

Mental Health Disparities, Treatment Engagement, and Attrition Among Racial/Ethnic Minorities with Severe Mental Illness: A Review

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Published online: 12 September 2017
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Abstract Mounting evidence indicates that there are mental health disparities in the United States that disadvantage racial/ethnic minorities in medical and mental health settings. Less is known, however, about how these findings apply to a particularly vulnerable population, individuals with severe mental illness (SMI). The aim of this paper is to (1) provide a critical review of the literature on racial/ethnic disparities in mental health care among individuals with SMI; (2) identify factors which may contribute to the observed disparities; and (3) generate recommendations on how best to address these disparities. Specifically, this article provides an in-depth review of sociocultural factors that may contribute to differences in treatment engagement and rates of attrition from treatment among racial/ethnic minorities with SMI who present at medical and mental health facilities. This review is followed by a discussion of specific strategies that may promote engagement in mental health services and therefore reduce racial/ethnic disparities in SMI.

Keywords Health disparities · Severe mental illness · Minorities · Treatment engagement · Treatment attrition

Introduction

We use the term “health disparities” to refer to differences in health outcomes that are associated with and contribute to social, environmental, or economic disadvantage for an identifiable group of individuals (Office of Disease Prevention

and Health Promotion, 2016). Examination of the role that race and ethnicity may play in the proliferation of health disparities is critical as more than 100 million people in the United States identify as belonging to a racial or ethnic minority group (U.S. Census Bureau, 2008), and by 2044, census estimates suggest racial/ethnic minorities will comprise over 50% of all Americans (Colby & Ortman, 2015).

Race and ethnicity are overlapping but distinct entities. Race refers to “the category to which others assign individuals on the basis of physical characteristics, and the generalizations and stereotypes made as a result” (American Psychological Association, 2003). Ethnicity refers to a group of people who share one or more characteristics, such as a common country of origin, language, religious/spiritual orientation, or cultural identity (Rice & O’Donohue, 2002). Though the constructs of race and ethnicity are distinct, they are typically not distinguished from one another within the literature base. As a result, throughout the current paper we refer to race/ethnicity broadly.

Research examining disparities within medical and mental health settings indicates that racial/ethnic minorities have less access to mental health services; are less likely to utilize and receive necessary mental healthcare; receive poorer quality of care; are less satisfied with professional mental health services; and have higher rates of dropout from these services when compared to Whites (Carpenter-Song, Whitley, Lawson, Quimby, & Drake, 2011; Dobalian & Rivers, 2008; Lasser, Himmelstein, Woolhandler, McCormick, & Bor, 2002; Olfson, Cherry, & Lewis-Fernández, 2009; Smedley, Stith, & Nelson, 2003; Wells, Klap, Koike, & Sherbourne, 2001, US Department of Health and Human Services, 2001). Mental health disparities among racial/ethnic minorities appear to be increasing (Cook, McGuire, & Miranda, 2007), and the problem is compounded for the especially

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vulnerable mentally ill population who are also ethnic/racial minorities. Finding strategies to reduce these disparities is paramount.

In this review, we examine the empirical evidence regarding the presence of racial/ethnic disparities in mental health care among individuals with severe mental illness (SMI). To achieve this aim, we conducted a comprehensive narrative review using PsycINFO, MEDLINE, CINAHLPlus, and PUBMED databases, with no limitations on year of publication. Studies that discussed the prevalence of racial/ethnic disparities in SMI, factors that may contribute to mental health disparities, and potential strategies to reduce disparities were included in the current review. Additionally, the review included empirical and theoretical articles. We excluded articles which used samples that lacked an SMI diagnosis; which focused solely on medical disparities; which were not available in English; or which were not published in peer-reviewed journals. No further exclusion criteria were used.

Key search terms included schizophrenia and/or psychosis, bipolar disorder, major depressive disorder, severe mental illness, disparity, race, ethnicity, mental health, treatment, engagement, and attrition/dropout. More specifically, we employed several search algorithms as the initial steps in generating a pool of articles for examination and possible inclusion in the smaller subset of articles we used in the review. The following search algorithms were used.

[(severe mental illness) AND (mental health OR treatment) AND (disparity OR disparities) AND {race OR ethnicity) AND (engagement OR attrition OR dropout)]

[(schiz OR psychosis) AND (mental health OR treatment) AND (disparity OR disparities) AND (race OR ethnicity) AND (engagement OR attrition OR dropout)]

[(bipolar OR depress) AND (mental health OR treatment) AND (disparity OR disparities) AND (race OR ethnicity) AND (engagement OR attrition OR dropout)]

This search yielded a total of 489 studies, which were scanned for inclusion. Of these, 79 studies met the inclusion criteria. Additionally, during our examination of these studies, we recognized there had been gaps in our initial search algorithm. We recognized that important concepts might be only partially represented in our initial pool of articles. We therefore redefined and expanded our search terms to ensure that we captured a broader range of studies, particularly those focused on sociocultural factors that may impact racial/ethnic disparities. The additional search terms we added to our initial search algorithm were stigma, family, spiritual/spirituality, religion, culture, and mistrust. More specifically, we used the following expanded search algorithms as a second step for generating a larger pool of articles for examination and possible inclusion in the final pool of articles selected for intensive review. The following search algorithms were used.

[(severe mental illness OR schiz OR psychosis OR bipolar OR depress) AND (stigma) AND (engagement OR attrition OR dropout)]

[(severe mental illness OR schiz OR psychosis OR bipolar OR depress) AND (family) AND (engagement OR attrition OR dropout)]

[(severe mental illness OR schiz OR psychosis OR bipolar OR depress) AND (spiritual OR spirituality OR religion) AND (engagement OR attrition OR dropout)]

[(severe mental illness OR schiz OR psychosis OR bipolar OR depress) AND (culture) AND (engagement OR attrition OR dropout)]

[(severe mental illness OR schiz OR psychosis OR bipolar OR depress) AND (mistrust) AND (engagement OR attrition OR dropout)]

This search yielded a total of an additional 350 studies that were scanned for inclusion. Of these, 52 studies met the inclusion criteria. With the addition of these 52 studies to the 79 additionally identified, a total of 131 studies were included in the current review. In the following sections, we provide a review of the literature that examines racial/ethnic disparities within SMI populations. We then examine sociocultural factors that appear likely to contribute to these observed disparities among SMI groups both in medical and mental health settings. Additionally, we offer recommendations on how best to address these disparities.

To organize our review of mental health disparities in SMI populations, we first categorized studies into two major groupings. The first group consisted of 61 articles that present empirical data as well as several publications that were meta-analyses and systematic reviews of a subset of relevant empirical studies. The second group consisted of 70 papers that do not report new empirical data. Instead, these papers are of a more conceptual nature and draw upon previously published data to articulate empirical generalizations based on previous findings and to generate theoretical concepts and models for understanding those findings. In a second step, we divided the first group (i.e., the empirical studies) into three clusters, and categorized each study based on our assessment of where it best fit our framework for organizing and examining the empirical data. For each cluster, we created a systematic review table format to help readers more easily follow our presentation and analysis of findings. There were three tables; within each table, studies were categorized based on whether the data presented were quantitative or qualitative in nature, or the in form of a review (either systematic, meta-analytic, or integrative). Table 1 includes 27 articles that document health disparities in racial/ethnic minority SMI subpopulations (25 quantitative studies; 2 qualitative). Table 2 includes 16 articles that focus on variables that contribute to the existence of racial/ethnic minority SMI health disparities (5 quantitative studies; 7 qualitative; 2 quantitative and qualitative; 2 systematic/integrative

