Summer 8-12-2022

Reframing Culturally Competent Care to Improve Mental Health Outcomes Among African Americans

Jaelen Kennedy-Valdez
jkennedyvaldez@usfca.edu

Follow this and additional works at: https://repository.usfca.edu/capstone

Part of the Community Health and Preventive Medicine Commons, Other Public Health Commons, and the Public Health Education and Promotion Commons

Reframing Culturally Competent Care to Improve Mental Health Care Among African

Americans

Jaelen Kennedy-Valdez

Department of Nursing and Health Professions

MPH638: Integrated Learning Experience

8/12/2022

Table of Contents

Abstract

African Americans are continuously disadvantaged when it comes to interacting with mental health services which has been evident in the utilization of services, treatment engagement, and quality of services compared to their White counterparts (Alang, 2019). Many researchers and providers have called for culturally competent care and tailored treatment for African Americans to address barriers to access and quality of health care (Alang, 2019). In this paper, a systematic review will be conducted to assess several models that have been integrated in the U.S. healthcare settings and services. In addition, we will define the components of culturally competent care and reframe the traditional model to advance to a more "sensitive" model to more effectively address systems of imbalance and oppressions within the U.S. healthcare space. Few studies examine the implications on African American perception, service engagement, and treatment outcomes and begin to show how culturally tailored health practices can reduce bias and encourage provider-patient relations (Henderson et al., 2018). Based on the empirical evidence, implementing culturally "sensitive" care in all behavioral health services to decrease mental health disparities and improve health outcomes for African Americans using a socio-ecological systems model is called for. The goal is to begin to evaluate their impact on mental health disparities among African Americans. In addition, quantitative assessments of particular health outcomes are also warranted for future work to increase substantial evaluations of programs/interventions.

Keywords: culturally competent care, culturally sensitive care (CSC), African Americans, mental health, barriers to Access, Disparities, Systematic Review, health outcomes, socio-ecological model

Introduction

In the United States, African Americans account for only 13.4% (34 million people) of the total population (https://www.census.gov/quickfacts/fact/table/US/PST120221, accessed July 09, 2022). Within that population, 16% (4.8 million people) reported having a mental illness in the last year (https://www.apa.org/advocacy/civil-rights/diversity/african-american-health, accessed June 25th, 2022). While African Americans are no more likely at risk to experience mental health disorders than the general population, mental disorders tend to be more persistent and critical among this population (Alang, 2019). A study revealed that African Americans are also more likely to report feelings of sadness, hopelessness, and worthlessness compared to White Americans (Holden et al., 2014). Yet in 2018, 18.6% of White Americans received mental health services compared to only 9% of African Americans, which shows that African Americans are less likely to utilize psychiatric services compared to whites, and if they do, it is of lower quality (https://www.apa.org/advocacy/civil-rights/diversity/african-american-health, accessed June 25th, 2022). To assess these disparities in racial and ethnic minorities, a national survey consisting of more than 200,000 adults showed that Black-White differences in mental health care increased from 8.2% to 10.8% in 2019 (Mcgregor et al., 2019). Contributing factors include lower access to behavioral health care, low mental health-seeking, and low likelihood of receiving evidence-based treatment (Le Cook et al, 2013).

In addition, research suggest that African Americans experience higher levels of environmental stressors that stem from historical systems of oppression such as racism, discrimination, and poverty (Baumgartner et al., 2019). In fact, African Americans living below the federal poverty line are three times more likely to report psychological distress than their

white counterparts (https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-America, accessed August 4th, 2022). African Americans are overrepresented in low-socioeconomic populations and experience racism and bias, which increases cultural mistrust of healthcare systems and increases burdens on access to care and health outcomes (McGregor et al., 2019).

In response, public health researchers have called for implementation of new healthcare strategies and protocols to strengthen provider-client relations and improve mental health outcomes among racial/ethnic minorities (https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-America accessed August 4th, 2022). Culturally competent care has been recognized as a key feature for effective health care delivery and increased awareness towards underrepresented minorities to improve attitudes and knowledge among providers (McGregor et al., 2019). This has led through cultural competence training, which was developed to help explore how social determinants act as barriers to service and treatment to begin encouraging linkages to existing community-based organizations, churches, and specialized behavioral health services (McGregor et al., 2019). Training models also promote culturally competent communication to demonstrate humility and respect for the individuals experiencing these challenges. However, there are various models and designs of curricula used in healthcare settings that will require different implementation strategies to be effective.

Further, limited research has examined the effectiveness of implementing these models in health care settings and its overall impact on African American mental health outcomes. It is critical that we address the functionality and gaps of these models to best improve mental health outcomes of African Americans and other communities of color. In this paper, we will (1)

examine the features and gaps in key models and curricula frameworks of culturally competent

care and (2) recommend a new socio-ecological approach to advance models to be more

"culturally sensitive" to decrease the gaps in implementation and access to services, as well as

use better integrated treatment methods among community of color for feasible results.

Background and Literature Review: Contextualizing the Problem

Historical and Sociocultural Factors that Influence Mental Health

African Americans occupy a unique space in modern American society due to the history

of slavery and discrimination that continues to shape social, economic, and physical lives

(Noonan et al., 2016). To begin to explore the mental health of African Americans, you have to

take in account the greater historical barriers that they have had to overcome. This started with

slavery, which brought millions of enslaved African Americans through the Trans-Atlantic slave

trade to southern colonies of the United States during the late 1700s

(https://www.ncbi.nlm.nih.gov/books/NBK44251/ accessed June 10th, 2022). Over a period of

200 years, African Americans faced displacement, subjugation, and exploitation by American

people, and this continued long after slavery ended with onset of racial segregation, which made

it extremely hard for free blacks to exercise their civil rights and engage in social, political and

economic freedoms. Researchers point to the resilience and collective strength through

community to form resilience and adopt traditions and practices that have remained central to

preserving and shaping experiences of African Americans (Sloan & Schmitz, 2021).

Historical adversity, including slavery, share-cropping, and racist exclusion from

educational, political, and social spaces have contributed to contemporary disadvantages,

including poorer mental health outcomes in African Americans. The Surgeon General Report

(2001) provides an overview of a number of barriers to mental health services including stigma,

cultural insensitivity by providers, not having insurance, disjointed services, geo-spatial barriers

to cultural-specific services. These factors are connected to long-term social, and economic

stressors of mental health challenges linked to poverty, racism, and discrimination for many

African Americans (https://www.ncbi.nlm.nih.gov/books/NBK44251/ accessed June 10th, 2022).

In addition, African Americans are overly represented in high risk populations, including those

who are homeless, incarcerated, have substance abuse problems, adverse childhood experiences,

placed on welfare which has only exacerbated mental health conditions in African Americans

and prolonged these impacts (https://www.ncbi.nlm.nih.gov/books/NBK44251/ accessed June

10th, 2022).

Cultural Perspectives: Stigmatization Implications on Mental Health

Stigma in mental health can be described as the "devaluing, disgracing, and degradation

of an individual with mental health challenge by the general public" (Abdullah & Brown, 2011).

Stigma can be thought of as being a by-product of social organization of psychiatry and have

been both created and maintained through complex social structures, interpersonal and

psychological factors (Stuart, 2008). Stigma can lead to discrimination and unfair treatment of

the individual, which occurs when someone is denied access to a service or resource, or

structural discrimination where someone experiences stigma at economic, social, and

institutional levels. For African Americans, stigma has led to under-utilization of seeking out and

using mental health services and if they do, they experience an overall lower quality of

assessments, treatments, and culturally sensitive care. Bailey et al. (2011) noted that religious

beliefs, distrust of medical professionals, communication, and cultural stigma play a significant role in the uptake of mental health services. In addition, African Americans are also less likely to receive proper diagnosis and treatment that they need compared to white adults. According to a full pooled data between 2011-2015, 10.2% of African Americans reported not getting the service they needed compared to 5% of the general population who had unmet needs (Alang, 2019). Furthermore, participants in the study aged 18-25 were more likely to report stigma as a barrier towards accessing services and Black adults aged 35-49 and 50-64 had a higher odds of reporting cost as being a barrier towards access. While difference appeared in the different age groups, all participants shared similar feelings of mistrust in institutions and a fear of experiencing "double" discrimination-having a mental illness and being black in America (Alang, 2019). Thus, minorities with mental illness endure discriminatory practices as it is upheld through healthcare providers, politicians, researchers, and other numerous societal systems (Gary, 2005). In addition, the lack of representation of providers that identify as ethnic minorities continue to increase health disparities and the lack of culturally competent care in these delivery systems. The Sullivan Commission Report (2004) details the various factors that interact to produce and maintain stigma in African American communities (see Appendix A). Moreover, a similar dynamic exists with self-stigma which is where an individual may feel less valuable to society which can manifest to low self-esteem and self-efficacy to continue to take care of their health (Gary, 2005). Individuals who face this may also experience a low desire towards help-seeking behaviors and quality of treatment, which results in higher mortality and morbidity rates.

The Access Gap

African American face barriers on a micro- and macro-level. On the micro level, individuals may face not having insurance or have access to specialized care given associations between race, socioeconomic status, age, gender, neighborhood etc. (Cook et al., 2017). For example, 14.2 % of African Americans were uninsured in 2019, which is 1.5 times greater than the white population (Baumgartner et al., 2019). Particularly in the U.S., insurance benefits are covered by the employer which leave many African Americans not able to obtain medical insurance due to high levels of unemployment compared to white counterparts (6.5% versus 3.2% in 2019) (https://www.census.gov/quickfacts/fact/table/US/PST120221 accessed July 17th, 2022). African Americans are also more likely to work marginalized jobs where they are not offered coverage which increases the gap in employer-based insurance gap with 46% in African American versus 66% of the white population (Baumgartner et al., 2019). Although the gap has lowered in recent years due to the implementation of the Affordable Care Act (ACA) in 2010, which helped to expand coverage and get more individuals covered under Medicare, Medicaid, and Children's Health Insurance Plan (CHIP). It is important to recognize that health insurance is one factor to increasing help-seeking behaviors, it alone however, does not eliminate overall mental health care disparities.

