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# Mental Health Disparities Among Minority Populations

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This is to certify that the doctoral study by

Arrey Eyongherok

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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2019

Abstract

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MSN, Walden University, 2017

BSN, American Sentinel University, 2014

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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## Abstract

Despite the existence of effective treatments, mental health care disparities exist in the availability, accessibility, and quality of services for racial and ethnic minority groups. People living with serious mental complaints often resist engaging in treatments and experience high rates of dropout; poor engagement can lead to worse clinical outcomes. Addressing the complex mental health care needs of racial and ethnic minorities warrants considering evidence-based strategies to help reduce disparities. This systematic review sought to provide an analysis of published literature about the barriers and effective strategies in identifying and treating minority patients with mental health disorders. The practice-focused question of this systematic review was: What are the barriers and effective strategies to identification and treatment of mental health disorders among minority populations. This project was guided by PRISMA and SQUIRE guidelines and Fineout-Overholt and Melnyk's appraisal form, comprising 11 studies published between 2014 and 2019, identified through Thoreau, Cochrane, CINAHL with Medline, EBSCO, and ProQuest, SAMHSA and PubMed databases. The systematic review results recommend intervention strategies such as integrated/collaborative care, workforce diversity, providers in minority neighborhoods, improving providers' cultural skills, and stigma reduction to help reduce mental health care disparities. These findings are significant to lowering the gap in practice and can be used by the entire health care system to improve mental health care, thereby leading to a positive social change. Implementing these strategies would benefit patients, families, their communities, and the entire health care delivery system.

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# Dedication

Lord, where would I be without your grace and mercy? To God be the Glory. I dedicate this project to my son Cyril Takem-Baiyee, whose keen watchful eyes kept me going and did not allow me to give up. To my parents, Simon and Mary Eyongherok, thank you for your survival and fighting straits. My rock and backbone, Priscilla Kokee-Eyongherok, you are the best sister imaginable. The rest of the Eyongheroks, Eucharia, Joan, Ade, Elizabeth, Louie Kokee, Sonia Ashu, Magda Ayuk, and Mickey Arthur, thank you for being part of my life's journey. I love you all. Grandma Frida, you always told me to face my fears no matter what!

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Section 1: Introduction

## Introduction

Mental health care disparity is a persistent problem among U.S. ethnic minority populations. In the United States, despite years of investigation, recognition, and treatment, mental ailment and its comorbidities remain a substantial public health issue (Holden et al., 2014). Compared with the majority population, ethnic minority groups are less likely to obtain mental health services. The 2010 U.S. Census data showed growing diversification of the U.S. population, with prominent development in ethnic and racial minority groups (National Institute of Mental Health, 2018). Additionally, the quality of health care and access are suboptimal, particularly for low-income and minority populations, and although overall quality is progressing, access is becoming inferior, and inequalities remain (National Institute of Mental Health, 2018). Successful interventions are needed to reduce disparities in access. The American Psychological Association (2014) explains a report by the U.S. Surgeon General purporting that the proportion of African Americans, Hispanics, Asian Americans, and Native Americans who receive necessary mental health care is lower than that of Caucasians. Primary care that comprises mental health screenings and treatments that consider a patient's language and cultural circumstance can assist in addressing mental health care disparities among ethnic minorities (American Psychological Association, 2014).

This DNP project sought to not only support or influence social change by bringing an awareness to mental health problems among minority groups, but also to prompt measures that can lessen mental health disparities in practice. A health care team

that considers culture, establishes respect, and evaluates and sustains patient diversities will provide patients a relaxed, supportive atmosphere in which to be open about their mental health concerns with providers. Thus, this project backs the mission of Walden University, which encourages positive social change.

## Problem Statement

Even though minorities are just as likely as nonminorities to experience extreme mental illnesses, such as bipolar disorder, anxiety, schizophrenia, and depression, they are less likely to obtain treatment. Continuous disparities in access to care are significant to clinical and community health because individuals from minority racial and ethnic groups often have levels of mental disease occurrence comparable to Caucasians and have more persistence and severity of mental conditions (Breslau et al., 2006; Breslau, Aguilar-Gaxiola, Kendler, Su, & Kessler, 2005; Williams et al., 2007). Subsequently, reducing minority groups' mental health care inequalities can lead to savings in costs for overall acute medical care (Cook, Liu, Lessios, Loder, & McGuire, 2015).

Addressing the U.S. populace's complex mental health requirements is an intricate problem that requires consideration from stakeholders who can provide exclusive viewpoints and approaches to support efforts for better well-being among every racial populace. These stakeholders include primary care providers, mental health workers, faith-based organizations, and family members. With mounting population diversity of numerous ethnicities and races and with substantial variations in the collection of many risk factors that can affect health and mental health results, it is crucial to outline planned clinic-based measures, targeted community-based events, and new

multidisciplinary explorations in an evaluation of evidence-based systems that can enhance people's longevity and quality of living.

## Purpose

Racial minorities presently make up approximately one third of the nation's population and are projected to become a majority by 2050 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). Minority populations are diverse groups that have unique behavioral health requirements and experience dissimilar proportions of mental ailments and access to treatment. Persons of color are inclined to experience more burdens resulting from mental illnesses that are frequently attributable to lower accessibility to care, improper care, and higher socioeconomic and environmental risk influences (SAMHSA, 2018). Additionally, in 2014, 3.8% of African American adults 18 years and older reported having a mental complaint within the last year, and the national average of such complaints was 3.3%. Likewise, the national average in 2014 for any mental condition in the previous year for adults was 18.1%, and 16.3% for African American adults (SAMHSA, 2018).

In the United States, Native Americans experience some of the highest rates of mental illnesses compared with other racial groups. In 2014, the proportion of Native Americans aged 18 years and older who indicated a mental disease within the last year was 21.2%, with a 4% frequency of serious mental sickness among this group. While a national average of 3.3% experienced co-occurring mental and substance use disorders within the last year in 2014, for Native Americans aged 18 years and older, it was 8.8% (SAMHSA, 2018). In 2014, 13.1% of Asian Americans 18 years and older reported a

mental ailment in the last year, compared with 3.9% of the national average. In addition, approximately 3.1% of Asian Americans and 1.2% of Native Hawaiians or other Pacific Islanders aged 18 years and older had serious suicidal thoughts.

The proportion of mental illnesses for Hispanics in 2014, specifically individuals ages 18 years and older, who stated they experienced a mental condition in the previous year was 15.6%. Approximately 3.5% of Hispanic adults had a serious mental disease. The proportion of individuals who described a major depressive occurrence was 5.6%, with approximately 3.3% of this population having a co-occurring mental health and substance use disorder (SAMHSA, 2018).

The purpose of this systematic review was to provide a comprehensive review of the barriers and effective strategies in identifying and treating minority patients with mental health disorders. The project question is: What are the barriers and effective strategies to identification and treatment of mental health disorders among minority populations? This systematic review identified current evidence-based literature that can be summarized and shared with health care providers caring for patients with mental health issues in this specific population.

## Nature of the Doctoral Project

This DNP project followed the Walden University manual for systematic reviews. I explored the current evidence regarding disparities in mental health care for specific populations. The sources of evidence for this review consisted of literature from Thoreau, Cochrane database, CINAHL with Medline, and ProQuest. Furthermore, I examined the challenges to mental health care and interventions proposed to improve initiation of

mental health services among racial and ethnic minority populations from the timeframe of 2014 to 2019. I followed the PRISMA and SQUIRE guidelines. I graded the literature using the Fineout-Overholt and Melnyk's critical appraisal evidence form (2010). The evidence obtained from this systematic review can be used to improve and guide practice strategies to encourage minority patients to seek mental health care.

## Significance

### Stakeholders

Because mental health can affect every aspect of a person's life, well-being, and social and functional abilities, it is imperative to identify stakeholders such as agencies, practitioners, people living with psychiatric disabilities, and their families. Approaches to improve health care overall, such as refining access to care and improving the quality of care, could significantly reduce mental health care disparities among minority populations. It is important to note that a diverse mental health workforce, in addition to provider and patient education, are significant in eradicating mental health care disparities. The effects of addressing mental health care challenges among ethnic and racial minority populations and other stakeholders cannot be undermined. Offering strategies for mental health care improvement not only helps to reduce cost, but it also instigates health care policies and reforms to lessen mental health care disparities among minorities.