Table 1 Racial/ethnic mental health disparities in SMI

Study	Method	Type(s) of SMI and sample size	Racial/ethnic group(s)	Health service outcome type	Findings
1. Barnes (2004)	Quantitative	Schizophrenia, mood disorders N = 2311	Blacks Whites Native Americans Asian Americans Hispanics/Latinos	Medical and mental	Blacks four times more likely than Whites to be diagnosed with schizophrenia
2. Barnes (2008)	Quantitative	Schizophrenia, bipolar disorder, major depressive disorder N = 2404	Blacks Whites	Medical and mental	Blacks more likely to receive schizophrenia diagnosis than Whites Race strongest predictor of schizophrenia diagnosis
3. Barrio et al. (2003)	Quantitative	Schizophrenia, schizoaffective disorder N = 4249	Blacks Hispanics/Latinos Whites	Mental	Blacks and Hispanics/Latinos use fewer case management services than Whites
4. Blow et al. (2004)	Quantitative	Schizophrenia, schizoaffective disorder, bipolar disorder N = 134,523	Blacks Hispanics/Latinos Whites	Medical and mental	Blacks and Hispanics/Latinos more likely to receive schizophrenia diagnoses than Whites
5. Chinman et al. (2000)	Quantitative	Schizophrenia, bipolar disorder, major depressive disorder N = 1785	Blacks Whites	Mental	Whites experienced greater reductions in psychotic symptoms after case management than Blacks
6. Choi et al. (2012)	Quantitative	Schizophrenia, affective disorders N = 2051	Blacks Hispanics/Latinos Whites	Medical and mental	Minorities more likely to receive schizophrenia diagnoses than Whites
7. Delbello et al. (2001)	Quantitative	Schizophrenia, affective disorders N = 1001	Blacks Whites	Medical and mental	Black adolescents more likely to receive schizophrenia diagnosis than Whites
8. Durbin et al. (2014)	Quantitative	Schizophrenia N = 194	Blacks Whites Hispanics/Latinos Other	Medical	Blacks more likely than all other ethnic groups to be psychiatrically hospitalized
9. Eack and Newhill (2012)	Quantitative	Schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder N = 925	Blacks Whites	Mental	Blacks have poorer mental health outcomes after psychiatric discharge than Whites
10. Fischer et al. (2008)	Quantitative	Schizophrenia, bipolar disorder N = 164,150	Blacks Whites	Medical and mental	Blacks more likely to experience 12-month disengagement from VA services than Whites
11. Fontanella et al. (2014)	Quantitative	Schizophrenia N = 8621	Blacks Whites	Medical and mental	Blacks less likely than Whites to receive outpatient care (including medication management and outpatient treatment) after hospitalization

Table 1 (continued)

Study	Method	Type(s) of SMI and sample size	Racial/ethnic group(s)	Health service outcome type	Findings
12. Fortuna et al. (2010)	Quantitative	Major depressive disorder N = 564	Blacks Whites Hispanics/Latinos Asians	Mental	Blacks less likely to be retained in mental health treatment than Whites
13. Hampton et al. (2010)	Quantitative	Schizophrenia, bipolar disorder, major depressive disorder N = 155	Blacks Whites	Medical and mental	Race not a significant predictor of inpatient admissions or outpatient mental health service use
14. Horvitz-Lennon et al. (2009)	Quantitative	Severe mental illness (unspecified) N = 6829	Blacks Hispanics/Latinos Whites	Mental	Blacks made fewer psychiatric outpatient visits than Whites
15. Kilbourne et al. (2005)	Quantitative	Bipolar I disorder N = 2316	Blacks Whites	Mental	Blacks less likely than Whites to have outpatient follow-up visits after index diagnosis
16. Kposowa et al. (2002)	Quantitative	Schizophrenia N = 18,533	Blacks Asians Hispanics/Latinos Whites	Medical and mental	Blacks, Asians, and Hispanics/Latinos more likely to receive schizophrenia diagnosis than Whites
17. Kreyenbuhl et al. (2003)	Quantitative	Schizophrenia N = 344	Blacks Whites	Medical	Blacks 3x more likely to receive antipsychotic medications than Whites
18. Kuno and Rothbard (2002)	Quantitative	Schizophrenia N = 2515	Blacks Whites	Medical	Blacks 76% less likely to receive new-generation antipsychotic medications than Whites Blacks more likely to receive depot medications than Whites Blacks more likely to receive second-generation antipsychotics than Whites
19. Lehman et al. (1998)	Qualitative & Quantitative	Schizophrenia N = 719	Blacks Whites Other	Medical and mental	Minorities receive higher doses of antipsychotics than Whites Minorities were less likely to receive treatment for co-occurring depression than Whites Minorities were less likely to receive family-based outpatient treatment than Whites
20. Phillips et al. (2001)	Quantitative	Schizophrenia, schizoaffective disorder N = 98	Blacks Hispanics/Latinos Whites	Mental	After treatment, Blacks and Hispanics/Latinos showed poorer outcomes in occupational and social functioning compared to Whites

Table 1 (continued)

Study	Method	Type(s) of SMI and sample size	Racial/ethnic group(s)	Health service outcome type	Findings
21. Rosenfield (1984)	Quantitative	Psychotic disorders N = 666	Blacks Hispanics/Latinos Whites Other	Medical and mental	Blacks more likely than Whites to be involuntarily hospitalized
22. Rost et al. (2011)	Quantitative	Schizophrenia N = 3359	Blacks Hispanics/Latinos Whites Other	Medical	Blacks more likely to receive anti-psychotic medications than Whites Blacks more likely to be hospitalized than Whites
23. Snowden and Hu (1997)	Quantitative	Schizophrenia, other psychosis, affective disorders N = 4000	Blacks Asians Hispanic/Latinos Whites	Medical and mental	Blacks less likely to utilize services (including medication management and psychosocial treatment) than Whites Asians and Hispanics/Latinos less likely to receive outpatient services and more likely to be hospitalized than Whites
24. Snowden and Pingitore (2002)	Quantitative	Not reported	Blacks Whites Other	Medical	Specialized services for racial/ethnic minorities increased outpatient service use among minorities Blacks more likely than Whites to utilize primary care/crisis services than psychiatric services
25. Wang et al. (2002)	Quantitative	Non-affective psychosis, mood disorders N = 5877	Blacks Whites	Medical and mental	Blacks 5x less likely to receive minimally adequate treatment (comprised psychosocial treatment and medication management) than Whites
26. Wang, (2007)	Qualitative & Quantitative	Major depressive disorder, bipolar disorder N = 3556	Whites Non-whites	Medical and mental	Minorities more likely to drop out of treatment provided by psychologists, psychiatrists and general practitioners than Whites
27. Young et al. (2005)	Quantitative	Schizophrenia, bipolar disorder, major depressive disorder N = 179	Blacks Whites Hispanics/Latinos Other	Medical and mental	Minorities more likely to use emergency services than community support services

reviews). Table 3 includes 18 articles that focus on variables linked to reducing health disparities in racial/ethnic SMI health disparities (10 quantitative studies; 4 qualitative; 2 quantitative and qualitative; 2 meta-analytic reviews).

Each empirical study was assigned to only one table, but decisions about which table was most appropriate for a specific article proved to be less difficult than one might expect, perhaps because empirical articles tend to be quite focused. In a small number of cases, when there was a question about the most appropriate table placement of an article (such that an article's findings were relevant to more than one table), the article was assigned to the table relevant to the discussion of the article within the current review (e.g., if the findings of the article discussed within the current review focused on ways to reduce SMI health disparities, this article was placed in Table 3).

Readers will note that Tables 1, 2, and 3 incorporate only 61 of the total of 131 articles included in the current review. The other 70 articles are not listed in tables because they were not sources of data, but rather were sources of concepts and theoretical models cited at various points based on the concept's relevance to particular empirical data patterns and empirical generalizations that flowed from data presented in articles included in Tables 1 and 2, or 3.

Racial/Ethnic Mental Health Disparities in SMI

Though racial/ethnic disparities in mental health care have been well documented, less is known about how these findings apply to individuals with severe mental illness (Eack & Newhill, 2012). SMI refers to a cluster of disorders (e.g., schizophrenia, bipolar disorder, and recurrent major depression) which typically produce long-term psychosocial and vocational impairments (Eack & Newhill, 2012; Lopez & Murray, 1998). As a result, people with SMI commonly live in poverty and are dependent on public mental health services to receive needed care (Hudson, 2005). In the following section, we discuss available literature that examines racial/ethnic mental health disparities within SMI populations. Table 1 summarizes results from 27 studies that confirm the presence of disparities in mental health outcomes and treatment that adversely impact racial/ethnic minority SMI populations.

Medical Settings

Within medical settings, research indicates that racial/ethnic minorities with SMI are more likely to utilize psychiatric emergency services versus community support services (Row 27 of Table 1, Young et al., 2005) and are more likely to be hospitalized when they do seek care (Row 8 of Table 1, Durbin, Rudoler, Durbin, Laporte, & Callaghan, 2014; Row

22 of Table 1, Rost, Hsieh, Xu, Menachemi, & Young, 2011) when compared to their White counterparts. Diagnostic disparities have also been noted within medical settings. Blacks, Asians, and Hispanic/Latinos who seek psychiatric services are more likely to be provided with a schizophrenia spectrum diagnosis than are Whites (Row 4 of Table 1, Blow et al., 2004; Buchanan & Carpenter, 2005; Row 6 of Table 1, Choi et al., 2012; Row 7 of Table 1, Delbello, Lopez-Larson, Soutullo, & Strakowski, 2001; Row 16 of Table 1, Kposowa, Tsunokai, Butler, & Butle, 2002). Relatedly, Barnes, (2008, [Table 1, Row 2]) found that Blacks treated in state psychiatric hospitals were more likely to be diagnosed with schizophrenia than Whites, and that race was the strongest predictor of an admission diagnosis of schizophrenia. These trends are troubling, as potential over-diagnosis of SMI among racial/ethnic minorities in medical settings may result in inaccurate psychopharmacological interventions, thereby having the capacity to impede patient recovery. Further, even when an accurate diagnosis of schizophrenia is provided, Blacks have been shown to receive higher dosages of antipsychotics, increased use of depot pharmacotherapy, and are less likely to receive second-generation antipsychotics (which are associated with less severe side effects) than Whites (Row 17 of Table 1, Kreyenbuhl, Zito, Buchanan, Soeken, & Lehman, 2003; Row 18 of Table 1, Kuno & Rothbard, 2002).

