

CALIFORNIA BAPTIST UNIVERSITY

Riverside, California

Racial and Ethnic Minorities Accessing Government-Funded

First-Episode Psychosis Programs

A Dissertation Submitted in partial fulfillment of the  
Requirements for the degree  
Doctor of Public Administration

Monique S. Browning

Division of Online and Professional Studies

Department of Public Administration

April 2020

Racial and Ethnic Minorities Accessing Government-Funded  
First-Episode Psychosis Programs

Copyright © 2020

by Monique S. Browning

This dissertation written by

Monique S. Browning

has been approved by the

Division of Online and Professional Studies at California Baptist University

in partial fulfillment of the requirements

for the degree Doctor of Public Administration

**Thomas V.  
Frederick**

Digitally signed by Thomas V. Frederick  
DN: cn=Thomas V. Frederick, o=California  
Baptist University, ou=OPS Behavioral  
Science, email=thfrederick@calbaptist.edu,  
c=US  
Date: 2022.08.08 10:45:46 -0700

Tom Frederick, Ph.D., Committee Chair



Elaine Ahmada, D.P.A., Committee Member



Yvonne Thai, Ph.D., Committee Member



Dirk Davis, Ed.D., Associate Vice President of Academics

## ABSTRACT

Challenges to accessing mental health care causes a postponement of mental health care for racial and ethnic minorities through stigma, cultural principles, client necessity, and available services. Applying mental health needs for all racial ethnicities and backgrounds in every FEP government-funded program reduces common collective negative effects of mental health services. Mental health inequity emphasizes the magnitude of the importance of understanding and addressing discrepancies as well as appreciating how historical and contemporary injustices shape the unequal distribution of mental health and health resources among racial and ethnic minorities. This study aspired to show the social factor of mental health disparities, specifically discrimination, results from socioeconomic hardship, lack of employment and education, impoverished communities, difficulty in accessing mental health care, and the need for cultural competence. This study recognizes the need of supportive elements for racial and ethnic minorities suffering from mental health who are anxious when accessing services.

*Keywords:* racial and ethnic minorities, first-episode psychosis, disparities, ecological model, cultural competence, access mental health, mental health, diversity, health care providers, government-funded programs

## ACKNOWLEDGEMENTS

I would like to extend my sincere gratitude to my Lord and Savior, Jesus Christ. Without Him I am nothing. I would like to express appreciation to my chair Dr. Thomas Frederick, my committee members Dr. Elaine Ahumada and Dr. Yvonne Thai, for giving me the opportunity to complete my study and for providing me with invaluable guidance throughout this research. To both programs and the participants who were willing to participate in the study, thank you for allowing me to interview each of you. To my family and associates, thank you for your support. To my parents, without your encouragement, wisdom, unconditional love, your undying guidance and support, my accomplishments would not have been achieved.

## DEDICATION

I dedicate this dissertation to my parents, Dorothy and L. C. Browning who have always supported my endeavors since I was born. Thank you for believing in me, for being my sounding board, and for pushing me to go the distance. Your guidance has fostered me into a strong independent Black educated woman who has flourished upon the backs of your undying love, compassion, faith in God, ethical values, hard work, and perseverance; thank you, Mommy and Daddy.

To my granny, Minnie M. Thompson, thank you for introducing me to the Father, Son, and Holy Spirit at a young age, for placing my name on the altar every Sunday, praying for me, and loving me with all your being. To my close inner circle, thank you for pushing me to go the distance, always encouraging me, assisting me when I needed it the most, no matter how far each of you were, the guidance, support, laughter, and love given never went unnoticed. The same support given will always be reciprocated tenfold. Thank you so much!

## TABLE OF CONTENTS

ABSTRACT .....	iv
ACKNOWLEDGEMENTS .....	v
DEDICATION .....	vi
LIST OF TABLES .....	xiii
LIST OF FIGURES .....	xiv
CHAPTER 1: INTRODUCTION .....	1
Rates of Mental Illness Among Ethnic Groups .....	4
Differential Rates of Accessing Mental Health Resources .....	5
Causes of the Disparities .....	6
Outcomes of Effects of Disparities .....	8
Background of the Problem .....	20
Problem Statement .....	21
Purpose of the Study .....	23
Research Question .....	23
Overview of Research Design .....	24
Significance of the Problem .....	24
Definitions of Terms .....	25
Organization of the Study .....	30
CHAPTER 2: REVIEW OF THE LITERATURE .....	31
Theoretical Construct .....	33
Cultural Race Theory .....	33
Ecological Model .....	37
Individuals .....	39
Microsystems .....	40
Organizations .....	41
Localities .....	42
Macrosystems .....	42
Ecological Model Integration .....	44
Inequalities in General Health Care .....	47
Health Literacy .....	50
Cultural Barriers .....	53
Cultural Barriers Among Black Americans .....	56
Cultural Barriers Among LatinX .....	60
Cultural Barriers Among American Indian/Alaskan Native .....	61
Cultural Barriers Among Asian Americans .....	62
Limited Access to Mental Health Care .....	63
Accessing Mental Health Care .....	66
Mental Health Support From Health Care Professionals and Providers .....	67

Mental Health Support From Family .....	70
Mental Health Support From the Community .....	71
Disparities Among First-Episode Psychosis .....	73
Racial and Ethnic Disparities in Mental Health Care .....	75
Policy Implementation .....	79
Publicly Available Data .....	80
Conclusion .....	89
CHAPTER 3: RESEARCH METHODOLOGY .....	92
Research Question .....	92
Research Design.....	92
Sampling .....	96
Engaging Racial and Ethnic Minority Communities .....	98
Describing FEP Government-Funded Coordinated Specialty Care Programs .....	99
Assembling Reliable Evidence .....	100
Rationalizing Decisions .....	100
Ensuring Use and Sharing Lessons Learned.....	101
Instrumentation: Interviews .....	103
Data Collection .....	105
Data Storage.....	105
Observation .....	105
Data Analysis .....	107
CHAPTER 4: RESULTS.....	113
Research Question .....	113
Description of Population and Sample .....	113
Qualitative Data Methods .....	114
Data Analysis Steps .....	115
Stage 1: Measure.....	115
Stage 2: Phenomenological Reduction .....	116
Stage 3: Imaginative Variation .....	116
Stage 4: Synthesis .....	117
Research Findings .....	118
Cultural Diversity in Coordinated Specialty Care Program Area.....	120
Profile: Community-Perceived Demographics of Clients Served .....	120
Profile: How Cultural Diversity Is Reflected.....	121
Competency Training.....	121
Diverse Staff .....	122
Language Accommodative Services and Staff .....	123
Tailored Services .....	123
Staff With Serious Mental Illness Experience .....	123
Staff Collaboration.....	124
Outreach.....	124
Profile: Ensuring Services Are Responsive to Cultural Diversity .....	125
Relationships With Other Involved Parties.....	125
Education .....	125



Outreach .....	126
Diverse Staff .....	126
Cultural Competency .....	126
Regular Meetings .....	127
Extra Support Programs .....	127
Client Assessment .....	127
Medication Subsidy .....	128
Supervision .....	128
Vocabulary .....	128
Strategy to Deliver Mental Health Services.....	128
Addressing Language Barriers.....	129
Open Discussions.....	130
Transition to Relevant Agencies .....	130
Tailored Approach .....	130
Awareness and Education .....	131
Transportation .....	131
Emphasis on Independence.....	131
Collaborations .....	132
Culturally Competent Staff.....	132
Expansion of Services .....	132
Funding Strategies .....	132
Grants .....	132
Medicaid .....	133
Not Available .....	133
Provision and Access to Services .....	133
Perspective on Challenges Faced.....	133
Challenges Faced by Clients.....	133
Stigma .....	133
Language Barrier .....	134
Lack of Funding.....	134
Housing Limitations.....	134
Unawareness .....	135
Transportation Limitations.....	135
Family Pressure.....	136
Religious Beliefs.....	136
Late Diagnosis .....	136
Provider Bias.....	136
Transition Between Programs.....	137
Environment.....	137
Communication Limitations .....	138
Challenges Faced by Providers .....	139
Language Barrier .....	139
Limited Resources .....	139
Distrust.....	140
Lack of Confidence in Treatment .....	140
Unwillingness .....	141

The Disconnect Between Micro- and Macrolevels.....	141
Client Overexpectation .....	141
Client Withholding Information .....	142
Countering Challenges.....	142
Clients .....	142
Open Discussion .....	142
Outreach Services .....	143
Understanding Clients' Needs .....	144
Diagnosis Evaluation .....	144
Relapse Prevention Plan .....	144
Safe Environment.....	145
Transport Assistance .....	145
Contact Higher Level.....	145
Health Care Funding.....	146
Education .....	146
Staff: Vocabulary .....	146
Language Services .....	148
Staff Open Discussions .....	148
Respecting Beneficiaries' Beliefs .....	148
Cultural Competency .....	149
Minimum Standards.....	149
Training for Service Providers.....	150
Ethnic Services Mandated.....	150
Development Plan: Available .....	151
Development Plan: Unavailable .....	152
Staff Reflection of Cultural Diversity: Present.....	152
Staff Reflection of Cultural Diversity: Partially Present .....	152
Staff Reflection of Cultural Diversity: None .....	153
Services Available to Family Members.....	153
Language Services .....	153
Psychoeducation .....	153
Support Coaching.....	154
Therapy Sessions .....	154
Information-Sharing Events.....	154
Convenient Meetings .....	155
Specialized Outreach and Programmatic Efforts in Place .....	156
Education .....	156
Health Care Cover.....	156
Housing .....	157
Community Visits .....	157
Transportation .....	158
Language Services .....	158
Creation of Safe Environment .....	158
Involving Clients.....	159
Partnerships.....	159
Early Diagnosis .....	160

Measures to Address Racial Disparity Issues .....	160
Language Services .....	160
Diverse Staff .....	160
Funding .....	161
Involving Clients.....	161
Strategy Work Group.....	161
Training.....	161
Collaboration to Improve Services .....	162
Collaboration With Ethnic Minorities .....	162
Sharing Ideas and Suggestions.....	162
Sharing Beliefs and Culture .....	163
Peer Support.....	163
Measures to Ensure Minorities Contribute to FEP Program .....	163
Language Services .....	163
Transportation .....	164
Constant Communication.....	164
Education and Awareness .....	165
Opportunity for Feedback.....	165
Safe Environment.....	165
Home Visits .....	166
Resilience Training .....	166
Family Groups .....	166
Peer Support.....	167
Therapy Sessions .....	167
Involvement of Family and Consumer in Treatment Plan.....	168
Transportation Assistance .....	168
Ensure Use of Medication.....	168
Decision-Making.....	169
Support System .....	169
Information Source .....	170
Notes Comparison.....	170
Awareness and Education .....	170
Creation of Treatment Plan.....	170
Providers and Leadership Collaboration.....	171
Awareness Creation .....	171
Consultations.....	171
Referrals.....	172
Training.....	172
Integrated Care.....	172
Funding .....	173
Sharing Information .....	173
Community Outreaches .....	174
Address Religious Needs .....	174
Naturalistic Observation .....	174
Systematic Observation .....	176
Program A.....	176

EBPs for Adult Services .....	180
EBPs for Children Services .....	180
Program B .....	182
Summary .....	186
CHAPTER 5: DISCUSSION.....	188
Summary of Results.....	189
Ensuring Services are Responsive to Cultural Diversity .....	189
Strategy to Deliver Mental Health Services.....	192
Challenges Faced in the Delivery of Services .....	194
Collaboration to Improve Access to Mental Health Services .....	196
Discussion of Results .....	197
Data Collection .....	200
Limitations of the Study.....	207
Recommendations .....	209
Conclusion .....	215
REFERENCES .....	216
APPENDICES .....	255
A. INFORMED CONSENT .....	256
B. SEMISTRUCTURED INTERVIEW QUESTIONS.....	260
C. NATURALIST OBSERVATION CHECKLIST FOR PROGRAM PROVIDERS .....	262

## LIST OF TABLES

Table 1. FEP Frequency Distribution .....	143
Table 2. FEP Program Distribution and Relative Frequency .....	147
Table 3. Underrepresented FEP Contribution.....	167

## LIST OF FIGURES

Figure 1. The Ecological Model .....	46
Figure 2. NVivo Coding Theme References.....	117
Figure 3. Data Collection Word Cloud.....	118
Figure 4. Minority Underutilization of Mental Health Services Theme.....	119
Figure 5. Expressions From Respondents.....	121
Figure 6. Cultural Diversity Measures.....	129
Figure 7. FEP Client Barriers.....	138
Figure 8. FEP Client Challenges.....	139
Figure 9. FEP Client Countered Bar Chart .....	147
Figure 10. Infrequent Cultural Competence Training Terms .....	150
Figure 11. Family Member Services Diagram.....	155
Figure 12. Racial Disparity Pie Chart.....	162
Figure 13. Underrepresented FEP Contribution Word Cloud .....	168

## CHAPTER 1: INTRODUCTION

Analyzing the differential outcomes from racial and ethnic minorities served in first-episode psychosis (FEP) government-funded coordinated specialty care programs connects public administration practices and research techniques to inform public health practices. FEP is a severe condition of the psychoanalysis of schizophrenia. Research has shown that intervention during the onset of psychosis can be associated with improved symptoms and functioning compared with traditional mental health care (Mueser et al., 2015). Unfortunately, limited indiscriminate customary trajectories have evaluated a multimodel, multidisciplinary group method with standard care in FEP; and according to Mueser et al. (2015), no nonacademic, community clinic trials have been conducted within the United States.

One of the most concerning public policy apprehensions in the United States today focuses on disparities regarding minority accessing mental health resources (Mueser et al., 2015). As for racial and ethnic minority communities, health disparities have been identified as one of the most crucial components to eliminate by the Healthy People 2010 and 2020 (Cook et al., 2017). According to Cook et al., disparities in mental health care usage is one of the most significant problems among minority populations. Research has indicated that the general fees of mental health treatment increased disparities in access to mental health psychotherapy between Black, LatinX, and White continued.

Racial and ethnic minorities often face disparities when seeking mental health services while living in impoverished neighborhoods, their socioeconomic status, their culture, and faith-based philosophy (Alegría et al., 2011; T. G. McGuire & Miranda,

2008). Disparity is an intricate mechanism that stems from many sources; for instance, harboring biased attitudes against certain groups that could exert less effort on behalf of a member of a particular group (Fiske, 1998; T. G. McGuire & Miranda, 2008). Therefore, health care providers often develop negative stereotypes toward their patients, for example, if a physician feels Black Americans are less likely than White Americans to comply with mental health services, the doctor might not prescribe or assist based on race, culture, and stigma (Delgado & Stefancic, 2017; Tate, 1997). Expanding the number of racial minority providers is considered an essential factor for improving health disparities. This is important for mental health care, where racial and ethnic minority providers are poorly represented, and it will make a difference in diversity by addressing minority patients' concerns and trust (Delgado & Stefancic, 2017).

An understanding of racial disparities in health care has significant effects on the progression of authentic methods in cultivating health and diminishing inequities. In other words, addressing these discrepancies will improve the public health and well-being of minorities. Williams and Sternthal (2010) specified that racial and ethnic minorities with amplified elevations of adversity encountered racial inequality. The probabilities of racial injustices in health require an examination of systematic evaluation to which the unique work-related conditions of racial and ethnic minorities contribute to theories of social experiences. Under social structures, the social class typically functions as socioeconomic status, which has demonstrated an understanding of racial disparities in health. Research has failed to reveal socioeconomic status among racial and ethnic minorities' dissimilarities in health (Williams & Sternthal, 2010).



Between 2004 and 2006, the state and local mental health care reports exhibited undesirable progress as federal mental health care expenditures increased during 2007-2009. T. G. McGuire and Miranda (2008) suggested that improving the quality of health care in general is likely to benefit minority patients who have access to care. General development may help reduce disparities through quality improvement, for instance, developing and improving materials for non-English speaking populations and virtual mental health resources for racial and ethnic minorities. In addition to overcoming barriers and incorporating cultural competence training, these measures would reduce mental health inequities by improving access to mental health services (Zimmerman, 2005). Additional interventions consist of integrating foreign language material and mental health educational video resources for racial and ethnic minority patients, providers, and family members (T. G. McGuire & Miranda, 2008). Material on cultural values and practices of overcoming obstacles to care for racial and ethnic minority patients should be incorporated in all training. Typically, quality promotion, prevention, and interventions reduce disparities. The discrepancy in mental health is significant and challenging to understand, but the decline of social inequities is unnecessary for attaining equality in mental health. Amending access to quality care would enhance the mental health of racial and ethnic minorities (T. G. McGuire & Miranda, 2008).

Cook et al. (2017) pointed out that access to mental health care influences socioeconomic factors and insurance though clinical need and treatment preferences did not impact these elements. Racial and ethnic communities experience comparable phases of mental illness commonalities as Whites, which causes disparities to be of great medical and public health importance. Cook et al. (2017) pointed out that racial and

ethnic communities have similar cases of serious mental illness, and reducing racial and ethnic disparities when accessing mental health care is viewed as helpful to manage costs of critical therapeutic care. Cook et al. indicated previous findings showed little progress toward decreasing mental health care disparities for racial and ethnic minority communities. The results given created a sufficient examination of racial inequity and social fairness, which caused substantial discussion among health care professionals who, in turn, recognized inequity as a social fairness concern, in addition to being a public health dilemma with evident health penalties.

### **Rates of Mental Illness Among Ethnic Groups**

Most racial and ethnic minority groups have limited cases of mental illness compared to Whites. However, the inequalities of mental health percentages are extensive among racial and ethnic minorities, and so are the inconsistent services of mental health access. Budhwani et al. (2015) showed that racism and discrimination damages mental health, chronic conditions, and emotional variance among racial and ethnic minorities. Richardson et al. (2003) examined the quality of mental health care for racial and ethnic minorities and how they were more likely to receive mental health counseling for substance use or be referred to a primary health care facility than to a mental health specialty clinic, unlike Whites, and American Indians and Alaskan Natives have an increase of posttraumatic stress disorder and alcohol dependency with a lower risk of major depression.

Racial and ethnic minorities in the United States are discriminated against when accessing mental health services. Alegría et al. (2016) reported that racial and ethnic minorities with mental health conditions seeking equivalent care were limited, compared

with Whites. The relationship of race and ethnicity to mental health care access and delivery is problematic, and the use of mental health outpatient services fluctuates with racial and ethnic minority groups, gender, age, and income (Alegría et al., 2011). The lack of cultural understanding from health care facilities contributes to underdiagnosing and misdiagnosing racial and ethnic minorities, which contributes to language barriers, stigma, and the lack of cultural competency.

### **Differential Rates of Accessing Mental Health Resources**

The occurrence of mental illness varies by race and ethnicity. Black and LatinX Americans are less likely to suffer from depression and anxiety more than Whites (Kessler et al., 2005; Riolo et al., 2005). Asian Americans have lower rates of mental illness compared to LatinX Americans. The decreased mental health burden among racial and ethnic minorities is astonishing because minorities have limited access to mental health care (Burgess et al., 2008), socioeconomic challenges, and tackling complex levels of race discrimination.

The reason for these disparities includes the lack of cultural competence of mental illness among racial and ethnic minorities, faith-based, family judgment when seeking assistance, and stigma among peers (Alcalá, 2014). Although racial and ethnic minorities suffer from lower levels of anxiety and depression than Whites, racial and ethnic minorities face several challenges when accessing and utilizing mental health services. The utilization of services from Black Americans, LatinX, Asian American, and American Indian/Alaskan Natives has shown minimal occurrences of accessing mental health services. Black Americans, LatinX, Asian Americans, and American Indian/Alaskan Native are less likely to use specialty mental health care services than

White Americans because of the lack of appropriate level of care, language barriers, and economic hardship (Alcalá, 2014).

### **Causes of the Disparities**

Ladson-Billings (1998) and Ford and Airhihenbuwa (2010) cautiously encouraged the use of critical race theory (CRT) to address racism's influence on educational disparities. CRT describes its origin in the field of public health. Ford and Airhihenbuwa (2010) created a technique to use CRT in health equity research. The CRT incorporates objective and sociopolitical measures based on concepts and strategies. CRT echoes the public health call to merge evidence-based practice (EBP) with practice-based evidence. The systematic nature of the technical process enhances the reliability of experimental results but does not eradicate the impact of racial bias. Health sciences have emulated whatever racial views permeated the public at the time and seldom have included the intellectual contribution of racial and ethnic minorities (Ford & Airhihenbuwa, 2010).

The Public Health Critical Race Praxis utilizes CRT theories and approaches to reporting on racial and ethnic disparities (Ford & Airhihenbuwa, 2010). CRT is an antiracist scholarly method, developed to recognize, understand, and undo the core causes of racial directives. The Public Health Critical Race Praxis is one of several models that translates CRT to empirical research. Ford and Airhihenbuwa urged health equity researchers to learn CRT linguistic and integrate the information into their research. CRT is known to reinforce effective communication about racial phenomena and generate more innovative theoretical models. This can illuminate a correlation of racism to public health, enhance the validity of outcomes, and provide policy officials and

interventionists. The verification desired to guide their work by culturally connecting health education models. The challenge of differentiating positive, existential, and adverse health behaviors in communities is to secure standard suppositions and collectively self-critique to understand how an individual unintentionally destabilizes the exertions to attain health equity (Ford & Airhihenbuwa, 2010).

McGee and Stovall (2015) examined another theory, the ecological model, which emphasizes the connection of racial and ethnic minority groups accessing mental health services by improving the best mental health practice and understanding the social characteristics of developing a phenomenon of continuity and change in improving the environment racial and ethnic minorities (McGee & Stovall, 2015). The ecological model of social growth studies the collaboration between ecological framework and specialized development, which commences with the assumption that an individual's perception of his or her environment and circumstance is crucial to understanding racial and ethnic minority experiences and responses (Spencer, 2008). In this study, the researcher integrated the ecological model to show several elements that explain why racial and ethnic minorities are at a higher risk of mental health disparities while Whites are more protected from mental health disparities. Societal factors influence whether racial and ethnic disparities are encouraged or inhibited. Bronfenbrenner (1977b) proposed four concepts that explore how social and human development contributes to a racial and ethnic minority group's environment. The four concepts consist of individual, macrosystem, microsystem, and organization, describing the relationship surrounded by concentric circles representing government-funded FEP programs (McGee & Stovall, 2015).

## **Outcomes of Effects of Disparities**

Health disparities are variations of community groups who have systematically and organizationally suffered social difficulties as a result of unhealthy conditions compared to prosperous individuals. Mental health equity is the ethical concept expressing the deficiency of excessive and biased mental health disparities (Williams & Collins, 2001). The goal of racial and ethnic minorities is to attain health equity by eliminating systematic disparities when accessing mental health services and social determinants among privileged and underprivileged communities (Braveman & Gruskin, 2003). Inequalities in poor health outcomes described by racial and ethnic communities place a massive load on the United States of America and its workforce and give rise to an extreme economic burden (Ng et al., 2017). Eliminating health disparities among racial and ethnic minority communities would reduce direct mental health care expenditures and indirect costs to the public (D. B. Matthews, 2018).

Policy efforts are needed to respond to racial and ethnic disparities in accessing mental health services (D. B. Matthews, 2018). Health providers categorized differences in cultural values, increasing clinician awareness to improve recognition and treatment of mental illness among racial and ethnic minorities, improving provider training in recognizing symptoms among racial and ethnic minority groups, and standardized screening to improve integrated care (De Maio, 2014). As the United States continues to diversify, cultural competency will become more relevant with various beliefs that will influence the ability to provide substantial mental health equity (McCullough et al., 2012). Government programs and educators should engage in cultural competency training and the utilization of diminishing the inconsistencies on racial and ethnic

disparities by improving mental health outcomes and increasing access to high-quality care for underprivileged communities (D. B. Mathews, 2018).

Racial and ethnic inequities in mental health affects the collaboration of multifaceted elements, including early and existing discrimination when accessing mental health care, genetics, education, income, general health care, cultural beliefs, and public and private organizations (C. P. Jones, 2002). Therefore, reforming the mental health care delivery system, improving access to quality care, improving cultural-linguistic, diversifying the workforce, and improving inequities in mental health influences should close the gap and accomplish valuable objectives considerably (LaVeist et al., 2009).

The meaning of social equity is identified as “fairness, justice, and equitable distribution” (Svara & Brunet, 2005, p. 254). Social equity harmonizes with governmental practices illustrating the structural make-up of the National Association of Public Administration Social Equity Panel. The council has aimed for four dimensions that shape, define, and measure social equity around fairness, access, quality, and outcomes. Rosenbloom and Carroll (1990) shared how there is a clear understanding of how public administrators are obligated by-law to put into effect regulations, policies, principles, theories, and tariffs that may not conform with social equity. However, without knowledge and concern for social equity, public administrators should follow the guidelines of the law or at least question whether the laws need to be altered. This creates an uneasiness of social equity that has steered the public administrator’s diplomacy under the law (Svara & Brunet, 2005).

Rosenbloom and Carroll (1990) mentioned a practical concern that equity and social equity often overlook the statutory bureaucratic due process, which is an individual

right though not one that defends large groups from biased dispossession of liberation or assets by the administration. If individual rights are generally maintained and constant across all racial and ethnic minority groups, there should be no social equity distress. However, declining to deliver the due process of displaced families of an inner-city revitalization venture or refuting subsidies to individuals will endure impartiality challenges (Rosenbloom & Carroll, 1990). In conjunction with inequitable methods used disproportionately with participants of identifiable groups, there is a social equity issue, just as there is an issue when using racial characteristics to single-handedly “describe” uninformed persons. When a person’s entitlement is steadily blocked toward representatives of parties well known with features such as income, ethnicity, race, age, or gender, there is a sizeable social equity problem (Svara & Brunet, 2005).

Rosenbloom and Carroll (1990) pointed out that legal examinations of parallel fortifications are additionally suitable to the “public from social equity” (p. 4), but the author focused on equal protection as a legal measure that tends to focus on individuals. A commitment to equal protection helps to prevent social equity difficulties from increasing or directs the improvement of socially inequitable practices such as delegating untrained health care professionals or constraining community administrations, outreach, and quality health services and resources (Rosenbloom & Carroll, 1990).

Though it is essential to consider potential imbalances of social equity, Rosenbloom and Carroll (1990) detected vital disparities in society, many of which could not be explained by variances in individual measurements or predispositions. The assurance of social equity reveals that public administrators are not apathetic to these settings. Models of diminishing disparities were driven by Rawls’s (1971) second theory,



which is “the community and financial imbalances prearranged, to a substantial subsidy of the slightest honor” (p. 11). Through growing policy proposals to moderate community and financial difficulties and selecting effective governance and administrative methods within a known policy, public administrators work toward embarking upon the influences of inequity centered on individual personalities or limited expectations generated by insufficient socioeconomic assets (Svara & Brunet, 2005).

Social equity is an essential pillar of public administration (Svara & Brunet, 2005). Bureaucrats are entrusted to work in such a way to regulate the United States, thus ensuring an equitable, fair, and just society. Public and state administrators must develop an accountability criterion that is fair and unbiased. Employing socially equitable public administrative practices, policies, and decisions will improve public access to vital health care services and resources.

Public administration, in the understanding of efficiency, is connected to public goods and services. Efficiency is identified through Woodrow Wilson’s (1887) body of work outlined in a measurable relationship of output and input where it is organically measured from a system based on principles, creativity, and social observations. While assessing and solidifying government programs and organizations, the need to evaluate performances focuses on the purpose, accomplishments, and location of where the organizations function. Schachter (1989) discovered efficiency as a significant influence of public administration, pointing out the definition among researchers on the subject. Binary distinctive concepts entail efficiency in public administration as the “ideal type,” contending that community groups are organized as administrations, an idea that offers sensible and practical configurations to community groups. Scholars’ assessment of

community groups is an indispensable objective in a democratic structure (Rutgers & van der Meer, 2010). This collection of objectives and diplomatic frameworks can deliver a foundation for community organizations confronting a lack of efficiency (Rutgers & van der Meer, 2010; J. Q. Wilson, 1989). Schachter (1989) indicated that community workshops permit two purposes of efficiency and the limitations of legislative accountability at the detriment of productivity. Efficiency in public administration integrates productivity with principles and responsibility in democratic governance.

When balancing equity and efficiency in mental health and general health care, the priority is to accomplish efficiency by amplifying mental health subsidies with restricted resources, limited support, and lack of services at the same time not conceding equity. According to Frederickson (2010), equitable, efficient, and economical are three public administrative pillars as essential components of value to a constant level of quality. Frederickson considered *equitable* as qualities composed of impartial, fairness, and equal opportunity, while *efficient* is preeminently achievable or favored, and *economical* is succeeding in being cost-effective. However, the market analysts have contended that equity and efficiency are jointly selective. Despite this, it does not automatically apply to mental health and general health care systems; in fact, the 2000 World Health Report recognized both equity and efficiency as essential instruments of a sound health system (Reidpath et al., 2012). The consensus of cultivating a health policy distributes maximum health benefits while disseminating resources impartially. Sassi et al. (2001) illustrated that supportive health care services possibly would enhance equity and efficiency outcomes.

The World Health Organization describes mental illness and substance use disorders as an estimated second most significant cause of disability and burdened disease globally (Shim & Rust, 2013). Among this condition, stigma is identified as a contributing factor for mental health and substance abuse outcomes of a significant public health issue. According to Shim and Rust, clients are less likely to seek mental health psychotherapy from a mental health professional than from their primary physician because of the stigma attached to mental illness, the services, medications, and specified behavioral specialists involved. With mental health being a well-known disability worldwide, the comorbidities have an adverse health outcome and revenue for populations as a whole.

Several scholars have verified the underutilization of mental health services (Kessler et al., 2001). One third of adults needing mental health services receive treatment annually. Epidemiological data have indicated that 50-60% of adults can benefit from mental health services but are not receiving the necessary services (Kessler et al., 2001). The disparities among the individuals who suffer from mental illness and individuals who use services are identified as “service gaps” (K. M. Cramer, 1999, p. 381). Service gaps are not limited to adults, given that mental health services are also not used by children (Horwitz, 2001). Only 5-7% of children and adolescents utilize mental health specialty care services. The decreased rate of utilization of services by children is influenced by their parents. Often, for children who obtain mental health services, a parent must consent to treatment. Many influencers, such as the sociobehavioral model and a person’s determinants, cause the underutilization of mental health services.

Shim and Rust (2013) indicated that mental health comorbidities exacerbate health outcomes, which influence primary medical ailments. Though useful psychotherapy resources and services under an individual's primary care physician amend the individual's health and well-being, the importance of mental health support rather than treatment of mental illness can decrease the overall stigma toward mental illness. Primary care physicians would be able to position themselves in a holistic patient-centered method; these primary care venues would implement interventions that identify flexibility, revitalization, and support of the patient's health and wellness (Shim & Rust, 2013; Unützer, et al. 2002). Individuals experiencing serious mental illness (SMI) often pass away 25 years earlier than anticipated because of heart disease, respiratory disease, diabetes, or other significant related health conditions. Therefore, in order for mental health services to be a success among those suffering from SMI, it is imperative for mental health and the public health systems to properly work and undoubtedly improve by addressing some of the stigma associated with mental illness. For instance, community and school shootings, tragic events, and natural disasters secure the need to put in action services required. Disasters are constant and can affect a person's life, health, and well-being. Often, tragedies cause individuals to experience stressful disorders of mental illness, domestic violence, opioid addiction, infectious risks, posttraumatic stress, and heart disease (Sandifer & Walker, 2018). Therefore, primary and mental health services must collaborate and prevent community power and constant strategies of a preventive framework, decreasing stigma associated with a diagnosis and treatment of mental illness.

Kane et al. (2015) performed a 2-year unsystematic organized assessment comparing individuals with untreated psychosis that influenced a psychotherapy response of FEP participants who took part in a multisite, indiscriminate customary trajectory team-based psychotherapy with standard care within the U.S. community psychotherapy facilities. According to Kane et al., “The Early Treatment Program study collaborated with the RAISE [Recovery After an Initial Schizophrenia Episode] initiative through NIMH [National Institute of Mental Health], intending the RAISE initiative to improve, assess, and fulfill patient-centered, combined psychotherapy for FEP promoting symptomatic and functional recovery” (p. 364).

Mental health is known as the primary function of an individual’s well-being. Fifty percent of the U.S. population will develop a mental health disorder within their lifetime, and it often begins during a person’s adolescent years (Valdez et al., 2017). The practitioner guide of *Disparities in Child and Adolescent Mental Health and Mental Health Services in the U.S.* points out racial and ethnic minorities are at increasing risk for mental illness disorders in adulthood (Valdez et al., 2017). An American Psychological Association article, “A New Look at Racial and Ethnic Disparities in Mental Health Care” addressed disparities in mental health services that have not been pursued or remedied since 2001, even with the U.S. surgeon general conveying that racial and ethnic minority groups are being unaided (Clay, 2016). T. B. Smith and Trimble (2016) identified the fact that Black Americans are 21% less likely than White Americans to employ mental health services, and LatinX s are 25% less likely to indulge in mental health services. T. B. Smith and Trimble (2016) indicated the reason for disparities in racial and ethnic minority groups is not only due to the socioeconomic status, the

disparities in revenue, or even access to health insurance but also to racial and ethnic minorities engaging in unequal mental health services. These outcomes are also relevant in the Asian American community; 51% of Asian Americans are less likely to seek mental health services than White Americans. A variety of mental health services can create a change in the inequity that is created by the fact that Black Americans do not seek services in community settings but in isolation. T. B. Smith and Trimble also pointed out the essential component of identifying cultural differences and having the understanding of shaping resources and services in a substantial way that replicates the specified racial and ethnic individuals' deep connection to their culture and who they are.

Disparities exist in the availability, accessibility, and quality of mental health treatment and services for racial and ethnic minorities (Chow et al., 2003; T. G. McGuire & Miranda, 2008). In essence, racial and ethnic minority communities endure substantial burden from unmet mental health needs with a significant loss to their overall health and productivity (Health Equity and Accountability Act of 2018; H.R. Res. 5942, 2018). According to the American Psychiatric Association (2017), disparities among racial and ethnic minorities engaging in mental health resources and services are identified as disproportionate with a problematic increase of sickness causing mental illness. Even though depression percentages are lesser in Black Americans (24.6%) and LatinX Americans (19.6%) than in White Americans (34.7%), depression is more incessant in Black and LatinX Americans. From the American Psychiatric Association (2017) mental health facts for the diverse population, there is a significant lack of racial and ethnic minority knowledge from health care professionals and providers that causes an unidentified diagnosis or a misdiagnosis of mental illness in racial and ethnic minority

groups and diverse communities. Often being misdiagnosed contributes to language barriers, stigma among minority communities, or cultural expositions of indicators (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a). Racial and ethnic minorities do not seek the attention of mental health services. According to the American Psychiatric Association (2017), in 2015, of adults suffering from mental illness, 48% of White Americans acquired mental health services while 31% of Black and LatinX Americans and 22% of Asian Americans attained mental health services. Therefore, the racial and ethnic minority communities' utilization of mental health services is carried out differently in comparison to White Americans and American Indian/Alaskan Native. For instance, individuals identifying as more than two races, who identify as Whites and American Indian/Alaskan Native, are more likely to obtain outpatient mental health services, prescription drugs than racial and ethnic minorities. Black Americans and individuals identifying themselves with two or more races use in-patient mental health services. Although Asian Americans were not as likely to seek mental health services as other racial and ethnic minority groups, the contributing factors (American Psychiatric Association, 2017) affecting access to psychotherapy for racial and ethnic minorities are the lack of diversity among mental health professionals, limited cultural and knowledgeable health professionals, distrust of health care providers, and lack of support of mental health services (uninsured, Medicaid, health insurance coverage).

This study examined how public administration policy addresses this issue through the implementation of first-episode, coordinated specialty care programs within the state and community levels by exploring increased access to essential services and

improving client outcomes such as symptoms severity, employment, education, and quality of life. The study also examined the successful or unsuccessful outcome of differential treatment among racial and ethnic minorities. This study provides evidence on how public administration could be used to create and apply public policies that encourage higher quality and unbiased health outcomes.

Efficiency, another core pillar of public administration, is to ensure that the government is producing the maximum output with the resources available (Manzoor, 2014). For the government to produce maximum output with available resources, it is essential to utilize data analysis decision makers. The data examined were obtained through research and analysis compiled by NIMH and SAMHSA administrators and the decision to select an EBP that provides a comprehensive yet direct approach to the treatment of FEP. In the United States, EBPs have been recognized as a critical factor in meeting the triple aim in health care, described as follows:

- Improving the patient experience of care (including quality and satisfaction)
- Improving health populations
- Reducing per capita health care cost (Berwick et al., 2008, p. 759)

Also, implementing administrative EBPs are characteristics inspired by performance measures while managing public health administrative practices such as the following:

- Leadership
- Workforce Development
- Organizational Principles and Environment
- Economic Procedures (Duggan et al., 2015, p. 1).



These practices are valuable when analyzing the appropriate circumstances that enhance the performance and advancement of the population's health.

The dissertation topic was manageable because of the data instruments the researcher utilized in the study. The qualitative method examined the behaviors, attitudes, and intentions of participants through interviews, observations, case studies, and documents to identify themes and an in-depth study of the phenomena.

The dissertation topic is relevant because of the economic cost and social burden of untreated psychosis on society. According to the 2010 assessment by the NIMH (n.d.-a), psychosis is an illness where a person loses connection with reality and may endure paranoia, delusions, or hallucinations. Also, a psychotic disorder is identified as a depressive or bipolar condition with psychotic characteristics but having a physical health condition that does not exhibit psychotic maladies from dejected and bipolar disorders are not instrumental when identifying psychotic characteristics (American Psychiatric Association, 2013). However, allotting a thorough evaluation and eliminating any suggestive precursors of delusions and schizophrenic aspects should always be considered when excluding any substantial health conditions (American Psychiatric Association, 2013). Psychosis is a complete loss of the ability to test reality. Individuals experiencing a psychotic episode may have hallucinations, delusions, and many other psychological symptoms. Some severe cases of depression and bipolar disorder (as well as many other disorders) may have psychotic features. Physical illnesses may also create symptoms that appear like psychosis. Therefore, the prevalence of such behavioral disorders places an economic and social burden on society. Studies estimate the direct and indirect cost of schizophrenia alone in 2013 was \$155 billion, with a rate of \$44,773

per individual with the disease. The cost of schizophrenia to law enforcement was estimated at \$7 billion in 2013.

The incarceration costs for patients with schizophrenia are estimated at over \$6 billion in emergency room care. The figures provided only represent schizophrenia as one illness with the psychotic feature but not other disorders such as bipolar or major depression (Cloutier et al., 2016). In Europe and the United States, research was conducted on FEP, the cost to society, and the various evidenced-based practices used to treat this challenge. Given this abundance of research, there were no challenges in obtaining research and resources for this study. As the lead public health advisor/program manager for the FEP initiative, the researcher is familiar with the topic, the grantee programs implementing FEP programs, and the government agencies working with state entities required to oversee fidelity to the program.

### **Background of the Problem**

According to the NIMH (2019), “Nearly one in five U.S. adults live with a mental illness” such as depression, bipolar disorder, and anxiety disorders (p. 1). Compared with non-LatinX Whites, racial and ethnic minorities have less access to mental health care, are least likely to be given a diagnosis of mental illnesses, and have meager mental health outcomes. This study addressed the impact on engagement and treatment outcomes of racial and ethnic minorities in evidence-based government-funded, coordinated specialty care programs for FEP. The study may also shed light on contributing factors for positive and negative outcomes for minority individuals.

Early intervention programs have been selected to connect current provisions to eliminate gaps among adolescents and adult mental health services. Essential

interventions comprise case management, individual or group psychotherapy, workforce development, educational services, family support, and minimal prescription quantities of restricted antipsychotic proxy's (R. K. Heinssen & S. Azrin, personal communication, January 4, 2019). Therefore, coordinated specialty care (CSC) uses a team of health professionals and specialists who work with clients to construct a personal treatment plan based on the clients' life goals and preferences.

This study examined data to identify how access to specific treatment approaches work best for minority individuals with FEP. It may add to the literature of evidenced-based practices used to lessen adverse health outcomes and disparities in minority communities. Additionally, this study contributes to the literature as one of the few studies conducted in the United States on the government-funded CSC of FEP with an emphasis on differential treatment outcomes for racial and ethnic communities. Recognizing that FEP treatment programs are effectively used in Australia, Canada, and the United Kingdom, Congress directed funds to develop evidence-based treatment models to present to states.

### **Problem Statement**

Despite the availability of effective treatments, ethnic groups do not access FEP programs at an equal rate despite having similar rates of mental illness among ethnic groups. Research demonstrates (Agency for Healthcare Research and Quality [AHRQ], 2016) that racial and ethnic minority groups are less likely to receive mental health care. An understanding of racial disparities in mental health care has significant effects on the progression of real methods in cultivating health and diminishing inequities. Williams and Sternthal (2010) specified racial and ethnic minorities with amplified elevations of

adversity encountered racial inequality. The probabilities of racial injustices in health require an examination of systematic evaluation to which work-related conditions of racial and ethnic minorities contribute to theories of social experiences (Williams & Sternthal, 2010). For example, in 2015, of adults with any mental illness, 48% of Whites received mental health services, compared with 31% of Black and LatinX Americans, and 22% of Asian Americans (AHRQ, 2016). Many reasons (Fiscella & Sanders, 2016) for this disparity have indicated that mental illness perpetuates substantial stigma, such as lack of insurance, underinsurance, cultural bias, and inadequate support for mental health services; therefore, seeking treatment is not always encouraged with minority communities.

The federal government's role in mental health services not only comprises regulating systems and providers and protecting the rights of consumers but also providing funding for services and resources to support EBPs to address the problem. Congress examined the prevalence of psychosis, the economic and social burden on society, and the enormous gap in meeting the needs of diverse communities in 2014. In essence, Congress required SAMHSA to set aside 5% of the mental health block grant allocations to address outreach and treatment of individuals with an early serious mental illness and those who had experienced a FEP. In 2016, Congress increased this and set aside 10% and required states to establish an evidence-based treatment to improve client outcomes. Out of this requirement came an emphasis on CSC programs, a standard treatment program created primarily for adolescents and young adults (15 years old to 30 years old) that incorporates a team-based, multicomponent approach to diagnosing and treating FEP (SAMHSA, 2016).

### **Purpose of the Study**

The purpose of this study was to understand racial and ethnic minorities underutilizing mental health services and also describe the differential access rates for treatment services in first-episode psychosis government-funded, coordinated specialty care programs. The best practices in the literature have focus on shared areas, specifically about how effective it is to communicate with diverse patient populations and improve relationships, best practices, and health outcomes. This research explored the effects of mental health services in meeting the needs of racial and ethnic minorities and the importance for the federal and state government to incorporate policies to educate, outreach, and build a diverse workforce in the mental health system while eliminating disparities.

### **Research Question**

The research question for this multiple case study design investigated access disparities for racial and ethnic minorities in seeking mental health treatment for FEP program funded by the federal government. The research question for the study was the following:

How have government-funded coordinated specialty care programs attempted to address racial and ethnic minorities' underutilization of mental health services?

This study focused on disparities in mental health outcomes, unmet needs, the social burden on society, and substantial gaps when gathering the demands of diverse populations. A qualitative multiple case study was used to explore the phenomena through the use of a replication strategy to attain parallel results.

## **Overview of Research Design**

A qualitative methodology was performed. The qualitative method adopted for this study included naturalistic observation and interviews. Conducting this study, the researcher viewed several aspects of the phenomenon by accessing the thoughts and feelings (Sutton & Austin, 2015) of FEP government-funded CSC program providers. Also, including program administrators, health care professionals, CSC team leaders, and state behavioral health authority representatives permitted the development, understanding, meaning, and experiences these participants encounter. No individuals receiving these resources were used in this study. This means that the focus was on how providers address the disparities of individuals seeking these services. The exploration of the FEP government-funded CSC program participants' behavior focused on the understanding of how individuals come across racial and ethnic minorities being served in FEP government-funded CSC programs. Case study research examines significant actions that are unable to be influenced; therefore, utilizing this method was useful for this study because of its valued tactic of examining the environment surrounding (Rowley, 2002) FEP government-funded CSC programs.

The study sample population comprised three out of 290 state FEP government-funded CSC programs. The researcher interviewed 13 participants from three identified FEP programs.

