserved areas. During its 6-year funding period, 40 nurses earned baccalaureate degrees in nursing. To date, occasional requests for scholarship applications are directed to the MFP staff. The lack of funding for this program initiative is the only known barrier to its restoration.

### *Allstate Foundation Fund*

During the 1980s, the EMFP assumed administrative responsibility for another fund, one established by the Allstate Foundation to support associate, baccalaureate, or doctoral study for American Indian and Alaska Native nurses. The predecessor group of the National Alaska Native American Indian Nurses Association had previously administered the fund. The EMFP managed the programs between 1985 and 1988; by the time the funds were exhausted, 22 American Indian and Alaska Native nurses who had received financial assistance and other support had completed either their associate or baccalaureate degrees in nursing.

## MFP Leaders

The MFP owes its success as much to the caliber of its leaders as it does to the funds that sustained it for a quarter century. All of the initiatives described above were conceptualized and implemented by MFP leaders. The following pages contain sketches of the MFP leaders who had the primary responsibility for nurturing and sustaining the program over nearly three decades.

### *Getting Started*

The seeds of the EMFP were planted in 1970, with the creation of the Center for Minority Group Mental Health Programs at the National Institutes of Health; the Center was established to serve as a focal point for all activities within the Institutes—including programs and research and training—that bore directly on meeting the mental health needs of minority groups.

The Center was the culmination of 2 years of negotiations between leaders of the Black Psychiatrists of America, including Dr. Chester Pierce of Harvard University; Dr. James Comer, Associate Dean of Yale Medical School; Dr. J. Alfred Cannon, Department of Behavioral Studies, Drew Post-Graduate Medical School; and Dr. Joseph R. Phillips of Meharry Medical College; as well as NIMH officials (Shapiro and others, 1976) and the U.S. Congress.

The mission of the Center was to: (1) serve as a focal point for NIMH activities that had a direct bearing on improving the mental health of minority groups and on increasing the number and competence of minority group members engaged in mental health research, training, and services; (2) stimulate and support projects designed primarily for training minority group members for professional careers in the mental health field; and (3) stimulate and support research designed to increase knowledge of minority group cultures, their relationships to other groups, and the particular mental health problems associated with these cultures (Shapiro and others, 1976).

By 1973, the Center had become alarmed at the lack of mental health professionals who could provide culturally competent care to an increasing racial, ethnic, and culturally diverse population having ever-expanding needs for mental health services and research. That year, the Center invited the American Sociological Association (ASA) to submit a grant proposal to support doctoral-level training of ethnic and racial minority sociologists. In 1974, a small training grant was awarded to the ASA from the NIMH for the purpose of supporting doctoral education for ethnic minority researchers and clinicians.

This effort quickly expanded as invitations to submit training grants were extended to the other core mental health professions of nursing (American Nurses Association), psychiatry (American Psychiatric Association), psychology (American Psychological Association), and social work (Council on Social Work Education). Each organization responded with enthusiasm, and the most effective national program for training ethnic minority mental health providers and researchers got under way.

Dr. Mary Harper, an NIMH staff person, was given responsibility for developing the framework within which all five of the ethnic minority Fellowship programs would function. With the support of the nation's African American mental health professionals, primarily psychiatrists, but also including psychologists, sociologists, social workers, and nurses who communicated frequently with members of the U.S. Congress about the need for more ethnic minority mental health professionals, she began her work.

These professionals emphasized the realities of the science, highlighting the fact that there were too few research instruments that had established reliability and validity for African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans. They pointed out that there were limited culture-specific theoretical models for providing clinical care to ethnic minority populations and that, as a rule, ethnic minority professionals were not in leadership and decision-making positions in mental health systems and were absent in academia. They argued that diagnostic and assessment processes for ethnic minority people were flawed, and that quality mental health care was compromised. Their debate was persistent, focusing on their belief that too little attention had been given to the cultural beliefs, values, and perceptions about health and mental health care among ethnic minority groups. These deficits compromised the potential for culturally appropriate, quality mental health care for ethnic minority people and their families.

Mental health human resource development among ethnic minorities, they reasoned, must be at the MD and PhD levels, terminal degrees with emphasis on excellence in theory-based research, practice, and leadership. The initial focus at the federal level, however, centered on nursing as it related to direct care (typically described as “bedside nursing”) for the mentally ill and their families. However, the program continued to emphasize the need for the participation of ethnic minority nurses in leadership positions in education, practice, public policy, and research. Basic program essentials for the EMFP at the ANA, including the following, were articulated:

- a clearly developed EMFP philosophy, in the form of a mission statement;
- an Advisory Committee composed of individuals with national reputations in psychiatric nursing;
- site visits to participating academic institutions, including face-to-face conversations with the institutions' presidents, and the deans or directors of the nursing programs;
- guidelines for curriculum content;
- criteria for selecting the Fellows; and
- criteria for selecting schools and colleges where Fellows would matriculate.

In 1974, the EMFP was launched. An announcement about the new program was published in *The American Nurse*. That original announcement is replicated in Box 1 (courtesy of Ruth Gordon, Montgomery, Alabama, and the library of the ANA, Silver Spring, Maryland).

The National Advisory Committee, representing the ethnic minority groups in the nation as well as other unwavering supporters, and reflecting geographic distribution, reviewed the applicants' packages and awarded the first fellowships. Members of the original Advisory Committee are listed in the announcement in Box 1 on page 33. In addition to the original Advisory Committee members, over time other individuals were appointed. Through the decades, numerous individuals served on this committee and provided leadership and vision for the program. All of the nurses who served in these capacities, along with their current professional affiliations, are listed in Box 2, found on page 34.

Also during these years, numerous ANA presidents and executive directors have worked with and contributed to the MFP; they are listed in Box 3 on page 35. Their support for the mission of this program was essential to its survival and development; they are acknowledged for their leadership in helping to create a well-educated and diverse work force, capable of providing the myriad services necessary for improving the nation's health.

**Box 1. First Announcement of the EMFP, 1974*****Ten Minority Fellowships To Be Awarded in March***

The first 10 Fellows under the ANA Registered Nurse Fellowship Program for Ethnic Racial Minorities will be announced in late spring.

These Fellowships, for the 1975-76 school year, are the first of 35 to be awarded during the six-year program.

Nurse-Fellows will be selected by the program's ad hoc advisory committee at their March meeting.

Applicants will include, but not be limited to, ethnic minority nurses (e.g., African-Americans, Asian Americans, Native Americans, and Spanish speaking/Spanish surnamed.) American citizenship or a permanent visa is also required.

Each Fellow selected must qualify for admission to and complete a doctorate in mental health and/or related areas from an accredited institution within the allocated time period.

Each Fellow is expected to work in the areas of mental health or social and behavioral science in ethnic racial minority communities.

The ANA Fellowship program is funded for six years for a total of \$955,407 by the National Institute of Mental Health, Department of Health, Education and Welfare.

Annual awards of up to \$7,500, including stipend, tuition, and if applicable, a dependency allowance to be made to each nurse-Fellow.

The awards, made directly to the nurse-Fellow, may be renewed for up to three years.

Members of the project's ad hoc advisory committee are: **Hazel W. Blakeney**, EdD, Chairperson, Department of Career Development, University of Maryland School of Nursing, Baltimore, and Chairperson, Commission on Nursing Education

**M. Elizabeth Carnegie**, DPA, editor, *Nursing Research*, New York City; **Effie Poy Chow**, project director, Health Service/Educational Activities, San Francisco Consortium

**Signe S. Cooper**, Professor and Chairperson in Nursing, University of Wisconsin-Extension, Madison, and Chairperson, Council on Continuing Education; **Herlinda Quintero Jackson**, East Los Angeles (Calif.) Mental Health Services; **Carmen D. Janosov**, Association Enfermeras Graduates de Puerto Rico, Hato Rey

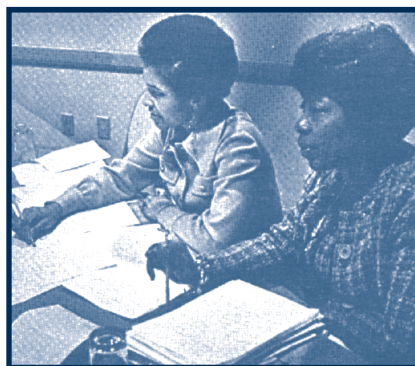
**Myra Levine**, visiting lecturer, Rush University, Chicago; **Martha Primeaux**, associate professor of nursing, Oklahoma University Health Center, College of Nursing, Oklahoma City; **Gloria Smith**, Interim Dean and Associate Professor, College of Nursing, University of Oklahoma; and **Ethelrine Shaw**, Associate Professor, Ohio State University School of Nursing, Columbus, and ANA First Vice President.

Project officer from HEW is Mary Harper, PhD, Assistant Chief, NIMH Minority Center. Ruth Gordon, PhD, is director of the project.

For more information about requirements to become a Fellow, write: Ruth Gordon, ANA Registered Nurse Fellowship Program for Ethnic Racial Minorities, ANA headquarters.

Ruth Gordon, project director (left), and Mary Harper, project officer, for the ANA Registered Nurse Fellowship Program for Ethnic Racial Minorities.

Source: *The American Nurse*. March 1975 (Vol. 7, No. 3), p.1.



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**Box 2. Additional Members of the EMFP National Advisory Committee**
**Willa Doswell, PhD, RN, FAAN**

Associate Professor  
College of Nursing  
University of Pittsburgh, Pittsburgh, PA

**Faye A. Gary, EdD, RN, FAAN\***

Medical Mutual of Ohio Professor of Nursing  
for Vulnerable and At-Risk Persons  
Frances Payne Bolton School of Nursing  
Case Western Reserve University  
Cleveland, OH

**Hector Gonzalez, PhD, RN, FAAN**

Professor and Chairman Emeritus  
Department of Nursing Education  
San Antonio College  
San Antonio, TX

**Susana P. Juarez-Leal, PhD, RN**

Pediatric Nurse Practitioner and Research  
Nurse  
School of Medicine  
University of Texas Health Science Center  
San Antonio, TX

**Betty Keltner, PhD, RN, FAAN**

Dean, School of Nursing  
Georgetown University  
Washington, DC

**Kem Louie, PhD, CS, FAAN\***

Director and Associate Professor  
Graduate Nursing Program  
William Patterson University  
Newark, NJ

**John Lowe, PhD, RN**

Associate Professor  
College of Nursing  
Florida International University  
Miami, FL

**Beverly Malone, PhD, RN, FAAN**

*(formerly President ANA)*  
General Secretary  
Royal College of Nursing  
London, England

**Betty Mitsunaga, PhD, RN, FAAN**

Professor Emeritus  
University of Wisconsin  
Milwaukee, WI

**Oliver Osborne, PhD, RN, FAAN**

Professor Emeritus  
Psychosocial and Community Health Nursing  
School of Nursing  
University of Washington  
Seattle, WA

**Freida Outlaw, DNSc, RN, CS**

Director of Children and Youth Services  
Department of Mental Health and  
Developmental Disabilities  
State of Tennessee  
Nashville, TN

**Ruth Perez, MS, RN, FAAN**

Juneta Examinadora De Enfermeras  
Ponce, Puerto Rico

**Carmen Portillo, PhD, RN, FAAN**

Associate Professor  
Department of Community Health Systems  
School of Nursing  
University of California, San Francisco

**Sally Ruble, PhD, RN**

Professor  
School of Nursing  
University of New Mexico  
Albuquerque, NM

**Mary Lou de Leon Siantz, PhD, RN, FAAN**

Associate Dean for Research  
School of Nursing and Health Studies  
Georgetown University  
Washington, DC

**Lillian Tom-Orme, PhD, MPH, RN, FAAN**

Research Assistant Professor  
Health Research Center  
University of Utah  
Salt Lake City, UT

**Sara Torres, PhD, RN, FAAN**

Dean and Professor  
College of Nursing  
University of Medicine and Dentistry of New  
Jersey  
Newark, NJ

**May Louise Wykle, PhD, RN, FAAN, FOSA**

Dean and Florence Cellar Professor of Nursing  
Frances Payne Bolton School of Nursing  
Case Western Reserve University  
Cleveland, OH

\*Denotes service as Chair of the Committee

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**Box 3. Presidents and Executive Directors of the ANA, 1974–2000**

Presidents		Executive Directors	
1972–1976	Rosamond C. Gabrielson	1970–1976	Eileen M. Jacobi
1976–1978	Anne Zimmerman	1977–1981	Myrtle K. Aydelotte
1978–1982	Barbara L. Nichols	1982–1989	Judith Yates Ryan
1982–1986	Eunice R. Cole	1989–1993	Barbara K. Redman
1986–1988	Margretta M. Styles	1993–1994	Shirley Girouard
1988–1992	Lucille A. Joel	1995–1997	Geri Marullo
1992–1996	Virginia Trotter Betts	1998–1999	Argene Carswell ( <i>interim</i> )
1996–1999	Beverly Malone	1999–2000	David Hennage
1999–2000	Mary Foley	2000–Present	Linda J. Stierle

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### *The MFP Directors*

One of the obvious strengths of the MFP has been its directors, who have orchestrated the program’s mission. They had backgrounds in academia and clinical practice, were active in their respective ethnic minority communities, and were leaders in nursing. Their commitment to the program, and willingness to work for the achievement of the goals and objectives of the MFP, served as a driving force for the program’s advancement. A list of the MFP directors is provided as Box 4, below. The contributions of these directors are discussed in the following pages.

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**Box 4. Directors of the MFP, 1974–2000**

1974	Elizabeth Allen	1977–1992	Hattie Bessent
1974–1977	Ruth Gordon	1992–1999	Carla Serlin
1977	Joyce Elmore	1999–2000	Cornelia Porter

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#### *Elizabeth Allen, PhD, RN (1974)*

As Director of Continuing Education at the ANA, Kansas City, Missouri, in 1973, Dr. Elizabeth Allen was asked to help develop a new program for advanced nursing education that would focus on psychiatric and mental health care of ethnic minority people. Dr. Pearl Dunkley, ANA staff, was responsible for oversight of the organization’s education and clinical practice programs, and was in full support of this new initiative. Dr. Allen, a psychiatric nurse well aware of the needs of large populations who were not receiving adequate services, used her expert knowledge in mental health care and service delivery to help with the development of specific goals and objectives for the new EMFP initiative. In addition to addressing the day-to-day needs of ANA’s continuing education program, Dr. Allen wrote a concept paper that outlined the aims, significance, and potential impact of the proposed program. The EMFP would eventually find its

first administrative home in the Department of Continuing Education, under the leadership of Dr. Allen, in 1974. This structure remained in place for about 6 months, until Dr. Ruth Gordon was appointed and became its first full-time director.

After this appointment, Drs. Allen and Gordon shared their knowledge, expertise, and vision about the future of the EMFP (Allen, 2003a, 2003b). Both women reviewed applications from the first group of potential Fellows. Based on their findings, selected individuals were invited to the ANA Headquarters for a face-to-face interview. After additional review and approval by members of the Advisory Committee, the first Fellows were accepted.

Dr. Allen vividly recalled the overwhelming support the EMFP received during its early years from the late Dr. Hazel Blakeney, who was the Chair of ANA's Commission on Education, a position she attained through the organization's national election. Other members of the original EMFP National Advisory Committee, all of whom provided unstinting support to the EMFP, are identified in its first announcement, reproduced in Box 1. Dr. Allen noted the astute and forward-thinking leadership of this original Advisory Committee and, nearly three decades later, she continues to acknowledge their visionary thinking (Allen, 2003a, 2003b).

### Ruth Gordon, PhD, RN (1974–1977)

Dr. Ruth Gordon, a psychiatric nurse with experience in academia, was the first full-time Director of the EMFP. She was one of the authors of the first funded EMFP grant, and had the Herculean task of implementing the program. Specific time and concentrated thought had to be given to several tasks, including:

- writing the criteria for selecting the Fellows, developing and distributing the application forms, and outlining the process;
- advertising the program and developing literature that explained and described the EMFP;
- creating guidelines for selecting colleges and universities;
- maintaining a nationally recognized psychiatric nursing advisory committee; and
- serving as its ambassador and advocate.

She was also responsible for managing the budget and communicating with NIMH and numerous other professional organizations about the fellowship program. Drs. Gordon and Harper worked closely together, receiving continued support and cooperation from dynamic nurse leaders such as Drs. Myrtle Aydelotte, Mary Elizabeth Carnegie, Rhetaugh Dumas, Pearl Dunkley, Carmen Janosov, Effie Poy Chow, Ethelrine Shaw-Nickerson, Gloria Smith, and countless others.

At the ANA Headquarters in Kansas City, Missouri, Dr. Gordon continued her work, and the first Fellows were admitted shortly after her arrival. Early on, Dr. Gordon required that the Fellows present research and theoretical papers at ANA's national and regional conferences (Gordon, 2003). Dr. Gordon left a solid foundation for the next director, Dr. Joyce Elmore, who assumed this position as director for a brief period.

### Joyce Elmore, PhD, RN (1977)

Dr. Joyce Elmore has played numerous important roles at ANA. Her appointment to the Directorship of the EMFP began when Dr. Gordon resigned. At ANA, Dr. Elmore was the Director, Nursing Education Department, and Coordinator, Careers and International Affairs. During her tenure there, she was also the Coordinator of Continuing Education. In addition to serving in these very demanding roles, she was appointed as the Interim Director of the EMFP and served in that capacity for several months. In this role, Dr. Elmore attended to the daily operations of the program, supervised the staff, and communicated with the Fellows, NIMH, and other agencies. She was described by those associated with her as a hard-working, conscientious, and caring leader. Moreover, she took her role as Director of the EMFP as an important and vital opportunity to inform numerous stakeholders, and public and private agents and agencies, about the key elements of the program. She also prepared the program and its Fellows for the arrival of the next EMFP Director (ANA, 2003; Bessent, 2003b).

### Hattie Bessent, EdD, RN, FAAN (1977–1992)

In 1977, Dr. Hattie Bessent's creative and forceful leadership was brought to the EMFP. She was able to make a case for EMFP support among many private and public funding agencies by clearly articulating its mission, goals, and objectives. The program was highly successful and respected under her leadership. Her contributions are numerous. Perhaps her legacy can best be described as a total commitment to the EMFP, nurturing it day by day and investing her time and energy in each of the Fellows, whom she envisioned as dynamic professionals, making unique contributions to humanity. She reached across disciplinary lines and obtained funding for leadership training opportunities, intending to educate all mental health professionals. During her tenure, the legislative internship program was elevated to its highest echelon.

Dr. Bessent continues to contribute to the scientific literature through her writing and research, the results of which are published and presented at national and international scientific conferences. Over the years, she has been active in the World Federation on Mental Health and frequently presents papers at its scientific sessions. Dr. Bessent retired from the EMFP directorship after 15 years of dedicated service. She was praised by Hawaii's Senator Daniel K. Inouye in the Congressional Record (July 21, 1987) for facilitating the acquisition of millions of dollars to support the doctoral education of nurses from ethnic minority backgrounds, and for coordinating Capitol Hill's nurse legislative internship program. Dr. Bessent has received many accolades for being a driving force in her dedicated service to ethnic minority nurses. She has also received honorary doctorates from universities throughout the nation, and lifetime memberships and awards from ethnic minority and mental health professional organizations. They have recognized her contributions to improving the well-being of individuals, families, and communities through her leadership in education, practice, public policy, and research. At the end of Dr. Bessent's dynamic and committed tenure, the ANA employed Dr. Carla Serlin as its next director.

### Carla Serlin, PhD, RN (1992–1999)

Dr. Carla Serlin took over leadership of the MFP in 1992, and worked diligently to address its mission, goals, and objectives. She continued several of the stellar practices that had been implemented by Drs. Allen, Gordon, Elmore, and Bessent. She also convened numerous conferences designed to strengthen the Fellows' research acumen and scholarly publication output. She was interested in excellence in clinical practice, and held national conferences on cultural diversity and practice. Dr. Serlin had an abiding interest in the Fellows, and communicated with deans and directors of nursing programs to find new ways of recruiting and funding more Fellows. Her fascination with technology as an aid to communication motivated her to encourage the use of computers in the daily operations of the MFP office and among the Fellows. She also encouraged the Fellows to explore professional pathways in substance abuse and mental health public policy and to contemplate how they could improve the quality of life of ethnic minority people through technology, public policy, and political action. Dr. Serlin also encouraged the Fellows to seek post-doctoral opportunities as a means of galvanizing their research careers. Moreover, she facilitated the Fellows' presence on peer reviews at the national and state levels, and always encouraged the Fellows to compete for research funding. In 1999, she resigned as director of the MFP and joined her husband in Colorado.

### Cornelia P. Porter, PhD, RN, FAAN (1999–2000)

Dr. Cornelia Porter, Associate Professor, University of Michigan School of Nursing, assumed the directorship while on leave from her tenured position. She herself was an EMFP Fellow (1980–1985) and a member of the Class of 1985, with a background in the care of children and their families. Dr. Porter's excellence in and commitment to her research and scholarly works were manifest in all of her leadership activities while at the MFP. She gently guided and directed the Fellows' thinking about their research, and encouraged them to publish in scholarly journals and to present their research at international, national, state, and local forums. Dr. Porter provided consultation to the Fellows on numerous topics, including research design and theory-building in mental health and psychiatric nursing. She initiated the expanded computer-based record system at the MFP, and helped to construct the MFP web site for easy access to important information. Her visions continue to be addressed by staff at the MFP with assistance from other personnel at the ANA. The Fellows fondly refer to her as a scholar, a researcher, and a prototype of future nurse leaders.

Her commitment to and expertise in teaching and research led her back to the University of Michigan at Ann Arbor, where she continued to demonstrate her dedication to the exploration of remedies for the health and mental health disparities that confront ethnic minority populations. Dr. Porter is a prolific writer, publishing many research and scholarly papers in professional journals. In 2003, she was appointed Dean of the School of Nursing, Florida Agricultural and Mechanical University, in Tallahassee, Florida, where she continued to help develop the next generation of nurse leaders in education, practice, public policy analysis, and research. Currently, Dr. Porter resides in upstate New York.