More research suggests that macro-level interactions may play a significant part in the availability and access of these services. This includes the numbers of services available on a county or state level. Researchers have pointed out that mental health provider density, availability of community care centers, use of health maintenance organization (HMO) at county level contribute to "initiation of services" (Cook et al., 2017). Cook et al. (2017) assessed this

contextual level of disparities within the local and state level by first identifying that low

initiation rates were associated with low density of specialized care in low-income segregated

communities. On the other hand, he and fellow researchers also identified that even in areas of

high density of specialized mental health services, rates of initiation were still low which

highlights that providers themselves are reluctant to serve low income, primarily Black

neighborhoods. Moreover, compositional findings showed a significant interaction between

economic status and race/ethnicity. For example, counties with residents with lower educational

attainment and income level had lower rates of mental health access and quality services or

resources (Dinwiddie et al., 2013).

At the state-level, disparities may exacerbate issues for individuals with these challenges

due to the variability in Medicaid, for example, demographic differences, eligibility levels, co-

payments, medication coverage. According to the Assistant Secretary for Planning and

Evaluation (ASPE), as of 2021 about 30% of African Americans rely on Medicaid, a government

subsidized program that provides medical coverage to qualifying low-income groups. Issues like

proximity or availability of mental health providers that accept Medicaid play a role in

accessibility. Further, some southern states have chosen not to expand Medicaid, where the

majority of uninsured African Americans live

(https://aspe.hhs.gov/sites/default/files/documents/08307d793263d5069fdd6504385e22f8/black-

americans-coverages-access-ib.pdf accessed July 21st, 2022). Thus, African Americans either

uninsured or underinsured are more likely to forgo care under limited state policies. Seemingly

these interactions, as pointed out by previous literature, is complex and limited research has been

able to disentangle variables related to healthcare knowledge, resource availability, levels of

perceived racism/discrimination, provider experiences to increase access and quality of care to underserved Black communities.

A Systematic Review: Addressing Culturally Competent Care

A Concept Analysis

The models and concepts of culturally competent care are widely acknowledged and published in contemporary literature as researchers try to address more practical ways to reduce healthcare disparities that ethnic/racial minorities face. However, previous literature struggles to clearly define cultural competence and integrate these models for proper implementation. By clearly laying out these frameworks, we can begin to provide a guide for providers, clinicians, and students in healthcare settings to improve the quality of services and health outcomes for racial/ethnic minorities. Henderson et al. (2018) undertook a full analysis of running concepts in literature and then formalized the definition of culturally competent care as, "the awareness, knowledge, and the skills of healthcare practitioners to apply it to their practice". Within this framework, one cannot simply just be culturally aware of clients, it involves actively acknowledging identified issues that antecede and attribute to current disparities to obtain the positive consequences of cultural competence, as well as employ higher levels of moral reasoning in clinical decision-making in the provisions of care (See Appendix B) (Hendeson et al., 2018). The adaptation of moral reasoning can be described based on Kohleberg's model of moral reasoning, which is when morals are learned over time through experiences when an individual has to make equitable and fair decisions based on personal beliefs (McLeod-Sordjan, 2014). Similarly, Bhui et al. (2007) conducted a literature review on models of cultural

competent care using inclusion criteria that showed the implementation in mental healthcare and provided some evaluation data for service provisions or training within the United States. Papers meeting this criteria all showed key aims to increase awareness and skills among staff to show respect for a patient's cultural beliefs and attitudes about mental health services and care. This included understanding language differences, how culture influences beliefs and attitudes, help-seeking behaviors, services and retention, variations in expression of distress, etc. (Bhui et al., 2007).

Understanding The Importance

Cultural Competence acts as a learning system to begin eliminating disparities for the most vulnerable, and for African Americans, it can be a tool to strengthen provider's role in decision-making, help shape individual's perception on safety, and acceptance in healthcare settings which is critical to their mental and physical health. Culturally competent care recognizes that everyone has the right to services regardless of discrimination, bias, and historical or generational experiences that get in the way (https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf accessed July 18th, 2022). In return, this will treat the individual as a storyteller of their culture, identities, and experiences, as well as tailoring their treatment and services to meet their needs instead of a generational approach. From an organizational standpoint, this increases program planning and communication between providers, thus strengthening treatment and diagnosis through referrals. Likewise, clients are more likely to seek help when they are feeling invested in and increase retention or follow up for treatment services. It is important to recognize that there is a lot of mistrust within the African American community around mental healthcare and providers,

therefore it becomes important to invest in their perspectives and experiences within their community to provide more tailored services to empower individuals. Nonetheless, past literature has highlighted how difficult this is due to the lack of knowledge and awareness of others' cultural background, and the power structures that clinicians embody to continue to perpetuate negative stereotypes of the most vulnerable.

Teaching and Learning Outcomes

Three researchers took the discretionary approach, noting that it is up to individual professions to implement and learn cultural competence based on an analysis of how to best do that within a particular group. However, one paper (Betancourt and Green 2010) noted that provisions in education and training for students and providers should be mandatory, similar to the UK policy. In the U.S, there are currently no national policies for compulsory cultural competence education for providers or institutions, and there has been a structural push by public health professionals to bring these cultural competence training and curriculum to providers in order to increase care provisions. Moreover, Chase et al. (2018) did the most recent meta-analysis on the effectiveness of cultural competence education to assess healthcare providers and patient outcomes. Several well researched models were included such as the 3-dimensional puzzle model (Schrim & Doorenbos, 2010), Camphina-Bacote's conceptual model (Camphina-Bacote, 2002), the ADDIE model (Molenda, 2003), and transcultural assessment model (Giger & Davidhizar, 2002). Each model described different contents of their education programs using key concepts on culture, cultural competence, transcultural nursing, cross-cultural communication skills, and assessment skills. In addition, 63% of authors proposed an in-classroom learning environment, followed by an online or hybrid modalities (Chae et al., 2018).

With classroom learning, healthcare professionals would learn through lecture, discussions, roleplays, and reflective exercises. Although only two studies cited actually giving clinical feedback reports and assessments (Sequist et al. 2010).

None of the 11 papers synthesized in this research used the same evaluation method for healthcare professional or patient outcomes, which included a range of self-reported assessments, cultural competence assessment tools, and cultural competence training questionnaires—often a combination of several assessments. Overall, results showed that there were significant effects of using cultural competence intervention methods compared to control groups. For example, Sequist et al. (2010) implemented a culturally competent curriculum program for clinicians where they participated in exercises for one to two days and were assessed a month later where they reported a significant increase in the awareness of health disparities in Black Patients ($d=$ 0.44, 95% CI= 0.517-718). Comparatively, Schrim & Doorenbos (2010) theoretical model showed that there was significant increase in cultural competence awareness using a skill assessment questionnaire among psychiatric staff after receiving 1-hour online training. As for patient outcomes, two studies showed that there were no significant improvements in patient psychological outcomes and others showed conflicting results and unclear measurement tools (Sequist et al., 2016; Thom et al., 2006). For instance, Kim and Lee (2016) study showed there was an improvement in 40 immigrant women with engagement and retention with their providers after implementing cultural competency training to these providers. However, there is limited evidence in research that shows that cultural competence education given to healthcare providers have a significant impact on patient outcomes, and when there were reported outcomes, there was a lack of consistent measurement (Kim & Lee, 2016).

Cultural Competence Models and Study Objectives

Essentially, there are many culturally competent models because the ideas surrounding 'culture' have been well researched since the 1950's. By comparing models we can begin to give basis to the tools researchers use to evaluate the effectiveness of culturally competent care in healthcare professionals (see Table 2). The models presented hold their value in the research community and give us a strong basis for conceptualizing cultural competence in healthcare settings but there are varying limitations that impede complete understanding and assessment of improved outcome among racial/ethnic minority populations. These frameworks represent an authoritarian approach to understanding how clinicians should provide the best care. In addition, these models focus on the knowledge of cultural awareness among providers instead of looking at which ways to increase the level of competence through more client-focused practices. Capell et al (2017) argues that cultural competence is a culturally bound construct, that should reflect the values systems and be inclusive of all people including outcomes of patient satisfaction and clinical care. Furthermore, the domains identified for each of these models do not fully measure the scope of cultural competence and limits the validity given that these models do not assess any real outcomes on clinician's perceptions or care of African American mental health patients. Therefore, a more "sensitive" model is needed to reflect the worldview and values systems relative to African Americans, as well as barriers that directly impact healthcare disparities including social, cultural, and environmental factors. Encouraging researchers to use this approach will help shift focus on providing patient-centered care rather than solely focusing on providers' cultural awareness. Therefore, in this paper we will begin a thorough review of models through history and explore weakness and strengths, while recommending a new systems approach to culturally competent care.

Table 2. Culturally Competent Theoretical Frameworks

Model Type	Description	Limitation
The Cross Cultural Adaptability Inventory (CCAI) (Davis & Finney, 2006)	This model was designed for cross-cultural training and research to evaluate a clinician's skill when dealing with a client of a different culture. It analyzes emotional resilience, flexibility, openness, autonomy and personal acuity. The assessment is used and totaled up to see what area an individual has to develop further to achieve cultural competence.	Limitation includes bias and focus on living amongst patients rather than treating them.
The Cultural Competence Assessment (CCA) (Schim et al., 2013)	This model was designed to assess cultural competence of healthcare providers and staff which is divided into two sub scales. Sub-Scale (1) addresses cultural diversity, awareness, and sensitivity, while sub-scale (2) addresses behaviors of cultural competence.	Limited evidence using this tool and has only previously been used on white healthcare professionals and not other groups, limiting validity.
The Cultural Self- Efficacy Scale (CSES) (Bernal & Forman, 1993)	CSES has cultural-specific components, unlike other tools, that look at cultural competency of nurses of all racial ethnicities. CSES is used to measure nurses' confidence level in serving members of different cultural groups.	Has potential for bias and unclear measurement tools for assessment, as well as definitions for racial groups, e.g."black" instead of African American
The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC) (Camphina-Bacote, 2003)	This model has been revised since its 1999 version but is a cultural tool that uses scale to measure several domains: cultural awareness,	Lack of validity with patient and clinician outcomes, as well as potential for confounding biases.

	knowledge, skill, and encounters. It can be used for all healthcare workers to measure their "eagerness" to embody cultural competence. The theoretical concept is that cultural competence is a process and learned over time, rather than a state.	

Methods

Research Question. How does the lack of culturally competent care in healthcare services contribute to poor mental health outcomes among African Americans?