## **Significance of the Problem**

The significance of this study is that it examined how government-funded evidence-based specialty care programs are addressing disparities in mental health outcomes for racial and ethnic minorities receiving treatment, stigma, limited support

within impoverished neighborhoods affected by inadequate health insurance, insufficiently diverse workforce, outreach, and policy implementation. This study focused on racial and ethnic minority communities enduring a more substantial burden from unmet mental health needs and thus undergoing a more significant loss to their overall health and productivity (Health Equity and Accountability Act of 2018; H.R. Res. 5942, 2018). The study focused on program efforts to effectively address racial and ethnic minorities' underutilization of government-funded FEP programs. Research has shown that outreach and the early identification of FEP and effective treatment engagement in government-funded specialty programs are essential to shortening the duration of untreated FEP and averting the functional deterioration common in psychotic disorder (NIMH, n.d.-b). In essence, the focus of this study was on how programs address equity issues discovered in the trends discussed earlier. Health care professionals within the study consisted of Asian American, Black, LatinX, White, and Asian-Pacific Islander. The overall aim of this study was to help public health administrators and policymakers understand how the delivery of government-funded services relates to individual client outcomes for minority communities, and whether such programs improve health outcomes for racial and ethnic minorities. The researcher examined and identified whether environmental and contextual factors related to the implementation of FEP government-funded CSC programs impacted.

### **Definitions of Terms**

The terms listed are defined to assist the reader in understanding the context of each term in this study.

**Agency for Healthcare Research and Quality (AHRQ).** An operational division (OPDIV) under the U.S. Department of Health and Human Services responsible for cultivating the protection and quality of America's health care network. AHRQ assembles data, instruments, and information required to advance health care networks, that aids the American population, along with health care providers, political officials who generate well-versed health care resolutions (AHRQ, 2014).

**Communities.** A common characteristic of interests existing in a social, religious, occupational, cultural and historical tradition, shared government, or individuals living in one setting.

**Community mental health block grant (MHBG).** A nondiscretionary grant which supports state authority and systems grantee to deliver, policies, and resources required through comprehensive community mental health services (SAMHSA, 2017).

**Coordinated specialty care (CSC).** A recovery-oriented treatment program for individuals with first-episode psychosis (NIMH, n.d.-a). CSC encourages joint decision-making and uses a team of health care professionals working with clients to generate a personalized treatment strategy. The health care professionals offer psychotherapy, medication management geared to individuals with FEP, family guidance and advocacy, case management, and work or educational support, depending on the desires and preferences of each person. The patient and health care team work together to ensure treatment outcomes, involving family members as much as possible. A connection between the client and the CSC team immediately develops once the psychotic symptoms begin (NIMH, n.d.-a).



**Differential.** Relating to diversity, a national origin, color, religion, socioeconomic status, or sexual orientation.

**Disparities.** The difference and inequity of diversity, race, culture, socioeconomic status, gender, and age.

**Early serious mental illness (ESMI).** Impacts a person experiencing the first onset, which comprises the first episode of psychosis where the individual can encounter symptoms that include problems in judgment, reflection, attitude, and social functioning (SAMHSA, 2020-b).

**Equity.** The value of being reasonably impartial and fair.

**Ethnicity.** A group of people partaking of a mutual and unique culture, belief, linguistic, origin, and being a part of an ethnic group. Ethnicity is also a group that is a minority within a superior society and traditions of the group's region.

**Evidence-based practice (EBP).** Known as a combination of medical knowledge, client principles, and reliable research data favorable toward the decision-making methods for a client's care (NIMH, n.d.-a).

**First-episode psychosis (FEP).** When someone experiences psychotic symptoms or a psychotic episode for the first time in his or her life (SAMHSA, 2014-b).

**Health care.** A revitalization, treatment, prevention, and management of the mind and body through health services and resources offered by health care professionals.

**Inequality.** Unfair and unjust with the lack of equity.

**Institute of Healthcare Improvement (IHI).** IHI's mission is to improve and circulate scientific data to enhance human health care. The institute offers independent,

appropriate, respected material and guidance on health and science policies to public and private sectors, professionals, and the public (IHI, 2019).

**Mental health.** A psychological adjustment and preservation to a person's health.

**Mental illness.** Develops from an individual with abnormal behavior, emotions or thoughts and causes distress to themselves and others (NIMH, 2019).

**Minority.** A group in society that is interconnected to a smaller majority in a dominant population, for instance, racial, ethnic, religious, social power, or financial.

**National Institute of Mental Health (NIMH).** One of 27 institutes under the National Institutes of Health, which is an OPDIV under the U.S. Department of Health and Human Services. NIMH is the prime research agency for mental illness (NIMH, n.d.-a).

**National Institutes of Health (NIH).** Identified as the world's largest biomedical research agency and OPDIV under the U.S. Department of Health and Human Services (NIH, n.d.-a, n.d.-b). NIH produces essential findings that enhance health and quality of life.

**Outcome.** A result or issue following an action.

**Racial.** A group of individuals related to shared ancestry or genetics, for example, skin color, lineage, or shared culture.

**Recovery After an Initial Schizophrenia Episode (RAISE).** NIMH defines RAISE as a significant research program that originated with dual studies evaluating various components of CSC treatments for people who were experiencing FEP (NIMH, n.d.-a). The first research aimed at whether or not the treatment was effective. The second study analyzed the best approach for clinics to commence with using treatment

programs. The objective “of RAISE was, and is, to help decrease the likelihood of future episodes of psychosis, reduce long-term disability, and help people to get their lives back on track so they can pursue their goals” (NIMH, n.d.-a, p. 4).

**Serious mental illness (SMI).** A mental, behavioral, or emotional disorder resulting in serious functional impairment, which impedes or constrains one or more essential life activities (NIMH, n.d.-a). These represent 40% of the American adult population.

**Specialized treatment early in psychosis.** Makes available all-inclusive treatment for individuals who suffer from early psychotic illness (Srihari et al., 2015). Early intervention in psychosis is an evidence-based practice that helps improve positive life outcomes of those with psychotic illness (Srihari et al., 2015).

**Stigma.** A characteristic of a disease, mental state, blemish, or criticism from individuals who label and dishonor one’s reputation.

**Substance Abuse and Mental Health Services Administration (SAMHSA).** A federal OPDIV under the U.S. Department of Health and Human Services “that leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance use disorders, and their families” (SAMHSA, 2020-a, para. 1).

**Treatment.** An action or behavior concerning an individual receiving medical aid, medicine, and pain management.

**Web Block Grant Application System (WebBGAS).** Where state mental health authorities and single state agencies can submit applications through an electronic application system (SAMHSA, 2017).

## **Organization of the Study**

The analysis in this study describes a variety of factors influencing racial and ethnic minority disparities in mental illness, identifying inequitable access to care and quality of care. Brondani et al. (2017) indicated the stigmatized social perspectives causing racial and ethnic minorities to postpone health care services that could ultimately cause illness progression. Mental health services are highly fragmented; this study determines the differential treatment of successful or unsuccessful outcome measures for minority communities. The results of this study will provide FEP government-funded CSC programs, health care professionals, state administrators, CSC team members, and peers, an opportunity to identify and eliminate mental health treatment disparities among racial and ethnic minorities.

Additional chapters are included in this study. Chapter 2 is a thorough review of the literature on health inequalities from general health care, mental health care, FEP, and policies detected and implemented to reduce disparities in standardized health and mental health treatment outcomes. Chapter 3 discusses the qualitative research methodology, provides a narrative description, phases of the research method, and the fundamentals of how the research was conducted. Also, Chapter 4 emphasizes the research outcomes, and Chapter 5 integrates the analysis and findings and concludes the research by presenting a summary of the overall study, implications, considerations, lessons learned, limitations, and any further expected proposed research.

## CHAPTER 2: REVIEW OF THE LITERATURE

This chapter presents the literature describing the effectiveness of programs that provide support for individuals experiencing first-episode psychosis (FEP). This study specifically focuses on three FEP government-funded coordinated specialty care (CSC) program sites from three states to identify successful or unsuccessful treatment outcomes regarding health disparities distributed among racial and ethnic minorities. The literature reviewed in this study examined the practical elements of differential treatment outcomes from overall health and mental illness, early serious mental illness, and policies identified and generated to diminish disparities in health and mental health care by and large. Although health and mental health care commonly differ in outcomes, one component identified is that generally, physicians tend to hold a belief about racial and ethnic minority culture and family dynamics of the patient's living situation or livelihood during a scheduled or unscheduled doctor's visit. Another general component is how effective health care professionals communicate with racial and ethnic patients and desire to establish and improve relationships, best practices, and treatment outcomes. In the remaining section of this study, the researcher identifies gaps in health care by identifying how culturally tailored interventions meet the needs of racial and ethnic minority patients. The gaps are identified by employing multidisciplinary health care provider groups and targeting patients' pathways to suitable and quality care. To meet the needs of racial and ethnic minority communities, it is imperative to encourage impoverished communities to seek and utilize mental health services. Also, it shows how the government is dedicated to outreach, educating, and developing a diverse workforce to eliminate disparities by creating and enforcing policies.

Health equity emphasizes the importance of understanding and addressing avoidable inequities as well as appreciating how historical and out-of-date injustices shape the unequal distribution of health and health resources across racial and ethnic minorities. Racial disparities in the literature frameworks address racial and ethnic disparities in health, which include a burden placed on the population (Dobalian & Rivers, 2008). The critical examination of the literature about disparities suggests vital elements that need to be addressed to achieve health equity. Mental health issues, from an ecological perspective, attend to several determinants, which involve a system of development using a cyclical and interactive process of disseminating results that involve a process and commitment to sustainability by addressing issues of race, ethnicity, racism, and social class (Reupert, 2017). By adapting and achieving health equity across health outcomes, critical race theory (CRT) implores individuals to be thoughtful about elements that address health disparities. The theoretical and methodological framing of race and racism is vital rather than secondary to health disparities, drawing attention to how disparate health outcomes are produced by specific social, economic, political, and legal measures rather than simply being a natural part of society (R. J. Cramer & Kapusta, 2017).

The chapter begins with the theoretical framework for the research study, which entails the CRT and the social-ecological model. The CRT is from the epistemic philosophy, which examines society and culture linking elements to classifications of race, law, and power (Delgado & Stefancic, 2012). Bell, Freeman, and Delgado established CRT to gauge insight on the impression of racism among racial and ethnic minorities (Delgado & Stefancic, 1993). In CRT, the aim is to understand and recognize

victims of systemic racism that is being influenced by the cultural interpretation of race and how individuals embody prejudicial actions. CRT shows how racism remains prevalent throughout this society but how people who are racist are determined to dismiss racial and ethnic minority civil liberties that were pledged by the U.S. Constitution. CRT not only pleads to racial and ethnic minorities affected by racism but also individuals who commit and are unaffected by racial discrimination (Utecht, 2014).

The social-ecological model developed by Uri Bronfenbrenner's (1977b) supports a multilevel approach to mental health disparities. The aim is to critically review and appraise the usefulness of the ecological approach in research and practice on mental health intervention planning, implementation, and evaluation. The researcher analyzed the applied ecological model by examining the literature on the determining factors and intervention approaches on a few analyzed themes, such as stigma, cultural influences, poor communication, policy practices, and perceptions among health care professionals and program staff. The researcher examined the literature and the usefulness of the ecological model to conclude whether any recommended practices, program planning, or evaluation are recommended for further research.

## **Theoretical Construct**

### **Cultural Race Theory**

CRT is a framework examining dominant structures conserving racial inequities and creating policies for action and change. Racial and ethnic disparities in the United States are endless despite the progress and deterioration of recognizable racism and discrimination (Cole, 2009). Racism continues through systems, guidelines, programs, and policies embedded among community businesses, private industry, government,

health care systems, and neighborhoods that steadily reproduce and generate inequality. Therefore, CRT uncovers and adjusts the correlations involving race, racism, and power (Kolivoski et al., 2014).

CRT is a technique focused on equity when conducting research and delivering knowledge and practical outcomes (Ford & Airhihenbuwa, 2010). CRT highlights the recent discussion of race and racism in the United States. It is essential to understand CRT and the constant cycle within society and the impact it has upon race and mental health disparities (Ford & Airhihenbuwa, 2010). CRT is attributed to an inclusive framework connecting the understanding of racial concepts and phenomena, along with the essential exploration of the knowledge process, that engulfs community involvement (Airhihenbuwa & Liburd, 2006).

Race is considered a natural disposition for individuals that are prejudiced toward a particular action (Andersen, 1995; Ford & Airhihenbuwa, 2010). The perception of race implies that the racialized perspectives would be appropriate to study racial and ethnic minorities accessing FEP services, because of the inequity practices of the mental health care system and stigma linking mental health services and racial and ethnic minorities. The public concept proposes several racial and ethnic minorities to endure social situations inversely (Ford & Airhihenbuwa, 2010). The researcher abstracted the community setting as racialized toward racial and ethnic patients and impoverished communities, which explains the unsettling incidents encountered by racial and ethnic minorities within this society.

CRT is adapted to utilize universal topics of public health practices when advocating social equity issues targeting racial and ethnic health injustices (Ford &



Airhihenbuwa, 2010). The framework for the CRT concept constructs on the drive, performance, and support for maintaining health equity (Ford & Airhihenbuwa, 2010).

The connection between social disparities in accessing mental health and the underprivileged racial and ethnic communities is recognized but elusive (Myers et al., 2015). The social determinant of health and mental health disparities, specifically discrimination, descends from socioeconomic hardship, employment, education, impoverished neighborhoods, access to mental health care, and cultural competence (Noonan et al., 2016). Race is an issue in health disparities that are not regulated by age, sex, and education (Paradies et al., 2015). In the United States, racism is a systematic, prearranged collective cultural phenomenon stemming from social and health disparities, demonstrated as similarly adjourning elements affecting mental health, that is not often explained (Paradies et al., 2015). Because racism is a significant phenomenon prompting racial and ethnic minority mental health disparities and most often exercising its threatening impressions through existing systematic humiliation and exclusion (Noonan et al., 2016), racial, community and gender inequalities are interconnected and deliver racial and ethnic minorities minimal health care compared to Whites.

Generally, systematized racist customs and traditions are replicated by White public officials, decision-makers, public administrators, educationalists, and health care professionals (Noonan et al., 2016). Discussing “health inequalities,” “cultural competence,” and “racial predisposition” at a single level within health care services neglects the public, influential, and structural level, causing health disparities among racial and ethnic minorities. At the singular level, this focus transformed into the

unsatisfactory allocation of resources to racial and ethnic minorities (Feagin & Bennefield, 2014).

Research into racial and ethnic minority health issues is both inadequate and prejudiced (Stockman et al., 2015). The standard description of racism as a cause of health disparities should be neutralized by equivalent universal measures through public programs, profitable endeavors, criminal system reform, shrunken exclusion in places of official authority, more comprehensive research, and suitable funding of public agencies and health care organizations (Noonan et al., 2016). In essence, policies of government-funded FEP programs, private health practices, and facilities serving racial and ethnic minorities are frequently regulated by public and private sector officials with minimal to no health care education. Properly trained and knowledgeable health care providers must educate, develop, and put into action health policies as they assess the implementation. With these elements, communities, health care professionals, and racial and ethnic minorities must understand political principles are critical in the constant campaign to expel the disparities in mental health outcomes in the United States that brings together racial dissimilarities (Noonan et al., 2016).

CRT is known for its body of work to seek and understand change among race, power, and racism. Because CRT is a novice in the public health field, the conceptual framework examines the inequalities in health and the role they play in racism (Noonan et al., 2016). In this study, CRT addresses the racialized structures of communities, theories, and the promotion of health equity. Focusing on race and racism, the researcher recognized how public mental health has perpetuated racial inequalities.

Ginwright (2010) explored radical therapy or treatment as a method for reestablishing the mental health and well-being of racial and ethnic minorities subjected to never-ending hardship, racism, and aggression. Ginwright's therapy comprises fostering a vital awareness of social repression, which counteracts depression and distrust to challenge racism and comparable practices of harassment. The revolutionary therapeutic method must also incorporate government agencies, private industry, and community organizations, offering essential opportunities for racial and ethnic minorities to connect with surrounding communities and participate in public events that deal with community challenges (Ginwright, 2010). Having a relationship with society confers racial and ethnic minorities an elevated consensus of purpose by affording them with prospects to form significant connections and aid them to expand their abilities to generate social change. Extreme therapy could offer racial and ethnic minorities healthier adaptation over mental health adversities that stem from racial repression by promoting optimism, determination, and intervention, which are important qualities for forming and safeguarding mental health. To conclude, the practice of therapy entails a positive, tangible relationship to racial and ethnic minority lives and to the methods of recovery to improve cultural competence, mental health disparities, health care provider representation, stigma, language barriers, and access to mental health services.

### **Ecological Model**

Mental health is a vital element of overall health. To enhance proper health care, countries all over the world must improve prevention and identify mental illness as a public health issue (World Health Organization [WHO], 2011). A comprehensive public health viewpoint is warranted when promoting mental health and preventing mental

illness (Degenhardt et al., 2009). Public mental health emphasizes the societal factors of health and wellness while creating efforts to produce positive mental health care for everyone (Jane-Llopis et al., 2005). Most theories identify elements among health disorders and illnesses that lead to the preparation and strategy of public mental health interventions and mandate public mental health policy and practices that are necessary to incorporate these elements (Krieger, 2014). Bronfenbrenner was instrumental in the ecological model when it came to health research (Rosa & Tudge, 2013).

Lewin and Bronfenbrenner created the ecological theory as a novel theoretical framework to comprehend human growth (Bronfenbrenner, 1977a). During the late 1970s, Bronfenbrenner went through several phases until his demise in 2005, developing what is now known as the ecological model. Bronfenbrenner's creation, the ecological model to understand human growth, influenced a variety of subjects, including health research (Grzywacz & Fuqua, 2000; Richard et al. 2011). The evolution of Bronfenbrenner's model includes an ecological method, a human growth perspective, and the development of individuals (Rosa & Tudge, 2013). Bronfenbrenner's (1977a) model urges the conceptual tool for leading intervention throughout the field of public mental health.

The consequences identified for public mental health policy and practice fluctuates when a particular perception is applied and administered. Even though Bronfenbrenner acknowledged the latest form of his model as the most appropriate, researchers follow a practical assessment of information and philosophy, believing his previous model is suitable for conducting public mental health interventions (Bronfenbrenner & Evans, 2000). The ecological model is known for improving access

to specialized care at multilevel interventions. The model presents five interdependent levels of factors hypothesized to influence access to care (Eriksson et al., 2018):

1. Individuals
2. Microsystems
3. Organizations
4. Localities
5. Macrosystems

### ***Individuals***

Individual factors, ranging from biological factors (e.g., genetics and neuroanatomy) to psychological factors (e.g., self-efficacy and cognition) and social factors (e.g., perceived social support), influence human behavior. Many individual factors influence access to specialized care among individuals with FEP, including the severity of psychiatric symptoms and mental health illiteracy (Norman et al., 2004). These barriers can hinder an individual's willingness to seek treatment because of paranoia and delusions. Disparities in mental health literacy and discouraging views of mental illness are obstacles often faced by racial and ethnic minority individuals who have FEP (Deupree, 2017; Norman et al., 2004). By incorporating mental health literacy, individuals can distinguish their mental health problems and understand the risks and causes of their psychosis when seeking appropriate treatment (Norman et al., 2004). Damaging perceptions, internal barriers to mental health care such as shame, guilt, and self-stigma can also deter mental health treatment and assimilate low self-esteem in the treatment process. Negative images and labeling of racial and ethnic minority individuals with serious mental illness (SMI) generate the intensity to which lower socioeconomic

status and workforce development are related to mental health and the increased risk of mental illness for racial and ethnic minority individuals (Wile & Goodwin, 2018).

Studies indicate that one third of individuals with FEP lack interest in receiving treatment and feel overwhelmed with the process of initiating care or acquiring too many steps when finding mental health treatment (S. I. Reed, 2008). Racial and ethnic minority individuals with FEP become cautious when seeking treatment and, if detected as the only mechanism of managing their symptoms or conflicting with their goals, pursuing treatment care alternatives (Anderson et al., 2013).

### ***Microsystems***

Microsystems are unique and distinctive to individuals; as such, racial and ethnic minorities commonly embrace relationships with their friends, family, and associates and participate in other day-to-day undertakings (Addington et al., 2008). Among racial and ethnic minorities with FEP, examples of microsystems that include disengagement from peer systems and misguided support from family, associates, and health care professionals could impede access to care (Addington et al., 2008). Also, transitioning from psychiatric facilities creates challenges for racial and ethnic minorities when returning to impoverished neighborhoods, community mental health programs, and a misdiagnosis of their early serious mental illness conditions (ESMI; T. G. McGuire & Miranda, 2008). Other factors consist of preventive interventions for ESMI. Some factors include depression; psychosis; anxiety that is not diagnosed or is untreated; and the lack of support, care, and treatment options for racial and ethnic minority adults and young adults (Horan et al., 2008). The elements described inhibit communication and access to treatment and alter relationships from the changed behavior of mental health

professionals toward racial and ethnic minorities suffering from ESMI, which could cause hesitation to ask for assistance from known associates and health care professionals (Anderson et al., 2013).

### ***Organizations***

The organizations factor refers to the government-funded CSC programs that contain an assortment of microsystems. Patterns of barriers may include disparities and the provision of care, including minimal collaboration between doctors and patients, inconsistent evidence-based practices (EBPs), limited representation, and treatment programs. The environment of the FEP government-funded CSC programs can impact the readiness of racial and ethnic minorities to establish and continue with care. Negative impressions of a patient's doctor because of limited understandings of necessary health information ultimately hinder patient outcomes (Vernon et al., 2007). To decrease patients' misunderstanding of health information, health care professionals are recognized as "they outreach, educate and guide patients of 'why' they need to exhaust medical services, and resources are vital when educating on why they need to retain health resources and services" (Deupree, 2017, p. 1). Many government-funded coordinated specialized care programs typically do not observe the outcomes of racial and ethnic minorities participating in their services. Among the 290 FEP government-funded CSC treatment programs within the United States, only a few revealed data indicating the benefits of their ESMI programs (Moe et al., 2018). The way each FEP government-funded CSC program creates intraorganizational relationships impacts access to care for racial and ethnic minorities with FEP. Successful methods will fluctuate based on doctor-patient behaviors within each program and a common goal of

streamlining referrals for eligible racial and ethnic minorities to specialized FEP treatment programs as well as providing appropriate integrated consultation and care (Partin & Burgess, 2012).

### ***Localities***

The localities factor defines a system of organizations optimizing access to elevated quality care for racial and ethnic minorities with barriers including lack of specialized care teams, the impact of institutionalization, and the inadequate direction of outreach, education, and communication among mental health stakeholders. Also, limiting access to services, the complexities of disproportionate and underrepresented services, and other pertinent programs in impoverished communities are factors of organizations accessing care (Chow et al., 2003; Eack & Newhill, 2012). Better quality of specialized treatment care for ESMI is essential in racial and ethnic minority communities. By improving doctor-patient consultation and patient-centered attitudes, an organizational change of interaction and addressing disparities play a key role in reducing health disparities among racial and ethnic minorities (Partin & Burgess, 2012).

### ***Macrosystems***

Macrosystems is the final step from the ecological model. Macrosystems are categorized by cultural influences, such as attitudes about change, stigma, disparities in approaches to care, and the economic impact of mental health in racial and ethnic minority outcomes (Wahowiak, 2015) in addition to policies and practices, discrimination, and lack of social acceptance for individuals faced with mental illness (T. G. McGuire & Miranda, 2008). Despite advances in mental health treatment, there are still significant economic disparities, stigma, and inconsistent policies on how the



treatment is delivered to racial and ethnic minority groups. The need for innovation and creativity in specialized treatment outcomes is warranted and vital when improving access to quality care.

The study utilized the ecological model to examine effective interventions (Stokols, 1996) to address disparities in racial and ethnic minority mental health. From a public health administrative perspective, the ecological model is effective as it encompasses a broad context that includes the micro- and macrolevels of society (McLaren & Hawe, 2004). This lens is essential for the development of relevant public policy and health care governance. Social-ecological theories originated from several specialties where health research inspired the community, developmental sensibility, and psychology (Richard et al., 2011).

The ecological model aligns with the methodology utilized in this study that allowed the researcher to conduct a qualitative survey of FEP government-funded CSC programs. The researcher identified the differential contributing factors of successful and unsuccessful outcomes affecting quality services to racial and ethnic minorities served by FEP government-funded CSC programs. Applying a qualitative method also reduced the partiality of actions and increased the rationality within the research. Understanding disparities for racial and ethnic minorities suffering from SMI is crucial when promoting quality health care.

In essence, the differential treatment outcomes in racial and ethnic minorities is a critical element to examine to identify opportunities for improving care. Navigating this process will instruct additional efforts to position the FEP government-funded CSC programs effectively in racial and ethnic minority communities. The model presented

optimizes a guide for further research examining factors accessing treatment outcomes among racial and ethnic minorities.

### ***Ecological Model Integration***

The ecological model brings an understanding to the study of public administration and its interrelated elements of social and cost-effective structure, its philosophies, merit systems, and antiquity (Peng, 2008). Constructing these elements, allows the community systems to develop instead of changing suddenly. Riggs's theoretical approach identified how ecology develops a community of systems that often generate alternative systems and organizations (Peng, 2008). Therefore, the ecological approach solidifies relationships between individuals and their environment. The relationship between public administration and the ecological theory offers detailed information that clarifies and forecasts the behavior of public administrative organizations, which permits the ecological method to report data that can be corrected. Because the ecological model is a construct of public administration, it also examines programs, policies, plans, and the design of public administration; these effects initiate the ecological construct, interrelationships, and living mechanisms in its environment (Gaus, 2009). For years, an individual's intuition and expertise of how relationships develop have been established from a public administration ecological approach. Understanding these mechanisms shows how individuals can understand what needs to be done and addressed within government affairs, public positions, and operational glitches. As a result of their understanding, individuals and public organizations would successfully implement, operate, and understand the ecological methods of government. Gaus's identification of these elements generates public administrators under the

ecological factors that properly focus on the demands and challenges of the external environment of their organizations (Gaus, 2009).

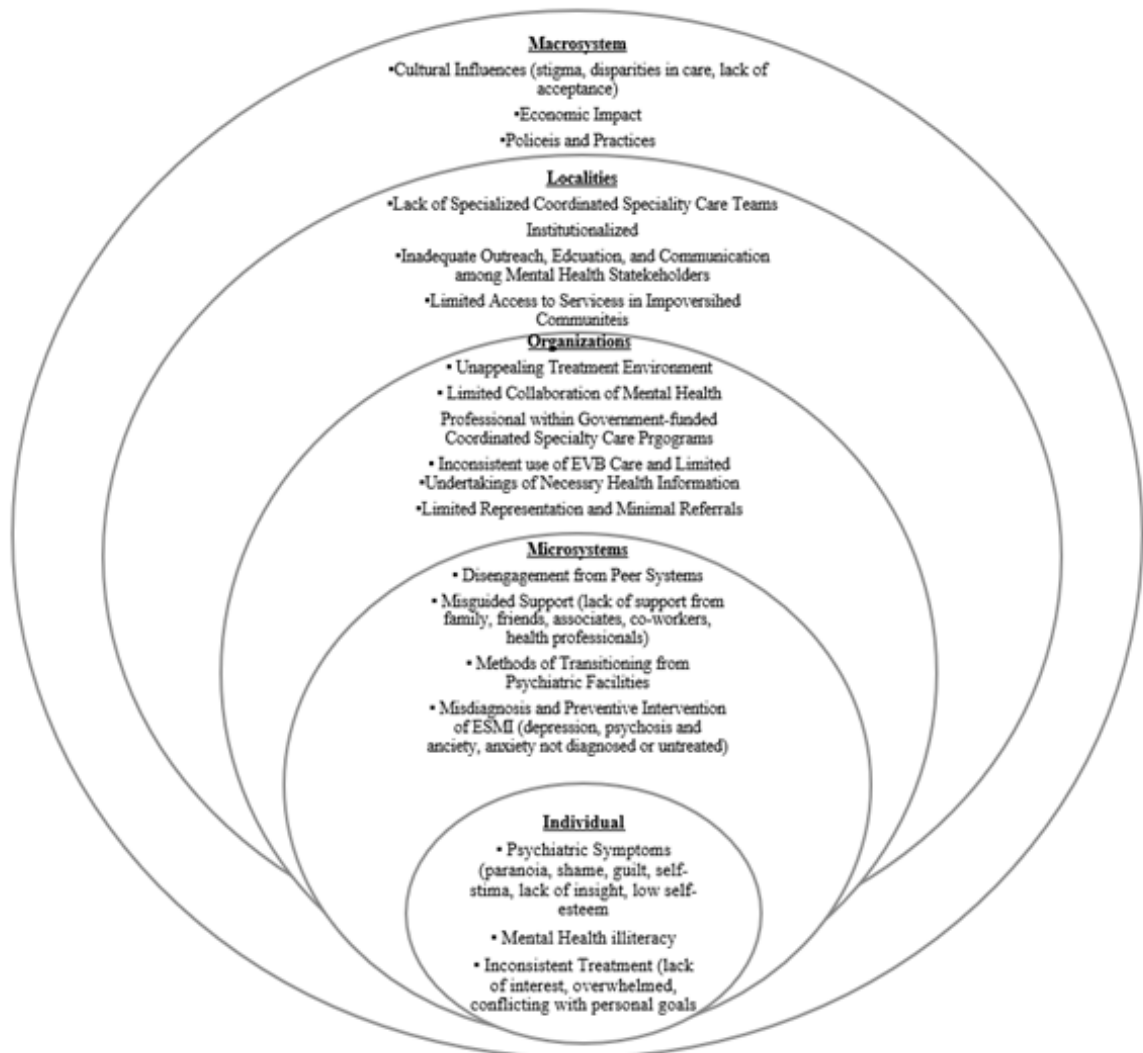
There is an aspect of social ecology reflecting an existent system of racial classification among different groups within this society, and hegemony addresses that through the supremacy of one race over another, which is supported by legitimizing customs and philosophies (C. P. Jones, 2002). When identifying how race impacts health, the researcher looked at institutionalized racism and personally mediated racism. Institutionalized racism stems from bigotry, racial prejudice of individuals through the existence of policies and practices that effectively weaken racial and ethnic minorities. Institutionalized racism can only exist in institutions where control is applied and continuous practices are capitalized. For instance, Black Americans are almost two thirds less likely than White Americans to have health insurance, which impacts health care accessibility. Institutional racism affects racial and ethnic minority health through health-related policies exposing greater health and environmental risks for this group (C. P. Jones, 2002).

Personally mediated racism comprises certain behaviors and attitudes inherent to racially prejudiced actions, discrimination, and stereotyping. Often, this can be intentional or unintentional. Personally mediated racism exhibits minimal respect, suspicion, devaluation, and dehumanization of racial and ethnic minorities (C. P. Jones, 2002). By confronting institutionalized and personally mediated racism, community leaders must address racial disparities in health, employment, education, and economic segregation but essentially keep the subject of racism in the political forefront. Another way is to engage health care professionals, elected officials, the criminal justice system,

and educators on the impact of how racism is functioning within racial and ethnic minority communities—implementing these methods warrants motivation and determination in hopes of success for social justice and health equity. Therefore, the need for innovation, policy, vision, and inventiveness is warranted and vital when improving quality care (C. P. Jones, 2002). Figure 1 shows the five phases of the ecological model.

**Figure 1**

*The Ecological Model*



## **Inequalities in General Health Care**

Nearly half of Americans are challenged with understanding and receiving health care, obtaining their medication, and gaining insurance information in addition to comprehending health care providers and professionals. Individuals with limited health literacy are least likely to be hospitalized, have access to or utilize health care, and least likely to adhere to disease management when suffering from a chronic illness. In this study, the researcher obtained articles to examine the inequalities of health care literacy. It is imperative to understand that effective communication is a crucial concern among diverse patient populations (Deupree, 2017). In Deupree's article, health literacy is a substantial component that was defined as an individual attaining, processing, and comprehending necessary health information and services by making appropriate health decisions. The article addressed the needs of racial and ethnic minorities when establishing and improving relationships, best practices, and health outcomes. Developing this framework improves health literacy that is impactful to patients' health and well-being, but considering a few barriers such as minimal communication with at-risk populations and EBPs related to racial and ethnic minority communities have been essential. According to the U.S. Department of Health and Human Services (HHS), nine out of 10 adults had a negative impression of their primary care physicians because of a limited understanding of necessary health information, which ultimately hindered patient outcomes (Vernon et al., 2007). The cost-effectiveness linked to the unnecessary health care expenses because of health illiteracy was calculated between \$106 and \$238 billion per year. Therefore, having health professionals outreach, educate, and guide patients of "why" they need to exhaust medical services and resources is vital when educating

patients on why they need to retain health resources and services. Critical elements that need to be understood and are associated with effective communication and patient knowledge have been the perception of auditory loss, verbal limitations, misconception, and intellectual deficiency when demonstrating health literacy and creating proper communication.

Sheikh's (2009) article examined racial and ethnic minorities and their views on quality primary care. The study found that elements of inequalities in health outcomes were complex, multifaceted, and not well understood, which moderately explained the constrained progress in reducing disparities. The analysis explained how a portion of the study misrepresented the differences of quality care received from surveyed patients expressing the disappointing delivery of primary health care services. In the study, Sheikh developed a General Practice Assessment Questionnaire that became a national patient survey for primary health care services that carried out featured framework outcomes. With certain restrictions, individuals were mindful of the proposed high expectations of care in racial and ethnic minority populations because of key factors from the perception of care. The researcher became aware that the data identified a proposed quality of care essential to the patients' reports. As residual differences and the perception of care ineffectively described basic elements, unfairness, and different experiences of health care treatment, it was important to receive compassion and personalized care appropriately in specified communities.

With cultural differences heightened and communication strained, racial and ethnic minority communities viewed primary care physicians more negatively than White patients because of poor experiences, poor communication, and lack of expectations

when evaluated and treated. Mead and Roland (2009) summarized the differences and quality of care received by racial and ethnic minority patients and White patients. The altering aspects of care rationalized well-known disparities in the United States and the United Kingdom. Also, they addressed cross-sectional exploration examining disparities among Whites and ethnic minority patients that recognized four primary care methods of administration, demographics, health, and wellness, and the proposition of reported treatment outcomes. Mead and Roland (2009) recognized substantial differences between Whites and ethnic minority patients continued after modifying scheduled appointments, which prolonged patient wait times. Once the office team and medical staff became aware of the disorganization and flawed communication, the outcome for Chinese and Black/Black British patients was received and corrected; however, Asian/Asian British patient assessments remained more than 2.5% lower than White patients.

According to Chin et al. (2012), over the past decade, researchers modified their emphasis from verifying health care disparities to pinpointing resolutions to close the gap in health care. Chin et al. assessed how systematic reviews, evaluating practices, providing technical assistance to health care organizations, and developing a roadmap reduced racial and ethnic disparities in health care. Chin et al. identified how culturally tailored interventions could meet the needs of patients by employing multidisciplinary health care provider teams and targeting patient's pathways of proper health care. The authors found how organizations should design, implement, and maintain interventions based on specific causes of disparities and their unique environments in addition to

recognizing that even with 10 years of research, additional studies were needed to conquer disparities successfully (Chin et al., 2012).

The inequalities of health care concerning racial and ethnic disparities have been examined by Partin and Burgess (2012) who conducted a study from the Department of Veterans Affairs Health Administration during 2000-2009; their designated intervention strategy clarified a framework of examined inequities and interrelated areas of “reducing health disparities” and “improving minority health” by influencing a mediation plan (p. 887). Within this study, Partin and Burgess also examined medical student behaviors, categorized relationships between patient-centered attitudes and clinical performance ratings among general patients identified as Black Americans but not general patients identified as White Americans. The research captured the perception of patient-centered attitudes were more important in improving physician behaviors with Black American patients than with White American patients, which played a significant role in reducing health disparities.

### **Health Literacy**

WHO defines health literacy as “the personal characteristic and social resources needed for individuals and communities to access, understand, appraise, and use information and services to make decisions about health” (Greenhalgh et al., 2015, p. 1). Minimal health literacy is linked to an insufficient encounter with health care, health education, lack of understanding, prescribed medicine, illness promotion, overall health condition, self-care, and simply staying alive. There is an overwhelming inequality in the acceptance and usage of health care. A few systematic reviews have combined several theories of health literacy including communication interaction, enthusiasm, self-



assurance, honesty, commitment, and attaining access to health care (Haun et al., 2014).

In the new age of study, health literacy is an evaluation of a person's knowledge and proficiency of a public health method that highlights the interreliant understanding of health, health approaches, actions, cultural elements, and strategy of administering health care (Parker et al., 1995).

Individuals with minimal health knowledge are often embarrassed and try to mask their health literacy from their health care providers and family. Even those who are educated with well-to-do backgrounds may not exude self-assurance or communication skills to ensure their health care needs are well defined when consulting their physicians and making decisions regarding their health (Jordan et al., 2010). This implies that even when health literacy needs are identified, addressing these requirements in certain populations requires attention throughout the health care system. WHO is incorporating and creating health literacy responsiveness, through which it will ensure health information and support are attainable and achievable to individuals with different levels of health literacy. Therefore, a community health literacy report could focus on the current health care system to eliminate health disparities by assessing and developing solutions (Sallis et al., 2008).

Health literacy comprises similar ideals. According to the HHS, health literacy is defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions” (Office of Disease Prevention and Health Promotion, n.d., para. 1). Sufficient health literacy can enhance an individual's ability to engage in their health and their family's health. Health illiteracy can cause volumes of difficulties within the health care system. People having

health literacy are unable to gather prescribed medicine, align medical group principles of health literacy, and the implementation of ensuring health education, support, and advising patient care.

Knowledge influences health literacy that is recognized more in impoverished communities and is identified with limited health outcomes. For instance, understanding health materials, inferring health care information, and increasing communication among health care providers are essential. The influence of inefficient health literacy could interfere with adult patients accessing health care, an increase in health care cost, and an increase of emergency room visits and hospital admissions; more than half the adults in the United States who did not graduate from high school experience inadequate health literacy. According to Healthy People 2020, disparities in health literacy affect racial and ethnic minorities from the various social and cultural level of classes (American Public Health Association, 2018). For instance, LatinX adults have the lowest health literacy average compared to all racial and ethnic minority groups, trailed by Black Americans, then Native Americans/Alaskan Natives. Individuals with little health literacy who identify English as a second language are more likely to convey poor health conditions. Culture and individuals at an older age are likely to experience health literacy challenges that cause intimidation to patients' competence in adhering to their doctor's directives. Older individuals with low health literacy often describe physical ailments, pain, restricted physical or daily activities with poor mental health. With improved practices, inadequate health literacy is a challenge and is often hard to distinguish. Inadequate health literacy is universal and challenging. Studies have shown patients, caregivers, and individuals with various educational and cultural backgrounds have trouble

understanding health information and effective communication from health professionals with straight forward instructions and explanations validating patients' comprehension while ensuring patients have an opportunity to maneuver the health care system easily, sustaining and enriching the patient's healthy living.

### **Cultural Barriers**

Even with significant medical development in a variety of chronic diseases, it has been suggested that racial and ethnic minorities acquire the minimum quality of care compared to White American patients. Racial and ethnic minority patients encounter heightened morbidity and mortality from certain chronic diseases compared to White American patients (Smedley et al., 2002). However, Smedley et al. (2002) proposed that social and ethnic disparities in health care stem from insignificant damaging outcomes. They recognized inequalities of racial and ethnic minority dissimilarities in the quality of health care with the inability to gain access to proper intervention, choices, and health desires. The journal in which their article appeared was updated with sources of disparities regarding impactful elements by assessing essential intercessions to lessen or remove racial and ethnic disparities in health care (Egede, 2006). Egede discussed three reports full of supporting elements to racial and ethnic disparities in primary and mental health care.

The initial study was performed in California, where over 50,000 respondents assessed the connection between insights of health care discrimination and the use of health services. In that study, nearly 5% conveyed some inequity (Egede, n.d.). For those individuals expressing discrimination who obtained insignificant preventive care services even with alleged discrimination, barely any changes reduced gender, racial, or

insurance disparities of preventive care (Egede, 2006). The second study by Huang et al. (2006) evaluated a section outline with levels of support, useful for well-validated patient health on depression among White American, Black American, Chinese American, and LatinX American primary care patients. The selection outline of ethnic groups determined a collective impression of hopelessness as an effective detention and monitoring tool for depression in a diverse population (Egede, 2006). The last analysis determined racial differences concerning innovative medical technology among 171 White and Black American patients. There were substantial racial dissimilarities as White Americans were more likely to receive new and advanced medical treatment than Black Americans to obtain new prescription drugs for their treatment plan. These findings were incredibly pertinent, and there were integral constraints on ethnic dissimilarities that were addressed. For instance, there were suitable data that the socioeconomic condition was a more robust element of health-related effects than racial and ethnic groups. Quite a few findings have revealed the influence of race and ethnicity on health outcomes that are often reduced considerably when a socioeconomic stance is ordered as racial and ethnic impressions fade away.

In Egede's (2006) study, inquiries arose concerning racial and ethnic disparities in health care because of the socioeconomic status, culture, and sometimes a combination of both. The assessment showed general health care from a genetic model considered race and ethnicity is a natural category distinguishing race and genes defined by health or the health and well-being of people defined by natural elements (Egede, 2006). In recent studies, a genetic makeup obtained by race and ethnicity instead of among racial and ethnic groups is a supplementary theory rather than an original concept. The perception

of race, though generally expressive, is of constrained natural inference. Also, the imperfections of race as a concept have setbacks with the validity and reliability of race evaluated in most research studies (Egede, 2006). With the growth of people from several racial groups, it is more and more problematic to categorize persons into a single race group, which obscures the understanding of race impacting research studies. Ethnicity is an alternative variable that is generally used in research on health disparities. The idea of ethnicity is an effort to expand different racial groups; however, similar to race, it conveys specific historical, political, and social baggage. Despite these restrictions, cultural origins, when joined with ethnic groups, offers more data for researchers to explain their understanding and rationalize its legitimacy, consistency, and stability. The perception of well-defined traditions commencing with race and ethnicity were intended as an improved justification for modifications in health performance and health effects.

A logical assessment of acculturation findings concentrated on LatinX American healthiness that included a few explanations of values, and in most instances, the definition of culture was unclear and vague (Egede, 2006). Regardless of the substantial restrictions of exploiting racial and ethnic groups, or values as prognostic and descriptive in health assessments, there are remnants to study cultural disparities in health findings. Potential evaluations associated with race, ethnicity, values, or acculturation and health findings should require an extensive link among these inconsistent health findings when offering a path correlation (Egede, 2006).

The outcomes of these evaluations emphasize the essential continuation of subsidizing the study on the perception of racial and ethnic inequalities in health findings.

Egede (2006) conveyed in the study how racial and ethnic dissimilarities affect health and how patient preferences impact medical decision-making, health evaluations, and findings. Often, research studies identified these elements precisely as they contribute to health care inequalities and outcomes (Egede, 2006).

### ***Cultural Barriers Among Black Americans***

Throughout the years, Black Americans' health inequities have been a cause of prejudices in American history and customs; for instance, Black Americans are likely to hold occupations that encompass hard labor, possess limited education, and experience bigotry in this society that has resulted in planned policies. Another barrier Black Americans are subjected to are the neighborhoods they live in; most often, their neighborhoods are saturated with liquor and tobacco stores, fast food restaurants, and pollution exposure, which causes unhealthy risk factors (Laffey & Ng, 2018). Health disparities are an unequivocal effect of strategies, techniques, customs, and lawful influential prejudices that safeguard White privilege at the expense of Black Americans' health and wellness. Social factors of health care are common causes of health disparity among Black and White Americans that remain constant.

The complexity of racial prejudice is a recognized distinction in health care that affects health care and the quality of health care obtained (Laffey & Ng, 2018). Cultural barriers in quality health care exhibit themselves in various ways, from commercial delivery, which affects the patient's ability to pay for health care services, an insufficient number of hospitals and health care facilities, few and far between health care providers, cultural biases in treatment services, and racial and ethnic upstanding care (Laffey & Ng, 2018). Randall (2017) mentioned that the life expectancy of Black women is 4 years less

than White women, and Black men's life expectancy is 6 years less than White men.

Black Americans are far more ill than White Americans and are expiring at a disturbing rate. Cultural factors affecting health care consist of socioeconomic status, impactful partisans, and lawful influences under which people live (Randall, 2017).

The pressure of surviving in an unfair society accounts for racial and ethnic disparities. Middle-class Black families experience modest health care compared to middle-class Whites. Middle-class Whites have been known to live 10 years longer than middle-class Blacks whereas impoverished Whites live 3 years longer than impoverished Blacks. Therefore, suitable government regulations must be accessible when abolishing prejudiced systems within health care (Laffey & Ng, 2018). According to Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq. was sanctioned as a Congressional determination to fight discrimination based on race, color, and national origin. Title VI is to ensure federal agencies, through the provisions of federal financial assistance, do not support entities engaged in programs or activities that have the purpose or effect of any prejudices (HHS, n.d.). Title VI should be a valuable instrument when eradicating racial discrimination; regrettably, Title VI unambiguously affects cases of deliberate inequity. Therefore, being educated about health care is vital for people to understand and know whether their health provider is doing more harm than good. Sadly, the health care system, through supervised care, has created reasons that reassure instinctive biases. Therefore, minorities will continue to face problems with health care inequity and unimaginable prejudices that are not lawfully identified or addressed and will endure mortality at an inconsistent rate of recurrence (Randall, 2017).