Treatment Utilization

Research also indicates that minorities with SMI have lower rates of initial treatment utilization (US Department of Health and Human Services, 2001). Barrio et al. (2003, [Table 1, Row 3]) examined a sample of individuals with schizophrenia spectrum disorders in San Diego and found that the use of case management services was significantly lower among Blacks and Hispanic/Latinos compared to Whites. Relatedly, Kilbourne et al. (2005, [Table 1, Row 15]) examined service utilization among veterans diagnosed with Bipolar I disorder seeking services at the Veterans Association (VA) inpatient and outpatient clinics and found that Blacks were less likely than Whites to have outpatient follow-up visits 90 days following their index diagnosis. They proposed that this may be due to system-level characteristics, such as a lack of culturally competent service providers in urban VA facilities; however, these factors were not assessed formally (Kilbourne et al., 2005). Horvitz-Lennon et al. (2009, [Table 1, Row 14]) examined utilization of psychiatric outpatient, housing, and case management services among 6829 Black, Hispanic/Latino and White homeless individuals with SMI and found that Blacks made fewer psychiatric outpatient visits than did Whites. Though the authors did not assess what led to the observed disparities, they surmised that higher rates of stigma and negative

Table 2 Contributors to racial/ethnic mental health disparities in SMI

Study	Method	Type(s) of SMI and sample size	Racial/ethnic group(s)	Health service outcome type	Findings
1. Abiri et al. (2016)	Integrative review, qualitative and quantitative	Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder N = 4256	Blacks Asians Middle Easterners Whites	Mental	Internalized stigma associated with avoidance and underutilization of mental health services
2. Borras et al. (2007)	Quantitative	Schizophrenia N = 103	Blacks Asians Middle Easterners Whites	Medical	Religious patients had higher levels of medication non-adherence than non-religious patients
3. Campbell and Long (2014)	Qualitative	Major depressive disorder N = 17	Blacks	Medical and mental	A lack of trust in doctors and treatment associated with lower service utilization among Blacks
4. Codjoe et al. (2013)	Qualitative	At risk for psychosis N = 20	Black Africans Black Caribbeans	Mental	Blacks emphasized need for professionals to understand cultural and religious beliefs Services that do not consider culture and/or religion may result in lower engagement
5. Grover et al. (2016)	Quantitative	Bipolar disorder N = 185	Not reported	Mental	Approximately 50% of patients cited supernatural etiological causes of their illness Supernatural causes of illness associated with seeking traditional services
6. Kessler et al. (2001)	Qualitative	Schizophrenia, non-affective psychosis, bipolar disorder, major depressive disorder N = 5877	Not reported	Medical and mental	Perceived inefficacy of treatment cited as a primary reason for not utilizing medical and psychiatric services
7. Lavoie-Tremblay et al. (2012)	Qualitative	Severe Mental Illness (unspecified) N = 54 family members N = 22 service providers	Not reported	Medical and mental	Rarity of collaboration between families and providers serves as a primary barrier to family-oriented care
8. Marshall and Solomon (2004)	Qualitative and quantitative	Severe Mental Illness (unspecified) N = 59 service providers	Whites Non-whites	Medical and mental	Majority of mental health providers (including psychiatrists, psychologists, social workers) have no contact with family members of patients
9. McCabe and Priebe (2004)	Qualitative and quantitative	Schizophrenia N = 119	Bangladeshis African Caribbeans West Africans Whites	Mental	Minorities more likely to cite supernatural and social causes of schizophrenia, Whites more likely to cite biological causes Biological explanatory model associated with better treatment satisfaction

Table 2 (continued)

Study	Method	Type(s) of SMI and sample size	Racial/ethnic group(s)	Health service outcome type	Findings
10. Merwin et al. (2006)	Quantitative	Not reported	Not reported	Medical and Mental	Rural residence and poverty associated with poorer access to medical and community-based mental health services
11. Mitchell and Romans (2003)	Quantitative	Bipolar disorder <i>N</i> = 147	Māoris Whites Other	Medical	Patients with strong religious beliefs showed lower rates of medication adherence than patients with weak religious beliefs
12. Smith et al. (2013)	Qualitative	Schizophrenia, schizoaffective disorder, bipolar disorder, other <i>N</i> = 56 patients <i>N</i> = 25 service providers	Blacks Hispanics/Latinos Whites Other	Medical and mental	Patients reported an inability to trust providers as a primary reason for disengagement from treatment Providers reported stigma as a primary reason for patients' treatment disengagement
13. Smolak et al. (2013)	Systematic review, qualitative	Schizophrenia spectrum disorders <i>N</i> = 43 research studies	Not reported	Mental	Religious patients and family members more likely to seek religious services over mental health professionals
14. Stowkowy et al. (2012)	Quantitative	Schizophrenia spectrum disorders <i>N</i> = 286	Whites Non-whites	Medical and mental	Not having a family member in treatment predicted disengagement from medical and mental health treatment
15. Uebelacker et al. (2012)	Qualitative	Major depressive disorder <i>N</i> = 30	Hispanics/Latinos	Medical and mental	Providers' lack of consideration of culture was reported to be a barrier to treatment
16. Willging et al. (2008)	Qualitative	Not reported <i>N</i> = 40 patients <i>N</i> = 120 service providers	Hispanics/Latinos American Indians	Medical and mental	Minorities who are socioeconomically disadvantaged and live in rural areas are less likely to receive medical and community-based mental health services

attitudes towards treatment within these groups may have impacted service utilization (Horvitz-Lennon et al., 2009). In a recent study, Fontanella, Guada, Phillips, Ranbom, and Fortney (2014, [Table 1, Row 11]) examined continuity of care in 8621 patients with schizophrenia living in Ohio and found that Black patients were less likely than Whites to receive regular outpatient care and follow-up visits after hospitalization. The authors indicated that a variety of factors may have influenced these findings, including cultural beliefs about illness and treatment and racial/ethnic mismatch between patients and providers (Fontanella et al., 2014).

Despite these findings, additional studies suggest a more complicated pattern. For example, Hampton, Chafetz, and White (2010, [Table 1, Row 13]) examined mental health service utilization among 155 Blacks and Whites with SMI after discharge from a residential crisis program in San Francisco and concluded that race was not a significant predictor of medical or outpatient service utilization. In describing the inconsistency of their findings with prior literature, the authors reported that the San Francisco Department of Mental Health's mission to provide culturally sensitive care may have reduced the levels of perceived stigma and increased treatment seeking within this population (Hampton et al., 2010). Relatedly, in a study examining service utilization among 4000 individuals with SMI in two separate counties on the West Coast, Snowden and Hu (1997, [Table 1, Row 23]) found that the provision of specialized programs serving racial/ethnic minority communities may impact service utilization in medical and outpatient settings. The authors found that in the county which provided specialized services for racial/ethnic minorities (e.g., use of racial/ethnic minority providers), Black, Asian, and Hispanic/Latino patients were more likely than Whites to utilize mental health programs (e.g., case management, medication management). However, in the county which did not provide specialized services for racial/ethnic minorities, Asians and Hispanic/Latinos were less likely than Whites to receive individual therapy, Hispanic/Latinos and Blacks were less likely to receive case management services, and Asians, Hispanic/Latinos, and Blacks were more likely to be hospitalized (Snowden & Hu, 1997). Thus, it appears that mental health services that consider the needs of racial/ethnic minorities may increase service utilization both in medical and community settings.

Quality of Care

Research also suggests that racial/ethnic minorities with SMI who utilize mental health services may receive less than optimal care. Specifically, a significant amount of literature demonstrates that Blacks with SMI are more likely than Whites to be involuntarily hospitalized, to use crisis

services, and to enter emergency treatment by means of law enforcement than Whites (Atdjian & Vega, 2005; Row 1 of Table 1, Barnes 2004; Lindsey & Paul, 1989; Row 21 of Table 1, Rosenfield, 1984; Snowden, 2001; Row 24 of Table 1, Snowden & Pingitore, 2002). In a study examining proportions of individuals with SMI who receive, "minimally adequate treatment" (defined as medication management and a minimum of four follow-up visits with a psychiatrist or other mental health specialist), Wang, Demler, and Kessler (2002, [Table 1, Row 26]) found that Blacks with SMI were five times less likely to receive minimally adequate treatment than were Whites. Relatedly, results from the Schizophrenia Patient Outcomes Research Team (PORT) indicated that in a sample of 719 adults with schizophrenia sampled from inpatient and outpatient programs in the Southern and Midwestern United States, rates of conformance to the PORT Treatment Recommendations (see Lehman and Steinwachs, 1998 for a detailed description) were lower for racial/ethnic minorities than Whites (Lehman et al., 1998). Specifically, racial/ethnic minorities with SMI were found to be more likely to receive higher doses of antipsychotic medications and were less likely to receive treatment for co-occurring depression than were Whites (Row 19 of Table 1, Lehman et al., 1998).