Research Strategy

A literature review was conducted to synthesize a history of culturally competent care concepts and their frameworks to analyze their strengths and weaknesses in addressing healthcare disparities for African Americans and address how delivery of care can be improved among mental health providers. Research papers were retrieved from multiple databases to find relevant information on cultural competency concepts, a systematic review of cultural competent models, determinants of mental health disparities among African Americans, social, historical and environmental barriers and socio-ecological models relative to racial/ethnic minorities seeking healthcare. The literature review was also used to provide recommendations about developing a more comprehensive concept of culturally competent care and using the socio-ecological model to address the gaps in mental health care among African Americans.

Target Population

The literature review will focus on African American adults in the United States (above 18 years old), including those with or without mental illness or diagnoses.

Key Words

Search keywords include: mental health disparities, culturally competent care, culturally sensitive care, mental health AND African Americans, Barriers to Access, Help seeking AND mental health, culturally competent care AND African Americans, socio-ecological model, determinants in mental health illness, racial minorities AND mental health, mental health stigma, African Americans AND mental health stigma, healthcare education, culturally sensitive models.

Table 1. Defining Key Words

Cultural Competence Models (CCM)	The CCM are theoretical frameworks that have been derived from researchers who have defined key domains or qualities of cultural competence, and have designed tools to assess healthcare professionals in these areas (Capell et al., 2007).
Culturally Sensitive Care	A revised approach to culturally competent care that focuses on patient-centered care, implementing health care center policies, and is based on the care of the individual rather than the beliefs and attitudes of healthcare professionals (Tucker et al., 2011)
Mental Health	Refers to emotional, psychological, and social well-being. It determines the way we think and act…(Bailey et al., 2011).
Black/African Americans	One of the largest of the many ethnic groups in the U.S. Individuals come from African

	Ancestry, along with other non-Black ancestry (U.S. General, 2001).
Culturally Competent Care	Has various definitions but can be summed up as a complex interaction of knowledge, beliefs, attitudes and skills of providers to enhance cultural communication and delivery of care to culturally diverse patients (Henderson et al., 2018).
Socio-ecological Model	Systems-thinking approach that describes the complex social and environmental determinants that shape individuals' mental health and well-being (Noonan et al., 2016).
Health Disparities	Barriers that are experienced by marginalized groups that increase poorer health outcomes including behavioral and mental health (Mcgregor et al., 2019).
Mental Health Stigma	A set of negative beliefs about those who have mental illness or use mental health, this includes perceived and personal stigma (Defreitas et al., 2018).

Databases

Several Databases were used to conduct the literature review including: PubMed, CORE, RefSeek, Directory of Open Access Journals (DOAJ), MEDLINE, Google Scholar, and ResearchGate.

Inclusion/Exclusion Criteria

This review included all relevant research papers applicable to our target population and area of research. All papers were dated between 1983 and 2019. This research only included

papers from Northern America in English and excluded international literature for the purposes of our target population. In addition, studies focused on the development and effectiveness of culturally competent care and patient-centered care models that focused on providers/clinicians, students, and racial/ethnic minorities. All peer-reviewed literature was prioritized and those studies that did not have full text available were excluded.

Competencies

For the purpose of this paper, competencies were addressed to meet the criteria for areas of research. See Appendix C for more information on the goals of this paper.

Analysis Process

First, the research question was developed to frame the purpose of research for this paper, which was to see if there was an association between culturally competent care and mental health outcomes in African Americans. Then a literature review was conducted of all historical models that looked at how culturally competent frameworks have tried to address mental health disparities among racial/ethnic minorities and their implications in current mental healthcare settings. While this paper focused on African Americans, most literature focused on general racial/ethnic minorities. For this reason, we use the words "racial/ethnic" minorities to represent the generalized findings but later scoped down to discuss disparities among the African American community. After research, there was limited evidence of a comparison between all models dating back to the very first model published to date–the only author that has achieved this is Butler et al.'s (2016) comparative analysis of models that help improve healthcare disparities among ethnic minorities and individuals who are disabled. Therefore, the intention

with this research was to synthesize all culturally competent frameworks that exist in medical

research by reviewing all literature that conceptualizes a model used in real-settings, have

quantifiable or qualitative measures, and significant outcomes. The challenge was to compile a

history of frameworks, starting from the earliest researched model to the most current models

discussed in academia.

To best organize each model, a meta-table was conducted to form an analysis on each

framework including when and where they derived from, how they are implemented or

addressed, and their strengths and limitations. In addition, models that were included were

published from 1983 to 2019 and included research findings of culturally competent care on both

an individual level and organizational level. Primary findings show that there were only several

foundational models that were being compared, as seen in Table 2, which characterizes the

limitation of studies comparing few models at a time. These are four conceptual frameworks that

are the most commonly cited and have been updated and reconceptualized over years of

research. From there, recommendations were made for a more sensitive model that includes

social and ecological factors that more effectively address mental health disparities in African

Americans.

Findings

Foremost, there are a number of cultural care frameworks out there that have been used in

healthcare education and public health research but the research was condensed down to 24

models that have been either implemented in a nursing or healthcare setting, or conceptualized

for educational purposes. The aim of this analysis is to look at all culturally competent care

models whose concepts are applied in diverse healthcare settings and assess overall effectiveness

in decreasing healthcare disparities among ethnic/racial minority populations. From this

approach, we will begin to understand the gaps that introduce the need for a new approach that

factors in social and cultural barriers in mental health care among African Americans. From the

comparative analysis several limitations were found: (1) lack of specificity, (2) inconsistent

domains, (3) provider focused, (4) most models do not account for health belief systems, (5)

limited evidence of long term outcomes on health disparities for ethnic minorities, and (6) do not

factor in social environments in determining health outcomes (Butler et al., 2016). These

limitations can be summarized into several domains such as as not adequately addressing risk

factors associated with poor mental health outcomes, assuring patients feel supported by their

provider, mistreatment or perceived prejudice or racism, and perceived social stigma,

Comparative Analysis: Existing Frameworks

Name	Author	Date Published	Brief Description	Who/Where is this Applied	Strengths	Limitations
LEARN Model	Berlin et al.	1983	A tool to encourage communication between patient-provider about health belief systems, including thematic analysis on listen, explain, acknowledge, recommend, and negotiate	Healthcare providers	Focuses on the patient health belief system	Unrealistic expectations of providers to gather in-depth information about patients and hard to codify the themes in a professional setting;, do not consider socio-ecological barriers, biases, and stigma
Cultural Competence Continuum Model	Cross et al.	1989	Emphasizes the cultural strengths in all cultures and examines how providers, institutions and provider can deal with different cultures in treatment using 6 developmental stages:	Training for clinical providers	Looks at levels of different systems including community attitudes	Limited scope of the patient as an individual; looks at the top-down process of implementing cultural competence

			cultural destructiveness, incapacity, blindness, precompetence, competence, and proficiency		policies, and mainstream institutions	
Four-Step Approach to providing Culturally-Sensitive Patient Teaching	Kittler et al.	1990	Explains a four-step process of self-evaluation, pre-interview research, in-depth interviewing, and unbiased data analysis	Tool for providers in clinical settings; firstly use on dietitians in hospital settings	Get to know patients on an individual level. Has a step by step process for providers to follow	Requires a lot of effort from provider to conduct in-depth surveying of patients
Leininger Sunrise Model	Leininger et al.	1991	A systematic approach for identifying beliefs, values, behaviors, and community customs for improving delivery of care. This includes The nursing professional has to consider the patients' physical, spiritual, and cultural needs to avoid the stereotyping of patients. In addition to this is the application of cultural restructuring for more patient-centered care.	Practice tool for clinical encounters	Systems thinking approach; focuses on patient-centered care and encompasses numerous aspects of culture.	No evidence of long-term patient outcomes; This model has not been applied to other healthcare settings or have any measurable tools or assessments for improved cultural competence
Development of Ethno-sensitive Model	Borkan et al.	1991	Discusses an assessment of ethno-sensitivity in family providers to understand and gain knowledge about cross-cultural issues, as well as use communication and practice skills for improved delivery. Presents 7 stages of development starting from fear, denial,superiority, minimization, relativism, empathy, and integration.	Family Practice training	Uses an individualistic approach; views cultural competence as skills developed overtime	Acceptance and evidence of this model has been limited.
BATHE Model	Stuart et al.	1993	Focuses on providing a culturally competent environment with the listed domains: background, affect, trouble, handling, empathy	A tool for providers in clinical settings	Environmental approach	Does not take into account systematic barriers, perceptions of providers, and biases/racism
Cultural Competence Model	Culhane-Pera et al.	1997	Goals are to increase self awareness about cultural influences on both providers and patients, and	Use on physician students	Had stone provider outcomes using a pre-	Focused primarily on the provider; does not measure patient outcomes

			increase multicultural communication using 5 areas of assessment: no insight, minimal emphasis, acceptance, incorporation, and integration of cultural awareness in all areas of life		and post follow up	
ACCESS Model	Narayanasamy et al.	1999	Assess cultural competence through: assessment, communication, cultural negotiation and compromise, establishing respect and rapport, sensitivity and safety	Used for nurses in mental health	Emphasizes individual patient awareness and cultural respect when establishing rapport; reframe the provider-patient relationship	Limited evidence on patient care and patient safety
Model of Culturally Competent Health Care Practice	Papadopoulos	1998	Focuses on the how the provider has to move through 4 stages: cultural awareness, knowledge, cultural sensitivity and competence	Used for all healthcare professionals	Describes the individual patient of being "true partners" with providers and ways providers can be supportive allies	Trouble codify key domains and assessing them in a real setting
Taxoconomy for Culturally Competent Care	Lister	1999	Looks at the cognitive, behavioral, and social taxonomy. Proposes 5 domains: cultural awareness, knowledge, understanding, sensitivity, and competence	Developed for clinical practitioners	Could be used for curriculum in the classroom because it discusses address power dynamics of practitioners and examine complex interactions between social groups	Does not account for other social groups such as socioeconomic class and gender
ETHNIC Model	Levin et al.	2000	Presents a framework for communication by asking questions in the following areas: explanation, treatment, healers, negotiation, intervention, and collaboration	Used a communication tools for providers	Allows for patient-centered conversation	Does not account for the socio-ecological systems that play a role in services