### Potential Contributions to Practice

Several aspects affect mental health disparities among minority groups, as well as social factors of health such as low levels of education, an absence of health insurance,

economic problems, and disadvantaged environmental situations (Treadwell, Xanthos, & Holden, 2012). Steps to address health disparities may consist of enacting health strategies; enhancing access to wide-ranging, cohesive and patient-centered quality health care; and promoting culturally focused prevention and intervention strategies for susceptible people. The potential contributions of my doctoral project to nursing practice is that policy-led mental health prevention strategies are likely to affect not only susceptible or difficult to reach populations, such as minority groups, but the entire population as well. Furthermore, the findings from my project may encourage a change to minority mental health disparities, with systemic improvements that could be implemented worldwide.

**Transferability**

Presently, more than 50% of patients obtain some mental health service therapy from a primary care provider, and primary care is the only current method of health care used by more than 30% of patients with a mental ailment accessing the health care system (APA, 2014). Thus, the outcomes of this DNP project can be potentially transferred into primary care practice; another practice area for possible transferability is the social worker domain.

**Implications for Positive Change**

Mental health disorders do not discriminate based on race, gender, ethnicity, skin color, or social identity. Everyone can experience the problems of mental disease irrespective of their background. However, identity and background could make access to treatment for mental health disorders much more problematic. The U.S. mental health

structure requires improvement, especially pertaining to serving marginalized communities. All persons must take on the challenges of mental health disorders, health coverage, and the stigmatization of mental complaints. In several communities, these difficulties are exacerbated by reduced access to care, cultural stigma, and lower quality of care (National Alliance on Mental Illness [NAMI], 2018). The information and inferences from this DNP project will expand knowledge on mental health care disparities among minority groups and bring awareness to the challenges faced by racial and ethnic groups in obtaining mental health services.

## Summary

Health care quality and access are suboptimal, particularly for minority and low-income populations. Although general quality of mental health care is expanding, access is becoming more difficult, and disproportionate access to quality continues. Likewise, disproportions in mental health care across ethnicity and race, geographic areas, and socioeconomic realms remain (National Institute of Mental Health, 2018). Compared with the majority, members of ethnic and racial minority populations in the United States are less likely to have access to mental health services, less likely to use public mental health amenities, more likely to use inpatient and emergency services, and more likely to obtain a lower quality of care (Holden et al., 2014). In Section 1, I introduced the project question and approach to the systematic review of the literature, the significance of the problem of mental health disparities, and the stakeholders involved in caring for mental health patients. The project question is: What are the barriers and effective strategies to identification and treatment of mental health disorders among minority populations? In

Section 2, I described the framework supporting the approach selected for this project, the literature relevant to the project, and my role in developing and completing the systematic review.

Section 2: Background and Context

## Introduction

In most industrialized nations, considerable disparities exist in access to mental health services for ethnic or minority populations (Memon et al., 2016). Psychiatric disorders are connected to significant emotional, functional, physical, and societal burdens (Holden et al., 2014). Ethnic minorities are recognized as susceptible to inequalities in mental health care, and they encounter unique challenges in seeking effective treatment. The project question is: What are the barriers and effective strategies to identification and treatment of mental health disorders among minority populations?

## Concepts, Models, and Theories

In this systematic review I used the standards for quality improvement reporting excellence (SQUIRE) framework, preferred reporting items for systematic reviews and meta-analyses (PRISMA), and the Fineout et al.'s (2010) model for grading literature. SQUIRE is used to identify the completeness and transparency of reporting of quality improvement work and contributes to the expansion of this body of literature by offering a guide to authors, editors, reviewers, educators, and other stakeholders (Goodman et al., 2016). Furthermore, the SQUIRE model provides understanding of the theoretical basis for improvement work, the effect of related factors on outcomes, and the development of methodologies for learning improvement work.

A systematic review is an appraisal of an evidently formulated question that uses systematic and clear methods to recognize, elect, and critically review appropriate studies and to gather and examine data from the studies contained in the review (PRISMA,

2015). In this systematic review, I used the PRISMA flow diagram to illustrate the flow of evidence through the different phases of a systematic review. In addition, PRISMA (2015) maps out the amount of records identified, included, and excluded and the explanations for exclusions. The Fineout et al. (2010) model was used to grade the evidence. This model grades evidence from a Level I (systematic review or meta-analysis) to Level VII (authoritative opinion of expert committee).

## Relevance to Nursing Practice

Since the publication of the Institute of Medicine's milestone report—*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* (Smedley, Stith, & Nelson, 2003)—growing evidence of numerous problems regarding access to health care services, quality of care obtained, and development in health outcomes among diverse populations continues to mount (Holden et al., 2014). Additionally, the Agency for Healthcare Research and Quality (AHRQ; 2012) issued its yearly report suggesting that although the U.S. health care system is intended to expand the physical and psychological well-being of every American by preventing, detecting, and treating ailments and by backing optimum functioning, health disparities persist, and the structure of health care allocates services inadequately and disproportionately across populations. In 2013, almost 10 years after the Institute of Medicine made its statement about unequal treatment, similar multidimensional challenges continue to occur and exacerbate the problem for health and mental health providers in pursuit of promising strategies to lessen and ultimately eradicate gaps in health care (Holden et al., 2014).

With mounting diversity in ethnicities and races and with substantial changes in the pattern of multiple risk factors that can affect health and mental health consequences, it is important to outline strategic clinic-based efforts, focused community-based plans, and groundbreaking multidisciplinary investigations. These efforts should comprise an evaluation of evidence-based models that could improve quality of life and longevity for this population. The delivery of mental health services in primary health care environments can be seen as a method to try to address gaps that ethnic minorities experience in relation to mental health assessment, diagnosis, and treatment. Therefore, the nursing practice setting provides an opportunity for ethnic and racial minority patients with wide-ranging physical, mental, and behavioral health issues to explain their concerns.

The general health of the U.S. population has improved during recent decades, but not all Americans have benefited equally from these developments. Minority populations continue to lag behind Caucasians in several areas, including timeliness, access to care, quality of care, and outcomes (AHRQ, 2013). Several factors influence these disparities and social determinants of health: for instance, low-level of education, economic challenges, nonexistence or inadequate health insurance coverage, and impoverished environmental circumstances (Treadwell, Xanthos, & Holden, 2012). Studies among low-income African Americans have shown that mental health treatment-seeking barriers involve stigma, poor access to care, and lack of awareness regarding mental disease (Gonzales & Papadopoulos, 2010; Ward, Clark, & Heidrich, 2009). Furthermore, ethnic minorities' inability to see the need for care is partly responsible for the low rates of care

for depression among this group (Nadeem, Lange, & Miranda, 2009). Other health care challenges that disproportionately affect minorities consist of health literacy problems, provider biases, and low-quality provider-patient communications (AHRQ, 2013).

Improvements in preventive services, care for chronic diseases, and access to care have led to a decrease, and in some cases the eradication, of disproportionate access to and receipt of care for certain minority groups in areas such as the timing of delivery of antibiotics, mammography, smoking cessation counseling, and vision care of pediatric patients (AHRQ, 2009). On the other hand, inequalities in care continue to be a challenge for some diseases and populations. For instance, African Americans, Asian Americans, Native Americans, and Hispanic Americans continue to fall behind Caucasians in the proportion of the population requiring mental health, and this gap has broadened (NAMI, 2017). Disparities have widened for African Americans and Hispanic Americans, compared with Caucasians, also in the ratio of adults detected with a major depressive condition who obtained treatment for their disease in the 12 months succeeding diagnosis (AHRQ, 2013).

Although minority community members have voiced the necessity for new approaches to discourse of culturally unique matters, findings demonstrate that most researchers still employ the traditional approaches they were taught (Stacciarini, Shattell, Coady, & Wiens, 2011). Furthermore, researchers still perceive mental health treatment from a health service standpoint (Stacciarini et al., 2011).

Discussions regarding bias and their links to mental health have been overlooked until recent years. Increasing the cultural competence of treatment clinicians who interact

with minority clients seems to be one technique for refining treatment outcomes, possibly making it less probable that clients will undergo microaggressions and stereotype-threat circumstances (Blume, 2016). The communicative structures act as anchors to the delivery of transformative methods that challenge the unhealthy infrastructures that constitute health. Acknowledgement that the disparities in health outcomes are frequently produced by exceedingly inadequate structures that are continuous and replicated by unhealthy policies arises as the foundation for health communiqué as health advocacy.