Paradies et al. (2015) documented that health disparities are not orchestrated by age, sex, and level of education but through race. Racism is frequent toward Black Americans in the United States. This mechanism is structured through common racial and ethnic experiences through marginalizing prejudices and inequity causing community health disparities. By demonstrating an unapproachable and in-depth aspect of affecting health care, racism is not often defined. Racism can be associated with unsuitable employment or housing, inadequate education, low income, and lack of access to care (Paradies et al., 2015). Some perils are affiliated with work-related dangers, contact with contaminated materials and antigens within their homes, neglected schools, lack of healthy food choices yet easy access to opioids, substances, violent communities, and ecological exposures (Paradies et al., 2015).

Juster et al. (2010) pointed out that racism affects destructive thoughts and expressive phenomena heading toward psychopathology and ill health. Lu and Halfon (2003) and Saban et al. (2014) indicated traumatic life events detract from dealing with mechanisms and genomic structures of hormonal, physiological, and neuronal systems from beginning to end; therefore, acquiring and deploying health information are recognized techniques when deterring illnesses. Renwick (2015) corroborated that Black Americans are the most impoverished minority group in the United States, and on the pinnacle point of the year 2000, their income has declined significantly for the past 50 years. Black Americans have made up the lowest household income within the United States, and being a part of an impoverished community is parallel to inadequate health outcomes with escalated death and diseases (Allan & Westwood, 2016).



Various elements, such as their physical environment, weather, topography, air quality, and vegetation, influence Black Americans' health overall. In addition to several elements causing insufficient health is asthma, a condition that affects Black Americans who live in impoverished housing (Kershaw et al., 2015). Transportation is also an issue when accessing health care services and preventive services once an emergency arises. Healthy eating is also an issue; not having readily available stores is a challenge for Black Americans, unlike in White neighborhoods. Not being exposed to healthy living increases obesity, heart disease, and diabetes, which are notably higher in Black Americans (Gaskin et al., 2014). Pollution can also affect Black Americans' health with polluted factories infiltrating their communities and decreasing the air quality. Another factor is violence. Black Americans are 6 times more likely to die by guns than White Americans (Kouznetsova et al., 2007). In 2009, 60% of Black men were likely to be killed by gun violence than White men, and Black men are 20 more times more likely of being exposed to violence than White men (Allan & Westwood, 2016). These measures have generally expressed similar results when determining health among various populations. Black Americans are known as the least healthy ethnic group in the United States (National Center for Health Statistics, 2015). Under Healthy People 2010, progression was recognized in diminishing health disparities among non-LatinX Blacks and the population as a whole (Cook et al., 2017). An increase of 34 objectives was cited and identified as coronary heart disease, pre- and postneonatal deaths, adolescent's deaths, HIV infection, diabetes, gun violence, a cardiovascular disease associated with chronic kidney disease, and homicide.

### ***Cultural Barriers Among LatinX***

In the past 20 years, LatinX have engulfed the United States creating difficulties for health care professionals and health care systems (U.S. Census Bureau, 2007). With an influx of LatinX migration, many areas across the United States were not equipped to provide health care needs, which resulted in numerous difficulties, such as cultural practices among physicians and communication barriers (Garcés et al., 2006). A person's lack of communication can cause problems when seeking treatment; this issue creates barriers when the patient and doctor are not aligned. Aside from language barriers, an individual's economic status can be a challenge along with minimal insurance or none at all. Limited transportation, inability to take off work, feeling awkward when trying to make appointments, and stalling to see the doctor can inhibit LatinX from accessing care (Reschovsky & Boukus, 2010). Therefore, it is essential to report these barriers among those LatinX accessing health care in addition to the health care professionals providing treatment to the patients. According to Reschovsky and Boukus, training health care professionals on racial and ethnic minority cultural environment, their beliefs, customs, and competency would allow a successful patient-doctor relationship. Kumagai and Lypson (2009) indicated the Liaison Committee from the Medical Education requires programs to identify and report on health inequities. Though not enough information recognizes operational training among physicians in medical surroundings, the HHS Office of Minority Health ([OMH], 2001) announced principles to warrant cultural competence be applied within every health care location. Aside from some challenges in educating health care professionals on different levels of cultural practices, proficient

guidance should stay in place to generate a keen comprehension of cultural backgrounds (A. A. McGuire et al., 2012).

### ***Cultural Barriers Among American Indian/Alaskan Native***

The American Indian and Alaska Native (AI/AN) community has encountered many barriers to their mental and general health care. These barriers consist of being homeless, lack of transportation, limited access to telephone services, being discriminated against, having mistrust, and frigid bureaucratic cultures of the health care system. These barriers can have harmful effects on an individual's health and livelihood (Call et al., 2006). Among this population, a high percentage of unmet needs have been found. The AI/AN population has been known to convey discrimination as a barrier to other racial and ethnic minority group. For an AI/AN experiencing these barriers and unmet needs, challenges are still prevalent (Wille et al., 2017). Sixty percent of the Western American tribe indicated having access to health care from the Indian Health Services remains unmet (Duran et al., 2000). In 2014, Congress disallowed allocations of 761 million dollars to qualified AI/AN communities because of insufficient funding, which caused individuals to use urgent care and emergency room services (Indian Health Services, 2015). With 71% of the AI/AN population residing within the inner-city gaining access to urgent and emergency room services, the remaining AI/AN population either resides outside the city limits or on reservations (Urban Indian Health Institute, 2013; Marrone, 2007).

AI/AN populations and health care professionals are known to have inconsistent communication that causes additional types of barriers when accessing excellent health care (Tripp-Reimer et al., 2001). It is vital to appreciate doctor-patient ideals and

practices because they can prompt how patients discuss their ailments if they trust the physician and even form consistent communication; therefore, having to identify and experience so many barriers has a significant impact on health disparities among AI/AN populations. The lack of transportation, mistrust, homelessness, limited telephone services, and frigid bureaucratic elements increase the dynamics of AI/AN communities feeling degraded, and the likelihood of not accessing health care services and interacting with health care professionals are elements that have gone on for decades. Unfortunately, this prolongs the AI/AN individual's access to care, which results in late diagnosis and treatment (Walls et al., 2015).

### ***Cultural Barriers Among Asian Americans***

There are four significant barriers to health care that influence disparities among Asian Americans: language and their culture, health literacy, health insurance, and immigrant status that is often unreported. Kim and Keefe (2010) contended that political officials and researchers should understand that Asian Americans, along with other racial and ethnic minorities, also need health care. Researchers conducted several studies concerning racial and ethnic minorities focusing on the inequities between LatinX, and Black Americans compared to White Americans (Snowden et al., 1982; Takada et al., 1998). The language barrier is one of the essential elements for Asian American accessing health care. Some Asian Americans with English as a second language experience barriers when seeking treatment, scheduling appointments, finding clinical facilities, effectively communicating with physicians, and understanding their medical conditions (R. S. Jones et al., 2006). Although having someone assist and understand the Asian American culture is essential when eliminating barriers within health care, it was

also found that health literacy and cultural beliefs concerning medical conditions prevent Asian Americans from accessing health care, which causes inadequate health effects (Kim & Keefe, 2010).

Although Asian Americans are often viewed as economically sound and an upstanding minority, their poverty rate is higher than that of Whites. Although having a high employment rate does not project the Asian American community to hold health insurance, many do not possess coverage (U.S. Census Bureau, 2004). This is due to self-employment and having too much income to be suitable for public subsidized health coverage programs despite too little income to obtain exclusive coverage. Refugees from Southeast Asia are known to qualify for health coverage and public subsidies because of their immigration status. Asian Americans with specific demographic features, such as youthful, unattached, and non-English speaking Chinese American women, were found to have issues with accessing health care (Kim & Keefe, 2010). Therefore, health education is vital among these communities for the Asian American population to understand the effects of proper health care instead of utilizing alternative medicine; this causes language and cultural upbringing, lack of health insurance, health literacy, and immigration status to enhance researchers' need to continue investigating health care access for Asian Americans (Kim & Keefe, 2010).

### **Limited Access to Mental Health Care**

Having access to mental health care among racial and ethnic minority communities is essential in the United States. An increase in rates of debilitating disorders, schizophrenia, and diagnostic issues often accounts for the difference between racial and ethnic minorities' access and White Americans' access. Racial and ethnic

minorities have an advanced proportion of mental health indicators, which weakens their performance. That is why former Surgeon General Satcher indicated in a comprehensive report that the level of mental health care in racial and ethnic minorities underwent unequal setback with mental illness because of limited access to services and minimal quality of health care and were more unlikely to obtain assistance when distressed than White Americans. Eack and Newhill's (2012) article helps identify the racial and ethnic disparities in mental health services and the outcomes between the overall populations suffering from mental illness. The study focused on racial disparities and SMI affecting an excessive analysis of specific mental health conditions and inequalities in the form of treatment, for instance, in-patient care. Regardless of this disparity, the study explained that racial and ethnic minority individuals with SMI utilize comparable methods of in-patient and out-patient mental health services and resources. The complexity of disproportionate and underrepresented services identified in the study showed racial disparities within mental health care among LatinX American populations. As the number of LatinX Americans increased, they, too, found themselves enduring the same standard of care and treatment as Black Americans suffering from SMI. The overall study addressed the infrequent treatment and unfavorable services of racial and ethnic minorities suffering from SMI.

Racial and ethnic disparities in general and mental health care have received increasing attention. In mental health care, researchers have frequently determined differences in rates and patterns of mental health treatment for Black Americans, LatinX Americans, and Asian Americans. Natural studies of an environmental delivery to people with mental illness and recent research of displacement revealed individuals with mental

illness, and participants from racial and ethnic minority groups in particular, are disproportionately concentrated in high-poverty areas. Eack and Newhill's (2012) article showed how mental health services are tailored to meet the needs of racial and ethnic minority groups in diverse communities, diminishing disparities in service areas, yet encouraged individuals living in low impoverished areas the opportunity to obtain mental health services.

Disparities and stigma are genuinely an issue, said Larke Huang (Wahowiak, 2015), from the Substance Abuse and Mental Health Services Administration (SAMHSA). Huang indicated in numerous symposiums, workgroups, articles, and seminars that racial and ethnic minorities are encountering mental illness at the same level as Whites. Huang researched not only racial and ethnic minorities facing disparities in mental illness but also lesbian, gay, bisexual, and transgender populations (Wahowiak, 2015). The article showed how poverty and stress were issues and essential risk factors when seeking assistance. Other factors to consider were the lack of health insurance, keeping scheduled appointments, limited transportation, time off work to obtain treatment, and unattainable childcare services, among other barriers. The article also mentioned insufficient mental health professionals who do not work in the public mental health systems and local health departments or clinics. Having limited access to care can stem from being stigmatized and can create barriers or issues for racial and ethnic minorities seeking assistance from friends, family, and so forth or seeking care from health care providers as a result of the stigmatization by these individuals. This researcher recognized the importance of properly training and treating racial and ethnic minorities suffering from mental illness because it often leads to unhealthy outcomes. To

close the gap, SAMHSA manages the Minority Fellowship program to reduce health inequities and improve health care and mental health outcomes annually through education and training for mental health practitioners.

### ***Accessing Mental Health Care***

Often, racial and ethnic minorities have been known to have limited access to care. Compared to the White population, racial and ethnic minorities are less likely to attain mental health care services within their community and are less likely to access mental health services (Schatell, 2017). In Hartford, Connecticut, a 2010 study was performed citing that White Americans believed mental illness consisted of a biomedical perspective, but LatinX and Black Americans felt no biomedical interpretations were aligned (Carpenter-Song et al., 2010). LatinX and Black Americans felt mental illness was caused by spirituality, moral character, and social reasoning for mental illness as socially damaging. Black Americans felt it should be contained within the family and not discussed publicly. Among these three ethnicities, White Americans sought mental health therapy more frequently than Black and LatinX Americans (Schatell, 2017). Although However, when mental health issues arose, many ethnic minorities sought out their primary care physician or a nonprofessional such as a family member, friend, religious leader, and community groups who were deemed trustworthy and able to communicate effectively. When accessing mental health services, it is imperative to educate both medical professional and ethnic minorities to fight stigmatism and reduce shame.

The American Psychological Association recommended that facilitating partnerships among behavioral health providers, educators, community leaders, families,



and public agencies to make certain culturally competent services are in place (T. B. Smith & Trimble, 2016). Creating a mental health program within communities targeting underserved populations is critical. Instructing community leaders and organizations on how to communicate and respond to mental health concerns can lead to peer services, training programs that encompass the understanding of racial and ethnic mental health culture, for instance, common beliefs and attitudes (Schatell, 2017). Providing relatable material, such as pamphlets, stories, videos, different treatment options, and informing underserved communities on how to access mental health care, building partnerships, and eliminating culture-based mental health disparities will increase the usage of services.

### ***Mental Health Support From Health Care Professionals and Providers***

Mistrust, lack of support, and uncertainty in primary care and mental health services signify another factor for racial and ethnic minorities with SMI seeking treatment. A racial and ethnic minority sample population of 29% indicated their inability to trust and obtain support from their health care professionals contributed to not accessing services even though 30% showed a disconnection of unmet needs for services rendered. Kessler et al. (2001) National Comorbidity Survey examined 5,877 individuals with SMI who encountered limited treatment from health care providers, such as mental health therapists, social workers, psychiatrists, and general practitioners. Of this assessment, Kessler et al. (2003) conveyed that 45% of patients needing therapy declined from engaging assistance because of the ineffectiveness of services; 38% of participants felt help most likely would not work; 11% stated the available services were not favorable, and 12% of participants stated that they sought out assistance, but the services were not useful. This argument was prominent among racial and ethnic minorities who

expressed a need for support with mental health services. By assessing the behaviors concerning the use of mental health services, Campbell and Long (2014) ran a qualitative analysis with 17 Black American participants explaining their encounters with depression. From Campbell and Long's study, a general argument for the lack of trust in physicians and services was identified in which the researchers asked the participants to discuss their experiences with depression. Therefore, a primary theme that emerged was the mistrust in doctors and the treatment provided, which caused hesitation for the use of services. The main reason for mistrust was due to the presumed impression that White providers would not acknowledge or empathize with discrimination among racial and ethnic minorities (Campbell & Long, 2014).

The actions of distrust result from past behaviors of segregation and prejudices suffered by Black Americans from official health care facilities. Therefore, for patients to acquire trust in them, physicians will need to develop an honest relationship with their patients. Incorporating a mutual understanding with compassion and diversity among health care professionals will need to transpire as a general practice when promoting trust and support within the mental health system concerning racial and ethnic minorities suffering from SMI (Maura & Weisman de Mamani, 2017). Studies recommend a cooperative exchange among health care and community-based mental health professionals and the racial and ethnic patient population suffering from SMI (Smedley et al., 2004). The relationship would improve patient participation with treatment outcomes and enhance medical commitment and fulfillment. Suggestions have been ascertained for general practitioners and mental health specialists to be more interactive and generate the patient's input for his or her specific treatment plan. This component relies on gaining

information concerning the patient's wishes for his or her mental health plan and options (Maura & Weisman de Mamani, 2017). Doctor-patient relationships operate on hope, respect, support, and fulfillment from the perspective of racial and ethnic minorities suffering from SMI.

In an analysis, 56 racial and ethnic minorities with SMI were evaluated about primary and mental health care for reasons of disconnect between them and general practitioners and mental health care professionals (Easter et al., 2016). The study also showed 25% of participants incorporating honest communication and 13% indicating empathy is an essential component when building trust and support (Maura & Weisman de Mamani, 2017).

Entrusting the assurance of health care services among racial and ethnic minority communities can enhance racial and ethnic health care providers. A high number of Whites represents a significant level of health care specialists only servicing 33.5% of racial and ethnic minority populations (García et al., 2006; Kopelowicz et al., 2012). Having limited racial and ethnic minority health care representation causes mistrust and a delay in seeking mental health care. Therefore, it is imperative to connect with appropriate providers who can offer profound services and understanding of ethnic proficiency (Miranda et al., 2008). The article suggested that having racial and ethnic health care professional could have a positive impact when accessing and adhering to patients' requests. Ensuring that racial and ethnic health care professionals work among culturally diverse populations would increase the likelihood that racial and ethnic minority patients would comfortably access services (García et al., 2006; Kopelowicz et al., 2012).

### ***Mental Health Support From Family***

Family participation in mental health services is valuable when obtaining care for SMI among racial and ethnic minorities; it produces fewer setbacks and minimal hospitalization for schizophrenia and bipolar disorder in addition to proper medication management. Family connection often portrays a caring position in contrast to detachment from mental health services in racial and ethnic minority families who have a SMI; this portrayal is prominent among LatinX family members. Stowkowy et al. (2012) assessed that 286 racial and ethnic persons diagnosed with FEP showed the disconnect between FEP patients and their family members, causing treatment challenges. Having family participation is imperative when successfully managing a chronic disease.

Marshall and Solomon (2004) reported how often mental health providers communicated and connected families and individuals with SMI engaged with their families and found the mental health professionals did not develop a connection between the patients and their family members. More than 50% of the mental health providers indicated they seldom provided material concerning the patient's prognosis, medication, or information about the illness. The omission of family involvement deters patients' commitment and lessens their dependability of accessing mental health care services but increases mental health inequities.

By confronting this obstacle, it has been advised to equip medical programs with necessary educational strategies that would educate family members, end stigma and the affliction of family anxiety, exhibit support from family, reduce family stress, include family members during treatment plans, and encompass the delivery of family psychoeducational involvement for mental health (Heru, 2015). With founded medical

and hospital facilities launched, creating an environment that accepts family support and involvement in planned treatment could forge a commitment among racial and ethnic family members diagnosed with SMI. In community settings, established family and psychoeducational programs exhibit success in supporting racial and ethnic minority patients and families coping with SMI. Guaranteeing family support as a helpful solution, the insertion of family could improve interaction in therapy settings and increase access to services (Weisman de Mamani & Suro, 2016; Whitley & Lawson, 2010).

### ***Mental Health Support From the Community***

Five decades ago, government-funded mental health services comprised massive state mental health facilities that were subsidized primarily with state expenditures (Exec. Order No. 13,217, 2001). Community-based services were exclusive to impoverished neighborhoods that were ill-equipped to provide mental health services and support to racial and ethnic minorities diagnosed with SMI. Therefore, federal allocations were issued to state-funded mental health facilities to develop community mental health centers to establish essential services for impoverished uninsured patients (G. Smith et al., 2005). In 1970, an agreement for supporting individuals with SMI through community living was adopted with an inclusive method for converging requirements rather than procuring services exclusively to treatment in workplace locations and outpatient facilities. Even though outpatient facilities were equipped to confront the requests of patients, the outpatient facilities struggled with limited services (Consolidated Appropriations Act, 2004).

With such challenges, the federal government created a community support program, placed in the Center for Mental Health Services under the SAMHSA, an OPDIV under the HHS. The community support program generated grants for states to assist individuals living with SMI. Moreover, a set of central values was confirmed, such as empowering racial and ethnic minorities with appropriate components of regular and authentic support and unique treatment services (G. Smith et al., 2005). The community support program emphasized the importance of support, confidence, empathy, and ensured the patient is adequately managing their mental health disorder. The community support program also highlighted the importance of family and friends' involvement, community support, and health care provider corroboration to maintain a prosperous lifestyle (G. Smith et al., 2005).

As the community support program engulfs various forms of support, it conveys a significant impact on public community mental health programs. In the past, community support programs had favorable outcomes serving individuals with mental illness by strengthening essential techniques and features of the community support program public mental health organizations (National Association of State Mental Health Program Directors Research Institute, 2002). As a result, states have modified their resources from community encouragement to actively supporting people with SMI. Therefore, this permits the state to assimilate a variety of all-inclusive practices for individuals with SMI encompassing several elements of services. At the time of this study, people diagnosed with mental illness require intensive and continuous supportive treatment plans (G. Smith et al., 2005). For that reason, many states developed their programs to commence and expand the use of EBPs in their communities; for instance, the state of Georgia restored

its Medicaid mental health coverage to adopt philosophies of recovery by redefining a collection of services with more peer support services. In New York state, the Office of Mental Health initiated a proposal called “Winds of Change,” whereby the states incorporate EBPs within their systems (G. Smith et al., 2005). In essence, the community support program framework inspired public mental health mechanisms by delivering several aspects in supporting individuals with SMI in community settings, emphasizing therapeutic care, rehabilitation, and other community lifestyle elements (Karakus et al., 2011). These methods include provisions and therapeutic treatment goals that support the need of each patient and allow and increase access to mental health services.

### **Disparities Among First-Episode Psychosis**

Oluwoye et al. (2018) analyzed the idea that individuals faced with mental illness often endured stigma. Their study showed stigma followed not only FEP patients but also family members, friends, peer supporters, and also mental health care providers. Individuals felt the need to act as if they had no mental illness in public so they were not stigmatized. Because of stigmatizing, prejudging, and labeling, those with serious mental illness are often terrorized, caricatured, and humiliated. Three main criteria implemented when characterizing FEP individuals are knowing the services and resources offered in behavioral health programs, being aware of their rights, and understanding their self-worth (participating in evidence-based programs allowed FEP patients to manage their symptoms, treatment outcomes, and life goals). Oluwoye et al. identified how it is essential for FEP patients to familiarize themselves with their rights. Being discriminated against because of a person’s mental illness or being denied a place to live is unlawful and violates a person’s civil liberties. As mentioned above, self-worth is important for

patients to understand. Self-worth allows individuals to create and implement programs that build hope, support, self-reliance and assurance, confidence, and strength. Incorporating these components, along with educating, outreaching, and communicating, can change the outcome of being stigmatized.

Ethnic differences in the form of health care service treatment are the topic of an extensive form of extensive works, particularly for generalized psychiatric disorders and specifically for the FEP. Cultural differences were studied by Oluwoye et al. (2018) in light of other minorities, Black-British, Black-African, Black-Caribbean, White-British, but primarily limiting the research to South and East Asian groups. Oluwoye et al.'s study found a reduced level of effect for second-generation Black-British cultures on indicators of troublesome access to mental health care compared to the first-generation Black-African and Black-Caribbean groups. Although ethnic differences did continue proportionally to the White-British group, Oluwoye et al. provided data that immigrants with FEP tend to have extended treatment delays and an increased likelihood of being referred to psychiatric services by emergency services compared to nonimmigrants. The impact of racial and ethnic experiences, such as socioeconomic status, and alternative methods for actual practices behind perceived disparities were not considered.

However, this researcher believed Anderson et al.'s (2017) article helped to identify the representation for an individual's origin of a developmental disorder and the appropriateness of different selections when seeking mental health assistance. Reviewing their article provided the researcher with an understanding of the effect of discouraging a minority's position with knowledge concerning health care delivery in communities and the ability to navigate general and mental health care systems economically,



linguistically, or with other barriers. Anderson et al. (2017) also focused on the mental health stigma identified by immigrants because of cultural beliefs, which often led to shame and avoidance of receiving general and mental health care services. Therefore, identifying and understanding an immigrant's position for seeking medical treatment in early psychosis is vital when addressing barriers and diminishing racial and ethnic disparities.

Srihari et al. (2015) acknowledged FEP patients with racial and ethnic backgrounds impacted social, cultural, and health care services. The research determined how the FEP in Europe, Australia, and the United Kingdom is a known high-profile initiative. The study focused on FEP in the United States enhancing health outcomes for people suffering from ESMI and whether the specialized treatment early in psychosis (STEP) was practical rather than systematic service outcomes of admitting patients in psychiatric facilities or a mental health program focused on workforce development. The initial assessment determined outcomes from a controlled setting that examined the effectiveness of the STEP process instead of the U.S. standard of care. The researchers identified that when an individual suffering from FEP takes advantage of the STEP program, the person will more likely be referred to a hospital rather than assigned to treatment areas in his or her local neighborhood, which would abolish preferred referrals.

### **Racial and Ethnic Disparities in Mental Health Care**

Health disparities imply dissimilarities in health effects that are related and impact communities, environmental factors, and financial difficulty for a group of individuals identified by race and ethnicity. Often, these effects portray the increase of mental health inequalities in more than 100 million racial and ethnic minorities in the United States.

The U.S. Census Bureau (2008) estimated a 50% increase in racial and ethnic groups by 2044. Research has been conducted to evaluate disparities among racial and ethnic minorities utilizing fewer mental health services and primary health care, receiving insufficient quality of care, and being less content with health care providers and professionals. Moreover, an increased rate of failed services compared to Whites as mental health inequities among racial and ethnic minority communities seem constant and unchanging, and with the multifaceted challenges conveyed, this population will remain susceptible to mental illness disorders with limited access and inappropriate care (Rice & O'Donohue, 2002).

Racial and ethnic minority populations consisting of Black, LatinX, AI/AN, and Asian Americans are excessively categorized as individuals in danger of mental illness. The shortage of care to the mental and behavioral health conditions of racial and ethnic groups and the inefficient delivery of ethnically and linguistically proper mental health care among racial and ethnic minority populations exhibits a well-defined demand for inspiring a partnership and discovering ways to discontinue the inequality of treatment (American Psychological Association, 2017). By discontinuing disparities, the federal government has championed laws and guidelines that would expand the health conditions of mental health treatment for racial and ethnic minorities (American Psychological Association, 2017).

In essence, the state of Virginia implements additional funding from some state allocations to ensure FEP consumers receive quality treatment, resources, and services. Virginia has increased the availability of resources and enhanced the FEP government-funded CSC program's credibility. Another state identified is Maryland, where the state

highlights resources of the overall success of FEP treatment services delivered to individuals who have a severe mental illness. The state of Maryland takes advantage of community partners and resources when assembling the FEP government-funded CSC program staff. Finally, the United States of America capital, Washington District of Columbia, which consists of a significant cultural, racial, and diverse ethnic population, has engaged with patients by reducing the suspicion and fear and increasing awareness and commitment by broadening the strengths and different perspectives of achieving the FEP objectives (Fortier et al., 1999). This method of design provided a sample of maximum variation of subjective representation of FEP government-funded CSC programs, which allowed the researcher to focus on a thorough understanding of the phenomena with up to 30 relevant individuals, within three program sites, from three different states (Maryland, Virginia, and Washington, DC).

In 2008, to sustain these guidelines and laws, the House of Representatives created Minority Mental Health Awareness Month in July (Aklin, 2017) that builds recognition and understanding of impoverished racial and ethnic communities attaining access to mental health treatment in the United States (Aklin, 2017; Turner et al., 2019). According to the U.S. surgeon general, racial and ethnic minorities have more limited admittance to mental health services than Whites, less likely to obtain necessary treatment, and are more likely to obtain mediocre treatment when cared for. Mental health disorder is one of the most significant common health challenges in the United States and most burdensome on the health care system (Turner et al., 2019). Often, racial and ethnic minorities have similar episodes of mental health issues compared to Whites. However, racial and ethnic minority groups have minimal access to mental health

services and are less likely to pursue and obtain needed treatment and, when obtained, are more likely to receive insufficient mental health therapy (Turner et al., 2019).

When Minority Mental Health Month was created, an initiative called Brother; You're on My Mind was originated to intensify knowledge among Black American men. The initiative was developed by the Omega Psi Phi Fraternity and the National Institute on Minority Health and Health Disparities. It stimulated communication and dissipated the untruths linked with mental health setbacks yet emphasized the significance of obtaining therapy (National Institute on Minority Health and Health Disparities, 2017). Mental health is essential to generally every stage of life, which is why it is essential always to promote dialogue, knowledge, and inquiries about mental illness. As a result, Mental Health America recognizes racial and ethnic minorities in impoverished neighborhoods continuing to be America's most vulnerable populations, for instance, individuals who are destitute, imprisoned, and uninsured families, (Mental Health America, 2017).

Measures of mental illness and behavioral health concerns are equivalent and even higher in rural areas than urban neighborhoods. With a lack of mental health and behavioral health providers and specialists in these communities, services have increased costs; the lack of mental health providers and specialists has also caused language barriers, unacceptably educated and inexperienced health care professionals, and health insurance deficiencies in addition to transportation problems, minimal prevention efforts, and negligible integration of physical, behavioral, and mental health services (Maura & Weisman de Mamani, 2017). Mental Health America (2017) recognizes these discouraging impressions of mental health disparities and the position of ethnic

proficiency. It supports various ground-breaking endeavors such as the Multi-State Initiative determined to eradicate mental and behavioral health inequities among racial and ethnic minority communities in rural neighborhoods. This will allow an evaluation of existing therapy methods and strategies directed toward rural populations needing access to primary, behavioral, and mental health care in addition to innovative methodologies and replicas by promoting efficient services with continued treatment throughout rural racial and ethnic minority communities (Mental Health America, 2006). As research continues, it is important to note the emphasis of policies to expel the disproportions of accessing primary, behavioral, and mental health care among racial and ethnic minority groups (Sanchez et al., 2016).

### **Policy Implementation**

T. G. McGuire and Miranda (2008) viewed standardized health disparities and how accessing quality health care should improve. However, they emphasized and addressed strategies for eliminating disparities in mental health care. To eliminate mental health care disparities, an experienced mental health workforce is needed in addition to educating health care providers and patients. T. G. McGuire and Miranda's study highlighted how racial and ethnic minorities in the United States increased levels of inadequate mental health care compared to White Americans. T. G. McGuire and Miranda also recognized how being impoverished with little health care could stem from mental illness and acknowledged how an increase of SMI among Black and LatinX Americans coupled with inflamed deprivation and insufficient health care was associated with disparity health outcomes. Their article expressed how the federal government is dedicated to educating, outreaching, and building a diverse workforce in the mental

health care system. Building these components allows policies to be implemented and eliminate disparities in mental illness. In essence, their research is beneficial because it shows mental health disparities having a prolific stance in understanding and communicating the patient's needs.

### **Publicly Available Data**

In 2015, SAMHSA reported a publicly known issue brief concerning racial and ethnic differences in mental health and the services used among adults. According to the Surgeon General, culture, race, and ethnicity were widely known to encompass mental health service utilization disparities between Whites and other racial and ethnic minorities (HHS, 2001). Several variances were identified in the study, including the cost of services, transportation, limited health care providers, and limited health insurance coverage, which were the most recurrent reasons for not utilizing mental health services among racial and ethnic minorities. However, White adults with mental illness and those with SMI expressed the lack of insurance and health care costs was the catalyst for them not using mental health services compared to other racial and ethnic minority groups (J. M. Gonzalez et al., 2011). In 2001, the U.S. Surgeon General identified the differences in racial and ethnic minorities' mental health delivery in ongoing national surveillance of mental health service utilization. With this information over a decade old, significant changes were placed; for instance, the Mental Health Parity and Addiction Equity Act of 2008 affected health coverage for mental health and access to health care (Centers for Medicare & Medicaid Services [CMS], 2016). The reason SAMHSA conducted this study was to ensure the use of mental health service among adults from various racial and ethnic minority groups was well represented nationally and to warrant impending policy

changes. The information used for this study was collected between 2008 to 2012 from the National Survey on Drug Use and Health, which focused on mental health issues. The federal government has collected this survey since 1971 through direct dialogue with a representative for the residents at their homes. This phase of the survey was sponsored by SAMHSA and managed by SAMHSA's Center for Behavioral Health Statistics and Quality (Office of Applied Studies, 2009).

The information collected identified information on racial and ethnic inequalities in mental health services utilization among adults with mental illness and SMI (SAMHSA, 2015). Based on the results, the reason for individuals not utilizing mental health services was due to unmet needs. These unmet needs included insufficient services, delayed services, needing extra services, lack of mental health care insurance, and health care costs. Additional reasons included respondents feeling they did not need services or could control their issues personally; stigma from family, friends, or coworkers; lack of transportation; limited to no services in their neighborhoods; and being over medicated. There were other reasons as well as being discriminated against, disclosing confidential information, and feeling the services would not benefit them in any way (SAMHSA, 2015). These data, which are nationally known, have revealed that adults of different racial and ethnic minorities sought mental health services in 2015. The general use of service, medication, outpatient, and inpatient services are increased causes for incomplete use of services. It is vital to understand that two or more races composed of 17.1% of individual adults were likely to make use of mental health services in 2015. White Americans made up 16.6%; American Indian and Alaskan Native tallied 15.6%; Black Americans made up 8.6%; LatinX, 7.3%; and Asian Americans, equaled 4.9%.

Communities using prescribed psychiatric medication resulted in 14.4% from Whites whereas two or more races accumulated 14.1% (Center for Behavioral Health Statistics and Quality, 2013).

Moreover, AI/AN reported 13.6%, succeeding Black Americans to 6.5%, LatinX to 5.7%, and Asian Americans to 3.1%. Employing the use of mental health services was more common among two or more races at 8.8%, Whites Americans, 7.8%, AI/AN at 7.7%, in addition to Black Americans at 4.7%, LatinX 3.8%, and Asian Americans at 2.5%. Making use of inpatient mental health services was more common among Black Americans at 1.4% than White Americans at 0.7% (Center for Behavioral Health Statistics and Quality, 2013). The expense of services and the rarity of health care insurance was significant for the limited use of mental health services around racial and ethnic minority communities. Trusting that mental health services would not help was the least cited reason among racial and ethnic minorities (SAMHSA, 2015).

According to visibly available data, the U.S. Census Bureau (2014), racial and ethnic minority populations in the United States will increase to 56% of the total population by 2060 from 38% in 2014. By 2050, 39% of the older adult population over 65 years old is estimated to be non-White. These estimates explain that the U.S. minority groups are becoming prevalent, and it is extremely important to identify mental health disparities among racial and ethnic minorities (Agency for Healthcare Research and Quality [AHRQ], 2016).

In recent years, CMS (2020) reported national data concerning insufficient patient primary and mental health services among racial and ethnic minorities. Since 1998, CMS has constructed a report from the Medicaid Health Outcome Survey (HOS), which is a



data collection of self-reporting health status information from a starting point and a continuation from the national representative of Medicare Advantage Beneficiaries (CMS, 2020). These data are used to evaluate changes in the physical and mental health outcomes and health-related quality of life over time. In 2013, HOS became the sizeable initial measurement of CMS surveys attaining data utilizing racial and ethnic groupings within the HHS assessment compilation guiding principles. HOS collected primary and mental health care outcomes of beneficiaries from limited racial and ethnic groups. In addition to those who self-identified as other races, AI/AN, Native Hawaiian, or other Pacific Islanders communicated the dismal significance of mental health conditions throughout numerous mental health strategies (CMS, Office of Minority Health, 2015).

Under CMS, mental health values became prominent because of inadequate diagnoses of melancholy from adults, increased health care costs, and morbidity. Despair is common among senior adults, and racial and ethnic minorities encounter mental illness more frequently than White individuals. It is noted that LatinX (Puerto Rico) populations are reported to have an escalation of depression rate at 40.9%. However, LatinX, Cuban descent extends to 34.5% while the remaining LatinX population ranges to 30.8%. American Indian and Alaskan Native Medicare recipients reported depression 9% more than White recipients, and Pacific Islander communities reported depression 14.4% more than Whites (CMS, Office of Minority Health, 2015).

CMS also assessed, from the HOS data survey, that AI/AN respondents lost, on average, 3.8 additional days of events because of deficient physical and mental health as opposed to White individuals. Samoan and other Pacific Islanders reported forgoing a standard 4.0 more days of events than White individuals though multiracial communities

were reported the most days missed of any group, collected at 11.6 days (CMS, 2020). Additional factors were highlighted in the CMS HOS report; for instance, AI/AN recipients described positive depression screenings 13.5% more than White individuals. Multiracial communities had the highest percentage, 31.1%, of positive depression screening out of any racial and ethnic group. However, Asian Americans were the lowest percentage of positive depression screenings, which fluctuated among Asian American groups. AI/AN, Blacks, most Native Hawaiian or Other Pacific Islanders significantly exacerbated the Mental Component Scores compared to White and Asian American recipients, and non-LatinX recipients had significantly better MCS scores of 51.8% than multiracial groups at 44.8% (CMS, 2020).

The insufficiencies in racial and ethnic minority data transpire more often in Medicare, Medicaid, and for-profit approaches, which, if continued, will inflame disparities in health care as a whole. An individual's socioeconomic status and the social elements of primary health and mental health care are substantial. Impoverished patients who have language barriers and lack transportation have an increased risk of health care and mental health care inequalities (Office of the Assistant Secretary for Planning and Evaluation, 2011). The indicators detailed in the CMS report can be identified as disappointing. However, sizeable initial initiatives commenced by building collaboration between Walgreens and Mental Health America, permitting patients to use an internet program to fulfill complete screenings for mental illness. Initiatives like this are to assist older and racial and ethnically diverse patients who have mental illness anxieties (CMS, Office of Minority Health, 2018). Patients can seek assistance if conditions are detected, and may receive access to increasing innovative methods of health care delivery. It is

appropriate for all recipients to attain quality health and mental health care among racial and ethnic minority groups. Adhering to collecting indicators is essential when surveying these groups, and understanding the unsurpassed practices to treat them will improve overall health (CMS, 2020).

The National Conference of State Legislatures (NCSL; 2018) summarized the challenges and unethical actions of behavioral health and mental health disparities that racial and ethnic minority communities encounter annually. Examining the concerns and expense of disparities in health care has been recognized by the National Institute of Mental Health ([NIMH], n.d.-b). NIMH identified communities composed of racial and ethnic minority groups have less access to mental health services and are unlikely to benefit from community mental health services despite the fact racial and ethnic minorities are commonly known to use inpatient hospital and emergency services but receive insufficient health care services, which carries a sizeable expense for states. Abolishing racial and ethnic inequalities could have decreased medical expenditures during 2003-2006 by \$229 billion, according to the Joint Center for Political and Economic Studies (JCPES; (LaVeist et al., 2009). JCPES is the nation's foremost represented research and public policy institution in the United States and is known for focusing on concerns of Black Americans and persons of color. From LaVeist et al.'s (2009) report, three methods were identified to determine the economic burden of health disparities:

1. Direct medical cost of health inequalities
2. Indirect costs of health inequalities
3. Costs of premature death

The Medical Expenditure Panel Survey was used to collect these data from 2002-2006 to evaluate the cost savings of diminishing health disparities for racial and ethnic minorities. Data from Medical Expenditure Panel Survey also identified the efficiency absent, which is linked with health disparities for racial and ethnic minority communities. The results accumulated to the following:

- Between 2003 and 2006, 30.6% direct medical care expenditures for African Americans, Asians, and Hispanics were excess costs due to health inequalities.
- Eliminating health disparities for minorities would have reduced direct medical care expenditures by \$229.4 billion for the years 2003-2006.
- Eliminating health inequalities for minorities would have reduced indirect costs associated with illness and premature death by more than one trillion dollars between 2003 and 2006.
- Between 2003 and 2006 the combined costs of health inequalities and premature death in the United States were \$1.24 trillion. (LaVeist et al., 2009, p. 1)

The accumulated direct and indirect costs of \$1.24 trillion within America grossed more than the domestic product of India, the world's 12th largest country, and in 2008 totaled \$309.3 billion annual loss to the budget. The massive untimely death characterizes the high cost of an individual's perspective and deficiency of the impact of humanity. With this severe affliction on the nation, health disparities will continue to agonize racial and ethnic minorities within this society (LaVeist et al., 2009). However, state legislatures adopted numerous policies removing obstacles of behavioral health services in addition to improving mental and emotional health among all racial and ethnic

minority groups. Although the methods vary when a developmental workforce emerges, it also cultivates health insurance coverage, which has available service and combines inexpensive and quality services (Sanchez et al., 2016).

From the NCSL (2018), data were collected and introduced behavioral and mental health disparities through the 2017 state legislation, noting that substance use and mental health utilization was deficient among racial and ethnic minorities. During 2008 and 2012, Black Americans, LatinX, and Asian Americans were least likely to use mental health services compared to those identified as White Americans, American Indian, and Alaskan Native. In NCSL (2018), Black and LatinX impoverished communities were less likely to use mental health services versus Whites with mental illness and impoverished would access mental health services. In 2014, mental health and substance use were reported for around 7% of health care costs. However, public programs such as Medicaid, Medicare, and other funding sources paid 60% of mental health costs and 70% of substance use equaling \$110 billion and 22 billion for FY 2014 (NCSL, 2018).

In the United States, Medicaid is recognized as being the most substantial mental health and substance use payer, billing 26% of all behavioral health expenditures in FY 2009, per the 2015 assessment from Medicaid and CHIP and Payment Access Commission (NCSL, 2018) whereas individuals enrolled in Medicaid with a diagnosed behavioral illness reported 50% of Medicaid allocations accumulated over \$131 billion. It was also stated that uninsured beneficiaries, compared to those Medicaid recipients, were known to partake in mental and substance use treatment. However, in a 2017 study, the Kaiser Family Foundation recounted gaps of 2.5 million Medicaid recipients conveyed unmet needs for mental health treatment. Numerous obstacles prohibited

individuals from obtaining health care, for instance, limited behavioral health care providers who allow Medicaid, inconsistent eligibility requirements for Medicaid, insufficient insurance coverage for mental health care services, and means of transport and language barriers (Kamal, 2017). Additional obstacles that racial and ethnic minorities endure are accessing mental health services. The sustainable labor force integrates the population's needs through severe labor force as insufficiencies continue. For instance, SAMHSA (2014a) has concerns about insufficient health care professionals, specialists, licensed clinical social workers, and psychiatrists for adolescents within the labor force. Also, general deficiencies of racial and ethnic minorities are minimized in the mental and behavioral labor force.

The role of a health care provider assisting racial and ethnic minorities is inadequate. Therefore, the HHS Office of Minority Health ([OMH], 2018) described direct elements, activities, and conditions for patients and their well-being when they receive services. OMH (2018) also indicated that when altering services to accommodate racial and ethnic minorities, communication is crucial, especially when health care experts provide essential care, which can impact disparities in mental health.

Sanchez et al.'s (2016) article stated that speaking the languages of racial and ethnic minorities has a positive impact on them when they seek mental health care services as does having a diverse labor force that affords vital delivery of these benefits. Another barrier includes little to no medication, lack of treatment, constant humiliation, and the insufficient doctor-patient relationship. Therefore, in 2017, lawmakers from 19 states contemplated 74 bills related to behavioral health disparities. Many of the bills concentrated on fostering discernment of behavioral and mental health inequities and

ethnic proficiency with health care professionals and services, with seven states initiating political decisions in 2017 comprising behavioral and mental health disparities (NCSL, 2018).

Furthermore, the rulings were envisioned by disparities suffered by racial and ethnic minority communities as a measure of behavioral and mental health strategies. In essence, behavioral and mental health inequities affect various communities across the United States, particularly racial and ethnic minorities, who are constantly overwhelmed with challenges in obtaining health care services that are ethnically suitable. Since 2017, state politicians are relying on policies to enhance health care services, access to care, and eliminate disparities in health care (NCSL, 2018).

### **Conclusion**

Mental health care is recognized to have limited resources and services throughout the world. The World Health Organization (2001) has elevated the shape of mental health by promoting useful developments to ensure policymakers are contributing exceptional opportunities with incomparable assistance and direction affecting mental health. The significance of implementing policies and practices is to improve the efficiency and equity of accessing mental health care by eliminating disparities and guaranteeing diversity among health care professionals, patients and families, mental health programs, cultures, and throughout impoverished neighborhoods (Knapp, 2006).

When working with racial and ethnic minority communities in mental health, there is an exploration of critical outcomes upon individuals and families among communities when practices and processes are limited while enabling mental health providers to work efficiently with ethnicities. After examining new techniques and

connecting cultures while permitting individuals' mental health care, it is crucial to encourage racial and ethnic minorities to seek treatment instead of undervaluing and discouraging their access to care. New methods for developing an integrated and holistic approach toward mental health care can create resource allocations for which the efficiency of resources are positioned (Gopalkrishnan, 2018). Implementing interconnections between government-funded FEP programs and other functions from the mental health system will evolve because there is a need for equal access to services and funding, which will aid in preventive measures; as a result, principles will be created without delay, to report and connect barriers of sources that are inappropriately disseminated (Knapp, 2006).

To enhance the implementation of efficiency and equity through transparency, it is necessary to effectively improve the availability of services. Attaining equitable results that support performance measures and the implementation of a strategic framework is to guarantee the methods and performance measures are applicable to racial and ethnic minority communities engaged with their treatment plan. Communities exposed to discrimination, inequity, and limited access to mental health services have a significant impact on racial and ethnic minorities' quality of life. Integrating compliance and approaches are mechanisms government-funded FEP programs need for racial and ethnic minority communities to deliver effective, accountable services.

In conclusion, the collection of research limiting mental health treatment of care suggests the necessity to establish culturally suitable interventions directed at racial and ethnic minorities in mental health. Racial and ethnic minorities suffering from mental health disparities are linked to minimal health care coverage, limited representation of



health care professionals, language barriers, nominal support, and insufficient access to care in impoverished communities (Jimenez et al., 2012).