Treatment Outcome

Racial/ethnic minorities also appear to experience poorer outcomes when they do receive treatment. Eack and Newhill (2012, [Table 1, Row 9]) followed 925 individuals with SMI for 1 year after a psychiatric hospital discharge. The authors found that in the year following hospitalization, Black patients demonstrated less improvement in psychotic symptoms, were less likely to return to work, and experienced less improvement in global functioning when compared to Whites. Importantly, the authors note that these findings persisted after adjusting for socioeconomic status, gender, and psychiatric diagnosis (Eack & Newhill, 2012). In conceptualizing their findings, the authors suggest that a critical factor for improving mental health systems for racial/ethnic minorities with SMI may include improvement in access to and quality of outpatient psychosocial interventions following psychiatric discharge (Eack & Newhill, 2012). Additional research in this area indicates that the content of psychosocial interventions may also play a role in the observed outcome disparities. Phillips, Barrio, and Brekke (2001, [Table 1, Row 20]) found that racial/ethnic minorities with SMI participating in an outpatient psychosocial rehabilitation program showed poorer outcomes in both occupational and social functioning when compared to White participants. The authors suggest that a lack of focus on race/ethnicity within the program may have

Table 3 Factors linked to reductions in racial/ethnic mental health disparities

Study	Method	Type(s) of SMI and sample size	Racial/ethnic group(s)	Health service outcome type	Findings
1. Benish et al. (2011)	Meta-analysis	Not reported N = 21 studies	Blacks Asians Hispanic/Latinos	Mental	Among minorities, culturally adapted interventions more effective than conventional interventions
2. Easter et al. (2016)	Qualitative	Schizophrenia, schizoaffective disorder, bipolar disorder N = 56 patients N = 25 service providers	Blacks Hispanics/Latinos Whites Other	Medical and mental	Among patients, honest communication and feeling understood associated with increased trust in providers
3. Fung et al. (2011)	Quantitative	Schizophrenia N = 66	Asians	Mental	Self-stigma reduction program associated with better psychological well-being and increased treatment adherence
4. Garcia et al. (2006)	Quantitative	Schizophrenia N = 30	Mexicans	Medical	Family involvement and support predicted higher medication adherence
5. Green et al. (2012)	Qualitative	Schizophrenia, bipolar disorder, affective psychosis N = 171	Blacks American Indians Asians Hispanics/Latinos Whites Mixed	Mental	Empathetic, compassionate, and honest communications from treatment providers may enhance treatment engagement
6. Griner and Smith (2006)	Meta-analysis	Not reported N = 76 studies	Blacks Hispanics/Latinos Asians Native Americans Whites	Mental	Culturally adapted interventions more effective, particularly among Hispanic/Latino populations
7. Kirmayer et al. (2003)	Qualitative	Not reported N = 29 service providers	Over 50 ethnocultural groups; specifics not reported	Mental	Cultural consultation increased treatment efficacy, enhanced provider/patient communication, and increased providers' knowledge of cultural aspects of cases
8. Klingaman et al. (2015)	Quantitative	Schizophrenia, bipolar disorder, major depressive disorder N = 228	Blacks American Indians Native Hawaiians Whites Multiracial	Medical	Collaborative patient-provider interactions improve treatment engagement and satisfaction
9. Kopelowicz et al. (2012)	Quantitative	Schizophrenia N = 174	Mexicans	Medical	Family involvement in treatment associated with fewer relapses and hospitalizations and higher medication adherence
10. Lucksted et al. (2011)	Quantitative	Schizophrenia, schizoaffective disorder, major mood disorder N = 34	Blacks Whites Multiple	Mental	Ending self-stigma intervention effective in improving self-report ratings of internalized stigma

Table 3 (continued)

Study	Method	Type(s) of SMI and sample size	Racial/ethnic group(s)	Health service outcome type	Findings
11. Phillips et al. (2002)	Qualitative	Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder N= 10	Whites	Mental	Intervention that integrated religious/spiritual content highly valued by participants
12. Rea et al. (2003)	Quantitative	Bipolar disorder N= 53	Blacks Asians Whites Other	Medical	Family-focused treatment associated with fewer patient hospitalizations compared to individual therapy
13. Revheim et al. (2010)	Quantitative	Schizophrenia, Schizoaffective disorder N= 40	Blacks Hispanics/Latinos Whites	Mental	Spiritually oriented group intervention led to improvements in self-efficacy and hopefulness compared to non-spiritual group
14. Sibitz et al. (2013)	Quantitative	Schizophrenia, schizoaffective disorder N= 80	Not reported	Mental	Empowerment and recovery program effective in reducing internalized stigma
15. Snowden et al. (2006)	Qualitative and quantitative	Not reported N= 59 ethnic program specialists	Blacks Hispanics/Latinos Asians Native Americans Whites Other	Mental	Minorities experience significant disparities in access to treatment Use of bilingual/bicultural staff and community outreach identified as most effective in engaging minority clients in treatment
16. Stanbridge et al. (2013)	Qualitative and quantitative	Not reported N= 62 (ward 1) N= 141 (ward 2)	Not reported	Medical and Mental	Family liaison services in inpatient settings increase family involvement in treatment
17. Weisman de Mamani et al. (2014)	Quantitative	Schizophrenia, schizoaffective disorder N= 46	Blacks Hispanics/Latinos Whites Other	Mental	Culturally adapted family-focused intervention effective in improving patient symptom severity
18. Weisman de Mamani and Suro (2016)	Quantitative	Schizophrenia N= 113	Blacks Hispanics/Latinos Whites Other	Mental	Culturally adapted family-focused intervention effective in reducing family member guilt and burden

contributed to racial/ethnic differences in outcomes and suggested that integrating cultural perspectives (e.g., values, beliefs, familial involvement) into traditional interventions may assist in improving outcomes. Relatedly, Chinman, Rosenhack, and Lam (2000, [Table 1, Row 5]) found that in a sample of 1785 homeless patients with SMI participating in the Center for Mental Health Services' Access to Community Care and Effective Services and Supports (ACCESS) program, White patients receiving case management services experienced greater reductions in psychotic symptoms compared to Black patients. The authors reported that cultural differences between patients and case managers (e.g., cultural knowledge and beliefs in racial/ethnic stereotypes) may have impacted outcomes (Chinman et al., 2000).

Treatment Engagement

Racial and ethnic minorities with SMI also appear to be at higher risk for disengagement from treatment. In a large-scale study, Hamilton, Moore, Crane, and Payne (2011) examined administrative data from 434,317 patients enrolled in CIGNA Behavioral Health (CIGNA) in order to assess rates of attrition by diagnostic group. This study examined data from both medical and community settings and analyzed treatment adherence across a variety of mental health providers (e.g., psychiatrists, psychologists, nurse practitioners). The authors found that individuals with schizophrenia/psychotic spectrum disorders experienced the highest dropout rates when compared to all other diagnostic groups assessed (e.g., mood, anxiety, and eating disorders). Follow-up research has replicated these findings (Harding et al., 2008) and indicates that rates of attrition among individuals with schizophrenia and bipolar disorder hover at approximately 30% (Doyle et al., 2014; Fischer et al., 2008; Kreyenbuhl, Nossel, & Dixon, 2009). Further, racial/ethnic minorities with SMI appear to be at an even greater risk for dropping out of mental health treatments prematurely (attrition) when compared to their non-minority counterparts (Row 17 of Table 1, Kreyenbuhl et al., 2009; Smedley et al., 2003, US Department of Health and Human Services, 2001; Row 26 of Table 1, Wang, 2007). In a study examining rates of service use among 164,150 veterans with schizophrenia and bipolar disorder, Fischer et al. (2008, [Table 1, Row 10]) found that Blacks were more likely to experience a 12-month disengagement from Veteran Association mental health services. Similarly, in a study examining racial/ethnic differences in medical and mental health treatment retention among individuals with major depressive disorder, Fortuna, Alegria, and Gao (2010, [Table 1, Row 12])

found that Black patients were significantly less likely to be retained in treatment when compared to Whites.