In the voices of the marginalized, the difficulties to accessing quality health are commonly understood as human rights injustices. Starting with the concept that health is an important human right, groups at the margins cocreate advocacy approaches focused on battling socioeconomic and political structures that reject health and well-being as a basic human right. Properly addressing the challenges encountered by marginalized people necessitates a delicate understanding of these situations. Designing and testing the suitability of prevention and promotion interventions among cultural and linguistic populations and the addition of culturally-specific customs may by themselves be protective. Engaging people and groups in mental health activities entails an understanding of how to appropriately communicate and encourage them. Culture and language are significant aspects of the process of engagement.

A present-day study documented and assessed steps taken by public mental health managers to recruit members of underrepresented ethnic minority groups into treatment (Snowden, Masland, Ma, & Ciemens, 2006). By measuring county-level ethnic program experts in the dispersed California state system, this research identified approaches

considered effective for reaching African American, Asian American, Hispanic, and Native American communities and overcoming challenges to treatment-seeking. Findings showed that undertaking outreach activities was related with greater access for Hispanics and Native Americans. For Asian Americans, hiring bilingual or bicultural employees was related with greater access but having a bilingual or bicultural receptionist was related with reduced access. For all minority populations along with for Caucasians, the overall supply of mental health practitioners in the district was strongly linked with better access. The research documented real-world initiatives to improve minority access and, in spite of limitations imposed by its cross-sectional design, offered preliminary evidence of effectiveness (Snowden, Masland, Ma, & Ciemens, 2006).

## Local Background and Context

The mental health care scheme is flawed (NAMI, 2017). Ideally, it was important to carry out an investigation of mental health disparities and its effect on minority populations. But, good reporting of these studies raises the probability that readers will be able to use the interventions and strategies in their own clinical settings and scholars will be able to replicate these studies. Mental health service providers have an ethical responsibility to safeguard that their patients understand the benefits and drawbacks of the different treatment choices accessible to them, so that they can make an informed decision (Chambless & Hollon, 1998). Culture includes many variables, affecting every aspect of lived experiences. Because cultural processes often differ among similar ethnic groups due to variances in gender, class, age, political affiliations, creed, background, and even personality, mental health needs and desires may differ as well.

The local gap in practice is that although mental health services are available in the primary care clinic the minority community does not access these services. Repeated attempts by the primary care clinic to support these patients for mental health care has been unsuccessful. Access to high quality mental health services are often not available to these patients, thus the importance of primary care providers offering these services. As difficult as it is for anybody to obtain suitable mental health care in the United States, it is even tougher for racial, ethnic, religious and gender minorities (NAMI, 2017). Not only are there the issues most of us experience, problems with insurance, lengthy wait times, trouble finding specialists, skyrocketing copays and deductibles, yet there are additional burdens of access and quality of care (NAMI, 2017).

In spite of the existence of effective therapies, disproportions lie in the accessibility, availability, and quality of mental health services for racial/ethnic minorities populations. The lack of extensive research that applies precisely to minority groups is necessary to gain knowledge about access, prevention, quality of care and service delivery. The findings of the surgeon general's landmark report published in 1999 persist currently 21 years later. This is a worrisome problem. Research and evidence about minority populations mental health care is still severely deficient. This systematic review explored the practice question: What are the barriers and effective strategies to identification and treatment of mental health disorders among minority populations?

## Role of the DNP Student

My professional background is family practice and addiction medicine. My day-to-day practice puts me in contact with not only vulnerable but also racial and ethnic

groups. It is significant to understand their needs and the existing disparities in mental health care. Mental health is inextricably linked to physical health. Likewise, mental health plays a role in substance use and recovery. Despite the high frequency of mental health and substance use difficulties, too many individuals in the United States go without treatment, partially because their conditions are undiagnosed (SAMHSA, 2018). As a clinician in a primary care practice, my role is to routinely screen every client I encounter from all ethnic and racial backgrounds. This DNP project provided me the opportunity to explore and synthesize the current evidence related to health care disparities with several ethnic minorities. Using this information, I will be able to make recommendations to stakeholders on how to better provide patient centered care.

## Summary

Section 2 introduced the frameworks and models that I used for this systematic review, my role in the project, and the literature supporting the project question. The project question is: What are the barriers and effective strategies to identification and treatment of mental health disorders among minority populations? This systematic review will identify current evidence-based literature that can be summarized and shared with health care providers caring for minority patients with mental health issues. Section 3 describes the process for completing the systematic review, and analysis and grading of the literature.

Section 3: Collection and Analysis of Evidence

## Introduction

Despite the presence of effective treatments, inequalities exist in the availability, accessibility, and quality of mental health amenities for ethnic and racial minorities (NAMI, 2017). After the surgeon general's landmark report of 1999, the conclusions of outstanding disproportions for minorities in mental health services have not changed. As publicized in the most current National Healthcare Quality and Disparities Reports, racial and ethnic minority populations continue to have less access to mental health services than Caucasians, and when they obtain care, it is more likely to be of lesser quality (NAMI, 2017).

## Practice-Focused Question

The project question is: What are the barriers and effective strategies to identification and treatment of mental health disorders among minority populations? In this systematic review, I identify current literature that can be summarized and shared with health care providers caring for minority patients with mental health issues.

## Sources of Evidence

### Published Outcomes and Research

In this systematic review, I synthesized existing evidence about health care disparities and interventions intended to improve initiation of mental health services among racial and ethnic minority groups. The online databases I explored included Thoreau, Cochrane database, CINAHL with Medline, EBSCO, and ProQuest. The following search terms and word groupings were used: *mental health, mental health care,*

*mental health illness* and *minority groups, mental health care* and *minorities, mental health* or *disparities, inequalities,* and *disproportions* and *minorities populations*. The search was in-depth and all-inclusive; every identified article was assessed to determine inclusion or exclusion.

**Inclusion and Exclusion Criteria**

The implementation of inclusion and exclusion criteria consisted of reducing the numbers of articles noted during the literature review search by filtering irrelevant articles to the practice question. Inclusion criteria included: (a) studies performed in the United States; (b) articles written in English; (c) articles that address ethnic and racial minority populations in the United States involving groups such as Hispanic Americans, African Americans, Native Americans, and Asian Americans; (d) published after the year 2014; (e) studies that address minority mental health care disparities, minority disparities, and primary care settings; (f) articles evaluating minority groups' mental health care outcomes. I removed duplicates.

The articles and studies I excluded were those: (a) that did not apply to ethnic and racial minority populations living outside the United States who undergo mental health care disparities; (b) that were not specific to mental health care clinical settings; (c) that were not associated with mental health care management and assess to care; (d) that were written in a foreign language or about a non-U.S. ethnic and racial minority population (e) that were not published between the years 2014–2019.

## Analysis and Synthesis

This systematic review synthesizes existing evidence about interventions intended to improve initiation of mental health services among racial-ethnic minority groups and assess the extent to which these interventions were effective. The review also comprised evidence discussing disparities in mental health services for ethnic minorities. The appraisal of the selected evidence uses the SQUIRE 2.0 guidelines. The critical appraisal tool for the evidence used is included in the review. A summary table of this review is included as Appendix A. In addition, the grading of evidence conforms to the Fineout-Overholt, Melnyk, Stillwell, and Williamson (2010) criteria: (a) study title, author, and date of publication; (b) problem description; (c) aim of the study, setting, and sample; (d) study design and intervention; (e) ethical considerations; (f) results; (g) limitations; and conclusion (SQUIRE, 2019). Using this critical appraisal guide and question format, each article went through an individual assessment. The inclusion criteria involved answering the seven queries. Failing to meet these criteria resulted in the removal or exclusion of the article.

Similarly, the included studies contain a system of hierarchy of which grades the evidence. The graded evidences employed the Fineout-Overholt and Melnyk system (2010). The system assigns and rates evidence in a hierarchy set-up represented by seven overall levels. Table 1 displays an outline of levels of hierarchy evidence along with the number of articles identified for each level. The studies eligible for the inclusion criteria also underwent proper examination for level of hierarchy and graded for evidence. The lesser the level of hierarchy is, the more important rigor happened within the parameter

of the studied article. The highest levels of evidence imply Levels I, II and III, with Levels VI and VII signifying lowest quality evidence.