9 Cultural Competent techniques/reducing disparities	Brach & Fraser	2000	Overview 9 cultural competence techniques to help reduce disparities in clinical treatment	Toll for facilitating services for providers	Shows direct guide of communication, easily applicable in different settings	Model focuses solely on the provider side, limited evidence on the influence of the patient's complex systems of race, culture, gender, etc.
Transcultural Assessment Model	Giger & Davidhizar	2002	Treats culture as a unique system that can be divided in 6 domains: communication, space, social organization, time, environmental control, and biological variation. Each domain requires health professionals to be aware that patients are influenced by social, cultural and biological factors.	All healthcare professionals in a clinical or research setting	Highlights culture as a system that can be complex and interact with health needs. One of the first models to factor in environment and biological determinants	limited evidence of how to implement or assess providers; Does not take in account into perceptions of healthcare professionals only the individual
Purnell Model	Purnell	2002	This model looks at factors of community, family, and person. It is divided into twelve domains that Purnell considers to be important when evaluating different ethnic groups: overview, heritage, communication, family roles and organization, workforce issues, bio-cultural ecology, high-risk behaviors, nutrition, pregnancy death rituals, spirituality, healthcare practices, and healthcare professionals.	This has been applied to nurses and pre-med students	Recognizes the dynamics between the community, society, all the way down to the individual. Also includes the power dynamics between culture and experiences against a traditional medical model.	Fails to take into account the of ecological barriers; does not discuss how to implement this in healthcare settings or in an educational setting; does not account for bias and stereotyping

Model of Cultural Competence	Campinhina-Bacote	2002	Model was first developed in 1998 and later updated in 2002. The concept of cultural competence can be defined as a process to achieve quality and equitable care. The model delves into five areas of focus: cultural awareness, cultural skill, cultural knowledge, cultural encounter, and cultural desire.	Healthcare professionals in all settings	Highlighted key features such as cultural desire and cultural awareness which is the willingness and capability to best serve patients regardless of their own biases; uses an standardized assessment tool	Relies on the overreliance on the desire to interact with patients; does not measure patient outcomes or satisfaction with delivery of care
GREET Model	Chong	2002	A culturally competent framework for non-native populations, specifically Latinos. Addresses language, nationality, race, class, and cultural perceptions as factors in disparities in healthcare.	Explains how cultural values can affect communication among providers; analyzes factors such as health beliefs systems within this population	Has a great analysis of the complex interactions of factors dealing with Latino populations and their uptake of direct services	Limited evidence that this works on other cultures; low reliability; does not account for variability within different social groups
BESAFE Model	McNeil	2003	A framework that looks at the pluralistic content of culturally competent care based on 6 elements: barriers to care, ethics in cultural care, sensitivity of the Provider, proper assessment based on cultural determination, awareness of physiological and ethno differences and encounters	Primarily used in HIV prevention but can be applied to all providers in healthcare settings	Framework developed for African Americans in primary care settings; assess the relationship between patient and provider as a process of cultural understanding	Dependent on prior awareness of one's culture; Limited evidence that this has worked across different environments/ecological contexts

Explanatory Models Approach	Kleinman & Benson .	2006	Examines 6 approaches clinicians can use to approach dialogue among patients. Providers are suggested to use a "mini-ethnography" in a series of steps: Ethnic identity, what's at stake, the illness narrative, psychological stress, influence of culture on clinical approach, and contextualizing problems of cultural competence.	Healthcare providers	Concentrates on asking individuals their experiences in healthcare, which clinicians can use to provider more informed treatment and form equitable decisions; feasible steps	Has not been implemented in real healthcare settings
CRASH Model	Rust et al.	2006	Training competency program for clinicians that focuses on 7 elements: importance of culture, respect, assess/affirm within-group differences, sensitivity, self-awareness, humility in practice	All medical professionals and students	Helps build confidence and skills to help providers communicate cross-culturally; demonstrates the necessity to look at the self-driven awareness and dominance of power. Also assesses factors of culture such as language, education, family, power/status, and acculturation	Limited evidence in the outcome of implementation within clinical settings; further research needed to assess, intermediate and long-term outcomes

3-D Puzzle of Culturally Congruent Care	Schim et al.	2007	The 3-D model looks at the concepts and relationships of "culturally congruent care", which is a holistic construct characterized by meanings, negotiated experiences, mutual understandings, and respect. It proposes four main constructs focusing on the provider: cultural awareness, diversity, sensitivity, and competence.	Has been formulated for nursing and healthcare settings	Recognizes cultural competence as a learned process that requires time and skill, as well as personal depth to meet the needs of diverse patients. Also asserts that affiliation, socialization and marginalization are essential for awareness.	This model is still in the early stages of development and does not have any evidence that it works in healthcare settings; Lacks individualistic approach
Cultural Empowerment Model	Garret et al.	2008	A model that assesses 6 domains: facilitating language, negotiating family involvement, understanding patient beliefs and outcomes, respect, negotiating care, and providing systems that are culturally competent. Integrates previous concepts of competency, culture, and awareness.	Healthcare providers	More of a systems approach to thinking about cultural competence. It empowers the individual and highlights the importance of systems of power.	Relies on negotiation between provider and patient. Does not have a clear way of implementation in all healthcare settings
Disability Disparities Model	Lewis	2009	One of the only models to focus on the intersection of disability and ethnic identity. It includes 5 macro and micro level concepts including help seeking tradition, the level of provider competence, patient-provider trust, and extent outcomes align with culture.	All healthcare providers	Model provides a conceptual framework for reducing healthcare disparities among disable patients. Recognizes both individual and societal factors that shape provider relationships.	Lack of attention to cultural and contextual factors, as well as assumes equitable access to resources.
QIAN Model for Cultural Humility	Chang et al.	2012	The QIAN model is based on cultural humility and	All Healthcare providers but has	Highly adaptable	Curriculum only looks at provider-

			Chinese philosophy, which has been divided into several curriculum domains: the importance of self-questioning, bi-directional cultural immersion, mutually active listening and process of negotiation.	primarily been used in Chinese healthcare systems	across cultures and a curriculum that could be implemented to enhance knowledge, appreciation, and skills.. Integrates the importance of family, health care systems and community.	patient dyad and not the other social, cultural, and environmental interactions; Lacks reliability
Cultural Competemility Model	Camphina-Bacote	2019	An intersectional approach of cultural "humility" and "competence" that examines the intersections of race, gender, and differences as it relates to individual lives', social practices, institutional arrangements, and other systems of power. By examining these interactions healthcare providers can bridge together differences between provider and patients for better outcomes	For all healthcare providers in clinical settings	Using an intersectional approach allows for valuable discussion and collaboration between healthcare providers and their patients; addresses the organizational and individual perspectives and how they engage within these systems	Hard to codify certain elements of this framework such as cultural awareness, desire, and knowledge

Discussion

Culturally competent care remains an operative system for dealing with different cultures and perspectives. As a result of creating this meta-analysis, several themes were synthesized from the included literature: (1) providers are key to shaping communication, (2) culturally competent care skills are the basis for awareness and checking system beliefs, and (3) culturally competent care is pluralistic and can be synthesized based on the provider/patient relationship. From 1980-200, models focused on distinct categories or steps of how one was supposed to

"become" culturally competent. It focused on areas of recognizing racism and seeking

reconciliation through both awareness and skill-based communication and treatment. There was

little evidence on how these models truly affect communities of color or how to apply these

teachings across various settings. Though, this has formed a foundation for research and allows

other prominent frameworks to derive new understandings relative to healthcare delivery for

minority populations. From 2000-2007, models began to develop more nuanced structure,

terminology, procurement and implementation for healthcare professionals. This is also the time

where organizations in the United States started to promote mandatory cultural competency

education for incoming healthcare professionals, particularly among nursing students. While

there are no mandatory federal laws requiring students and/or providers to have culturally

competent training. Many organizations during this time all had their own set of training that

attempted to advocate for cultural competency in some shape or form and researchers started to

examine social and environmental factors that influenced patients' care.

      Thus, the introduction of cultural humility, empathy, and empowerment. Many models

started to look at micro- and macro-levels of influence and draw conclusions based on different

cultures that they worked with. An outcome of this was that patients' felt more 'secure' with

treatment when providers worked with them, their families, and used similar communication

levels. From 2012-2019, there was a shift in adding more environmental contexts, in which

providers were suggested to examine their systems of power from an individual and

organizational standpoint. The most recent model, "cultural competemility" compiles earlier

ideas together of "humility" and "competence" to form an integrative approach of forming

relationships with people of various identities. The outcomes of comparing these models focus

on concepts because quantitative data merely exists and direct implementation has only focused

on focus groups. Together these model conclude that providers' beliefs can be changed with a more integrative approach and the need for evidence-based outcomes are important for substantial outcomes.

Gaps in Models

The primary interventions included professional staff training and group-focused activities such as mentoring or supervisory fieldwork. The wide range of concepts explored represent the lack of consistency with key terms and assessment tools across the explored forms of intervention which has led to limited analyses, measurement, and improvement of outcomes among diverse patients. For instance, there was an inconsistency in terminology for cultural competency, cultural awareness, cultural knowledge, and respect which makes it challenging to address how effective each model is in increasing cultural knowledge.

Another common criticism among the models is that they have been developed for a specific type of providers or healthcare settings, most commonly nursing professionals, which limits the generalizability of these models. In addition, most of these frameworks assume that everyone has access to the same resources and that communication between patient and provider is framed upon cultural knowledge or awareness, which undermines the complex interactions between individuals, providers and their environments. For instance, 9 out of the 23 articles describe the ability for providers to use their "desire" to learn skills and use previous interactions to form understandings around culture, assuming that they have these interactions and are always acknowledging their own "systems of power". While this may be true for some— it is invalid to assume that all providers are willing to learn at the will to help ethnic minorities.

Both Chang et al. (2012) and Garret et al.(2008) were able to highlight these complex interactions from using a more precise systems approach. While other researchers created set domains to describe the skills that a provider must learn in order to achieve cultural competence. Jongen et al. (2018) describes this as using "categorical approaches" which can tend to ignore inter-group variability and increase cultural misunderstandings. By creating domains, researchers face using institutionalized terms and approaches to describe individual experiences. It is important to look directly at patients on their socio-cultural perspectives to create more impactful interactions and services.