In essence, this study also included a literature exploration discussing racial and ethnic disparities in mental health care deriving from multiple complex factors, comprising discrimination in health care, socioeconomic status, health care access overall, cultural beliefs, and community systems. Unfortunately, there is no easy solution to eliminating mental health disparities though the solution is indicative of obtaining proper resources to address the different challenges affected (American College of Physicians, 2010). Improving access to care, reforming health care delivery, cultivating cultural and linguistic understanding, stigma, diversifying health care workforce, enhancing social effects of health, and implementing policies would dramatically enrich the lives of racial and ethnic minorities suffering from ESMI.

## CHAPTER 3: RESEARCH METHODOLOGY

The purpose of this chapter is to demonstrate the research method for this qualitative mixed-methods approach to investigating the processes and policies that first-episode psychosis (FEP) programs use to address ethnic minorities' utilization of these services. This technique could provide a richer understanding of how agencies are addressing mental health disparities among racial and ethnic minorities in accessing those services. The methodology chapter includes the research design, participants, sample method, the implemented instrument, data collection, and data analysis.

### **Research Question**

How have government-funded coordinated specialty care programs attempted to address racial and ethnic minorities' underutilization of mental health services?

### **Research Design**

A qualitative methodology was applied to this study. The qualitative methodology facilitates the study because it will aid health agencies in understanding mental health disparities, treatment outcomes, relationships between doctors and patients, health promotion, health professionals in the development of FEP government-funded coordinated specialty care (CSC) programs and policies (McKim, 2017). The methodology offers an analysis examining contributing factors to positive or negative outcomes for minorities and as such, incorporating a qualitative methodology study will provide a clear understanding of attitudes and evaluate the elements affecting quality services toward FEP government-funded specialty care programs. The qualitative methodology seeks to determine the meaning of the phenomenon through the description. It intends to develop concepts that aid in understanding natural phenomena with an

emphasis on the meaning, experiences, and views of the FEP government-funded CSC program participants (Al-Busaidi, 2008). A qualitative exploration of principles and knowledge was needed for this study as it developed concepts that can help understand the social phenomena in natural settings, emphasizing the meanings, experiences, and views of the participating FEP government-funded CSC programs. The qualitative research used in this study identified cultural and social factors affecting treatment outcomes and mental health disparities among racial and ethnic minorities positively and negatively. To illustrate the qualitative methodology, a multiple case study design was implemented.

The method employed in this study entails recognizing the changing aspects of a phenomenon existing within a specific setting. The mixed-method approach employed strategies containing multiple levels of analysis within a single research project; this approach combined data collection methods such as archives, surveys, interviews, questionnaires, and observations (Creswell, 2018). According to Creswell (2013), a case study method “explores real-life, a limited modern method or multiple limited methods over time, through detailed, extensive data collection involving multiple sources of information, records, explanations, and themes” (p. 97).

Every so often, case studies have a dual purpose; for instance, case studies include information of elements from their programs and organizations as well as reports from larger programs of the organizations. The reasoning expected by a case study can be either descriptive or verifiable (Gerring, 2004). Therefore, a qualitative multiple case methodology incorporated and required an implementation to analyze a comprehensive assessment within the FEP government-funded CSC program frameworks. With the

multiple case method appropriately applied, there was a benefit of evaluating three state FEP government-funded CSC programs that cultivate principles for differential treatment outcomes that connect racial and ethnic minorities (Baxter & Jack, 2008).

The multiple case study design allowed the study to make a compelling assessment to address the challenges and social issues among racial and ethnic minority communities, mental health disparities, stigma, and treatment outcomes from the FEP government-funded CSC programs. This action allowed the researcher to assess intellectual behaviors, the development of different approaches, techniques, and observations. The study made a convincing case for the integration of information when compiling these elements. Therefore, the multiple case study demonstrates a connection, a form of influence, education, and valuable tools and methods from these impactful elements assessed.

The case study approach considered how the phenomenon is affected by health disparities within the FEP government-funded CSC programs. A comparative method is a research approach formulating or assessing generalizations extending across multiple case studies. The fundamental intent of a comparative case study is the development of knowledge that equally applies in natural and social science settings, incorporating a qualitative method (Knight, 2001). The comparisons among the agencies was used to obtain an understanding of the provider's experience (Zainal, 2003). The case study explored the challenges of racial and ethnic minority disparities in mental health; by conducting this study, the researcher assessed the effectiveness (Yin, 1994) of health disparities among racial and ethnic minorities being served in FEP government-funded CSC programs. In this study, the researcher only selected a small number of participants

within a small geographical area from a simple approach and comparable systems to examine in close detail. The researcher's goal was to interpret the data by developing conceptual categories supporting, and challenging the assumptions made regarding the study (Zainal, 2003). This qualitative approach helped to explore and describe the data in real life and the complexities of real-life situations that were captured (Zainal, 2003). This leads to the validity and reliability concept where the researcher trusted in "truth value," which identifies reliability as credible and dependable, whereas validity comprises trustworthiness (Morse et al., 2002). Reliability assesses a person's actions with similar outcomes from assessments. Validity evaluates mechanisms in an analysis precisely for detailed actions (McMillan & Schumacher, 2006). The connection between reliability and validity can be misunderstood; for instance, evaluating the effectiveness of mental health promotion in racial and ethnic minorities in FEP government-funded CSC programs can be reliable without validation, but the measurements cannot be valid unless they are reliable and precise. The significance of reliability and validity is to stipulate valid and reliable unbiased results and ascertain the truth (Morse et al., 2002). Therefore, when the researcher engages in various instruments, the validity and reliability enrich the study and provide a clear understanding of the researcher's assessment of the data and expose the concepts and clarifications produced by further assessments, documents, and participants (Johnson, 1997). There are several strategies implemented to conceptualize the truthfulness and unbiased paradigm (McMillan & Schumacher, 2006).

In this study, triangulation was used to examine the consistency of different instruments that increase the number of reasons and threats affecting the evaluation. Interviews were conducted for three FEP program sites to obtain an understanding and

perspective of racial and ethnic minorities accessing mental health care. During the analysis phase, the researcher acquired comments from participants working in three different FEP programs located in Washington, DC, Maryland, and Virginia to include areas of similarities or differences. This is a method of validating data from many sources to examine consistency in this study (O'Donoghue & Punch, 2003); therefore, the data triangulation method was applied. Data triangulation comprises unique sources of material to enhance the validity of a study. For example, in-depth interviews were conducted with each organization to attain an understanding of their knowledge for program results. In the development of the assessment, comments from the participant's organizations were evaluated to conclude sections of conformity as well as sections of discrepancy (Guion et al., 2011).

### **Sampling**

The specific design for this study comprised the purposive sampling, which relied on the scholar's identification of three selected nationwide individual state FEP government-funded CSC programs. The three selected states were conveniently located, have a sizeable diverse population, and were accessible to evaluate and assess. Among the participating FEP government-funded CSC programs, up to 30 relevant individuals comprising program administrators, health care professionals, CSC team leaders, and state behavioral health authority representatives also contributed to the multiple case study. To better understand the sampling technique, the population consisted of 290 FEP government-funded CSC programs. The intent of choosing three individual states was to capture essential information on racial and ethnic minority groups accessing FEP government-funded CSC services. The 290 FEP government-funded CSC programs have

shared characteristics, such as receiving federal funding, incorporating the mental health block grant (MHBG) guidelines, providing mental health services, resources, and employing staff with intimate knowledge, professional experience, and participation in each FEP program. Thus, the study was contingent upon the thoroughness and consistency of information gathering (Etikan et al., 2016). Each of the 290 FEP programs is known as a unit (Laerd Dissertation, n.d.). The 290 FEP programs are located nationwide in the Pacific Jurisdictions, Guam, Puerto Rico, and the Virgin Islands. The researcher was compelled to conduct the study within DC, Maryland, and Virginia because of her knowledge, experience, availability, and willingness to participate and the ability to communicate with the FEP program staff practices and views in an articulate, significant, and insightful manner. Choosing 13 participants among three state programs also captured and ensured the participants would offer ample saturated insight. For this qualitative study, the comparable level of staff would not generate insignificant concepts when they were being interviewed and observed. Therefore, proposing up to 30 participants helped the researcher build and maintain relationships that improved an open dialogue that mitigated the validity of this research. When selecting the sample (*N*) of FEP programs from this population of 290 programs, the choice to use purposive sampling reflected key components composed of rich data compiled from the MHBG state applications (Laerd Dissertation, n.d.). The selected programs are to stipulate the proposed operational FEP government-funded CSC programs to help program administrators, health care professionals, CSC team leads, and state behavioral health authority representatives fully adhere to the suitable psychotherapy of racial and ethnic minority communities being served in the FEP

government-funded CSC programs. FEP government-funded CSC programs need to evaluate guidelines to consider adequacy and limitations. Health care professionals are knowledgeable of the unique characteristics of mental health patients. The strategy technique for interceding psychotherapy is to improve the structure of FEP government-funded CSC programs. Integrating the principal criteria for each FEP government-funded CSC program will stimulate innovation upon the outcome improvement and will continue to achieve attainable outcomes. Some criteria consist of the following:

- Engaging racial and ethnic minority communities
- Describing the FEP government-funded CSC program
- Assembling reliable evidence
- Rationalizing decisions
- Ensuring use and sharing lessons learned

### ***Engaging Racial and Ethnic Minority Communities***

Engaging racial and ethnic minority communities is a measurable criterion that will help screen program development while accomplishing the program goals and objectives and the need for evaluating collaborative resources between program activities and prevention (Sanchez et al., 2016). The assessment is a constant evaluation to help alter changes in program objectives. Thus, the assessment is a constant evaluation that can help create changes. For instance, mental health providers can develop communicating and adopting patient-centered methods, including patients in their treatment decisions, ensuring the patients understand their medications, and overcome stigmatization among family, mental health practitioners, and individuals within their communities (Sanchez et al., 2016).



### ***Describing FEP Government-Funded Coordinated Specialty Care Programs***

As mentioned, CSC programs are a team approach model that encourages patients from children, adolescents, and adults to work with their family, psycho-therapists, and recovery specialists while restoring their mental health (C. Gonzalez et al., 2017). The government-funded CSC programs exhibit a cohesive assessment focusing on goals, healing, and delivering minimal prescription medication resulting in the smallest number of side effects. The government-funded CSC programs use state funds allocated by the federal MHBG under the Substance Abuse and Mental Health Services Administration (SAMHSA) OPDIV of the U.S. Department of Health and Human Services (HHS). The FEP government-funded CSC programs have illustrated an increase in quality life, decrease in the use of hospital services, lessening of psychopathology, and fulfillment of employment and educational practices (C. Gonzalez et al., 2017).

In essence, FEP government-funded CSC programs are well aligned with the ESMI population. Therefore, obtaining psychoanalytic services through a government-funded CSC program formulates positive clinical, operational, and quality of life outcomes (C. Gonzalez et al., 2017). These results are apparent among those experiencing psychosis symptoms. The impact of these programs is correlated through a reduction of long-term public expenditures coupled with SMI, a return on the program's investment, and the increases in a more robust program. Also, there are economic systems that support the FEP government-funded CSC programs within the public health sector.

### ***Assembling Reliable Evidence***

When conducting an evaluation, one should address a well-versed depiction of the FEP government-funded CSC programs by displaying assessments and suggestions of health care professional credentials, an affinity for recovery-oriented care, intervention approaches toward patients, family members, and their preferred recovery methods. These relationships are developed through various outreach components, for instance, entrenching community systems, promotional materials, health care facilities, church organizations, colleges, and universities along with secondary schools. Also, online programs, social media, the criminal justice system, mental health professionals, and managed organized care programs. The primary factor is to understand the systematic and outreach methods identified to individuals experiencing FEP and to recognize their environment and the creative ways of providing and integrating these mechanisms.

### ***Rationalizing Decisions***

Viewpoints replicate the principles held by the FEP government-funded CSC program participants, and those principles offer a foundation for generating decisions concerning program implementation. Exposing specifics concerning a program's operation is not necessary to depict evaluative assumptions. Decisions are statements concerning the merit, worth, or significance of a program. Because several principles can be applied to a given program, most health care programs could influence unusual or unfluctuating contradictory conclusions (Rogers & Hough, 1995). Unpredictable claims regarding a program's value, worth, or reputation often indicate that health care programs could use different principles of opinions. In an assessment, such misunderstandings can be a means for describing appropriate principles and for bartering the applicable origins

on which the program should be evaluated (Scriven, 1998). Forming recommendations is a well-defined component of program assessment that entails information beyond what is necessary to form conclusions concerning program implementation. Recognizing a program that is proficient when diminishing the risk of sickness does not interpret necessarily into a suggestion to maintain an effort explicitly once opposing primacies or additional operational alternatives options are present (Gholipour, 2016). Thus, suggestions are made for continuing, expanding, redesigning, or terminating a program from assessing the program's effectiveness. Justifying assessments based on data includes principles, examination, and a combination of having an understanding, enduring discernment, and providing suggestions (M. Reed, 1999). When unique but similar well-supported inferences occur, each may perhaps be exhibited with a synopsis of its strong points and limitations. Inventive methods could be used to ascertain consensus among FEP patrons when assigning significant assessments. Therefore, methods for examining, integrating, and inferring results should be agreed on before the data collection when commencing guaranteed essential evidence of availability (Gholipour, 2016).

### ***Ensuring Use and Sharing Lessons Learned***

Incorporating a known technique concentrated on procedures assisting individuals has an advantage when participating in the evaluation. Organizing for this procedure provides FEP program staff and clients an opportunity to discover constructive and nonconstructive elements of impending findings and to measure possibilities for CSC program improvements. Delivering and welcoming comments generates an environment of commitment among clients and staff; it allows the evaluation to inform individuals of

how the evaluation is progressing. Gaining a clear perspective and regularly communicating provisional results, conducting conditional analyses, and composing narratives are urged when maintaining episodic examinations throughout every phase of the evaluation method. Therefore, it is imperative to communicate the methods and lessons learned from the assessment to the proper individuals in an efficient manner, impartially and unwaveringly. The assessment encourages FEP program professionals to shed light on their interpretation of the program objectives. For instance, they engage with the evaluation's rationality, persuasion, and principles to identify essential results and create solutions by making changes. The other procedures for the evaluation consist of outlining instruments when identifying outcomes and results through organizational corroborations linked with successful solutions. The advantage of incorporating these procedures is to ensure the underlying principle for commencing an evaluation proceeding is crucial at the initiation of the program.

In general, as part of being health care professionals, they often acknowledge the initial phase of any evaluated program and include their input. Consequently, mental health care practices are generated as FEP clients are assessed with program objectives outlined, inquiries listed, information compiled, assessed, and clarified; decisions formalized; and the objective lesson distributed. Therefore, the structure for the program evaluation satisfies these inquiries provided as follows:

- What is the most effective way to evaluate a program?
- What is being captured and discovered from the CSC program?
- How will lessons learned from the assessment be applied to ensure mental health efforts are more effective and accountable?

These inquiries are essential for overall health care and program officials when integrating strategies that are valuable, trustworthy, practical, and achievable while initiating the structure of a superlative method. The most favorable approach is one that undertakes each step in the framework in a way that adjusts the program environment and meets or goes beyond all-important principles (Gates, 2017).

In essence, an assessment is the only way to isolate programs that foster health and avert harm, illness, or debility from individuals; it is a motivating power for developing operational public and mental health policies, refining existing programs, and revealing outcomes of resource investments. The assessment also focuses on the mutual objectives of public and mental health programs that inquire whether the amount of investment complements the responsibilities achieved (Mpofu et al., 2014).

### **Instrumentation: Interviews**

In line with the ethical principles of social research, the researcher asked for voluntary participation and informed consent (see Appendix A). The researcher required participants submit a consent form through an encrypted email signed either manually or digitally. The consent form had an opening statement to introduce the analysis and provide information concerning the purpose, intent, inspiration, the university they were representing, potential use of data, and methods of data collection. Followed by a statement indicating that by signing the form, the respondent agreed they were choosing to participate in the interview at will and had been informed regarding the research project and potential risks. Thus, each participant was protected at all times through confidentiality unless the research participators were in agreement or requested the publication of their personal information. The researcher wrote a script for the telephone

interviews to ensure all questions asked of participants were necessary for the research and that the researcher was not collecting data that would not be used, in line with the principle of social responsibility. Participants were informed that at any time during the process, they could end the interview and opt out.

This study was based on an in-person interview by exploring participants' perspectives concerning the successful and unsuccessful treatment outcomes of disparities among racial and ethnic minorities within the FEP government-funded CSC programs (Boyce & Neal, 2006). The researcher administered a semistructured interview that combined both structured and unstructured interviews; to view the list of semistructured interview questions, please refer to Appendix B. The semistructured interviews were where the researcher developed and organized a list of questions answered by the respondents with additional follow-up questions for in-depth explanation and clarification. For the participants' convenience and schedule, they had the opportunity to select in-person or phone interviews; choosing either instrument provided the same responses with duplicate semistructured interview questions.

When conducting a question and answer session, the researcher abstained from exhibiting a difference of opinion from the participant's perspectives. It was essential to arrange the interviews during a convenient time frame effectively so the respondent was relaxed and comfortable and experienced limited interruptions in a secure environment (Connaway & Powell, 2010).

## **Data Collection**

### **Data Storage**

Data storage and management procedures were put in place to secure all participant surveys, consent forms, and recordings by the principles outlined in the Data Protection Act of 1998. Files that may be downloaded and transferred from a collection device or platform (e.g., audio recorder, survey platform) were saved on a secure drive that was only accessible to the researcher. Once the data have been transferred and secured, they were deleted from the collection devices or survey platform.

### **Observation**

Observation is a structured and unstructured data collection method that is identified as a participatory study. The structured, systematic model is managed with certain variables with a predefined agenda. The unstructured observation model is conducted in an open and free manner where there is no predetermined variable or objectives (Research Methodology, n.d.). The goal of observational research is to obtain a snapshot of specific accounts of an individual, group, or site.

The researcher conducted a naturalistic observation model. The naturalistic observation model comprised observing health care professionals, state representatives, and the CSC team's behavior in the FEP government-funded CSC programs and how the programs implement culturally sensitive materials and include diverse clientele. The researcher observed the building structure and ease of accessing each program within the suburban neighborhood of Maryland, the office complex in Virginia, and the downtown urban area of District of Columbia. The researcher counted persons of color who were health care professionals and providers in addition to the number of persons of color

accessing the FEP programs. Further, the researcher evaluated the number of racial and ethnic minorities accessing these mental health services, describing the ease of accessing programs demographically.

Additionally, the representation among health care professionals and providers in FEP government-funded CSC programs were described. This observation occurred in the waiting rooms when the facility was busy at different times; the researcher observed how rooms were furnished and what different activities were available, examined and described the tone and quality of interaction between staff and clients, noted the process of enrolling clients in FEP programs, and monitored how health care providers and professionals used office equipment and technology. The researcher participated in a naturalistic manner to ensure the observation was inconspicuous so that the participating programs were in their natural settings and were not aware of their being monitored.

In this naturalistic observation method, the researcher incorporated an observation checklist. The checklist comprised frequency, duration, timing, ratings, and used a guide to focus on the limited number of specific behaviors and situational sampling, as shown in Appendix C. This generated a description that triangulated findings from observing other onsite activities such as interviews to acquire a comprehensive explanation and understanding of the study.

The researcher identified behaviors being observed in their natural environment; the naturalistic observation had a firm theory of validity, which is increasingly hard to formulate with other research studies (Patankar & Sabin, 2010). However, if another researcher is interested in replicating this study, the researcher should look at the client's participation and the client's philosophy of mental health and use the social equity theory



in his or her study to theoretically determine the overview of different locations of the FEP government-funded CSC programs across the United States, the Pacific Jurisdictions, Guam, the Virgin Islands, and Puerto Rico, and the client's phases of life. Also, other researchers should incorporate the effectiveness to optimize business strengths that will improve FEP program operations and efficiently implement accountability among clients and health care providers.

In conducting the naturalistic observation model, the researcher observed the participants' social behaviors that led to understanding their assessment of racial and ethnic inequities when accessing mental health services (Urban Institute, n.d.). The researcher also observed the FEP government-funded CSC program site by reviewing their data, brochures, customer service surveys and pamphlets to identify their interaction with racial and ethnic minority communities.

In conclusion, as mentioned, it is imperative to follow the ethical procedures of informed consent. The researcher emphasized and assured anonymity, and confidentiality was in place for each data collection and ensured the identification of the minimalisms and complexities throughout this study.

### **Data Analysis**

Program strategies for advancing health equity are a challenge on health outcomes, costs, and political and service constraints when implementing health equity initiatives. Racial and ethnic minorities disproportionately endure mental illness and have limited access to health care (Heider, 2016). The programs selected have encountered health disparities and have shared their methods of enhancing health equity by benefitting from their distinctive practices and resources. Both agencies have created

policies to tailor their health care settings, from increasing access to care for impoverished communities to intertwining health equity methods in a comprehensive health care delivery system with excellence attempts to commence distinct health equity initiatives focusing on social elements of health for all communities (Heider, 2016).

The cross-sectional case analysis showed a comparison of three state FEP government-funded CSC program sites and examined and drew from any findings within the snapshot of data obtained from each agency. The study measured the successful and unsuccessful contributing outcomes from the differential treatment of mental health disparities across two groups, Whites and racial and ethnic minorities. The researcher compared the successful and unsuccessful mental health disparities in the same racial categories and only viewed the measure at one point in time (Institute for Work & Health, 2015). The benefit of implementing a cross-sectional case analysis is that it allows comparison among many variables at the same time. For instance, in addition to the White and racial and ethnic minority groups, the study also included subgroups such as educational level, income, and health care coverage.

With data showing access to care and quality intervention expanding the progression of mental health disorders, the principal aim is to diminish racial and ethnic mental health inequalities by transforming the health care system under the HHS through initiatives. Health agencies are integrating behavioral and mental health services into primary care services to confront the social determinants of mental health care. There are programs and health facilities that may perhaps improve the decline of mental health disparities. To focus on this belief, there are general methods for improving access to reducing disparities. Alegría et al. (2016) proposed expanding outreach beyond mental

health facilities with a focus on engaging racial and ethnic minority groups. Alegría et al. also discussed the auspicious programs customized to lessen behavioral and mental health disparities. Some promising intercessions might expand access to behavioral and mental health care, such as combining mental health services into programs that provide housing, employment, social services, language-specific treatment; diminishing the stigma connected with acquiring treatment; and appropriately educating patients, families, and health care professionals unfamiliar with culturally competent protocols. Incorporating these elements for mental health can involve community organization, primary care programs, facilities, and telehealth. Tele-health has thousands of units extending difficult populated areas, for instance, impoverished and uninsured communities (Alegría et al., 2016). Tele-health has integrated mental and behavioral health outreach and triage screenings to their services. This mechanism will offer and deliver more supportive mental health treatment, interventions, and evidence-based practices (EBPs) in addition to increasing adequately trained and educated health care professionals in the workforce and delivering mental health resources, materials, and services to patients and their family members (Alegría et al., 2016).

Connecting multiple case study methods and cross-sectional case analysis ignites the scholar's concept, inspires further inquiries, forms innovative factors, generates alternative outcomes, and creates viewpoints and ideals (Stretton, 1969). Cross-sectional case analysis permits researchers to describe codes that may have impacted the outcomes of a case. Cross-sectional case analysis also searches for or composes a description as to why one case is unique or similar to other cases, understands the challenges or distinctive outcomes, and extends communication of the models, principles, or concepts revealed or

assembled from an initial case (Khan & VanWynsberghe, 2008). Cross-sectional case analysis increases the scholar's ability to recognize existing correlations among cases, understand how information is gathered from primary cases, enhance and improve models (Ragin, 1997), and assemble or analyze theories (Eckstein, 2002). Additionally, cross-sectional case analysis permits the researcher to evaluate cases from several settings, by groups, communities, populations, programs, or individually. This element affords opportunities to understand diverse cases and collect essential evidence from revising policies (Khan & VanWynsberghe, 2008).

In this study, the researcher used qualitative methods derived from semistructured interviews and naturalistic observations. Obtaining unmodified results from qualitative data is impossible, unlike quantitative methods by which distinctive data preparation and data analysis are transparent.

The following are steps of the data preparation for the qualitative study analysis process (Haregu, 2012).

- Phase 1: The researcher used two quality audio recording devices and conducted a naturalistic observation analysis. Using the audio recordings offered a verbatim transcription of the semistructured interviews. For the method analysis, the researcher obtained assistance from REV transcription services to decipher dialogue from each participant. This process allowed the researcher to submerge in the data. When conducting the naturalistic observation, the researcher observed the body language, heightened speech and demeanor, took notes, and gauged the environment to understand what each participant communicated fully.

- Phase 2: Using audio recording and transcription services was vital when interpreting the interviews. This allowed the researcher to become conversant with the data significantly in addition to connecting the naturalistic observation analysis to compare what was said and displayed.
- Phase 3: After being familiarized with the data, the researcher carefully reviewed transcripts line by line by coding, paraphrasing, and labeling the description of what she perceived from the audio recording and the naturalistic observation check-list. For this research study, coding was done through NVivo, a digitally equipped method to keep track of themes and sub-themes.
- Phase 4: Once a few transcripts coded, the researcher requested assistance from a colleague to ensure the coding was accurate and appropriately aligned with the transcripts. Using NVivo was useful and quickly allowed the researcher to retrieve the data effortlessly.
- Phase 5: The researcher outlined the data to generate and summarize each transcript. This method decreased the data and preserved an organic impression of each semistructured interview, illustrating the coded participant responses.
- Phase 6: The researcher outlined themes and subthemes from each transcript, comparing and contrasting consistency and maintaining the connection to other aspects of each participant's interpretation. This method automatically identified using NVivo.
- Phase 7: The researcher progressively viewed the variances among the data and descriptions identified, generating typologies, cross-examining theoretical

concepts, and extracting connections between groupings to examine formal and unplanned connections.

Using these phases of data analysis was essential when evaluating themes that generate explanatory and analytical emphasis on the phenomena that impact health care services and ignite health policy (Gale et al., 2013).

## CHAPTER 4: RESULTS

The purpose of this study was to understand racial and ethnic minorities underutilizing mental health services and will also describe the differential access rates for treatment services in first-episode psychosis government-funded coordinated specialty care programs. Recognizing the effect of eliminating disparities through knowledge, training, representation, and proper guidelines form the purpose of this study. By evaluating the methods used in the chosen states, illustrate the principal and accompanying data components paralleled with the reliability and validity assessment delivering precise data for health professionals, government officials, coordinated specialty care (CSC) program coordinators, and peer specialist to develop practices and health outcomes of improving relationships with clients suffering from first-episode psychosis (FEP).

### **Research Question**

How have government-funded coordinated specialty care programs attempted to address racial and ethnic minorities' underutilization of mental health services?

### **Description of Population and Sample**

The population for this study focused on Washington, DC, and Virginia; the two areas selected were based on location accessibility and comprised a purposive sample. In Chapter 3, three program locations were identified in the study: Washington, DC, Maryland, and Virginia. Unfortunately, Maryland's FEP program did not participate in the study after several attempts with state officials. Virginia and Washington, DC, provided insight into their FEP programs, comprising 13 participants overall. The research study highlights the differential treatment of mental health disparities between

Whites and racial and ethnic minorities. The purpose of selecting these states summarizes the importance of racial and ethnic minorities accessing FEP government-funded CSC programs. The chapter includes an examination of analysis consistent with the literature review, qualitative methodology, and connection to the research question. Chapter 4 comprises responses from semistructured interview questions, a naturalistic observation checklist, and an inductive coding mechanism examining data collection.

The sample of individuals interviewed consisted of eight women and five men ranging from social workers, psychiatrists, data specialists, peer specialists, program coordinators, government officials, and clinicians, totaling 13 participants. Each participant's code name was identified as Program A representative or Program B representative. For example, Program A had six women (one clinician, one program coordinator, two social workers, one psychiatrist, and one government official) and two men (one psychiatrist, and one data specialist) in their respective programs. Program B included two women (one clinician and one peer specialist) and three men (one social worker, one government official, and one psychiatrist) employed in their facilities. The representatives coded were categorized as Participants 101-113. The researcher enlisted the program and participants utilizing the purposive sampling based on the location, accessibility of evaluating, and assessing a diverse population (Laerd Dissertation, n.d.).

### **Qualitative Data Methods**

The participants received an initial email request, inquiring about their interest and consent. Once the participants expressed interest, they were given a confidentiality consent form and asked to sign for discretionary purposes. The researcher interviewed 13 participants from seven semistructured questions, followed with organic supplemental



inquiries. Two digital audio recorders acquired the interviews, one through a Samsung voice app (Voice Recorder) and one through a Sony digital recorder. Both recorders captured the 13 participants' responses accurately for transcription purposes. The transcription services were conducted by Rev services. Rev transcription is a service by which the company transcribes auditory and video recordings to text and subtitles in over eight languages. After the transcribed audio, the researcher used NVivo 12, which is software that efficiently imports raw data from any source, providing visualization tools, data management, and it discovers complexity within the analyzed data. NVivo handles bulk data that identify themes and subthemes. NVivo software permitted the researcher to collect a variety of documents into one while searching through the designs. Reading through the data responses created an understanding of where the themes were arising and which themes were suitable for the nodes in NVivo.

### ***Data Analysis Steps***

#### **Stage 1: Measure**

1. The researcher ensured that the interview process flowed in a continuous pattern and concluded in a bid to minimize any form of bias that might generate from the interview questions. For instance, there were explicitly designed questions for the interviews; the researcher allowed the use of additional questions with the view of grasping an in-depth perspective of the participants on the subject of the discussion.

### **Stage 2: Phenomenological Reduction**

1. All transcripts were read several times, and unrelated and repetitive text was removed to ensure clarity. At the initial stage, the data were qualitative and read about eight times, followed by careful and meticulous study of the transcript.
2. Each transcript was read through to ascribe meaning to expressions and identify commonalities. Participants' meaning units were assigned through the identification of specific phrases and sentences. In some instances, the phrase could mean more than one thing (two or more codes on the same phrase or sentence), and in some instances, participants may have indicated the same phrase or more than one phrase using a different sentence structure.
3. Significant statements from each participant were identified.
4. The analysis of all transcripts unrelated to the research question labeled themes from the participant's perspective were removed.
5. Textual description based on the responses of the participants was formulated at this stage.
6. All relevant codes were labeled

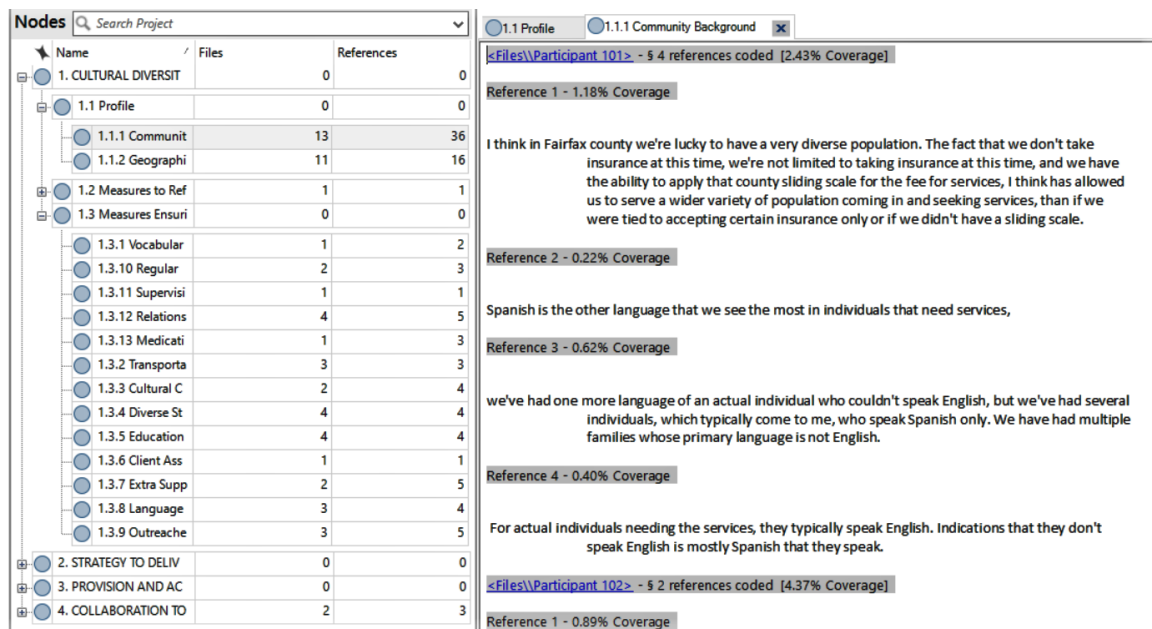
### **Stage 3: Imaginative Variation**

1. The codes were grouped to form themes.
2. Using NVivo 12 (qualitative analysis software program owned by QSR International), a coding process, similar statements were grouped with codes to form themes.

Figure 2 shows a screenshot of NVivo coding theme references.

**Figure 2**

*NVivo Coding Theme References*



**Stage 4: Synthesis**

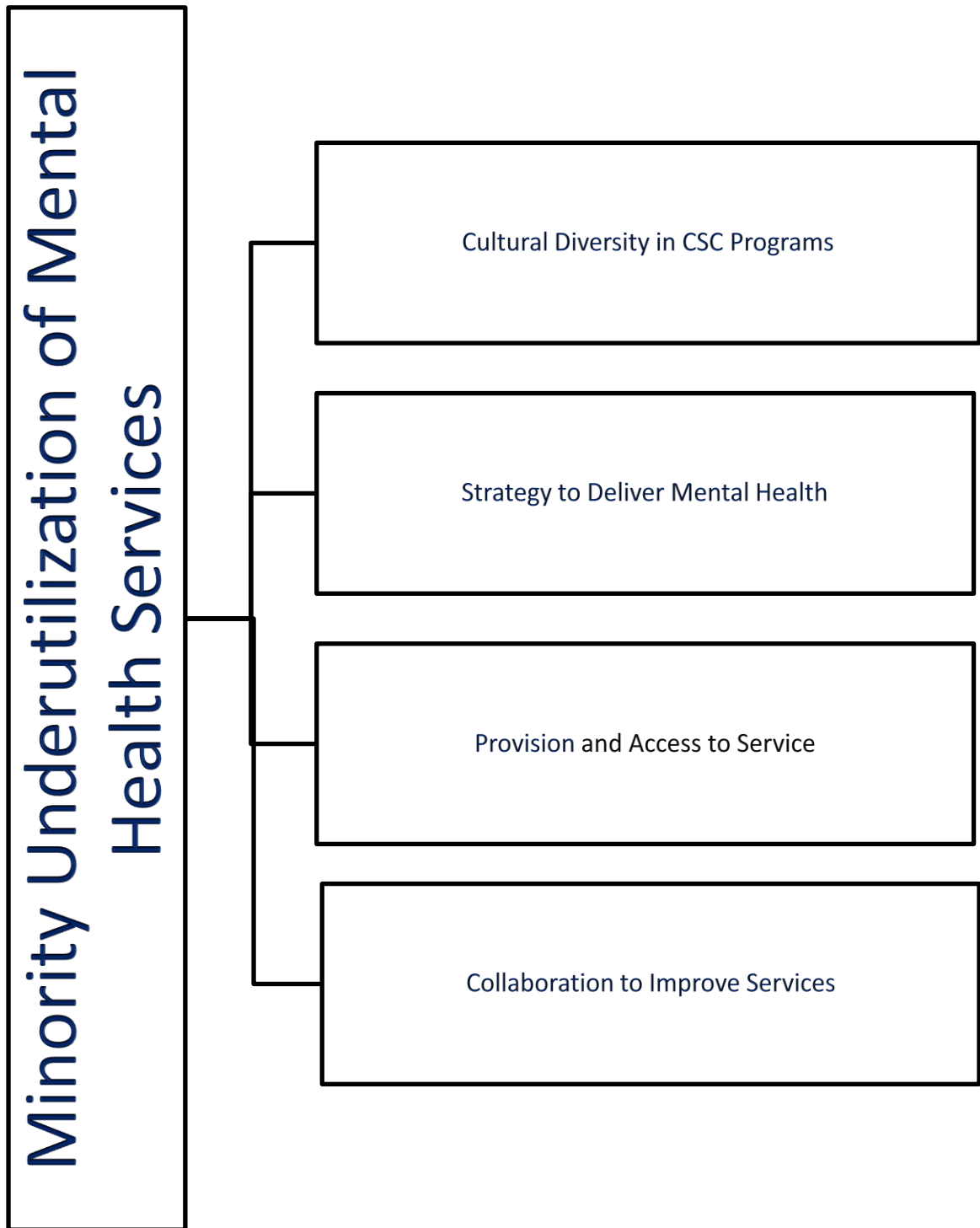
1. The textual descriptions were read and reread and developed into emerging themes.
2. The primary emerging themes were then labeled and checked against the verbatim responses from the participant.
3. The structural descriptions emerged from the analysis of the textual descriptions of ( $N = 13$ ) participants. The following section reveals the developed themes and their supporting codes upon completion of organization and extraction from NVivo.

A word cloud figure generated to depict the most used words by the participants was done as an initial step to check whether most used words aligned with the research focus. It provided a quick review of the collected data. The word cloud shows the



**Figure 4**

*Minority Underutilization of Mental Health Services Theme*



## **Cultural Diversity in Coordinated Specialty Care Program Area**

### ***Profile: Community-Perceived Demographics of Clients Served***

The participants described serving people from various backgrounds; when it comes to ethnicity, the majority of those being served are the Black and LatinX or the Spanish-speaking communities. One of the respondents said, “I would say 90% of our clients are African Americans” (Program Participant106). A different respondent also commented, “In terms of the cultural diversity that we work with, we primarily work with consumers in the African American community” (Participant 110). There are Whites who also access these FEP services though not in large numbers. “I would say that the majority of my clients are not Caucasian” (Participant 113). Another respondent also said, “Spanish is the other language that we see the most in individuals that need services” (Participant 101).

Regarding income, there is a wide range among the population that tends to access the FEP program. There are clients from impoverished backgrounds, according to some of the respondents, and those termed as well-off. Participant 105 said, “I think that one of the distinguishing features of this demographic is that there is a very wide range of incomes . . . so a very diverse, wide range, socioeconomically.”

Some are from impoverished backgrounds and are homeless or could be in housing programs, and according to one of the respondents, these are the majority if not the only people who access the FEP services. According to Participant 109, “This agency really don’t service people that are not impoverished communities. Literally, that’s it, for the most part. It’s probably a handful that’s not. But for the FEP program specifically, most of them are couch surfing.” These individuals move from one place to another

seeking housing and mostly end up sleeping on other people’s couches; a term used by some of the respondents for this is “couch surging.” Figure 5 shows some of the words the respondents used to describe the profile of the clients who receive the FEP services.

**Figure 5**

*Expressions From Respondents*



***Profile: How Cultural Diversity Is Reflected***

The following are the measures taken by the agencies offering the FEP program to reflect cultural diversity.

**Competency Training.** To ensure that staff members are culturally competent, they are taken through training on cultural diversity and how to handle marginalized communities. Participant 107 stated, “We educate ourselves, go to training seminars on how to serve certain populations that may be experiencing discrimination.” According to some of the respondents, these sessions of training are offered by the county and mandatory for staff who are going to work with diverse groups of people, “The county

actually does do mandatory cultural diversity trainings. We try to get staff as involved in that kind of training” (Participant 112). Some respondents also admitted to seeking out and doing training and looking up content on their own accord. Participant 104 said,

I don’t know like, as a team personally, what they may do individually to go out and get those things. I know myself. I can talk about myself. I like to read up on things. So, I do do a lot of looking up sometimes on cautious I don’t understand.

Unfortunately, no additional comments were made on the quality of training and how effective it would be if included with diverse individuals.

**Diverse Staff.** Another way of reflecting cultural diversity according to some of the respondents is having a diverse team to deal with a diverse population coming into the agency for assistance. One of the respondents commented,

I’m going to be 100% honest with you and say and possibly because those who are receiving services and those delivering the services were of the same ethnic background it really hasn’t come up as an issue in terms of disparity or even inability to access services. (Participant 102)

Most of the respondents said that their teams consist of staff members who are multilingual, and this helps in working with clients who cannot speak or understand English. Participant 107 said, “We are very fortunate to have multilingual staff on our team, and that is one of the key ways of how, for our program, that we try to assist individuals with SMI.” Although both programs are looking to increase their hiring efforts to employ multilinguists, the staff they have currently were hired for their skill-set, knowledge, and expertise, not necessarily for their bilingual abilities. However,



Participant 103 also said, “Staff available don’t represent every language. There are languages that they don’t have any staff able to communicate in.”

**Language Accommodative Services and Staff.** Most of these agencies have interpretation services available to cater to those clients who cannot speak or understand English. This might not be the case in some of the agencies; some respondents admitted to having very few multilingual staff on their teams, and this can sometimes limit them. One of the comments made about this was, “We have had multiple families whose primary language is not English. For that, we have access to interpretation services, pretty unlimited thankfully” (Participant 101). These services are done using either an iPad or by a physical interpreter. This helps in ensuring that clients from different cultures are catered to. The fact that there are tools in place to help translate reflects cultural diversity.

**Tailored Services.** Services offered are individual-based and tailored to fit the needs of each client. The needs are done by keeping one’s culture and beliefs in mind. Participant 107 stated,

We respect their culture, their background, we’re competent about the, I guess, that certain demographic just understanding intergenerational things that affect kids when they are just transitioning into adulthood phase, and we make sure that we’re doing what they want to do.

Another comment made about this was, “We tailor fit the services to the client or the youth” (Participant 107).

**Staff With Serious Mental Illness Experience.** According to one single respondent, this particular agency also hires staff members who have dealt with young

people and people with mental health issues. The agency ensures staff members understand what the clients' needs are and deliver appropriate services to them. According to Participant 102, "It ensures that it meets those things because staff that works on the project, either young adults who have experience or have had someone in their family experience SMIs."

**Staff Collaboration.** As staff collaborates, effectively communicates, and have an open dialogue, it will enable staff to deliver culturally competent services. When staff comes together, they can share ideas and come up with solutions on how to handle specific cases, and also refer cases to best-suited caseworkers. One of the respondents said,

I think what our program does is try to provide the opportunity for us to coordinate with each other. Our team is already diverse, so we have people from different places. We have some people that are bilingual, and we do kind of depend on each other for some support with being culturally aware. (Participant 104)

**Outreach.** There are efforts to take information about the FEP program out into the community. This has been done through radio broadcasting, videos, and the creation of websites. There are community outreaches done through visits to the communities that may not be aware of the existence of the FEP program. One respondent said, "We encourage our staff members to identify any populations that they feel are not being served, and we try to encourage a full discussion around outreach to different community organizations that may not be familiar with our services" (Participant 103).

### ***Profile: Ensuring Services Are Responsive to Cultural Diversity***

Various measures have been put in place to make sure that the services provided for the SMI clients respond to cultural diversity.

**Relationships With Other Involved Parties.** Creating a relationship with other parties who handle the clients is one of the ways that the agencies ensure that this is achieved. Being in contact with other support systems a client has in the community is a way to ensure they are getting services that suit their needs. Participant 113 related, “Truancy, we are always having a good relationship with the schools. The schools know that we’re involved, so we’re all working together.” When a client is a truant, then the caseworkers can handle the situation better when they are in contact with the school. All this is to ensure the client gets the services they need:

In some cases, like in extreme cases, we do make reports to Child Protective Services if we need to. Those are more in the cases of they’re not going to school, but they’re also not getting proper nutrition, or not being clothed every day, or having soiled clothing, because we’ve had a couple people on other clinicians’ caseloads where that’ll happen. Then we do have to put in a report too. (Participant 112)

**Education.** Another way of ensuring that the services respond to different cultures is through education. The staff members educate themselves on current cultural issues and discrimination. Participant 107 said, “I mean we educate ourselves on the current disparities in impoverished communities.” Another respondent commented, “Training each clinician to handle that in a very sensitive way. Providing the education

behind it but not pushing the issue, kind of allowing them to still make their own decisions” (Participant 107).

**Outreach.** Cultural diversity is achieved when staff outreaches to the community and individuals in the neighborhood, which reduces any barriers clients may have that are stopping them from accessing services at the facilities. One respondent said,

One of the good things about a CSC program is that we do have the ability to do community engagement, community outreach, as opposed to individuals that may have difficulties with transportation or accessing a mental health center.

(Participant 103)

When services are taken to them at their homes, they have nothing hindering them from receiving the appropriate services for their conditions.

**Diverse Staff.** Having a diverse team also helps in capturing cultural diversity; not having this can cause obstacles when serving clients. According to one of the respondents, “If you don’t have diversity on your team, then it’s sometimes harder to have those conversations or even bring awareness” (Participant 108). Having staff from different backgrounds ensures that various clients can be assisted with minimal to no obstacles.

**Cultural Competency.** Having staff members who know and understand the culture of clients is an excellent way of ensuring that the services provided respond to cultural diversity. Staff can do this by learning the different cultures, what their needs are, and how to handle them, “We try to inform ourselves about the different cultural background of individuals from beginning the assessment, and we take that into

consideration when we're assessing for symptoms and proposing treatment interventions," said Participant 101.