Table 1

*Level of Evidence*

| Level | Hierarchy Rating System of Evidence | Number of Articles |
|---|---|---|
| Level 1 | Systematic review & meta-analysis of randomized controlled trials; clinical guidelines based on systematic reviews or meta-analyses | 1 |
| Level II | One or more randomized controlled trials | 0 |
| Level III | Controlled trial (no randomization) | 0 |
| Level IV | Case-control or cohort study | 0 |
| Level V | Systematic review of descriptive & qualitative studies | 6 |
| Level VI | Single descriptive or qualitative study | 4 |
| Level VII | Expert opinion | 0 |

*Note.* Adapted from *Evidence-based practice in nursing & healthcare: A guide to best practice (3rd ed.)* (pp. 11). Philadelphia, PA: Wolters Kluwer Health.

## Protections

This project followed the DNP Manual for Systematic Reviews. An Institutional Review Board (IRB) approval was obtained from the Walden University IRB prior to project implementation. The Walden University IRB approval number for this project is 04-17-19-0542555.

## Summary

In Section 3, I discussed the practice-focused question, reported the sources of evidence and explained the key search terms used. Furthermore, I discussed the analysis of data and inclusion and exclusion criteria methods in selecting the appropriate articles for this systematic review. In Section 4, I discuss the complete data analysis of the

literature as well as the synthesis of the literature, the strengths and limitations of the systematic review and the implications and recommendations to practice.

Section 4: Findings and Recommendations

## Introduction

In the United States, racial and ethnic minority populations have well-documented health inequalities. Although the general prevalence rates of mental disease are similar across racial and ethnic populations (Breslau et al., 2006), the burden of mental complaints is greater among minority groups. Racial and ethnic minority populations undergo worse health status and higher health risks compared to Caucasians (Olshansky et al., 2012). These disparities are consistent across an array of diseases and services, as well as physical and mental health concerns (Ghods et al., 2008). Refining access to mental health treatment is likely to lessen gaps in persistence and severity because evidence-based care works for minorities as it does for Caucasians. In the mental health discipline, treatment is based on the relationship between the patient and the clinician (Howgego, Yellowlees, Owen, Meldrum & Dark, 2003). This important association is based on respect, shared trust, and open communication between the patient and clinician. The characteristics of this rapport are associated with health outcomes.

Furthermore, social determinants contribute to these noted inequalities but fail to completely clarify them. The exploration of racial and ethnic differences in abandoning mental health services has yet to assess the many forms of services provided and the rationale behind why racial and ethnic populations cease treatment. Cultural barriers and health care provider biases can contribute to a lesser quality of services, which could contribute to these disproportions. Still, evidence connecting cultural competency and health outcomes is absent. The goal of this systematic review of the most recent literature

was to offer a comprehensive investigation of published literature about the barriers and effective strategies in identifying and treating minority patients with mental health disorders.

The practice-focused question of this systematic review was: What are the barriers and effective strategies to identification and treatment of mental health disorders among minority populations? I collected evidence from the following databases: Thoreau, Cochrane database, CINAHL with Medline, EBSCO, ProQuest, SAMHSA, and PubMed. The included articles were systematic reviews, surveys, and mixed-method studies. Search terms I employed for this SR were *mental health, mental health care, mental health illness* and *minority groups, mental health care* and *minorities, mental health* or *disparities*, *inequalities*, *disproportions* and *minorities populations*. After I completed selection, appraisal, and grading of appropriate articles, I incorporated the articles into a literature review matrix (see Appendix A). I graded the evidence using the Melnyk and Fineout-Overholt system of hierarchy of evidence.

## Findings and Implications

Racial and ethnic minorities are recognized as susceptible to mental health disparities, and they encounter unique challenges relating to mental health care. The search of the literature between 2014 and 2019 yielded 1,060 articles. After I removed duplicates, 640 articles remained; from these 640 publications, I screened 339 articles using the full text. Of these 339 articles, evaluated and reviewed the titles and abstracts. Finally, I included 11 articles in this review. Five articles were systematic reviews, four

were surveys, and two were mixed-methods studies. Figure 1 below illustrates these findings and the breakdown of article classification.

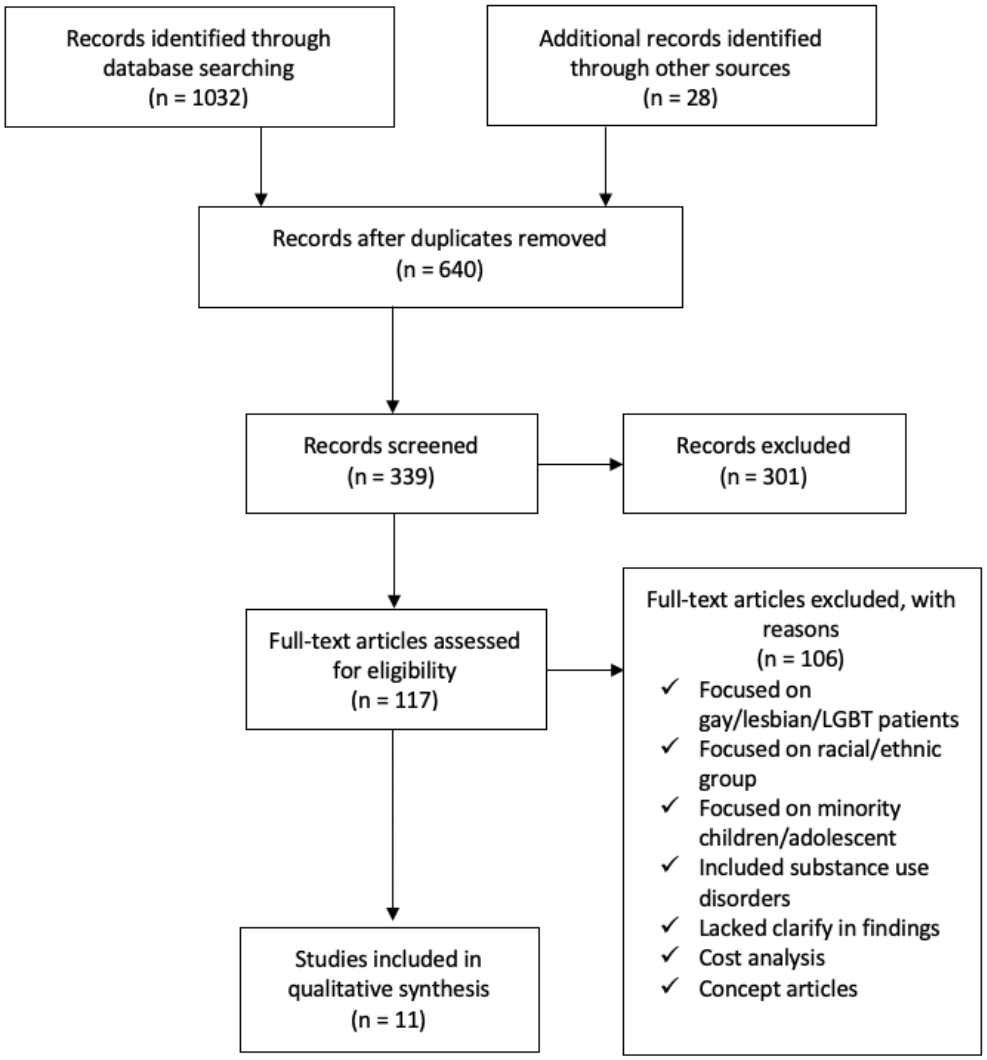


*Figure 1*. PRISMA flow diagram. Adapted from Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., The PRISMA Group. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses

## Study Outcomes and Limitations

Three of the chosen (n = 11) articles I reviewed showed that interventions using a system of integrated care lowered racial and ethnic disparities in the commencement of mental health care. Effective interventions to reduce gaps in mental health care in ethnic and racial groups necessitates dissemination and implementation. Many sociocultural factors have been recognized as potentially contributing to engagement in treatment and adherence of racial and ethnic minorities in mental health care. Educating health care providers in stigma reduction practices and improving their cultural competency skills are strategies that can help reduce the gaps in practice. The common themes among the studies were related to mental health care, predisposing characteristics, perceived need, and patient satisfaction.