## *Program Managers, Administrative Assistants, and Consultants*

Assisting the directors were a group of knowledgeable and highly skilled people who helped with the multiple functions that were required to execute and maintain the MFP. Those individuals, beginning in 1974 and extending to 2000, have made outstanding contributions to the overall program and to the enhancement of the Fellows' careers. Mrs. Yvonne Myrick was employed with the MFP for more than two decades. Teresa U. Bisel, Joan Hagler, and Joan Stover were also long-time MFP employees. Another impressive group of assistants are listed alphabetically: Richardean Benjamin, Malika Braithwaite Gooden, Vanessa M. Corley, Carol B. Dill, Carolene Evans, Cynthia Gross, Joan M. Hagler, Rhonda E. Hall, Robbie Ross, Gwinder Smith, Patricia Smothers, Barbara Tucker, and Elizabeth Zapata (ANA, 2003; Myrick, 2003). The ANA, the MFP, and the Fellows are grateful to them for their service and commitment. Though they are no longer at the MFP, they continue to serve as its friends and advocates.

The late Dalmas Taylor, PhD, served as consultant to the MFP for some 20 years. His tireless commitment to the program was in addition to his responsibilities as professor, dean, and then provost at various academic institutions throughout the nation. The MFP Fellows, staff, and the ANA will always be grateful for Dr. Taylor's intellectual acumen, wisdom, and vision.

Over the past decades and under the guidance of a diverse group of leaders, the MFP has been successful in competing for funds and administering programs that have enabled nurses from ethnic minority backgrounds to advance their education and to make outstanding contributions to the discipline and to substance abuse and mental health disorders prevention and treatment. The MFP has helped to nurture and support the dreams and aspirations of many ethnic minority nurses who have earned recognition as leaders in education, practice, public policy, and research. Today, these nurses are employed throughout the global community and are role models and symbols of hope for the future.





# The Minority Fellowship Program Fellows

This section of the report presents an overview of the personal and professional characteristics of the program participants. It includes information about the Fellows' ethnic minority backgrounds, grade point averages, marital status, publication productivity, and other important information.

## Demographics of Research and Clinical Fellows

### *Ethnic Minority Composition of the Program*

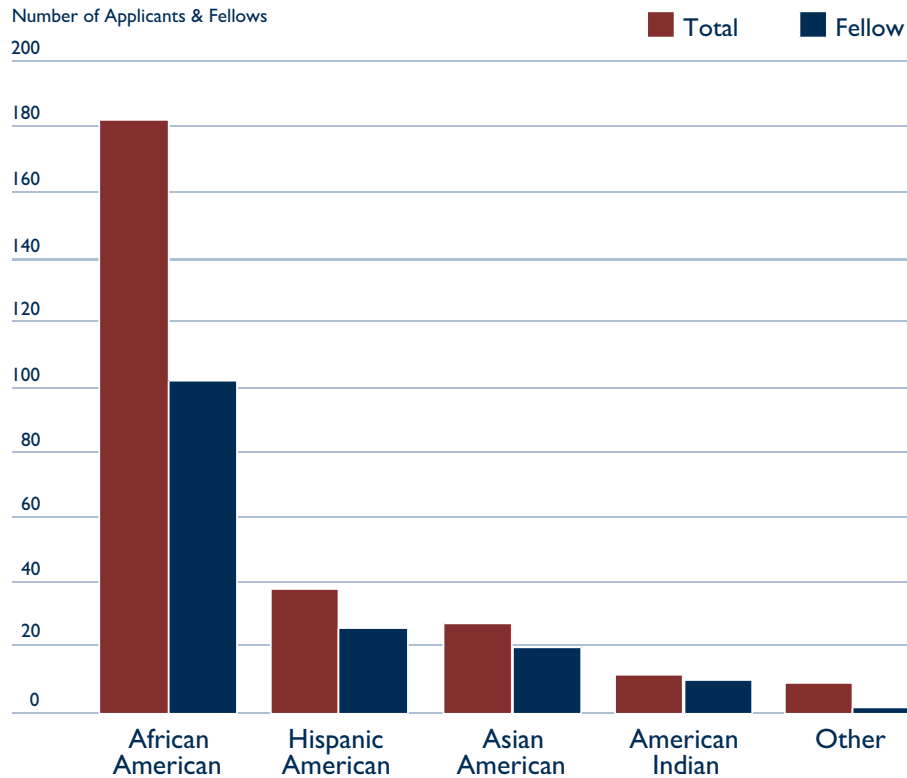
Comparisons of the backgrounds of the Fellows from 1975 to 2000 indicate that the program has awarded funding to nurses across the spectrum of ethnic minority groups. All of these Fellows had career goals of providing services to, or conducting research on, underserved ethnic minority groups. Because different populations have varying needs, and there are many avenues for health service delivery, it is important that the total pool of substance abuse and mental health professionals embrace a range of intellectual and practical interests.

The largest percentages of applicants to the MFP were African Americans (70%), followed by Hispanic Americans (15%), and Asian Americans (10%). Since the first cohort of Fellows in 1975, nurses of Hispanic and American Indian and Alaska Native descent have remained the most underrepresented groups of nurses when compared with their own percentages in the total population (see Figure 10).

The group designated as Other in the graphics and discussion in this section comprises ethnic minority Fellows who are Hawaiians, Guamanians, Pacific Islanders, and Marshall Islanders. As Figure 10 indicates, their representation among the Fellows is very low.

Recruitment and outreach efforts to all ethnic minority groups involved in substance abuse and mental health care are an important task at the MFP. Information in this section will help the MFP's National Advisory Committee and staff to develop materials for recruitment targeted at specific groups. For example, brochures and fact sheets could be developed for American Indians and Alaska Natives and widely distributed throughout the United States. The objective of this approach is to attract the attention of young men and women and interest them in

Figure 10. Ethnic Minority Composition of Applicants and Fellows



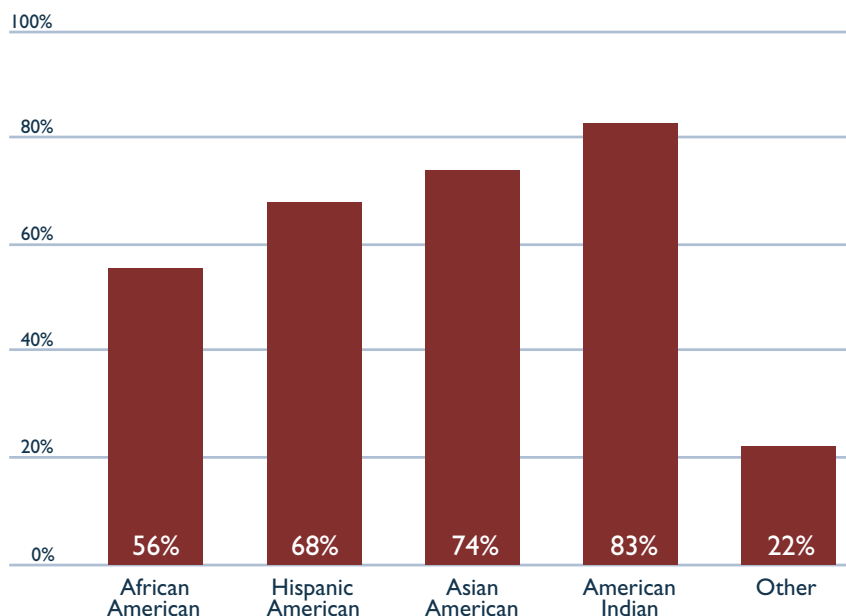
Source: MFP Archives at the ANA.

careers in substance abuse and/or psychiatric and mental health nursing. Once they are identified, additional substance abuse and mental academic health support systems could be developed to guide and direct them into appropriate doctoral programs. Recruitment materials would be strategically placed in American Indian and Alaska Native communities and in selected colleges and universities. Additional activities would be designed to strengthen relationships between and among MFP staff, advisory members, the National Alaska Native American Indian Nurses Association, and numerous other stakeholders. This approach, like other initiatives, is intended to be long term.

Figure 11 shows the percentage of fellowships awarded within each ethnic minority group of applicants. As the figure indicates, the highest percentage of accepted applications occurred among American Indians (83%), followed by Asian Americans (74%), Hispanic Americans (68%), and finally, African Americans (56%). The Other category had the lowest Fellow-to-applicant ratio, at 22%. These data indicate that if an American Indian or Alaska Native nurse applied to the fellowship program, his or her likelihood of being accepted would be quite high.



**Figure 11. Percentage of Fellows Accepted for Each Ethnic Minority Group of Applicants**



Source: MFP Archives at the ANA.

## Age

At the time they applied to the MFP, the Fellows' mean age ranged from 37.25 (Asian American) to 39.44 (Other) (see Table 4). It is evident from these data that most of the nurses were in a similar age range when they decided to pursue the doctorate degree. Three of the major groups represented shared virtually the same age at the time of application: Asian Americans had a mean age of 37.25; African Americans followed closely with a mean age of 37.44; and Hispanic Americans had a mean age of 37.74 years.

**Table 4. Age of Applicants at the Time of Admittance to the MFP (in ascending order)**

Ethnicity/Minority	N	Mean	Standard Deviation	Minimum	Maximum
Asian American	16	37.25	9.25	21	54
African American	126	37.44	6.98	20	52
Hispanic American	27	37.74	6.47	21	49
American Indian	10	39.25	7.29	30	54
Other	9	39.44	8.38	30	54

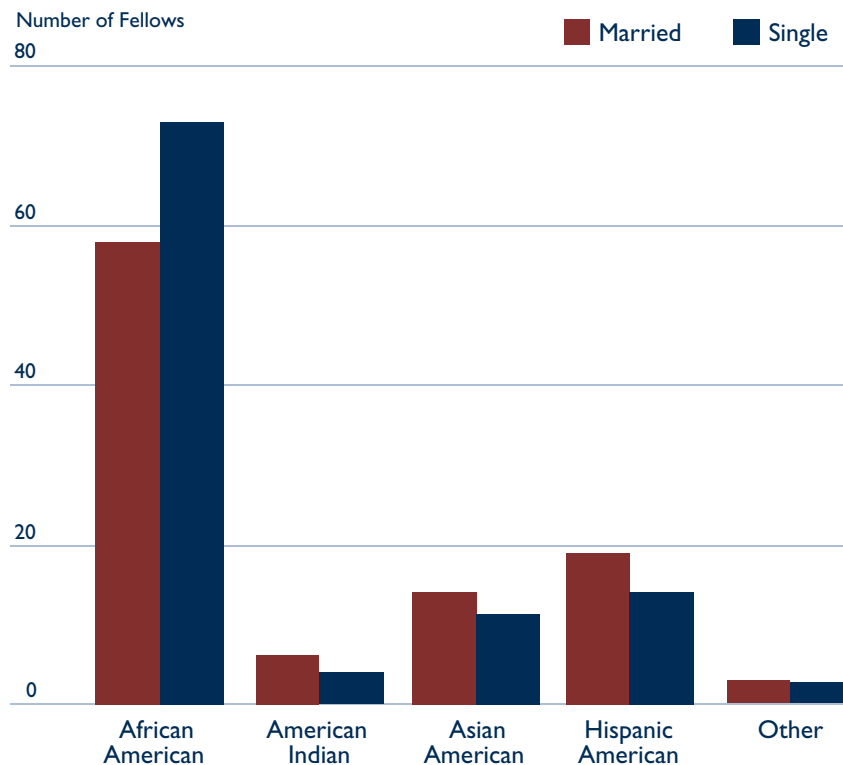
Source: MFP Archives.

## Marital Status

Among the Fellows, 100 indicated that they were married, while 58 reported being single (data on marital status were not obtained from the remaining Fellows). Comparing Fellows with those not awarded fellowships showed that there was no difference in marital status. The findings suggest that the majority of Fellows began their doctoral programs with family responsibilities. Financial support was critical for the Fellows, especially those with families, who would forgo employment to pursue additional educational opportunities. Moreover, financial support was vital because this population of nurses was more likely to have limited financial resources, with finite material and human support systems upon which to rely (see Table 1 of this report).

As Figure 12 shows, more African American women were single than married, unlike the other ethnic minority Fellows—American Indian, Asian American, and Hispanic American—where more were married than single. In the Other category, the numbers of married and single Fellows were about the same.

Figure 12. **Fellows' Marital Status by Ethnic Minority Group**



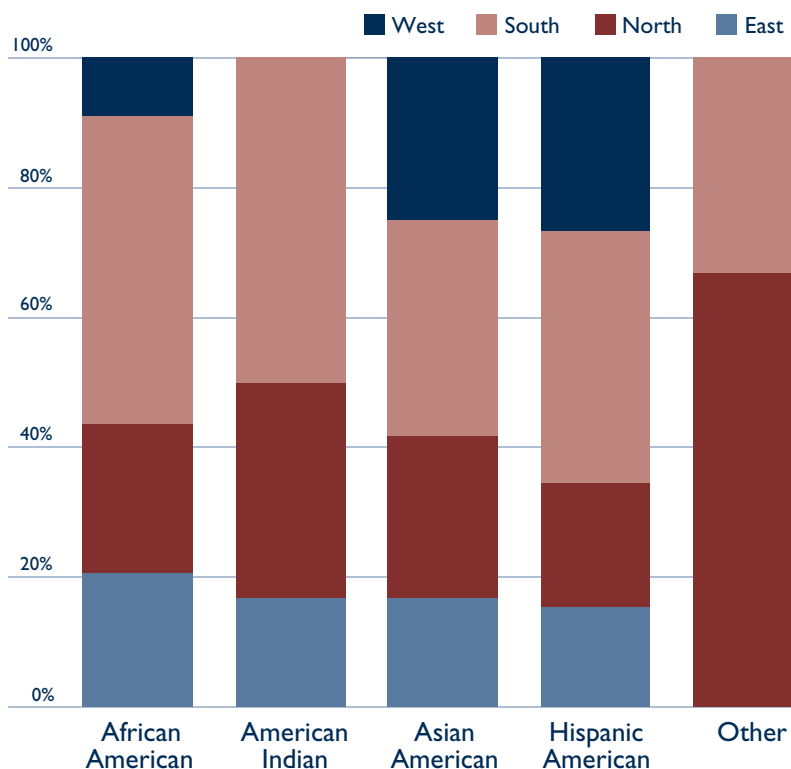
Source: MFP Archives.

## Region of Origin

Figure 13 shows that the largest concentration of African American Fellows lives in the South (63%), with the second largest concentration residing in the North (22.8%), closely followed by the East (20.8%), with a smaller population living in the West (8.9%). However, because the total number of African American Fellows is almost 10 times larger than the number of Fellows in the other groups, these findings should be read with caution. Moreover, in this category, there were large amounts of missing data.

American Indian and Alaska Native Fellows also typically live in the South (50.0%), with a rather sizable population in the North (33.3%), and a smaller number (16.7%) in the East. Hispanic American Fellows are more likely to live in the South (38.5%), but the West is also home to a substantial population (26.9%), with a smaller number residing in the East (15.4%). The Other category includes Fellows who live in the North (66.7%) and the South (33.3%).

Figure 13. **Distribution of Fellows by Region of Origin**



Source: MFP Archives.

## Clinical and Research Fellowships

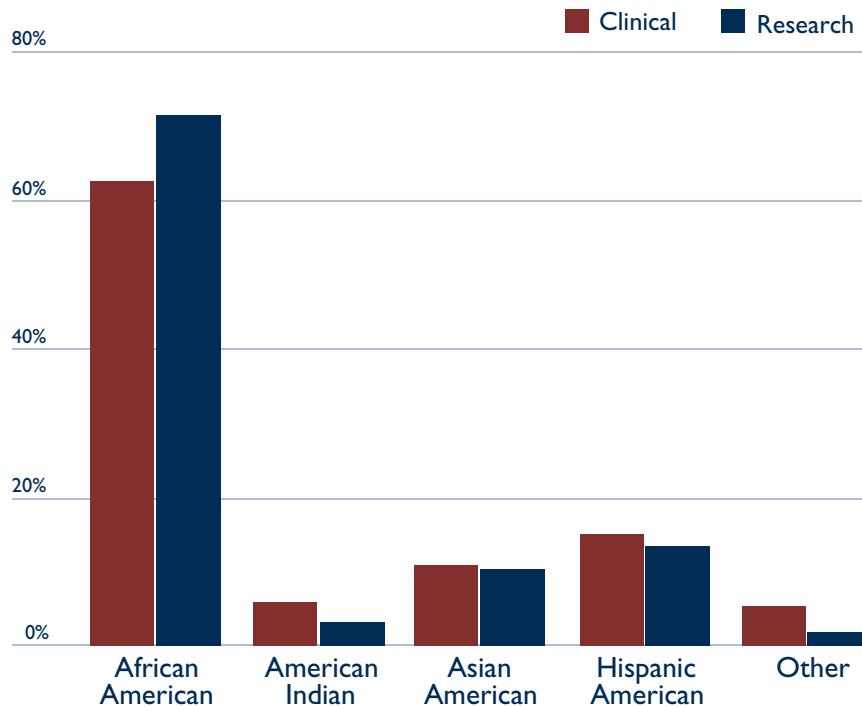
Until 1996, two types of fellowships were available to applicants: clinical and research (see Section 4 for a description of the types of fellowships). Figure 14 depicts the types of fellowships that were awarded, by ethnic minority status. Both fellowships provided similar types of support.

As determined by ethnicity, African Americans received slightly more research fellowships than clinical fellowships. On the other hand, American Indians received more clinical fellowships than research fellowships, as did Hispanic Americans and those nurses who were classified as Other. Asian Americans received slightly more clinical than research fellowships.

## Fellows' Publications

Fellows continue to make substantial contributions to the scientific community through their research and scholarly writings. As shown in Figure 15, the majority

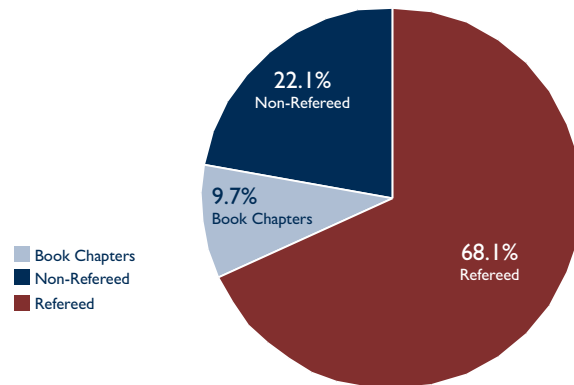
**Figure 14. Percentage of Clinical and Research Fellowships Among Ethnic Minority Groups**



Source: MFP Archives.

**Figure 15. Fellows' Writings by Type of Publication**

Source: MFP Archives.



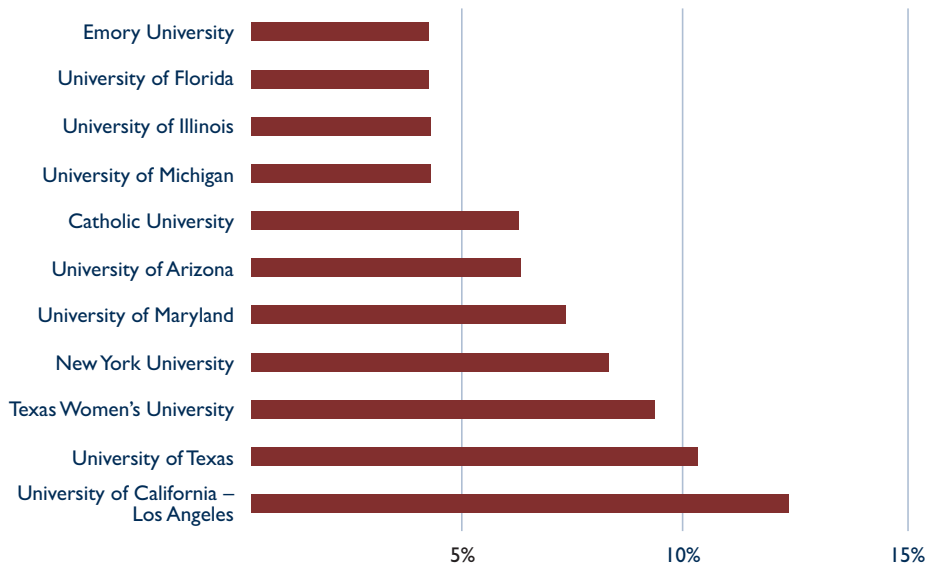
of the Fellows' publications appeared in refereed journals (68.1%), followed by non-refereed publications in journals and other documents (22.1%), and then book chapters (9.7%). Clearly, the Fellows have contributed to the scientific base of substance abuse and mental health nursing. Their findings could help to reduce or eliminate health disparities.

### *Fellows' Matriculation in Selected Colleges and Universities*

The Fellows have been enrolled in 54 different colleges and universities throughout the country. Interestingly, this trend has remained unchanged since the first fellowships were awarded in 1975 (Bessent, 1997). The data also indicate that nurses from specific ethnic minority backgrounds tend to cluster at certain universities. For example, the universities that enrolled five or more MFP Fellows were the Universities of Arizona and Texas for Hispanic American nurses; the Universities of Maryland and California and the Catholic University of America (Washington, D.C.) for African Americans; and New York University for Asian American nurses (although fewer than five). The data suggest that few nurses relocate for educational experiences. As noted earlier, Fellows tend to be older than many students, and already have family responsibilities. Thus, moving to a new location to attend school might be more difficult for Fellows than it would be for more typical, younger students. In a 1993 evaluation summary of the MFP, 69 Fellows (33 Clinical, 36 Research) ranked on a scale of 1 (lowest) to 5 (highest) the location of the university as the most important factor in their selection of a doctoral program (Serlin, 1998; see Figure 16).

As illustrated in Figure 16, the highest number of Fellows attended the University of California at Los Angeles, followed by the University of Texas, Texas Women's University, and then New York University. This figure highlights those universities that had at least four Fellows in attendance between 1975 and 2000; however, there were at least 43 institutions of higher learning throughout the United States that had up to three Fellows enrolled during this same time period.

Figure 16. **Universities Attended by Fellows**



Source: MFP Archives.

### *Grade Point Average Among Fellows*

Fellows enrolled in doctoral programs demonstrated their academic excellence by maintaining high grade point averages across all grading periods. As Table 5 shows, Asian American nurses had the highest average (3.81 out of 4.00), with nurses listed in the Other group reporting the next highest average (3.70). African American nurses ranked third (3.60), followed by Hispanic Americans (3.57) and American Indian and Alaska Native nurses (3.20).