Factors Which May Account for the Racial/Ethnic Mental Health Disparities in SMI and Implications for Improving Health Equity

Table 2 summarizes 16 studies that highlight factors that may play a part in producing the health disparity outcomes documented by studies in Table 1. Poverty appears to be one consistent factor that influences disparities, as research indicates that racial/ethnic minorities with SMI who are socioeconomically disadvantaged are less likely than their White counterparts to receive medical and community-based mental health services (Row 10 of Table 2, Merwin, Snyder, & Katz, 2006, US Department of Health and Human Services, 2001; Row 16 of Table 2, Willging, Waitzkin, & Nicdao, 2008; Wilson, 2009). Reform in this area requires structural and policy changes to health systems, including increasing affordability and accessibility of evidence-based mental health services (for more detailed discussions of these topics see Cohen, 1993; Dewa, Tugg, Stergiopoulos, Ghavam-Rassoul, & deRuiter, 2012; Ware, & Goldfinger, 1997; Wilton, 2004).

Table 3 summarizes 17 studies linked to specific steps for reducing Racial/Ethnic health disparities. In this section, we discuss sociocultural factors which have been identified as having the potential to impact treatment engagement and attrition (either favorably or unfavorably) in SMI populations. These include stigma, mistrust in the behavioral health system, familial support, religiosity/spirituality, and cultural beliefs. Table 4 provides an overview of these five types of variables, and for each of them, outlines community strategies, provider strategies, and patient strategies for reducing health disparities among racial/ethnic minorities with SMI. In reviewing each of these factors, we discuss specific strategies which may improve engagement and adherence to medical and community-based mental health services, and therefore may assist in reducing racial/ethnic disparities in SMI.

Stigma

Stigma refers to, "an attribute that is deeply discrediting... turning a whole and usual person to a tainted and discounted one" (Goffman, 2009, p. 3). Internalized stigma, or the process by which one adopts stigmatizing views (Mashiach-Eizenberg, Hasson-Ohayon, Yanos, Lysaker, & Roe, 2013), has been linked to poor adherence to treatment (Breland-Noble, 2013; Corrigan, Larson, & Ruesch, 2009), especially among racial/ethnic minorities with SMI (Snowden, 2012). In explaining this link, Hwang, Myers, Abe-Kim, and Ting

(2008) assert that the following factors work to reduce treatment engagement among racial/ethnic minorities: less access to knowledge about mental illness and available treatments; stigmatizing beliefs about mental illness; and collectivistic orientations which place a greater emphasis on social/familial appearances and therefore limit one's willingness to identify oneself as suffering from SMI. Similarly, Whitley and Lawson (2010) report that stigma within racial/ethnic minority community or family networks may reduce the utilization of both medical and community-based mental health services. These authors also report that the stigma associated with the use of mental health services may result in a preference for using primary care clinics to receive needed treatment for mental disorders. However, primary care services have been found to underdiagnose and undertreat mental illness (Snowden & Pingitore, 2002; Wang et al., 2002), and so the potential efficacy of these services may be limited and thereby contribute to disparities (Whitley & Lawson, 2010).

Discrimination has also been associated with poorer mental health outcomes and has been identified as a barrier to treatment engagement and adherence among racial/ethnic minorities (US Department of Health and Human Services, 2001). Thus, it may be that the experience of belonging to two minority groups, i.e., both SMI and a racial/ethnic minority, may put individuals at elevated risk for underutilization of mental health services, which highlights the critical need to address disparities within this population (Row 1 of Table 2, Abiri, Oakley, Hitchcock, & Hall, 2016).

Reducing Stigma

Though racial/ethnic minority groups with SMI may be at greater risk for the negative impacts of stigma, little research has examined specific strategies to reduce stigma within this population. At the local level, psychoeducational programs aimed at contradicting common stereotypes about mental illness can lead to improved attitudes towards individuals with mental illness as well as lower rates of stigma and discrimination (Corrigan & Penn, 2015). Despite these benefits, racial/ethnic disparities exist in access to and utilization of these services (Snowden et al., 2006; Row 15 of Table 2, Uebelacker et al., 2012). Methods to overcome these barriers may include provision of anti-stigma messages by cultural/religious community leaders or respected figures; collaborations with community-based organizations (e.g., outreach efforts at community events); provision of non-traditional services (e.g., weekend/evening hours, home visits); and use of bilingual/bicultural staff who can convey these messages in terms that patients can relate to and understand (Row 15 of Table 3, Snowden, Masland, Ma, & Ciemens, 2006; Uebelacker et al., 2012; Whitley and Lawson 2010).

Interactive psychoeducational and community outreach programs may also be effective in modifying negative

attitudes among medical and community-based mental health personnel, who, themselves, can be important sources of stigmatization (Corrigan & Penn, 2015). Promoting naturalistic, interpersonal contact (e.g., volunteer groups, community activities) between racial/ethnic minorities with SMI and medical and community mental health professionals may assist in promoting greater understanding of what it is like to suffer from SMI, and in reducing negative attitudes towards SMI patients held by some mental health personnel (Couture & Penn, 2006; Gaebel & Baumann, 2003). Such interactive programs may also serve to disconfirm stereotypes about racial/ethnic minorities with SMI and promote destigmatizing interactions with medical and mental health providers, which may in turn aid in alleviating patient fears of discrimination and increase levels of trust in mental health systems.

Strategies to reduce the personal burden of stigma on individuals with SMI, such as engagement in peer support groups and participation in community clubhouses, have also been discussed in the literature (Corrigan & Penn, 2015). However, these approaches may need modification to better meet the needs of racial/ethnic minorities. Relevant modifications may include explicit discussions of cultural beliefs and the impact of SMI patients belonging to two minority groups (SMI and a racial/ethnic minority), as well as the identification and achievement of culturally specific goals (e.g., attending church regularly). Further, input from members of patients' cultural community can provide valuable assistance when developing programming for racial/ethnic minorities with SMI, and also provide direction in bringing to bear relevant sociocultural resources (e.g., religious/spiritual institutions or practices, familial supports) that may increase adherence within the SMI-racial/ethnic minority population (Barrio, 2000). Specialized psychosocial interventions which target stigma in racial/ethnic minorities with SMI have also demonstrated effectiveness in improving self-esteem, internalized stigma, perceived social support, quality of life, treatment adherence, and readiness for change (Row 3 of Table 3, Fung, Tsang, & Cheung, 2011; Row 10 of Table 3, Lucksted, Drapalski, Calmes, Forbes, DeForge, & Boyd 2011; Row 14 of Table 3, Sibitz, Provaznikova, Lipp, Lakeman, & Amering, 2013). Thus, increased provision of these programs in medical and community-based mental health settings may facilitate recovery and reduce health disparities within this population.

Mistrust/Lack of Confidence in Services

Mistrust or lack of confidence in medical and mental health services may represent another likely contributor to the decreased engagement of racial/ethnic minorities with SMI in the healthcare system (Kreyenbuhl et al., 2009, US Department of Health and Human Services, 2001). For

Table 4 Overview of strategies to reduce mental health disparities

Sociocultural variable	Community strategies	Provider strategies	Patient strategies
Stigma	<p>Anti-stigma messages by cultural/religious community leaders</p> <p>Outreach efforts at community events</p> <p>Provision of non-traditional services (e.g., home visits)</p> <p>Bilingual/bicultural staff</p> <p>Increased diversity among providers</p>	<p>Naturalistic, interpersonal contact between providers and patients (e.g., volunteer groups, community activities)</p> <p>Use of cultural brokers in program development</p>	<p>Engagement in peer support groups/community clubhouses</p> <p>Engagement in psychosocial interventions specific to stigma reduction.</p>
Trust/confidence in mental health systems	<p>Increased diversity among providers</p>	<p>Collaborative care</p> <p>Empathetic communication</p> <p>Customization of content, approach, or delivery of intervention to consider culture</p>	<p>Patient involvement in treatment decisions (e.g., treatment preferences, treatment options, treatment planning)</p>
Family involvement	<p>Provision of family-focused treatment and psycho-educational programs in community settings</p> <p>Increased access to providers with family therapy training</p>	<p>Provider education in family stigma/burden, family stress and coping, and information exchange with family members</p> <p>Identification and inclusion of family support persons in treatment</p>	<p>Involvement of family members in treatment planning</p>
Religious/spiritual values	<p>Incorporation of religious/spiritual practices, beliefs, and community networks into treatment</p> <p>Provision of services in non-clinical settings (e.g., churches)</p>	<p>In-depth assessments of religiosity/spirituality</p> <p>Consideration of both patient and provider religious/spiritual values when conceptualizing cases and developing treatment plans</p>	<p>Involvement of significant religious/spiritual supports (e.g., religious mentors and/or healers) in treatment planning</p> <p>Engagement in religiously/spiritually oriented treatment interventions</p>
Culture	<p>Involvement of family and community members, religious/spiritual supports, and indigenous providers in treatment development and delivery</p>	<p>Promoting cultural competence in service providers</p> <p>Inquiring about cultural history and identity</p> <p>Awareness of within group diversity</p>	<p>Engagement in culturally adapted treatment interventions</p>

example, Smith, Easter, Pollock, Pope, and Wisdom (2013, [Table 2, Row 12]) conducted qualitative interviews with 56 individuals with SMI (55% African American, 25% Hispanic, 7% Caucasian, 13% Other) who had disengaged from care. When asked to discuss their primary reasons for service disengagement, approximately 29% of the sample expressed that inability to trust their providers had contributed to service disengagement, and approximately 30% of the sample reported disengagement due to perceptions that services were not meeting their needs (Smith et al., 2013). Similarly, in a study utilizing data from the National Comorbidity Survey, Kessler et al. (2001, [Table 2, Row 6]) examined reasons for limited treatment engagement among 5877 individuals with SMI who had sought mental health treatment from medical doctors, psychiatrists, social workers, and/or mental health counselors. The authors reported that 45% of patients who reported a need for treatment indicated that they had not pursued treatment due to concerns about its effectiveness (Kessler et al., 2001). Specifically, 38% of respondents reported a belief that, “help probably would not do any good;” 11% indicated that they were “not satisfied with available services;” and 12% reported that they “went in the past and it did not help.”