From this literature review, I found that many sociocultural factors influence racial and ethnic minority individuals in seeking mental health care, and when they do seek help, they encounter challenges during treatment. Due to these factors, individuals from racial and ethnic groups are less likely to participate or stay in treatment. The use of psychosocial interventions—such as integrated/collaborative care, increased diversity in workforce, providers practicing in minority neighborhoods, improved clinicians' cultural competency skills, stigma reduction—can assist in lessening mental health care disparities. For instance, Holden et al. (2014) pointed out that primary health care environments could be a promising setting for assessment, screening, and treatment of mental diseases for racial and ethnic minority groups. Similarly, an inclusive, innovative, culturally centered integrated care model is significant to addressing the challenges in the

health care system at the individual level, which consists of the patient and provider features, and at the system level, which comprises practice culture and system functionality problems.

## Findings and Implications

The review of the literature yielded five systematic reviews, four surveys, and two mixed methods studies. These studies' findings are summarized below and categorized by key findings, which comprise variables identified to prevent mental health care engagement and interventions to help reduce disparities.

### Variables Identified to Prevent and Encourage Mental Health Care Engagement

Cook, Zuvekas, Chen, Progovac, and Lincoln (2017) carried out a review to assess the individual, neighborhood, and policy predictors of disparities in mental health care. Cook et al. (2017) tried to understand mental health care access, which necessitates not only understanding behavior change but also knowing the interrelationships among the social context, individual episode factors, the disease history of the person, social supports/networks, and the health care delivery structure that leads individuals to formal treatment. Cook et al. (2017) reviewed surveys and responses from Panels 9 to 13 (corresponding to years 2004–2009) of the Medical Expenditure Panel Survey with samples consisting of non-Latino White, non-Latino African American or Black, and Hispanic or Latino adults 18 years and older with probable psychiatric disorder (N = 13,211) episodes of mental health care representing 10,399 individual respondents. The findings indicated that racial and ethnic disparities arise because minorities are more likely to live in neighborhoods where initiation of treatment is low, because of a

differential influence of neighborhood disadvantage on treatment initiation for minorities compared with Caucasians. Likewise, low rates of initiation in neighborhoods with a high density of specialists implies that interventions to increase mental health care specialists, without a focus on treating racial and ethnic minorities, might not reduce access disparities. Hence, the presence of specialists already practicing in environments of significant African American and Latino population need suggests that greater access to existing resources can reduce disparities.

Breslau et al. (2017) used logistic regression models to test for variation across groups in the relationship between severity of mental illness and perceived need for treatment. Breslau et al. (2017) aimed to resolve contradictory evidence about racial/ethnic differences in the perceived need for mental health treatment employing a large and diverse epidemiologic sample from 6 years of a repeated cross-sectional survey of the U.S. civilian non-institutionalized population (N = 232,723). The result of this study finds out that all minority groups are less likely to perceive a need for mental health treatment, even after adjusting for mental health status, suggesting that differences in perceived need could be a neglected cause of racial/ethnic disparities in mental health care use.

DeCarlo and Miranda (2014) conducted a systematic review of clinical trials to examine the participation and inclusion of U.S. racial-ethnic minority groups in randomized trials. This study also examined progress in making the mental health workforce more diverse and in better representing racial-ethnic minority groups in randomized intervention trials of common mental disorders since the publication of the

U.S. surgeon general's 2001 report on Mental Health: Culture, Race, and Ethnicity. The findings from this review indicate that from 1999 to 2006, professionals from racial-ethnic minority groups increased from 17.6% to 21.4% in psychiatry, from 8.2% to 12.9% in social work, and from 6.6% to 7.8% in psychology and ethnic match between provider and client encourages clients to stay in treatment. Similarly, an integral part of reducing mental health care disparities is increasing the diversity of the workforce evidence-based treatment.

Ma and Saw (2018) carried out a qualitative study to identify facilitators and barriers to the successful implementation of primary care behavioral health integration in a multilingual behavioral health care setting. This research involved seven focus groups and five semi structured interviews. The respondents included were 41 patients and five providers partaking in integrated care at a community mental health clinic located in California and provides serves to Asian immigrants. Results from the study reveal that limited system-level preconditions and cross-organizational dynamics challenged integrated care. Changing organizational culture and practice, improving patient-provider and provider-provider communication, and increasing patient participation improved clinical outcomes and facilitated effective implementation.

Kalibatseva and Leong (2014) conducted a literature review which focused on culturally sensitive treatments for depression and to answer many questions that understand and evaluate these treatments and their relevance to addressing prevailing disparities among racial and ethnic populations in the United States. The review of this literature identified 16 studies relating to culturally sensitive treatments for depression.

The two authors found that culturally adapted mental health interventions are more effective for racial and ethnic minorities compared to traditional unadapted psychotherapy. Data found in all reviewed studies suggest substantial reductions in depressive symptomatology posttreatment.

Bignall, Jacquez, and Vaughn (2015) conducted a qualitative data analysis employing semistructured interviews and surveys to study causes of mental health issues as perceived by community ethnic populations across a range of mental health conditions. This investigation employed a grounded theory method to identify attribution themes conducted on focus groups of African Americans (n = 8), Asian Americans (n = 6), Latino/Hispanics (n = 9), and Caucasians (n = 11). Results from this study suggested that there is enormous variability in causal beliefs of individuals about different mental disorders and that racial/ethnic minorities attributed the cause of certain mental illnesses to be a normal aspect of life or a spiritual etiology more than Caucasians.

**Interventions to Help Reduce Disparities**

Lee-Tauler, Eun, Corbett, and Collins (2018) conducted a systematic review to synthesize existing evidence on interventions intended to reduce racial-ethnic disparities in initial access to mental health care and the extent to which these interventions are successful. The population examined were members of racial-ethnic minority groups of all ages in the United States. Lee-Tauler et al. (2018) looked at SR of 29 qualitative synthesis studies which measures participants of racial-ethnic minority groups residing in the United States, who underwent interventions recognized as collaborative care

(N = 10), psychoeducation (N = 7), case management (N = 5), colocation of mental health services within existing services (N = 4), screening and referral (N = 2), and a change in Medicare medication reimbursement policy that served as a natural experiment (N=1). The findings from Lee-Tauler et al. (2018) review indicates that reduction of disparities in the initiation of antidepressants or psychotherapy was noted in seven interventions (four relating to collaborative care, two linking colocation of mental health services, and one involving screening and referral). Most (N = 23) interventions incorporated adaptations designed to address social or cultural barriers to care.

Maura and Weisman (2017) conducted a review of the literature review examining the empirical evidence about the presence of racial/ethnic disparities in mental health care among people with severe mental illness (SMI). Maura and Weismann (2017) comprehensive narrative reviewed a total of 131 studies with no limitations to the year of publication. The study findings suggest that racial/ethnic minorities with SMI are more likely to use emergency psychiatric services versus community support services likewise minorities with SMI have lower rates of initial treatment utilization. Similarly, racial/ethnic minorities appear to experience poorer outcomes when they do receive treatment and racial/ethnic minorities living with SMI who use mental health services may receive less than optimal care. Furthermore, many sociocultural variables were recognized as potentially contributing to treatment engagement and adherence within racial/ethnic minorities with SMI.

Williams et al. (2015) conducted a systematic review to explore minority participation in a large obsessive-compulsive disorder (OCD) treatment program over a

thirteen-year span. This study was based on the use of mental health care and barriers to treatment for OCD in four specific ethno-racial minority groups, followed by an examination of minority participation in a large intensive/residential OCD treatment facility. The respondents involved 924 children or adults diagnosed with OCD at Rogers Memorial Hospital between 1999 and 2012. Treatment comprised a combination of pharmacotherapy and daily cognitive behavioral therapy. The results from this study identify that minority patients required substantially longer stays, regardless of no differences in mean OCD severity pre- or posttreatment. The percentage of minority patients significantly increased over a 13-year span. These results signify a large disparity in receipt of OCD treatment among ethnic minority groups. Likely barriers to OCD treatment consist of language, cultural mistrust, economic, knowledge of OCD. Additionally, differential symptom manifestation can yield misdiagnoses and poorer treatment outcomes.

