Volume 36/Number 2/April 2014/Pages 173–188

Cultural Competency, Culturally Tailored Care, and the Primary Care Setting: Possible Solutions to Reduce Racial/Ethnic Disparities in Mental Health Care

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Racial and ethnic minorities in the United States are less likely to receive treatment for psychiatric disorders than are White Americans. For two decades, clinicians and researchers have worked to reduce health and health care disparities, with at best minimal success. In 2001 the Surgeon General issued a seminal report that described the magnitude of the problem (U. S. Department of Health and Human Services, 2001). Nevertheless, the vexing problem of unequal treatment persists. This review provides preliminary evidence for reducing racial and ethnic disparities in mental health treatment in primary care settings by giving priority to culturally competent practices and cultural tailoring in assessment, diagnosis, and treatment.

Significant racial/ethnic disparities have long existed in mental health care in the United States (Cook et al., 2014; Wells, Klap, Koike, & Sherbourne, 2001). While psychiatric problems in general are undertreated in the United States (U.S. Department of Health and Human Services [USDHHS], 1999; Wang, Lane, et al., 2005), racial/ethnic minority populations persistently receive even lower rates of mental health treatment than White Americans (Cook et al., 2014; Wells, Klap, Koike, & Sherbourne, 2001. In 2001 the Surgeon General described the magnitude of mental health care disparities in the United States (USDHHS, 2001). For two decades, clinicians and researchers have made significant attempts to reduce disparities, but their success has been at best minimal.

Among the many reasons for inequitable treatment levels are patient, provider, and systemic factors (Betancourt, Green, Carrillo, & Ananhe-Firempong, 2003), from instrumental barriers, such as service accessibility and availability and lack of parity in insurance coverage, to culturally based perceptions, preferences, and stigma. It has been suggested that more culturally competent providers and cultural tailoring of evidence-based treatments

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are possible paths to reducing mental health treatment disparities (Whaley & Davis, 2007; Yamada & Brekke, 2008). It has also been suggested that primary care is an important setting for efforts to reduce disparities, because that is where many racially, ethnically, and culturally diverse clients access mental health care (see, e.g., Pingitore, Snowden, Sansone, & Klinkman, 2001).

The literature on mental health treatment in primary care settings is distinct from the evidence of the importance of cultural competence and cultural tailoring in health care delivery. With a few critical exceptions (see Miranda, Duan, et al., 2003; Trinh et al., 2011), generally the two bodies of literature are not linked, despite clear indications that doing so would be valuable to decrease the racial and ethnic disparities in mental health care (Betancourt et al., 2003; McGuire & Miranda, 2008). To provide clinicians and researchers with critical information to guide future culturally responsive practice and research, we therefore explore two sources of evidence related to the history of unequal mental health care and possible solutions to ameliorate it: cultural competency among providers, and cultural tailoring of mental health services in primary care settings.

This article aims to (a) summarize the evidence of racial and ethnic disparities in U.S. mental health treatment; (b) review solutions that have been put forward for cultural tailoring of interventions in primary care settings; and (c) examine how culturally tailoring existing efficacious and effective counseling models may be useful and culturally responsive and thereby reduce mental health care disparities. We conclude with recommendations for mental health care providers working in primary care settings, while keeping in mind that because many factors contribute to the problem of racial/ethnic disparities in mental health, sustainable solutions may require multiple methods (Cook et al., 2014).

RACIAL/ETHNIC DISPARITIES IN MENTAL HEALTH CARE IN THE UNITED STATES

A variety of clinical mental health care providers (psychiatrists, mental health counselors, psychologists, psychiatric nurses, family therapists, and social workers—as well as primary care physicians) have a critical need to learn how to improve the treatment they provide to racial and ethnic minorities, given that the current disparities lead to significant rates of untreated mental illness among them. Understanding the growing literature on cultural competence and cultural tailoring of mental health interventions is therefore critical for several reasons:

1. As U.S. demographics change, patient populations are becoming more diverse, which demands that all clinicians be aware of recent advances in best practices and culturally competent care for an ever-widening range of racially, ethnically, and culturally diverse groups.
2. Heightened awareness of mental health problems and interventions in different groups means that a growing multicultural population is seeking mental health treatment, often in primary care settings. Those who

seek treatment likely also have expectations that the services offered will be in forms consonant with their own cultural values, beliefs, and experiences (e.g., under-resourced families and communities, bilingual backgrounds, new immigrants).

3. Recent changes in health care coverage and the direction of health insurance parity mean that more people will have access to and use mental health services and will thus need treatment that can flexibly meet their needs.