**Regular Meetings.** Another way is having regular meetings and discussions among the staff members about the different cases that might be posing challenges to some of the caseworkers. This way, the staff can come up with solutions together as Participant 112 said, "We have many staff meetings through the week actually. We speak with our psychiatrist throughout the week; we also do team staffing on Fridays. . . . We talk about different issues that might be going on for some people's families."

**Extra Support Programs.** There are other support programs in place to help clients from various cultural backgrounds, which might not necessarily be direct services for mental health. Some programs help these clients get housing, employment, and even food. Participant 113 said, "We definitely help people get into a shelter until we can have them sit down and apply for housing." Another respondent also commented, "We create job opportunities, internships to make sure that the minorities are getting access to some type of employment readiness just to support them" (Participant 107).

**Client Assessment.** According to one of the respondents, to ensure that the services provided to the clients are receptive to cultural diversity, client assessments are completed. This helps staff understand the needs of the client and whether the agency can provide the services they need:

We get referrals, and then we do an assessment. We do a psychiatric assessment. . . . We have a process; in fact, that first thing I said is to see if they qualify for our program; there are guidelines. If they do will take them, and we work with

them. If they don't, will assess to see what are the services that they need, and then we refer them to those services. (Participant 106)

**Medication Subsidy.** Medication subsidy is enacted to ensure clients can receive medication even when they are not able to afford it. Participant 103 stated, "To reduce any barriers to getting the mental health services they may need. The agency will also do a CSB subsidy for the cost of the medications." This subsidy reduces the costs of medication or covers the full cost of the medication for individuals below the poverty level.

**Supervision.** According to one respondent, supervisions are also done to ensure that the services provided to the beneficiaries are responsive to cultural diversity, "providing supervision to clinicians that are doing direct service" (Participant 108).

**Vocabulary.** Use of vocabulary that is respectful to the clients and that they use themselves to describe their condition is another way of ensuring all cultures are respected and clients' beliefs are respected. One of the respondents commented, "We use the language that they use, not just in terms of the language barrier, but the vocabulary they use, to refer to different symptoms or different concerns. We use the same words they use" (Participant, 101).

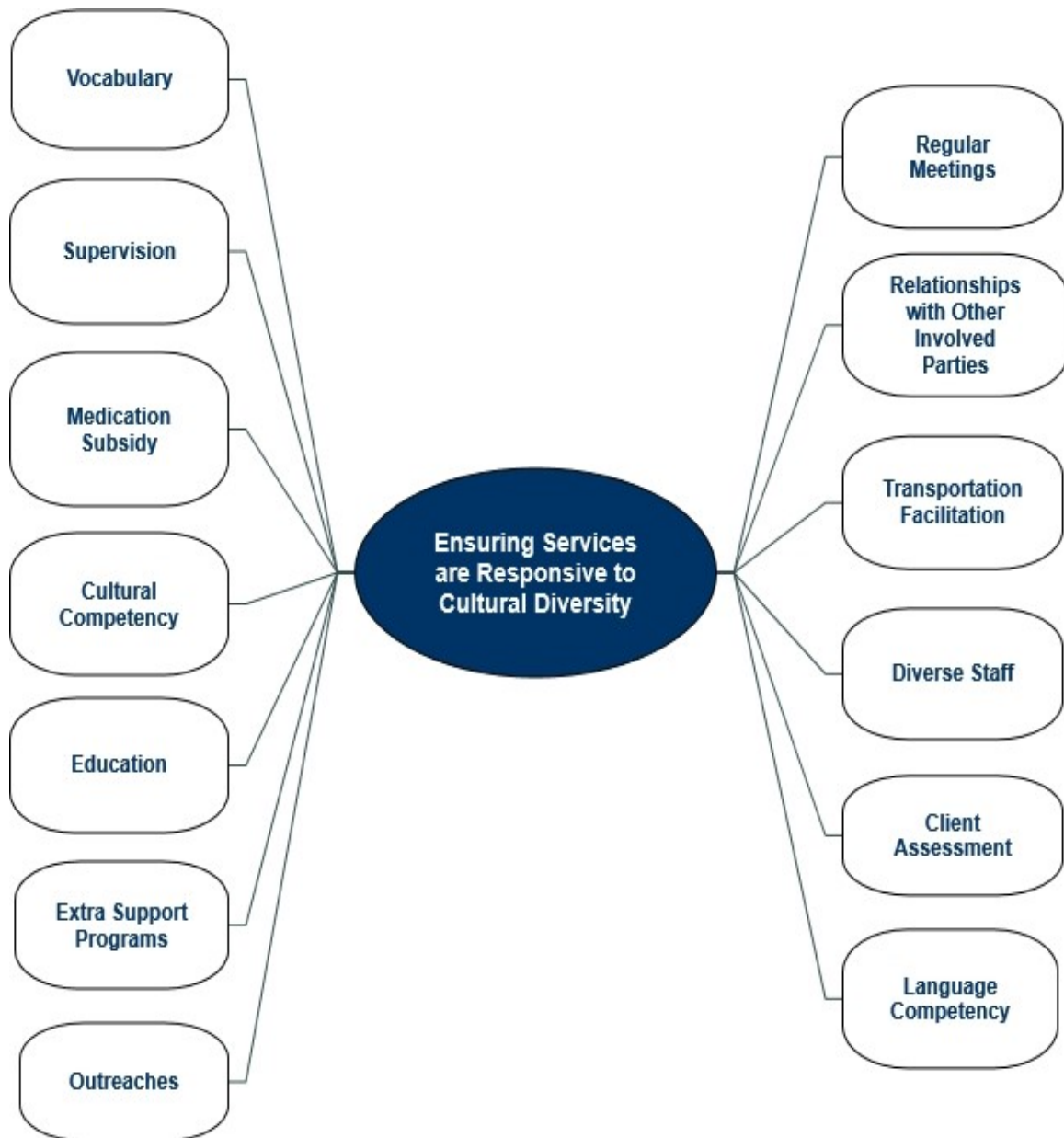
Figure 6 shows measures in place to ensure that the services provided are responsive to cultural diversity.

### **Strategy to Deliver Mental Health Services**

The following are strategies used by various agencies to assist the minority ethnic groups in the community access mental health services:

**Figure 6**

*Cultural Diversity Measures*



***Addressing Language Barriers***

One of the ways to ensure services are delivered effectively to the clients is by eliminating language barriers. One of the respondents commented, “For the language barrier, like I said, we have interpretation services in those three different ways: in

person, by phone, and by video” (Participant 101). By having translation services in place, all clients can access services without interference.

**Open Discussions.** Having open discussions with clients also contributes to receiving excellent FEP services. When a caseworker sits down with a client to find out the root of their behavior or their belief, then the caseworker helps the client appropriately. A comment made about this was as follows:

Having an open dialogue with individuals about their culture or their identity and how that may have played an impact on the services that they receive and what they would like and just really being person-centered and talking to them about we have to sometimes do different graphic information, how do they identify, and really just having an open dialogue about how their upbringing or culture has really influenced them and how it influences them today. (Participant 103)

**Transition to Relevant Agencies.** Other steps put in place include transitioning clients from one agency to the next depending on where they will get the best services for their condition. If they need a higher level of care, they are transitioned into an agency that can give them the best care. One of the respondents said,

So the steps are that if this person needs high level of care or just needs more intense care, we’re able to make sure that we can continue care that they need. And so that’s the step is just creating an intake for this population like a separate intake. (Participant 107)

**Tailored Approach.** Giving individualized care to clients is another strategy to assist in delivering the best care for FEP clients. The provider is sensitive to their beliefs,



culture, and tailors the care around what the client wants and believes; this effect is compared to a one-size-fits-all approach.

**Awareness and Education.** Being culturally competent is also a way of ensuring that clients receive the best services when pursuing an FEP program. One comment indicated, “I think being, as you just mentioned, culturally and linguistically aware and competent would be the biggest thing. I don’t think it’s a matter of race, but I think it’s a matter of awareness” (Participant 102). Awareness should also be executed throughout the community to avoid victimization and stigma. Participant 111 declared, “I guess the most important would be educating the community, would probably be the most important.”

**Transportation.** Assisting clients with transportation was another factor that was revealed during the interviews as a strategy to help clients receive mental health services. One of the respondents said, “The program provides transportation for young adults, so the kid won’t have to spend money out of his own pocket.” Another one commented, “CSB in general, we have a partner from the independent center who helps to do the metro cards, and its reduced fare cards” (Participant 104).

**Emphasis on Independence.** Another strategy that helps clients get better mentally is to have them become independent and not dependent on other people as Participant 110 shared, “The ultimate goal should be though, is making all the consumers in the FEP programs to be independent.” Therefore, the caseworkers strive to make a client independent using the TIP model, where clients establish life choices through available options of employment, housing, and educational opportunities.

**Collaborations.** Collaborating with other government programs and agencies in the community is another way of ensuring that clients can access mental health services effectively and efficiently. Referring to them from one provider to the next is a way to help clients get the best appropriate services for their conditions. One of the respondents said, “also collaboration with community partners. If we don’t have a dialogue with other communities’ partners, then we don’t have access” (Participant 108).

**Culturally Competent Staff.** Employees hired by agencies that offer mental health services like the FEP programs must ensure that staff with highly skilled experience work with clients. A comment made about this was as follows:

Another initiative is that we hire people from D.C., who are familiar with the environment, hire people who are representative of those populations. There’s sort of understanding of where the clients are coming from; that’s I think it’s important and effective. (Participant 106)

**Expansion of Services.** Another way of ensuring that mental health services are accessed is through the expansion of existing services, according to one of the respondents. Participant 106 said,

A third would be it’s sort of an initiative to expand services. We are small, we are one entity in this city, and the demand is much higher than what we can manage. There’s always this constant push to expand our services.

**Funding Strategies.** According to some of the respondents, several funding strategies are to help improve mental health service access.

**Grants.** External and other grant funding was the primary source of funding mentioned by the respondents. The agencies receive grants from various institutions and

establishments to help put programs together for the impoverished and the ethnic minority communities to help them access mental health services available. Participant 106 said, “With the FEP specifically, we get the grants, we get 10% of the Block grant goes towards FEP. That has been supporting our program over the last 4 years” (Participant 106). Participant 110 said,

Well, that’s where we’re really talking about our grants. We apply for multiple grants every year. And what these grants can do for us is they really can allow us to kind of open up our services to increase engagement.

**Medicaid.** Some respondents mentioned Medicaid as a source of funding for their services as indicated by Participant 106: “As a nonprofit most of our funding is through Medicaid.” Another respondent commented, “Well, here as an agency we, Medicaid is the funding that supports us to provide mental health services for minorities and ethnic groups” (Participant 106).

**Not Available.** Some respondents admitted to having little to no funding strategy in place to help them provide services to the underserved racial and ethnic communities. Participant 103 said, “I don’t believe that for our funding that we have anything in particular set aside for that.”

## **Provision and Access to Services**

### ***Perspective on Challenges Faced***

#### **Challenges Faced by Clients**

**Stigma.** Stigma is one of the most significant challenges faced by clients who have FEP among other mental health conditions. Participant 101 said, “That psychosis base has a very strong stigma against it, unfortunately.” This is because a person may

react to hallucinations and voices, which are symptoms of this condition. It is accompanied by discrimination, and most times, FEP is misconceived to be because of substance abuse.

***Language Barrier.*** The language barrier is another challenge that was mentioned by the respondents as a factor that hinders clients from receiving the appropriate mental health care. One respondent said,

The Hispanic population would be, I think, the most significant minority. I think that has been challenging, both language-wise. I've had concerns about some of the cognitive therapy of psychosis that we've been, I think, less able to do that effectively just because of language. (Participant 111)

***Lack of Funding.*** Lack of funds is another challenge that prohibits clients from seeking mental health care services. The fear of health care costs for services provided is substantial. Participant 101 stated, "We still have some families that will decline because of the fear of the fee or the cost of the services." Participant 101 also said, "I know sometimes I've had at least a couple cases that they decline services because they didn't understand how the cost of the program would work." Also, the lack of funding for the agencies to enable them to deliver mental health care services such as tracking and advocacy services is a challenge. Participant 108 said, "I also wish we had more funding for advocacy work and awareness work so we could spread the word of our program and also make the program larger than it is."

***Housing Limitations.*** Some of the clients who seek out these FEP services are homeless, so they cannot seek services consistently because they are always worried about their living conditions and their survival as stated by Participant 107: "They're

homeless. So, their focus [is] on eating and living and can't retain services." Another respondent also commented,

But it's tough because, for example, there's a housing crisis. If you don't have access to basic needs like adequate shelter, you can afford shelter, a home, then where do the initiatives for the other disparities support? . . . That's why it's tough because there's progress in some areas, and then there's not progress in others.

(Participant 108)

**Unawareness.** Lack of awareness is another challenge faced by racial and ethnic minority groups who need FEP services. The fact that they may not be aware of what FEP is makes very clear the need for them to access these services. They end up using other methods to try and get better, with some resorting to their religious and cultural remedies. A comment made about this was the following:

I would say there's limited awareness. A lot of people in the community don't know what first-episode psychosis is. It's a relatively new area in the field of mental health too, so I'd say it's limited. Clients, they're informed by who they're working with, so unless there's been a dialogue between them and the case manager or clinician, typically there's limited awareness there too.

(Participant 108)

**Transportation Limitations.** Lack of transportation means leads to clients not accessing mental health services. So, clients' movement is limited if they don't have a means of transport to move from one place to the other. Participant 106 said, "If you don't have a car it's hard to navigate without the car. It's limited."

***Family Pressure.*** There are instances where a client may not be on the same page with his or her family when it comes to their mental health care. Having to fight family to get what they want can limit their access to appropriate services for their mental health condition. One respondent commented, “We’ve had actual cases where the individual doesn’t want to get off medications, but the family are pushing for them to get off medications because of their beliefs and their cultural background” (Participant 101).

***Religious Beliefs.*** According to some of the respondents, religious beliefs are another factor that inhibits clients from seeking mental health services. Some people believe that their faith will make their family members better:

There’s also the religious part. For one of the families, there’s a religious part of, Well, God will take care of him. God will work through you guys to help him get better. Now he’s better, and he will take care of him moving forward. (Participant 101)

***Late Diagnosis.*** Being diagnosed late is another contributor to clients not being able to receive the appropriate services for their mental health needs and get better; if identified at a later stage, they might end up not getting stable with minimal care:

One of the most upsetting elements have been when people are identified and come into the program, and they’ve been sick for a while, and their likelihood of doing well diminishes when they’re psychotic for a longer period of time without treatment. And I wish that they were brought in sooner. (Participant 111)

***Provider Bias.*** According to one of the respondents, there are mental health care providers who are biased against Black people and will not give them the services they need for their conditions. Participant 105 said,

I also think that there's an overrepresentation of young Black guys that are referred to this program because . . . I don't know why. I can't say for sure, but it seems like White doctors and therapists just get freaked out. They just don't think critically when they see a young Black guy, who's got any kind of problems or trouble or communication problems or especially anger problems. They don't think as well. They just want him to go somewhere else. We can't handle him. He needs someone else. He needs special, special, special, special care.

***Transition Between Programs.*** Clients face challenges when they have to transition to other programs outside the FEP program that are put in place by some of the agencies. This is because, under the FEP program, they tend to get intensive care that they would not get in other programs that they may transition into. Participant 111 stated,

I think the biggest challenge would be the transition of somebody graduating from the program and then going off to their own treatment outside of the program. The program itself, I feel, is very intensive treatment that is actually beyond what any insurance would pay for and beyond what most families with money to pay for. So that's one of the one of the great things about the program.

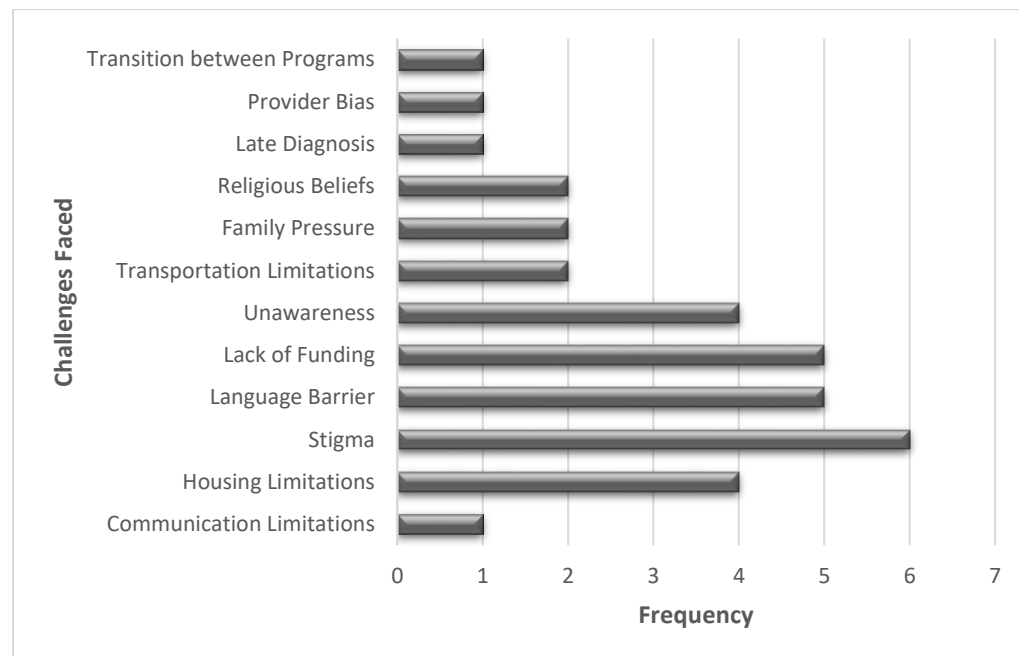
***Environment.*** The neighborhoods that some clients reside in possess a challenge for them. This may be because of the lack of stability in neighborhoods or concerns regarding their limited success compared to others. This may interfere with clients' mental health and their ability to access care. Participant 110 said, "If we have a client who comes in with depression and they're in a community where they are consistently





**Figure 8**

*FEP Client Challenges*



**Challenges Faced by Providers**

***Language Barrier.*** The language barrier came up as something that hinders providers from giving their clients the appropriate services for their conditions. Hence, it affects the delivery of mental health services. Participant 110 said, “I’ve had situations where I’ve had to go to other people from different departments because I’ve had a couple of clients who are Spanish only speaking, and I don’t speak Spanish, and it’s inconvenient.”

***Limited Resources.*** Having limited resources also came up as a challenge to the delivery of mental health services by the providers. A participant commented, “Because providing the services in Spanish to then document everything in English, or looking for resources in Spanish, they’re not necessarily available. For the families, it takes a little

bit more time and effort” (Participant 101). Having limited resources results to providers giving limited care to the clients according to Participant 106:

We see a lot of times situations where the need is much greater than what we can offer. There is a deficit that is not retained our competency, but it’s there, and it impacts how we can serve in that way.

***Distrust.*** According to some of the respondents, some clients do not trust health care providers enough to make much of their mental health status fully. They only come in to get specific types of care and not everything. Participant 105 said,

I think different family’s mistrust and misuse the different health care services for different reasons. I think that a lot of the Middle Eastern and West African families just don’t trust authority figures, in general. They just think that it’s all a scam and is a hustle, and they know better, and they’re going to get what they need from us and not mess with the rest. We’ll hear from them half stories of what’s actually happened in the past, or who they’ve contacted, or who they worked with, and then it’ll only come out months later the whole story, and the parents will tell us, “Oh, we didn’t trust the school,” or, “We didn’t trust this clinic or this doctor, so we just did what we thought would be best for the kid.” I think that’s about mistrust and misuse.

***Lack of Confidence in Treatment.*** Some clients do not have confidence in the health care system as a whole when it is providing FEP services. They will partake in some services but opt out of others. Participant 105 said, “A lot of our families from Southeast Asia just don’t believe in therapy. They just don’t get it, and so the families

will be happy to bring the patients in for medication management appointments, but not when it comes to therapy.”

***Unwillingness.*** One of the respondents also mentioned unwillingness as one of the main factors hindering the delivery of mental health services. Participant 107 said, “It could be the symptoms are just intense that I’m not willing to do anything. So, it’s just willingness, I guess.”

***The Disconnect Between Micro- and Macrolevels.*** There is a disconnect between individuals in leadership positions of the FEP program and direct service staff working with clients personally. This is because there is no communication from the top to the bottom about issues that affect service delivery, and direct service employees feel unheard and underappreciated. One of the comments made about this was as follows:

There’s definitely a break in communication because one side doesn’t feel necessarily heard, and you see that more with the individuals that have more contact with the clients directly. They may feel like, “Well, what’s being done at the macrolevel, because we continue to see the same issues and you guys continue to have your meetings and all of that.” But they’re not necessarily made aware.  
(Participant 108)

***Client Overexpectation.*** There are instances where clients may expect primary care services in addition to mental health services. This hinders providers from doing the job they are supposed to do and deliver the proper services they are required to deliver. One of the respondents commented,

The FEP program is based on psychosis, and a lot of times, there are other issues that the client may want to address other than their psychosis. And that’s a

challenge, and a barrier is that we're not just doing case management and just running around doing things for people. It's just we're actually helping doing modules doing work. And I think that the expectation of service is a barrier.

Because people expect certain things when they know they're involved in mental health or any type of community support of that nature. (Participant 107)

***Client Withholding Information.*** When a client withholds information, that is important; it alters services delivered to them, and it becomes a hindrance. Also, it could lead to clients having an extended care plan or an improper care plan because of the lack of information. Participant 105 illustrated this:

The teachers, who want the kid to get the treatment, will not emphasize some parts of the behavior, because they think it'll scare us or intimidate us, or they'll attribute a lot of behaviors to a psychosis, because they think, oh, we're the program that handles psychosis, and if this young man is being inappropriate with the females or losing his temper or not coming to class, and they attribute it to psychosis, then we're going to help and fix it.

Table 1 shows the frequency distribution and relative frequency of the challenges faced by the providers (out of 13 participants).

***Countering Challenges.*** These are suggested by respondents to be ways in which these challenges are countered.

### ***Clients***

**Open Discussion.** Having open discussions with clients and their families is one of the methods used, but respondents indicated that there are challenges. Having discussions helps providers and the clients identify some of the triggers and reasons

**Table 1***FEP Frequency Distribution*

Challenges faced	Frequency	Relative frequency (%)
Distrust	2	15.4
Lack of confidence in treatment	1	7.7
Unwillingness	1	7.7
Disconnect between micro- and macrolevel	1	7.7
Language barrier	4	30.8
Limited resources	2	15.4
Client overexpectation	1	7.7
Client withholding information	1	7.7

behind some of the beliefs and behaviors that the clients may have. One comment made about this was, “We ask opening questions and start with the concerns the families or individuals have, including cultural and religion concerns” (Participant 101). Also, these discussions can be used by providers as a chance to educate the clients and their families about mental health as Participant 108 indicated:

We have frequent discussions about that, especially demystifying the mental health service industry. We really try hard to really empower our clients for that reason. . . . We are collaborating with them to help them get to where they want to go.

**Outreach Services.** Going out into the communities to meet clients and offer services in their homes is another way of solving the challenges with accessing care. One of the respondents said, “We offer to everybody to meet with them in the home or by their house” (Participant 103).

**Understanding Clients' Needs.** Another way of solving some of these challenges is through understanding one's clients and approaching them in a way that speaks to their needs. Participant 105 said,

You really have to go incredibly slow with these boys, because they're so ashamed. They know they're different in a lot of ways, but the different of the learning disability is their own little secret, and that they're very ashamed about it, and they don't know how quite to deal with it. . . . We have to slow it down a lot, and we have to really lower the bar in terms of their engagement and participation.

**Diagnosis Evaluation.** Another way of countering the challenges mentioned, such as misdiagnosis, is evaluating a client for some time and not rushing his or her diagnosis. This enables a care provider to make an accurate diagnosis and hence give appropriate medication and care. Participant 103 said,

What we do is for our program we try to have the first 6 months with an individual to really evaluate their diagnosis and look at the symptoms that they're experiencing. . . . It's very easy for anybody when they go to a hospital to get slapped with a diagnosis that may not be appropriate, and so we try to be mindful of that.

**Relapse Prevention Plan.** Relapse Prevention was mentioned by one of the respondents as a measure put in place to help clients discontinue their medication if desired:

We do as much for them as we can in terms of our Relapse Prevention Plan. We provide them with options and then help them get off of the medications if that is

what they are looking to do. It's kind of to be respectful of their beliefs and their goals. (Participant 101)

**Safe Environment.** Creating a safe environment for clients is another way of solving some of the challenges, like a stigma, that they faced when accessing mental health services. The providers try to create an environment where a client will feel safe and not judged in any way or looked down upon. Participant 110 said,

We really try and destigmatize the delivery of mental health services by allowing a space for clients to feel safe, heard, and really validating their experience if stigma is something that is really affecting their ability to engage in services.

**Transport Assistance.** Having programs in place to assist clients from minority ethnic groups who are impoverished and cannot get a means of transportation to health care centers helps them access services and resources quickly. Alternatively, for the young clients who cannot afford their own transportation and their guardians or parents not available to take them for services, “We have a good cab voucher program, that we can bring people in, the teenagers, especially, if the parents are working and can’t bring the kids in,” suggested Participant 105.

**Contact Higher Level.** According to one respondent, they had to contact people who were on a higher level for assistance when one of the providers refused to attend to a client who needed their services. The respondent said,

To me, it seemed like there was a pattern of refusing this kid services. No one would just come out and say why, but it sure looked like we were getting blocked, over and over and over, and the excuses were thin, so we took it upon ourselves to try to raise it up to a higher level. (Participant 105)

**Health Care Funding.** For those clients who cannot afford to pay for their own care and medication, there are programs and steps put in place to help them acquire health cover. Participant 101 stated, “Once individuals are in the program, if they’re eligible to apply for other health insurances, we’ll refer them also to the Benefits Department so they can apply for benefits through them.”

**Education.** Educating clients and their families about psychosis is another way of solving problems that may be encountered by the client and the provider. In addition to psychosis education, clients and their families are also educated on ways they can obtain services efficiently with minimal or no costs. One of the respondents said, “Our Clinical Coordinator will also make sure to explain the cost of the program, how the cost of the program is handled. If they express any concerns, then we can address them right there” (Participant 101).

Figure 9 shows ways that the challenges faced by the clients are countered. Table 2 shows the frequency distribution and relative frequency (out of 13 participants) of how challenges faced by the clients are countered.

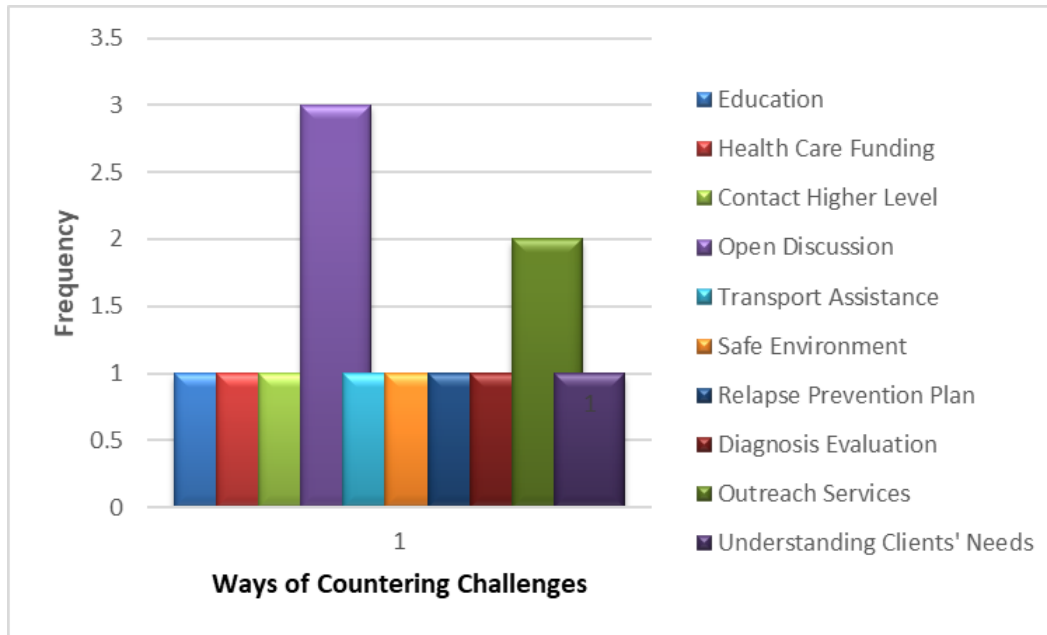
### ***Staff: Vocabulary***

Some of the challenges providers might face when treating clients can be overcome by using sensitive vocabulary when speaking to those clients. Using terms that the clients are used to and the kind they themselves use to refer to their condition and their feelings is important. One comment made about this was, “The vocabulary that we’re using, we’re not stuck on labels or specific names, but we’ll try to use those same labels for words that the families are using” (Participant 101).



**Figure 9**

*FEP Client Countered Bar Chart*



**Table 2**

*FEP Program Distribution and Relative Frequency*

Ways of countering challenges	Frequency (out of 13 participants)	Relative frequency (%)
Education	1	7.7
Health care funding	1	7.7
Contact higher level	1	7.7
Open discussion	3	23.1
Transport assistance	1	7.7
Safe environment	1	7.7
Relapse prevention plan	1	7.7
Diagnosis evaluation	1	7.7
Outreach services	2	15.4

**Language Services.** Having translation services in place also helps to counter the language barrier. One of the respondents commented,

If there are interpreters available for things like I think Farsi and some different Asian dialectics, there's interpreters for that. A lot of times, paperwork is done in English and Spanish, so there's that opportunity. More recently, I've seen individuals reaching out where they're looking for staff who speak other languages so that they are better able to converse with individuals. (Participant 102)

**Staff Open Discussions.** Staff having open discussions among themselves about observations made on clients or ideas on how to handle treatment and care of some clients and how best to approach them is a way to solve problems. Participant 105 said,

We have an educational specialist on the team, named Crystal, and she's African American, and so every once in a while, if I have a question as to whether or not something that I'm observing or experiencing would be specific to the African American population, sometimes I'll ask her, like, "Is this a religious thing? Is this a racial thing?" And we'll discuss. (Participant 105)

**Respecting Beneficiaries' Beliefs.** Another way of solving problems faced by providers is by respecting their clients' beliefs. In addition to the mental health care plan put in place, the providers will allow them to include their religion in handling the situation as well. One respondent said,

If religion is a big part of that person's culture or background, we try to incorporate FEP services, so the individual therapy, the medication management, incorporating medication but also really respecting and valuing their perspective

of using prayer, because a lot of families will use prayer as a way to try to. . . .  
They say, “We’re praying out the demons,” for example, as mental health care.  
(Participant 112)

### ***Cultural Competency***

**Minimum Standards.** According to most of the respondents, the minimum standards required for staff cultural competency include taking part in some form of cultural competency training. Participant 103 said, “For our agency as a whole we require, when a staff person is onboarded, that they take an 11-hour online class in cultural competency, and that has to be done annually thereafter.” This training is not a thorough training according to some of the respondents; one of them commented,

A little. Thirty minutes. Having been a consumer here, I’ve been offended before, in reference to my hair. Going through the actual training that we do have here at this agency, being offended in the cultural competency training . . .not by oncoming staff, I would say. Just seeing my coworker that has offended me, still staying in that same mind frame even like now. I think they could do better.  
(Participant, 109)

Some respondents also admitted to no minimum standards required when it comes to cultural competency, as indicated by Participant 105:

I don’t think there are any. I mean, there are things that we all understand, I mean, I think that we all understand to be sensitive to, but I think that we just take it for granted that it’s all what we think it is.

They don’t have a training requirement for their staff.

Figure 10 shows some of the words used by the respondents to show the minimum requirements needed for staff cultural competence.

**Figure 10**

*Infrequent Cultural Competence Training Terms*



***Training for Service Providers.*** When it comes to the training of service providers, some respondents admitted to having them, and some said training is not available for providers. For some, there is no specific training set aside but is within a broader training that is available. Participant 108 stated, “Within the broader training that is done here, there’s a cultural competency component. An exclusively culturally competent training, no, but it’s within a broader training.” And one of the respondents said that this training is only available for staff who deal directly with the clients and not the administrative staff like human resources, for instance.

***Ethnic Services Mandated.*** The respondents admitted to not having ethnic services mandated for clients from the various ethnic groups, “No. Like if you’re Black,

you get the services? No, there's not," Participant, 107 responded. Another respondent also said,

Yeah, no, no. I think it's just an adaptation. The key points of the program of first diagnosis, medication management, cognitive therapy of psychosis, educational and occupational support/treatment, family education, I mean, to me, these are the key areas. So, diagnosis, medication, there's no different diagnostic criteria or different medication management. (Participant 111)

***Development Plan: Available.*** Some respondents said there are cultural competency development plans in place. One respondent admitted to there being CMEs (Continuing Medical Education) touching on cultural competency that doctors have to attend. The respondent said,

DC does have cultural competency, I think, through the DC medical board, there are cultural competency, there are some plans there. I know there are some things, there are CME stuff, there's a push of having some of the CME that doctors have to do, have to speak to cultural competency. But nothing that's specific to this program that I know of. (Participant 111)

Also, there are plans in place, according to a different respondent, to meet with community members and get feedback on how to serve them better and what they feel is lacking:

Part of that planning involved going out and having open; I guess maybe it's called like a town hall meeting, things like that, within the community to provide the community an opportunity to give feedback about what they feel is lacking

from county government and services. So, this is a full county-wide plan.

(Participant 103)

For some, it is available but really needs improvement. Participant 106 said, “There’s always efforts to improve that.”

***Development Plan: Unavailable.*** Some respondents were not aware of any efforts to develop cultural competency in their agencies. Participant, 110 said,

I mean D.C. does not offer a lot of that. I have not come across many opportunities where it’s a chance to learn more about what people in D.C. are going through. . . . So, it would be nice to see that more.

A different respondent also said, “Not that I’m aware of, but I don’t know” (Participant 108).

***Staff Reflection of Cultural Diversity: Present.*** Some respondents admitted to their agencies reflecting cultural diversity. According to one of them, they can have conversations about the ethnic minority and what affects them like marginalization and its effects. This is possible because they have diverse staff. Participant 108 said, “I do believe that, because we are a diverse staff, I believe that we bring in our own cultural background, and we can have conversation that maybe other teams don’t.”

***Staff Reflection of Cultural Diversity: Partially Present.*** For some agencies, there is minimal diversity with staff. Available staff is not able to handle increased cases affecting clients from various ethnic minority groups. This typically ends up with some staff members being overworked:

Probably not. I mean, not precisely. I think that the percentage if you just go through percentage of patients and percentage of staff, I think that that doesn't reflect. . . . I guess he does enormous amount of the work. (Participant 107)

Another respondent said, "I think obviously it could be more. We don't even have a male on the team, and I think that that's definitely needed. We do need a male clinician sometimes" (Participant 111).

***Staff Reflection of Cultural Diversity: None.*** One of the respondents felt that there was no diversity when it comes to staff: "No. No, it doesn't. I say that because again, Fairfax County, we're fortunate to have a diverse population. Most of our staff is not diverse" (Participant, 101).

### **Services Available to Family Members**

***Language Services.*** There are interpreters present to help those family members who cannot communicate in English. Participant 104 stated, "Interpreters are available and offered. We scheduled them for them. So, if we know someone's coming, and lots of times, we let them know if you need an interpreter, let me know, and I can have them scheduled." This is done through having a live person in the room doing the translation, or it can be done through an iPad. According to Participant 104, "We have an iPad. I think it's called in demand or on-demand or something. But we literally can just push the button, and a live person comes up that can translate face-to-face."

***Psychoeducation.*** Psychoeducation is also offered to the family members. They are made aware of how to handle their family members with psychosis and how to support them. Participant 104 said,

It's a psychoeducation and process group for families only. That is meant to give them tools and understanding the presentation of their loved ones, how to provide support through that recovery process, understanding a little bit better of what we do as well in Turning Point.

During these sessions, the family members are also given a chance to ask questions about anything they may not understand. "We have family education sessions. We do that once a month. We get a doctor to stand up there and answer questions from family members," said Participant 105. These education sessions help mitigate stigma even within the family circle.

***Support Coaching.*** Coaching the family members on how they can give support to their loved ones who are going through psychosis and other mental health conditions, so they don't need constant specialist care. Participant 104 said, "I know for me personally, my goal is to support coaching so that they don't need me. That they can just maybe check in with a question, but that's usually what we do for the family."

***Therapy Sessions.*** There are also therapy sessions for family members available to help them support their loved ones better. "We also do family therapy. If the family needs that therapy piece as a whole, our clinicians offer that to them," stated Participant 104.

***Information-Sharing Events.*** There are social events that are organized by the agencies to help family members of various clients come together and share their stories and experiences. Some people who were also invited to these events to give support to families transitioned from the program. One of the respondents said, "We also encourage family members to meet and greet and share information, so we provide snacks and a



room and a safe place for them to bond and learn about the program and each other” (Participant 105).

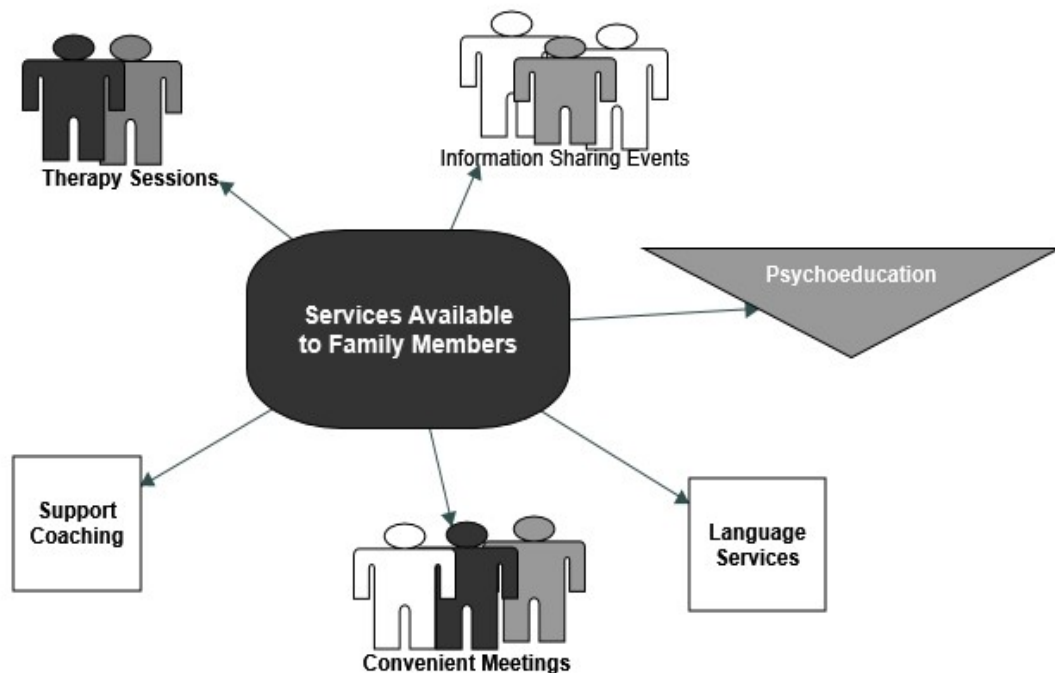
**Convenient Meetings.** For parents who are not able to attend these events and meetings, the service providers create time to meet with them when they are available or even meet them at their homes for convenience’s sake. Participant 104 responded,

We don’t transport parents, but what we do try to do is provide opportunities for them the meet with us. Again, we can come to their home for meeting. We also schedule things to try to make it easy for them to get to, especially when we have those parents who need to be at work, but they also need to be here with us.

Figure 11 shows the services available to family members, according to the respondents.

**Figure 11**

*Family Member Services Diagram*



### **Specialized Outreach and Programmatic Efforts in Place**

There are some programmatic efforts put in place for the racial and ethnic minority groups with ESMI who are from impoverished communities.

***Education.*** Educating people about these FEP programs available in the community and doing outreaches into the community to make people aware of this is one of the efforts made to help the ethnic minorities from poor communities. One of the respondents said,

But we try to go out to all the schools. Our goal is to go to each school and to let them know that we exist and to talk to them about the early warning signs of psychosis, but also to encourage them if they're not sure to let the people know so we can help to screen them and find the appropriate services. (Participant 104)

Also, educating people about psychosis and helping family members understand their loved ones who are going through this. According to Participant 110,

You have other people who have their families very much involved, where I don't know how to talk to my parents about these voices. In those cases where you get the parent in, then it's also about educating the parent. Where it's just like because now you have to deal with the family, of like, "Look, the reason that your kid was screaming all last night in the bathroom and then punched a hole in the wall is not because he has anger problems. It's because of the fact that there's a person who's telling him very negative things inside of his head, and has been doing so for a very long time.

***Health Care Cover.*** Some measures have been put in place to help those people who don't have insurance and are not able to afford the cost of medication and care.

Making them aware of how they can still get cover is one of the steps taken. Participant 101 said,

I know sometimes I've had at least a couple cases that they decline services because they didn't understand how the cost of the program would work, and I would have to call them, families who are Spanish speaking, I would have to call them to explain to them that it wouldn't be necessarily an issue.

These agencies receive grants that enable them to provide care to the FEP clients who don't have any form of insurance. Participant 108 stated,

Because we're under grant funding we can take them, so inadvertently our efforts are always to have those people that don't have health care coverage or have very little health care coverage. That's one of our main efforts, is to engage them with us.

***Housing.*** There are programmatic measures put in place to help clients not necessarily from the ethnic minority groups, but everyone who needs help getting housing. "We do not have our own housing, but we do ensure that they have some stable living situation. Again, these are not minority specific. It's just whoever needs it," said Participant 105.

***Community Visits.*** Some respondents said that they conduct on-site visits for everyone and not primarily for the ethnic minority. Participant 101 stated, "I don't believe we do specialized outreach for that specific population, but we do outreach in different settings like hospitals and schools." They do the outreaches to make sure they capture even those people who usually would be out of their radar. According to Participant 104,

We're making sure that we are gathering or catching those people who may not usually be on our radar. So, I think that in itself, even though it's not specific to one population, I think because it's not, it's kind of helping with that.

***Transportation.*** There are also measures in place to assist those who have limited means of transportation when receiving mental health services. This is done mainly done for the minority groups and is done through getting the clients a subsidized Metro card and SmarTrip card. "We've talked about the transportation where we obviously provide money for SmarTrip cards," said Participant 110. According to a different respondent, a stipend is given to clients, which they have to sign for in advance: "We have a transportation stipend in our program that they will sign a request for that week or that 2 weeks to help them make the appointments with us" (Participant 107).

***Language Services.*** There are interpretation services that have been put in place to help curb language barriers. This helps cater to ethnic minorities. One of the comments made about this was:

We always let them know that language is not a reason to decline or deny services because we have interpretation services available. There isn't a whole lot of need to advertise that there's a Spanish speaking position in the team because the demand is there, whether you advertise it or not, the demand is definitely there. (Participant 101)

***Creation of Safe Environment.*** Creating a safe place where young adults who have nobody to talk to can open up and talk about their mental health challenges and make them understand that it is okay to open up about it. One of the respondents commented,

And by having a transitional age youth program, you're creating an environment for young adults to be young adults, which is what they are. So, I think ultimately, that is something that I am very, very proud of, and working at Community Corrections for, is just the ability where we are creating an environment where young adults can talk about mental health. (Participant 110)

***Involving Clients.*** Involving families and having consultations with clients who are receiving mental health services has been established, and while during these consultations, health care providers give feedback on services rendered by also giving input on the type of services clients need or how they can get better. One of the respondents said, "Sitting on committees, groups, meetings and ensuring that individuals who are in the minority groups with ESMI participate on those groups, meetings and so forth and give input and taking in their input and utilizing that input when possible" (Participant 102).

***Partnerships.*** Working together with other organizations or agencies is also something that is in place to help the ethnic minority groups from impoverished communities. For instance, in the case of homelessness, some organizations can help them look for housing in partnership with these mental health agencies. One of the respondents said,

We work in conjunction with another agency whose specific goal is eradicating homelessness. And so being able to partner with that and offer the ability to assess and determine what services they might need, individuals might need, really speaks to just as specialized programming partnerships that occur. (Participant 102)

**Early Diagnosis.** There are steps put in place to make sure mental health issues are detected early to avoid psychosis. This is done in schools where these signs can be caught early, especially the students who already have special needs or mental illness. Participant 104 said, “We’re trying to get to the school systems where we know that there are already people with mental illness or disabilities, they may already have another IEPs. Some schools they have only students with IEPs.”

### ***Measures to Address Racial Disparity Issues***

**Language Services.** Materials used for treating ethnic minorities has been translated into their respective languages. This makes it easier for them to access information and care the same way that clients from other ethnic groups are receiving. There are various ways that these translation services are offered when needed. Participant 101 said, “We’re not limited to call for it and interpret it in person, we have the video use available to us anytime on the phone as well.”