Budhwani and De (2019) conducted a study which used a multivariate linear and logistic regression models to address perceived and enacted stigma in clinical settings critical to ensure delivery of high-quality patient-centered care, reduce health disparities, and improve population health outcomes of minority groups populations in the United States. The authors collected data came from the Behavioral Risk Factor Surveillance System's between 2012 and 2014. Poor health was measured by the number of days the participant was physically or mentally sick over the past month and depressive illness diagnosis. Findings from this study noted that in health care settings, stigma, attributed to being a racial or ethnic minority, is related to poorer physical health and worse mental

health. Similarly, perceived stigma was related to additional 2.79 poor physical health days and 2.92 more days of poor mental health. Likewise, perceived stigma in health care environments related with 61% higher odds of reporting a depressive disorder. A percentage of participants found health care too expensive (7–15%) with people of color having the greatest levels of perceived costliness. Hence reducing perceived stigma in the clinical environment can produce improved mental and physical health outcomes in minority clients thus lowering health disparities.

Michalopoulou et al. (2014) conducted a study to examine the relationship between cultural competency and functional health outcomes and to better understand the manner in which cultural competency connects to health outcomes. Michalopoulou et al. (2014) collected data collected from patient satisfaction surveys in seven mental health clinics. Patient satisfaction is monitored at seven clinics involving (n = 94) minority patients. Findings from the survey revealed that cultural skills are strongly associated with visit satisfaction. Fifty-nine percent of individuals extremely satisfied with the visit stated their clinician as having cultural skills compared to zero percent of individuals not extremely satisfied with their visit. The results confirmed that the process of care characteristics such as respect, trust and communication are vital variables that facilitate the relationship between clinicians' cultural competency and patients' functional outcomes.

**Implications**

The key focus of this systematic review was to recognize the barriers and effective strategies in identifying and treating minority patients with mental health

disorders. Findings from this SR suggest that clinicians should work to understand their patients' mental health attributions so as to provide more successful treatment to racial/ethnic minorities groups. Likewise, actively engaging with community organizations to improve mental health literacy and the use of cultural competence to address mental health complaints is vital. Providing minorities with culturally adapted treatments during mental health care can contribute to favorable outcomes. Furthermore, findings from the SR stress the significance of patient participation, peer services, and interdisciplinary communication to positively implement integrated care in the aspect of language and operational challenges in environments serving multilingual and multicultural minorities.

To increase diversity in the workforce, adding more providers from racial/ethnic group is highly recommended to encourage minority consumers to stay in treatment. Reducing the perceived stigma in the clinical environment cannot be overlooked. Lowering stigma could yield better mental and physical health outcomes in minority clients thereby lessening health disparities. Evidence from this SR suggests that integrated care models hold promise in reducing disproportions in mental health care racial/ethnic minority groups. More significantly, it is valuable that effective interventions to lower the gaps in mental health care be broadly disseminated and implemented.

**Social Change Implications**

The purpose of this systematic review was to offer evidence that can lead to effective interventions to reduce the gaps in mental health care for racial/ethnic minority

populations therefore an improved health standing, better-quality care and more patient satisfaction. If health care settings implement evidence-based interventions proven to reduce mental health care, it is projected that this modification will benefit patients, their families, communities, health care providers, society, and the health care system. The social implications of this systematic review are many with the potential of positively changing primary care which is the first point of care for most patients. As difficult as it is for anyone to obtain appropriate mental health care in the United States, it is even tougher for racial/ethnic minorities with disparities existing in the accessibility, availability, and quality. By exploring the findings from this project on bridging the gaps in mental health care health care, organizations can implement effective interventions to improve outcomes and patient satisfaction.

These interventions can improve a better patient-provider relationship, improve collaborative care, reduce the use of psychiatric emergency services, thereby reducing cost. Moreover, the implications for this social change implies potential policies changes can help improve better insurance reimbursements and incentivize practices that integrate mental health into primary care. Specialist care is not the first pathway individuals for experiencing mental health problems. Even when patients do seek specialist care, the specialist clinic does not necessary communicate with the patient's primary care doctor, they do. Consequently, these patients are likely to undergo redundancy in services or a gap in timely, effective care.

Hence, it is then suggested to lower the high level of bias in mental health care, discrimination, and stigma in all minority groups to include racial/ethnic minority, and other religious and gender groups.

## Recommendations

After analyzing and synthesizing the articles in this SR, the following recommendations were developed. To reduce racial/ethnic disproportions in the initiation of mental health care, providing interventions that employ a model of integrated care hold promise in lessening these disparities. According to Breslau et al. (2017), clinical interventions aimed at collaborative care in primary care can lessen disparities in care, and it could be improved with strategies to address the diversity of perceptions among individuals testing positive for depression. Mistrust of the health care system can influence an individual to adhere to or engage in treatment. The use of peer services can help improve engagement.

Strong evidence suggests reducing stigma in the clinical setting is beneficial, and non-clinical interventions, involving anti-stigma campaigns, can be targeted to be more culturally centered with a bigger emphasis on faith-based and additional community-based establishments, such as carrying work on public health outreach by means of barbershops. The neighborhood, the residents' educational level, diversity of the workforce and the concentration of mental health care providers are linked with disparities of mental health care. Thus, it is recommended to improve mental health care there should be more access to resources.

The key strategies for reducing mental health care disparities in racial/ethnic groups from this systematic review are: (a) implement integrated/collaborative care intervention for racial/ethnic patients; (b) involve more racial/ethnic minorities in research studies; (c) train more mental health providers from racial/ethnic minority population; and (d) initiate cultural competency training for clinicians to help alleviate mental health stigma and bias encountered in the practice.

## Strengths and Limitations

The review of the current literature on this systematic review employed the last five years of research studies to establish the benefits reducing mental health care disparities in racial/ethnic minority groups. This review provided a collection of the up-to-date published problems regarding the care of racial/ethnic minority and the challenges and interventions to reduce the disparities that exist within these groups of individuals. These SR findings provide promising results that can be used to engage stakeholders to adopt evidence-based interventions therein to improve mental health care for all irrespective of socio-cultural background.

A limitation of this systematic review is that among the 11 articles not all studies included every racial/ethnic minority group experiencing mental health care disparities. Thus, limiting its generalization. Further research is required to examine the impact of mental health care disparities in all racial/ethnic minority populations.

## Summary

The emphasis of this systematic review was to offer an analysis of the present published literature which reports the evidence on the interventions that can improve mental health care and reduce disparities in racial/ethnic groups. These findings suggested that customization of content, approach, or delivery of interventions should consider culture, engagement of health care provider cultural competence training, stigma, and bias reduction, increase workforce diversity, and integrate care and other psychosocial interventions can reduce mental health care disparities. Developing trust and confidence in mental health systems can help racial/ethnic minority patients engage and stay in treatment. Health care organizations can use these findings to create appropriate interventions to improve mental health care for racial/ethnic minority patients. Based on the evidence, implementing collaborative and culturally-centered patient care can assist patients in many ways, as well as provide guidance, support, and continuity of care. Furthermore, the results from this systematic review can be implemented to the growth of developing new practice guidelines in the primary care practice and other settings across the health care system.

# Section 5: Dissemination Plan

## Introduction

The objective of this systematic literature review was to provide a comprehensive analysis of the recently published evidence for the barriers and effective strategies in identifying and treating minority patients with mental health disorders. The approach designated for this project was founded on the hypothesis that employing culturally patient-centered care that targets ethnic minority patients in clinical practice can result in lowering mental health care disparities. Executing cultural competence to honor diversity implies understanding the fundamental needs of the target audience and developing and maintaining services to meet those needs advantageously. It is significant to frequently and justly assess legislative and operational practices to safeguard that every voice is heard and reflected. Furthermore, the use of cultural competence as a framework to guide the implementation of culturally competent patient-centered care remains a remarkable component of this project. In the concluding section of this systematic review, I discuss the plan for dissemination and provide a self-analysis and a summary to conclude the systematic review.

## Dissemination Plan

Effective community mobilization is significant in executing a successful knowledge dissemination. Partnerships, including key stakeholders, provide an important base to mobilize the entire community to address mental health care disparities in racial and ethnic minorities. The findings of this systematic review will be disseminated to many stakeholders, such as racial and ethnic minority individuals living with mental

illnesses, their families, community centers, policymakers, local health care organizations, and other establishments that foresee the well-being of minority populations. Additionally, I intend to share the findings and recommendation of these systematic review with clinicians at my practicum site, which is a primary care practice that serves many racial and ethnic minority individuals. The information will consist of background data, evidence from the literature, and reasons it is relevant to provide effective culturally integrated/collaborative patient-centered care. In addition, I will present these systematic review results through a PowerPoint exhibition, handouts, and in-service meetings with stakeholders and audiences.