All Americans of whatever race or ethnicity underutilize mental health services. Data from the National Comorbidity Survey Replication (NCS-R; Wang, Lane, et al., 2005) found that of respondents who had received psychiatric diagnoses in the previous 12 months, only 41% had received treatment, and the disparity was greatest among racial/ethnic minority groups (e.g., HHS, 2001; Wang, Lane, et al., 2005), who were less likely to receive care than White Americans with mental disorders. Furthermore, members of racial/ethnic minorities who do receive mental health care are far less likely than White Americans to be treated by a mental health professional; instead they often access care in primary care or emergency room settings (Snowden, 2012). The problems of lack of treatment and inadequate treatment recommendations for racial/ethnic minorities have persisted despite such major changes in U.S. mental health care as community programs promoting awareness and expansion of primary care and managed care mental health services (Wang, Berglund, et al., 2005; see also Cook et al., 2014).

Evidence for Racial/Ethnic Disparities in Mental Health Care

The data supporting less utilization of mental health care by racial and ethnic minorities than by White Americans have been consistent over time. Freiman and Cunningham (1997) reported that minorities were less likely to seek mental health care in any clinical setting. Although one community study reported a decrease in disparities over time (Cooper-Patrick et al., 1999), other national data support the conclusion that the disparities persisted (Wells et al., 2001) and continue to the present (Cook et al., 2014; Neighbors et al., 2007).

Findings from the Collaborative Psychiatric Epidemiology Survey Program (CPES; Alegría et al., 2008), a group of epidemiological studies funded by the National Institutes of Health, highlighted the continued significant disparities in mental health treatment of racial and ethnic minority populations. For example, in a combined sample of more than 8,000 nationally representative individuals with depressive disorders, about 40% of non-Hispanic White patients had not received treatment, compared to about 59% of Black American, 64% of Latino American, and 69% of Asian American patients (Alegría et al., 2008). Among Caribbean Blacks who met criteria for psychiatric disorders, only one-third had used formal mental health care services, with the rate varying by birthplace and generational status (Jackson et al., 2007). Thus the evidence is robust that the vexing problem of undertreatment of minorities persists.

Factors Contributing to Racial/Ethnic Disparities

The specific causes and correlates of racial and ethnic disparities in mental health utilization are not clear. Instrumental barriers that have been investigated are the demographic and economic factors that affect the availability and accessibility of services (Alegría et al., 2002) and factors that affect the cost of care and insurance coverage (Thomas & Snowden, 2001). Racial and ethnic minority individuals and those of low socioeconomic status (SES) reported experiencing more instrumental barriers to using services—such as lack of insurance, time, and transportation—than White Americans and higher SES individuals (Leong & Lau, 2001; Smedley, Stith, & Nelson, 2003).

Even when access to services is similar, differences in utilization are apparent. Since even among populations with equivalent levels of insurance and care, racial/ethnic minorities use mental health care less often than White Americans (Smedley et al., 2003; Thomas & Snowden, 2001; Wells et al., 2001), differences in access do not fully explain the long-observed disparities in utilization. Institutional barriers may make it difficult for minority groups, such as Asian Americans, to acknowledge that psychological problems require professional help (Akutsu, Tsuru, & Chu, 2004; Wang, Lane, et al., 2005).

Cognitive or perceptual barriers to treatment utilization have also been explored, especially patient perceptions of and attitudes toward mental health treatment. Several studies have found that such factors may influence the disparities observed. Black Americans, for example, are likely to doubt the efficacy of treatment for particular mental health problems (Carpenter-Song et al., 2010); mistrust the mental health system (Whaley, 2001); and prefer to use informal networks and spiritual practices or clergy (Boyd-Franklin, 2010). Barriers related to treatment perceptions, preferences, and issues of trust likely underlie many other observed differences in treatment.

The role of stigma is complicated. For example, an early study found that at moderate levels of depression, African Americans were no more likely than White Americans to fear being stigmatized, though they did report greater fear of mental health treatment and of being hospitalized than White Americans (Sussman, Robins, & Earls, 1987). Similarly, Alvidrez (1999) found no evidence that stigma is an obstacle to Latinas and African American women making mental health visits. In that study, observed differences in utilization were related to nuanced differences in perceptions of treatment that could not be assessed by the research questions asked. Diala et al. (2000) found that among respondents who did not receive treatment, Black Americans reported more favorable views of mental health treatment than White Americans—although among those who did use services, they had significantly more negative perceptions of treatment. Among Asian American groups, delay in seeking treatment was associated with stigma and avoidance of shame related to mental illness and treatment (Leong & Lau, 2001). What is critically needed is a greater understanding of how stigma is directly or indirectly related to seeking and utilization of treatment by racial/ethnic minorities.