On the other hand, models that used a more "cross-cultural" approach looked more at how the interactions between health beliefs, personal, and social experiences influence provider-patient interactions (Jongen et al., 2018). These models have used more individualistic approaches and emphasize the importance of removing power dynamics but they do not have clear evidence of implementation in healthcare settings or quantifiable outcomes. Only a few studies have reported a significant change in behaviors related to knowledge and skills after implementation of training which is important to assessing effectiveness of desired outcomes by each model. Moreover, researchers fall short of describing the importance of racism, bias, stigma, and marginalization by not articulating how they are forms of barriers from an individual to societal standpoint. The lack of attention to these issues in the training curriculum undermine all goals of forming meaningful relationships and reducing healthcare disparities.

Recommendations

Meeting Mental Healthcare Needs

To address the gaps in mental healthcare needs among African Americans, this paper proposes to use a culturally sensitive framework that emphasizes patient-focused care, creating a patient-provider relationship based on understanding and trust, and a process of actively re-empowering the individual to decrease barriers and stigma. The difference between *cultural sensitivity* and *cultural competence* is that sensitivity improves on the idea that cultural contexts and altering health care delivery is based on a bi-directional relationships of the provider-patient, with active use of recognizing the individual as its own complex system. This framework has been cited several times in literature as an integrative approach of previous categorical and cross-cultural models, however it shifts the focus onto the patient rather than the provider (i.e. psychologists, physicians, nurses). By definition, culturally sensitive care uses interpersonal skills to acknowledge the patients' concerns and take all aspects of their background in account (Sperry, 2010). Healthcare providers, students, and staff are called on to assess their own attitudes and beliefs in their delivery of services to meet the needs of patients (Tucker et al., 2011). One of the mechanisms of culturally sensitive care is to link healthcare disparities to the complex systems that individuals interact with on a daily basis (i.e. their individuals beliefs and biological linkages, their neighborhoods and communities, interactions with providers and institutions, societal and policy standards), which can be illustrated through the socio-ecological model (see Figure 1). This framework aims to show the complex interactions between systems that can both increase or decrease the likelihood of seeking mental health care. For example, for

African Americans you have to account for racism, stigma, and marginalization within society

that impedes treatment seeking, diagnosis, and care.

Using culturally sensitive care training can help promote trust in patient-provider

relationships, which can enhance patient satisfaction with care. This model has shown an

observational increase in interpersonal control and a decrease in stress levels (Tucker et al.,

2018). It has also shown significant direct effects of confidence and comfort among African

Americans after providers received a comprehensive training program with a culturally sensitive

curriculum. The training itself can be implemented through digital tools or in-person assessments

but can be done over periodic basis to make sure that providers are meeting the needs of their

patients. The importance of culturally sensitive care relies on the need for assessing the patient as

their own individual with varying experiences and identities relating to their mental health. In

return, this works to decrease assumptions or bias about other people's cultures.

The goals of the culturally sensitive training are to first gain adequate knowledge of the

current state of cultural competence in the organization, which is the process of finding where

healthcare disparities exist within the system. The organizations can develop tailored training

plans, use focus groups and assessments to identify their own beliefs to build cross-cultural

awareness. Secondly, scenario-based training with key topics on stigma and racism should be

covered to address how these function in both organizational and individual spaces. Even after

the training phase, organizations should continue building knowledge about the local populations

that they serve. Specifically in African American communities, clinicians should learn about

resources and tools available in the community that can help form stronger relationships, i.e.

churches and local community centers. This is an integrative approach of using all providers like

therapists, psychologists, psychiatrists, and social workers to help increase access and utilization

of services. Third, culturally sensitive care seeks to develop strong communication utilizing the

clients' perspective. This includes creating dialogue with clients on common goals with their

care, understanding the clients' process of dealing with mental health or other issues,

establishing understanding and respect, as well as validating their experiences (Lynam, 1992).

Essentially, cultural sensitivity shifts the paradigm of just being aware of "different cultures" and

instead aims to help providers focus on individual empathy, empowerment, and quality of care.

Case Illustration

Sperry et al. (2010) used a case study to examine the strategies of using culturally

sensitive care. In his analysis, he tells a story of his encounter with a 23 year old Black male,

named Marcus, who visited a White mental health counselor due to experiencing signs of

depression. Marcus shared with the counselor that he experienced increased isolation, low

energy, and hypersomnia (Sperry, 2020), which he acknowledges may be a part of him drawing

from law school and experiencing racism at school. In the initial consultation, the mental health

counselor used the explanatory model to allow Marcus to express his beliefs and experiences

around depression. After this a care plan was written and followed up with interviews from

Marcus' mother and sister to better understand the dynamics of his personality. Afterwards, he

referred Marcus to a physician to get a medical examination which showed he was also

experiencing hypothyroidism, which has common symptoms of low energy and feelings of

sadness. The mental health counselor considered factors of individual health, cultural dynamics,

and social experiences to develop an effective treatment plan. In addition, they added another

black counselor to be a part of his treatment to increase culturally sensitive care. The author

outlined several importance factors that made this intervention successful in implementing

culturally sensitive strategies (Sperry, 2020):

1. Identify the patient's identity, personality, level of acculturation, beliefs and experiences
    prior to treatment in a respectful and understanding manner

2. Identify socio-ecological influences of treatment and care (i.e. family dynamic,
    relationships with mentors, organizational barriers, school and neighborhood interactions,
    etc.)

3. Develop a care plan tailored to that individual and can be used to address contextual
    issues of stigma, racism and personality dynamics

4. Culturally sensitive care can be molded to fit the individual and it is viewed as an on-
   going process with clinicians

Using Socio-Ecological Model to Understand Barriers

The culturally sensitive model considers complex interactions of the individual, family,

community, and society that contribute to health care disparities (CDC, 2020). To best

understand how to provide culturally sensitive care, providers should be aware of all the

systemic barriers. The first system level is the various factors that influence individual health

such as health beliefs, biological/genetic factors, stress and coping responses. Individuals may

have underlying predispositions that make them more susceptible to mental health disorders and

coping strategies may vary based on experiences and beliefs. For example, African American are

more likely to have strong coping skills due to historical and cultural factors. The second level

looks at relationships that may be a source of support for the individual and influence their

behavior and experiences (CDC, 2020). For example, this could be peers, partners, family,

mentors, and teachers. African Americans who do not have strong support systems are more

likely to experience poor mental and physical conditions across their lifetime (Alang, 2019).

Moreover, the third level assesses how organizations interact to help increase health care

services, resources, and access for individuals. It also explores how local clinicians and providers

can support the health care needs of diverse populations. For African Americans, interactions

between church, spiritual services, and community centers create safe spaces for individuals to

live, learn, and work but also the collaboration between these organizations to promote health

and wellness.

The fourth community level examines the physical and social environment that shape an

individual's social wellbeing. This includes interaction with schools, neighborhoods, housing

conditions, and social environments. This is important to consider because there may be a lack of

resources and access to mental health resources or service within communities. In addition, poor

social environments can contribute to stigmatization and marginalization of its members. The

last level represents the society and policies that can influence the way people uptake and

navigate mental health care. Society plays a large role in establishing social norms, standards of

health, education, and help maintain social inequalities. Ethnic minorities tend to receive less

resources and lower employment and educational opportunities. The policies that govern our

society perpetuate health and economic qualities for African Americans and other marginalized

populations.

Figure 1. Addressing Mental Health Barries Using Socio-Ecological Model
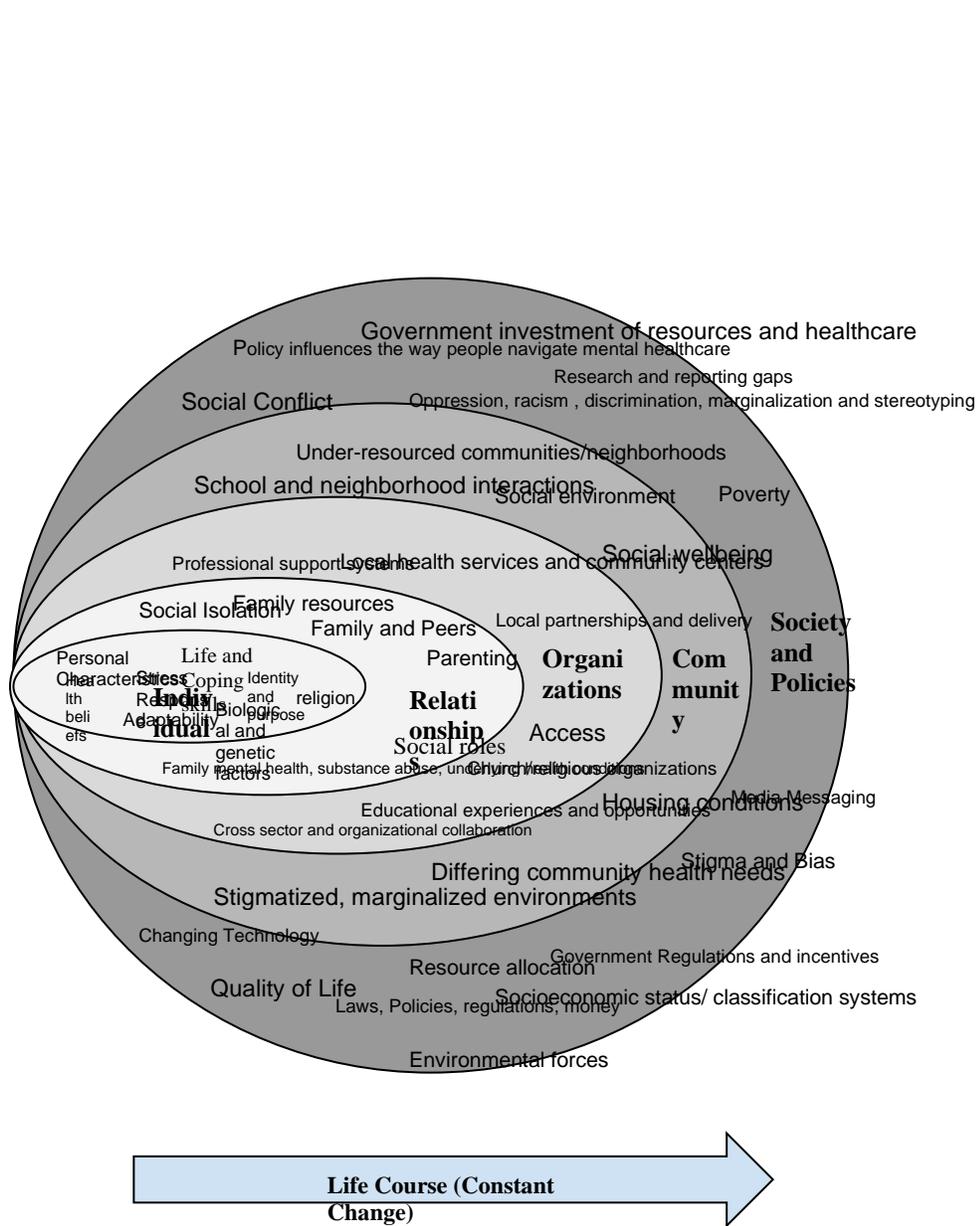
Implications and Future Research