It is imperative that clinicians possess cultural competence skills and that its principles are promoted in all practice settings and organizational leadership becomes aware of the benefits it has to offer for racial and ethnic minority patients and health care providers. Mental health care management is not a one- size- fits- all method, as engagement transpires in the context of a person's unique nature, social and living conditions, and symptom burden. To successfully expand treatment engagement in racial and ethnic populations, approaches that target their attitudes, perspectives, behaviors, and core needs and presumed roadblocks may be implemented. Looking outside local health care communities and organizations, there are several potentials for knowledge dissemination to other health care establishments which can offer valuable understandings and resources in managing racial/ethnic groups mental health care needs. Moreover, conducting a needs assessment can assist in identifying cultural commonalities and differences with this population and the general population common needs.

Addressing these challenges can further encourage research techniques and tools for expanding engagement within the framework of culturally patient-centered care.

Postgraduation, I intend to prepare the findings from this SR for journal publication, if possible, in the Journal of Mental Health, Religion and Culture, and Substance Abuse and Mental Health and Services Administration (SAMHSA). Another possibility with my SR review findings is to develop early screening guidelines for primary care clinicians to use during routine medical visits and consultations.

## Analysis of Self

My Doctor of Nursing Practice (DNP) program commenced in 2017 post completion of Master of Science of Nursing degree. The task of exploring and analyzing data has been priceless. I learned that the course of writing a systematic review is a step-by-step process that can be tough, overwhelming and time constraining. Yet, captivating as I research further work conducted by other scholars and researchers. I learned thought-provoking, valuable, meaningful and useful information at the end of this process. Likewise, this course has provided me with the skill to understand how to appraise an article for quality, trustworthiness and synthesize the data for applicability. Carrying out this review improved my ability to recognize and identify gaps in practice and the current literature. I feel confident in generating hypotheses and concepts on what needs to be originated and/or investigated. Hopefully, possessing these skills will guide me in future endeavors. Moving forward, I anticipate continuing with the process of translating and disseminating my findings into practice by generating new clinical guidelines for primary care practices to use.

## Summary

Mental health illnesses are pervasive, with incidence rates of mental disease diagnoses among racial/ethnic minorities being comparable to or less than that of Caucasian Americans **(**Bignall, Jacquez, & Vaughn, 2015). While minorities have an equitable occurrence of mental health ailments, inequalities do exist in the use of mental health services, especially when undergoing mental distress. Thus, understanding racial/ethnic minority mental health attributions are crucial to promote and encourage treatment-seeking behaviors and educate community-based mental health services. Also, reducing perceived stigma in clinical environments could produce healthier mental and physical health results in racial/ethnic minority patients thus lowering health disparities.

This systematic review was conducted to provide a comprehensive analysis of the up-to-date available evidence for barriers and effective strategies in identifying and treating minority patients with mental health complaints. The findings of this review indicate that cultural practices and views contribute to ethnic variances in help-seeking activities. Likewise, perceived health care stigma and lack of cultural competence in clinicians can influence racial/ethnic minorities to disengage in treatment. Modifying health care organizational culture and practice, improving patient-provider and provider-provider communication, and enhancing patient participation can help boost clinical outcomes and facilitate effective mental health care service utilization.

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# Appendix A: Literature Review

| Authors | Aim/Setting samples | Design/Intervention | Results | Limitations | LOE |
|---|---|---|---|---|---|
| Lee-Tauler, S. Y., Eun, J., Corbett, D., Collins, P. Y (2018). A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups. | To synthesize current evidence on interventions intended to reduce racial-ethnic disparities in initial access to mental health care and summarize the extent to which the interventions are effective in U.S. racial-ethnic minority groups of all ages (N=29) | Systematic reviews that measures participants initial access to or attitudes toward mental health care. Interventions involved collaborative care, psychoeducation, case management, colocation of mental health services, screening and referral and a change in Medicare medication reimbursement policy which served as a natural experiment | Interventions that used a model of integrated care reduced racial-ethnic disparities in the initiation of mental health care. Also, a reduction of disparities in the initiation of antidepressants or psychotherapy was noted in seven interventions (four involving collaborative care, two involving colocation of mental health services, and one involving screening and referral). Most (N=23) interventions incorporated adaptations designed to address social or cultural barriers to care. | Studies were heterogeneous and lacked a meta-analysis of results and effect sizes. Interventions were diverse in terms of type, setting, sample size, and severity of symptoms or diagnoses. Target outcome was difficult to ascertain. Some studies with many outcomes lacked a clear distinction between initial access to mental health care and subsequent follow-up. No explicit inclusion of other underrepresented minority groups. | V |

| Authors | Aim/Setting samples | Design/Intervention | Results | Limitations | LOE |
|---|---|---|---|---|---|
| Cook, B. L., Zuvekas, S. H., Chen, J., Progovac, A., & Lincoln, A. K. (2017). Assessing the Individual, Neighborhood, and Policy Predictors of Disparities in Mental Health Care | To assess individual- and area-level predictors of racial/ethnic disparities in mental health care episodes for non-Latino White, non-Latino African American or Black, and Hispanic or Latino adults with psychiatric illness. 13,211 episodes of mental health care of (N= 10,399) Detailing health care use and expenditures including psychotherapy, outpatient, inpatient, emergency room, office-based visits, and prescription drug use. | Surveys and responses from Panels 9 to 13 of Medical Expenditure Panel Survey. Between 2004-2009 | Disparities arise due to minorities living in neighborhoods where treatment initiation is low, instead of a differential influence of neighborhood disadvantage on treatment initiation for minorities compared with Caucasians. Also, the neighborhood level, average education of the neighborhood residents and the density of specialist mental health care providers are related with disparities in initiation of mental health care. The presence of specialists in areas of extensive Black and Latino need indicates greater access to existing resources can reduce disparities. | Non-inclusion of Native Americans or Asian/Pacific Islanders in sample size. Sample restricted to adults with probable depressive illness limiting the sample to people with clinical need for mental health care excluding those who may be overusing or receiving inappropriate care. PHQ-2 and K-6 scales used are not as precise as diagnostically related instruments. | VI |

| Authors | Aim/Setting samples | Design/Intervention | Results | Limitations | LOE |
|---|---|---|---|---|---|
| Maura, J., & Weisman de Mamani, A. (2017). Mental Health Disparities, Treatment Engagement, and Attrition Among Racial/Ethnic Minorities with Severe Mental Illness | Review of racial/ethnic disparities in mental health care among people with severe mental illness; identify factors which can contribute to the observed disparities; and to generate recommendations on how best to address these disparities. (N=131) studies | Literature reviews. Intervention includes conducting a wide-ranging narrative review with no limitations on year of publication including studies that discussed the prevalence of racial/ ethnic disparities in severe mental illness, factors that can contribute to mental health disparities, and potential strategies to lessen disparities | Racial/ethnic minorities with SMI are more likely to utilize psychiatric emergency services versus community support services, have lower rates of initial treatment utilization, experience poorer outcomes, obtain less than optimal care. Compared to Caucasians, African Americans with SMI are more likely to be involuntarily hospitalized and enter emergency treatment by means of law enforcement. Many sociocultural variables contribute to treatment engagement and adherence of racial/ethnic minorities with SMI. | Failed to systematically evaluate methodological aspects of studies described. Questionable methodological rigor and broad term racial/ethnic minorities use to describe all people who represent racial, ethnic, and/or cultural minorities, though it is a heterogeneous population | V |

| Authors | Aim/Setting samples | Design/Intervention | Results | Limitations | LOE |
|---|---|---|---|---|---|
| Breslau et al. (2017). Racial/ethnic differences in perception of need for mental health treatment in a US national sample. | To resolve contradictory evidence regarding racial/ethnic differences in perceived need for mental health treatment in the USA using a large and diverse epidemiologic sample from 6 years of a repeated civilian non-institutionalized population (N = 232,723). | Cross-sectional survey Logistic regression models used to test for variation across groups in the relationship between severity of mental illness and perceived need for treatment. Perceived need compared across three non-Hispanic groups (whites, blacks, and Asian-Americans) and two Hispanic groups. | All minority groups are less likely to perceive a need for mental health treatment, even after adjusting for mental health status. Differences in perceived need can be a neglected cause of racial/ethnic disparities in mental health-care utilization. Disparity in care results from a convergence of social and service system factors, putting minorities at a disadvantage when they seek care | Study lacks interviews in languages other than English and Spanish | V |