This theme also appears to expand to racial/ethnic minority samples, who report decreased confidence in mental health services (Hwang et al., 2008). In a study examining attitudes towards mental health service use, Campbell and Long (2014, [Table 2, Row 3]) conducted qualitative interviews with 17 Black patients who were asked to discuss their personal experiences with depression. The authors reported that a primary theme that emerged was a lack of trust in doctors and treatment, which contributed to reluctance toward service use (Campbell & Long, 2014). Specific reasons for this lack of trust included a belief that White providers would not understand their experience, and a belief that they would be discriminated against because of their race/ethnicity. The authors conceptualized this mistrust as being due to a history of exclusion and injustices experienced by Blacks at the hands of the formal healthcare systems. As such, the authors recommended that healthcare professionals validate feelings of mistrust and spend more time building rapport and trust with their patients (Campbell & Long, 2014).

Fostering Trust and Confidence

Collaborative care, empathetic communication, and increased diversity among providers have emerged as primary methods to foster trust and confidence in the mental health systems among racial/ethnic minorities with SMI. Specifically, research suggests that collaborative interactions between medical and community-based mental health providers and racial/ethnic minority patients with SMI may enhance patient involvement in treatment decisions, and

therefore improve treatment engagement and treatment satisfaction (Row 8 of Table 3, Klingaman et al., 2015; Kreyenbuhl et al., 2009). As such, recommendations have been made for medical/mental health providers to be more patient centered and for decision making to occur in a synergistic manner with more input from their patients (Kreyenbuhl et al., 2009). Specifically, this approach involves obtaining knowledge about patient preferences in treatment, providing and asking opinions regarding treatment options, and assessing preferences for involvement in treatment plans (Levinson, Kao, Kuby, & Thisted, 2005).

Respectful patient–provider interactions may also serve to foster trust and satisfaction in medical and mental health systems among racial/ethnic minorities with SMI. In a study examining reasons for treatment disengagement among 56 racially/ethnically diverse individuals with SMI, 25% of patients reported that honest communication and 13% of patients reported that feeling understood by providers were important factors in building trust and meaningful relationships with their providers (Row 2 of Table 3, Easter, Pollock, Pope, Wisdom, & Smith, 2016). Relatedly, in a study examining strategies to enhance engagement among youth with SMI, Green, Wisdom, Wolfe, and Firemark (2012, [Table 3, Row 5]) interviewed 171 racially/ethnically diverse patients with schizophrenia, bipolar disorder, or affective psychosis and found that patients reported they valued empathetic, compassionate, and honest communications from their treatment providers.

Increasing diversity among health care providers themselves may represent another means to increase trust and confidence in mental health services among racial/ethnic minorities. Currently 81% of psychiatrists, 93% of psychologists, and 92% of social workers are White, whereas 33.5% of the populations they serve are minorities (Miranda, McGuire, Williams, & Wang, 2008). Miranda et al. (2008) argue that having limited access to racially/ethnically diverse providers may serve to limit patient’s trust in and willingness to seek mental health services. Chin et al. (2012) further suggest that providing opportunities for patients to interact with more racially/ethnically matched providers could offer greater opportunities to customize the content, approach, or delivery of an intervention to better consider the cultural context (Chin et al., 2012). Increased diversity of providers may also improve access to care and facilitate patient preferences in providers, as racial/ethnic minority providers are more likely to practice in racial/ethnic minority communities and racial/ethnic minority patients are more likely to select same race/ethnicity providers (Smedley, Butler, & Bristow, 2004). Thus, methods to increase diversity among health care providers may serve to reduce health disparities within the SMI-racial/ethnic minority population. Several strategies to increase diversity among providers

include improving admission policies (e.g., inclusion of underrepresented groups in admission committees), reducing financial barriers to higher education in medical training (e.g., provision of minority student scholarships and stipends), and encouraging diversity in medically oriented educational institutions by means of minority student mentoring programs, minority faculty role models, and so forth (Smedley et al., 2004).

Limited Familial Involvement in Mental Health Systems

Familial involvement in mental health services has been found to have beneficial effects in the treatment of SMI (Marshall & Solomon, 2004), including fewer relapses and episodes of hospitalization in bipolar disorder (Row 12 of Table 3, Rea et al., 2003) and schizophrenia (Row 9 of Table 3, Kopelowicz et al., 2012; Leucht & Heres, 2006), as well as higher rates of medication adherence among racial/ethnic minorities with SMI (Row 4 of Table 3, García, Chang, Young, López, & Jenkins, 2006; Kopelowicz et al., 2012). Familial involvement also appears to play a protective role against disengagement from mental health services among racial/ethnic minorities with SMI, a finding that appears to be particularly pronounced among Mexican Americans (García et al., 2006; Kopelowicz et al., 2012). In a study examining predictors of disengagement from both medical and community-based treatments, Stowkowy, Addington, Liu, Hollowell, and Addington (2012, [Table 2, Row 14]) examined 286 racially/ethnically diverse individuals with first episode psychosis and found that not having a family member to participate in the program was a significant predictor of disengagement from treatment.

Though familial involvement is crucial to the successful management of chronic illness (Heru, 2015), collaboration between families and mental health providers is a rare occurrence (Row 7 of Table 2, Lavoie-Tremblay et al., 2012). In a study examining the frequency of provider contact with families of individuals with SMI, Marshall and Solomon (2004, [Table 2, Row 8]) reported that the majority of mental health providers (including psychiatrists, psychologists, and social workers) reported no contact with the families of their patients. Further, over half of the providers surveyed reported that they rarely or never gave information to family members regarding the patient's diagnosis, medications, or prognosis, and indicated that relatives were rarely involved in treatment planning (Marshall & Solomon, 2004). These observed trends may be particularly impactful among racial/ethnic minorities who are more likely than Whites to live with family members (Snowden, 2007) and who demonstrate higher rates of medical and psychosocial treatment adherence when family members are included in treatment (García et al., 2006; Kopelowicz et al., 2012). As such, the exclusion

of families from treatment may discourage patient engagement and reduce adherence in this population and thereby contribute to health disparities.

Promoting Family Involvement

Research suggests that the limited collaboration between medical and mental health treatment providers and family members of individuals with SMI may be in part due to medical education curriculum guidelines which provide limited information regarding how best to involve family members in treatment planning (Riebschleger et al., 2008). As such, the educational experiences of mental health professionals, such as psychiatrists, primary care physicians, and psychologists, may not prepare them for working with families of individuals with mental illness (Riebschleger et al., 2008). In order to address this gap in knowledge and experience, it is recommended that medical education curriculum guidelines include education on family stigma and burden; family stress and coping; the importance of familial support; information exchange with family members; and the provision of family psychoeducational interventions for mental illness (Riebschleger et al., 2008).

Additionally, within already established medical settings, such as hospitals and/or clinics, developing an atmosphere which welcomes familial support and participation in treatment planning may serve to increase familial involvement and therefore enhance engagement among racial/ethnic minorities with SMI. Specific interventions may include the identification of family support persons during the initial intake procedure; providing psychoeducational materials which can be shared with family members; including family members in psychiatry visits; and providing access to family psychoeducational programs (Heru, 2015). These interventions may not only serve to enhance familial involvement, and therefore patient engagement in treatment, but may also benefit providers who gain a better understanding of psychosocial history, familial interactions, and family functioning. In inpatient facilities, including a treatment provider with family therapy training who is involved in all stages of treatment (e.g., admission, assessment, therapy, and post-discharge follow-ups), may improve family engagement during the inpatient stay and post-discharge (Row 16 of Table 3, Stanbridge, Burbach, Rapsey, Leftwich, & McIver, 2013). This approach may represent an avenue for providers to increase familial involvement even within more structured inpatient settings.