Some researchers have investigated the possibility that perceived discrimination, as a function of distinct social and individual histories, may underlie

disparities in treatment. Discrimination—defined as a behavioral manifestation of a negative attitude, judgment, or unfair actions toward members of a group (Banks, Kohn-Wood, & Spencer, 2006)—has been found to be a ubiquitous aspect of life for most if not all racial and ethnic minorities (Kessler, Mickelson, & Williams, 1999). It is plausible that discrimination experiences may be linked to patient and provider behaviors, disparities, and decisions about mental health treatment. Among Chinese Americans, Spencer and Chen (2004) found that language-based discrimination is associated with increased use of informal services, such as a minister or priest, and reliance on relatives and friends for help with emotional problems. Among Black Americans, those who reported having highly salient racial or ethnic identities and having experienced discrimination were found to be less likely to use mental health services (Richman, Kohn-Wood, & Williams, 2007). Experiences of discrimination—whether collective and vicarious, or individual and tangible—could be associated with decreased utilization of mental health services.

Disparities in Mental Health Treatment in Primary Care Settings

Three decades ago, growing recognition of the primary care setting as a principal site for mental health services among all races, ethnicities, and cultures led to a body of literature that examined how primary care physicians identify mental health disorders. Several studies found that physicians were identifying less than half of their patients who met criteria for major depressive disorder and, of those identified, only a small proportion received adequate treatment (see Epstein et al., 2008; Higgins, 1994; Schulberg, Magruder, & deGruy, 1996). When Wang, Berglund, and colleagues (2005) analyzed NCS-R data from more than 9,000 respondents, they found that of the approximately 40% of those with a psychiatric diagnosis who received treatment, 22.8% were treated by a primary care physician and only 16% by a mental health specialist.

For racial/ethnic minorities, problems of detection and treatment of mental health problems in primary care settings are particularly widespread. Data from the Medical Outcomes Study (MOS; Borowsky et al., 2000) found that physicians are significantly less likely to detect psychiatric problems among Black and Latino Americans than among White Americans. Improving the ability of primary care providers to identify and treat psychiatric issues among racial/ethnic minorities could improve rates of mental health service utilization and reduce the disparities. Clinicians and researchers have also discussed the growing need for mental health providers to work alongside primary care physicians to improve the quality of care (Aitken & Curtis, 2004; Borowsky et al., 2000).

For instance, providing depressed primary care patients with either medication or psychotherapy has been shown to improve the degree and rate of improvement in depressive symptom severity compared to usual physician care (Coulehan, Schulberg, Block, Madonia, & Rodriguez, 1997). A randomized controlled trial (RCT) in 46 primary care clinics in the United States provided evidence that quality of care, mental health outcomes, and depressed patient

employment all improved when primary care clinics took measures to improve interventions, such as institutional commitments, training of staff and patient educators, identification of potentially depressed patients, and access to nurses and psychotherapists (Wells et al., 2000). However, two years later many of the improved outcomes had not been sustained.

In another study (Unützer et al., 2002), elderly depressed patients at 18 primary care clinics were randomly assigned to an IMPACT (Improving Mood Promoting Access to Collaborative Care Treatment) intervention. The study found that when a depression care manager provided education, care management, medication or psychotherapy support, and problem-solving treatment—all supervised by both a psychiatrist and a primary care expert—reduction of depressive symptoms and several additional positive outcomes were greater than in patients receiving usual care.

Research into improving mental health care for racial and ethnic minorities in primary care settings, though limited, has been promising. Miranda, Duan, and colleagues (2003), who conducted an RCT that screened depressed, low-income, minority women in family planning clinics, found that random assignment to either medication or manualized therapy with cultural adaptations, such as bilingual care and experienced providers, reduced depressive symptoms significantly compared to usual care (in this case, community referral). Trinh and colleagues (2011) tested a care model described as a "culturally focused psychiatric consultation service" for Asian American and Latino American primary care patients with depressive symptoms. This RCT tested the efficacy of multilingual consultations and toolkits for both providers and patients in separate visits, first for facilitating provision of appropriate culturally informed care and then to increase patient knowledge of treatment and access to resources (Trinh et al., 2011). These studies indicate that pairing culturally focused interventions and primary care settings can improve the quality and utilization of treatment for minorities.

The promising evidence these studies produced provide direction for mental health providers to contribute to the development of tailored intervention models. Providers must also be involved in advocacy for policy and organizational changes in mental health care systems to allow for inclusion of coordinated, co-located, and integrated tailored care models (Aitken & Curtis, 2004; Alvarez et al., 2014; Blount, 2003; Vogel et al., 2014) in primary care.