| Authors | Aim/Setting samples | Design/Intervention | Results | Limitations | LOE |
|---|---|---|---|---|---|
| DeCarlo Santiago, C., & Miranda, J. (2014). Progress in improving mental health services for racial-ethnic minority groups: A ten-year perspective | Examined progress in making mental health workforce more diverse and better representation of racial-ethnic minority groups in randomized intervention trials of common mental disorders since the publication of the U.S. Surgeon General's 2001 report | Literature review of clinical trials to examine the participation and inclusion of United States racial-ethnic minority groups in randomized trials. | Between 1999 and 2006, professionals from racial-ethnic minority groups increased from 17.6% to 21.4% in psychiatry, from 8.2% to 12.9% in social work, and from 6.6% to 7.8% in psychology. Reporting race-ethnicity in clinical trials has improved from 54% in 2001 to 89% in 75 studies of similar disorders published by 2010, although few ethnic-specific analyses are being conducted. | Modest amount of data missing from data regarding mental health professionals. Methodology limitation. Lacked clarity on U.S. born psychiatrists. Search focused solely on evaluation of inclusion of participants from racial-ethnic minority groups in randomized trials on major depressive disorder, bipolar disorder, schizophrenia, and ADHD, lacked broad generalizations. | I |

| Authors | Aim/Setting samples | Design/Intervention | Results | Limitations | LOE |
|---|---|---|---|---|---|
| Williams et al. (2015). Minority participation in a major residential and intensive outpatient program for obsessive-compulsive disorder. | Investigate minority participation in a large OCD treatment program over a thirteen-year span between 1999 and 2012. (N= 924) children or adults diagnosed with OCD at Rogers Memorial Hospital between 1999 and 2012 involving non-Hispanic White (93.3%), 2.4% Hispanic/Latino American, 1.2% Asian American, 0.9% African American, 0.8% biracial/multiracial, 0.7% Indian American, 0.6% other, 0.1% Native American, and 0.1% Pacific Islander. | Literature review surrounding utilization of mental health care and barriers to treatment for OCD in four specific ethnoracial minority groups, followed by an examination of minority participation in a large intensive/residential OCD treatment facility. Treatment included a combination of pharmacotherapy and daily cognitive behavioral therapy. | Ethnic minorities are much less likely to partake in specialized, intensive OCD treatment compared to non-Hispanic Whites, and when they do receive care, they require longer stays but experience the same degree of gains. Potential barriers to OCD treatment include language, economic, cultural mistrust, knowledge of OCD. African Americans with OCD report more contamination symptoms than non-Hispanic Whites | Neither the YBOCS-SR nor the CY-BOCS-SR was thoroughly validated in ethnoracial minority groups. Data on comorbid disorders wasn't examined, which could differentially impact treatment-seeking and an individual's effort in a treatment program. Findings may not generalize to other treatment venues. | V |

| Authors | Aim/Setting samples | Design/Intervention | Results | Limitations | LOE |
|---|---|---|---|---|---|
| Budhwani, H., & De, P. (2019). Perceived Stigma in Health Care Settings and the Physical and Mental Health of People of Color in the United States. | To address perceived and enacted stigma in clinical settings to ensure delivery of high-quality patient-centered care, reduce health disparities, and improve population health outcomes. Involving US minority populations | Data came from the Behavioral Risk Factor Surveillance System's (2012-2014) and multivariate linear and logistic regression models employed. Reaction to Race module analyzed to test that perceived stigma in health care settings would be associated with poorer physical and mental health. | Stigma, attributed to being a racial or ethnic minority, in health care settings is associated with poorer physical health and worse mental health. Perceived stigma was associated with additional 2.79 poor physical health days and 2.92 more days of poor mental health. Also, perceived stigma in health care settings associated with 61% higher odds of reporting a depressive disorder. A proportion of respondents found health care too costly (7–15%) with color people having the highest levels of perceived costliness | The BRFSS relied on respondent self-report data lacking corroboration by clinical or work records subjected to possible errors and biases. Possibility of respondents being different from those who declined to participate. BRFSS interviews excluded willing respondents non-English or Spanish speakers. Subject measure and casualty outcome measures of the number of poor health days cannot be inferred from cross-sectional data. | V |

| Authors | Aim/Setting samples | Design/Intervention | Results | Limitations | LOE |
|---|---|---|---|---|---|
| Michalopoulou et al. (2014). Linking Cultural Competence to Functional Life Outcomes in Mental Health Care | To examine the relationship between cultural competency and functional health outcomes and to better understand the manner in which cultural competency relates to health outcomes. Patient satisfaction monitored at seven university-affiliated outpatient mental health programs in the Detroit Michigan metropolitan area (N=94) minority patients. | Data collected from patient satisfaction surveys in seven mental health clinics. Patients' perception of clinicians' cultural competency indirectly associated with patients' self-reported improvements in social interactions, improvements in performance at work or school, and improvements in managing life problems through the patients' experience of respect, trust, and communication with the clinician. | Cultural skills are strongly related to visit satisfaction:59% of those highly satisfied with the visit reported their clinician as having cultural skills compared to 0% of those not highly satisfied with the visit. Confirms process of care characteristics trust, respect and communication are important variables that mediate the relationship between clinicians' cultural competency and patients' functional outcomes. | Observational lacking systematic way of sampling and collecting responses from a representative sample. Surveys ratings is solely based on patient perceptions of their quality of care, clinicians' cultural competency and clinical improvement with improvement on clinical outcomes was not empirically tested. Small sample involving few non-African American minorities and race concordant patient-clinician pairs. | VI |

| Authors | Aim/Setting samples | Design/Intervention | Results | Limitations | LOE |
|---|---|---|---|---|---|
| Ma, K. P. K., & Saw, A. (2018). A Qualitative Study on Primary Care Integration into an Asian Immigrant-specific Behavioural Health Setting in the United States | To identify facilitators and barriers to successful implementation of primary care-behavioral health integration in a multilingual behavioral healthcare setting. Interviews were conducted with (N=41) patients and (N=5) providers participating in integrated care in a community mental health clinic in California serving Asian immigrants. | Seven focus groups and five semi-structured interviews were conducted with 41 patients and 5 providers participating in integrated care in a community mental health clinic in California serving Asian immigrants. | Limited system-level preconditions & cross-organizational dynamics challenged integrated care. Changing organizational culture & practice, improving patient-provider & provider-provider communication, & increasing patient involvement enhanced clinical outcomes & facilitated successful implementation. | Convenience sampling used for recruitment, selection biases, and risks of misinterpretation and social desirability bias. Transferability of findings is limited to Asian American adult immigrants with SMI and focus groups not representative of all patients and all providers | VI |

| Authors | Aim/Setting samples | Design/Intervention | Results | Limitations | LOE |
|---|---|---|---|---|---|
| Kalibatseva, Z., & Leong, F. T. L. (2014). A critical review of culturally sensitive treatments for depression: recommendations for intervention and research. | To review culturally sensitive treatments for depression and answer several questions for understanding and evaluation of these treatments and relevant to addressing existing disparities. Lifetime prevalence rates of depression among U.S. racial and ethnic groups. (N=16) studies | Literature review of 16 studies of culturally sensitive treatments for depression. Review focused on culturally sensitive treatments for depression | Reviews shows that culturally adapted mental health interventions are more effective for racial and ethnic minorities than traditional unadapted psychotherapy. All of the reviewed studies that provided data found significant decreases in depressive symptomatology posttreatment. | None of the studies examining these culturally sensitive treatments has empirically assessed directly the specific role of the adaptations. | V |
| Bignall, W., Jacquez, F., & Vaughn, L. (2015). Attributions of Mental Illness: An Ethnically Diverse Community Perspective | To provide a detailed picture of causes of mental health problems as perceived by community ethnic groups across a range of mental health conditions. A grounded theory approach to identify attribution themes conducted focus groups with African American (n = 8; 24 %), Asian American (n = 6; 18 %), Latino/Hispanic (n = 9; 26 %), and White (n = 11; 32 %) participants | Qualitative data analysis techniques based on grounded theory using semistructured interviews and surveys | Findings indicated that there is great variability in causal beliefs of individuals regarding different mental disorders, and that ethnic minorities attributed the cause of certain mental disorders to be a normal part of life or a spiritual etiology more than Whites | Semistructured interviews and surveys limited in their ability to generalize beyond the specific mental disorders included in the prompts. | VI |