Within community settings, the provision of family-focused treatment and psychoeducational programs has demonstrated effectiveness in assisting racial/ethnic minority patients and their family members in managing SMI (Kopelowicz et al., 2012; Rea et al., 2003; Row 17 of Table 3, Weisman de Mamani, Weintraub, Gurak, & Maura,

2014; Row 18 of Table 3, Weisman de Mamani & Suro, 2016). By harnessing familial support as a therapeutic strategy, the inclusion of family members in treatment for racial/ethnic minorities with SMI may serve to improve treatment engagement and reduce dropout among patients, and also provide family members with opportunities to discuss difficulties encountered when trying to help manage the patient's illness (Heru, 2015; Whitley & Lawson, 2010). Using this strategy could be an effective and efficient approach to reducing observed disparities within this population.

Religion/Spirituality

Another prominent sociocultural variable which may impact service engagement among racial/ethnic minorities with SMI is religion/spirituality. Though these constructs can be considered separately, with religion referring to shared belief systems and distinct social/behavioral practices, and spirituality referring to broader transcendent considerations of life's meaning (Mohr, Brandt, Borrás, Gillieron, & Huguelet, 2006), in the current review we consider these constructs together as they are highly interconnected and are typically not differentiated from one another within the literature base (Hill & Pargament, 2008). Individuals with SMI commonly use religion/spirituality as a means to cope with their illness (Loewenthal, 2007; Pesut, Clark, Maxwell, & Michalak, 2011; Tepper, Rodgers, Coleman, & Maloney, 2001). Moreover, the use of religion/spirituality may be particularly prevalent among racial/ethnic minorities with SMI, who appear to engage in more religious coping when dealing with adversity when compared to Whites (Hwang et al., 2008). Though religion/spirituality has been linked to better quality of life (Shah et al., 2011a, 2011b), lower psychotic symptoms (Mohr et al., 2006), and lower rates of depression and anxiety (Rosmarin, Bigda-Peyton, Öngur, Pargament, & Björgvinsson, 2013), among SMI populations, research indicates that stronger endorsement of religious/spiritual beliefs may be associated with poorer engagement with medical and psychosocial treatment.

In a review of the literature examining the impact of religion on mental health service use in schizophrenia, Smolak et al. (2013, [Table 2, Row 13]) reported that patients and family members who identified as religious/spiritual were more likely to seek religiously/spiritually oriented services and reported caution towards conventional mental health professionals and treatments. Similarly, in a study examining 103 racially/ethnically diverse patients with schizophrenia enrolled in an outpatient public psychiatric facility, Borrás et al. (2007, [Table 2, Row 2]) found that patients who reported a spiritual/religious affiliation demonstrated higher rates of medication non-adherence when compared to patients with no religious affiliation. In a study examining the role of spiritual beliefs on illness management among

individuals with bipolar disorder, Mitchell and Romans (2003, [Table 2, Row 11]) reported that patients with, "strong" religious beliefs showed lower rates of treatment adherence to medically oriented mental health services than patients who reported, "weak" religious beliefs. These finding may shed light on the observed disparities among racial/ethnic minorities with SMI, as these groups commonly endorse religious/spiritual orientations (Hwang et al., 2008) and may be more likely to turn to religion/spirituality as a primary source of comfort and support (Weisman de Mamani, Tuchman and Duarte, 2010). Consequently, medical and mental health professionals' reluctance to discuss religious/spiritual themes when providing services (Hathaway, 2011) may inadvertently contribute to treatment dissatisfaction and disengagement, particularly among racial/ethnic minorities.

Considering Religious/Spiritual Values

Though religious/spiritual values appear to be a foundation for coping among racial/ethnic minorities with SMI, stronger endorsement of these beliefs may be associated with poorer engagement with medical and psychosocial treatments (Borrás et al., 2007; Mitchell & Romans, 2003; Smolak et al., 2013). Thus, strategies that foster these values while also engaging patients in mental health services may be particularly effective in reducing disparities within this population. It would be especially valuable to better understand how religiously/spiritually informed views of mental illness and its causes, religious/spiritual ideals and practices, and religiously/spiritually based coping strategies influence treatment engagement and adherence among SMI-racial/ethnic minority individuals. Such understanding may help identify SMI patients' beliefs and behaviors that clinicians can build on and thereby more fully engage patients in treatment and promote adherence to treatment protocols (Borrás et al., 2007). Further, knowledge of religious/spiritual orientations and beliefs may assist providers in gaining a clearer picture of nuanced differences between religious/spiritual beliefs and pathological beliefs. Viewing an SMI patient's beliefs in their cultural context can help clinicians better assess whether an SMI patient's beliefs represent delusional thought content or hallucinatory experiences, or represent beliefs that are normal within the patient's cultural context (Gearing et al., 2011). Thus, an in-depth assessment of religiosity/spirituality by providers may not only generate opportunities for reframing maladaptive religious beliefs (e.g., accepting the idea that mental illness is a not punishment from God), but also may assist providers in generating accurate diagnoses and developing treatment plans which are congruent with patients' ideals. Finally, we note that it is important for providers to assess and consider their own personal religious/spiritual orientation and to consider how

their own belief structures may result in either minimizing or pathologizing a patient's religious/spiritual beliefs and behavior (Gearing et al., 2011; Smolak et al., 2013).

Another avenue in which to consider religious/spiritual values among racial/ethnic minorities with SMI is in treatment planning. For patients and families who report a strong religious/spiritual orientation, incorporating positive aspects of religious/spiritual coping (e.g., practices, beliefs, community networks) into treatment may enhance patient engagement (Smolak et al., 2013). Other avenues to enhance engagement within this population may include the involvement of significant religious/spiritual supports in treatment, collaboration with religious mentors and/or healers, and the provision of services in non-clinical settings, e.g., churches (Row 7 of Table 3, Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003; Whitley & Lawson, 2010). Additionally, research that examines psychosocial interventions for SMI, which include religious/spiritual content, is limited, but the available literature does indicate that these interventions show promise. In a study by Phillips, Lakin, and Pargament (2002, [Table 3, Row 11]), a psychoeducational program for SMI which incorporated discussions of personal and community religious/spiritual resources, religious/spiritual goals and struggles, and themes of forgiveness and hope was well received by patients who saw value in having an open forum in which they could discuss and explore religious/spiritual beliefs. In a more recent study by Revheim, Greenberg, and Citrome (2010, [Table 3, Row 13]), a group of racially/ethnically diverse patients with schizophrenia who participated in a spirituality-based group intervention that discussed the use of spiritual beliefs to cope with one's illness reported higher rates of self-efficacy and hopefulness when compared to patients who did not attend the spirituality group. Thus, religiously/spiritually oriented treatment interventions may be effective channels in which to incorporate these values into mental health services and potentially enhance engagement among racial/ethnic minorities with SMI. However, additional research is warranted to examine the potential utility of these models in enhancing engagement and adherence to treatment among racial/ethnic minorities with SMI.

Cultural Differences in Explanatory Models and Treatment Seeking

A considerable amount of literature has examined the role that cultural beliefs may play in fostering or discouraging treatment engagement and adherence in racial/ethnic minorities with SMI. Culture refers to, "a complex and dynamic process through which shared symbols and meanings created through social interactions orient how persons think, act, and feel in the world" (Carpenter-Song et al., 2011, p. 5). One's cultural background may play a significant role in how individuals and communities conceptualize and respond to

mental illness, and thereby impact perceptions of appropriate medical, spiritual, or psychosocial interventions (Bhugra, 2006; Carpenter-Song et al., 2011; Hwang et al., 2008). Specifically, beliefs that problems are psychological make one more likely to seek psychological services; beliefs that problems are somatic make one more likely to seek primary care services; and beliefs that problems are religious/spiritual in nature make one more likely to seek religiously/spiritually oriented services (Hwang et al., 2008). These considerations are important when addressing racial/ethnic treatment disparities in SMI, as literature indicates that racial/ethnic minorities may be more likely to perceive their illness to be related to moral or religious/spiritual issues rather than being medical or psychiatric in nature (Whitley & Lawson, 2010). As such, racial/ethnic minorities may be less likely to seek mental health services, or to dropout of services, which do not consider cultural diversity in explanatory models of mental illness (Codjoe, Byrne, Lister, McGuire, & Valmaggia, 2013; Sue, 2006; Whitley & Lawson, 2010).