Table 5. **Grade Point Averages of Fellows Across All Grading Periods**

<b>Ethnicity/Minority</b>	<b>N</b>	<b>Mean</b>	<b>Standard Deviation</b>	<b>Minimum</b>	<b>Maximum</b>
Asian American	28	3.81	0.28	3.00	4.00
Other	9	3.70	0.42	2.93	4.00
African American	182	3.60	0.42	3.15	4.00
Hispanic American	37	3.57	0.50	3.00	4.00
American Indian and Alaska Native	10	3.20	0.43	3.00	4.00

Source: MFP Archives.

## *Fellows' Dissertations*

All Fellows completed dissertations as a requirement of their doctoral study. Numerous publications were the direct outgrowth of their dissertation research, and many Fellows continued to pursue research programs that began when they were Fellows. Table 6 offers examples of the Fellows' dissertation titles, along with their ethnic minority background, and the year they graduated.

These titles indicate that the Fellows were interested in substance abuse and mental health prevention and treatment issues that confront ethnic minority people. The Fellows continue to make contributions to the scientific literature that influence education, practice, public policy, and research. Selected abstracts from these dissertations and other research and scholarly articles are featured on the MFP web site, [www.nursingworld.org/emfp](http://www.nursingworld.org/emfp).

## *Graduation Rates*

In spite of the many challenges within the substance abuse and mental health professions and delivery systems, the MFP has had an impressive success rate. From 1975, when the first cohort of Fellows was selected, through 2000, nearly 275 Fellows received support. Available data show that 63% of all prior Fellows have completed their doctorates and about 26% are expected to complete their dissertations in the near future.

## *Post-Graduate Accomplishments*

Data about post-graduate productivity of alumni (1991–1997) were solicited by a survey of 147 Research Fellows (supported by NIMH funds) via mail, fax, telephone, Internet web searches, and networking with other program graduates. The purpose of the survey was to collect specific information on outcome measures, such as completion of the doctorate, attrition, and scholarly productivity through refereed publications, podium and poster presentations, funded research, academic appointments, and community service. With focused effort, information was obtained on the activities of 91 Fellows (response rate=62%) who had earned a PhD after receiving funding from NIMH.

Of the 91 respondents, 32% have been awarded research funding and 33% have published in refereed journals. Among those with research funding, 47% studied mental health and illness and psychosocial processes that involve substance abuse and mental health conditions. About 53% were awarded funding to increase the retention of ethnic minority Fellows in schools or colleges of nursing and other research projects.

**Table 6. Sample of Fellows' Ethnicity and Research Dissertation Titles: 1976–2000**

<b>Ethnic Minority Demographics</b>	<b>Dissertation Title</b>	<b>Date</b>
African American	Residents' Perceptions of Territorial Rights in Two Homes for the Elderly: An Exploratory Study	1976
African American	The Relationships Between and Among Selected Nurses and Patients on Measures of State Anxiety and Self-Discipline in a Clinical Setting	1977
Hispanic American	An Ethnoscience Study to Determine the Perception, Causation, Resolution and Categorization of Illness for Mexican Americans	1978
African American	The Relationship of Maternal Age to Acceptance and Control in Child Rearing Practices of Young Mothers	1979
African American	Curricular Innovations in Baccalaureate Schools of Nursing	1979
Hispanic American	A Comparative Study of Puerto Rican Families With or Without Identified Mentally Ill Members	1979
American Indian	Caring for the American Indian Patient	1980
African American	The Role of the Professional in Drug Dependency Treatment	1980
Asian American	A Study of Foreign Nurse Graduates: Factors Related to Test Taking	1980
Asian American	Cultural Variations of Sex Role Differences of the Chinese	1980
African American	An Ecological Study of Essential Hypertension	1980
African American	An Investigation of Autonomic Response Patterns During Exposure to Complex Sound Patterns in Black and White Young Adult Females	1980
Hispanic American	Planning Change in a Screening Program for Sickle Cell Anemia and Sickle Cell Trait in a Rural Clinic	1980
African American	The Role of the Psychiatric Nurse Specialist in the Care of the Chronic Psychiatric Patient in a Community Health Center	1981
African American	Selected Dimensions of Coping in Black Female College Freshmen	1981
African American	Racism as Counter Transference in Psychotherapy Groups	1982
Asian American	A Study of the Family Support System as Examined Through Child Rearing Rituals in Katmandu, Nepal	1982
Asian American	Attitudes Toward Death Among Nurses, Physicians, Elementary School Teachers, and Professors in Taiwan, Republic of China	1983
African American	A Comparison of Coping Responses of Non-Depressed Black Females and Clinically Depressed Black Females to Perceived Racial Prejudice and Discrimination	1984
Hispanic American	A Comparative Analysis of Wife Abuse Among Anglo-American and Mexican American Battered Women: Attitudes, Nature, Severity, Frequency, and Response to the Abuse	1986



<b>Ethnic Minority Demographics</b>	<b>Dissertation Title</b>	<b>Date</b>
African American	The Relationship of Adolescent Postnatal Depressive Symptomatology to Mother and Infant Integrative Behavior and Quality of Stimulation in the Home	1988
African American	The Mentally Disordered Offender in the Criminal Justice System	1989
Pacific Islander	Integrative Aging in Widowed Immigrant Filipinos: A Grounded Theory Study	1989
African American	An Attributional Study of Seclusion and Restraints of Psychiatric Patients	1989
American Indian	The Relationship of Self-Esteem, Depression, and Acculturation to Alcoholism Rates in Two Oklahoma Indian Tribes	1990
African American	A Community-Based Educational Approach to Enhance Learning Outcomes in Black Hypertensive Patients	1991
African American	The Relationships Between the Perceptions of Rewards, Cost, and Coping Strategies of Black Female Caregivers	1991
African American	Perceptual Determinants of Early Adolescent Health Promoting Behaviors in One Alabama Black County	1992
African American	African American Caregivers and the Chronically Mentally Ill	1993
American Indian	Behavior Problems Among American Indian Adolescents	1993
Hispanic American	Development of an Instrument to Measure Culturally Competent Care for Mexican Americans	1994
African American	Coping Strategies and Perceptions of Marital Satisfaction of Parents of Hospitalized Depressed Adolescents	1994
Asian American	Multiple Roles of Korean Immigrant Wives: Impact on Mental Health	1995
Hispanic American	Cognitive Behavioral Processes That Affect the Decisions of Substance-Dependent Schizophrenics in Choosing Complete Inpatient Treatment	1996
African American	Relationships Between Family Functioning and Female Adolescent Sexual Behavior	1997
African American	Determinants of Help-Seeking Behaviors for African American and Latino Women with HIV/AIDS	1997
African American	The Relationship of Selected Psychological Variables and Coping Strategies Among Low Income African American Women Who Undergo Breast Cancer Screening Procedures	1998
African American	Post-Partum Depression in African American Women	1998
African American	Social Psychological Responses of Black Families to Menarche: A Mental Health View	1999
African American	The Relationship of Sense of Coherence, Hope, and Spirituality to Psychosocial Outcomes of Breast Cancer in African American Women Over 50 Years	2000
Hispanic American	The Sleep Architecture of Depressed and Non-Depressed Mexican Americans and Caucasians	2000

## Employment Settings and Selected Positions

### *Employment*

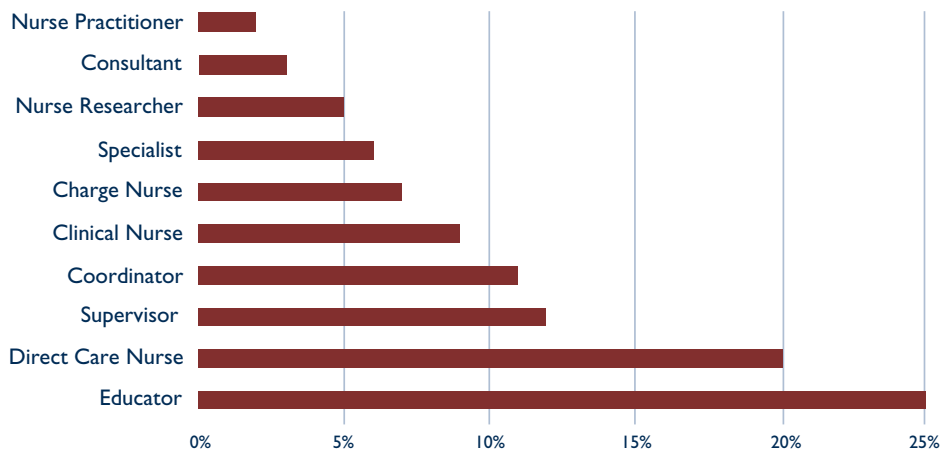
Fellows have tended to be employed in academic institutions or as clinicians in practice settings in the positions of direct care nurse, supervisor, coordinator, clinical nurse, charge nurse, and nurse specialist. A smaller percentage of Fellows are employed as researchers (Figure 17).

These data suggest that a large number (25%) of the Fellows were employed as educators in colleges and universities. Meanwhile, a substantial number (20%) were working in clinical care settings, providing direct care to patients and their families. Those Fellows who identified themselves as nurse researchers were fewer, at about 5%.

### *Fellows as Educators*

The available data indicate that, while the Fellows were employed in a variety of positions and settings in the health care system, the predominant employment setting remains the academic institution, where Fellows function as faculty members. Fellows in academic institutions were actively engaged in teaching some aspect of research (60%) and substance abuse and mental health prevention and treatment (37%). They also function in leadership and public health policy promulgation roles, as evidenced by their administrative and deanship positions.

Figure 17. **Fellows' Employment Positions**



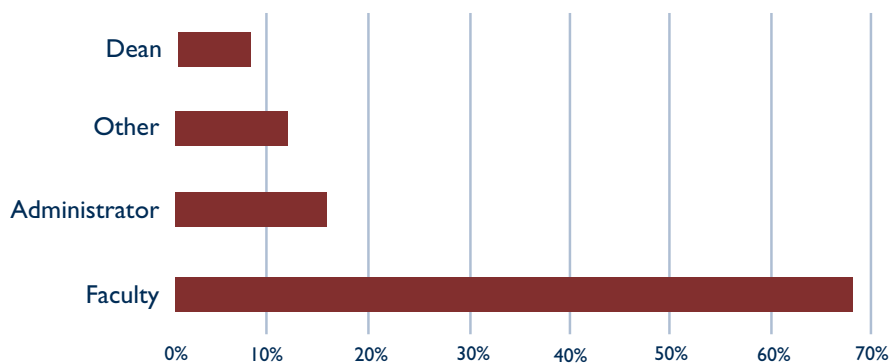
Source: MFP Archives.

In their various roles and responsibilities, graduates are demonstrating the successful attainment of the objectives of the Fellowship Programs supported by NIMH and SAMHSA.<sup>9</sup> Figure 18 presents some descriptive data.

## Estimated Financial Cost of Educating the Fellows

Fellows attended public and private institutions. They could request funding for 1 to 5 years, with the request renewable each year. The renewal approval is based on the successful completion of all of the requirements of this program. We have calculated the cost of educating 266 Fellows (stipend and tuition) by taking the average amount of the fellowship over a 5-year period and multiplying that number by the total number of Fellows. A 20% administrative cost has been added to this amount. The total cost is calculated to be about \$1,500,000. This calculated cost does not include the expense of other fellowship-related activities, such as seminars and workshops, that are among the known key elements of the MFP that have helped make it a success.

Figure 18. **Educators' Positions**



Source: MFP Archives.

9. In 2003, the Fellows were designated as SAMHSA Fellows at the ANA, in recognition of the source of financial support for the Fellowship Program and its professional organization.





# Fellows' Profiles and Personal Stories

**W**hile Section 5 delineated the personal and professional characteristics of the Fellows as a group, it did not shed light on any of the individual Fellows. In this section, we illuminate some of the individual Fellows' profiles and personal stories. Eight profiles are presented, two from each of the four ethnic minority groups. Their education, current employment, and contributions to the profession are described. In addition, the contributions of the MFP to each Fellow's career development are highlighted.

Although the most visible benefit of the program is the awarding of fellowships, other aspects—including professional support, dynamic leadership in colleges and universities, and a climate that optimizes and respects the contributions of culturally diverse individuals—may well have an equal impact on the ethnic minority nurses who have successfully completed this program.

The goals and objectives of the MFP are illustrated through the array of contributions that Fellows have made to the profession and to the care of individuals with substance abuse and mental health disorders and their families. These contributions also highlight the Fellows' educational and research expertise, leadership skills, ability to promulgate public health policy, clinical acumen, and public service, which are the hallmarks of this program. The profiles presented in this section demonstrate the range and depth of the Fellows' professional activities, as well as the unique contributions each individual has made.

In addition to the profiles, the section includes summaries of telephone interviews with six other Fellows, which elicited general comments and perceptions about the program, as well as their views on leadership and socialization.

## African Americans/Blacks



### Gloria B. Callwood

PhD, RN

*Class of 1988*

#### Education

1988 PhD  
Medical Sociology  
University of Florida,  
Gainesville, FL

1962 BS  
Nursing Education  
Hampton University,  
Hampton, VA

1978 MN  
Psychiatric Nursing  
Clinical Specialist  
University of Florida,  
Gainesville, FL

#### Current Position

##### **Director, School of Nursing**

University of the Virgin Islands, U.S. Virgin Islands, St. Thomas, Virgin Islands

#### Contributions to the Profession

As an undergraduate at Hampton Institute, Dr. Callwood was inducted into the prestigious Alpha Kappa Mu National Honor Society, which recognizes outstanding scholarship among young students. Her potential for a brilliant career in nursing was evident even during the early years of her undergraduate studies. During her career, she has served as the American Red Cross Leadership Award Chair of the St. Thomas/St. John Chapter, 1996–1998, and she received the Clara Barton American Red Cross Award in 2000. Moreover, in 2000, Dr. Callwood received the Who's Who Among American Teachers for classroom pedagogical excellence. At the 50-year anniversary of the Virgin Islands State Nurses Association, she was the recipient of their Recognition Award. Dr. Callwood has served as Regional Director, Caribbean Nurses Organization, 1986–1990, and is a charter member of the St. Thomas Hospital Board of Trustees, St. Thomas, Virgin Islands.

In addition to these activities, she has been (1990–1992) and is currently (2002–2004) President, Virgin Islands State Nurses Association, and until recently was the Financial Secretary of the Chi Eta Phi Nursing Sorority, Southeast Region. Other leadership responsibilities include serving as President, Mu Eta Chapter, Chi Eta Phi Nursing Sorority, 2001–2003.

Within the Government of the Virgin Islands Hospital System (1962–1995), Dr. Callwood served in leadership positions in mental health services, including staff nurse, head nurse, supervisor, nurse consultant, and psychiatric liaison for

medical/surgical units. One important assignment was the coordination of preparing and planning for the hospital system's Joint Commission for Accreditation of Health Organizations Committee site visit. The site visit was a resounding success, and members of the hospital staff credited the favorable outcome to Dr. Callwood's intellectual acumen and hard work.

She also devotes time to private counseling to help individuals and families who are experiencing distress in their personal lives. Her expertise is sought from far-away places. For example, for more than 4 years, she has served as a writer for test items for the Commission on Graduates of Foreign Nursing Schools. Moreover, she has consulted with international Ministries of Health, including the Kingdom of Lesotho, in Southern Africa.

During Dr. Callwood's tenure at the University of Florida, she worked as a research scholar and faculty member, where she taught psychiatric nursing and medical sociology, supervised master's-level students, and administered a federal grant. In her present role as Director of the Department of Nursing, she is responsible for leadership of the associate and baccalaureate programs and for a recently funded grant from the Office of Health Disparities, Department of Health and Human Services. Dr. Callwood also serves on numerous university-wide committees and task forces.

This outstanding nurse leader continues to focus on her research and scholarship. She has published several refereed manuscripts in professional journals, and she frequently contributes chapters to psychiatric nursing textbooks.

Dr. Callwood continues to address community-based health issues as they relate to physical and mental health care. She is the Coordinator of the Virgin Islands/Florida/Caribbean AIDS Education and Training Center, a project funded by the Health Resources and Services Administration. In addition, she is Principal Investigator of the Virgin Islands Minority Organ Tissue Transplant Education Grant. Currently, Dr. Callwood is a Project LEAD Fellow, part of a leadership-focused program sponsored by the Kellogg Foundation for 2002–2007.

### Contributions of the MFP to Dr. Callwood's Career Development

“For me, the MFP provided an educational opportunity that would not otherwise have existed,” comments Dr. Callwood. She continues, “It has helped me and my family in countless ways.” When she began her master's studies in psychiatric nursing at the University of Florida, she and her husband were responsible for the care of eight young children. The fellowship gave Dr. Callwood the chance to study in the United States and complete her PhD. Her husband remained in the Virgin Islands and continued his employment at the high school, where he also served as the bandmaster of the Virgin Islands Steel Band. Although being separated from her family was a hardship, the MFP has aided Dr. Callwood in attaining her career goals. Her participation in the program also inspired her children to obtain academic degrees and embark on professional careers in engineering, social work, teaching, art, and music. Thus, the MFP has also helped another generation—eight productive children—who work in various professions throughout the United States and the Caribbean.



## Stephanie L. Ferguson

### PhD, RN, FAAN

*Class of 1996*

#### Education

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|--|---|
| <p><b>1996</b> PhD<br/>Nursing<br/>University of Virginia,<br/>Charlottesville, VA</p> <p><b>1987</b> MS<br/>Child Health Nursing<br/>Virginia Commonwealth University<br/>Medical College of Virginia,<br/>Richmond, VA</p> | <p><b>1985</b> BS<br/>Nursing<br/>University of Virginia,<br/>Charlottesville, VA</p> |
|--|---|

#### Current Positions

**Consultant, Nursing and Health Policy, and  
Director of the Leadership for Change Program**  
International Council of Nursing, Geneva, Switzerland

**Formerly Associate Professor, Coordinator, PhD Program in Nursing;  
Deputy Director, World Health Organization Coordinating Center**  
College of Nursing, George Mason University, Fairfax, VA

#### Contributions to the Profession

Until May 2003, Dr. Ferguson was an Associate Professor at the George Mason University (GMU) College of Nursing and Health Sciences; Coordinator, PhD in Nursing Program, and Director, Washington Health Policy Institute, Center for Health Policy, Research and Ethics; and Deputy Director of the World Health Organization's (WHO) Collaborating Center in Nursing and Midwifery, all of which are at GMU. Dr. Ferguson was appointed by USHHS Secretary Tommy Thompson to serve until 2006 on the National Advisory Council for Nursing Research, National Institutes of Health. In 2001, she was appointed by the U.S. Department of Defense to serve as an expert on global health issues for the National Security Forum. Dr. Ferguson is a member of the American Red Cross International Task Force for Nursing Issues. She also served as the Treasurer of the Board of Directors of Virginia Health Information, Inc.

Dr. Ferguson is a consultant to the WHO, Geneva, Switzerland. Her expertise also extends to the Pan American Health Organization, where she serves as a consultant to the Chief Nurse Scientists of the WHO. In 2000, she contributed to WHO



Resolution 49.1 on “Strengthening Nursing and Midwifery.” She is the editor-in-chief of the *Nursing and Midwifery News*—Journal of the Global Network of WHO Collaborating Centers for Nursing and Midwifery Development. In 1996–1997, Dr. Ferguson was a White House Fellow and worked with Secretary Donna E. Shalala at the USHHS.

Dr. Ferguson is a Distinguished Practitioner in the National Academies of Practice. She speaks nationally and internationally on a variety of topics ranging from adolescent health, HIV/AIDS and sexually transmitted disease prevention, to leadership development and health policy strategies, including coalition building and effective techniques for policy development and evaluation. She has been the keynote speaker on leadership issues for the Army Nurse Corps in Europe, the U.S. Navy in San Diego, Nurses for the Veterans Administration, and the Public Health Nurse Corps. Dr. Ferguson is a co-editor of the Child Health Policy Column for the *Journal of Pediatric Nursing*, editor of *Pediatric Nursing’s Research to Health Policy Column*, and a member of the editorial board of the *Newborn and Infant Nursing Reviews Journal*. She continues to serve as the National League of Nursing’s consultant to the National Student Nurses Association’s Board of Directors. Dr. Ferguson also served on the USHHS Health Resources and Services Administration task force for examining nursing’s work force issues as related to racial, ethnic, and gender diversity. In addition, she has had numerous gubernatorial appointments in Virginia.

Dr. Ferguson’s outstanding career in public service demonstrates the multitude of influential policy and decision-making roles a nurse can assume that have a direct impact on the health of children and their families at the local, state, national, and international levels. Her career has been dedicated to addressing the mental and physical health needs of vulnerable populations.

### Contributions of the MFP to Dr. Ferguson’s Career Development

“The MFP helped me conduct my own research and pursue my passion, have research and tuition funds, and focus on community-based programs for teens as they relate to pregnancy prevention and pregnancy management.” It also provided her with opportunities to focus on multicultural issues in teen pregnancy. Dr. Ferguson acknowledged that too few choices are typically available to the ethnic minority doctoral student because, in many instances, Caucasian faculty members are actively involved in research that centers on their own interests, which is seldom directly related to ethnic minority populations. Instead, they pursue research goals that are useful for other populations and interests. She also suggests that having the University of Virginia’s College of Nursing supplement the funds received from the MFP allowed her to meet the expenses related to her research and dissertation. Dr. Ferguson proudly acknowledges that the MFP catapulted her to an internship in health policy at the University of Virginia, where she gained additional knowledge and skills that have helped to define her outstanding career in public service. In short, Dr. Ferguson states, “Thank God for the MFP, and I pray that it never goes away. What would we do without it?”