**Diverse Staff.** These agencies that care for clients with mental illnesses have diverse members of staff to help them reach as many people as they can from as many backgrounds as they can reach. This helps them provide appropriate and effective services to the clients. One respondent said,

It’s something that I can’t really say that we are doing a whole lot. I think it’s starting. Whether it’s on purpose or not, I can see it happening just because we have people at the table now that are not the same race and not the same background. And even sometimes people look alike, but their upbringing is different. (Participant 104)

**Funding.** There are grants in place to help close the gap between the ethnic minorities and the other ethnic groups who are more affluent. These funds enable the ethnic minorities who are from impoverished communities to access mental health care services without having to pay for the services. One of the respondents commented,

I think for us here, we try and get whatever funding we can get to address mental health disparities because there's such a huge disparity gap between folks that are high on the socioeconomic status and low on it. There's just a huge gap, and so I think here we try and get as much funding that the state can provide to address those gaps. And I think the DC Government and the Department of Behavioral Health also is aware of those disparities and really tries to see how they can make those gaps smaller and the disparities. (Participant 108)

**Involving Clients.** Including the clients in the development of the program is another measure to address the racial disparity. Just asking them what they feel would work for them and involving them in creating it is important. Participant 106 said, "To have inclusion, one of the things that we have learned is that inclusion, which is part of it is bringing the voice of the clients into the development of our program."

**Strategy Work Group.** There is a group that has been formed to come up with a plan to help caseworkers ensure the racial disparities present are mitigated. Participant 103 said, "I think on the agency and county level there's been the identified workgroup put in place in order to come up with tool to help case managers address some of the ethnic and racial disparities in services."

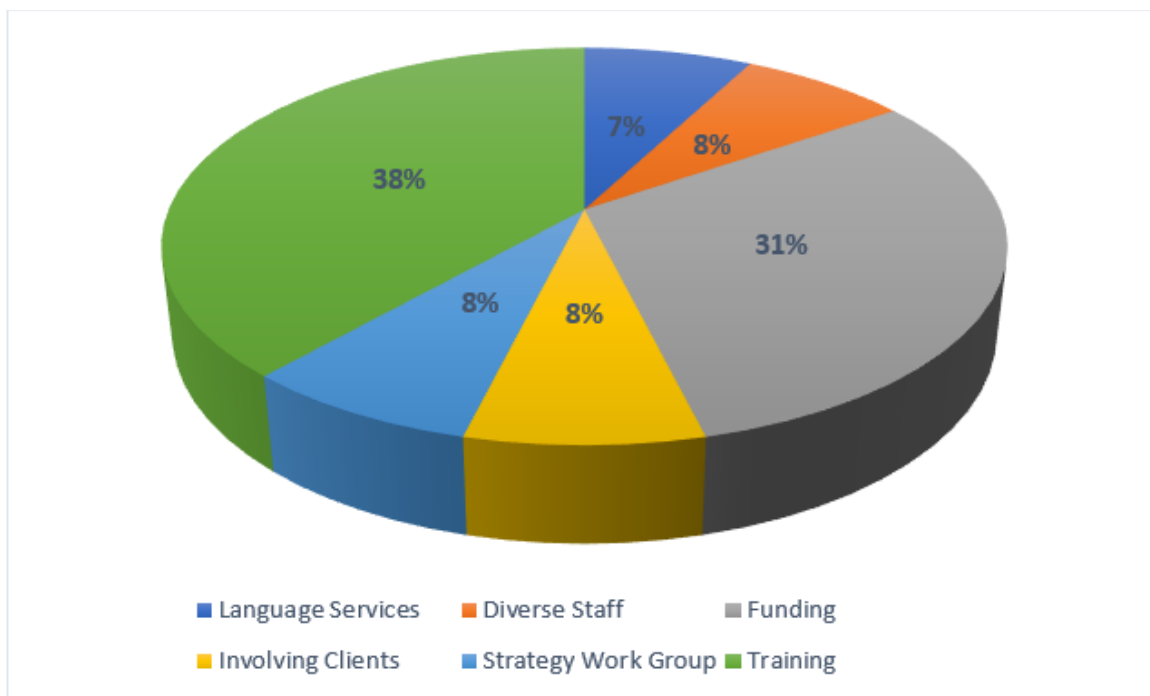
**Training.** There is also training put in place to help the staff members understand different cultures and learn more about cultural formulation interview and how to conduct

them. One of the respondents commented, “I think, handouts about doing culturally sensitive interviewing from the CSC programs in New York, like OnTrack” (Participant 105).

Figure 12 shows the various measures that the programs use to address the racial disparity, according to the participants.

**Figure 12**

*Racial Disparity Pie Chart*



## **Collaboration to Improve Services**

### ***Collaboration With Ethnic Minorities***

**Sharing Ideas and Suggestions.** There are instances where people have been invited to meetings with the care providers in order for them to give their input on what services they would like and what their needs are. One of the respondents said,



So, we've started that, and we've had individuals of the minority populations that have indicated, "It would be good for us to have a Facebook group." Or, "It would be good for us to do this more of," thing like that. And getting their input on that has been something that we've sought in order to really develop that component of our program. (Participant 103)

**Sharing Beliefs and Culture.** Giving the clients a chance to share things that they feel are important about their culture is another way that the clients from the ethnic minority groups can contribute to the program. A comment made about this was the following:

We do at least try to incorporate that component when we're doing intake, for example, ask some of those questions, what things are important to them, and if it has a cultural base or ethnic background base to it. (Participant 112)

**Peer Support.** There are some clients or former clients who act as peer support for some of the current clients. Participant 106 said, "They just share their own experience, what happened to them, how they managed. And now they're successful because they're working and they are taking their medications. It's a good role model for the youth to have."

### ***Measures to Ensure Minorities Contribute to FEP Program***

The following are the measures in place to help clients from ethnic minority groups contribute to the FEP program.

**Language Services.** There are translation services available to clients who cannot communicate in English. These translation services are available in various languages to cover every ethnic minority group that accesses FEP services. This way, they can give

feedback effectively and communicate well. Participant 104 explained, “Then we bring in again, interpreters and we also bring opportunities for them to learn English as well. So, we’re helping them to kind of peel away a little bit of that language barrier, which includes us communicate often.” There are various translation service options, for instance, there are live people who help translate in real time, and there is also the use of iPads.

***Transportation.*** There are measures in place when it comes to transport facilitation for clients from ethnic minority groups. The agencies help them get to their appointments through various transportation programs and partnerships that enable them to not use their funding for transportation. One of the respondents commented, “We provide taxis to our clients in general who needs them. We do have some who may utilize them, but can also have other resources to get them here” (Participant 104).

***Constant Communication.*** Another way that the clients can contribute is through constant communication with their providers. They can help adjust and tweak their treatment plan accordingly when they share their progress with their providers. Participant 110 explained,

There’s really a consistent effort being put forth where it’s just like, “Hey, just checking in with you, making sure everything’s good. Let’s talk about any goals that are coming up. Hey, have you been hearing any voices within the last couple of days? How’s things been going with your medication? Have you been taking your meds? Do we need to come up with a system that works for you to take meds on time?” Things like that.

***Education and Awareness.*** Educating the community, especially the clients' families, is a way that the providers can help destigmatize mental illness. Through awareness, they can understand a person's behavior and symptoms when that person is going through an episode of psychosis and not putting unrealistic expectations on them. They can also help them in their treatment process by giving them support. Participant 106 explained,

Kind of teaching people what the difference between those things are. And if you want your kid to be normal and back to the way things were, that is not going to happen. Just making sure that they don't put pressure on this person who is experiencing psychosis and mental illness. And he says, support them by accepting them. Acceptance of the diagnosis is very hard for many parents.

***Opportunity for Feedback.*** Allowing the clients to give feedback is another measure that's been put in place to ensure that they contribute to their care plan by giving feedback. This is done through having open discussions with them about things that affect their recovery and mental health. One of the respondents said,

When we get into feedback from individuals about the program, either as an alumni or while they are in the program, we also try to ask what parts of the programs have been most helpful, and that includes if we were open to talk about their religion, their culture, or if they felt like it was not judgmental, they felt more open to talk about that. (Participant 101)

***Safe Environment.*** The creation of a safe environment for clients is another way that some of the providers ensure the clients can contribute to the FEP program. One of

the respondents said that this is not a programmatic initiative, but their own to help clients feel at ease. The respondent said,

That's not a programmatic thing. That's just something I do. I don't think that there's a lot of systematic stuff in our FEP program. I think it's just a lot of individual thoughtfulness, but I think that you'd have to ask our director. She would probably know more about the programmatic stuff. (Participant 105)

***Home Visits.*** Another form of support is visiting clients in their homes and offering care services to them. This shows that a provider cares for the wellbeing of the client. According to Participant 110,

When engagement is an issue, especially with young adults, you really kind of have to go that extra mile to show that you care. And to show that like, "Hey, I know you're going through this, and I know you hate what you're going through, but you have somebody there who's here to support you.

***Resilience Training.*** This is a standard support system mentioned by the respondents as a measure in place to help the clients. This helps them with the knowledge they need about psychosis and making them aware of the resources available to them and helping them understand themselves. This way, they can learn how to cope and manage their illness.

***Family Groups.*** This is when families are brought together and educated on psychosis and giving them a chance to share their experiences. They also get to process the struggles they might be going through with their loved ones who have psychosis.

Participant 112 said, "The client gets a chance to share, and family gets to share as well,

that's important, but we do that across the board for all families regardless of background."

**Peer Support.** According to one of the respondents, young clients get a mentor who is a peer in that they have also gone through the same illness and treatment process. This way, they can get support from an individual who has gone through the same thing they may be going through.

**Therapy Sessions.** The clients also go through therapy sessions with their care providers. "Then individually we do the individual therapy," said Participant 112. This helps them cope better and manage their treatment process more effectively.

Table 3 shows the frequency distribution of the measures in place to ensure that minorities contribute to the FEP program.

**Table 3**

*Underrepresented FEP Contribution*

Measures to ensure minorities contribute to FEP program	Frequency	Relative frequency (%)
Language services	3	23.1
Transportation	2	66.7
Constant communication	1	7.7
Education and awareness	6	46.2
Opportunity for feedback	1	7.7
Safe environment	1	7.7
Home visits	2	66.7
Resilience training	4	30.8
Family groups	1	7.7
Peer support	1	7.7
Therapy sessions	1	7.7



to see whether the medication is effective. “Sometimes the medication, the families are really involved in making sure they’re getting medication and working,” said Participant 107.

***Decision-Making.*** Clients and their families are typically involved in decision-making, depending on the client’s case. Some clients do not like to include their family in decision-making, so they are allowed to make decisions about their treatment plan. Participant 102 said, “In our case, it should organically grow from what the client, not necessarily the family, but from what the client wants to achieve.” A different respondent also said, “We ensure decision-making and we’re very clear with that from the beginning, meaning that the individual will be in the driver’s seat of the treatment” (Participant 101). As much as the family might contribute and give their opinion on how they feel everything should be handled, the ultimate decision lies with the client, so they are not forced to do what they do not want to do.

***Support System.*** The family members are involved as much as possible because they are the ones who will act as a support system for the client. However, if the presence of the family is limiting the client’s progress, then they will be shown how they can still give their support. One of the respondents said,

We also have some times when the family involvement is not needed as often and if the client let’s say verbalized that it’s impeding their progress, then we kind of help the parent to figure out how they could still support the client, but allow them to be who they are and allow them to reach their goals, and sometimes it’s allowing them to fail so they can reach the goal. (Participant 104)

**Information Source.** Parents can also get involved because they act as a source of information for the providers. This especially is for the adolescents: “Most of the time unless they’re a minor and we need the parent. But they’re there for the intake; they are able to provide us information. We listen to all the information given,” said Participant 104. Another way they give information is by telling the providers how the client is progressing and alerting them if something is not right. Participant 102 explained, “Some parents are really good at that like calling and texting something is off.”

**Notes Comparison.** The caregivers and family members are involved and given a chance to share their experiences and concerns. They are also given a chance to ask questions about symptoms, and they can come in to see the care providers, and together they can discuss and collaborate on the treatment plans. One of the respondents said,

Just also asking them like what are your goals for them and just discussing who we can get everybody on the same page just to assist with that support. Make sure they have their say-so and their input, and maybe the client doesn’t see certain things because of their symptoms. (Participant 109)

**Awareness and Education.** There is psychoeducation provided to the clients and the families. They are also educated on how the program works and what the agency’s expectations are from them. Participant 104 said,

They usually get a lot of psychoeducation about how our program works, what our expectations may be as far as meetings and things like that. But we tailor that, and it’s like this is the overall goal and expectation.

**Creation of Treatment Plan.** Involvement in the creation of treatment plans depends on clients and their families’ relationships. If they have a great relationship, then



the family will have a say in it; if their relationship is not good, then the client has the final decision. According to Participant 107, “If they can collaborate and there’s a good relationship there, then a treatment plan is done with the parent and the youth” (Participant 108). The treatment plan is ultimately what the clients agree to do and wants to do, keeping their goals in mind: “The client is the director of the treatment plan”

### **Providers and Leadership Collaboration**

***Awareness Creation.*** There are collaborations and partnerships with various parties to help create awareness about the available programs dealing with FEP. “One of the things that we do is we try to make partnerships, of course, so that will be people be aware,” said Participant 104. Also making the community aware of psychosis in partnership with other departments is important. Participant 107 stated,

Educating the community, participate in trainings and doing presentations to inform the community on psychosis in youth, specifically in DC so that it doesn’t go unnoticed and more people can kind of get help early if it’s more available to them. And what I mean by that is, Department of Behavioral Health is deeply involved, so we coordinate with them on efforts to, I guess, get the word out in the city.

***Consultations.*** There are also collaborations between agencies whereby one agency might consult another when it comes to managing psychotic patients. This way, they can find out what resources to use for various cases. Participant 101 said,

I know that we’ve reached out to other teams across the state, which we have consulted, at the beginning of this program, we used to have consults every few

months, to see what resources they are using, like if they have the manuals of intervention, the different languages, and if we can have copies of that.

***Referrals.*** There are also partnerships in place when it comes to referrals. One care center might refer clients to a different agency for appropriate treatment. Participant 102 commented, “For some, it’s really focused on referrals because we know that people are there, and then some it’s just getting that information out so that they can help us to see if they have a need for our services.” Another respondent said, “We get referrals, so basically we have a stable referral system with several psychiatric hospitals in DC, the major psychiatric hospitals and they refer clients to our programs” (Participant 107).

***Training.*** Some agencies provide FEP programs that come together for training and discuss how to navigate through various types of cases. Participant 112 explained, “There’s other FEP programs along even the East Coast, we’ve talked to New York’s On Track Program, they have this on-demand training that we do once every couple weeks, I believe. So, we all kind of get together through voice chat, and we’ll do case presentations, for example. We may do a case presentation; we might talk about how to actually navigate that case in particular in terms of talking about those visual or audio hallucinations or delusions.

If there are people who have insight into how specific cases are managed best, they give their contribution.

***Integrated Care.*** Having an integrated care system is another way that agencies and departments can work together to deliver health services to a client at a go. One of the respondents commented,

You see a lot more integration as well. If someone is coming to get mental health services here, why not have a primary care physician as well? You see a lot more integration, and you see that in how the big people, like Department of Behavioral Health and the Health Department, are also advocating for that because before funding sources really didn't focus on that. You see more grants coming out with goals of integrated care. (Participant 108)

Some agencies are putting measures in place to ensure that different departments are aware of each other's presence and they communicate with one another in terms of care.

**Funding.** There are some collaborations that have led to FEP program receiving funds to help facilitate the services they offer to clients with psychosis. Participant 110 stated,

In terms of our government agencies that we partner with, the Department of Behavioral Health certainly has done a lot in funding this program a lot, and we'd obviously love. . . . We always love to give a shout out to DBH for helping us fund it.

**Sharing Information.** There are also collaborative meetings that take place between various agencies and parties where information and concerns are shared. Participant 102 said, "The board joint meetings where we talk about some of the . . . specifically to the subject where you talk about some of the barriers, some of the issues, some of the concerns that have come up." There is also networking in these joint meetings, which leads to future collaborations.

***Community Outreaches.*** With organizing community visits and outreach programs, members of the community attend school, and faith-based organizations are educated about mental health illness. This is possible because of the collaboration between health care agencies and individuals responsible for managing, coordinating, and developing these establishments. One of the respondents said, “So we’re definitely doing a lot of outreach to that. We also have pediatricians and doctors’ offices on that list to go outreach so that again, we’re focusing on the need of everyone and not just a specific population” (Participant 104).

***Address Religious Needs.*** Some agencies seek out faith-based leaders to assist in addressing the religious needs of the clients seeking psychosis treatment. Participant 101 said, “We also try to look, whenever applicable, for religious leaders in the community that we could partner with to address specific religious needs for specific families.”

### **Naturalistic Observation**

During the semistructured interviews, the researcher conducted a naturalistic observation, which entailed a trajectory of results, giving the researcher an understanding of programs, participant’s enrollment, treatment planning, outreach, family involvement, communication, technological services with successful participants from the overall program performance. In other words, the researcher investigated the process of engaging with these agencies by using naturalistic observation. Incorporating a naturalistic observational approach created an understanding of the phenomena by giving an accurate account of behaviors, frequency, interactions, and how much time was spent on the tools listed above as if the researcher were seeking out these services. The naturalistic observational tool allowed the researcher to identify any reluctant, misguided,

or indifferent responses of participants by organically observing how programs organize and prioritize and how staff, clients, and family members interconnect along with any identified disparities.

The naturalistic observation provides descriptions of social interactions from providers, which permitted an alternate interpretation of the interviews and offered an understanding of the study. The researcher created and used a naturalistic observation table listed in the Appendix C. The research was helpful as it enabled the researcher to observe candidly and naturally and allowed the researcher to study aspects not manipulated because of ethical concerns. The naturalistic study also served the principle of supporting the external validity of the research as the findings observed occurred in an organic nature. Within the naturalistic observation aspect of the study, the researcher also incorporated the National Outcome Measures conducted through Substance Abuse and Mental Health Services (SAMHSA). The National Outcome Measures have been recognized as significant, real-life outcomes for individuals who struggle to conquer and maintain recovery; develop strength; and work, understand, live, and take part in community activities (SAMHSA, 2009). SAMHSA upholds the data identified from states: safeguarding organizations, technical assistance, and fiscal support through set-asides for mental health and substance use block grant programs. The National Outcome Measures (NOMs) data illustrate valuable services and resources to the mental health and substance use organizations and populations by achieving quality outcomes among the most recent criteria of health care and prevention (SAMHSA, 2009). The data are the essence of quality assurance at every level of government, whether federal, state, or local communities. Utilizing these tools establishes changes and builds lessons learned from

agencies, setting goals and reporting performances. The data have also highlighted priorities, cross-organizational partnerships when accomplishing common objectives, and the exploration of goals and techniques enhancing outcomes of federally funded programs (SAMHSA, 2009).

### **Systematic Observation**

Items observed from program professionals were as follows:

1. Outreach
2. Participant enrollment
3. Treatment planning
4. Family involvement
5. Communication
6. Technology in services
7. Successful participants
8. Measuring success
9. Factors to success
10. Accomplishments
11. Challenges to success

### ***Program A***

The researcher conducted a session of naturalistic observation for each FEP program and participant. The purpose of carrying out semistructured interviews and naturalistic observation was to understand whether there is a difference between programs, their program professionals, and delivery services for FEP clients.

Program A is the only program within the localized urban area that caters to a large variety of coffee drinkers, residents, local businesses, ranging from early morning Whites to racial and ethnic minority clients looking to attain community behavioral health services. After 20 minutes of observing the neighborhood, the researcher noted the area is commencing with gentrification. As gentrification floods the area, it has and will affect the neighborhood of imposing individuals with increased incomes, migration, and displacement, causing an effect on the area's historical culture and a decline in social capital that alters the neighborhood's characteristic for racial and ethnic minorities. With the urban residential area attracting new residents with heightened revenue, housing and storefronts are improving in conjunction with the increased cost of living and property values. The upsurge of costs places pressure upon real-estate affecting displaced low-income residents, causing displaced individuals and their families to lessen and cease services or ultimately displace the program with limited access.

Observing the phases of each programming professional allowed the researcher to identify how Program A limits outreach within the agency, but throughout the community, substantial representation with the program's website provides valuable information monitored by a local tech company. Unfortunately, the website does not fully explain or identify what FEP is and what the FEP program has to offer clients and their families. Continuing the naturalistic observation, the researcher recognized that Program A's participant enrollment equaled few clients seeking services from the FEP program, indicating a small percentage of mental health population expressing psychosis. Regrettably, the researcher was unable to observe the intake process to fully engage and understand who from staff is involved in the entry of the FEP program. As for treatment

planning, the resiliency trainer is present, and infrequently, psychiatrists are present because of availability. Most often, the resiliency trainer is present during and throughout the treatment plan. The resiliency trainer encourages family participation, particularly from parents, to support the client who has FEP. In general, 50% is family support, and the other 50% estranged relationships have shattered support. A key factor is communication with clients, their families, and staff. When staff communicated with one another, the researcher observed face-to-face interaction, phone conversations, and unlimited text and emailed messages to inform each member of the staff the client was ready to proceed to their next appointment. Observing communication between clients, families, and staff face-to-face created a dialogue that was open, comforting not only for the client, family, or their caregiver, but also gave the staff with a sense of accomplishment. Witnessing interaction among clients, their families, and caregivers between staff via phone showed how Program A team members could convey how the client was feeling and how family members or caregivers needed understanding from the client's behavior by actively listening to the sound of his or her voice. This technique allowed staff to inform the client, family member, or caregiver to come in and seek guidance, reassuring staff that face-to-face interaction is critical when distributing services, and proper resources are necessary when providing essential mental health services to their clients.

Examining Program A, the researcher also viewed their technology more thoroughly concerning community education using technology, skill-building videos, webinars, workshops, and any other mechanisms used, such as their music therapy program. The researcher found Program A tries and implements as many methods as it



can to support the client's recovery. For instance, the resiliency trainer creates ways for the client to express themselves through poetry, music, and overall artistry. One expressive artistry is a mural that clients made collaboratively with local art supplies, allowing youth a creative outlet with other resources accessible by Program A.

Therefore, Program A utilizes unlimited therapeutic areas locally like Speedy Greens services where music studios and vocational services not available to Program A can be obtained and connected to the client. The researcher noticed how Program A uses several incentives to pique the interest of the clients to increase their engagement so they can fulfill their treatment plan and goals. Witnessing the clients' behaviors, the researcher found a large percentage of clients needed more support than others, and Program A's objective is to ensure clients stabilize from needing so much support by living independently, being motivated, and implementing the use of supportive strategies. The success of this measurement draws from the NOMs from SAMHSA, which apply the trajectories of client outcomes for various programs providing direct services. SAMHSA identifies 10 domains for the NOMs, which embody meaningful, real-life outcomes for individuals striving to attain and sustain recovery, build resilience, and work, learn, live, and participate fully in their communities. The NOMs represent the beginning of a state-level reporting system that creates an accurate and current national picture of substance use and mental health services (SAMHSA, 2009). Mental health FEP programs that receive government-funding from SAMHSA, a federal agency, are required to report their NOMs annually. The NOMs for Program A measures are only available for FY 2018 because SAMHSA was awaiting data for 2019, which would not be available until the end of September 2020. Unfortunately, reviewing FY 2018 and FY 2017, Program A

failed to complete the output tables for their NOMs therefore revealing no data for the number of CSC programs, clients receiving CSC-FEP services, admissions to CSC-FEP services during the year, and by no means the number of programs with staff training specifically in CSC evidenced-based practices (EBPs; SAMHSA, 2019).

#### **EBPs for Adult Services**

- Supported housing
- Supported employment
- Assertive community treatment
- Family psychoeducation
- Dual diagnosis treatment
- Illness self-management
- Medications management

#### **EBPs for Children Services**

- Therapeutic foster care
- Multisystemic therapy
- Functional family therapy

The researcher expected Program A NOMs would be completed and provided to SAMHSA in its entirety by the end of the FY 2020 to show the number of CSC programs, patients utilizing the CSC-FEP programs, admission rates, and training for staff if provided.

The researcher viewed Program A staff as very hard workers who ensure every client receives substantial, equal, and upstanding services; the team is quite small, the work is demanding, intense, and challenging as the program aims to sustain proper staff.

Staff members who have been with the program since its inception motivate one another through hard times and encourage one another to stay working with the program as this commitment and determination show vital dedication among staff and clients.

Unfortunately, this leads to limited awareness because residents and those within the community are uninformed of FEP because the field is relatively new to mental health in the United States. Even though education is provided to clients, sufficient dialogue between client, case manager, or clinician, typically provides adequate awareness.

Therefore, the challenges found that could be of success are additional funding for tracking purposes aside from the NOMs, more ways of monitoring, and showing data that the program has affected the community and clients on a larger scale. In addition to more funding for advocacy work, awareness is needed so everyone in the area can be cognizant of the FEP program and what it offers, which would increase not only services but increased locations throughout the urban district.

In conclusion, Program A services individuals with little to no health insurance composed of 99% of racial and ethnic minority groups (approximately five Black American clients), with 1% of the White community (one White client). All services provided are not focused on racial and ethnic minorities or Whites; services are for all represented clients within the program. With a community comprising racial and ethnic minorities, one to two staff members feel no disparities placed because the community served is prominently Black Americans, LatinX, and very few White Americans.

However, 98% of the staff feel the population serviced, identified as racial and ethnic minorities, continue to adhere to inequities, especially with the community changing, limited resources, lack of support, and minimal services throughout the local region.

### ***Program B***

Program B is one of eight programs across the state. Program B is located in an upper-middle-class suburban business complex. The location has a covered garage, easy access to the interstate, and drop-off and pick-up area for clients and families where individuals come in contact with working professionals along with clients seeking behavioral health services. The building is half a mile from shopping malls, dine-in eatery places, medical offices, charming hotels, and refined residential neighborhoods. The images of the building should be modeled in a magazine with its upscale settings. Program B does not have crowded areas filled with clients hanging around the building all day. Clients looking to obtain services go to the building, go to their specific area, communicate to the front desk representative, and wait to be called for their appointment. The demographic area is mixed with White American, Black American, Hispanic, African, Asian American, and Asian Pacific clients. The area is in an affluent county with a large portion of non-English speaking racial and ethnic minorities comprising primarily diverse cultures.

The researcher observed how Program B conducted their outreach efforts and found Program B participants connect with other institutions that are likely to encounter individuals from the age range of 16 to 25 years old receiving services through schools, hospitals, outpatient mental health programs, criminal justice programs, the court system, and housing programs. The researcher also viewed Program B as having pamphlets, brochures, and FEP program information stationed throughout the building in at least five different languages for non-English speaking clients and their families. Program B's outreach consists of advertising the FEP program on a radio show, making videos, and

broadcasting commercials locally to ensure the public knows and understands the services provided. Program B also developed a well-organized website explaining the coordinated services it provides for the population served, not only for individuals who speak English but also for the Spanish speaking population. The program can identify at-risk individuals who have FEP from a confidential online screening. Program B's website includes eligibility of the program and identifies the program goal, and classifies how a client can participate. Informing potential clients that the services are on a fee-for-service basis based on sliding and accepting insurance with their contact information if the public needs additional assistance. With outreach, Program B's staff members also engage in outreach throughout the community among clients, families, the client's caregivers, and local government programs and agencies to educate individuals concerning the FEP program and what services are offered.

Enrollment services and educating individuals about the program are robust. First, the client is introduced to Program B's clinical coordinator to conduct an assessment. The clinical coordinator leads the team and partners with the primary clinician so that clients can have face-to-face interaction during their intake process. Once the individuals are enrolled in the FEP program, the intake is completed by the primary clinician. Often, case managers walk clients around to introduce them to most members of the team so they can get acclimated. Once the client is familiar with his or her case manager, shows dependency, and is introduced to one of the psychiatrists, the client is scheduled to participate in a psychiatric evaluation. The client is not necessarily introduced to the psychiatrist at the initial intake but encounters the primary clinician. If the client is under the age of 18, the adolescent's family member or caregiver is involved

in making the required decisions on behalf of the client. As for education, the program details expectations from participants before intake. During this procedure, the client is being assessed to ensure eligibility is determined; then, the staff offers the client services explaining what the program proposes so the client can decide whether or not he or she wants to utilize the recommended resources. When the client decides to take part in the services, the clinician facilitates meetings with the supported employment educational specialists and ensures the client receives and is involved in every service offered. The researcher observed how approximately 99% of the clients accept services rendered with a clear understanding of what FEP is and how the process will continue. Unfortunately, participating in the program does not guarantee how the client's involvement throughout the program will be characterized during treatment. Clients and their families are described as involved in their recovery process because they envision a need for assistance with services obtained.

Communication is an essential component for Program B. Connecting with the patients, their families, or caregiver by telephone using interpretive services through an iPad software service or phone service allows the client to feel more at ease when seeking treatment and also assists the team member in knowing and understanding how to help the client more efficiently. The mechanisms that Program B has are essential when connecting with its clients, especially face-to-face interviews because the representative action, body language, and dialogue give each individual a sense of understanding and what to look for when information is conveyed or missed.

Program B's technological services are used among team members when engaging with one another, their clients, the client's family members, or caregiver daily

through text messages, emails, or by mobile phone; this can be overwhelming when team members are always out educating the community and ensuring clients receive proper resources and services. Other elements of technological services used are musical video clips, music in general, and workshops to engage the client's interest. Program B's participants ensure their clients have substantial resources by traveling to their client's destination and being flexible, engaging, and making sure the client's goal and participation are a success. Integrating provider services outside the program provides insight into the client's illness and manages care like medication and independent living support groups and making appointments. The researcher observed participants coordinating services with external providers, which created solidarity, flexibility, team collaboration, and social interactions. This generates the local public, surrounding community, and external providers a keen understanding of what FEP entails.

As the researcher continued examining Program B, a review of the state's appropriate domain from the NOMs was looked over. The state reported in FY 2018 that among eight of the FEP programs, their admissions averaged 10.8 individuals per program totaling 86 CSC-FEP client admissions. For clients currently receiving CSC-FEP services, the number of clients served per program averaged 24.9 with an overall total of 199 individuals statewide. The NOMs also identified the number of programs with staff training specialty in the CSC EBPs as being 100%. With FEP being a new program nationally, the state of Program B has flourished with utilizing the allocations from the federal government, growing more programs and partnering with the state's Behavioral Health Division to hold a statewide "Youth Services Summit" (SAMHSA, 2020-c).

With several progressive methods used and identified by Program B, some of the challenges noted were program participants' concern for staying funded and becoming self-sustained. The researcher did see Program B as being proactive with implementing interpreters, language software, and phone services employing interpreters as well, but often it could be challenging to attain because of the availability of the iPad software service. Program B only has one iPad for the entire office, and if a non-English speaking client happens to come in without an appointment and an interpreter is not available to come right in to the office or is stuck in traffic, the client would have to communicate with an interpreter by phone, which is impersonal and not private. These elements can hinder a client's trust and cause him or her not to want to seek services or resources from Program B. The data exposed the fact that additional exploration of both programs because of their uniqueness and their individualistic issues of inadequate data, minimal educational outreach to staff, and the need to close the gap on language barriers is essential. The study suggests that racial and ethnic inequities among the two programs should be explored through imminent studies addressing these mechanisms in other states and regions.

### **Summary**

The purpose of this study was to understand racial and ethnic minorities underutilizing mental health services and will also describe the differential access rates for treatment services in first-episode psychosis government-funded coordinated specialty care programs. Semistructured interviews provided evidence of each program participant's understanding of his or her interaction with staff, clients, the client's family, caregiver, community, and external providers within Virginia and the District of



Columbia (Hartson & Pyla, 2019). The geographic areas chosen were based on their locality and convenience with two programs totaling 13 participants with code names referred to as Program A participant and Program B participant, Participants 101-113.

When each participant was recruited, the researcher sent an email to both program coordinators to inquire who from their staff would be interested in participating in the study. Several staff contacted the researcher ranging from psychiatrists, case Managers, program coordinators, employment specialists, resiliency coordinators, and data managers. For each participant, a location and time were scheduled for their choosing. The researcher conducted semistructured interview sessions that were recorded, thoroughly documented, and stored in a safe, private, secure area with only the researcher's knowledge. Once the interviews were scheduled in no particular order, the qualitative method permitted the researcher to ask seven questions that focused on services, training, geographic area, strategic steps that are important for the program to identify, and collaboration between staff, external providers, clients, and the client's families. The questions also focused on cultural competency, training, outreach, and support mechanisms among the client's family and caregiver. The qualitative data were analyzed through NVivo 12, which identified consistent themes that fulfilled the inquiries from the research.

## CHAPTER 5: DISCUSSION

Racial and ethnic minority disparities in accessing necessary mental health services are a national concern that continues to limit communities accessing and underutilizing services and resources. Because of mental health inequities, policy efforts should focus on improving access and the quality of mental health care services for racial and ethnic minorities, for instance, increasing staff with multilingual expertise (Miranda et al., 2008). Providing educational and treatment material and culturally sensitive training to providers, staff, local communities, families, and partnered agencies and organizations such as the criminal justice system, housing, faith-based organizations, and schools. Improving quality mental health care services and educating health care professionals, staff within health organizations, families, and communities would expand and increase the appropriate conditions for minorities (Miranda et al., 2008). To abolish inequities among racial and ethnic minorities suffering from mental health, it is essential for the federal government to implement government-funded programs to incorporate policies ensuring outreach, education support, and cultural competency training and placing health care professionals and staff with diverse backgrounds and proficiency in various languages in workforce practices (Miranda et al., 2008).

This study intended to understand the influence of mental health services and the essential linkage of racial and ethnic minorities and the position of all levels of government and community organizations join together to establish guidelines and strategies to inform, develop a robust, diverse workforce, and outreach to mental health systems through eliminating inequities. The basis of this work may create a conscious effort for government-funded FEP programs, local communities, external and internal

partnerships that allow policies, initiatives, and public knowledge to be effectively enforced. The goal was to attain knowledge through the phenomenological understanding of the program participants to enhance the government-funded FEP programs. The researcher examined the phenomenological information focusing on the research question.

### **Summary of Results**

Research Question: How have government-funded coordinated specialty care programs attempted to address racial and ethnic minorities' underutilization of mental health services?

#### **Ensuring Services are Responsive to Cultural Diversity**

The study cited various ways through which services rendered were in tandem with cultural diversity, for instance, creating bonding and good relationships with all parties involved, such as schools and communities and ensuring that clients received the necessary support because it showed clients' recovery accomplishments. This research trend reflects the results of the interview participants. For example, a participant clarified how all parties were involved by phrasing, "The school knows that we are involved, so we are all working together" (Participant 107). Mental health and various mental disorders have been shaped by social, socioeconomic, and physical environments (Umberson & Montez, 2010). The risk of many disorders is associated with social inequity; therefore, it is imperative to improve conditions of individuals' daily living by building relationships, understanding social determinants, and applying strategies and interventions to reduce mental illness (World Health Organization and Calouste Gulbenkian Foundation, 2014). Realizing the effects of each social context in a person's

life could alter the susceptibility and exposure to harmful practices and pressures. Social engagements and organizations like schools, local businesses, mental health facilities, socioeconomic status, and environments may have a significant influence on the possibilities that empower an individual's daily life. Therefore, a systematic assessment of providing appropriate engagement through health professionals, teachers, program officials, and community groups could ensure interventions are culturally adjusted and implemented and could expand access to mental health services (World Health Organization and Calouste Gulbenkian Foundation, 2014).

Educating health care professionals on significant and current issues affecting racial and ethnic minorities was also identified as important. Participant 107 reported that "staff was trained on current racial and ethnic disparities, though a few participants indicated they were taught in matters on racial discrimination in receiving mental health care." Educating clients, their families, the community, program officials, and health care professionals could improve an individual's mental health and increase his or her knowledge by reducing stigma and accessing services and resources. The importance of mental health education would integrate cultural and linguistic components when approaching racial and ethnic minorities, which eliminates disparities and increases an understanding of first-episode psychosis (FEP).

Another method was organizing outreach programs by which mental health clinics are developed in urban and business communities. The benefit of community outreach is to increase awareness of services for individuals with anxiety, those with apprehensions about seeking mental health programs, and those unable to access mental health services. Having mental health community outreach allows clients to feel wanted

and a part of the mental health system. Integrating outreach enhances clients' awareness of their symptoms, helps with their treatment, and identifies available providers and resources.

Moreover, an additional way of responding to racial disparities was using the client's native language. Communicating in a preferred language, as suggested by Participant 103, allowed clients to be and feel comfortable and have the desire to participate in the program. Program B staff applied technology and in-person translators to communicate with clients and their families. This component was highly effective, but participants suggested increasing diverse staff to work with racial and ethnic minority clients to reduce disparities among the programs. Although diverse staff understood the culture of clients and the unfortunate issues faced, Participant 101 reported, "The cultural background of a patient made assessment and diagnosis easier." Participant 108 indicated, "It was hard to deal with patients if a health care staff was not from the same background or did not understand the cultural background and language of the client." Reviewing both participants' statements showed that communicating effectively with clients would create successful interaction and improve mental health services, recovery, and access to care.

Another method participants commented on was the use of support programs and medical subsidy. To address racial and ethnic disparities, the government-funded FEP program, A & B, provided impoverished individuals free services to ensure they receive health and wellness resources and support services, such as housing, supportive employment, education, and family services. Recognizing these essential components "helps in reducing barriers to accessing mental health services" (Participant 103).

However, this method was not identified only among racial and ethnic minorities but with each client served. Therefore, program supervisors ensured that all patients received full access to mental health services when directly providing care for clients. Participant 108 observed that supervising the delivery of services would ensure that patients from any racial and ethnic minority background were never overlooked.

### **Strategy to Deliver Mental Health Services**

The study highlighted several strategies applied by stakeholders in mental health services. Participant 101 suggested the use of phone, video, or in-person translations for interpreting information to clients with language barriers. Other participants suggested the elimination of language barriers as a critical strategy of ensuring racial and ethnic minorities accessing mental health services could use both technological and in-person translation services. Another strategy was open communication; participant 103 reported that “having open dialogues with clients about their culture and identity made a massive impact on the kind of services they received.” Having open communication with clients, their families, and caregivers shows the gaps between health care professionals and the client. This would permit clients to be relaxed and have a productive dialogue concerning their mental health illness. Open communication helps in understanding the clients’ culture, thus helping professionals to know how to assist and adequately care for them in a healthy manner

Integrating a proper transition between various interagencies and external agencies is vital. Agencies are to provide clients’ medical history and any essential information concerning the clients, including their cultural background, to transition efficiently so clients can receive quality services for their illness. Participant 107 said,

“Some patients need specialized care, so a proper transition from one facility to another was essential.” Often, when clients transition to other agencies, they seek assistance in accessing, obtaining, and utilizing services. Individualized care and the emphasis on patient independence are another way of delivering mental health care, particularly to impoverished clients. Personalized care would ensure a patient’s mental health history and cultural beliefs would be considered. Participant 110 said that “the ultimate goal for FEP programs was to make patients independent.” Therefore, developing a client’s independence is crucial because it shows he or she is capable of accessing and seeking services;

Another strategy is program outreach. When educating and helping racial and ethnic minorities access mental health services, organizations outreach throughout communities by supporting programs in delivering services to clients. Outreach often supports agencies in delivering services to clients who do not have access to transportation, public or personal. This is where both programs offer transportation services and vouchers for their clients to access mental health services, employment opportunities, school, and other health care and supportive services. Providing transportation was a way of ensuring the client’s needs were met. Participant 104 reported, “Patients were provided with metro cards which reduced fares,” and Participant 111 indicated that “there was a program providing transport for young adults to and from their required destination.” Incorporating this approach allows the client and his or her family a sense of stress-free financial obligation toward transportation, limited stress, and anxiety, which prevent them from retrieving services. However, outreaching to clients and informing them of what resources the program has to offer gives the client the chance

to develop respect within themselves and for others, being authentic, building collaborative relationships, engaging with others, actively listening and being willing to be a part of the treatment process (“Building Partnerships, “2009).

Another way of ensuring access to mental health services is expanding facilities to impoverished patients who have no easy access to general and mental health services. This was identified by Participants 106 and 108 expressing agencies, programs, and community partners need to work together in delivering services and being culturally aware of producing adequate services to racial and ethnic minorities. Therefore, it is essential to invest and recruit culturally competent staff and to have mental health workers familiar with the environment and culturally represent minority groups. This would also improve the funding strategies when accessing mental health services. With the programs funded by the government, the expenditures are only 10% of what the state and the FEP program receives. Therefore, a funding strategy would benefit government-funded programs by recruiting competent cultural staff and implementing cultural competency training.

### ***Challenges Faced in the Delivery of Services***

Participants identified language and communication barriers as a critical impediment to access mental health services. Participant 111 said that “the Hispanic community was the most significant minority disadvantaged by language.” Participant 111 added that “it was challenging to offer cognitive therapy effectively due to language challenges.” Participant 110 said that they “had to seek translation services from other departments when they had a Hispanic patient.” Some clients from the ethnic minority



groups also faced challenges when interacting with their service providers because of the lack of means of communication.

Also, there was a lack of funding. Participants said that the cost of running a mental health facility was very expensive, and financial support was not forthcoming. They lacked funding for advocacy and awareness creation to make the program more prominent, as reported by Participant 108. Participant 103 noted that “some patients declined medical care due to the cost of services” in addition to the housing and transportation challenges. Most of the clients seeking help from FEP programs were homeless and also did not have a means of transport. The patients only focused on getting food and could not frequently seek mental health services. Participant 108 noted that “it was hard for a homeless person to seek mental health services. The movement to health facilities was a problem for patients who could not afford transportation.” In respect to delivering services, a rushed diagnosis, misdiagnosis, or late diagnosis was a challenge as well when accessing mental health services, according to participants. For instance, Participant 103 gave an example that most Black Americans were diagnosed with severe mental illness compared to the White Americans, which could be fallacious.

Also, patients were faced with family pressure and religious beliefs. Participants reported that some patients disagreed with their family on ways of receiving mental health care or refused to acquire resources and services. Some religious beliefs barred patients from accepting mental health services because the families were opposed to their mental illness, which comprised limiting access to mental health care. Participants noted that some clients discontinued their medication because of their cultural, religious, and family beliefs. Another challenge faced was bias toward patients from other minority

health care professionals, particularly Black Americans. Participant 105 said, “A White service provider freaked out when they got a Black patient” and therefore did not provide the same quality of care compared to the White patients. This led to referring Black American clients to other facilities or providers of color.

### ***Collaboration to Improve Access to Mental Health Services***

The participants identified partnerships with ethnic minorities as a way of improving the delivery of mental health services. Collaboration with ethnic minorities could be done by sharing ideas and suggestions. The caregiver and family members often were invited to meet with the client and case manager to give their opinions on the type of care received by the individual suffering from mental illness. The collaboration was organized through sharing beliefs and cultural viewpoints, involving families and consumers in the treatment plan. Family involvement was done by offering transportation to parents and their children for treatment services. Families made sure the patients took the prescribed medicine; for instance, Participant 107 said that “family monitoring ensured that patients were taking medication, and it was working.” Another collaborative effort was the family offering support to patients to achieve their treatment goals (Participant 104). Family members, especially parents, provided information on the progression of children who were clients to their health care providers. This cultivated the family in creating and being involved in the client’s treatment plan (Participant 108).

Health care providers formed leadership collaborations as well as educating communities on psychosis and participating in the training. Agencies formed consulting collaborations according to Participant 101, who said, “They had consultations with other agencies to borrow ideas on how to manage clients.” Participant 107 reported that “the

Department of Behavioral Health was heavily involved in collaborating and creating awareness for accessing mental health services,” which permitted health care providers to refer clients to other agencies for specialized care with a stable referral system to other psychiatric hospitals. Agency collaborations led to FEP programs receiving funding to facilitate services offered to clients. Participant 110 identified the Department of Behavioral Health as a critical financier of the FEP programs in their state.

Another collaborative contribution was language translation services in the form of in-person interpreters, language software for iPad, and phone interpretation services to non-English speaking clients. These language services were available to clients so they could access FEP services. Among the collaborative efforts, transportation and communication were also methods used to ensure access to mental health services was being utilized. Transportation services were provided in the form of metro cards, taxis, telehealth, vouchers, and case managers conveniently meeting clients in their homes or places accessible to the client. As for communication, goals were consistently met by clients and their health care providers, receiving proper guidance and feedback about their progression in the program, according to Participants 101 and 110.

### **Discussion of Results**

According to this study, the following are challenges that hinder racial and ethnic minorities from fully utilizing mental health services in government-funded coordinated specialty care (CSC) programs. It has been noted that language barriers and lack of proper communication are significant challenges when accessing mental health services (Yun et al. 2019). Most of the clients are LatinX, Asian, and other ethnicities that do not speak English. Health providers have difficulty in administering services to LatinX,

Asian, and other ethnicities. The complexity is that health care providers who do not speak the language are unable to communicate effectively with clients and their families. Health care professionals are compelled to use translators or seek help from other departments, which is time consuming and could lead to distortion of information conveyed.