Empirical data have provided some support for these assertions. In a study examining how explanatory models of schizophrenia differed between racial/ethnic groups, McCabe and Priebe (2004, [Table 2, Row 9]) found that racial/ethnic minorities (Bangladeshis, African Caribbeans, and West Africans in their sample) were more likely to cite supernatural and social causes of schizophrenia, whereas Whites more often cited biological causes. These findings have also been replicated among Black African and Black Caribbean individuals at risk for developing psychosis (Row 4 of Table 2, Codjoe et al., 2013). Though less work has examined these relationships in bipolar disorder, Grover, Hazari, Aneja, Chakrabarti, and Avasthi (2016, [Table 2, Row 5]) found that in a sample of 185 individuals with bipolar disorder, approximately 50% of patients cited supernatural etiological causes for their illness. Thus, it appears that etiological models may differ among racial/ethnic groups.

Cultural differences also appear to impact treatment-seeking patterns among racial/ethnic minorities with SMI. In a study examining barriers and facilitators of treatment for Hispanic/Latinos with depression, respondents indicated that cultural differences impacted service utilization (Row 15 of Table 2, Uebelacker et al., 2012). Specifically, respondents reported that a lack of consideration of cultural differences between providers and patients, such as not providing services in one's preferred language, served as a primary barrier to seeking treatment and led to seeking traditional treatments which appeared more culturally concordant (Uebelacker et al., 2012). Culture also plays a role in the perception of symptoms as being related to mental illness, thereby having the potential to influence interest in treatment. For example, delusional thought content (observed in schizophrenia, bipolar disorder, and major depressive disorder with psychotic features) can only be labeled as such if the beliefs

are not culturally normative (Bhugra, 2006). Thus, it appears that racial/ethnic differences in perceptions regarding the etiology and presence of SMI and in preferred avenues of treatment have the potential to impact service utilization and potentially contribute to the observed disparities within this population.

Incorporating Culture

Incorporating cultural perspectives into mental health treatment has been deemed a moral and ethical responsibility of providers because factors related to culture have significant potential to impact recovery and rehabilitation (Trimble & Fisher, 2006). Such cultural considerations may be particularly important among racial/ethnic minorities with SMI who report that cultural differences between themselves and providers can serve as a primary barrier to treatment engagement and adherence (Codjoe et al., 2013; Sue, 2006; Uebelacker et al., 2012; Whitley & Lawson, 2010). Thus, increasing the likelihood that a patient's initial contact with the mental health system is culturally sensitive may not only serve to foster recovery and rehabilitation (Western Intercollegiate Commission for Higher Education, 1997) but also may foster engagement with and utilization of services for the SMI population (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009).

A primary method of increasing awareness of cultural values and beliefs within mental health systems involves promoting cultural competence in service providers. The goal of cultural competence is to, "create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture, or language proficiency" (Betancourt, Green, Carrillo, & Park, 2005, p. 1). Within medical settings, simple interventions such as asking the patient what will help them to feel respected, inquiring about cultural history and identity, and awareness of within group diversity may serve to affirm the patient's cultural experience and thereby foster trust and rapport within the patient-provider relationship (Anthony, 2003; Carpenter-Song et al., 2011; Holden et al., 2014; McCabe, Saidi, & Priebe, 2007; Yamada & Brekke, 2008). Additional strategies to improve cultural competence among providers include the involvement of family and community members, religious/spiritual supports, and indigenous providers in gathering data on relevant cultural beliefs and behaviors which may impact treatment engagement and adherence (Carpenter-Song et al., 2011). Open dialogue between providers and patients about the potential benefits and limitations of various treatment approaches is also encouraged (Carpenter-Song et al., 2011). These discussions may be aided consultation with members of patients' cultural community, including non-biomedical healers, who may assist in the development of integrative approaches in

which both modern and alternative (e.g., prayer) mental health services can be utilized by patients, thereby creating a cultural bridge which may facilitate treatment engagement and adherence in racial/ethnic minorities with SMI (Hwang et al., 2008; Kirmayer et al., 2003).

Recent work also indicates that interventions which consider and integrate cultural perspectives into the intervention may be more effective than one-size-fits-all approaches (Row 1 of Table 3, Benish, Quintana, & Wampold, 2011; Row 6 of Table 3, Griner & Smith, 2006). Several modifications have been made to evidence-based treatments in an attempt to make them more culturally integrative, including providing therapy in one's preferred language; using culturally specific phrases and metaphors to enhance understanding of content; explicit discussions of religion/spirituality; the use of the family support system to cope with mental illness; as well as attention to how cultural beliefs and behaviors may influence perceptions of mental illness and appropriate means of intervention (Griner & Smith, 2006). Thus, the inclusion of the abovementioned cultural adaptations may assist providers in more effectively adapting to the expectations, needs, and goals of racial/ethnic minorities with SMI (Miranda et al., 2005), which in turn, may enhance treatment engagement and adherence and reduce observed health disparities.

Study Limitations and Conclusions

Overall, this review indicates that racial/ethnic minorities with SMI experience significant mental health disparities reflected in diagnostic biases, reduced quality of services, poorer illness outcomes, and lower levels of treatment engagement and adherence. Several sociocultural variables have been identified as potentially contributing to treatment engagement and adherence within racial/ethnic minorities with SMI. These include stigma, mistrust in the behavioral health system, familial support, religiosity/spirituality, and cultural beliefs. Based on the literature reviewed in this paper, we offered various suggestions to improve treatment engagement and reduce attrition among minorities suffering from SMI. Table 4 summarizes these suggestions. Overall, we believe that the implementation of these recommendations in medical and community mental health settings may represent important first steps in reducing mental health disparities for minorities with SMI.

There are several limitations of the current review that should be noted. Primarily, in the current narrative review, we did not systematically evaluate methodological aspects of the studies described. As a result, we cannot speak to the quality or methodological rigor of the empirical studies discussed. Further, though substantial efforts were made to include all pertinent literature in the current review, several studies (e.g., those not available in English or those not

published in peer-reviewed journals) may have been missed. As such, the results of the current review should be interpreted with caution.

Additionally, throughout the current review, we utilized the broad term racial/ethnic minorities to describe all individuals who represent racial, ethnic, and/or cultural minorities, which is actually a quite heterogeneous population. We used this term because the literature, as it stands, does not typically distinguish between these groups individually. In fact, within the literature, comprehensive racial/ethnic demographic data are quite sparse. Analyses specific to particular racial/ethnic subgroups, and analyses that allow comparisons between different minority subgroups, are rarely reported. We recognize that use of the term racial/ethnic minorities may serve to artificially group together a very diverse group of individuals, and so we see this as a primary limitation of the current review.

As a means to compensate for the SMI literature not differentiating between racial/ethnic subgroups, whenever possible, findings specific to various racial/ethnic subgroups were presented and discussed in detail. This analysis demonstrated that much of the work examining racial/ethnic disparities in SMI has focused on the experiences of Blacks, who have been shown to be more likely to be involuntarily hospitalized (Barnes, 2004); more likely to be diagnosed with schizophrenia (Barnes, 2008); more likely to receive higher dosages of antipsychotics (Kreyenbuhl et al., 2003; Kuno & Rothbard, 2002); less likely to receive regular outpatient care (Fontanella et al., 2014; Horvitz-Lennon et al., 2009; Kilbourne et al., 2005; Wang et al., 2002); more likely to drop out of mental health treatments prematurely (Fortuna et al., 2010; Fischer et al., 2008); and, when in treatment, to show poorer outcomes when compared to Whites (Chinman et al., 2000; Eack & Newhill, 2012). Thus, it appears that for Blacks, disparities in treatment outcomes and adherence are widespread, i.e., they present in medical, psychiatric, and community settings. Though some of the abovementioned findings have been replicated among other racial/ethnic subgroups, e.g., Hispanics/Latinos and Asians are more likely to be hospitalized (Snowden & Hu, 1997), more likely to be provided with a schizophrenia spectrum diagnosis (Blow et al., 2004; Buchanan & Carpenter, 2005; Choi et al., 2012), and less likely to receive individual care than are Whites (Snowden & Hu, 1997), very little research has examined disparities among these and other racial/ethnic minorities groups, and so the experience of other subgroups remains unclear.

We recommend that future research consider examining findings for various racial/ethnic groups separately as a means to further clarify how these trends differ among individuals of various racial/ethnic backgrounds. Additionally, when possible, researchers may consider reanalyzing large published datasets (e.g., Lehman & Steinwachs, 1998;

Hamilton et al., 2011) with results partitioned for various racial/ethnic minority subgroups, so as to further elucidate how the observed disparities function within different racial/ethnic groups with SMI. This research will be particularly important to assist in efforts to tailor patient, provider, and community strategies to combat the observed disparities in ways that best meet the needs of specific racial/ethnic subgroups. As such, we encourage continued research in this area to more accurately address the needs of this particularly vulnerable population.

Compliance with Ethical Standards

Conflict of interest Jessica Maura and Amy Weisman de Mamani declare they have no conflict of interest.

Human and Animal Rights and Informed Consent No human or animal studies were performed by the authors for this article.

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