## American Indians and Alaska Natives



**John Lowe**

PhD, RN

*Class of 1996*

### Education

1997	PhD Nursing University of Miami, Miami, FL	1981	BSN Nursing Eastern Mennonite College Harrisonburg, VA
1986	MS Psychiatric Nursing Oral Roberts University, Tulsa, OK		

### Current Position

**Associate Professor, College of Nursing**  
Florida Atlantic University, Boca Raton, FL

### Contributions to the Profession

Dr. Lowe's contributions to the profession are heavily based in his research program that evolved from his doctoral dissertation: *Cherokee Self-Reliance*, which investigated cultural values that contribute to the Cherokee Nation's health and well-being, particularly with regard to the prevalence of substance use and abuse. He has developed and published *A Cherokee Nation Self-Reliance Model*, which was conceptualized during his dissertation work. The dissertation and his doctoral studies were supported by the MFP. Dr. Lowe has continued to focus on research that was initially developed during his fellowship years, and he has been successful in attaining funding for several of his research initiatives. A few examples of funded studies that have evolved from his dissertation are described below:

- The Teen Intervention Project—Cherokee (TIP-C), an intervention study that utilizes a combined student assistance program and the Cherokee Self-Reliance Model. The interventions are specifically designed for Cherokee Nation teen substance-abuse prevention, and are conducted within Cherokee Nation schools. This program is funded by the National Institute on Alcohol Abuse and Alcoholism Minority Supplemental Grant to R01 AA10246-05S1. The Teen Intervention/Prevention Project—Cherokee (TIPP-C), a study that began in December 2002, is an expansion of the original TIP-C study. This study will test an add-on HIV/AIDS risk-reduction intervention and prevention program with a Cherokee adolescent population participating in a culturally based Cherokee Self-Reliance school-based program. It is designed to prevent early substance use and abuse. An R-15 AREA grant has been submitted to the National Institutes of Health for funding to support this study.
- Cherokee Teen Talking Circle, a research investigation being conducted at schools within the Cherokee Nation, is designed to examine the relationship between self-reliance and HIV/AIDS knowledge, attitudes, and behaviors among Cherokee adolescents. The Association of Nurses in AIDS Care funds this study.

- Nursing in the American Indian culture is an ongoing study being conducted with other doctorally prepared American Indian nurses. Through an examination of nursing in the American Indian culture, a conceptual framework and model are evolving and being fine-tuned. This initiative is funded by a grant from Johnson & Johnson Company.

A prolific writer, Dr. Lowe has published his research and scholarship in numerous refereed journals. These publications are available on the Internet through PubMed and Medline. He also writes for local groups and community-based organizations that focus on mental health and substance abuse issues in American Indian populations.

Dr. Lowe shares his knowledge and expertise with many community groups and academic and health-related organizations by serving in the following roles:

- ANA's MFP, National Advisory member
- American Nurses Foundation research grant reviewer
- USHHS grant reviewer
- USHHS Special Project of National Significance expert advisor
- Cherokee Nation Healthy Nations consultant
- Florida Nurses Association Board of Directors
- Florida Nurses Foundation Board of Trustees
- Alumni, Tribal Institutional Review Board of Southern California
- National Native American AIDS Prevention Technical Support Center Advisory Board Member.

He also supports the American Nurses Credentialing Center. Dr. Lowe's commitment to the health and welfare of the Cherokee Nation and other U.S. populations is obvious.

### Contributions of the MFP to Dr. Lowe's Career Development

Dr. Lowe is one of the few American Indian male nurses who has attained a doctoral degree, and the MFP assisted him in all aspects of this successful journey. Among the contributions the MFP made to his dynamic career, Dr. Lowe listed first the financial assistance that was crucial in his pursuit of doctoral study. Equally important are the value that the MFP placed on providing educational opportunities for ethnic minority nurses; its emphasis on excellence in education, research, public policy, practice, and leadership; and the faith and support the program provided for Dr. Lowe and his contributions to the field. "The MFP was what was needed for my success as a doctoral student," commented Dr. Lowe.

As a Fellow, Dr. Lowe acknowledged the significance that the MFP afforded his research; his contributions were valued, and perceived as playing an important role in conducting the culturally appropriate scientific work that could produce a body of knowledge specific to American Indians' physical and mental health care needs. "The support [I received] nurtured the confidence I needed to be successful in doctoral pursuits and, later, in my professional career. The MFP Director and Advisory Board members served as role models, mentors, and friends; these roles were distinct but intertwined, and necessary. Forums, small informal discussion groups, in-depth one-to-one conversations, telephone calls, e-mails, etc., are some of the activities that helped to galvanize my thinking, while, at the same time, fostering my sense of independence and validating my professional contributions to nursing as well as substance abuse and mental health care."



## Lillian Tom-Orme

### PhD, MPH, MS, RN, FAAN

*Class of 1988*

#### Education

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|--|--|
| <p><b>1996</b> MPH<br/>University of Utah,<br/>Salt Lake City, UT</p> <p><b>1988</b> PhD<br/>University of Utah,<br/>Salt Lake City, UT</p> <p><b>1981</b> MS<br/>University of Utah,<br/>Salt Lake City, UT</p> | <p><b>1977</b> BSN<br/>University of Utah,<br/>Salt Lake City, UT</p> <p><b>1973</b> Diploma<br/>Good Samaritan School of<br/>Nursing<br/>Salt Lake City, UT</p> |
|--|--|

#### Current Position

**Research Assistant Professor, Department of Family and Preventive Medicine, School of Medicine**  
Health Research Center, University of Utah, Salt Lake City, UT

**Consultant, Diabetes Project**  
Indian Walk-In Center, Salt Lake City, UT

#### Contributions to the Profession

Dr. Tom-Orme is an outstanding professional who has made contributions to the nursing profession for almost three decades. While her many honors attest to her commitment to improving the overall well-being of all people, she has made specific offerings to American Indian and Alaska Native communities. A few examples of the recognition she has received for her professional contributions are:

- American Diabetes Association Reaching People Award
- National Impact Award, National Indian Health Board
- Research Fellow, University of Pennsylvania
- National Institutes of Health/National Cancer Institute Award of Merit
- Fellow of the American Academy of Nursing
- University of Utah Young Alumni Par Excellence Award
- The 1989 Utah Department of Health Employee Incentive Award
- President, National Alaska Native American Indian Nurses Association (NANAINA).

Her research interests are broad and varied, centering on health and mental health beliefs, behaviors, and outcomes among American Indian and Alaska Native people. She does research on mental health, diabetes, breast and cervical cancer, health policy, and health systems issues, employing both qualitative and

quantitative research methods in her investigative approaches. Her research support is expansive, with a focus on health outcomes and lifestyle-related behaviors.

Dr. Tom-Orme's excellence in research is recognized nationwide, and her professional talents are often sought by state and national health organizations. She serves as a member of the National Institutes of Health scientific review panels, and commits her time and expertise to scientific reviews that address ethnic minority populations. She participates in the activities of the Agency for Healthcare Research and Quality, Disparities Special Emphasis Panel, and on the Advisory Board, Office of Research on Minority Health. She is a member of the Panel of Experts, Office of Women's Health, Public Health Service, USHHS. Significantly, she is a member of the Institutional Review Board, Indian Health Service, Office of Research.

Dr. Tom-Orme is an inexhaustible writer who has published important research and scholarly papers in numerous scientific journals. She frequently makes scientific presentations across the nation, and is often asked for expert advice on mental health care issues as they affect special populations.

Nevertheless, Dr. Tom-Orme finds the time to participate in a variety of professional associations, sharing her expertise and passion for improving health care for American Indians, Alaska Natives, and others. She holds member and leadership positions in the:

- American Diabetes Association
- Awakening the Spirit: Pathways to Diabetes Prevention and Control program
- Native American Design Team
- Scientific and Medical Meetings Oversight Committee
- Committee on Cultural Diversity
- American Indian and Alaska Native Caucus, 2000–2002 (Chair) of the American Public Health Association (APHA).

Furthermore, she is a member of two other APHA groups—the Refugee Health Caucus and the American Indian, Alaska Native, and Native Hawaiian Caucus—and numerous other such bodies. This Fellow is a productive and focused professional whose commitment to improved health care is unmistakable.

### Contributions of the MFP to Dr. Tom-Orme's Career Development

Dr. Tom-Orme is quick to admit that the fellowship aided her with the financial obligations involved in pursuing doctoral study. She attended a university in the West, and remained in close communication with her family and members of the American Indian community. During the years of her doctoral study, she was a focused and excellent student, studying transcultural nursing and becoming an expert in applying theory to clinical practice. After obtaining her PhD, Dr. Tom-Orme's intellectual curiosity took her back to school, where she earned yet another degree, the MPH. From two perspectives, nursing and public health, Dr. Tom-Orme articulates and writes about the epidemiology of disease, methods of prevention, and health outcomes. Currently, she is a committed member of the MFP National Advisory Committee, and is the immediate past President of NANAINA. Her commitment to and passion for helping all people through reducing health care disparities is ongoing.

## Asian Americans and Pacific Islanders



**Kem Louie**  
**PhD, RN, APRN, FAAN**  
*Class of 1983*

### Education

**1983** PhD  
 Nursing  
 New York University, NY

**1975** MA  
 Nursing  
 Psychiatric Nursing,  
 Clinical Specialist  
 New York University, NY

**1972** BSN  
 Nursing  
 Rutgers College of Nursing  
 State University of New Jersey,  
 Newark, NJ

### Current Position

**Director and Associate Professor, Graduate Nursing Program,  
 School of Nursing**  
 William Patterson University, Wayne, NJ

### Contributions to the Profession

Dr. Louie has been Chairperson of the Graduate Nursing Program and Professor, College of Mount Saint Vincent, New York (1992–2000); Associate Professor, Lehman College–CUNY; Visiting Assistant Professor of Psychiatry, Einstein College of Medicine, Bronx, New York; Assistant Professor, Villanova University, Villanova, Pennsylvania; and Assistant Professor, Felician College, Lodi, New Jersey. She has functioned as a psychiatric nurse clinical specialist, and worked in staff nurse positions in acute care psychiatric settings. Her contributions to nursing include leadership, research, and scholarly activities in the profession.

Numerous awards and special invitations have been bestowed upon Dr. Louie because of her commitment to nursing in general, and psychiatric nursing in particular. Listed here are some of the honors and invitations that she has received:

- Appointed by then-Governor Christie Todd Whitman of New Jersey to serve on the State Commission on Aging
- Invited to participate in the National Asian Pacific American Families Against Substance Abuse Conference, Los Angeles
- Participant, Division of Nursing's Cultural Diversity Task Force, Washington, D.C.
- Participant, Division of Nursing's Third Minority Nursing Conference, Washington, D.C.
- Presenter, Nursing Summit on Violence Against Women, U.S. Public Health Service, Office of Women's Health, Washington, D.C.
- Member, ANA's Expert Work Group on *Scope and Standards of Addictions Nursing Practice*
- Consultant, Facilitation Skills Development Program, Center for Substance Abuse Prevention, USHHS, Washington, D.C.
- Member participant, First Asian American Pacific Islander Health Summit Planning Group, Centers for Disease Control and Prevention, Atlanta.

Dr. Louie has also collaborated with other nursing groups on mental health concerns. She is an honorary member of the Philippine Nurses Association of New Jersey. Dr. Louie's research is multifaceted. She continues to publish in refereed scholarly journals. Listed below are just a few examples of her research:

- Louie, K. B. (2001). White paper on the health status of Asian Americans and Pacific Islanders and recommendations for research. *Nursing Outlook*, 49, 173–178.
- Louie, K. B. (1997). Successful grant writing for addictions nursing. *Journal of Addictions Nursing*, 9 (1), 17–21.
- Kuramoto, A. M., and Louie, K. B. (1996). Asian/Pacific Islander American nurses workforce: Issues and challenges for the 21st century. *Journal of Cultural Diversity*, 3 (4), 112–115.
- Louie, K. B. (1995). Cultural considerations: Asian American and Pacific Islanders. *Imprint: National Student Nurses Association*, 42 (5), 41–46.
- Louie, K. B., and Pollock, S. (1995). Successful strategies for ethnic minorities in graduate programs. *Nurse Educator*, 20 (5), 8–9.
- Louie, K. B. (1992). Spanning cultural differences. *Addictions Nursing Network*, 4, 48–52.
- Louie, K. B., Nkongho, N., and Willie, R. (1992). Implementing career development in a drug prevention program. *Journal of the New York State Nurses Association*, 23 (1), 16–18.

Her research awards have focused on substance abuse and mental health care. She is the recipient of the Nurse Faculty Development Award in Alcohol and Other Drug Abuse, funded by the National Institute of Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, and Office of Substance Abuse Prevention. She functioned as the project director for 5 years and managed all aspects of the grant. Of particular interest is her research program, PLAN (Pupils, Lawyers, and Nurses) Against Drugs, a project funded through an award from the New York State Substance Abuse Services. Currently, she is deeply involved in this prevention program.

### Contributions of the MFP to Dr. Louie's Career Development

The MFP helped Dr. Louie with the financial obligations that accompany full-time doctoral study. She was able to focus on her studies and benefit from the rich educational opportunities that were available in her academic environment. Being a student at New York University placed Dr. Louie in the midst of an intellectual community where new ideas and information were constantly being promulgated. The fellowship allowed for dialogue with creative, dynamic thinkers in substance abuse and mental health disorders and nursing care. Dr. Louie has had numerous unique experiences, including serving as a member of the MFP National Advisory Committee while she was a student. In this role, she articulated the needs and perceptions of the Fellows and advised the other members of the committee. Moreover, Dr. Louie participated in the review process and shared her insights about the overall approach to the selection and review practices of the committee. Some years later, Dr. Louie was asked to chair the MFP National Advisory Committee. In that role, she was the leader of a group of outstanding ethnic minority nurses and helped to plan the yearly goals and objectives of the MFP. She continues to support the MFP and its Advisory Committee members. Fellows and other supporters of the MFP are in constant dialogue with Dr. Louie. This outstanding professional has distinguished herself as the prototype of an ANA Fellow. Currently, in her role as director of a nursing program and a researcher, she focuses on helping others attain their career goals in substance abuse and psychiatric care.



## Jillian Inouye

### PhD, APRN-BC

*Class of 1987*

#### Education

- |  |   |
|--|---|
| <p><b>1987</b> PhD<br/>Developmental Psychology<br/>University of Hawaii,<br/>Honolulu, HI</p> | <p><b>1968</b> MS<br/>Psychiatric Nursing<br/>University of California,<br/>Los Angeles, CA</p> |
| <p><b>1980</b> MS<br/>Psychology<br/>University of Hawaii,<br/>Honolulu, HI</p>                | <p><b>1966</b> BS<br/>Nursing<br/>University of Hawaii,<br/>Honolulu, HI</p>                    |

#### Current Position

##### **Professor, Graduate Chair, and Director**

Office of Nursing Research

School of Nursing and Dental Hygiene, University of Hawaii, Honolulu, HI

#### Contributions to the Profession

Dr. Inouye has made substantial contributions to the nursing profession and to the mental health care of ethnic minorities and other populations. She is a licensed psychologist, a qualified mental retardation professional, a board-certified clinical specialist in psychiatric nursing, and an advanced practice RN. These outstanding credentials clearly attest to Dr. Inouye's commitment to excellence in research and clinical practice. In her role as nurse researcher, she has published numerous data-based refereed manuscripts that focus on a variety of psychiatric and mental health nursing topics, including child abuse prevention, HIV/AIDS, and health beliefs and behaviors. She has written book chapters on Asian American and Pacific Islander health disparities and psychiatric care, including schizophrenia, depression, substance use and abuse, and other topics. Equally significant are her research projects on health care disparities, children and mental health problems, and role strain among nurses from different cultures. She is a founding member of the Asian American and Pacific Islander Nurses Association and currently serves as Vice President and board member of the National Coalition of the Ethnic Minority Nurses Association.

Dr. Inouye also shares her knowledge and experiences with others throughout the world. She has presented her research in many different countries, including Denmark, Japan, Thailand, Hong Kong, and Switzerland. Dr. Inouye is an outstanding nurse scholar who continually contributes to the scientific literature.



Examples of her published research are listed here, and many more are available through PubMed, Medline, and other Internet sources:

- Inouye, J., Cerney, J., and Hollansworth, J. (2001). Child abuse prevention program with POTS base telehealth: A feasibility project. *Telemedicine Journal and E Health*, 7 (4).
- Inouye, J., Flannelly, L., and Flannelly, K. (2001). The effectiveness of self-management treatment for individuals with HIV/AIDS. *Journal of the Association of Nurses in AIDS Care*, 12, 73–84.
- Flannelly, L., and Inouye, J. (2001). Relationships of religion, health status, and socioeconomic status to the quality of life of individuals who are HIV positive. *Issues in Mental Health Nursing*, 22 (3), 253–272.
- Flannelly, L., and Inouye, J. (2000). The relationship between prayer, health beliefs, and health status among individuals who are HIV positive. *The Hong Kong Nursing Journal*, 36 (1), 25–30.

Dr. Inouye also finds time to volunteer at various mental health service facilities and provide mental health care to underserved populations in local communities in Hawaii. Her extensive expertise enables her to provide a unique level of service to vulnerable people and their families.

### Contributions of the MFP to Dr. Inouye's Career Development

Dr. Inouye was a diligent student, one who accepted the fellowship with the goal of completing her program and then aiding others. The fellowship provided the funds that permitted her to study full time, concentrating on mental health issues and cultural variations that affect mental health services. It also provided a mechanism for linkages with other nurse researchers, especially those ethnic minority nurses who were studying at other universities.

“The MFP’s Legislative Internship was an invaluable experience in providing exposure to policy issues that shape health care for not only ethnic minorities but for all groups that experience health disparities,” according to Dr. Inouye. The MFP staff was and remains a vital source of information and provides a base for national and international nurse connections. Being a Fellow meant that one was “linked” and not alone in the pursuit of the PhD. It was also a source for consultation with new friends and for generating new ideas and paradigms intended to improve the health and well-being of all peoples in the global community.

## Hispanic Americans



**Sara Torres**  
PhD, RN, FAAN

*Class of 1986*

### Education

1986	PhD Nursing Research University of Texas, Austin, TX	1972	BS Nursing State University of New York, Stony Brook, NY
1975	MS Psychiatric/Mental Health Nursing Adelphi University, Garden City, NY	1971	AS Nursing State University of New York, Farmingdale, NY

### Current Position

#### **Dean, School of Nursing**

University of Medicine and Dentistry of New Jersey, Newark, NJ

### Contributions to the Profession

Dr. Torres is nationally known for her research on interpersonal violence; she conducted one of the nation's first comparative studies of Hispanic women's attitudes toward domestic violence. She has received funds from the National Institutes of Health, has published numerous articles, and has presented at state, national, and international conferences on domestic violence. She is the editor of a book, *Hispanic Health Care Educators Speak Out*, and of *Hispanic Health Care International*, the official journal of the National Association of Hispanic Nurses. She was a Visiting Distinguished Professor at the College of Nursing of the University of Puerto Rico in San Juan.

Dr. Torres has received numerous awards, including the U.S. Surgeon General's Exemplary Service Award and the National Association of Hispanic Nurses' Ildaura Murillo Rhode Award for Educational Excellence. Dr. Torres is a Fellow of the American Academy of Nursing and a member of Sigma Xi, the Scientific Research Society. She is involved in international health activities and is a consultant on mental health nursing to the Pan American Health Organization. She has served as the Director, WHO Collaborating Center on Mental Health Nursing at the University of Maryland School of Nursing in Baltimore.

Dr. Torres has served on committees of numerous associations and agencies, including the ANA, the American Academy of Nursing, the National League of

Nursing, the Food and Drug Administration's Psychopharmacologic Drugs Advisory Committee, the U.S. Department of Justice and the USHHS Violence Against Women Advisory Council, and the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Injury Prevention and Control. In addition, Dr. Torres is a past president of the National Association of Hispanic Nurses. Currently, she is on the board of the Kellogg-funded Community Scholars Program and the ANA's MFP National Advisory Committee. She has served in numerous study groups for several National Institutes of Health agencies and is currently a reviewer for the National Institute of Nursing Research.

In her role as Dean, School of Nursing, University of Medicine and Dentistry of New Jersey (Newark), she guides the college's educational process, fosters an environment supportive of research and faculty scholarship, serves as the chief academic nursing leader for the university, and promotes nursing education and service among community groups. She also maintains her own program of research and scholarship, and continues to publish in reputable research journals.

### Contributions of the MFP to Dr. Torres' Career Development

The MFP strengthened Dr. Torres' career in several significant ways. First, it created opportunities for mentoring and provided her contact with nationally recognized leaders in the nursing and mental health disciplines. Second, it provided a supportive network of scholars who aided her in the development of her research programs and nurtured her future professional growth. Third, the program provided financial support for her studies and, at the same time, placed her in the middle of a group of budding scholars where ideas and career dreams could be discussed and nurtured. Fourth, the MFP Fellows, once connected, tend to become life-long friends. These diverse friendships enhance science and theory, and enrich the lives of all Fellows. These MFP educational opportunities have helped to create a dean, a researcher, and a clinician. We celebrate the contributions of Dr. Torres, a member of the Class of 1986.



## Irma G. Aguilar Ray

### PhD, RN

*Class of 2000*

#### Education

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|--|--|
| <p><b>2000</b> PhD<br/>Nursing<br/>University of Texas Health<br/>Science Center at San Antonio, TX</p>  | <p><b>1980</b> MA<br/>Counseling<br/>University of Texas of the<br/>Permian Basin<br/>Odessa, TX</p> |
| <p><b>1999</b> Psychiatric Mental Health<br/>National Certification,<br/>American Association of<br/>Critical-Care Nurses<br/>Washington, D.C.</p> | <p><b>1974</b> BS<br/>Nursing<br/>West Texas State University,<br/>Canyon, TX</p>                    |
| <p><b>1990</b> MS<br/>Psychiatric Nursing<br/>University of Texas at El Paso, TX</p>   | <p><b>1968</b> Diploma<br/>Nursing<br/>Hotel Dieu School of Nursing,<br/>El Paso, TX</p>             |

#### Current Position

##### **Director of Nursing Programs**

Tarrant Community College, Fort Worth, TX

#### Contributions to the Profession

Dr. Aguilar Ray is a teacher and scholar, a researcher, and a leader in nursing and mental health care. She has devoted much of her career to teaching young men and women who are interested in nursing and specifically in psychiatric nursing. As a scholar and leader, she has pursued her passion in several Texas universities and community college systems. At the University of Texas, Southwestern Medical Center, she accepted a fellowship and conducted research in the Sleep Study Unit, where she was able to expand her thinking and enhance her experience in this special area of research.