CULTURAL COMPETENCE AND CULTURAL TAILORING OF MENTAL HEALTH CARE INTERVENTIONS AS POSSIBLE SOLUTIONS TO RACIAL/ETHNIC DISPARITIES

Mental health counselors, counseling psychologists, and other providers who are culturally competent and experienced in providing culturally tailored interventions are poised to take a leading role in bridging the gap between general and mental health care in primary settings. (Later we provide recommendations for how this bridge could be structured.) Primary care settings are ideal sites for integrating findings from the literature on cultural competence

and cultural tailoring, since racial/ethnic minorities are more likely than White Americans to receive mental health care in primary care settings (Pingitore et al., 2001). Primary care physicians may face unique challenges in detecting and treating the mental health problems of patients from backgrounds different from their own. Fears of a variety of barriers may engender reluctance to seek treatment or disclose emotional problems, which then impedes diagnosis, assessment, and treatment. Negative treatment experiences or simply the expectation of discrimination could hamper patient–provider discussions, and cultural variations in emotion-related language and symptom expression may complicate detection (Trinh et al., 2011). Therefore, improving the detection and treatment of mental health problems in primary care requires some degree of cultural awareness, sensitivity, and responsiveness.

Cultural Competence and Reducing Disparities

All human helping disciplines (e.g., social work, medicine, psychology, and counseling) must address growing evidence that mental health and illness are in part cultural experiences. In particular, differences in how disorders manifest may be related to racial and ethnic differences in how people characterize psychological distress and related symptoms (Guarnaccia, Guevara-Ramos, Gonzáles, Canino, & Bird, 1992); how they seek help for the distress (HHS, 2001; Neighbors, Jackson, Campbell, & Williams, 1989); and how they respond to treatment. Group differences in the experience of mental health and the outcomes of treatment have been explored most notably by medical anthropologists and cultural psychiatrists (see Jenkins, Jenkins, & Barrett, 2004; Kleinman, 1988). Few researchers in these fields dispute that culture affects how illness and distress are experienced.

Although there is empirical evidence that racial, ethnic, and cultural differences in experiences of mental illness do exist, the evidence is not abundant. Leong and Lau (2001) described cognitive and affective characteristics of Asian Americans that deter help-seeking, such as notions of etiology that do not distinguish between psychological and physical ailments and avoidance of intense exploration of highly negative emotions. In a qualitative study of ethnically diverse adults diagnosed with psychiatric disorders, Carpenter-Song and colleagues (2010) found significant variation in themes related to how mental health problems are conceived: Euro-Americans reported greater acceptance of biomedical explanations of illness; Latino and African Americans voiced alternative "non-biomedical explanations" (p. 246), such as "*nervios* [nerves]" (p. 238), "*problemas emocionales* [emotional problems]" (p. 238), difficulties resulting from supernatural or demonic experiences, or character deficiencies, such as laziness.

Hays, Prosek, and McLeod (2010) took a mixed-methods approach to examining the role of culture in clinical decision-making. Their findings suggested that (a) providers' conception of patient cultural identities and their acknowledged cultural bias influenced their diagnoses, and (b) a cultural match between providers and patients influenced how cases were conceptualized. Other researchers have questioned the application of standard

conceptualizations of mental illness, describing them, for example, as cases of oppressive colonialism forced upon American Indians, for whom current diagnostic criteria misconstrue the meaning of, experience of, and response to psychological distress (Gone, 2008). Although psychological research on the cultural experience of illness has been limited, there are indications that it may in part explain disparities in treatment.

The literature on cultural competence has evolved from early cookbook-style approaches, which detailed specific cultural differences, to approaches that focus on cultural processes and dynamics. In a seminal article on cultural competence and evidence-based practice, Whaley and Davis (2007) drew on various definitions of cultural competence to define it as

> a set of problem-solving skills that includes (a) the ability to recognize and understand the dynamic interplay between heritage and adaptation dimensions of culture in shaping behavior; (b) the ability to use this knowledge acquired about an individual's heritage to maximize effectiveness of assessment, diagnosis and treatment; and (c) an internalization (i.e., incorporation into one's clinical problem-solving repertoire) of this process of recognition, acquisition, and use of cultural dynamics so that it can be routinely applied to diverse groups. (p. 565)

As the definition evolves, training in cultural competence has been advancing through, e.g., process-oriented training models that emphasize the importance of shifting lenses between the cultural perspectives of therapist and client (Betancourt et al., 2003; López, 1997). Many training programs now incorporate multicultural competency principles into curricula (Lakes, López, & Garro, 2006; Smith, Constantine, Dunn, Dinehart, & Montoya, 2006).