This paper provided a comprehensive literature review of all published culturally competent models in literature to improve comparative evidence for both harms and benefits of using each concept. This comparative analysis can help provide researchers and decision makers on the net benefits of using each model, and assess areas of improvement and implementation. For instance, an unintended consequence of using culturally competence interventions is that providers may actually start to use different communication scripts depending on the patient that they are working with or categorize people based on their culture when trying to reduce negative stereotypes and bias (Lynam, 1992). Creating interventions that best fit healthcare settings remains challenging for decision makers due to the elusiveness of cultural competence. Hence, researchers have suggested new terminology such as cultural responsiveness, cultural sensitivity, cultural humility, and cultural competemility to drive more effective approaches and restructure frameworks to focus on skills, knowledge, and communication in various healthcare settings. While there is no "one size fits all model", culturally sensitive care is a framework that has shown the strongest link between individual care and positive health behaviors and outcomes (Tucker et al., 2012). In addition, previous research has shown that utilizing this approach was positively linked to high levels of patient satisfaction when providers invested in patients' complex lives by providing more information, tailoring treatment plans, incorporating family or friends, understanding previous conditions or diagnoses, integrating multiple clinicians, etc. (Tucker et al., 2012).

The first culturally sensitive model was developed to increase patients' adherence to treatment plan recommendations (engagement in healthy lifestyles, dietary adherence, and

medication adherence) and improve long term health outcomes among minority patients (Brody et al., 1989). The model was tested to see the variability in patient-perceived cultural sensitivity, patient-perceived trust in their provider, patient-perceived satisfaction with their provider, self-reported stress, and self-report adherence to treatment plans. While this was tested on diverse groups of patients, African American had the largest increase in patient-perceived satisfaction which had a direct effect on treatment adherence. This is important because of the lack of trust in healthcare among African Americans that is intertwined in their social and cultural beliefs. Therefore, the interpersonal component of this model emerged as a key focus to increase engagement and empowerment among minority communities. The sensitive model also further suggests that this model can be used to separate study groups to assess how race/ethnicity and socioeconomic status impact healthcare outcomes (Tucker et al., 2012). This is because most models simply look at variables of interest for all groups instead of looking at race/ethnicity and socioeconomic status as factors that influence psychosocial and biological outcomes. Oyemade and Rosser (1980) would suggest that this causes more negative stereotyping and marginalization of these groups. Another finding from a focus-group study that looked at the effects of culturally sensitive care among African American participants which showed that participants experienced service providers who did not understand the complexities or social context of their lives (Woods-Giscombe et al., 2016). This resulted in patients feeling frustrated with providers and more likely to discontinue services. It is important for further research to assess the link between race/ethnicity and provider satisfaction to understand more about how it helps to promote engagement and treatment adherence.

     In addition, there is empirical evidence that implementation of culturally sensitive training can lead to improved confidence when working with communities of color. Arif et al.

(2019) conducted research to assess how to administer culturally sensitive training to

pharmaceutical students and how it can increase overall knowledge, self-confidence, and

awareness to provide quality care to diverse patients at health screenings. Other themes such as

stigma and bias were highlighted in the training and students were able to participate in focus

groups for larger discussions about systems of power and access. Unlike other cultural

competence models, the sensitive approach focuses on the process of engaging with patients over

a course of time and rather than an end product, but focuses on the emotional and cognitive

preparation (Scholes & Moore, 2000). A large aspect of culturally sensitive care is

understanding that providers must critically reflect on their own perceptions and actively suspend

their own cultural views and beliefs to best help patients. This also calls for providers to view the

context of power of which they operate in, for instance the institutions, the healthcare system,

and politics of the organization that have been historically marginalizing for racial/ethnic

minorities. Though this effort is not easy and studies have highlighted that achieving culturally

sensitive care is about setting realistic goals and creating learning objectives within individual

practices. Therefore, decision makers should be informed on the factors that contribute to

inequities in mental health services to be able to address them in their course curriculum and

training programs for future health professionals.

Limitations

        Like other frameworks, culturally sensitive models are still evolving and still are not

enough to look out all complex outcomes that African Americans face in healthcare. One

limitation is that there is limited research in the application of culturally sensitive frameworks in

literature and as a result, unclear implementation strategies in mental health settings. This also

increases variability in outcomes that are not consistent across literature. Another limitation is that there is limited research looking at the intersections of race and mental health diagnosis on the delivery of culturally sensitive care. In addition, several studies have noted the importance of spirituality and use of faith-based practices to increase African American engagement with behavioral health services, but limited data has discussed measurable outcomes. This model also assumes that providers are willing to acknowledge and dismantle their previous notions of culture and beliefs, which is not always valid and delivery of care may still result in bias and further marginalization of diverse populations.

Future Research

To fully understand culturally sensitive care, future research is needed to assess the data and outcomes associated with ethnic differences and mental health conditions. This should include a large national representation and comprehensive epidemiological analysis with key variables (e.g. neighborhood/region, income level, race/ethnicity, age, mental health symptoms or diagnosis, health insurance status, and type of treatment or service modality)(Woods-Giscombe et al., 2016). Evidence-based research is important to help draw on effective strategies that can be implemented across various health settings to optimize clinical training and care services. More research should also look into the best way to implement culturally sensitive models to provide a distinct guide on how institutions and clinics should train and assess their faculty over a period of time. This will allow for more consistency across practices and research.

Conclusion

In conclusion, African Americans face a multitude of barriers when it comes to seeking care and working with mental health providers. Racial gaps in treatment and access in mental health services have been attributed to structural, cultural, and systemic barriers faced by racial/ethnic minorities (Lee et al., 2021). Mental health providers and various healthcare modalities have been called upon to provide better culturally competent care, which is the skills, communication and knowledge to best serve diverse populations. However, gaps in models and its outdated approach shifts the focus for providers to focus on culturally sensitive care, which is a patient-focused framework where providers tailor treatments to meet the needs of individuals. The culturally sensitive framework aims to provide a systems-thinking approach where providers consider individual, community, and societal factors as influences on the uptake of care. This aims to show that just relying on clinical training and curriculum is not sufficient enough and in order to create change, one must undergo critical self-reflection. This is an important aspect to building provider-patient relationships and reducing racism and bias in mental health care services. This paper aims for students, researchers, and public health professionals to begin to rethink health care delivery and access, as well as promote cross-cultural understandings that are needed in contemporary literature.

References

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: an integrative review. *Clinical psychology review*, *31*(6), 934–948. https://doi.org/10.1016/j.cpr.2011.05.003

Alang S. M. (2019). Mental health care among blacks in America: Confronting racism and constructing solutions. *Health services research*, *54*(2), 346–355. https://doi.org/10.1111/1475-6773.13115

American Psychological Association. (n.d.). *African Americans have limited access to mental and Behavioral Health Care*. American Psychological Association. Retrieved July 16, 2022, from https://www.apa.org/advocacy/civil-rights/diversity/african-american-health

Arif, S., Wang, S., Lakada, I. Y., & Lee, J. Y. (2019). An Elective Course to Train Student Pharmacists to Provide Culturally Sensitive Health Care. *American journal of pharmaceutical education*, *83*(8), 7027. https://doi.org/10.5688/ajpe7027.

Bailey, R. K., Patel, M., Barker, N. C., Ali, S., & Jabeen, S. (2011). Major depressive disorder in the African American population. *Journal of the National Medical Association*, *103*(7), 548–557. https://doi.org/10.1016/s0027-9684(15)30380-1

Bernal, H., & Froman, R. (1993). Influences on the cultural self-efficacy of community health nurses. *Journal of Transcultural Nursing*, *4*(2), 24-31.

Betancourt, J. R., & Green, A. R. (2010). Commentary: linking cultural competence training to improved health outcomes: perspectives from the field. *Academic medicine : journal of the Association of American Medical Colleges*, *85*(4), 583–585. https://doi.org/10.1097/ACM.0b013e3181d2b2f

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. *BMC health services research*, *7*, 15. https://doi.org/10.1186/1472-6963-7-15

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical care research and review : MCRR*, *57 Suppl 1*(Suppl 1), 181–217. https://doi.org/10.1177/1077558700057001S09

Brody, D. S., Miller, S. M., Lerman, C. E., Smith, D. G., Lazaro, C. G., & Blum, M. J. (1989). The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. *Medical care*, *27*(11), 1027–1035. https://doi.org/10.1097/00005650-

N.d. *Black/African Americans*. National Alliance on Mental Illness. (2022). Retrieved August 4, 2022, from https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American

Campinha-Bacote, J. (2003). Cultural desire: The key to unlocking cultural competence. *Journal of Nursing Education*, *42*(6), 239-240.

Campinha-Bacote, J. (2019). Cultural competemility: A paradigm shift in the cultural competence versus cultural humility debate—Part I. *Online Journal of Issues in Nursing*, *24*(1).

Campinha-Bacote J. (2002). The Process of Cultural Competence in the Delivery of Healthcare Services: a model of care. *Journal of transcultural nursing : official journal of the Transcultural Nursing Society*, *13*(3), 181–201. https://doi.org/10.1177/10459602013003003

Capell, J., Veenstra, G., & Dean, E. (2007). Cultural competence in healthcare: critical analysis of the construct, its assessment and implications. *Journal of Theory Construction & Testing*, *11*(1).

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

Centers for Disease Control and Prevention. (2022, January 18). *The social-ecological model: A framework for prevention*. Centers for Disease Control and Prevention. Retrieved July 16, 2022, from https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

Chang, E. S., Simon, M., & Dong, X. (2012). Integrating cultural humility into health care professional education and training. *Advances in health sciences education : theory and practice*, *17*(2), 269–278. https://doi.org/10.1007/s10459-010-9264-1.