Regarding her research, several interlocking themes emerge: sleep and insomnia, depression, cultural issues, chronic mental illness, death and dying, as well as other topics that are interrelated and may be manifested differently across various population groups. Her research on “The Sleep Architecture of Clinically Depressed Caucasian, Hispanic, and African American People” is frequently cited in the scientific and clinical literature. Although Dr. Aguilar Ray’s focus on sleep research continues to dominate her thinking, she still makes contributions to nursing science in other areas. Two refereed publications and a book chapter from Dr. Aguilar Ray’s repertoire of contributions are included here:

- Aguilar, I. G. (1997). Hospice home health care: Yesterday, today and tomorrow. *Home Health Nurse*, 15, 15.

- Ienatsch, G. E., and Aguilar, I. G. (1995). The eggs and us. *Medical Surgical Nursing*, 4, 222–224.
- Aguilar, I., and Barry, G. (1995). Mental health and psychological responses to illness. In: M. A. Matheson, et al. (eds.), *Nursing Care of Adults*. Philadelphia: Saunders.

Dr. Aguilar Ray is also a consultant to numerous mental health-related programs, such as the Hospice of the Southwest; she is a Clinical Sleep Consultant at Southwestern Medical Center; and she serves in various other professional organizations. She:

- participates in the Southern Nursing Research Society;
- serves as a Hospice Nurses Association National Board Member;
- is a member of the Association of Professional Sleep Societies; and
- is a member of the ANA and the Texas Nurses Association.

Requests for her professional consultation and scientific presentations are ongoing and numerous. Honors and recognitions for her contributions to nursing are granted frequently. She is:

- a member of the Texas Hall of Fame;
- a recipient of the Sleep Researchers Society Award;
- an active member in the Delta Kappa Chapter of Sigma Theta Tau, Who's Who in American Women; and
- one of the leaders in the Mexican-American League for Defense and Educational Fund.

### Contributions of the MFP to Dr. Aguilar Ray's Career Development

Dr. Aguilar Ray makes her position about the MFP very clear, citing several examples of significant impacts that the MFP has had on her career development. The financial support, consisting of a total of \$50,000 during her tenure, was an essential part of the MFP contributions. Without these funds, her dreams would not have been realized. The funds helped with her tuition and living expenses. She traveled long distances to construct the type of academic program that would provide expert content in sleep research, and much of the related expense was defrayed by the MFP/SAMHSA funds.

Beverly Robinson, PhD, RN, FAAN, and a former MFP Fellow, who was her mentor and constant supporter, helped her every step along the way. According to Dr. Aguilar Ray, “Dr. Robinson helped me construct my program of study, provided emotional support, assisted me in finding a mentor and teacher in sleep research, and encouraged me to get beyond many barriers and persevere onward.”

Dr. Aguilar Ray continues, “The MFP Office at the ANA Headquarters was priceless. Dr. Carla Serlin (former MFP Director) would tell me and the other Fellows, ‘If you need help, pick up the phone and call me.’ To this day, I remember those words.”

The teaching and mentoring that were provided by Dr. John Orme, the sleep research expert, were described as “awesome.” He constructed tutorial sessions for her, provided face-to-face tutoring, and assisted with her research. “I learned, and I enjoyed being an MFP Fellow,” states Dr. Aguilar Ray. “Without the MFP ... my dreams for a PhD and to become a nurse researcher would have gone astray.”

## Interviews With Selected Fellows About the MFP

In addition to the profiles, six former Fellows who reflected the four ethnic minority groups represented in the program were interviewed. Data were collected in telephone interviews that lasted from 30 to 60 minutes. Four domains—general comments, leadership, socialization, and perceptions of the MFP—were created (Porter, 2001; Gary, 2003), and the Fellows were asked to respond to each of them. Gary (2003) also conducted telephone interviews with the Fellows, and supplemented the work that Porter had begun. The results of both interviews are presented, along with the years that the Fellows matriculated in their respective doctoral programs.

### *African American Fellow, 1980–1985*

**General comments.** “I really liked my educational experience and my relationship with the MFP. I learned about the MFP during my admission interview with the associate dean. She encouraged me to apply. I was a Fellow during the era of the site visits and the 4:00 a.m. calls from Dr. Bessent. The site visit was my first meeting with Dr. Shaw-Nicholson and Dr. Gloria Smith. I was impressed with these direct, no-nonsense, professional women. I had never encountered anyone like them.”

**Leadership.** “I learned the academic style, including communication and its subtle meanings. Leadership means different things to different people. The MFP helped me to build self-confidence, which is indirectly related to leadership. The monthly, very early morning calls that required direct responses sharpened my ability to speak distinctly. The calls helped me to feel less alone because I was the only one (ethnic minority) in my doctoral program. I was selected for a congressional summer internship and got to play out my ideas of leadership. The MFP contributed to my growth as a leader by providing me the opportunity to observe a different kind of leadership style as manifested by African American professionals.”

**Socialization.** “I never attended any of the annual conventions because I never had enough money. I was never as connected with the other Fellows as I would have liked.”

**Perceptions.** “At one time we could be very, very proud to announce that we were Fellows.” This Fellow is supportive of efforts to continue the program in its inspiring path.

### *African American Fellow, 1990–1995*

**General comments.** “I would not have been able to pursue the doctoral degree without the financial support of the fellowship. I am grateful to the director for granting me a 6-month extension. I was so close to finishing and had no money. She was cooperative and talked with me about my progress.”

**Leadership.** “I attended the ANA conventions, which we were expected to attend. They were compulsory. They contributed to my understanding of leadership. They had speakers, panels on grant writing, and presenters who spoke to the importance of being a leader in professional associations and of community involvement in grass roots organizations.”

**Socialization.** “The MFP supported the development of my research skills and promoted my education. We were expected to call the office, and we were also expected to receive calls from the director. We had to explain to her what we had done that year and what we planned to do—she asked all kinds of questions. I had to support my decisions with a clear rationale. I met with the director on two occasions. She provided consultation about the research process, and provided a list of all Fellows in the program so I could develop a more extensive support system. Graduates I met at the convention stated that they would provide support for critique and writing, but I did not need them because I had a faculty mentor who was a previous Fellow. I was fortunate to have a previous Fellow as a mentor working with me. She encouraged me to make presentations at regional meetings, to write proposals, and other things.”

**Perceptions.** “The fellowship put me in touch with nurses and other mental health specialists who were nationally known and making significant contributions to the science. I appreciated the opportunity to learn from other Fellows, and to participate in dialogue across the disciplines—I learned about the link between substance abuse and mental health disorders, and about co-occurring disorders. But most of all, the fellowship helped me to believe that I could be successful and make a difference in the lives of other people. It provided me with a safety net and an additional resource on which my career could be planned and nurtured. I will always support the MFP. It has made the difference in my life and kept me from feeling isolated or disconnected from others. This opportunity to become a PhD-prepared nurse would not have happened without the MFP.”

### *American Indian Fellow, 1991–1996*

**General comments.** “The MFP provided financial support and help with becoming a professional. It aided me with leadership knowledge and skills, and created a bridge to other opportunities in nursing and health care systems. It placed me in leadership settings and I learned from others.”

**Leadership.** “The exposure to nursing leaders was useful because I learned from role models as I came into contact with others. The way the program approached mentoring and capacity building was seen as a culturally competent framework, and was congruent with the way that American Indians learn from their elders and other people in their culture. The approach was a respectful one.”

**Socialization.** “[The MFP] provided resources that allowed me to attend conferences and symposia. I was able to meet other researchers and scholars in nursing and mental health care. This exposure assisted me and helped to socialize me into another role, one as a mental health nurse researcher, and now I have selected nursing research as my focus for future contributions in academia. There are many contributions from this fellowship.”

**Perceptions.** “Without this fellowship, my education would not have been as it is. The MFP provided the foundation for what I am able to contribute to nursing and mental health care today. It has made the difference in my career. Even having the exposure to the director and the National Advisory Committee has helped me to gain insight into issues surrounding research, health policy analyses, and career decisions in mental health nursing.”

### *Asian American and Pacific Islander Fellow, 1979–1980*

**General comments.** “I was the only non-White student in my program. I realized the importance of the fellowship and being connected to and participating in activities with others like myself. I wanted to benefit from the activities. I knew it was to support us to be a success, to mainstream ourselves into the scientific community. One of the benefits was being selected for the summer legislative internship, and I worked in the office of Senator John Heinz, who was interested in aging. My mentor came and spent a couple of days with me during the internship.”

**Socialization.** “The MFP helped to keep me focused on my goals. It aided in the shaping of my thoughts about research and leadership.”

**Leadership.** “I had lots of communication with my mentor and the director, both telephone calls and written correspondence—even after graduation, I received information about the leadership training.”

**Perceptions.** “The problem with the MFP is visibility . . . and one can link visibility with status. That is, not enough people know about [the program] because it is not advertised as it used to be. In terms of health disparities and women of color in nursing . . . we are such a small group of people that we end up as a drop in the bucket.”

### *Asian American Post-Doctoral Fellow, 2000*

**General comments.** “The MFP is an excellent program. Ethnic minority nurses need a lot of encouragement to complete their studies. It is necessary to educate more ethnic minority nurses in nursing research, especially since there is a national interest in nurse-generated research. Besides, the population of the United States is changing, and more ethnic minority nurses will be needed to care for this diverse population and to do research to better understand the culture, health beliefs, and needs of the various ethnic populations.”

**Leadership.** “My fellowship provided opportunities for me to participate in conferences, seminars, etc., that are local and that exist in different parts of the nation. We are able to meet and discuss scientific issues with individuals who have made significant contributions to the discipline. Having an extensive knowledge base in research will place nurses in a position of leadership, and allow for the generation of new knowledge and protocols for care.”



**Socialization.** “The MFP provided the funds that allow for advanced study. Dialogue with other people in the various disciplines in the local community as well as throughout the United States is essential in mental health care. It helps me to become ‘socialized’ as a researcher, and to learn the daily rhythms of a researcher, which sometimes means that a person is on the computer all day, and all other reality is temporarily blocked out.”

**Perceptions.** “In the future, the MFP staff and advisors should consider providing more opportunities for fellowships and post-doctorates. They must also connect with young nurses who are interested in research. There are not too many post-doctoral opportunities for nurses; more focus should be placed on expanding the post-doctoral opportunities; efforts should be made to encourage ethnic minority nurses to participate in them. Most people think of nursing as a clinical profession, but evidence-based outcomes will require that nurses become more involved in clinical and empirical research. This is essential, especially as the need for a better understanding of health care delivery and ethnicity/minority/racial issues continue to be evident in all segments of health care systems. Efforts must be made to reduce and eliminate health care disparities.”

### *Hispanic American Fellow, 1983–1988*

**General comments.** “The fellowship helped me to manage the environment at the institution where I studied. Frequently, there were one, maybe two, ethnic minority students . . . The EMFP also helped me to feel a part of a group, and I knew I had a resource of capable people that I could rely upon.”

**Leadership.** “I observed leaders in nursing at different meetings and conventions. I also knew that the EMFP Advisory Committee and the staff would help me to make the contacts that I needed to develop for my research.”

**Socialization.** “This program helped to protect me from a feeling of isolation and from thinking that I was alone in my classes and at the institution. It made me think that I could do the work and that I had someone I could call on to get advice and answers. I loved that about the program.”

**Perceptions.** “The MFP is an excellent program. Over the past several years, I have not received much communication from the program. I was happy to hear from the staff and to participate in the making of this document. I had a wonderful education and I am happy to be reconnected with the MFP. Thank you for talking with me, and I hope to hear from you again soon.”





# Recruitment and Retention

**W**e have stressed throughout this report that a diverse work force is essential to meeting the health care needs of the nation. As America's population grows in diversity, with ethnic minority groups increasing in population percentages (National Advisory Council on Nurse Education and Practice, 2000; National Advisory Mental Health Council Workgroup on Racial/Ethnic Diversity in Research Training and Health Disparities Research, 2001; USHHS, 1996, 2001a; Spratley and others, 2000; U.S. Census Bureau, 1996; Sullivan Commission, 2004), the need for a nursing work force more closely reflecting the overall population becomes more urgent. In fact, the challenge facing the profession is two-fold: to catch up and, at the same time, to keep up with the numbers of ethnic minority nurses needed to combat health disparities and improve the state of the nation's health.

Recruitment and retention of ethnic minority nurses in all levels of nursing education is essential. It is the key element for the advancement of ethnic minority nurses into doctoral and post-doctoral programs that prepare them for leadership in education, clinical practice, policy promulgation, research, and community service.

Yet, during the three decades that the MFP has been in existence, there has not been a substantial increase in the ethnic minority nurse work force; this raises issues as to whether there are adequate opportunities for ethnic minority people to pursue careers in nursing. For example, in 1998, only 16% of all newly licensed nurses were reported as being members of one of the ethnic minority groups (National Council of State Boards of Nursing, 1999). These data are similar to licensure information reported in previous years (Roth and others, 1979; Sullivan Commission, 2004). Clearly, nursing has not yet attained a culturally diverse work force.

[Nursing] has a struggle promoting cultural competence because the profession is so overwhelmingly homogeneous, with nearly 90% white women. There is a need to work with current practitioners but particular energy should be focused on preparing a new generation of nurses. (Hegyvary, 1997, p. 18.)

Despite the obstacles, for almost 30 years, the MFP has succeeded in recruiting and retaining highly qualified nurses from ethnic minority backgrounds by widely publicizing the funding opportunities, maintaining a careful and rigorous

screening process, and ensuring that the Fellows attend graduate nursing programs where they would be trained in substance abuse and mental health disorders research and clinical practice. Since its inception, the MFP has used a systematic, nationwide recruitment effort to reach potential applicants. This is consistent with historical trends, which indicate that recruitment of ethnic minority persons into nursing requires a focused and steady approach, as short-term programs yield limited results.

Few programs have documented their success with recruitment and retention of ethnic minority nurses in the nation's education and work force systems. Yet successful programs are operating throughout the nation. Dissemination of model programs for educating ethnic minority nurses should be given a high priority, as they could act as a catalyst in rekindling conversations on the rationale and essential needs for a culturally competent work force.

Mindful of these factors, the MFP has, for years, employed a systematic, intensive recruitment and retention agenda. Some of its features are listed below.

## Recruitment

### *Literature Dissemination*

Program recruitment through announcements to graduate programs in nursing and behavioral sciences, as well as personal contacts with nursing deans and associate deans of graduate programs in nursing, have been used throughout the decades of the MFP. This is part of the program's larger strategy, where linkages with leaders in academic institutions constitute a key element in the overall success of the MFP.

### *Publications and Announcements*

Literature about the MFP was made available at numerous professional meetings and conventions, and announcements about the program were placed in *The American Nurse*, the official newspaper of the ANA, and the *American Journal of Nursing*, its official professional journal. In fact, during the early years, pictures and descriptions of the new Fellows were included in *The American Nurse*. This practice is being considered for reinstatement.

### *Fellows' Contributions to the Profession*

Publications about the Fellows' achievements were distributed in 1983 and 1997. Several directories about the Fellows have been published, some containing descriptions of their contributions in research, public policy, and clinical practice. Numerous publications were completed during the 1980s and 1990s under the leadership of Porter (2000), Serlin (1994), and Bessent (1997, 2002).

## *Collaboration with Health-Related Organizations*

Maintenance of close relationships with the various ethnic minority nurse organizations was and remains a high priority for the MFP. These organizations have continued to provide assistance with outreach efforts, help articulate the mission of the MFP, and share their points of view about the contributions of the MFP to both the ethnic minority and majority communities. Support has been sought and received from other organizations such as the American Academy of Nursing, the American Association of Colleges of Nursing, the Association of Psychiatric Nurses, the National Institute of Nursing Research, and the National League of Nursing.

## *Invitational Luncheons and Meetings*

During national conventions, scientific meetings, and invitational conferences, deans of schools and colleges of nursing with substantial numbers of ethnic minority students were sought out for dialogue about recruitment and retention of a culturally diverse student population. One purpose was to discuss the MFP and its particular strategies for recruiting and retaining nurses in education programs. The focal point was substance abuse and mental health disorders prevention and treatment.

## *Participation at Selected Meetings*

During professional meetings, literature was displayed at booths where MFP staff, National Advisory Committee members, former Fellows, and friends shared essential program information and responded to queries. Informal conversations took place among alumni, matriculated, and potential Fellows. Similar occasions were used to inform the audience about the MFP, careers in substance abuse disorders and psychiatric nursing care, and the various pathways to advanced degrees in nursing.

## *Visibility to Potential Benefactors*

Directors of the MFP made numerous visits to public and private foundations and organizations, and to congressional committees and offices on Capitol Hill to reinforce support for the MFP. This commitment to maintaining the visibility of the program also served as an outreach activity, making the MFP's mission and accomplishments known to a wide circle of potential partners and benefactors.

## *MFP Newsletter: A Vehicle for Communicating*

For several years, the MFP produced a newsletter that communicated the salient activities of the program. In recent years this activity has been suspended, but it is scheduled for reinstatement in 2007. This biannual publication will help to inform all stakeholders and supporters of the program's priorities, activities, and accomplishments.

## *Enhanced Awareness of the MFP through Scholarship*

Over time, the directors of the program and their staff realized that they could increase the visibility of the program through their own scholarly activities. Therefore, they began to publish in nursing journals (e.g., *American Journal of Nursing*, *Minority Nurse*, mental health specialty journals) and participated in multiple interviews for nursing newsletters and magazines (e.g., *Nursing Spectrum*, *Minority Nurse*). The MFP directors have also presented research and scholarly papers at conventions, scientific conferences, and meetings.

## *Fellows' Scholarly Contributions as Recruitment*

During their graduate studies, Fellows have always been encouraged to write for scholarly and research journals. It was thought that this approach increased the self-confidence of the Fellows in their ability to be successful in academic, policy, and practice settings. Their scholarly productivity was acknowledged in different forums, including conferences and recruitment visits, and at international, national, and state meetings.

## *Site Visits as an Outreach Activity*

Site visits permitted the MFP representatives to meet with undergraduate and other interested students. During these visits, they emphasized the importance of graduate education, informed students about the steps necessary to prepare for success in nursing and higher education, and shared information about the program. The MFP staff was careful to follow up with any requests from the Fellows, the on-site students, the faculty and administrators, or any others.

## **Retention**

Commitment to a diverse student population typically begins with the college and university leaders and deans of nursing programs, who are responsible for maximizing the human potential of all individuals within their academic communities. Cultural diversity, a component of quality mental health care, is a critical domain that requires focused awareness and action. Fostering the development of ethnic minority nurse leaders, developing a critical mass of faculty and leaders within the colleges and universities, and publicly acknowledging one's commitment to diversity are essentials that are linked to retention of ethnic minority Fellows, faculty, and staff (National Advisory Council on Nurse Education and Practice, 2000; Spratley and others, 2000). The MFP staff and program facilitators have employed a variety of methods to enhance the Fellows' retention and progress while they were enrolled in academic institutions.

## *Colloquia Participation*

Enrichment experiences were MFP-sponsored and included, for example, the ANA Convention, which is held in different locations throughout the United States. Fellows were provided the opportunity to present their research and to share educational and research experiences with other Fellows, senior investigators, and ethnic minority researchers and scholars.

## *Congressional Summer Internships*

This innovative program enhanced the Fellows' horizons, aided in their leadership development, and helped them envision a professional future with even more possibilities. Many Fellows made lasting political, academic, and personal friendships that have endured over several decades. Moreover, several Fellows who share common research interests have collaborated on major initiatives in substance abuse and mental health disorders education, practice, public health policy, and research.

## *Social Support*

Fellows received close monitoring of their academic progress, including their involvement in research, leadership opportunities, and expanded professional and personal networks. The directors contacted Fellows by telephone on a monthly basis to discuss their progress and academic performance. They were encouraged to communicate any tensions or perceived barriers that they were experiencing in their respective academic communities. The directors and the National Advisory Committee members responded to concerns expressed by the Fellows.

## *Academic Support*

During the first 15 years of the program, Fellows received annotated bibliographies of topics related to minority group health, advanced education, scholarships for women and men, and so forth. In more recent times, research and scholarly manuscripts written by the Fellows were featured on the MFP web site. At any time during the program's history, if a Fellow requested assistance with a specific course or the development of a body of knowledge or set of skills, the MFP Director would help to secure the necessary resources and then monitor the Fellow's progress.

## *Mentoring*

Advisory Committee members were assigned to Fellows based on the mutuality of their research interests, geographic location, and other factors. Advisory Committee members and Fellows were expected to have a minimum of one telecommunication contact each month. As needed, the Advisory Committee member would communicate with the MFP director regarding the Fellow's needs and overall progress.

## *Socialization and Professional Growth*

When funds were available, Fellows were supported to attend professional meetings; they were encouraged to submit abstracts and to present their research. Grant-writing workshops, public policy seminars, and cutting-edge symposia on the science regarding the brain, the mind, and behavior were convened throughout the United States.

## *Site Visits*

This useful strategy has been employed throughout the duration of the program. The broad purpose of the annual visits is to become acquainted with Fellows within their educational environments and to have a discourse with their advisors, faculty, and administrators. The visits permitted the site visitors (MFP Director and Advisory Committee member) to assess the specific needs and progress of the Fellows and to have a better understanding of the environmental barriers and facilitators that inhibited or aided in the successful completion of their programs of study. Site visits were also used for recruitment purposes and public relations opportunities, and they provided additional openings for dialogue about the necessity of a culturally diverse academic and practice work force in nursing. Moreover, the site visits helped to create and solidify relationships among MFP staff and Fellows with administrators, researchers, and scholars at universities throughout the United States and world communities.

## *Position Locator Service*

MFP staff disseminated information to the Fellows about positions in academic, practice, and policy-making institutions and organizations. This custom continues as a career-enhancement service for the Fellows.

## *Career Planning*

Fellows have been recommended for faculty, elected, and appointed positions in nursing organizations at international, national, state, and local levels. Many Fellows have acquired national and international reputations in nursing and health care. They have been nominated for membership on health-related boards, commissions, task forces, and other policy-making groups. The MFP has helped to link Fellows with various career opportunities throughout the world.

## **Barriers to Recruitment and Retention**

The MFP initiative has faced barriers that, at times, required creative strategies to overcome. Barriers threatened to impede an increase in the numbers of ethnic minority nurses who enrolled in and graduated from academic programs, regardless of their level of educational readiness. Brief discussions about some of these barriers are presented; critical aspects of the barriers include:



- restrictive admission policies;
- limited systematic and long-term mentoring infrastructures; and
- a scarcity of ethnic minority leaders in education, administration, and research (Lillie-Blanton and Correa-Alfaro, 1995; National Advisory Council on Nurse Education and Practice, 2000).