To achieve the improved elements of mental health outcomes for racial and ethnic minorities accessing services, the researcher suggests integrating systems of care by regulating and offering mental health services and incorporating ethical practices to generate advocacy and parity programs. Promoting mental health policy to decrease stigma for the prevention and treatment of mental health complexities is an essential component to integrate government-funded programs, health care professionals, and administrative officials (Ashaye et al., 2003). This is to ensure culturally competent care is offered to racial and ethnic minorities who value their family's cultural and spiritual beliefs by ensuring that mental health resources and services are obtainable. Knowing the inconsistency of mental health symptoms coinciding with racial and ethnic minority cultures will allow understanding to address the specific services needed (Ashaye et al., 2003). As government-funded FEP programs, health care professionals, public officials, and community organizations accept the culture, ethnicity, and spiritual awareness from racial and ethnic minority assessments, mental health practices on outcomes of care will increase. Having mental health outcomes evaluated regularly guarantees client care when using stratified quality measures of treatment for addressing inequalities among racial and ethnic minorities in need of quality progression (Kilbourne et al., 2018).

Unfortunately, some mental health programs that rely on government expenditures do not receive adequate funding to subsidize a large number of individuals seeking mental health services. This leads to clients facing challenges such as being misdiagnosed or having a diagnosis delayed, which could cause a delay in treatment, not accessing mental health services, and ultimately, underutilizing services (Saha et al., 2007). The provision of mental health care faces challenges from family pressure and awkward religious ideas. Families and patients often express conflicting opinions on how to deal with mental illness and accessing mental health services; because of these dynamics, family and cultural-religious beliefs prohibit clients from seeking mental health treatment. This leads to faith-based communities advocating for nonmedicinal practices that engulf patients facing prejudice and underutilizing mental health services. Unfortunately, these characteristics leave health care providers in an awkward position of wanting to assist the client or referring the client to another provider, prolonging a treatment plan (Hankerson & Weissman, 2012).

The study has identified ways of accessing FEP mental health services. The programs should primarily employ multilingual and racial and ethnic minority health care providers who represent clients appropriately. Program A has adequate health care providers representing racial and ethnic minorities. Program B will need to increase its health care provider representation to accommodate the racial and ethnic minority clients who access mental health services. Some ways to accomplish this are ensuring non-English clients have interpreters on site when a client is in need, having government-funded FEP program organized sessions for cultural competency training, and offering English and Spanish courses for their local communities. Also, it is important for FEP

programs to acknowledge inadequate funding as agencies supplement their programs through government and grant funding. The programs do offer free services to reduce economic stress for utilizing other services such as transportation, assistance with housing, education, and supportive employment. Programs also provided clients with the ease of transportation, enabling patients to access mental health care. The FEP programs also organized transitioning services for clients who seek additional supportive services to internal and external agency programs. These programs reported that their transitioning services were well-established ensuring that clients seeking specialized advanced care were managed timely and appropriately. Finally, the health care providers organized outreach activities and mental health awareness through creative practices by educating their communities from radio stations, social media, family activities, and faith-based events. In addition, they provided mental health guidance to schools, criminal justice systems, housing authorities, and hosting community events for clients, patrons, and families. These programs have taken and administered services to clients who are unable to access and who underutilize mental health services to ensure they receive adequate care.

### **Data Collection**

The primary data collection tool used in this study consisted of one-on-one, semistructured face-to-face interviews. A digital recorder was used during the interviews. The digital recorder had a built-in microphone that promoted high-quality audio and suppressed unwanted noise. The researcher used the digital recorder to support the ability to preserve and transcribe the interviews verbatim for data analysis.

A naturalistic observation model was applied by observing health care professionals, state representatives, and the CSC team's behavior in the FEP government-funded CSC programs. The researcher observed how the programs implement culturally sensitive materials and diverse clientele. The researcher observed building structure and ease of accessing each program within the business complex in Virginia and the urban area of the District of Columbia. Also, the researcher viewed racial and ethnic minorities who were health care professionals and providers in addition to the number of racial and ethnic minorities accessing the FEP programs. Also, the researcher evaluated the number of racial and ethnic minorities who accessed these mental health services and described the ease of accessing programs demographically.

The researcher analyzed the participant's responses based on the qualitative research question. The results illustrated comparable information from participants and the literature review, such as having programs and facilities partnering among communities, families, and behavioral health providers and ensuring culturally competent services were put in place and recognized (T. B. Smith & Trimble, 2016). The study also showed educating the community and families about mental health stigma and decreasing the shame of receiving services (Schatell, 2017). The study also documented in the literature review that limited mental health professionals were not well represented among racial and ethnic minorities (Wahowiak, 2015), a finding that was also validated by several participants. Another finding was to ensure culturally competent and culturally represented providers shared a connection with clients and their families. This would allow clients to feel comfortable seeking and accessing services. The collective and collaborative effort to ensure clients receive mental health services was an essential

technique adhered to by participants. The data showed that this was vital and should be implemented. The participants were knowledgeable and had experience directly related to the research study and provided valuable in-depth and personal research data regarding challenges and barriers. Each participant reflected on challenges and social issues among racial and ethnic minority communities, mental health disparities, stigma, and treatment outcomes from the FEP government-funded CSC programs.

The researcher also recognized how the literature review, the ecological model, and public administration combined throughout this study. The literature review contributed to the research on racial and ethnic disparities in mental health care; mental health support from family, the community, and health care professionals; cultural barriers; and access to mental health care. The study identified and summarized vital factors that contributed to existing research yet pinpointed gaps for future research, for instance, examining the cultural competency training curriculum and how it impacts health care professionals, clients, and their families; increasing the retention of racial and ethnic representation among health care providers; and how that has affected the utilization of mental health services among minorities. In addition, the researcher collected data on the increase of government funding to impoverished communities to show how services were being accessed more by racial and ethnic minorities. The performances of public administration and the ecological model influence the operations of effective communication among diverse cultures, making appropriate decisions for the public, and using the strategies of implementing policies and practices necessary to strengthen an individual's knowledge and skill while promoting mental health access to racial and ethnic minorities (Crump et al. 2007). Public administration fosters the



coalition and network of organizational practices that influence the legislature (Frederickson, 2005). Therefore, the public administration pillar, social equity, was met with challenges for racial and ethnic minorities about accessing care, which increased disparities in services, education, supportive employment, and socioeconomic status (“Role of Social Equity in Public Administration,” n.d.). The distribution of equity and efficiency comes from providing resources of equal and effective access to mental health services. This guarantees due process, promoting awareness and consistency in delivering services. Another pillar, efficiency, provides accountability and affirmation of the government’s unique qualities of justice and fairness. It is important for public administrators to ensure FEP programs are conducted most effectively by communicating with government officials and the population serviced regarding applying principles of equity for racial and ethnic minorities accessing mental health services, increasing racial and ethnic minority health care workers to those underrepresented populations, and integrating cultural competency (Bryson et al., 2014).

Employing critical race theory (CRT) in mental health disparities generates analyzed procedures and principles through a race-conscious lens that can facilitate critical inquiries that confront the dangers that explicitly influence racial and ethnic minorities (Yosso, 2005). CRT in mental health disparities must take an active role in praxis as it maintains attention and success to advance mental health, manage cooperative efforts, and foster access to racial and ethnic minorities who seek mental health services. Racialized approaches are a complete series of activities formed to evade deeply embedded, insistent historic public obstacles (McGee & Stovall, 2015).

CRT acknowledges that racism and discrimination uncaringly influence the mental health of racial and ethnic minorities by deteriorating their expression, self-assurance, and mental efficacy. New efforts in sociology and public health have inspired a rising concern that racism contributes to hindering racial and ethnic minority health (Brown, 2003). Brown (2003), believed well-established coping strategies cannot fully mitigate the effects of racial discrimination and that only the elimination of racism will improve race-related anxiety for racial and ethnic minority populations.

Given that racially discriminatory practices are multifaceted, CRT's multiframework can assist in connecting and accentuating the correlation between race and mental health. For instance, the power that racial stratification has on health outcomes could clarify theories and cross-theme methodologies provided by CRT (Ford & Airhihenbuwa, 2010). The public health community has approved the theories of CRT to examine organizational racism in health care, applying their results to advance a health care praxis that increases community-based participatory studies and hence the outcomes in the development of methods that help racial and ethnic minority communities (Roberts, 2005). CRT focuses on the mental and psychological stress and incompetence that racism intensifies in racial and ethnic minorities when they suffer discriminating levels of racial stereotyping, prejudice, and other forms of preconception (D. D. Matthews et al., 2013).

The ecological model acknowledges the importance of change and the possibilities of maintaining and implementing change for racial and ethnic minorities who access mental health services, support from families, caregivers, health care providers, and better representation for underserved populations. The five categories of

the ecological model consist of individuals, interpersonal, organizations, community, and society:

- Individual—would work if the behaviors, beliefs, and attitudes of people adjust in a more supportive manner.
- Interpersonal—works if family members, friends, and health care professionals change their behaviors, attitudes, and beliefs concerning mental illness.
- Organizations—influence internal and external programs and organizations by amending engagement practices with schools, workforce development, support services, faith-based organizations, and communities as a whole.
- Community—modifying local policies and guidelines to improve racial and ethnic minorities accessing mental health services, by incorporating cultural competency training, providers representing racial and ethnic minorities, and increase community knowledge about mental illness.
- Society—involves changes of government-funded FEP policy on a national level, which would include new legislative guidelines.

This study identified all five ecological categories, showing that change is possible and sustaining change is possible if mental health providers adjust to the support of individuals, interpersonal mechanisms, organizations, local communities, and public policies. Therefore, it is essential to address the issues racial and ethnic minorities endure within the ecological model. The FEP program identifies the implications based on the ecological model phases described as the following (Thompson et al., 2015):

- Individual phase identifies how racial and ethnic minorities with mental illness encounter challenges of stigma, lack of mental health literacy, inconsistent

treatment, and low self-esteem. It is vital to inspire racial and ethnic minority individuals to uplift themselves, practice self-care, and acquire benevolence within self that reduces adverse effects, causing stigma (Thompson et al., 2015).

- Organization phase recognizes FEP programs are government-funded programs that deliver services to state, local, and community levels. Among these programs, it is essential to deliver adequate mental health promotion toward practical barriers. Some of these barriers comprise commitment, collaboration of mental health services, standards, adequate racial and ethnic minority representation, accessibility of primary resources, and services. When distributing mental health promotion, the dedication of triumph and sustainability is critical for racial and ethnic minorities (Thompson et al., 2015).
- Macrosystem phase impacts the economic level, stigma, disparities of care, lack of coverage, and access to care with minimal acceptance from society. This causes discrimination toward racial and ethnic minorities, which leads to mediocre second-rate mental health care services. Valuable intercessions focusing on these developed elements afford a basis for diminishing negative mental health outcomes (Thompson et al., 2015).

In essence, promotion and interference in racial and ethnic minority communities accessing mental health services influence some phases throughout the ecological model. The ability to promote, support, and impact mental health outcomes among racial and ethnic communities is essential (Thompson et al., 2015). Preventing access to mental health services, the inequity of racial and ethnic minority health care provider representation, language barriers, stigma, and mental health illiteracy suggests mental

health promotion from different levels of the ecological model can help tackle the challenges of mental illness within the FEP programs. Mental health should be community focused and population based as efforts of addressing racial and ethnic minorities accessing care are essential. Accomplishing this concept requires collaboration, additional and new policy guidelines from the government and support from communities, faith-based organizations, families, health care professionals, and clients.

### **Limitations of the Study**

Although this study makes significant contributions to understanding how government-funded CSC programs attempt to address racial and ethnic minorities' underutilization and access to mental health services, it had several limitations. In qualitative research, the researcher may serve as the most significant research instrument and, at the same time, present limitations to the study such as unrecognized biases that may influence study confirmability and interpretation of the data. Another limitation was the sample size. The study selected three individual federal state FEP government-funded CSC programs; only two of the three agencies participated. This introduces the possibility of some new data from the missing interviews that could nuance the finding of this study. Developing the theory and accurately reflecting the phenomenon under investigation was also a limitation; the participants were mental health workers, and no patient or client was a participant, so views of patients were not taken. The researcher used naturalistic observation and in-depth interviews to capture data triangulation. Categorizing each program and comparing the number of participants was implemented by evaluating the underutilization and access to mental health services in Program A and

Program B. The researcher initially identified the stakeholders such as health care professionals, program coordinators, peer supporters, clinicians, and government officials. Then, the researcher conducted in-depth face-to-face interviews to understand what the stakeholders recognized as outcomes of their programs. The researcher triangulated their responses by examining the results that were consistent among the participants. The data suggest that if every participant perceiving the underutilization and access to mental health services from different perspectives realizes the outcome, then the results are authentic.

Also, the study involved the use of a naturalistic observation model, which has various limitations. It was hard to control the behavior of participants because of environmental pressures. It was challenging to determine whether the participants behaved in the same manner when not under observation. Human beings tend to be on their best behavior when under observation, meaning that the researcher could not get the correct information. This method also required much time to capture participants' behavior, especially when participants recalled that they were under observation.

Another challenge was obtaining accurate data from the National Outcome Measures that provide vital information on how well the program is doing, whether or not services are being implemented, how many clients are seen, and whether the program is achieving the required quality outcomes of health care and prevention. It was difficult to view the limitations and lessons learned from Program A and any of their objectives and techniques to ensure their quality assurance was maintained at every level of government.

## **Recommendations**

Accessing mental health services contributes to delaying or to forgoing mental health care, stigma, cultural beliefs, a client's desires, and available services. Another factor associated with accessing care among racial and ethnic minorities is hesitating in recognizing symptoms and seeking help, lack of appropriate mental health providers representing racial and ethnic minorities, and the use of general or alternative services such as faith-based leaders, peer counseling, and family member support. As mentioned in the literature review and assessed data obtained by the researcher, stigma, language barriers, and cultural competency about mental illness are factors associated with underutilization and access to mental health services. Another distinction for addressing racial and ethnic minorities' underutilization of access to mental health services in FEP is derived from cultural mistrust in community mental health services, suggesting that racial and ethnic minorities as health care providers are necessary for better developed culturally sensitive interaction (Addington et al., 2015). Additional supportive networks and outreach strategies targeted families in both CSC programs and community settings by identifying barriers or challenges in treatment engagement plans that increased participation in evidence-based psychoeducation interventions (Kane et al., 2015).

The number of interventions could increase and remain constant when there is improved access to general, behavioral, and mental health care. As indicated by a few of the participants, lessening language barriers was essential when accessing mental health. One suggestion is enforcing data collection of mental health care, therapeutic, treatment options, and addressing other barriers to care. It is imperative to create programs and collaboration and to address cultural preferences of racial and ethnic minorities to clients,

their families and caregivers, health care providers, and community organizations. One method is expanding the use of family advisory committees with diverse members of racial and ethnic minorities providing feedback on initiatives to reduce disparities, suggesting ways for staff to recognize minority patients' concerns, and assisting with creating strategies to reach individuals with mental illness. Another method for racial and ethnic minorities accessing mental health services is contingent upon a suitable workforce; there is a significant lack of workforce representation among racial and ethnic minority health care professionals, paraprofessionals, and providers nationwide, according to Substance Abuse and Mental Health Services [SAMHSA], 2014). The HHS Office of Minority Health indicates the insufficiency of executing culturally competent services for underrepresented racial and ethnic minority health care professionals, case managers, peer specialists, and program coordinators (SAMHSA, 2015).

Unfortunately, mental health providers are limited in rendering and implementing cultural competency training among racial and ethnic minority communities and within their workforce (NCSL, 2018). The HHS Office of Minority Health describes cultural competency as considerate and receptive services to health care principles, practices, and the needs of diverse clients. The description identifies that when tailoring individual services to specify cultural and language preferences, health care professionals adhere to conceivable outcomes for diverse populations within the general, mental health, and behavioral health communities. It is essential to include and implement cultural competency among providers and services, for this eliminates inequities in mental health and substance use treatment and services (NCSL, 2018).



Studies dispense variations of delivery through government systems and service industries within sociodemographics, which often uncovers communities, racial and ethnic minorities, and public administrators' cultural variances, theories, principles, and language barriers. Government programs are proficient when executing and providing services and programs to impoverished communities composed of racial and ethnic minorities. Communicating and expanding cultural competence in public administration generates innovative methods among government agencies. Cultural competence expounds, assimilates, and transmutes cultural consciousness and understanding about racial and ethnic minorities and the clear customs, socially exclusive abilities, values, and procedures in progressive quality efficiency of government agencies of their initiatives, resources, and service delivery integrated within various communities.

Integrating cultural competence within public agencies is imperative when providing services and materials and delivering programs to racial and ethnic minorities facing linguistic barriers, socioeconomic disparities, mental health, and health care disparities, unequal workforce, and social justice (C. P. Jones, 2002). Private industry, mental health providers, individuals, communities, and government of all levels need to understand racial and ethnic minority cultural values and their belief systems by familiarizing themselves with elements of cultural competence. Assimilating a government and workforce cultural competency curriculum for mental health providers and health care professionals and providing programs on racial and ethnic minority communities instills an organizational structure by applying and administering diversity of cultural experience. Public administrators need to understand diversity and cultural

experiences and realize their importance when generating inclusive practices, distinct principles, behaviors, values, and appropriate cultural methods improves outcomes.

It is important to recognize cultural competence. Recognizing cultural competence as an essential element is critical when educating society and diversifying the population. Communities, health care professionals, providers, and government entities are not equal in their perception, ideas, protocols, delivery of services, and indulgence when it comes to racial and ethnic minorities. To recognize this issue, society, government officials, communities, and health care professionals must renovate, innovate, and provide quality services of cultural competence. To appreciate social competencies and experiences, awareness is eminent and must employ racial and ethnic minorities' perspectives and cultural disparities to achieve change.

People should understand, gain knowledge, and include cultural elements of racial and ethnic minority competencies when delivering services from communities, government agencies, health care providers, and public administrators. This allows for supportive constructs when addressing, developing, and educating the social proficiencies of racial and ethnic minorities. By integrating these components, government agencies can employ cultural knowledge and create awareness among professionals, communities, and society as a whole. Combining cultural experience to understand and achieve cultural competence in public administration and government agencies is inevitable and demands the detection of numerous actions. Being aware of cultural competence, an individual's traditions, and his or her behaviors expressed within communities, organizations, public agencies, and health care programs is significant.

From an organizational perspective, cultural competence implies a collection of consistent activities, practices, and approaches that permits public administrators, mental health providers, and community officials to work with racial and ethnic minority groups effectively. The assurance of improving cultural competence is essential when sustaining periodic reviews and modifications. Individual public agency initiatives propose plans to assist public administrators to cultivate social interests, workforce development, and health care programs to acclimate them to behavioral mental health services. Cultural competence requires constant dedication to candidness and education, being proficient, taking risks, encountering ambiguity, distress, and not permitting prompt resolutions or simple explanations.

In essence, cultural interest is not maintained without a government-funded agency obligation and sustenance. Enhancing the effectiveness of racial and ethnic minorities, government-funded FEP programs examine the provisions of cultural competence constructed throughout programs, health care providers, clients, and communities across profound measures. FEP programs need to ensure guidelines of authorization through the government while agencies go beyond the obligations and disposition to guarantee acceptable requirements of racial and ethnic minorities served. By committing to this effort, cultural competence expands and enhances the deliverance of mental health services through an appropriate all-inclusive assessment of society. In general, cultural competence has an underlying influence on providers, staff, government officials, and communities by forming relationships constructed on empathy and awareness of racial and ethnic minority cultural beliefs and the pressure communities,

government, and organizations endure along with the viewpoints, assessment, and policies managed.

In essence, the researcher also recommends government-funded programs integrate the HHS Office of Minority Health free accredited internet learning program of Improving Cultural Competency for Behavioral Health Professionals (Think Cultural Health, 2019). The program was created to offer information and services connecting cultural competencies. This toolkit allows health care organizations to summarize the framework when evaluating and guiding ambulatory care, mental, general, and behavioral health care along with hospital settings.

The pledge of implementing mental health requirements for all races, ethnicities, cultures, and genders in every FEP government-funded programs can reduce the social impacts of mental health. As health care providers, public administrators, and government officials, it is imperative to educate families and offer support to encourage a confident connection between the client and the health care worker. The significance of collecting protective factors of building resiliency among clients and their families increases access to care, a commitment from health care professionals on learning, and acknowledging and implementing cultural competence when addressing the mental health needs of clients. Ensure federal health care agencies implement policies on evaluating the FEP program's cultural competency training and educational designs; develop recruitment and retention of racial and ethnic minority health professionals; and ensure phone interpreting services are secure and confidential and readily available for patients and their families. In addition, increase the number of IPADs for every health care provider to assist with language barriers.

## **Conclusion**

The most concerning disparity in accessing mental health is the unmet need for mental health care in communities of racial and ethnic minorities. The commitment to adopting mental health requirements for all races, ethnicities, cultures, and genders in all FEP government-funded programs is to reduce the social impacts of mental health. It is imperative to educate families and receive support to encourage a secure connection between the client and the health care worker. Important considerations include increasing protective factors of building resiliency among clients and their families, increasing access to care, a commitment from health care professionals on learning, acknowledging, and implementing cultural competence when addressing the mental health needs of clients. The researcher is hopeful that the FEP government-funded programs will work to ensure the stressors from racial and ethnic minority clients would subside by increasing representation for non-English clients. Also, it is important to educate care providers and the public about mental illness and how to eliminate the disparities, misconceptions, and stigma while exploring and implementing policy options and recommending strong supportive guidelines for racial and ethnic minorities suffering from mental health who are afraid of accessing services.

## REFERENCES

- Addington, J., Heinssen, R. K., Robinson, D. G., Schooler, N. R., Marcy, P., Brunette, M. F., Correll, C., Estroff, S. E., Mueser, K., Penn, D., Robinson, J., Rosenheck, R., Azrin, S., Goldstein, A. B., Severe, J., & Kane, J. (2015). Duration of untreated psychosis in community treatment settings in the United States. *Psychiatric Services, 66*(7), 753-756. <https://doi.org/10.1176/appi.ps.201400124>
- Addington, J., Penn, D., Woods, S. W., Addington, D., & Perkins, D. O. (2008). Social functioning in individuals at clinical high risk for psychosis. *Schizophrenia Research, 99*(1-3), 119-124. <https://doi.org/10.1016/j.schres.2007.10.001>
- Agency for Healthcare Research and Quality. (2014). About AHRQ. <https://www.ahrq.gov/cpi/about/index.html>
- Agency for Healthcare Research and Quality. (2016, April 27). 2015 national healthcare quality and disparities report and 5th anniversary update on the national quality strategy. <https://www.ahrq.gov/research/findings/nhqdr/nhqdr15/index.html>
- Airhihenbuwa, C. O., & Liburd, L. (2006). Eliminating health disparities in the African American population. *Health Education Behavior, 33*(4), 488-501. <https://doi.org/10.1177/1090198106287731>
- Aklin, C. F. (2017, July 13). Minorities and mental health: Moving beyond stigma. <https://nimhd.blogs.govdelivery.com/2017/07/13/minorities-and-mental-health-moving-beyond-stigma/>
- Al-Busaidi, Z. Q. (2008). Qualitative research and its uses in health care. *Sultan Qaboos University the Medical Journal, 8*(1), 11-19.

- Alcalá, H. E. (2014). Differential mental health impact of cancer across racial/ethnic groups: Findings from a population-based study in California. *BMC Public Health*, 14(1), Article 930. <https://doi.org/10.1186/1471-2458-14-930>
- Alegria, M., Alvarez, K., Ishikawa, R. Z., DiMarzio, K., & McPeck, S. (2016). Removing obstacles to eliminating racial and ethnic disparities in behavioral health care. *Health Affairs*, 35(6), 991-999. <https://doi.org/10.1377/hlthaff.2016.0029>
- Alegria, M., Pescosolido, B. A., Williams, S., & Canino, G. (2011). Culture, race/ethnicity and disparities: Fleshing out the socio-cultural framework for health services disparities. In B. A. Pescosolido, J. K. Martin, J. D. McLeod, & A. Rogers (Eds.), *Handbook of the sociology of health, illness, and healing* (pp. 363-382). Springer.
- Allan, H. T., & Westwood, S. (2016). English language skills requirements for internationally educated nurses working in the care industry: Barriers to UK registration or institutionalised discrimination? *International Journal of Nursing Studies*, 54, 1-4.
- American College of Physicians. (2010). *Racial and ethnic disparities in health care, updated 2010*. [https://www.acponline.org/system/files/documents/advocacy/current\\_policy\\_papers/assets/racial\\_disparities.pdf](https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/racial_disparities.pdf)
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

- American Psychiatric Association. (2017). Mental health disparities: Diverse populations. <https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts>
- American Psychological Association. (2017). Disparities in mental health status and mental health care. <https://www.apa.org/advocacy/health-disparities/health-care-reform>
- American Public Health Association. (2018, November 13). Achieving health equity in the United States. <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/achieving-health-equity>
- Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: does it matter? *Journal of Health and Social Behavior*, 36(1), 1-10.
- Anderson, K. K., Fuhrer, R., & Malla, A. K. (2013). “There are too many steps before you get to where you need to be”: Help-seeking by patients with first-episode psychosis. *Journal of Mental Health*, 22(4), 384-395. <https://doi.org/10.3109/09638237.2012.705922>
- Anderson, K. K., McKenzie, K. J., & Kurdyak, P. (2017). Examining the impact of migrant status on ethnic differences in mental health service use preceding a first diagnosis of schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 52(8), 949-961. <https://doi.org/10.1007/s00127-017-1403-z>
- Ashaye, O. A., Livingston, G., & Orrell, M. W. (2003). Does standardized needs assessment improve the outcome of psychiatric day hospital care for older people? A randomized controlled trial. *Aging & Mental Health*, 7(3), 195-199. <https://doi.org/10.1080/1360786031000101166>



- Baxter, P. E., & Jack, S. M. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, 13(4), 544-559. <http://www.nova.edu/ssss/QR/QR13-4/baxter.pdf>
- Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27(3), 759-769. <https://doi.org/10.1377/hlthaff.27.3.759>
- Boyce, C. & Neale, P. (2006). *Conducting in-depth interviews: A guide for designing and conducting in-depth interviews*. Pathfinder International.
- Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology & Community Health*, 57(4), 254-258. <https://doi.org/10.1136/jech.57.4.254>
- Brondani, M. A., Alan, R., & Donnelly, L. (2017). Stigma of addiction and mental illness in healthcare: The case of patients' experiences in dental settings. *PLOS ONE*, 12(5). <https://doi.org/10.1371/journal.pone.0177388>
- Bronfenbrenner, U. (1977a). Lewinian space and ecological substance. *Journal of Social Issues*, 33(4), 199-212. <https://doi.org/10.1111/j.1540-4560.1977.tb02533.x>
- Bronfenbrenner, U. (1977b). Toward an experimental ecology of human development. *American Psychologist*, 32(7), 513-531. <https://doi.org/10.1037//0003-066x.32.7.513>
- Bronfenbrenner, U., & Evans, G. W. (2000). Developmental science in the 21st century: Emerging questions, theoretical models, research designs, and empirical findings. *Social Development*, 9(1), 115-125. <https://doi.org/10.1111/1467-9507.00114>
- Brown, T. N. (2003). Critical race theory speaks to the sociology of mental health: Mental health problems produced by racial stratification. *Journal of Health and Social Behavior*, 44(3), 292-301. <https://doi.org/10.2307/1519780>

- Bryson, J. M., Crosby, B. C., & Bloomberg, L. (2014). Public value governance: Moving beyond traditional public administration and the new public management. *Public Administration Review*, 74, 445-456.
- Budhwani, H., Hearld, K. R., & Chavez-Yenter, D. (2015). Depression in racial and ethnic minorities: The impact of nativity and discrimination. *Journal of Racial and Ethnic Health Disparities*, 2(1), 34-42. <https://doi.org/10.1007/s40615-014-0045-z>
- Building partnerships: Key considerations when engaging underserved communities under the MHSA. (2009). *PsycEXTRA Dataset*. <https://doi.org/10.1037/e574272010-001>
- Burgess, D. J., Ding, Y., Hargreaves, M., Van Ryn, M., & Phelan, S. (2008). The association between perceived discrimination and underutilization of needed medical and mental health care in a multi-ethnic community sample. *Journal of Health Care for the Poor and Underserved*, 19(3), 894-911.
- Call, K., McAlpine, D., Johnson, P., Beebe, T., McRae, J., & Song, Y. (2006). Barriers to care among American Indians in public health care programs. *Medical Care*, 44(6), 595-600. <http://www.jstor.org/stable/40221323>
- Campbell, R. D., & Long, L. A. (2014). Culture as a social determinant of mental and behavioral health: A look at culturally shaped beliefs and their impact on help-seeking behaviors and service use patterns of Black Americans with depression. *Best Practices in Mental Health: An International Journal*, 10, 48-72.

- Carpenter-Song, E., Chu, E., Drake, R. E., Ritsema, M., Smith, B., & Alverson, H. (2010). Ethno-cultural variations in the experience and meaning of mental illness and treatment: implications for access and utilization. *Transcultural Psychiatry*, 47(2), 224-251. <https://doi.org/10.1177/1363461510368906>
- Center for Behavioral Health Statistics and Quality. (2013). *Results from the 2012 National Survey on Drug Use and Health: Mental health findings*. Substance Abuse and Mental Health Services Administration.
- Centers for Medicare & Medicaid Services. (2016, March 30). Medicaid and children's health insurance programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid managed care organizations, the Children's Health Insurance Program (CHIP), and alternative benefit plans. *Federal Register*. <https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>
- Centers for Medicare & Medicaid Services. (2020, June 16). Health Outcomes Survey (HOS). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS>
- Centers for Medicare & Medicaid Services, Office of Minority Health. (2015). *Medicare health outcomes survey data brief: Asians Americans and Pacific Islanders*. [https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH\\_Dwnld-MedicareHealthOutcomesSurveyDataBrief.pdf](https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Dwnld-MedicareHealthOutcomesSurveyDataBrief.pdf)

- Centers for Medicare & Medicaid Services, Office of Minority Health (in collaboration with the Rand Corporation). (2018). *Racial and ethnic disparities in health care in Medicare advantage*. <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/2018-National-Level-Results-by-Race-Ethnicity-and-Gender.pdf>
- Chin, M. H., Clarke, A. R., Nocon, R. S., Casey, A. A., Goddu, A. P., Keesecker, N. M., & Cook, S. C. (2012). A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. *Journal of General Internal Medicine*, 27(8), 992-1000. <https://doi.org/10.1007/s11606-012-2082-9>
- Chow, J. C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health*, 93(5), 792-797. <https://doi.org/10.2105/ajph.93.5.792>
- Clay, R. A. (2016). A new look at racial and ethnic disparities in mental health care. *Monitor on Psychology*, 47(1), 18. <https://www.apa.org/monitor/2016/01/publication-disparities>
- Cloutier, M., Aigbogun, M. S., Guerin, A., Nitulescu, R., Ramanakumar, A. V., Kamat, S. A., DeLucia, M., Duffy, R., Legacy, S. N., Henderson, C., Francois, C., & Wu, E. (2016). The economic burden of schizophrenia in the United States in 2013. *Journal of Clinical Psychology*, 77(6), 764-771. <https://doi.org/10.4088/JCP.15m10278>
- Cole, M. (2009). Critical race theory: Origins and varieties. *Critical Race Theory and Education*, 7-22. [https://doi.org/10.1057/9780230620117\\_2](https://doi.org/10.1057/9780230620117_2)

- Connaway, L. S., & Powell, R. P. (2010). *Basic research methods for librarians*. ABC-CLIO.
- Consolidated Appropriations Act of 2004, Pub. L. No. 108-199, 118 Stat. 3 (2004).  
<https://www.govinfo.gov/content/pkg/PLAW-108publ199/pdf/PLAW-108publ199.pdf>
- Cook, B. L., Trinh, N.-H., Li, Z., Hou, S. S., & Progovac, A. M. (2017). Trends in racial-ethnic disparities in access to mental health care, 2004-2012. *Psychiatric Services*, 68(1), 9-16. <https://doi.org/10.1176/appi.ps.201500453>
- Cramer, K. M. (1999). Psychological antecedents to help-seeking behavior: A reanalysis using path modeling structures. *Journal of Counseling Psychology*, 46(3), 381–387. <https://doi.org/10.1037/0022-0167.46.3.381>
- Cramer, R. J., & Kapusta, N. D. (2017). A social-ecological framework of theory, assessment, and prevention of suicide. *Frontiers in Psychology*, 8, Article 1756. <https://doi.org/10.3389/fpsyg.2017.01756>
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches*. SAGE Publications.
- Creswell, J. W. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage.
- Crump, D., Janis, W., & McLaughlin, C. (2007). *Mental health—A public health approach: Developing a prevention-oriented mental health system in Washington state*. Washington State Board of Health.

- Degenhardt, L., Whiteford, H., Hall, W., & Vos, T. (2009). Estimating the burden of disease attributable to illicit drug use and mental disorders: What is 'global burden of disease 2005' and why does it matter? *Addiction*, 104(9), 1466-1471. <https://doi.org/10.1111/j.1360-0443.2009.02715.x>
- Delgado, R., & Stefancic, J. (1993). Critical race theory: An annotated bibliography. *Virginia Law Review*, 79(2), 461-516. <https://doi.org/10.2307/1073418>
- Delgado, R., & Stefancic, J. (2012). *Critical race theory: An introduction* (2nd ed.). New York University Press.
- Delgado, R., & Stefancic, J. (2017). *Critical race theory: An introduction* (3rd. ed.). New York University Press.
- De Maio, F. (2014). *Global health inequities*. Palgrave Macmillan.
- Deupree, J. P. (2017). Communicating effectively with diverse patient populations. [https://www.elsevier.com/\\_data/assets/pdf\\_file/0020/475400/Communicating-Effectively-with-Diverse-Patient-Populations.pdf](https://www.elsevier.com/_data/assets/pdf_file/0020/475400/Communicating-Effectively-with-Diverse-Patient-Populations.pdf)
- Dobalian, A., & Rivers, P. A. (2008). Racial and ethnic disparities in the use of mental health services. *Journal of Behavioral Health Services & Research*, 35(2), 128-141. <https://doi.org/10.1007/s11414-007-9097-8>
- Duggan, K., Aisaka, K., Tabak, R. G., Smith, C., Erwin, P., & Brownson, R. C. (2015). Implementing administrative evidence based practices: Lessons from the field in six local health departments across the United States. *BMC Health Services Research*, 15, Article 221. <https://doi.org/10.1186/s12913-015-0891-3>

Duran, B., Bulterys, M., Iralu, J., Graham, C., Edwards, A., & Harrison, M. (2000).

American Indians with HIV/AIDS: Health and social service needs, barriers to care, and satisfaction with services among a western tribe. *American Indian and Alaska Native Mental Health Research*, 9(2), 22-35.

<https://doi.org/10.5820/aian.0902.2000.22>

Eack, S. M., & Newhill, C. E. (2012). Racial disparities in mental health outcomes after psychiatric hospital discharge among individuals with severe mental illness.

*Social Work Research*, 36(1), 41-52. <https://doi.org/10.1093/swr/svs014>

Easter, A., Pollock, M., Pope, L. G., Wisdom, J. P., & Smith, T. E. (2016). Perspectives of treatment providers and clients with serious mental illness regarding effective therapeutic relationships. *Journal of Behavioral Health Services & Research*, 43, 341-353. <https://doi.org/10.1007/s11414-015-9492-5>.

Eckstein, H. (2002). Case study and theory in political science. In R. Gomm, M.

Hammersley, & P. Foster (Eds.), *Case study method: Key issues, key texts* (pp. 119-163). SAGE Publications.

Egede, L. E. (2006). Race, ethnicity, culture, and disparities in health care. *Journal of General Internal Medicine*, 21(6), Article 667. <https://doi.org/10.1111/j.1525-1497.2006.0512.x>

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of

Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory & Health*, 16(4), 414-433. <https://doi.org/10.1057/s41285-018-0065-6>

- Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, 5(1), 1-4. <https://doi.org/10.11648/j.ajtas.20160501.11>
- Exec. Order No. 13,217, 3 C.F.R. 774 (2001).  
<https://www.govinfo.gov/content/pkg/CFR-2002-title3-vol1/pdf/CFR-2002-title3-vol1-eo13217.pdf>
- Feagin, J., & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Social Science & Medicine*, 103, 7-14. <https://doi.org/10.1016/j.socscimed.2013.09.006>
- Fiscella, K., & Sanders, M. R. (2016). Racial and ethnic disparities in the quality of health care. *Annual Review of Public Health*, 37, 375-394.  
<https://doi.org/10.1146/annurev-publhealth-032315-021439>
- Fiske, S. T. (1998). Stereotyping, prejudice, and discrimination. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (pp. 357-411). McGraw-Hill.
- Ford, C. L., & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis *American Journal of Public Health*, 100, S30-S35. <https://doi.org/10.2105/AJPH.2009.171058>
- Fortier, J. P., Convisser, R., & Pacheco, G. (1999). *Assuring cultural competence in health care: Recommendations for national standards and an outcomes-focused research agenda*. U.S. Department of Health and Human Services.  
[https://minorityhealth.hhs.gov/Assets/pdf/checked/Assuring\\_Cultural\\_Competence\\_in\\_Health\\_Care-1999.pdf](https://minorityhealth.hhs.gov/Assets/pdf/checked/Assuring_Cultural_Competence_in_Health_Care-1999.pdf)



- Frederickson, H. G. (2005). The state of social equity in American public administration. *National Civic Review*, 94(4), 31-38. <https://doi.org/10.1002/ncr.117>
- Frederickson, H. G. (2010). *Social equity and public administration: Origins, developments, and applications*. M.E. Sharpe.
- Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, 13, Article 117. <https://doi.org/10.1186/1471-2288-13-117>
- Garcés, I. C., Scarinci, I. C., & Harrison, L. (2006). An examination of sociocultural factors associated with health and health care seeking among Latina immigrants. *Journal of Immigrant and Minority Health*, 8(4), 377-385. <https://doi.org/10.1007/s10903-006-9008-8>
- García, J. I. R., Chang, C. L., Young, J. S., López, S. R., & Jenkins, J. H. (2006). Family support predicts psychiatric medication usage among Mexican American individuals with schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 41, 624-631.
- Gaskin, D. J., Thorpe, R. J., Jr., McGinty, E. E., Bower, K., Rohde, C., Young, J. H., LaVeist, T. A., & Dubay, L. (2014). Disparities in diabetes: The nexus of race, poverty, and place. *American Journal of Public Health*, 104(11), 2147-2155. <https://doi.org/10.2105/AJPH.2013.301420>
- Gates, E. F. (2017). Learning from seasoned evaluators: Implications of systems approaches for evaluation practice. *Evaluation*, 23(2), 152-171. <https://doi.org/10.1177/1356389017697613>

- Gaus, J. M. (2009). *Reflections on public administration*. University of Alabama Press.
- Gerring, J. (2004). What is a case study and what is it good for? *American Political Science Review*, 98(2), 341-354. <https://doi.org/10.4135/9781473915480.n7>
- Gholipour, R. (2016). Policy making: A new method to manage public issues. In R. Gholipour & K. Rouzbehani, *Social, economic, and political perspectives on public health policy-making: Advances in public policy and administration* (pp. 1-19). IGI Global. <https://doi.org/10.4018/978-1-4666-9944-1.ch001>
- Ginwright, S. A. (2010). *Black youth rising: Activism and radical healing in urban America*. Teachers College Press.
- Gonzalez, C., Fakhari, P., & Busemeyer, J. (2017). Dynamic decision making: Learning processes and new research directions. *Human Factors*, 59(5), 713-721. <https://doi.org/10.1177/0018720817710347>
- Gonzalez, J. M., Alegría, M., Prihoda, T. J., Copeland, L. A., & Zeber, J. E. (2011). How the relationship of attitudes toward mental health treatment and service use differs by age, gender, ethnicity/race, and education. *Social Psychiatry and Psychiatric Epidemiology*, 46(1), 45-57. <https://doi.org/10.1007/s00127-009-0168-4>
- Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health*, 6, 179. <https://doi.org/10.3389/fpubh.2018.00179>
- Greenhalgh, T., Snow, R., Ryan, S., Rees, S., & Salisbury, H. (2015). Six ‘biases’ against patients and carers in evidence-based medicine. *BMC Medicine*, 13(1), 1-11. <https://doi.org/10.1186/s12916-015-0437-x>

- Grzywacz, J. G., & Fuqua, J. (2000). The social ecology of health: Leverage points and linkages. *Behavioral Medicine*, 26(3), 101-115.  
<https://doi.org/10.1080/08964280009595758>
- Guion, L., Diehl, D., & McDonald, D. (2011). Conducting an in-depth interview.  
<http://edis.ifas.ufl.edu/fy393>
- Hankerson, S. H., & Weissman, M. M. (2012). Church-based health programs for mental disorders among African Americans: A review. *Psychiatric Services*, 63(3), 243-249. <https://doi.org/10.1176/appi.ps.201100216>
- Haregu, T. N. (2012, March). *Qualitative data analysis* [SlideShare slides].  
<https://www.slideshare.net/tilahunigatu/qualitative-data-analysis-11895136>
- Hartson, R., & Pyla, P. S. (2019). *The UX book: Agile UX design for a quality user experience*. Morgan Kaufmann Publishers.
- Haun, J. N., Valerio, M. A., McCormack, L. A., Sørensen, K., & Paasche-Orlow, M. K. (2014). Health literacy measurement: An inventory and descriptive summary of 51 instruments. *Journal of Health Communication*, 19, 302-333.  
<https://doi.org/10.1080/10810730.2014.936571>
- Heider, F. (2016, December 6). Moving the needle on health outcomes: State strategies for advancing health equity. <https://nashp.org/moving-the-needle-on-health-outcomes-state-strategies-for-advancing-health-equity/>
- Heru, A. M. (2015). Family-centered care in the outpatient general psychiatry clinic. *Journal of Psychiatric Practice*, 21, 381-388.  
<https://doi.org/10.1097/PRA.0000000000000097>

Horan, W. P., Kern, R. S., Green, M. F., & Penn, D. L. (2008). Social cognition training for individuals with schizophrenia: Emerging evidence. *American Journal of Psychiatric Rehabilitation, 11*(3), 205-252.

Horwitz, E. (2001). Language anxiety and achievement. *Annual Review of Applied Linguistics, 21*, 112-126. <https://doi.org/10.1017/s0267190501000071>

H.R. Res. 5942, 115th Cong., 164 Cong. Rec. 85 (2018) (enacted).  
<https://www.congress.gov/congressional-record/2018/05/23/house-section/article/H4694-5>

Huang, F. Y., Chung, H., Kroenke, K., Delucchi, K. L., & Spitzer, R. L. (2006). Using the patient health questionnaire-9 to measure depression among racially and ethnically diverse primary care patients. *Journal of General Internal Medicine, 21*(6), 547-552. <https://doi.org/10.1111/j.1525-1497.2006.00409.x>

Indian Health Services. (2015). *Justification of estimates for appropriations committees* (Issue brief).  
<https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/documents/FY2015CongressionalJustification.pdf>

Institute for Work & Health. (2015, August). Cross-sectional vs. longitudinal studies.  
<https://www.iwh.on.ca/what-researchers-mean-by/cross-sectional-vs-longitudinal-studies>

Institute of Healthcare Improvement. (n.d.). About us.  
<http://www.ihl.org/about/Pages/default.aspx>

- Jané-Llopis, E., Barry, M., Hosman, C., & Patel, V. (2005). Mental health promotion works: A review. *Promotion & Education, 12*(9), 9-25.  
<https://doi.org/10.1177/10253823050120020103x>
- Jimenez, D. E., Cook, B., Bartels, S. J., & Alegría, M. (2012). Disparities in mental health service use of racial and ethnic minority elderly adults. *Journal of the American Geriatrics Society, 61*(1), 18-25. <https://doi.org/10.1111/jgs.12063>
- Johnson, B. R. (1997). Examining the validity structure of qualitative research. *Education, 118*(3), 282-292.
- Jones, C. P. (2002). Confronting institutionalized racism. *Phylon, 50*(1/2), 7-22.  
<https://doi.org/10.2307/4149999>
- Jones, R. S., Chow, T. W., & Gatz, M. (2006). Asian Americans and Alzheimer's disease: Assimilation, culture, and beliefs. *Journal of Aging Studies, 20*(1), 11-25.
- Jordan, J. E., Buchbinder, R., & Osborne, R. H. (2010). Conceptualising health literacy from the patient perspective. *Patient Education and Counseling, 79*, 36-42.
- Juster, R., McEwen, B. S., & Lupien, S. J. (2010). Allostatic load biomarkers of chronic stress and impact on health and cognition. *Neuroscience & Biobehavioral Reviews, 35*(1), 2-16. <https://doi.org/10.1016/j.neubiorev.2009.10.002>
- Kamal, R. (2017, July 31). What are the current costs and outcomes related to mental health and substance use disorders? <https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-start>

- Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., Addington, J., Brunette, M. R., Correll, C. U., Estroff, S. E., Marcy, P., Robinson, J., Meyer-Kalos, P. S., Gottlieb, J. D., Glynn, S. M., Lynde, D. W., Pipes, R., Kurian, B. T., Miller, A. L., . . . Heinssen, R. K. (2015). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, *173*(4), 362-372. <https://doi.org/10.1176/appi.ajp.2015.15050632>
- Karakus, M., Frey, W., Goldman, H., Fields, & Drake, R. (2011, February). *Federal financing of supported employment and customized employment for people with mental illnesses: Final report*. <https://aspe.hhs.gov/basic-report/federal-financing-supported-employment-and-customized-employment-people-mental-illnesses-final-report>
- Kershaw, K. N., Osypuk, T. L., Do, D. P., De Chavez, P. J., Diez Roux, A. V. (2015). Neighborhood-level racial/ethnic residential segregation and incident cardiovascular disease: The multi-ethnic study of atherosclerosis. *Circulation*, *131*(2), 141-148. <https://doi.org/10.1161/CIRCULATIONAHA.114.011345>
- Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. W., Rosenheck, R. A., Walters, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, *36*, 987-1007.

- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. *Archives of General Psychiatry*, 62(6), 593-602.
- Kessler, R. C., Ormel, J., Demler, O., & Stang, P. E. (2003). Comorbid mental disorders account for the role impairment of commonly occurring chronic physical disorders: Results from the national comorbidity survey. *Journal of Occupational and Environmental Medicine*, 45(12), 1257-1266.  
<https://doi.org/10.1097/01.jom.0000100000.70011.bb>
- Khan, S., & VanWynsberghe, R. (2008). Cultivating the under-mined: Cross-case analysis as knowledge mobilization. *Forum: Qualitative Social Research*, 9(1), Article 34. <http://www.qualitative-research.net/index.php/fqs/article/view/334/729>
- Kilbourne, A. M., Beck, K., Spaeth-Rublee, B., Ramanuj, P., O'Brien, R. W., Tomoyasu, N., & Pincus, H. A. (2018). Measuring and improving the quality of mental health care: A global perspective. *World Psychiatry*, 17(1), 30-38.
- Kim, W., & Keefe, R. H. (2010). Barriers to healthcare among Asian Americans. *Social Work in Public Health*, 25(3-4), 286-295.  
<https://doi.org/10.1080/19371910903240704>
- Knapp, M. (2006). Economic barriers to better mental health practice and policy. *Health Policy and Planning*, 21(3), 157-170. <https://doi.org/10.1093/heapol/czl003>
- Knight, C. (2001). Human–environment relationship: Comparative case studies. In *International encyclopedia of the social & behavioral sciences* (pp. 7039-7045).  
<https://doi.org/10.1016/b0-08-043076-7/04195-4>

- Kolivoski, K. M., Weaver, A., & Constance-Huggins, M. (2014). Critical race theory: Opportunities for application in social work practice and policy. *Families in society*, 95(4), 269-276.
- Kopelowicz, A., Zarate, R., Wallace, C. J., Liberman, R. P., Lopez, S. R., & Mintz, J. (2012). The ability of multifamily groups to improve treatment adherence in Mexican Americans with schizophrenia. *Archives of General Psychiatry*, 69(3), 265-273. <https://doi.org/10.1001/archgenpsychiatry.2011.135>
- Kouznetsova, M., Huang, X., Ma, J., Lessner, L., & Carpenter, D. O. (2007). Increased rate of hospitalization for diabetes and residential proximity of hazardous waste sites. *Environmental Health Perspectives*, 115(1), 75-79. <https://doi.org/10.1289/ehp.9223>
- Krieger, N. (2014). Got theory? On the 21st c. CE rise of explicit use of epidemiologic theories of disease distribution: A review and ecosocial analysis. *Current Epidemiology Reports*, 1(1), 45-56. <https://doi.org/10.1007/s40471-013-0001-1>
- Kumagai, A. K., & Lypson, M. L. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine*, 84(6), 782-787. <https://doi.org/10.1097/acm.0b013e3181a42398>
- Ladson-Billings, G. (1998). Just what is critical race theory and what's it doing in a nice field like education? *International Journal of Qualitative Studies in Education*, 11(1), 7-24. <https://doi.org/10.1080/095183998236863>
- Laerd Dissertation. (n.d.). Purposive sampling. <http://dissertation.laerd.com/purposive-sampling.php>



- Laffey, A. E., & Ng, A. (2018, May 2). *Diversity and inclusion in the law: Challenges and initiatives*.  
<https://www.americanbar.org/groups/litigation/committees/jiop/articles/2018/diversity-and-inclusion-in-the-law-challenges-and-initiatives/>
- LaVeist, T. A., Gaskin, D. J., & Richard, P. (2009). *The economic burden of health inequalities in the United States*. Joint Center for Political and Economic Studies.  
[https://hsrc.himmelfarb.gwu.edu/sphhs\\_policy\\_facpubs/225/](https://hsrc.himmelfarb.gwu.edu/sphhs_policy_facpubs/225/)
- Lu, M., & Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: A life-course perspective. *Maternal and Child Health Journal*, 7(1), 13-30.  
<https://doi.org/10.1023/a:1022537516969>
- Manzoor, A. (2014). A look at efficiency in public administration. *SAGE Open*, 4(4).  
<https://doi.org/10.1177/2158244014564936>
- Marrone, S. (2007). Understanding barriers to health care: A review of disparities in health care services among indigenous populations. *International Journal of Circumpolar Health*, 66(3), 188-198. <https://doi.org/10.3402/ijch.v66i3.18254>
- Marshall, T., & Solomon, P. (2004). Provider contact with families of adults with severe mental illness: Taking a closer look. *Family Process*, 43, 209-216.
- Matthews, D. B. (2018). Equitable community development for good mental health: A discussion of economic and racial equity in housing. *Community Development Innovation Review*, 13(1), 61-67. <https://www.frbsf.org/community-development/files/economic-and-racial-equity-in-housing-matthew-mental-health-and-community-development-cdir-13-1.pdf>

- Matthews, D. D., Hammond, W. P., Nuru-Jeter, A., Cole-Lewis, Y., & Melvin, T. (2013). Racial discrimination and depressive symptoms among African-American men: The mediating and moderating roles of masculine self-reliance and John Henryism. *Psychology of Men & Masculinity*, 14(1), 35-46.  
<https://doi.org/10.1037/a0028436>
- Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings*, 24(3-4), 187-210. <https://doi.org/10.1007/s10880-017-9510-2>
- McCullough, J. C., Zimmerman, F. J., Fielding, J. E., & Teutsch, S. M. (2012). A Health dividend for America. *American Journal of Preventive Medicine*, 43(6), 650-654.  
<https://doi.org/https://doi.org/10.1016/j.amepre.2012.08.013>
- McGee, E. O., & Stovall, D. (2015). Reimagining critical race theory in education: mental health, healing, and the pathway to liberatory praxis. *Educational Theory*, 65(5), 491-511. <https://doi.org/10.1111/edth.12129>
- McGuire, A. A., Garcés-Palacio, I. C., & Scarinci, I. C. (2012). A successful guide in understanding Latino immigrant patients: An aid for health care professionals. *Family & Community Health*, 35(1), 76-84.  
<https://doi.org/10.1097/FCH.0b013e3182385d7c>
- McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. *Health Affairs*, 27(2), 393-403.  
<https://doi.org/10.1377/hlthaff.27.2.393>

- McKim, C. (2017). The value of mixed methods research: A mixed methods study. *Journal of Mixed Methods Research, 11*(2), 202-222.
- McLaren, L., & Hawe, P. (2004). Ecological perspectives in health research. *Journal of Epidemiology & Community Health, 59*(1), 6-14.  
<https://doi.org/10.1136/jech.2003.018044>
- McMillan, J. H., & Schumacher, S. (2006). *Research in education: Evidence-based inquiry*. Pearson Education.
- Mead, N., & Roland, M. (2009). Understanding why some ethnic minority patients evaluate medical care more negatively than white patients: A cross sectional analysis of a routine patient survey in English general practices. *BMJ, 339*, Article b3450. <https://doi.org/10.1136/bmj.b3450>
- Mental Health America. (2006). *Mental Health America multi state initiative: Eliminating behavioral health disparities among racial and ethnic minority populations in rural communities*.  
[https://www.mhanational.org/sites/default/files/disparities\\_Multistate\\_Mtg.pdf](https://www.mhanational.org/sites/default/files/disparities_Multistate_Mtg.pdf)
- Mental Health America. (2017). The state of mental health in America.  
<https://www.mhanational.org/issues/state-mental-health-america>
- Miranda, J., McGuire, T. G., Williams, D. R., & Wang, P. (2008). Mental health in the context of health disparities. *American Journal of Psychiatry, 165*(9), 1102-1108.  
[10.1176/appi.ajp.2008.08030333](https://doi.org/10.1176/appi.ajp.2008.08030333)

- Moe, A. M., Rubinstein, E. B., Gallagher, C. J., Weiss, D. M., Stewart, A., & Breitborde, N. J. (2018). Improving access to specialized care for first-episode psychosis: An ecological model. *Risk Management and Healthcare Policy*, 11, 127-138.  
<https://doi.org/10.2147/RMHP.S131833>
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2), 13-22.  
<https://doi.org/10.1177/160940690200100202>
- Mpofu, E., Lam, M. K., Mpofu, N., Johnson, E. T., & Evans, W. D. (2014). Monitoring and evaluation of community-oriented health services. (2014). In E. Mpofu (Ed.), *Community-oriented health services: Practices across disciplines* (pp. 117-134). Springer Publishing. <https://doi.org/10.1891/9780826198181.0006>
- Mueser, K. T., Penn, D. L., Addington, J., Brunette, M. F., Gingerich, S., Glynn, S. M., Lynde, D. W., Gottlieb, J. D., Meyer-Kalos, P., McGurk, S. R., Cather, C., Saade, S., Robinson, D. G., Schooler, N. R., Rosenheck, R. A., & Kane, J. M. (2015). The NAVIGATE program for first-episode psychosis: Rationale, overview, and description of psychosocial components. *Psychiatric Services*, 66(7), 680-690.  
<https://doi.org/10.1176/appi.ps.201400413>
- Myers, H. F., Wyatt, G. E., Ullman, J. B., Loeb, T. B., Chin, D., Prause, N., Zhang, M., Williams, J. K., Slavich, G. M., & Liu, H. (2015). Cumulative burden of lifetime adversities: Trauma and mental health in low-SES African Americans and Latino/as. *Psychological Trauma: Theory, Research, Practice, and Policy*, 7(3), 243-251. <https://doi.org/10.1037/a0039077>

National Association of State Mental Health Program Directors Research Institute. (2004, October). *Serving individuals with co-occurring developmental disabilities and mental illness: Systems barriers and strategies for reform.*

<https://www.nasmhpd.org/sites/default/files/ServingIndividualswithCoOccurring.pdf>

National Center for Health Statistics. (2015). *Health, United States, 2015: With special feature on racial and ethnic disparities.* Centers for Disease Control.

<http://www.cdc.gov/nchs/data/hus/hus15.pdf>

National Conference of State Legislatures. (2018, February). The costs and consequences of disparities in behavioral health care.

[https://www.ncsl.org/Portals/1/HTML\\_LargeReports/DisparitiesBehHealth\\_Final.htm](https://www.ncsl.org/Portals/1/HTML_LargeReports/DisparitiesBehHealth_Final.htm)

National Institute of Mental Health. (n.d.-a). Glossary.

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/glossary.shtml>

National Institute of Mental Health. (n.d.-b). Recovery After an Initial Schizophrenia Episode (RAISE).

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml>

National Institute of Mental Health. (2019, February). Mental illness.

<https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>

National Institute on Minority Health and Health Disparities. (2017). Brother, you're on my mind. <https://www.nimhd.nih.gov/programs/edu-training/byomm/>

National Institutes of Health. (n.d.-a). Impact of NIH research.

<https://www.nih.gov/about-nih/what-we-do/impact-nih-research>

National Institutes of Health. (n.d.-b). Who we are. <https://www.nih.gov/about-nih/who-we-are>

Ng, J., Zhang, Q., Scholle, S. H., & Guerino, P. (2017, December). *Racial and ethnic disparities in mental health among diverse groups of Medicare advantage beneficiaries*. Center for Medicare and Medicaid Services.

<https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Highlight-Vol11-Dec-2017.pdf>

Noonan, A. S., Velasco-Mondragon, H. E., & Wagner, F. A. (2016). Improving the health of African Americans in the USA: An overdue opportunity for social justice. *Public Health Reviews*, 37, 12. <https://doi.org/10.1186/s40985-016-0025-4>

Norman, R. M., Malla, A. K., Verdi, M. B., Hassall, L. D., & Fazekas, C. (2004). Understanding delay in treatment for first-episode psychosis. *Psychological Medicine*, 34(2), 255-266. <https://doi.org/10.1017/s0033291703001119>

O'Donoghue, T., & Punch K. (Eds.). (2003). *Qualitative educational research in action: Doing and reflecting*. London: Routledge.

Office of Applied Sciences. (2009). *Results from the 2008 National Survey on Drug Use and Health: National findings*. U.S. Department of Health and Human Services.

Office of Disease Prevention and Health Promotion. (n.d.). Health literacy. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/health-literacy#1>

- Office of the Assistant Secretary of Planning and Evaluation. (2011). *U.S. Department of Health and Human Services Implementation guidance on data collection standards for race, ethnicity, sex, primary language, and disability status.*
- Oluwoye, O., Stiles, B., Monroe-DeVita, M., Chwastiak, L., McClellan, J. M., Dyck, D., Cabassa, L. J., & McDonell, M. G. (2018). Racial-ethnic disparities in first-episode psychosis treatment outcomes from the RAISE-ETP study. *Psychiatric Services, 69*(11), 1138-1145. <https://doi.org/10.1176/appi.ps.201800067>
- Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLOS ONE, 10*(9), Article e0138511. <https://doi.org/10.1371/journal.pone.0138511>
- Parker, R. M., Baker, D. W., Williams, M. V., & Nurss, J. R. (1995). The test of functional health literacy in adults: a new instrument for measuring patients' literacy skills. *Journal of General Internal Medicine, 10*(10), 537-541. <https://doi.org/10.1007/BF02640361>
- Partin, M. R., & Burgess, D. J. (2012). Reducing health disparities or improving minority health? The end determines the means. *Journal of General Internal Medicine, 27*(8), 887-889. <https://doi.org/10.1007/s11606-012-2108-3>
- Patankar, M. S., & Sabin, E. J. (2010). The safety culture perspective. In E. Salas & D. Maurino (Eds.), *Human factors in aviation* (pp. 95-122). Academic Press.
- Peng, W. (2008). A critique of Fred W. Riggs' Ecology of Public Administration. *International Public Management Review, 9*(1), 213-226.

- Ragin, C. (1997). Turning the tables: How case-oriented research challenges variable-oriented research. *Comparative Social Research*, 16, 27-42.
- Randall, V. R. (2017, June 30). Inequality in health care is killing African Americans. [https://www.americanbar.org/groups/crsj/publications/human\\_rights\\_magazine\\_home/human\\_rights\\_vol36\\_2009/fall2009/inequality\\_in\\_health\\_care\\_is\\_killing\\_african\\_americans/](https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/human_rights_vol36_2009/fall2009/inequality_in_health_care_is_killing_african_americans/)
- Rawls, J. (1971). *A theory of justice*. Harvard University Press.
- Reed, M. (1999). Book review: Utilization-focused evaluation: The new century text (3rd ed.). *American Journal of Evaluation*, 20(1), 151-153.  
<https://doi.org/10.1177/109821409902000119>
- Reed, S. I. (2008). First-episode psychosis: A literature review. *International Journal of Mental Health Nursing*, 17(2), 85-91.  
<https://doi.org/https://doi.org/10.1111/j.1447-0349.2008.00515.x>
- Reidpath, D. D., Olafsdottir, A. E., Pokhrel, S., & Allotey, P. (2012). The fallacy of the equity-efficiency trade off: Rethinking the efficient health system. *BMC Public Health*, 12(S1). <https://doi.org/10.1186/1471-2458-12-s1-s3>
- Renwick T. (2015, October). Income and poverty data. U.S. Census Bureau.  
[https://www.pdx.edu/prc/sites/www.pdx.edu.prc/files/01\\_Renwick\\_Income\\_Poverty.pdf](https://www.pdx.edu/prc/sites/www.pdx.edu.prc/files/01_Renwick_Income_Poverty.pdf)
- Reschovsky, J., & Boukus, E. (2010). *Modest and uneven: Physician efforts to reduce racial and ethnic disparities* (Issue brief No. 130). Center for Studying Health System Change.



- Research Methodology. (n.d.). Case studies. <https://research-methodology.net/research-methods/qualitative-research/case-studies/>
- Reupert, A. (2017). A socio-ecological framework for mental health and well-being. *Advances in Mental Health, 15*(2), 105-107.  
<https://doi.org/10.1080/18387357.2017.1342902>
- Rice, N., & O'Donohue, W. (2002). Cultural sensitivity: A critical examination. *New Ideas in Psychology, 20*, 35-48.
- Richard, L., Gauvin, L., & Raine, K. (2011). Ecological models revisited: Their uses and evolution in health promotion over two decades. *Annual Review of Public Health, 32*(1), 307-326. <https://doi.org/10.1146/annurev-publhealth-031210-101141>
- Richardson, L. P., DiGiuseppe, D., Garrison, M., & Christakis, D. A. (2003). Depression in Medicaid-covered youth: Differences by race and ethnicity. *Archives of Pediatrics & Adolescent Medicine, 157*(10), 984-989.
- Riolo, S. A., Nguyen, T. A., Greden, J. F., & King, C. A. (2005). Prevalence of depression by race/ethnicity: Findings from the National Health and Nutrition Examination Survey III. *American Journal of Public Health, 95*(6), 998-1000.
- Roberts, S. (2005). [Review of the book *An American health dilemma*. Vol. 2, Race, medicine, and health care in the United States, 1900-2000]. *Bulletin of the History of Medicine, 79*(2), 349-351. <https://doi.org/10.1353/bhm.2005.0089>
- Rogers, P. J., & Hough, G. (1995). Improving the effectiveness of evaluations: Making the link to organizational theory. *Evaluation and Program Planning, 18*(4), 321-332. [https://doi.org/10.1016/0149-7189\(95\)00033-x](https://doi.org/10.1016/0149-7189(95)00033-x)

- Role of social equity in public administration. (n.d.). [https://ifioque.com/career-workshop/management/social\\_equity](https://ifioque.com/career-workshop/management/social_equity)
- Rosa, E. M., & Tudge, J. (2013). Urie Bronfenbrenner's theory of human development: Its evolution from ecology to bioecology. *Journal of Family Theory & Review*, 5(4), 243-258. <https://doi.org/10.1111/jftr.12022>
- Rosenbloom, D. H., & Carroll, J. D. (1990). *Toward constitutional competence: A casebook for public administrators*. Englewood Cliffs, NJ: Prentice Hall.
- Rowley, J. (2002). Using case studies in research. *Management Research News*, 25(1), 16-27. <https://doi.org/10.1108/01409170210782990>
- Rutgers, M. R., & van der Meer, H. (2010). The origins and restriction of efficiency in public administration: Regaining efficiency as the core value of public administration. *Administration & Society*, 42(7), 755-779. <https://doi.org/10.1177/0095399710378990>
- Saban, K. L., Mathews, H. L., DeVon, H. A., & Janusek, L. W. (2014). Epigenetics and social context: Implications for disparity in cardiovascular disease. *Aging and Disease*, 5(5), 346-355.
- Saha, S., Fernandez, A., & Perez-Stable, E. (2007). Reducing language barriers and racial/ethnic disparities in health care: an investment in our future. *Journal of General Internal Medicine*, 22, 371-372. <https://doi.org/10.1007/s11606-007-0372-4>
- Sallis, S. E., Owen, N., & Fisher, E. B., Jr. (2008). Echological models of health behavior. In K. Glantz, B. K. Rimer, & K. Viswanath, *Health behavior and health education: Theory, research, and practice* (4th ed., pp. 465-486). Jossey-Bass.

- Sanchez, K., Ybarra, R., Chapa, T., & Martinez, O. N. (2016). Eliminating behavioral health disparities and improving outcomes for racial and ethnic minority populations. *Psychiatric Services*, 67(1), 13-15.  
<https://doi.org/10.1176/appi.ps.201400581>
- Sandifer, P. A., & Walker, A. H. (2018). Enhancing disaster resilience by reducing stress-associated health impacts. *Frontiers in Public Health*, 6, 373.  
<https://doi.org/10.3389/fpubh.2018.00373>
- Sassi, F., Grand, J. L., & Archard, L. (2001). Equity versus efficiency: A dilemma for the NHS. *BMJ*, 323(7316), 762-763. <https://doi.org/10.1136/bmj.323.7316.762>
- Schachter, H. L. (1989). *Frederick Taylor and the public administration community: A reevaluation*. State University of New York Press.
- Schatell, E. (2017, July 10). Challenging multicultural disparities in mental health. <https://www.nami.org/blogs/nami-blog/july-2017/challenging-multicultural-disparities-in-mental-he>.
- Scriven, M. (1998). Minimalist theory: The least theory that practice requires. *American Journal of Evaluation*, 19(1), 57-70. [https://doi.org/10.1016/s1098-2140\(99\)80180-5](https://doi.org/10.1016/s1098-2140(99)80180-5)
- Sheikh, A. (2009). Ethnic minorities and their perceptions of the quality of primary care. *BMJ*, 339, Article b3797. <https://doi.org/10.1136/bmj.b3797>
- Shim, R., & Rust, G. (2013). Primary care, behavioral health, and public health: Partners in reducing mental health stigma. *American Journal of Public Health*, 103(5), 774-776. <https://doi.org/10.2105/AJPH.2013.301214>

- Smedley, B. D., Butler, A. S., & Bristow, L. R. (2004). *In the nation's compelling interest: Ensuring diversity in the health care workforce*. National Academy of Sciences.
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. National Academy Press.
- Smith, G., Kennedy, C., Knipper, S., O'Brien, J., & O'Keeffe, J. (2005). *Using Medicaid to support working age adults with serious mental illnesses in the community: A handbook*. ASPE.
- Smith, T. B., & Trimble, J. E. (2016). *Foundations of multicultural psychology: Research to inform effective practice*. American Psychological Association.
- Snowden, L. R., Collinge, W. B., & Runkle, M. C. (1982). Help seeking and underservice. In L. R. Snowden (Ed.), *Reaching the underserved* (pp. 281-297). Sage.
- Spencer, M. B. (2008). Fourth annual Brown lecture in education research—Lessons learned and opportunities ignored since Brown v. Board of Education: Youth development and the myth of a color-blind society. *Educational Researcher*, 37(5), 253-266. <https://doi.org/10.3102/0013189x08322767>
- Srihari, V. H., Tek, C., Kucukgoncu, S., Phutane, V. H., Breitborde, N. J., Pollard, J., Ozkan, B., Saksa, J., Walsh, B. C. & Woods, S. W. (2015). First-episode services for psychotic disorders in the U.S. public sector: A pragmatic randomized controlled trial. *Psychiatric Services*, 66(7), 705-712. <https://doi.org/10.1176/appi.ps.201400236>

- Stockman, J. K., Hayashi, H., & Campbell, J. C. (2015). Intimate partner violence and its health impact on ethnic minority women. *Journal of Women's Health, 24*(1), 62-79. <https://doi.org/10.1089/jwh.2014.4879>
- Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion, 10*(4), 282-298. <https://doi.org/10.4278/0890-1171-10.4.282>
- Stowkowy, J., Addington, D., Liu, L., Hollowell, B., & Addington, J. (2012). Predictors of disengagement from treatment in an early psychosis program. *Schizophrenia Research, 136*, 7-12. <https://doi.org/10.1016/j.schres.2012.01.027>
- Stretton, H. (1969). *The political sciences: General principles of selection in social science and history*. Routledge & Kegan Paul.
- Substance Abuse and Mental Health Services Administration. (2009). *2009 mental health national outcome measures (NOMS): CMHS uniform reporting system*. <https://www.samhsa.gov/data/report/2009-noms-cmhs-uniform-reporting-system>
- Substance Abuse and Mental Health Services Administration. (2014a). *Improving cultural competence* (Treatment Improvement Protocol [TIP] Series No. 59. HHS Publication No. [SMA] 14-4849). <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf>
- Substance Abuse and Mental Health Services Administration. (2014b). *State and local government partnerships*.

Substance Abuse and Mental Health Services Administration. (2015). *Racial/ethnic differences in mental health service use among adults*.

<https://store.samhsa.gov/product/Racial-Ethnic-Differences-in-Mental-Health-Service-Use-among-Adults/sma15-4906>

Substance Abuse and Mental Health Services Administration. (2016, February 8).

*Guidance for revision of the FY2016-2017 block grant application for the new 10 percent set-aside*. <https://www.samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

Substance Abuse and Mental Health Services Administration. (2017, September 15).

Glossary of terms and acronyms for SAMHSA grants.

<https://www.samhsa.gov/grants/grants-glossary>

Substance Abuse and Mental Health Services Administration. (2019, June 20). *2018*

*uniform reporting system (URS) output tables*.

<https://www.samhsa.gov/data/report/2018-uniform-reporting-system-urs-output-tables>

Substance Abuse and Mental Health Services Administration. (2020-a, May 27). About

us. <https://www.samhsa.gov/about-us/>

Substance Abuse and Mental Health Services Administration. (2020-b, April 30). Early

serious mental illness treatment locator. <https://www.samhsa.gov/esmi-treatment-locator>

- Substance Abuse and Mental Health Services Administration. (2020-c). FY 2020 Project AWARE (advancing wellness and resiliency in education) state education agency grants. <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2020-aware-foa.pdf>
- Sutton, J., & Austin, Z. (2015). Qualitative research: Data collection, analysis, and management. *Canadian Journal of Hospital Pharmacy*, 68(3), 226-231. <https://doi.org/10.4212/cjhp.v68i3.1456>
- Svara, J. H., & Brunet, J. R. (2005). Social equity is a pillar of public administration. *Journal of Public Affairs Education*, 11(3), 253-258. <https://doi.org/10.1080/15236803.2005.12001398>
- Takada, E., Fort, J. M., & Lloyd, L. S. (1998). Asian Pacific Islander health. In S. Loue (Ed.), *Handbook of immigrant health* (pp. 303-327). plenum.
- Tate, W., IV. (1997). Critical race theory and education: History, theory, and implications. *Review of Research in Education*, 22, 195-247. <https://doi.org/10.2307/1167376>
- Think Cultural Health. (2019). Improving cultural competence for behavioral health professionals. <https://thinkculturalhealth.hhs.gov/behavioral-health/>
- Thompson, N. J., McGee, R. E., Munoz, L. C., & Walker, E. R. (2015). Reflections on mental health advocacy across differing ecological levels. *Journal of the Georgia Public Health Association*, 5(1), 126-134.
- Tripp-Reimer, T., Choi, E., Kelley, L. S., & Enslein, J. C. (2001). Cultural barriers to care: Inverting the problem. *Diabetes Spectrum*, 14(1), 13-22. <https://doi.org/10.2337/diaspect.14.1.13>

- Turner, N., Pope, L., & Schroeder, K. (2019, July 24). Racial disparities in mental health and criminal justice. <https://www.vera.org/blog/racial-disparities-in-mental-health-and-criminal-justice>
- Umberson, D., & Montez, J. K. (2010). Social relationships and health: A flashpoint for health policy. *Journal of Health and Social Behavior*, 51, S54-S66.  
<https://doi.org/10.1177/0022146510383501>
- Unützer, J., Katon, W., Callahan, C. M., Williams, J. W., Jr., Hunkeler, E., Harpole, L., Hoffing, M., Della Penna, R. D., Noël, P. H., Lin, E. H., Areán, P. A., Hegel, M. T., Tang, L., Belin, T. R., Oishi, S., & Langston, C. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *JAMA*, 288(22), 2836-2845.  
<https://doi.org/10.1001/jama.288.22.2836>
- Urban Indian Health Institute. (2013). *Health disparities in UIHO service areas*.  
[http://www.uihi.org/wp-content/uploads/2013/04/UIHO\\_Fact-Sheet\\_2013-04-05.pdf](http://www.uihi.org/wp-content/uploads/2013/04/UIHO_Fact-Sheet_2013-04-05.pdf)
- Urban Institute. (n.d.). Observation. <https://www.urban.org/research/data-methods/data-collection/observation>
- U.S. Census Bureau. (2004). Poverty status of population in 2003 by sex and age, by Asian alone or combination or White alone not Hispanic: March 2004.  
<https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-01.2003.html>
- U.S. Census Bureau. (2007). *The American community-Hispanics: 2004*.  
<https://www.census.gov/library/publications/2007/acs/acs-03.html>



- U.S. Census Bureau. (2008). American Community Survey 1-year estimates. ACS demographic and housing estimates: 2008. <https://www.census.gov/programs-surveys/acs>
- U.S. Census Bureau. (2014, May 6). Fueled by aging baby boomers, nation's older population to nearly double in the next 20 years, Census Bureau reports. <https://www.census.gov/newsroom/press-releases/2014/cb14-84.html>
- U.S. Department of Health and Human Services. (n.d.). Civil rights. <https://www.hhs.gov/civil-rights/for-individuals/special-topics/needy-families/civil-rights-requirements/index.html#:~:text=Title%20VI%20of%20the%20Civil%20Rights%20Act%20of%201964%2C%2042,or%20other%20Federal%20financial%20assistance>
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the surgeon general*. [https://www.ncbi.nlm.nih.gov/books/NBK44243/pdf/Bookshelf\\_NBK44243.pdf](https://www.ncbi.nlm.nih.gov/books/NBK44243/pdf/Bookshelf_NBK44243.pdf)
- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). National action plan to improve health literacy. <https://health.gov/our-work/health-literacy/national-action-plan-improve-health-literacy>
- U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). Homepage. <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2>
- U.S. Department of Health and Human Services, Office of Minority Health. (2001, March). *National standards for culturally and linguistically appropriate services in health care*. <https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>

- Utecht, C. (2014). A review of critical race theory: The cutting edge (3rd ed.).  
*Multicultural Perspectives*, 16(3), 180-181.  
<https://doi.org/10.1080/15210960.2014.926751>
- Valdez, C. R., Butler, A., Casas, J. M., Cort, N., Guidino, O., Isaac, P., Rodgers, C. R. R., Caldwell, L., Forman-Alberti A., & Chatman, A. (2017). *Addressing the mental health needs of racial and ethnic minority youth: A guide for practitioners*. American Psychological Association.  
<https://www.apa.org/pi/families/resources/mental-health-needs.pdf>
- Vernon, J. A., Trujillo, A., Rosenbaum, S. J., & DeBuono, B. (2007). *Low health literacy: Implications for national health policy*. George Washington University.
- Wahowiak, L. (2015). Addressing stigma, disparities in minority mental health: Access to care among barriers. *The Nation's Health*, 45(1), 1-20.  
<http://thenationshealth.aphapublications.org/content/45/1/1.3>
- Walls, M. L., Gonzalez, J., Gladney, T., & Onello, E. (2015). Unconscious biases: Racial microaggressions in American Indian health care. *Journal of the American Board of Family Medicine*, 28(2), 231-239.  
<https://doi.org/10.3122/jabfm.2015.02.140194>
- Weisman de Mamani, A., & Suro, G. (2016). The effect of a culturally informed therapy on self-conscious emotions and burden in caregivers of patients with schizophrenia: A randomized clinical trial. *Psychotherapy*, 53, 57-67.  
<https://doi.org/10.1037/pst0000038>

- Whitley, R., & Lawson, W. B. (2010). The psychiatric rehabilitation of African Americans with severe mental illness. *Psychiatric Services*, 61, 508-511.  
<https://doi.org/10.1176/appi.ps.61.5.508>
- Wile, M., & Goodwin, K. (2018). *The costs and consequences of disparities in behavioral health care*. National Conference of State Legislatures.  
[http://www.ncsl.org/Portals/1/Documents/Health/DisparitiesBH\\_32068.pdf](http://www.ncsl.org/Portals/1/Documents/Health/DisparitiesBH_32068.pdf)
- Wille, S. M., Kemp, K. A., Greenfield, B. L., & Walls, M. L. (2017). Barriers to healthcare for American Indians experiencing homelessness. *Journal of Social Distress and the Homeless*, 26(1), 1-8.  
<https://doi.org/10.1080/10530789.2016.1265211>
- Williams, D. R., & Collins, C. (2001). Racial residential segregation: A fundamental cause of racial disparities in health. *Public Health Reports*, 116(5), 404-416.  
<https://doi.org/10.1093/phr/116.5.404>
- Williams, D. R., & Sternthal, M. (2010). Understanding racial-ethnic disparities in health: Sociological contributions. *Journal of Health and Social Behavior*, 51(1), S15-S27. <https://doi.org/10.1177/0022146510383838>
- Wilson, J. Q. (1989). *Bureaucracy: What government agencies do and why they do it*. Basic Books.
- Wilson, W. (1887). The study of administration. *Political Science Quarterly*, 2, 197-222.
- World Health Organization. (2001). *The world health report 2001—Mental health: New understanding, new hope*. <https://www.who.int/whr/2001/en/>
- World Health Organization. (2011, November 21). *The ecological framework*. <https://www.who.int/violenceprevention/approach/ecology/en/>

- World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*.  
[https://www.who.int/mental\\_health/publications/gulbenkian\\_paper\\_social\\_determinants\\_of\\_mental\\_health/en/](https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/)
- Yin, R. K. (1994). *Case study research and applications: Design and methods*. SAGE Publications.
- Yosso, T. (2005). *Critical race counterstories along the Chicana/Chicano educational pipeline*. Routledge.
- Yun, K., Jenicek, G., Gerdes, M. (2019). Overcoming language barriers in mental and behavioral health care for children and adolescents—Policies and priorities. *JAMA Pediatrics*, 173(6):511-512.  
<https://doi.org/10.1001/jamapediatrics.2019.0400>
- Zainal, Z. (2003). *An investigation into the effects of discipline-specific knowledge, proficiency, and genre on reading comprehension and strategies of Malaysia ESP students* [Unpublished doctoral dissertation]. University of Reading.
- Zimmerman, F. J. (2005). Social and economic determinants of disparities in professional help-seeking for child mental health problems: Evidence from a national sample. *Health Services Research*, 40(5), 1514-1533. <https://doi.org/10.1111/j.1475-6773.2005.00411.x>

## APPENDICES

## APPENDIX A

### Informed Consent

## CONSENT TO PARTICIPATE IN RESEARCH

### An Effective Study of Public Agencies in Coordinated Specialty Care Programs

You are welcomed to participate in a research study conducted by Monique S. Browning, who is a doctoral candidate from the Online Professional Studies of the Doctor of Public Administration program at California Baptist University. Ms. Browning is conducting this study for her doctoral dissertation. Dr. Thomas Frederick is her faculty sponsor for this project.

Your involvement in this study is exclusively voluntary and can withdraw from the study at any given time without penalization. You should read the information below carefully and ask questions about anything you do not understand, before determining if you are interested in participating or not participating. You are asked to participate in this study because your organization is a government-funded specialty care program.

### PURPOSE OF THE STUDY

The purpose of this study will be to describe the outcomes of racial and ethnic minorities served in first-episode psychosis government-funded coordinated specialty care programs. The best practices in the literature focus on shared areas, specifically about how effective it is to communicate with diverse patient populations, improve relationships, best practices, and health outcomes. Included in this research will explore the effects of mental health services in meeting the needs of racial and ethnic minorities and the importance for the federal and state government to incorporate policies to educate, outreach, and build a diverse workforce in the mental health system while eliminating disparities.

### PROCEDURES

If you agree to participate in this research, I will conduct an interview with you at a time and location of your choice. The interview will involve themes concerning:

1. Racial and Ethnic disparities in mental health care.
2. Mental health support from family, the community, and health care professional and providers.
3. Health Literacy
4. Cultural barriers amongst racial and ethnic minorities.
5. Accessing Mental Health care.

It should last approximately two hours. With your permission, I will audiotape and take notes during the interview. The recording is to accurately record the information you

provide and will be used for transcription purposes only. Please note the audio recording will be stored in a secure location behind a firewall, and the recordings will be transcribed by a reputable and professional software company (REV) where the transcription will be stripped of any personal identifying information. If you choose not to be audiotaped, I will take notes instead and code the information to protect each participant's identity. If you agree to be audiotaped but feel uncomfortable or change your mind for any reason during the interview, I can turn off the recorder at your request. Alternatively, if you do not wish to continue, you can stop the interview at any time.

I expect to conduct only one interview; however, follow-ups may be needed for added clarification. If so, I will contact you by email or phone unless otherwise requested by the participant. If participants wish to use their full names in the study, this request will be adhered to as well. Participation is voluntary, and the interviewee has the right to terminate the interview at any time.

Once I have conducted the interviews, you will be assigned a subject number in order to de-identify you from your responses. The subject number and your identity will be kept in my researcher's codebook that only I have access to. This subject number will be connected with a fictitious name given to your agency so that your responses will be confidential.

## **POTENTIAL RISKS AND DISCOMFORTS**

I expect any risks, discomforts, and inconveniences will be minor, and I believe they are not likely to occur. If discomforts become an issue, you may discontinue your participation.

## **PROSPECTIVE BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

It is not likely you will benefit from participating in this study, the research should help us learn how to improve mental health disparities among racial and ethnic groups being served in first-episode psychosis government-funded coordinated specialty care programs.

This study will not include procedures that will improve your first-episode psychosis government-funded coordinated specialty care program, disparities, the socio-economic status, stigma, or equity of the programs.

## **COMPENSATION FOR PARTICIPATION**

The government-funded specialty programs will not receive any payment or other compensation for participating in this study. There is also no cost to your government-funded specialty care program for participation.

## **CONFIDENTIALITY**

Any information obtained in connection with this study that can be identified with your government-funded specialty care program will remain confidential and will be disclosed only with the permission of your program or as required by law. Confidentiality will be maintained by applying a number code to let Ms. Browning and Dr. Thomas Frederick (**Supervisor**) know which program is monitored. We will not use the facility name in any of the information we receive from the assessment or in any of the research reports once the study is finalized.

Information that can identify the program individually will not be released to anyone outside the study. Ms. Browning will, however, use the information gathered in her dissertation and any publications. Ms. Browning may also use any information from this study in any way she thinks is best for publication or education. Any information used for publication will not identify the program individually.

The recordings made will not be heard by anyone outside the study unless we have a signed separate permission form allowing Ms. Browning to use them. The records and transcripts will be deleted from the secure firewall database, and the transcription software account will be eliminated, five years after the study.

## **DATA STORAGE TO PROTECT CONFIDENTIALITY**

The notes taken during the interviews and all tape recordings will be kept in a Sentry Safe Fire-Safe Chest, as well as on a password-protected computer file under the code name CBU-DSCF (California Baptist University – Data Store Confidentiality File). No one but myself and my supervisor, Dr. Frederick, will have access.

## **TIME INVOLVEMENT**

Your initial participation will take approximately two hours. It may extend to a few more hours if you agree to follow-up interviews.

## **HOW WILL THE RESULTS BE USED**

The results of the study will be used in research reports that would be published in scholarly journals and books, or presented at professional conferences. The research may be the basis of policy recommendations. In these reports, every effort will be made to keep the confidentiality of the participants while accurately representing their words and their conditions.

## **PARTICIPATION AND WITHDRAWAL**

You can choose whether or not you want your program to participate in this study. If you volunteer the government-funded program to be in this study, you may withdraw at any time without consequences of any kind. The government-funded specialty care program



staff may decline to answer any questions they do not want to answer. There is no penalty if the government-funded specialty programs withdraw from this study, and the program will not suffer the loss of any benefits to which the government-funded specialty care program is otherwise entitled.

## **PRINCIPAL INVESTIGATORS**

If you have additional questions or concerns about the study, please contact

Ms. Monique S. Browning  
Principal Investigator  
Online Professional Studies  
Public Administration  
California Baptist University  
Riverside, CA  
xxx-xxx-xxxx  
xxxxx@xxxxx.xxx

## **RIGHTS OF RESEARCH SUBJECTS**

The California Baptist University Institutional Review Board is a committee tasked with the review of research and the protection of human participants. If you should have any questions regarding the nature of the research, your participation, or rights as a research participant, please contact the IRB via email at [IRB@calbaptist.edu](mailto:IRB@calbaptist.edu).

---

I understand the information defined above. The government-funded specialty care program's questions have been answered to the program's satisfaction, and agree to participate in this research study. The government-funded specialty program has received a copy of this form.

\_\_\_\_\_  
Printed Name of Subject

\_\_\_\_\_  
Signature of Subject

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

## APPENDIX B

### Semistructured Interview Questions

1. Describe the CSC program geographic service area and any unique characteristics of the community. Describe how the CSC program ensures that services reflect cultural diversity (racial and ethnic minorities) and any special needs of individuals with SMI.
  - a) As an individual working with the FEP program, please describe the program's perspective on racial and ethnic minority challenges affecting the delivery of mental health services.
2. What do the Commissioner and the agency leaders say are the 2-3 significant strategic steps they see as most important for realizing the vision for the delivery of mental health services for racial and ethnic minorities in the FEP programs?
  - a) Describe efforts of coordination/collaboration with health professionals, program administrators, state behavioral officials, and CSC team leaders of CSC programs that have been undertaken to improve the mental health services and reduce fragmentation for racial and ethnic minority groups and their families?
3. What progress has been made, and what assistance has the State provided when addressing racial and ethnic disparity issues?
4. How does the CSC program ensure services are responsive to cultural diversity and racial and ethnic minorities?
  - a) Does staff reflect the cultural diversity of racial and ethnic minorities?
  - b) Does the state have a cultural competency development and improvement plan?
  - c) What are the minimum standards for staff cultural competence?
  - d) Is there a cultural competency training program from service providers?
  - e) Are there ethnic services mandated? If so, what are they?
  - f) What funding strategies or target dollars address the needs of underserved racial and minority groups? Please provide specifics.
5. How have ethnic and racial minorities been used in collaborative efforts to develop CSC programming?

- a) What plans, initiatives, or actions are used to ensure racial and ethnic minorities have the knowledge, skill, development, access, resources, support, and time to contribute meaningfully to first episode-psychosis programs? Please provide at least three examples.
  - b) What involvement strategies (funding for training, transportation, language barriers, etc.) are available to racial and ethnic minority groups and their families?
- 6. Describe the outreach and specialized programmatic efforts, if any, specifically conducted for racial and ethnic minority groups with ESMI who are homeless or live in impoverished communities, have lack of transportation, language barriers, lack of support, minimal health care coverage, stigmatized, and have limited quality of care?
- 7. Describe how consumers and their families (racial and ethnic minorities) are involved with the consumers' treatment plans? Describe any specific services available for family members of racial and ethnic minorities with ESMI, including services in languages other than English. Are interpreters available as needed?

## APPENDIX C

### Naturalist Observation Checklist for Program Providers

Location \_\_\_\_\_ Date \_\_\_\_\_

Provider Observation	Frequency (Always, Often, Sometimes, Never)	Duration (minutes/hours)	Rating (1-5)
<b>Outreach</b> – Distribution of flyers, development of websites, being on local news programs.			
<b>Participant Enrollment</b> – Being educated about the program, introduction to team members. Team Lead, Primary Clinician or Psychiatrist conducts intake.			
<b>Treatment Planning</b> – Who (Team lead, Primary, and Rehabilitation Clinicians, Recover Coach/Skills Trainer, Supported Employment and Education Specialist or the entire team) is present?			
<b>Family Involvement</b> – Family members and family support			
<b>Communication</b> – Differentiating CSC programs in general (treatment As usual, recovery-oriented, person-centered approach). Face-to-face Communication between team members, email, or phone (via text).			
<b>Technology in Services</b> – websites to disseminate information, educate the community, using laptops, skill-building videos, webinars, resume workshops and music therapy			

<b>Successful Participants</b> – Providers expressing participant success when Meeting goals, provider mentioning participant engagement in the program, and community success. Provider expressing participant insight in their illness, and managed care (medication, independent living, support groups making appointments).			
<b>Measuring Success</b> – Provider reporting improvements, updates to recovery Plans. Tracking engagement in employment status, education, family Involvement, medication adherence, questionnaire depression scale.			
<b>Factors in Success</b> – Flexible team members, team collaboration, solid Communication, passionate team lead, and administrative leadership. Family Involvement. Group or social club interactions			
<b>Accomplishments</b> – Community understanding of the roles of the program. Successful discharges decreased the dropout of treatment and the program.			
<b>Challenges to Success</b> –			

**Recommendations: Design/Scope –**

---