Chong. (2002). *The Latino patient : a cultural guide for health care providers*. Intercultural Press.

Cook, B. L., Zuvekas, S. H., Chen, J., Progovac, A., & Lincoln, A. K. (2017). Assessing the Individual, Neighborhood, and Policy Predictors of Disparities in Mental Health Care. *Medical care research and review : MCRR*, *74*(4), 404–430. https://doi.org/10.1177/1077558716646898

Davis, S. L., & Finney, S. J. (2006). A factor analytic study of the cross-cultural adaptability inventory. *Educational and Psychological Measurement*, *66*(2), 318-330.

DeFreitas, S. C., Crone, T., DeLeon, M., & Ajayi, A. (2018). Perceived and Personal Mental Health Stigma in Latino and African American College Students. *Frontiers in public health*, *6*, 49. https://doi.org/10.3389/fpubh.2018.00049

Dinwiddie, G. Y., Gaskin, D. J., Chan, K. S., Norrington, J., & McCleary, R. (2013). Residential segregation, geographic proximity and type of services used: evidence for racial/ethnic disparities in mental health. *Social science & medicine (1982)*, *80*, 67–75. https://doi.org/10.1016/j.socscimed.2012.11.024

Garrett, P. W., Dickson, H. G., Whelan, A. K., & Roberto-Forero (2008). What do non-English-speaking patients value in acute care? Cultural competency from the patient's perspective: a qualitative study. *Ethnicity & health*, *13*(5), 479–496. https://doi.org/10.1080/13557850802035236

Gary F. A. (2005). Stigma: barrier to mental health care among ethnic minorities. *Issues in mental health nursing*, *26*(10), 979–999. https://doi.org/10.1080/01612840500280638

Giger, J. N., & Davidhizar, R. (2002). The Giger and Davidhizar Transcultural Assessment Model. *Journal of transcultural nursing : official journal of the Transcultural Nursing Society*, *13*(3), 185–201. https://doi.org/10.1177/10459602013003004

Henderson, S., Horne, M., Hills, R., & Kendall, E. (2018). Cultural competence in healthcare in the community: A concept analysis. *Health & social care in the community*, *26*(4), 590–603. https://doi.org/10.1111/hsc.12556

Holden, K., McGregor, B., Thandi, P., Fresh, E., Sheats, K., Belton, A., Mattox, G., & Satcher, D. (2014). Toward culturally centered integrative care for addressing mental health disparities among ethnic minorities. *Psychological Services, 11*(4), 357–368. https://doi.org/10.1037/a0038122

HP -2022 07 health insurance coverage and access to care among black ... Assistant Secretary for Planning and Policy. (2017, February). Retrieved July 17, 2022, from https://aspe.hhs.gov/sites/default/files/documents/08307d793263d5069fdd6504385e22f8/black-americans-coverages-access-ib.pdf

Jesse C. Baumgartner, Sara R. Collins, and David C. Radley (2019). *Racial and ethnic inequities in health care coverage and access, 2013–2019*. Racial and Ethnic Inequities in Health Care Coverage and Access | Commonwealth Fund. Retrieved July 16, 2022, from https://doi.org/10.26099/spz0-mk34

Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competency interventions: a systematic scoping review. *BMC health services research*, *18*(1), 232. https://doi.org/10.1186/s12913-018-3001-5.

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: the problem of cultural competency and how to fix it. *PLoS medicine*, *3*(10), e294. https://doi.org/10.1371/journal.pmed.0030294

Le Cook, B., Manning, W., & Alegria, M. (2013). Measuring disparities across the distribution of mental health care expenditures. *The journal of mental health policy and economics*, *16*(1), 3–12.

Lee, M., Lu, W., Mann-Barnes, T., Nam, J. H., Nelson, J., & Ma, G. X. (2021). Mental Health Screening Needs and Preference in Treatment Types and Providers in African American and Asian American Older Adults. *Brain sciences*, *11*(5), 597. https://doi.org/10.3390/brainsci11050597

Leininger M M (1991) Culture care diversity and universality: A theory of nursing. National
    League for Nursing Press, New York, NY.

Levin S, Like R, Gottlieb J. (2000).ETHNIC: a framework for culturally competent clinical
    practice. In Appendix: useful clinical interviewing mnemonics. *Patient Care;34*(9):188–
    1889.

Lewis A. (2009). Disability disparities: a beginning model. *Disability and rehabilitation*, *31*(14),
    1136–1143. https://doi.org/10.1080/09638280902773737

Lister P. (1999). A taxonomy for developing cultural competence. *Nurse education today*, *19*(4),
    313–318. https://doi.org/10.1054/nedt.1999.0642

Lynam, M. J. (1992). Towards the goal of providing culturally sensitive care: Principles upon
    which to build nursing curricula. *Journal of Advanced Nursing*, *17*(2), 149-155.

Mama, S. K., Li, Y., Basen-Engquist, K., Lee, R. E., Thompson, D., Wetter, D. W., Nguyen, N.
    T., Reitzel, L. R., & McNeill, L. H. (2016). Psychosocial Mechanisms Linking the Social
    Environment to Mental Health in African Americans. *PloS one*, *11*(4), e0154035.
    https://doi.org/10.1371/journal.pone.0154035

McGregor, B., Belton, A., Henry, T. L., Wrenn, G., & Holden, K. B. (2019). Improving
    Behavioral Health Equity through Cultural Competence Training of Health Care
    Providers. *Ethnicity & disease*, *29*(Suppl 2), 359–364.
    https://doi.org/10.18865/ed.29.S2.359.

McLeod-Sordjan, R. (2014). Evaluating moral reasoning in nursing education. *Nursing ethics*,
    21(4), 473-483.

McNeil J. I. (2003). A model for cultural competency in the HIV management of African
    American patients. *Journal of the National Medical Association*, *95*(2 Suppl 2), 3S–7S.

Molenda, M. (200) In Search of the elusive ADDIE model. *Performance Improvement,* 42(5),
    34-37.

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

Office of the Surgeon General (US), Center for Mental Health Services (US), & National
    Institute of Mental Health (US). (2001). *Mental Health: Culture, Race, and Ethnicity: A*

Supplement to Mental Health: A Report of the Surgeon General. Substance Abuse and
Mental Health Services Administration (US).

Oyemade, U. J. P. L., & Rosser, P. (1980). Development in Black children. *Advances in
Behavioral Pediatrics*, *1*, 153-179.

Purnell L. (2002). The Purnell Model for Cultural Competence. *Journal of transcultural
nursing : official journal of the Transcultural Nursing Society*, *13*(3), 193–201.
https://doi.org/10.1177/10459602013003006

Renzaho, A. M. N., Romios, P., Crock, C., & Sønderlund, A. L. (2013). The effectiveness of
cultural competence programs in ethnic minority patient-centered health care—a
systematic review of the literature. *International Journal for Quality in Health Care*,
25(3), 261-269.

Rust, G., Kondwani, K., Martinez, R., Dansie, R., Wong, W., Fry-Johnson, Y., Woody, R.,
Daniels, E. J., Herbert-Carter, J., Aponte, L., & Strothers, H. (2006). A crash-course in
cultural competence. *Ethnicity & disease*, *16*(2 Suppl 3), S3–36.

Schim, S. M., & Doorenbos, A. Z. (2010). A three-dimensional model of cultural congruence:
framework for intervention. *Journal of social work in end-of-life & palliative care*, *6*(3-
4), 256–270. https://doi.org/10.1080/15524256.2010.529023

Schim, S. M., Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally congruent care: putting
the puzzle together. *Journal of transcultural nursing : official journal of the
Transcultural Nursing Society*, *18*(2), 103–110.
https://doi.org/10.1177/1043659606298613

Schim, S. M., Doorenbos, A. Z., Miller, J., & Benkert, R. (2003). Development of a Cultural
Competence Assessment instrument. *Journal of nursing measurement*, *11*(1), 29–40.
https://doi.org/10.1891/jnum.11.1.29.52062

Scholes, J., & Moore, D. (2000). Clinical exchange: one model to achieve culturally sensitive
care. *Nursing Inquiry*, *7*(1), 61-71.

Sequist, T. D., Fitzmaurice, G. M., Marshall, R., Shaykevich, S., Marston, A., Safran, D. G., &
Ayanian, J. Z. (2010). Cultural competency training and performance reports to improve
diabetes care for black patients: a cluster randomized, controlled trial. *Annals of internal
medicine*, *152*(1), 40–46.

Sloan, L. M., & Schmitz, C. L. (2021). Resilience and the claiming of voice by marginalized
communities. In *The Palgrave Handbook of Positive Peace* (pp. 99-123). Singapore:
Springer Singapore.

Sperry, L. (2010). Culture, Personality, Health, and Family Dynamics: Cultural Competence in
the Selection of Culturally Sensitive Treatments. *The Family Journal*, *18*(3), 316–320.
https://doi.org/10.1177/1066480710372129

Stuart H. (2008). Fighting the stigma caused by mental disorders: past perspectives, present
activities, and future directions. *World psychiatry : official journal of the World
Psychiatric Association (WPA)*, *7*(3), 185–188. https://doi.org/10.1002/j.2051-
5545.2008.tb00194.x

Tip 59: Improving cultural competence. Substance Abuse and Mental Health Services
Administration. (n.d.). Retrieved July 17, 2022, from
https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf

Tucker, C. M., Marsiske, M., Rice, K. G., Nielson, J. J., & Herman, K. (2011). Patient-centered
culturally sensitive health care: model testing and refinement. *Health psychology :
official journal of the Division of Health Psychology, American Psychological
Association*, *30*(3), 342–350. https://doi.org/10.1037/a0022967.

U.S. Bureau of Labor Statistics. (n.d.). *Labor force characteristics by race and ethnicity : BLS
Reports*. U.S. Bureau of Labor Statistics. Retrieved July 16, 2022, from
https://www.bls.gov/opub/reports/race-and-ethnicity/

U.S. Census Bureau quickfacts: United States. United States Census. (n.d.). Retrieved July 17,
2022, from https://www.census.gov/quickfacts/fact/table/US/PST120221

Woods-Giscombe, C., Robinson, M. N., Carthon, D., Devane-Johnson, S., & Corbie-Smith, G.
(2016). Superwoman Schema, Stigma, Spirituality, and Culturally Sensitive Providers:
Factors Influencing African American Women's Use of Mental Health Services. *Journal
of best practices in health professions diversity : research, education and policy*, *9*(1),
1124–1144.