### *Restrictive Admission Policies*

Like other health professions, nursing relies heavily on standardized tests, a mechanism that does not necessarily predict success and could be culturally biased. Nursing continues to limit reliance on other factors that indicate one's capacity to excel in academia. Alternative approaches should be explored to identify those applicants who might be successful in academic nursing programs.

### *Limited Mentoring Opportunities*

Once an ethnic minority person is admitted to a college or school of nursing, barriers do not vanish. Instead, the student is likely to encounter an environment where there are few ethnic minority faculty members and students, a dearth of mentors, and a scarcity of educators who are knowledgeable about or interested in some of the health issues that many ethnic minority students would want to explore. According to Bessent (1997), mentors do not necessarily need to be faculty members. Others, including health professionals, educators, community leaders, and entrepreneurs across disciplines, who are willing to commit time and invest in ethnic minority students can also help to bolster the Fellows' self-confidence, assist them in problem solving, and cultivate long-term, trusting relationships. These relationships can be beneficial to both the mentor and the student. As a rule, academic institutions have not adequately planned mentoring programs designed to assist ethnic minority students. If mentoring programs are to be successful, a solid infrastructure and visible commitment at the highest levels of leadership—whether in academic institutions, nursing organizations, or health care systems—are needed (National Advisory Council on Nurse Education and Practice, 2000; Harper, 2003).

### *Scarcity of Ethnic Minority Leaders*

About 9% of nursing faculty nationwide are ethnic minority people (National Advisory Council on Nurse Education and Practice, 2000). This fact makes it difficult to obtain a critical mass of minority faculty, though they are vital in recruiting and retaining ethnic minority students. Caucasian faculty members, deans, and administrators in the colleges and universities could aid in efforts to recruit and retain ethnic minority faculty by developing environments that facilitate a diverse educational setting and workplace. By design, they should create a setting that embraces all faculty, staff, and students, regardless of their racial, ethnic, religious, or cultural backgrounds.

## *Complex Pathways to Advanced Nursing Education*

National nursing data suggest that individuals who receive their first educational degree from a baccalaureate program are more likely to pursue advanced nursing degrees. However, the largest percentages of nurses—about 70% of the entire nursing population—are graduates of associate and diploma programs (Spratley and others, 2000). One issue is clear: baccalaureate nursing education provides one pathway of opportunity, and it should be strengthened. However, others are needed as well. Stepwise career opportunities for associate and diploma graduates, who are more likely to be ethnic minority nurses (National Advisory Council on Nurse Education and Practice, 2000; Spratley and others, 2000; Grosel and others, 2000), also deserve immediate attention from nursing's decision-makers. Developing advanced education options that will help large groups of nurses attain baccalaureate and advanced degrees are the keys to nursing's future.

## *Nursing's Public Image*

Ethnic minority populations are not adequately informed about the breadth and scope of the nursing profession and lack information about the numerous opportunities that exist. They have too few chances to interact with and observe the work of nurses, and have even less exposure to nurses who have expertise in substance abuse and mental health disorders prevention and treatment. In addition, little is known about their significant and multiple contributions to health care.

## *Gender and Nursing*

Nursing's public image may also have an adverse effect on the recruitment of men into the profession. About 5.4% of all nurses in the nation are men. Statistics reveal that male nurses are younger than their female counterparts; about 38% are under the age of 40. In contrast, about 31% of female nurses are under the age of 40. Male nurses have a higher percentage of employment in nursing, with approximately 88% actively participating in the work force. About 81% of female nurses, on the other hand, are employed in nursing. Men are more likely to have associate degrees in nursing, but equal percentages of men and women attain baccalaureate or higher degrees (Spratley and others, 2000).

Male nurses tend to gravitate toward emergency, trauma, and acute care clinical practice environments. Of particular interest to the MFP is the research finding that suggests that mental health and psychiatric nursing attracts about 34% of the male nurses (Trudeau, 1996). Though the number of existing male nurses is small, there is evidence that they are interested in and gravitate to psychiatric nursing. Perhaps targeted recruiting efforts could be implemented to ensure that more male nurses will enter and remain in the discipline.

At the MFP, additional concentrated activities will be initiated to persuade men to consider a career in substance abuse disorders prevention and treatment, as well as mental health nursing. The ANA and the MFP are encouraged by the success that the U.S. Army has had in recruiting and retaining men in nursing. The percentage of male nurses in the Army is distinctly higher than it is in the civilian population: in the Army, 36% of all nurses are male, while among civilians, only 5.4% of the nurses are male (<http://malenursemagazine.com/stats.html>).

The MFP recognizes the efforts of organizations that recruit and support men in nursing. It acknowledges the contributions that men have made and can make to the profession and to the care of humankind. The MFP also advocates for research dissemination about antecedent conditions that impact men's substance abuse and mental health issues, and the mental health care that they receive. At the same time, the MFP acknowledges a need for the nursing profession and the MFP to become more assertive in recruiting men into nursing (American Assembly of Men in Nursing [2003], <http://people.delphiforums.com/brucewilson/>). Beginning in 2003, the MFP had representatives at selected men-in-nursing conferences and conventions. Furthermore, the MFP will request the assistance of male nurses and create a task force to inform the organization about strategies and approaches for recruiting and retaining male nurses in substance abuse and psychiatric nursing.

### *Constrained Financial Resources*

Limited funding has curtailed recruitment and retention activities in a variety of ways. However, technological advances have helped to buffer some of the undesirable impact of curtailed material resources. The newly enhanced ANA-MFP web site contains a plethora of information on the program, its many activities, and invitations to join in its mission. Scientific and clinical data are also easily accessible on this web site (<http://www.ana.org/emfp/>).

### *Fellows' Career Paths and Financial Assistance*

Potential Fellows are usually interested in the type of program that a particular university offers and its specialization in substance abuse and mental health. This content, however, may not be evident at first glance. The applicant typically has to inquire about how the required content can be attained at the college or university. If the applicant is diligent and "connects" with a person at a college or university, he or she may find answers to questions about content. If not, the potential applicant could postpone the application, elect a different field of study, or choose to pursue graduate work without the support of the MFP. In the case of the latter, completion of a doctoral program could take years. A financial package for doctoral students in substance abuse and mental health nursing is essential to ensuring program completion, the acquisition of skills in substance abuse and mental health nursing, and other essential benefits, such as mentoring, networking, interdisciplinary collaboration, and so forth.

### *Limited Resources for Recruitment*

The MFP has limited resources for recruitment. However, we recognize that work needs to be done in ethnic minority communities to present nursing as a viable and attractive professional alternative for young people. Collaborating with selected public schools, parents of children and adolescents, community leaders, and college and university personnel is key to creating a “pipeline” for future MFP nurses who could become expert nurse leaders in education, practice, public policy, and research. This approach is perceived as crucial to attaining a level of cultural diversity that enriches the education of all students in any academic setting.

### *Diversity Limitations in Schools and Colleges of Nursing*

The MFP acknowledges that dialogue is beginning among nursing leaders in schools and colleges of nursing about the need for a more diverse faculty, staff, and student mix. While such efforts are critical for the development of a culturally diverse professional group, they must be strengthened in order to meet the remarkable shifts in demographic diversity that are rapidly developing in this nation.

### *Diversity in Nursing—Still Only a Start*

Although some progress has been made, diversity has yet to become an integral part of the nursing profession. This situation creates barriers to the development of academic, practice, and research environments where human potential could be fully realized and where differences such as religion, ethnicity, race, or socioeconomic status would not interfere with the making of a nurse. The field of nursing needs to unravel its long history of homogeneity, where the overwhelming majority of its members have been Caucasian. The discipline of nursing needs to develop a nationwide plan to educate, hire, and promote African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans to all levels and roles in the profession. It is important to communicate to all of America’s ethnic minorities, as well as to the majority of the population, that nursing embraces diversity and that all groups are welcome in the profession.

# Gazing Into the Future

**A**s this report has demonstrated, the Minority Fellowship Program (MFP) has been producing successful outcomes for nearly three decades. But much remains to be done. With the ethnic minority population in the United States rapidly expanding, a shortfall of culturally competent, superbly educated nurses is inevitable. The dimensions of the problem are described below.

## The 1995–2050 Profiles of the Nation’s Population by Race and Origin

Between 1995 and 2050, Asian Americans are projected to have the *highest percentage increase in the U.S. population*, followed by Hispanic Americans, American Indians (and Alaska Natives), and African Americans (see Table 7). At the same time, the non-minority or Caucasian population will experience the least growth over this 55-year period. Figure 19 depicts this pattern of changing demographics.

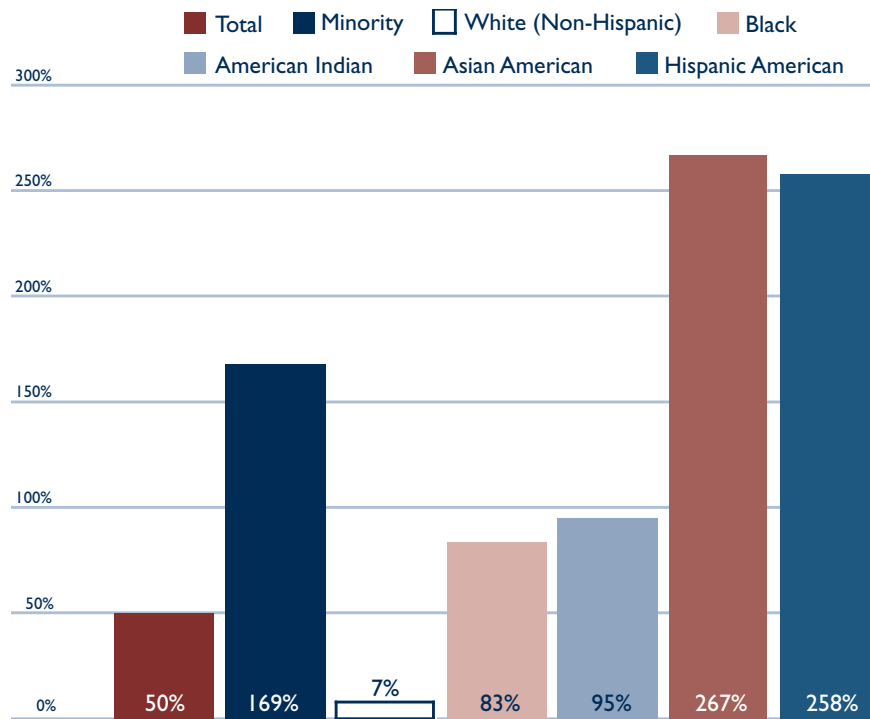
**Table 7. Projections of the Population of the United States by Race and Hispanic Origin: 1995–2050 (Millions, Resident Population)**

Year	Total	Minority	Race						
			Non-Minority Non-Hispanic White	White	African American	American Indian	Asian American	Hispanic American	Non-Hispanic
1995	262.8	69.3	193.6	218.1	33.1	2.2	9.4	26.9	235.9
2000	274.6	77.6	197.1	225.5	35.5	2.4	11.2	31.4	243.3
2005	286.0	86.2	199.8	232.5	37.7	2.6	13.2	36.1	249.9
2010	297.7	95.3	202.4	239.6	40.1	2.8	15.3	41.1	256.6
2015	310.1	105.1	205.0	247.2	42.6	2.9	17.4	46.7	263.4
2020	322.7	115.3	207.4	254.9	45.1	3.1	19.7	52.7	270.1
2025	335.0	125.9	209.1	262.2	47.5	3.3	22.0	58.9	276.1
2030	346.9	136.9	210.0	269.0	50.0	3.5	24.3	65.6	281.3
2035	358.5	148.4	210.1	275.5	52.5	3.7	26.8	72.6	285.8
2040	370.0	160.4	209.6	281.7	55.1	3.9	29.2	80.2	289.8
2045	381.7	172.9	208.8	288.0	57.8	4.1	31.8	88.1	293.6
2050	393.9	186.0	207.9	294.6	60.6	4.4	34.4	96.5	297.4

Source: U.S. Census Bureau, 1996, *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995–2050*, Current Population Reports, pp. 25–1130, Washington, DC.

Having examined the projected population growth over the next several decades, let us consider the percentages of nurses that will be needed to provide culturally competent care to a diverse population of individuals, families, and communities (*Nurse Reinvestment Act: Provisions and Appropriations Requests*, 2003; Hecker, 2001). Using the concept of the parity rule, which suggests that the percentage of ethnic minority nurses in a society should match or be similar to the percentage of ethnic minority people who live in that society, calculations for the number of recommended nurses were determined. As indicated in Figure 19, based on parity, there should be a 267% increase in Asian American nurses, a 258% increase in Hispanic American nurses, a 95% increase in American Indian nurses, an 83% increase in African American nurses, and a 7% increase in Caucasian nurses over the designated period of time. Overall, there should be a 50% increase in the total number of nurses for this nation. Data in Table 8 suggest the need for a major demographic shift in nursing’s academic institutions and in its future work force.

Figure 19. **Percent Increase in Population: 1995–2050**



Source: U.S. Census Bureau, 1996, *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995–2050*, Current Population Reports, pp. 25–1130, Washington, DC.

Figures 20 and 21, which were generated by using data from Tables 7 and 8, will help the reader to visualize the projected increases needed in ethnic minority nurses by displaying the pattern of constant growth in the population that is projected to occur through the year 2020. Percent increases are evident among each of the ethnic minority groups.

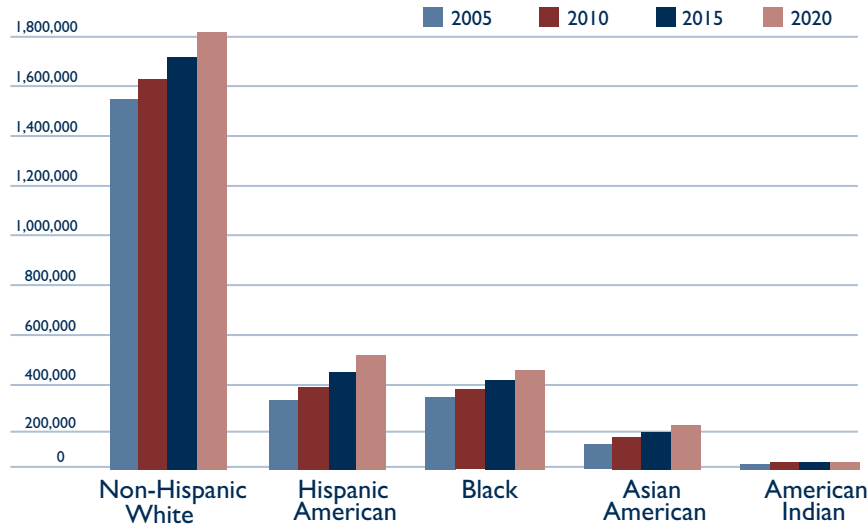
In Figure 20, the projected numbers of RNs needed in the years 2005, 2010, 2015, and 2020 are illustrated, broken out for both White and ethnic minority groups. Figure 21 shows the same data in greater detail—the projected number of RNs needed in four different periods for the ethnic minority groups of Hispanic American, African American, Asian American, and American Indian nurses (the projected numbers of White RNs needed are excluded from this chart).

**Table 8. National Supply and Demand Projections for Full-Time-Equivalent Registered Nurses: 2000–2020**

Year	Supply	Demand	(+) Excess (-) Shortage	Percent Change
2000	1,889,243	1,999,950	-110,707	-6
2001	1,912,667	2,030,971	-118,304	-6
2002	1,937,336	2,062,556	-125,220	-6
2003	1,959,192	2,095,514	-136,322	-7
2004	1,989,329	2,128,142	-138,813	-7
2005	2,012,444	2,161,831	-149,387	-7
2006	2,028,548	2,196,904	-168,356	-8
2007	2,039,772	2,232,516	-192,744	-9
2008	2,047,729	2,270,890	-223,161	-10
2009	2,059,099	2,307,236	-248,137	-11
2010	2,069,369	2,344,584	-275,215	-12
2011	2,075,218	2,379,719	-303,828	-13
2012	2,075,218	2,426,741	-351,525	-14
2013	2,068,256	2,472,072	-403,816	-16
2014	2,061,348	2,516,827	-455,479	-18
2015	2,055,491	2,562,554	-507,063	-20
2016	2,049,318	2,609,081	-559,763	-21
2017	2,041,321	2,656,886	-615,565	-23
2018	2,032,230	2,708,241	-676,011	-25
2019	2,017,100	2,758,089	-740,989	-27
2020	2,001,998	2,810,414	-808,416	-29

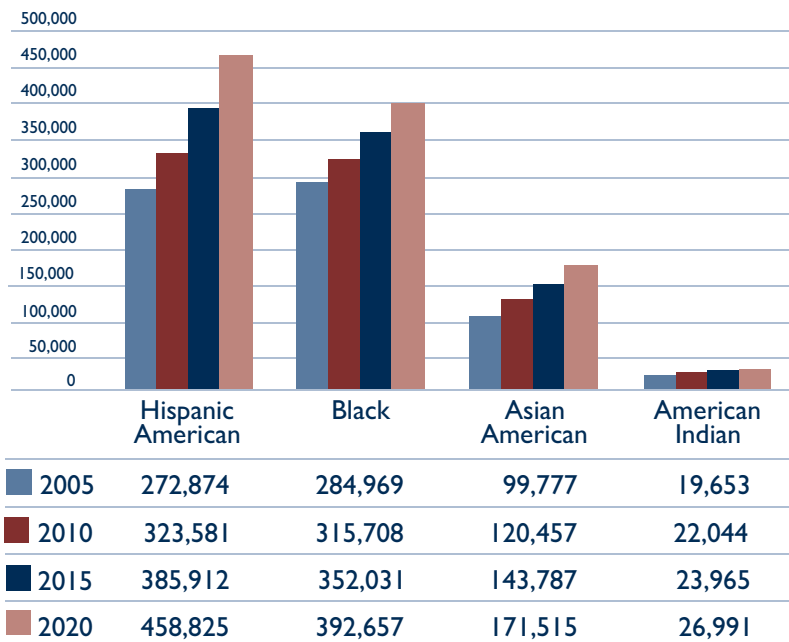
Source: USHHS (2002). *Projected Supply, Demand, and Shortages of Registered Nurses: 2000–2020* (July 2002), [www.ftp://ftp.hrsa.gov/bhpr/nationalcenter/rnproject.pdf](http://ftp.hrsa.gov/bhpr/nationalcenter/rnproject.pdf).

**Figure 20. Projected Number of Nurses Needed in Four Different Time Periods for Non-Hispanic White and Ethnic Minority Groups**



Source: U.S. Census Bureau, 1996, *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995*; and USHHS, 2002, *Projected Supply, Demand, and Shortages of Registered Nurses: 2000–2020* (July 2002), [www.ftp://ftp.hrsa.gov/bhpr/nationalcenter/mproject.pdf](http://ftp.hrsa.gov/bhpr/nationalcenter/mproject.pdf).

**Figure 21. Projected Number of Nurses Needed in Four Different Time Periods for Ethnic Minority Groups**



Source: U.S. Census Bureau, 1996, *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995*; and USHHS, 2002, *Projected Supply, Demand, and Shortages of Registered Nurses: 2000–2020* (July 2002), [www.ftp://ftp.hrsa.gov/bhpr/nationalcenter/mproject.pdf](http://ftp.hrsa.gov/bhpr/nationalcenter/mproject.pdf).



### *Hispanic Americans*

According to the projections shown in Figure 21, in the year 2010, 323,581 Hispanic American nurses will be needed to achieve parity in providing adequate health care; 5 years later, in 2015, 385,912 Hispanic American nurses will be required to meet this disparity. By 2020, 458,825 Hispanic American nurses will need to be employed in the profession in order to meet parity. This is the largest projected increase in need from among the different ethnic minority groups.

### *African Americans*

The number of African American RNs needed is expected to increase significantly as well. For example, in 2010, there should be 315,708 African American nurses licensed to practice in the United States. In the year 2015, 352,031 African American nurses will be needed to satisfy parity, and in 2020, 392,657 African American nurses should be educated as RNs and in the work force (see Figure 21).

### *Asian Americans*

The number of Asian American nurses needed is also projected to increase in the population. Their percent increases are expansive, though not as dramatic as the projections among Hispanic Americans and African Americans. By 2005, 99,777 Asian American nurses should be available; in 2010, 120,457 Asian Americans are expected to be in the work force; in 2015, the projection is for 143,787. Finally, by 2020, there should be 171,515 Asian American nurses licensed to practice in America (see Figure 21).

### *American Indians*

American Indians will also demonstrate growth in the general population, and should thereby experience increases in the nursing work force. The projected data suggest that in 2005, 19,653 American Indians should have been educated for professional roles in nursing; 5 years later, in 2010, the number of nurses in this population should increase to 22,044; by 2015, expectations are for 23,965 professional nurses in this population. By the year 2020, there ought to be 26,991 American Indian professional nurses (see Figure 21).

## **Commentary: Implications for Nursing's Future Work Force**

The MFP's mission is, in part, defined by these projected increases in the number of nurses needed in order to attain parity. The enormity and importance of the challenge that confronts the nursing profession in its efforts to create a diverse work force demand the best thinking and concerted efforts from the entire nursing community, as well as from private and public health and social policy agents and agencies. Nursing's mission to diversify its work force should be addressed at the highest levels of government and supported by influential private sector stakeholders (National Advisory Council on Nurse Education and Practice, 2000; Needleman and others, 2001). The sense of urgency is palpable.

# Recommendations for the Development of Ethnic Minority Nurse Leaders for the 21<sup>st</sup> Century: The MFP Model

The MFP is one of the most successful programs in the nation for educating ethnic minority nurses at the graduate level. Our years of experience in administering this program have produced the insight for making the following recommendations for leadership development of ethnic minority nurses.

## I. Assess Academic Environments for Potential Nurse Leaders

Assess academic environments that facilitate the growth and development of potential ethnic minority nurse leaders, as evidenced by enrollment and retention figures, graduation rates, career placement, and the endorsement of cultural diversity.

### Strategies

- Systematically study environments and disseminate the findings regarding academic institutions' cultures and the extent to which they are humane, facilitative of diversity, and embrace excellence in academic pursuits.
- Conduct workshops and support formal courses and informal small-group discussions that focus on cultural competence and self-understanding among Caucasian faculty who are in the majority in most schools and colleges of nursing. They still have control of the opportunity to structure policies and practices that have direct and long-term consequences for educating ethnic minority nurses.

## 2. Develop Institutional Profiles

Develop profiles of institutions that promote diversity in nursing leadership and disseminate those profiles, along with the variables that are influential in stimulating and maintaining a culturally diverse educational setting and work force.

### Strategies

- Collect and analyze data about specific academic and practice institutions and develop models based on their philosophies, strategies, management, and evaluation processes.
- Implement programs for internships and summer institutes at institutions that manifest desirable characteristics and attributes.
- Among those institutions that have inadequate track records regarding the facilitation of ethnic minority students and faculty, collect and analyze data that will help to determine the barriers to cultural diversity, leadership opportunities, and academic excellence.
- Develop a more informed awareness of, and data set about, the relationship between central administrative leaders, staff, and their values and priorities, and those of nursing leaders, when fostering opportunities for ethnic minority nurses within academic and service institutions.

### 3. Disseminate Professional Cultural Competency Standards

Disseminate cultural competency standards for education, practice, public policy, research, and leadership in nursing.

#### Strategies

- Inform the nursing community, and the larger health care system, about the changing demographics and their potential impact on health care in general, and nursing in particular.
- Develop linguistic standards for leadership in education, practice, public policy, and research in nursing, and review current documents, such as those developed by the American Psychological Association (Jones, 2003), the Office of Minority Health, USHHS, and others as appropriate, as antecedents for nursing.
- Identify benchmark cultural diversity programs in nursing leadership currently operating in practice and education settings, and distribute that information to the nursing community; key people from the selected benchmark programs would be asked to conduct leadership workshops for other nurse leaders who wish to support cultural diversity in nursing at the administrative and decision-making levels. Robust evaluation mechanisms would be embedded in the overall initiatives.

### 4. Expand Leadership Programs

Create and expand leadership programs that will take ethnic minority nurses to places that they might not ordinarily go of their own volition.

#### Strategies

- Support opportunities for ethnic minority nurses to participate in intensive, reputable leadership training institutes, and mentor them to and through leadership positions in health service organizations, schools and colleges of nursing, and professional organizations.
- Convene a series of institutes that explore different ethnic and cultural perspectives on the concept of leadership in nursing and health care systems. Publish proceedings generated from these institutes.
- Recognize and sustain those programs in academia and health care systems that have developed exemplary programs in cultural diversity, and reward their efforts in public forums, such as the ANA Convention, the American Academy of Nursing, the Division of Nursing, the National League of Nursing, American Association of Colleges of Nursing, and others.
- Sponsor year-long leadership fellowship programs for ethnic minority nurses that offer the chance to participate in day-to-day roles and functions related to their special assignments. The Fellows would have mentors and coaches, work full time in this capacity-building program, and then be assisted in attaining leadership positions in education, practice, public policy, or research. The mentoring and coaching would continue until the Fellow and mentor determined that the services were no longer needed.

- Partner with stakeholders, such as universities, research organizations, foundations, and political and governmental agencies, and develop model programs for leadership in public policy, practice, and research.
- Strengthen relationships with key organizations, such as the American Association of Colleges of Nursing, the National League of Nursing, SAMHSA, NIMH, public and private foundations, the ethnic minority nursing organizations, and others.

## 5. Develop Research, Statistics, and Health Policy Institutes

Develop a leadership summit for research, statistics, and public policy in substance abuse and mental health that would provide the Fellows with knowledge and expertise that are not otherwise available, but are essential for addressing health care disparities as they now exist in the 21st century.

### Strategies

Develop MFP Intensive Research, Statistics, and Health Policy Institutes. They would be designed to convene for 1 week, three times each year, and feature a competency-based curriculum that embraces the use of technology and specifies required readings and homework throughout the year. The week-long institutes would be under the direction of nationally known experts, who would function as faculty and mentors and represent numerous disciplines. Content would include such sessions as:

- Culture, Communications, and Competence: The Cornerstones of Success
- Culturally Sensitive Strategic Leadership and Management—
  - Demographic Shifts and Their Implications for Health Systems’ Organizational Transformation
  - Research Utilization and its Application to Change in Health Systems and Organizational Transformation
- Ethnic Minority People in Leadership and Authority: Enhancements and Pitfalls
- Making a Case for Change in Substance Abuse, Mental Health, and Primary Care Delivery Systems
- Research, Statistics, and Evidence-Based Practice and Health Policy
- Maintaining Commitment to Excellence in Research and Health Policy
- Mentoring and coaching in the MFP
- Grant Writing and Publishing.

The instructional format of the institute would be structured around these teaching and learning activities:

- lectures and formal presentations;
- group discussions;
- individual conferences, teleconferences, and video streaming;
- case analyses and presentations;
- assigned readings;

- scenario construction and role playing;
- working lunches and dinners with faculty and mentors; and
- site visits and homework.

The week would end with each participant’s presentation of a “Next Step” plan of action that delineates his or her responsibilities over the upcoming 4 months. The Fellow’s mentor and key faculty members would have reviewed and discussed this plan before it was approved for presentation to the group. Moreover, the plan would include a public substance abuse and/or mental health issue that would be addressed through the Fellows’ research and scholarship efforts. It would conclude with projected outcomes and their impact on the reduction and elimination of health care disparities.

Current or past Fellows would be eligible to apply for this initiative. This program is not yet fully conceptualized, but efforts are being made to solidify the structure and fund it. At this stage of development, ideas and strategies from the global nursing community are welcomed and can be shared at [www.emfp.org](http://www.emfp.org).

## 6. Expand Research on Diversity and Racial and Ethnic Minority Health Disparities

A better understanding of the causes and consequences of health disparities as experienced by ethnic minority persons could be improved if there were more diversity among health professionals. Ethnic minority nurses in substance abuse and mental health research could help to advance the agenda because of their broad-based cultural perspectives, experiences, and different world views, all of which impact the conceptualization of problems, how the research questions are constructed, and the study design implemented. The interpretation and distribution of findings from the data are other critical areas that are driven by one’s culture, life experiences, and world views (National Academies, 2003, 2004; Smedley and Smedley, 2005; *Healthy People 2010*, USHHS, 2000b; Lowe and Struthers, 2001; Mezzich and others, 1996; USHHS, 1994, 2001a, 2001b; U.S. Census Bureau, 2001b).

### Strategy

Support Fellows’ initiatives to expand the scientific base of knowledge through publishing, making poster and podium presentations, and serving on local, state, national, and international advisory boards, and other policy-promulgating entities.

## 7. Strengthen the MFP Within the SAMHSA Framework

Much of the effectiveness of the MFP stems from its close ties with its funding organization, SAMHSA. Maintaining and strengthening the MFP’s ties to SAMHSA is seen as a critical element to the continued success of the MFP.

The MFP’s mission, through its focus on scholarship, practice, public policy, and research, is integrally entwined with SAMHSA’s priorities, programs, and principles. This connection, involving Fellows and alumni from all five fellowship programs, strengthens the interdisciplinary nature of the program, where

dissemination of research findings across all of the disciplines provides a greater benefit to all of the participants.

The First National SAMHSA Minority Fellowship Program Conference: Cultural Competence and Reducing Health Disparities was the most significant effort to date to maximize the value of the organizations' combined efforts. For the first time ever, the Substance Abuse and Mental Health Services Administration convened Fellows for a 3-day conference in Washington, D.C., December 11–13, 2003. Current Fellows and alumni from among their five fellowship programs were invited to participate. Attendees included Fellows from adult psychiatry, child psychiatry, clinical psychology, substance abuse and mental health nursing, and social work. Among representatives from the nursing field, MFP Advisory Board Members, invited alumni, and mentors joined the Fellows and alumni at this conference.

Several organizations co-sponsored the SAMHSA fellowship event, including the:

- American Academy of Child and Adolescent Psychiatry,
- American Psychiatric Association,
- American Psychological Association,
- American Nurses Association, and
- Council on Social Work Education.

The conference provided a forum for the exchange of information among SAMHSA, past and current Fellows, and grantees with regard to conceptual models and interventions that are related to reducing health disparities. The conference was also designed to provide feedback to the SAMHSA leadership and staff and MFP Directors to: (1) determine how their training experiences have affected their ability to achieve project goals; and (2) identify specific learning needs that should be addressed to maximize their ability to contribute to ethnic minority communities.

Based on survey data from the Fellows, six topics were identified as being of highest interest to the Fellows; these were embedded within the conference. The six topics were: (1) children and families; (2) co-occurring disorders; (3) substance abuse treatment and prevention of HIV/AIDS; (4) trauma and violence; (5) community-based treatment and prevention, and reducing stigma and barriers; and (6) cultural competence and reducing health disparities.

This first conference had three anticipated outcomes:

1. MFP Fellows would know more about SAMHSA and its various programs in the field.
2. MFP grantees would learn more about SAMHSA and its various programs and would use that information to identify further training and career enrichment opportunities for their Fellows.
3. SAMHSA would gain additional knowledge about the MFP Fellows and their capabilities and would use this information to generate additional ideas for opportunities that could enhance the Fellows' career development.

Furthermore, the conference gave rise to many new and novel ideas about the future of the prevention and treatment of substance abuse and mental health disorders. One such idea is the establishment of SAMHSA Institutes, which would be convened every 2 years. The first SAMHSA-sponsored national Institute should focus on the six topics that were identified in the previous paragraphs.

One of the highlights of the First National SAMHSA MFP Conference was the participation of SAMHSA Administrators. James Stone (M.S.W., Deputy Administrator, SAMHSA) and Joyce T. Berry (Ph.D., J.D., Director, Division of State and Community Systems Development, Center for Mental Health Services) provided opening remarks. Keynote addresses were given by A. Kathryn Power (M.Md., Director, Center for Mental Health Services); H. Westley Clark (M.D., J.D., M.P.H., C.A.S., F.A.S.A.M., Director, Center for Substance Abuse Treatment); and Beverly Watts Davis (Director, Center for Substance Abuse Prevention). Their insights added greatly to the content and quality of the conference. Fellows and alumni had opportunities to interact with these outstanding SAMHSA leaders and to share their career goals with them.

### **Interdisciplinary Mentoring Across the MFP Initiatives**

Another outcome of the December 2003 SAMHSA interdisciplinary conference was the initiation of a task force to develop an interdisciplinary mentoring program for all Fellows. Its purpose was conceptualized as an effort to assist Fellows and alumni to maximize their careers in substance abuse and mental health prevention, treatment, and rehabilitation. At this juncture, the task force is (1) collecting data about the Fellows' mentoring needs, (2) determining the best evidence-based model to employ for this program, and (3) constructing the human and material infrastructure needed to implement and evaluate it. This approach could have far-reaching advantages for Fellows, and provide additional chances for them to fine-tune their thinking across a variety of professional domains, such as research, health policy, practice, and so forth.

### **MFP Participants Address SAMHSA's Goals**

The MFP is directly linked to SAMHSA's program issues, which serve as a backdrop and framework for the Fellows' and alumni's scholarship, practice, public health policy, and research domains. Included among these important program issues are co-occurring disorders, substance abuse and treatment capacity, seclusion and restraint, strategic prevention frameworks, children and families, mental health system transformation, disaster readiness and response, homelessness, aging, HIV/AIDS and hepatitis, and criminal justice. Many of the Fellows and Alumni pursue dissertations and later research, and participate in public policy initiatives that overlap these program issues. Their career goals typically reflect SAMHSA's program priorities and principles.

## Strategies

- Continue to strengthen the ties between MFP and SAMHSA through continuing conferences and establishing biannual SAMHSA Institutes.
- Proceed with developing an interdisciplinary mentoring program. Continue networking with Fellows and others from the fields of adult psychiatry, child psychiatry, clinical psychology, and social work.
- Participate through chat rooms, e-mail, video streaming, and other media, sharing research ideas; interdisciplinary research; collaboration around research and service initiatives; information on publications; and so forth.
- Continue with dissertations, research, and public policy initiatives that are linked with SAMHSA's priorities, programs, and principles.

## 8. Sponsor a Variety of Continuing Education Programs for Fellows

Continuing education programs for MFP Fellows in nursing are designed to address specific learning needs of the Fellows as well as keep them involved in patterns of life-long learning and career enhancement. Two of the programs are described below; they are typical of the many knowledge-based activities, structured in a number of formats, that are designed to assist the MFP Fellows and alumni.

### Micro-Mini Seminars

During the Micro-Mini Seminar that was presented in June 2004 in conjunction with the ANA's National Convention in Minneapolis, Minnesota, the Fellows were involved in an intensive 8-hour Institute. Its focus: The Linkage Between Theory and Research. The purpose was to initiate the linking process that connects theory to research and strengthen the Fellows' appreciation and understanding of education, practice, public policy, and research as they relate to eliminating and reducing health care disparities among ethnic and minority people and communities. During the Micro-Mini Seminar, the Fellows had the opportunity to: (1) strengthen their acumen regarding the important link between theory and research; (2) articulate examples of the theory-to-empirical measures-to-clinical applicability to use in their research and practice; (3) demonstrate insight about the need for the translation of research to service; and (4) network with nationally known nurse researchers and clinicians. They were able to discuss the dynamic relationship between research and evidence-based practice and acquire additional knowledge about the social determinants of health. Finally, the Fellows dialogued about the process of conceptualizing approaches to developing a research program based on, but beyond, the dissertation.

### Summer Institute

Typically, MFP Institutes are conceptualized as week-long intensive seminars that focus on topics that will strengthen the Fellows' ability to conduct relevant and reliable scientific investigations that are clinically applicable. Topics are generated from Fellows' knowledge interests and needs, historical and current issues, and projected future trends in substance abuse and mental health disorders. The objectives of the MFP Institutes are to provide Fellows with opportunities to: (1) augment their knowledge and skills sets about cogent issues related to ethnic



minority populations; (2) strengthen their knowledge of research design and statistical methods; (3) develop intellectual incubators where current ideas can be explored and debated, and where novel thinking can emerge; and (4) expand thinking about career paths and opportunities in substance abuse and mental health disorders education, practice, public policy, and research.

The 5-day Intensive Summer Institute (ISI) of 2004, held at Case Western Reserve University, Cleveland, Ohio, focused on statistical and quantitative research methods. The Fellows attained quantitative research knowledge, including measurement theory, descriptive statistics, statistical inferences, regression analysis, factor analysis, and structural equation modeling. The ISI provided a forum on theoretical and “hands-on” approaches to applying statistical methods to research, clinical, and health policy issues about substance abuse and mental health disorders across the lifespan and among ethnic minority populations. Discussions were held about the relevance of statistics in the discovery process, including the exploration of the social and biological determinants of substance abuse and mental disorders. The prevention of diseases and disorders was also explored, with a focus on well-being among individuals, families, and communities. The importance of the use of epidemiological data was also emphasized.

### Strategies

- Address the mission of SAMHSA and the MFP and cultivate Fellows’ capacity for expertise in substance abuse and mental health care.
- Strengthen opportunities for interdisciplinary collaboration among all SAMHSA Fellows and the alumni across domains in practice, public health policy, and research.
- Expand the theoretical and practical knowledge related to cultural competency and ethnic minority populations within the context of substance abuse and mental health disorders prevention and treatment.

## 9. Promote Knowledge Enhancement Through Publishing

MFP staff has collaborated with Dr. Sandra Thomas, editor, *Issues in Mental Health Nursing*, and attained the opportunity to publish theoretical and research papers in the journal. The general theme of the papers addressed the stigma about mental illness among ethnic minority groups, including African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans. The publication was released in December of 2005; other such opportunities are anticipated with a variety of journals. These journal articles are also available through PubMed and Medline.

### Strategies

- Use published research to advance health literacy for all people, especially as it relates to substance abuse and mental health, and the removal of stigma.
- Encourage the proliferation of knowledge that is associated with the elimination of health disparities and the enhancement of the quality of years of life for all people.

## 10. Use Technology for the Advancement of the MFP

As technology continues to advance, the MFP will adapt new computer-based tools to enhance its work.

- Recruitment and retention efforts will be facilitated through technology. The MFP web site will aid in advertising, recruiting, and informing program graduates about employment opportunities, as well as recent findings in mental health care; it will also feature the Fellows' research and scholarly accomplishments.
- Program applications and continuing reviews will be generated and stored in a computer database. Survey and program outcome data will also be generated and shared through this electronic medium.
- Newsletters featuring highlights about the Fellows' clinical practice, leadership, public policy, and research activities will be published bi-annually and will be available in electronic medium and hard (paper) copy.
- Fellows will also be linked to the SAMHSA web site, where they can connect with other MFP Fellows who are psychiatrists, psychologists, and social workers.
- Fellows' poster and podium presentations will be featured on the Internet.
- Fellows and alumni will be able to communicate through chat rooms, black board, e-mail, and smart phones. These technologies will not only enhance communications among the Fellows, alumni, and other stakeholders, they will also facilitate communications and work among the five MFP initiatives, SAMSHA, and other agents and agencies.
- Each Fellow will have an electronic portfolio that is featured on the web site. Their electronic portfolio will contain such information as their clinical expertise, research program, community service projects, career goals, publications, and other information.

### Strategies

The MFP will continue to use technology to facilitate all aspects of its recruitment and administrative efforts. Fellows will use the Internet, the Intranet, chat rooms, etc., to share ideas on research and their studies.

## 11. Link the MFP to National Initiatives

The *President's New Freedom Commission on Mental Health* (2003), the SAMHSA Matrix of Principles (USHHS, 2006; see graphic on page 102), and *Healthy People 2010* (USHHS, 2000b) are federally driven blueprints that help undergird the significance of the MFP. For example, the President's New Freedom Commission on Mental Health embraces the promise and opportunity for full community participation for all people with disabilities, including those with psychiatric disorders. The Commission suggests a transformed mental health system that embraces six goals:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer- and family-driven.
3. Disparities in mental health services are eliminated.

4. Early mental health screening, assessment, and referral to services are common practices.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

The MFP's mission, through its focus on scholarship, practice, health policy, and research, is entwined with each of these goals. Through the Fellows' and alumni's efforts, it is envisioned that all people will have enhanced opportunities to live respected and productive lives in their chosen communities.

Finally, the MFP shares the objectives that were promulgated by Healthy People 2010, which are to reduce the disparities in health outcomes that are experienced by ethnic minority and disadvantaged populations and to improve the quality of health care for all people. Increasing the racial and ethnic diversity in the nursing work force and enhancing the ability of all nurses to provide health care that is culturally competent will achieve these objectives (*Healthy People 2010*, USHHS, 2000b).

### Strategies

The MFP will participate in national programs and compete for funding through national initiatives. In addition, the MFP will strengthen relations with pertinent public and private organizations and become more familiar with funding mechanisms, priorities for funding, and the availability of human and material resources to enhance the knowledge and skills sets that will be required of all of the MFP Fellows.

## In Closing

In the recent book, *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce* (National Academies Press, 2004), authors from the Institute of Medicine argue that the profile of the nursing work force must change. Indeed, our contention throughout this report has been that a better understanding of the causes and consequences of health disparities as experienced by ethnic minority persons could be improved if there were more diversity among health professionals (Sullivan Commission, 2004; USHHS, 1996, 2001a).

For three decades, the MFP has helped to make this dream a reality by focusing on educating ethnic minority individuals at the doctoral level and providing them with expertise in substance abuse and mental health disorders prevention and treatment. This program—born of a need, created with a mission—is one of the nation's best known and most successful models for the critical work of diversifying nursing's work force in substance abuse and mental health disorders.

The MFP at the ANA is grateful to the many stakeholders who have helped to sustain this program for more than three decades. It is especially indebted to NIMH and SAMHSA for their vision, which created the program; for their fiduciary commitment, which has sustained it; and for their personally demonstrated levels of foresight and dedication, which continue to inspire us.

# SAMHSA Matrix of Priorities

		Cross-Cutting Principles									
		Science to Services/ Evidence-Based Practices	Data for Performance Measurement & Management	Collaboration with Public, Private & International Partners	Reducing Stigma & Discrimination & Other Barriers to Services	Cultural Competency/ Eliminating Disparities	Community & Faith-Based Approaches	Trauma & Violence (eg, Physical & Sexual Abuse)	Financing Strategies & Cost-Effectiveness	Rural & Other Specific Settings	Disaster Readiness & Response
Programs/Issues	Co-Occurring Disorders										
	Substance Abuse Treatment Capacity										
	Seclusion & Restraint										
	Strategic Prevention Framework										
	Children & Families										
	Mental Health System Transformation										
	Suicide Prevention										
	Homelessness										
	Older Adults										
	HIV/AIDS & Hepatitis										
	Criminal & Juvenile Justice										
	Workforce Development										

**A Life  
In The  
Community  
For  
Everyone**

**Building  
Resilience &  
Facilitating  
Recovery**

Source: USHHS, 2006.



# References

- Aday, L. (2001). *At Risk in America*. San Francisco: Jossey-Bass.
- Aguilar-Gaxiola, S.A., Zelezny, L., Garcia, B., Edmondson, C., Alejo-Garcia, C., and Vega, W.A. (2002). Translating research into action: Reducing disparities in mental health care for Mexican Americans. *Psychiatric Services*, 53(12), 1563-1568.
- Alegria, M., Perez, D.J., and Williams, S. (2003). The role of public policies in reducing mental health status disparities for people of color. *Health Affairs* (Millwood), 22(5), 51-64.
- Allen, E. (2003a). Personal Communication. Ann Arbor, MI, April 17, 2003.
- Allen, E. (2003b). Personal Communication. Ann Arbor, MI, May 7, 2003.
- American Assembly of Men in Nursing. Retrieved May 13, 2003, from <http://people.delphiforums.com/brucewilson>.
- American Indian Heritage Foundation (2003). *American Indian/Alaska Native population by region*. Retrieved September 26, 2003, from <http://www.indians.org>.
- American Nurses Association (2003). Library and Files; Internal Documents. Washington, DC. Retrieved May 13, 2003.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). Washington, DC: American Psychiatric Press.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR™). Washington, DC: American Psychiatric Press.
- Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., Fielding, J.E., Normand, J., and the Task Force on Community Preventive Services (2003). Culturally competent healthcare systems. A systematic review. *American Journal of Preventive Medicine*, 24(3 Suppl), 68-79.
- Anderson, N.B., and Nickerson, K.J. (2005). Genes, race, and psychology in the Genome Era: An introduction. *American Psychologist*, 60(1), 5-8.