Appendices

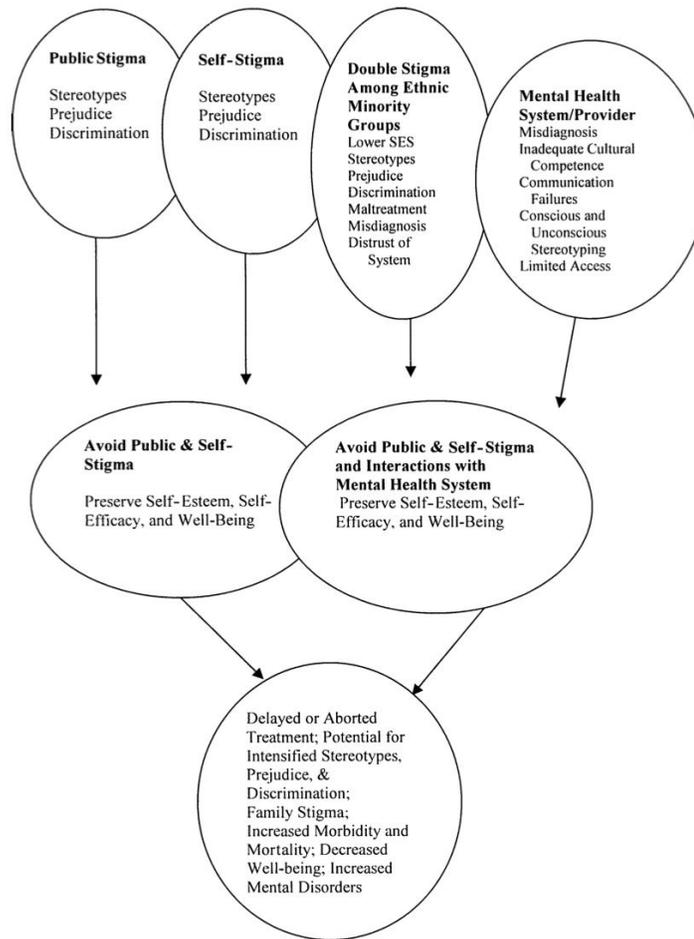**Appendix A. Thematic Analysis of Stigma on Ethnic Minorities**

FIGURE 1. Sources: Corrigan, 2004b; Corrigan, River Lundin, Penn, Uphoff-Wasowski, Campion et al., 2001; Gary, 1991; Lefley, 1989; Rowe, 2005; Smedley, Stith, & Nelson, 2003; U.S. Department of Health and Human Services, 1999.

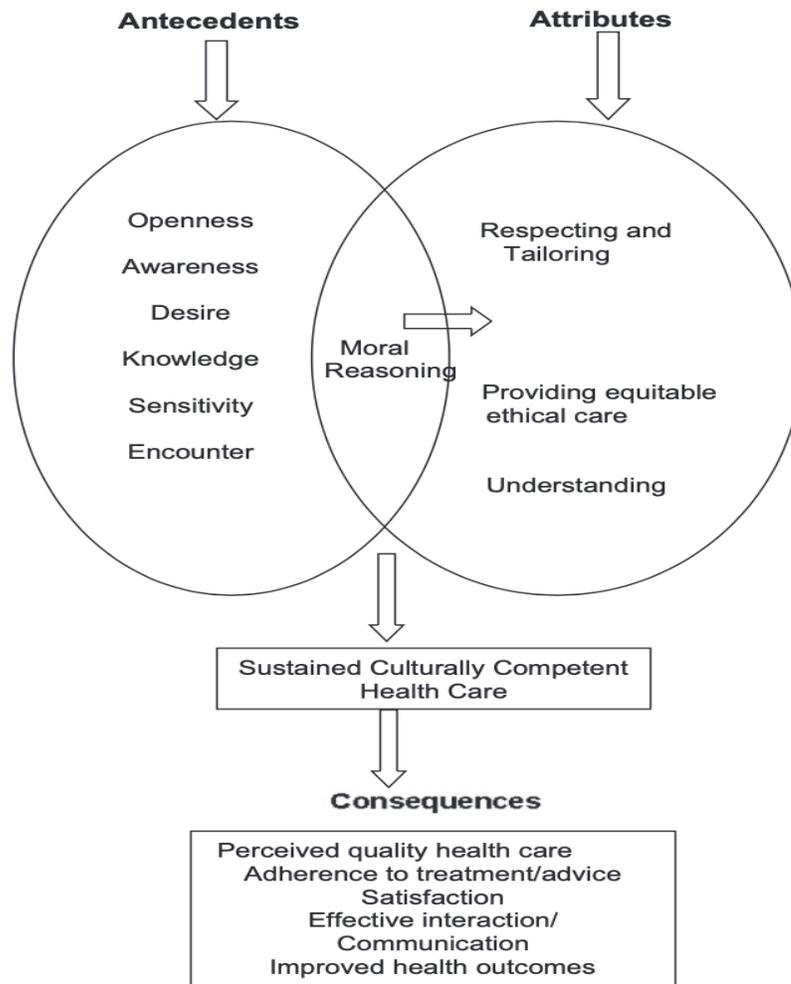**Appendix B. Concepts Model of Cultural Competence**

FIGURE 2 A theoretical model of the concept of cultural competence

Appendix C. Table of MPH competencies applied in the ILEX paper

CEPH Foundational Competencies

Competency	Choose at least 2 foundational competencies and briefly note why you feel it is relevant to your ILEX paper or presentation. (Note: all students can choose Competency #19, and mention your specific audience)
Evidence-based Approaches to Public Health	
1. Apply epidemiological methods to the breadth of settings and situations in public health practice	
2. Select quantitative and qualitative data collection methods appropriate for a given public health context	Created a table to synthesize relevant culturally competent findings that are evaluated based on strengths and weaknesses of culturally competent care and solutions
3. Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming and software as appropriate	
4. Interpret results of data analysis for public health research, policy and practice	
Public Health & Health Care Systems	
5. Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings	Compared the concepts and frameworks of interventions within health care systems and how they address health care disparities among ethnic minorities. The strengths, limitations, and healthcare setting were assessed.
6. Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community and societal levels	Discussed how stigma and bias are perpetuated by the society and are imposed by hospitals and other institutions at organizational and community levels
Planning & Management to Promote Health	
7. Assess population needs, assets and capacities that affect communities' health	

8. Apply awareness of cultural values and practices to the design or implementation of public health policies or programs	
9. Design a population-based policy, program, project or intervention	
10. Explain basic principles and tools of budget and resource management	
11. Select methods to evaluate public health programs	
Policy in Public Health	
12. Discuss multiple dimensions of the policy-making process, including the roles of ethics and evidence	
13. Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes	
14. Advocate for political, social and economic policies and programs that will improve health in diverse populations	
15. Evaluate policies for their impact on public health and health equity	
Leadership	
16. Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making	
17. Apply negotiation and mediation skills to address organizational or community challenges	
Communication	
18. Select communication strategies for different audiences and sectors	

19. Communicate audience-appropriate public health content, both in writing and through oral presentation	This paper address public health issues among a vulnerable population and an oral presentation will be given to public health professionals and peers to prevent this research
20. Describe the importance of cultural competence in communicating public health content	Assessed cultural competence effectiveness of delivery of health care services and use concepts to form new culturally sensitive framework
Interprofessional Practice*	
21. Perform effectively on interprofessional teams	
Systems Thinking	
22. Apply systems thinking tools to a public health issue	Used the Socio-Ecological model to look at how barriers determine access and help seeking among African Americans for mental health care services

MPH- Community and Public Health Practice Competencies

Competency	If CPHC is your program concentration, choose at least 2 competencies you plan to draw on and mention how it is relevant.
1. Apply qualitative methods to assess community assets for addressing public health and environmental issues	
2. Analyze how issues of power, race and ethnicity, sex and gender identify, and socioeconomic factors affect the development, implementation, and evaluation of community-based projects	Analyzed intersections of race and ethnicity, power, and power systems affect the way mental health care is utilized among African Americans. Used this to develop intervention needed to fix existing gaps in research.
3. Develop a research project proposal using mixed methods to address a public health problem	Used research paper to address mental health disparities in African Americans using culturally competent care models and addressing the weaknesses and strengths for decreasing these disparities.
4. Apply project management strategies to improve the quality of programs and services in public health settings	
5. Identify environmental health risks in vulnerable communities and examine strategies to reduce exposures	

MPH- Health Policy and Leadership Competencies

Competency	If HPL is your program concentration, choose at least 2 competencies you plan to draw on and mention how it is relevant.
1. Predict how health policies may impact risks and drivers of health outcomes at the health system and public health sector level	
2. Synthesize evidence from literature review and/or databases to write a policy paper for a specific audience, identifying a problem and proposing alternative approaches to meet health needs in underserved communities	
3. Design a leadership plan and strategies to manage stakeholders and related political processes, addressing conflict, resistance, and cooperation in the implementation process	
4. Communicate recommendations to improve organizational strategies and capacity to implement health policy	
5. Advocate and make recommendations on legislation or regulation related to a current environmental health issue, drawing on risk assessment evidence	

MPH- Behavioral Health Competencies

Competency	If BH is your program concentration, choose at least 2 competencies you plan to draw on and mention how it is relevant.

1. Plan a health education training, curriculum, or workshop including stakeholder identification, resource planning and timeline, volunteer recruitment and marketing, strategy selection, and monitoring process.	
2. Effectively deliver evidence-based health education and behavior change intervention skills such as motivational interviewing, health coaching, peer education, mindfulness, or social media messages to individuals or groups.	
3. Analyze the impact of chronic conditions and propose strategies to address prevention and management across all levels of the Socioecological Model.	Analyzed the impact of behavioral and mental health outcomes amngAfrican Americans based on 5 levels of the socioecological model: interpersonal, relationships, community, organizational, and society.
4. Formulate strategies for mental health and substance abuse prevention and treatment in community settings.	
5. Develop a data collection and analysis plan including measures and methods for research on behavioral health.	