Bessent, H. (1979). *Future Nurse Researchers: The Registered Nurse Fellowship Program for Ethnic/Racial Minorities and the Clinical Fellowship Program for Ethnic/Racial Minorities*. Kansas City, MO: American Nurses Association.

Bessent, H. (Ed.) (1983). *Nurse Researchers: Selected Abstracts: The Registered Nurse Fellowship Program for Ethnic/Racial Minorities and the Clinical Fellowship Program for Ethnic/Racial Minorities*. Kansas City, MO: American Nurses Association.

Bessent, H. (1997). *Strategies for Recruitment, Retention, and Graduation of Minority Nurses in Colleges of Nursing*. Washington, DC: American Nurses Publishing.

Bessent, H. (2002). *Minority Nurses in the New Century*. Washington, DC: American Nurses Publishing.

Bessent, H. (2003a). Personal Communication. Jacksonville, FL, April 18, 2003.

Bessent, H. (2003b). Personal Communication. Jacksonville, FL, April 20, 2003.

Bessent, H. (2004). Personal Communication. Jacksonville, FL, May 1, 2004.

Carnegie, M.E. (2000). *The Path We Tread: Blacks in Nursing Worldwide, 1854–1994*. Sudbury, MA: Jones and Bartlett.

Centers for Disease Control and Prevention, Office of Minority Health (2003). *American Indian and Alaska Natives Population*. Retrieved September 26, 2003, from <http://www.cdc.gov/omh/Populations/AIAN/AIAN.htm>.

Clayton, L., and Byrd, W. (2001). Race: A major health status and outcome variable, 1980–1999. *Journal of the National Medical Association*, 93(35s–54s).

Coll, C., and Garriod, M. (2000). Minorities in the United States. Sociocultural context for mental health and developmental psychology. In: A. Sameroff, Lewis, M., and Miller, S.M. (Eds.), *Handbook of Developmental Psychopathology. Second Edition*. New York: Kluwer Academic/Plenum Publishers.

Compton, W.M. (III), Cottler, L.B., Ben Abdallah, A., Phelps, D.L., Spitznagel, E.L., and Horton, J.C. (2000). Substance dependence and other psychiatric disorders among drug dependent subjects: Race and gender correlates. *American Journal of Addiction*, 9(2), 113-25.

Davis, B. (2003). Personal Communication. Hampton, VA, April 18, 2003. Ethnic Minority Fellowship Program; EMFP Archives. Washington, DC.

Drentea, P., and Goldner, M. (2006). Caregiving outside of the home: The effects of race on depression. *Ethnicity and Health*, 11 (1) 41-57.

Evans, D.L., Foa, E.B., Gur, R.E., Hendin, H., O'Brien, C.P., Seligman, M.E.P., and Walsh, B.T. (Eds.) (2005). *Treating and Preventing Adolescent Mental Health Disorders—What We Know and What We Don't Know*. Oxford University Press: Oxford.

Ferris, T., Kuhlthau, K., Ausiello, J., Perrin, J., and Kahn, R. (2006). Are minority children the last to benefit from a new technology? Technology diffusion and inhaled corticosteroids for asthma. *Medical Journal*, 44 (1), 81-86.

Gary, F. (1991). Sociocultural diversity. In: Gary, F., and Kavanagh, C. (Eds.), *Psychiatric Nursing*. Philadelphia: Lippincott, 136-162.

Gary, F. (2003). Consultant, SAMHSA Minority Fellowship Program of the American Nurses Association; Internal Documents. Washington, DC.

Gary, F. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing*, 26(10), 979-1001.

Gary, F., and Kavanagh, C. (Eds.) (1991). *Psychiatric Nursing*. Philadelphia: Lippincott.

Gary, F., and Porter, C. (2005). *Ethnic Minority Fellowship Program Assessment Report, 1974-2000*. Washington, DC: American Nurses Association.

Gary, F.A., Yarandi, H.N., and Scruggs, F.C. (2003). Suicide among African Americans: Reflections and a call to action. *Issues in Mental Health Nursing*, 24(3), 353-375.

Gary, F.A., and Yarandi, H.N. (2004). Depression among southern rural African American women: A factor analysis of the Beck Depression Inventory—II. *Nursing Research*, 53(4), 251-259.

Gonzalez, H. (2003). Personal Communication. San Antonio, TX, May 16, 2003.

Gordon, R. (2003). Personal Communication. Montgomery, AL, April 7, 2003.

Griffith, E. (1996). African American perspective. In: Mezzich, J., Kleinman, A., Fabrega, H., and Parron, D. (Eds.), *Culture and Psychiatric Diagnosis. A DSM-IV Perspective*. Washington, DC: American Psychiatric Press.

Grosel, C., Hamilton, M., Kogano, J., and Eastwood, S. (Eds.) (2000). *Health and Health Care 2010*. Institute for the Future. San Francisco: Jossey-Bass.

Hammond, P. (2003). Personal Communication. Hampton, VA, April 18, 2003.

Harper, M. (2003). Personal Communication. Columbus, GA, April 1, 2003.

Hecker, D. (2001). Occupational employment projections to 2010. *Monthly Labor Review*, November, 2001, 57-84.

Hegyvary, S. (1997). "Toward Culturally Appropriate Care," Caring for the Emerging Majority: A Blueprint in Action. *Nurse Leadership Invitational Congress Proceedings*. In: National Advisory Council on Nurse Education and Practice. *A National Agenda for Nursing Workforce Racial/Ethnic Diversity. Report to The Secretary of Health and Human Services and Congress*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing.

Helmets, K.F., Krantz, D.S., Merz, C.N., Klein, J., Kop, W.J., Gottdiener, J.S., and Rozanski, A. (1995). Defensive hostility: Relationship to multiple markers of cardiac ischemia in patients with coronary disease. *Health Psychology*, 14(3), 202-209.

- Hendricks, L. (2003). Personal Communication. Washington, DC, March 19, 2003.
- Howell, H.B., Brawman-Mintzer, O., Monnier, J., and Yonkers, K.A. (2001). Generalized anxiety disorder in women. *The Psychiatric Clinics of North America*, 24(1), 165-178.
- Insel, T.R., and Scolnick, E.M. (2006). Cure therapeutics and strategic prevention: Raising the bar for mental health research. *Molecular Psychiatry*, 11, 11–17.
- Johnson, R.L., Saha, S., Arbelaez, J.J., Beach, M.C., and Cooper, L.A. (2004). Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine*, 19(2), 101-110.
- Jones, J. (2003). Personal Communication. Washington, DC, March 15, 2003.
- Kulis, S., Napoli, M., and Marsiglia, F.F. (2002). Ethnic pride, biculturalism, and drug use norms of urban American Indian adolescents. *Social Work Research*, 26(2), 101-112.
- LaFromboise, T., and Howard-Pitney, B. (1995). Suicidal Behavior in American Indian Female Adolescents. In: Canetto, S.S., and Lester, D. (Eds.), *Women and Suicidal Behavior*. Springer Publishing: New York.
- LaVeist, T., Bowie, J., and Cooley-Quille, M. (2000). Minority health status in adulthood: The middle years of life. *Health Care Financing Review*, 21(4), 9-21.
- Lillie-Blanton, M., and Correa-Alfaro, A. (1995). *Summary Report. In the Nation's Interest: Equality in Access to Health Care*. Washington, DC: Joint Center for Political and Economic Studies.
- Lillie-Blanton, M., and Hoffman, S.C. (1995). Conducting an assessment of health needs and resources in a racial/ethnic minority community. *Health Services Research*, 30(1 Pt 2), 225-36.
- Link, B.G., Phelan, J.C., Bresnahan, M., Stueve, A., and Pescosolido, B.A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health*, 89(9), 1328-1333.
- Lipsky, S., Caetano, R., Field, C., and Larkin, G. (2006). The role of intimate partner violence, race, and ethnicity in help-seeking behaviors. *Ethnic Health* 11(1), 81-100.
- Lowe, J., and Struthers, R. (2001). A conceptual framework of nursing in Native American culture. *Journal of Nursing Scholarship*, 33(3), 279–283.
- Lynch, J., Kaplan, G.A., and Salonen, J. (1997). Why do poor people behave poorly? Variation in adult health behaviors and psychosocial characteristics by stages of the socioeconomic life course. *Social Science & Medicine*, 44(6), 809-819.



Manson, S., Shore, J., and Bloom, J. (1985). The depressive experience in American Indian communities: A challenge for psychiatric theory and diagnosis. In: Kleinman, A., and Good, B., (Eds.), *Culture and Depression*. Berkeley, CA: University of California Press, 331–338.

Marangell, L.B., Silver, J.M., Goff, D.C., and Yudofsky, S.C. (2003). Psychopharmacology and electroconvulsive therapy. In: Hales, R.E., and Yudofsky, S.C. (Eds.), *Textbook of Clinical Psychiatry, Fourth Edition*. Washington, DC: American Psychiatric Association.

Marder, S. (1998). Antipsychotic medications. In: Schatzberg, A., and Nemeroff, C. (Eds.), *Textbook of Psychopharmacology*. Washington, DC: American Psychiatric Press.

Mayberry, R., Mili, T., and Ofili, E. (2002). Racial and ethnic differences in access to medical care. In: LaVeist, T. (Ed.), *A Public Health Reader—Race, Ethnicity, and Health*. Jossey-Bass: San Francisco, pp. 161-197.

Men in Nursing—Statistical Analysis. *Male Nurse Magazine*. In the profession. Retrieved May 13, 2003, from <http://malenursemagazine.com/stats.html>.

Mezzich, J., Kleinman, A., Fabrega, H., and Parron, D. (1996). *Culture and Psychiatric Diagnosis. A DSM-IV Perspective*. Washington, DC: American Psychiatric Press.

Myrick, Y. (2003). Personal Communication. Kansas City, MO, May 13, 2003.

National Academies (2003). Smedley, B., Stith, A., and Nelson, A. (Eds.). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press.

National Academies (2004). Smedley, B., Butler, A., and Bristow, L. (Eds.). *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce*. Washington, DC: National Academies Press.

National Advisory Council on Nurse Education and Practice (2000). *A National Agenda for Nursing Workforce Racial/Ethnic Diversity. Report to The Secretary of Health And Human Services and Congress*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing.

National Advisory Mental Health Council Workgroup on Racial/Ethnic Diversity in Research Training and Health Disparities Research (2001). *An Investment in America's Future: Racial/Ethnic Diversity in Mental Health Research Careers*. Rockville, MD: National Institutes of Health, National Institute of Mental Health.

National Council of State Boards of Nursing (1999). From [http://www.ncsbn.org/public/regulation/boards\\_of\\_nursing](http://www.ncsbn.org/public/regulation/boards_of_nursing).

National Institutes of Health, National Institute of Mental Health. (1987). *Report of the Task Force on Nursing*. Rockville, MD: National Institute of Mental Health.

National Institutes of Health, National Institute of Mental Health (1998). *Bridging Science and Service. A Report by the National Advisory Mental Health Council's Clinical Treatment and Services Research Workgroup*. From <http://www.nimh.nih.gov/research/bridge.htm>.

National Institutes of Health (2000). *Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities—Fiscal Years 2002-2006*. Bethesda, MD: National Institutes of Health, p. 38. From <http://www.nih.gov/about/hd/strategicplan.pdf>.

Needleman, J., Beurhaus, P., Mattke, S., Stewart, M., and Zelevinsky, K. (2001). *Nurse Staffing and Patient Outcomes in Hospitals*. From <http://bhpr.hrsa.gov/nursing/staffstudy.htm>.

*Nurse Reinvestment Act: Provisions and Appropriations Request* (2003). American Nurses Association, Internal Document, Washington, DC.

Olin, S. (1999). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: U.S. Department of Health and Human Services, pp. 1-41.

Oppenheimer, D.B., and Shultz, M.M. (1999). Gender and race bias in medical treatment. *Journal of Gender Specific Medicine*, 2(4), 27-30.

Ossorio, P., and Duster, T. (2005). Race and genetics: Controversies in biomedical, behavioral, and forensic sciences. *American Psychologist*, 60(1), 115-128.

Ostrove, J., and Feldman, P. (1999). Education, income, wealth, and health among whites and African Americans. *Annals of the New York Academy of Sciences*, 896, 335-337.

Owens, K., and King, M. (1999). Genomic views of human history. *Science*, 286, 451-453.

Pachter, L.M. (1994). Culture and clinical care. Folk illness beliefs and behaviors and their implications for health care delivery. *Journal of the American Medical Association*, 271(9), 690-694.

Porter, C. (2000). Director, SAMHSA Minority Fellowship Program of the American Nurses Association; Internal Documents. Washington, DC.

Porter, C. (2001). Director, SAMHSA Minority Fellowship Program of the American Nurses Association; Internal Documents. Washington, DC.

Powell, D., and Gillis, C. (2004a). Building capacity and competency in conducting health disparities research. *Nursing Outlook*, 53(3), 107-108.

Powell, D., and Gillis, C. (2004b). Partnering in the cultivation of the next generation of minority nurse scientists: Responding to a compelling national agenda. *Journal of National Black Nurses Association*, 14(2), 34-43.

*President's New Freedom Commission on Mental Health* (2003). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. The entire report is available electronically at <http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html>.

Raghavan, R., Zima, B., Andersen, R., Liebowitz, A., Schuster, M., and Landsverk, J. (2005). Psychotropic medication use in a national probability sample of children in the child welfare system. *Journal of Child and Adolescent Psychopharmacology*, 15, 97-106.

Richters, J.E., Arnold, L.E., Jensen, P.S., Abikoff, H., Conners, C.K., Greenhill, L.L., Hechtman, L., Hinshaw, S.P., Pelham, W.E., and Swanson, J.M. (1995). NIMH collaborative multisite multimodal treatment study of children with ADHD: I. Background and rationale. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(8), 987-1000.

Robbins, J., Hirsch, C., Whitmer, R., Cauley, J., and Harris, T. (2001). The association of bone mineral density and depression in an older population. *Journal of the American Geriatrics Society*, 49(6), 732-736.

Rogler, L. (1996). Hispanic perspective. In: Mezzich, J., Kleinman, A., Fabrega, H., and Parron, D. (Eds.). *Culture and Psychiatric Diagnosis. A DSM-IV Perspective*. Washington, DC: American Psychiatric Press.

Rogler, L., Cortes, D., and Malgady, R. (1991). Acculturation and mental health status among Hispanics: Convergence and new directions for research. *American Psychologist*, 46, 585-597.

Rollman, B.L., Hanusa, B.H., Belnap, B.H., Gardner, W., Cooper, L.A., and Schulberg, H.C. (2002). Race, quality of depression care, and recovery from major depression in a primary care setting. *General Hospital Psychiatry*, 24(6), 381-390.

Roth, A., Graham, D, and Schmittling, G. (1979). *1977 National Sample Survey of Registered Nurses: A Report on the Nurse Population and Factors Affecting Their Supply*. Kansas City, MO: American Nurses Association.

Rowe, D. (2005). Under the skin: On the impartial treatment of genetic and environmental hypotheses of racial differences. *American Psychologist*, 60(1), 60-70.

Schatzberg, A., and Nemeroff, C. (Eds.) (2003). *Textbook of Psychopharmacology, Third Edition*. Washington, DC: The American Psychiatric Press.

Schireman, T., Reichard, A., and Rigler, S. (2005). Psychotropic medication use among Kansas Medicaid youths with disabilities. *Journal of Child and Adolescent Psychopharmacology*, 15, 107-115.

Schneider, E., Zaslavsky, A., and Epstein, A. (2002). Racial disparities in the quality of care for enrollees in Medicare managed care. *Journal of the American Medical Association*, 287(10), 1288-1294.

- Schwartz, R. (2001). Racial profiling in medical research (Editorial). *The New England Journal of Medicine*, 344(18), 1–3.
- Serlin, C. (1994). Director, Ethnic Minority Fellowship Program of the American Nurses Association; Internal Documents. Washington, DC.
- Serlin, C. (1996). Ethnic Minority Fellowship Program of the American Nurses Association; Internal Documents. Washington, DC.
- Serlin, C. (1998). Ethnic Minority Fellowship Program of the American Nurses Association; MFP Internal Survey, 1998. Washington, DC.
- Shapiro, R., Ralph, J., and Lopez, R. (1976). The Center for Minority Mental Health Programs. *Urban Health*, 5(2).
- Shelder, J., Mayman, M., and Manis, M. (1993). The illusion of mental health. *American Psychologist*, 48(11), 1117–1131.
- Shields, A.E., Fortun, M., Hammonds, E.M., King, P.A., Lerman, C., Rapp, R., and Sullivan, P.F. (2005). The use of race variables in genetic studies of complex traits and the goal of reducing health disparities. *American Psychologist*, 60(1), 77-103.
- Simeon, J., Wiggins, D., and Williams, E. (1995). World wide use of psychotropic drugs in child and adolescent psychiatric disorders. Progress in neuro-psychopharmacology. *Biol Psychiatry*, 19(3), 455.
- Size, T. (Ed.) (2003). *Eye on Health*. Sauk City, WI: The Rural Wisconsin Health Cooperative.
- Smedley, A., and Smedley, B. (2005). Race as biology is fiction, racism as a social problem is real. *American Psychologist*, 60(1), 16-26.
- Snowden, L., and Cheung, F. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist*, 45(3), 347-355.
- Son, B.K., Markovitz, J.H., Winders, S., and Smith, D. (1997). Smoking, nicotine dependence, and depressive symptoms in the CARDIA Study. Effects of educational status. *American Journal of Epidemiology*, 145(2), 110-116.
- Spratley, E. (2000). *RNs Employed in Nursing by Gender and Ethnicity for Years 1992, 1994, and 2000*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing.
- Spratley, E., Johnson, A., Sochalski, J., Fritz, M., and Spencer, W. (2000). *The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing.
- SPSS, Inc. (2001). *SPSS User's Guide*. Chicago: SPSS, Inc.

- Stierle, L. (2003a). American Nurses Association Internal Organization Chart, Executive Leadership. Office of the Chief Executive Officer/Executive Director. Washington, DC: American Nurses Association.
- Stierle, L. (2003b). Personal Communication. Washington, DC, March 20, 2003.
- Stuart, G. (2001). Roles and function of psychiatric nurses: Competent caring. In: Stuart, G., and Laraia, M. (Eds.), *Principles and Practice of Psychiatric Nursing. Seventh Edition*. Philadelphia: Mosby Co.
- Stump, T.E., Clark, D.O., Johnson, R.J., and Wolinsky, F.D. (1997). The structure of health status among Hispanic, African American, and white older adults. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, Spec. No. 52, 49-60.
- Sullivan Commission (2004). *Missing Persons: Minorities in the Health Professions*. A Report of the Sullivan Commission on Diversity in the Healthcare Workforce. Durham, NC: The Commission. From [http://admissions.duhs.duke.edu/sullivancommission/documents/Sullivan\\_Final\\_Report\\_000.pdf](http://admissions.duhs.duke.edu/sullivancommission/documents/Sullivan_Final_Report_000.pdf).
- Trudeau, R. (1996). Male registered nurses, 1995. *Health Reports*, 8(2), 21-27.
- U.S. Census Bureau (1996). *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050*. Current Population Reports. Washington, DC.
- U.S. Census Bureau (1999a). *Statistical Abstract of the United States*. Washington, DC.
- U.S. Census Bureau (1999b). *Income 1999*. Retrieved May 13, 2003, from <http://www.census.gov/hhes/income/income99/99tablea.html>.
- U.S. Census Bureau (2000a). Retrieved May 13, 2003, from <http://www.census.gov/main/www/cen2000.html>.
- U.S. Census Bureau (2000b). *Decennial Census Data and Population Projections*. From <http://www.census.gov/main/www/cen2000.html>.
- U.S. Census Bureau (2000c). *Money Income in the U.S., 1999*. Current Population Reports, P60-209. Available from <http://www.census.gov/prod/2000pubs/p60-209.pdf>.
- U.S. Census Bureau (2001a). *Profiles of General Demographic Characteristics: 2000 Census of Population and Housing, United States*. Retrieved May 6, 2003, from <http://www.census.gov/main/www/cen2000.html>.
- U.S. Census Bureau (2001b). *The Hispanic Population: Census 2000 Brief*. Retrieved May 13, 2003, from <http://www.census.gov/main/www/cen2000.html>.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (1994). *CMHS Minority Fellowship Program 20 Year Report*. Washington, DC: Government Printing Office.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (1996). *Mental Health, United States, 1996*. DHHS Pub. No. (SMA) 96-3098. Washington, DC: Government Printing Office.

U.S. Department of Health and Human Services (2000a). *Healthy People 2000*. Retrieved May 13, 2003, from <http://odphp.osophs.dhhs.gov/pubs/hp2000>.

U.S. Department of Health and Human Services (2000b). *Healthy People 2010 (Conference Edition, in Two Volumes)*. Washington, DC, January 2000. Also available at: <http://www.fpeca.usf.edu/Data%20Center/Resources/Health/Volume1/opening.htm>. See also: [www.health.gov/healthypeople](http://www.health.gov/healthypeople).

U.S. Department of Health and Human Services (2001a). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report to the Surgeon General*. DHHS Pub. No. SMA-01-3613. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Available from <http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA-01-3613/sma-01-3613A.pdf>.

U.S. Department of Health and Human Services (2001b). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Executive Summary*. Retrieved May 13, 2003, from <http://www.mentalhealth.org/cre/execsummary-2.asp>.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, National Center For Workforce Analysis (2002). *Projected Supply, Demand, and Shortages of Registered Nurses: 2000–2020*. Washington, DC: Government Printing Office.

U.S. Department of Health and Human Services, Health Resources and Services Administration (2003). *United States Health Personnel Factbook*, June 2003.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2006). SAMHSA Priorities: Programs & Principles Matrix. Available from <http://www.samhsa.gov/templates/matrix.aspx>.

Van-Ryn, M. (2002). Research on the provider contribution to race/ethnicity disparities in medical care. *Medical Care*, 40(1), Supplement, I-140–I-150 (2002). SAS/STAT. Cary, NC: SAS Institute, Inc.

Yee, A., Fairchild, H., Weizmann, F., and Wyatt, G. (1993). Addressing psychology's problems with race. *American Psychologist*, 48(11), 1132–1140.



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