No matter what the approach, increasing racial, ethnic, and cultural knowledge, awareness, and skills is considered central to cultivating competence among practicing clinicians (American Psychological Association, 2003; Arredondo et al., 1996; Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003). Providers must be knowledgeable about common racial/ethnic experiences and perspectives that may be quite different from their own while being aware of their own beliefs and assumptions. In particular, clinicians must resist the harmful tendency to make evaluative judgments that may undermine the effectiveness of psychotherapy and treatment. Recommendations for working with clients of a different race or ethnicity are also relevant for other areas of diversity, such as gender, sexuality, or physical ability. Among the useful recommendations put forward by Cardemil and Battle (2003) are to (a) suspend preconceptions about clients' race/ethnicity and that of family members; (b) recognize that clients may be quite different from other members of their own group; (c) consider how differences between therapist and client might affect treatment; (d) acknowledge that power, privilege, and racism might affect client interactions; and (e) err on the side of discussion when in doubt and be willing to take risks with clients.

Although recognizing the value of cultural awareness, knowledge, and skills in the psychotherapeutic process, study results have been mixed with

regard to outcomes and the related benefits of cultural competencies. A 2011 special section of the *Journal of Counseling Psychology* highlighted findings related to client perceptions, cultural competence of therapists, and therapy process and outcome. Owen, Leach, Wampold, and Rodolfa (2011) found that the degree to which patients perceived therapists as culturally competent was related more to the therapeutic relationship or personal beliefs about the therapist than to consistent characteristics of the therapist. Some clients who may be more aware of cultural issues may be more likely to perceive cultural competence or lack thereof on the part of the therapist. Further, cultural competence can be seen as a process that can unfold at multiple levels, from overt to subtle, with the importance of the level depending on client issues and the focus of the therapy (Owen et al., 2011). Although some have debated the methodology for investigating such complex issues in the context of actual clinical encounters (Worthington & Dillon, 2011), clearly for some clients, the importance of their perceptions of the therapist's cultural competence is not debatable.

The literature on utilization of mental health services and the burgeoning evidence for the importance of cultural competence indicate that developing cultural competence in primary care settings may alleviate the health care disparities discussed here (Betancourt et al., 2003). Furthermore, elucidating culturally competent treatment practices may help offset perceptions, beliefs, and barriers that deter racial/ethnic minorities from seeking treatment for psychological problems, accepting treatment recommendations, and benefitting from treatment. Therefore, study of cultural competencies in primary care settings should be part of the demand for empirically validated treatment approaches.

Cultural Tailoring of Empirically Based Mental Health Treatment Approaches

Although examples and evaluations of culturally adapted treatment approaches are not new, debate about the need and methods for using them to effectively treat racial and ethnic minority clients has intensified. In reviewing cultural competence and evidence-based practice, Whaley and Davis (2007) made a cogent argument for more culturally adapted and tailored interventions as human helping fields move from investigating efficacy to determining effectiveness. There is growing consensus on how—and how much—treatment approaches should be tailored (Griner & Smith, 2006; Lau, 2006). For example, mental health care providers must conceptualize and measure fidelity to an established treatment, but they must also determine the degree to which that treatment fits the proposed population (Norcross & Wampold, 2011).

Within the breadth of culturally tailored effective and efficacious treatments are simple inclusion of racial/ethnic minority clients, changes in the delivery of services, translation, treatment processes, and inclusion of specific cultural components of treatment. In 2001 Bernal & Scharró-del-Río argued that the attention to empirical validation is discriminatory because there is a lack of knowledge about treatment efficacy and effectiveness for racial and ethnic minorities, and that a research base for this knowledge should consider hypothesis-testing, hypothesis-generating, and discovery-oriented approaches. Griner and Smith (2006) responded to this critique in their systematic review

of 59 studies of cultural adaptations to treatment—a review that indicated that, progressively applied, cultural tailoring works.

Lau's analysis (2006) of cultural adaptations suggested two areas as the foundation of adaptation: (a) the process of engaging patients in culturally relevant treatment—the ecological validity of the treatment process—both subjectively, in terms of cultural perceptions of psychological services, and objectively, in terms of treatment accessibility and barriers to treatment; and (b) treatment outcomes, specifically the degree to which evidence-based treatments produce differential outcomes for various cultural groups. Lau argued that in both areas adaptation or tailoring should be guided by research findings and not applied without data-driven justification. Following up on Lau's work, Barrera and Castro (2006) crafted a sequential framework for empirical study of cultural adaptations, with stages for investigating both engagement and intervention. The sequence moves from information-gathering to preliminary adaptation design and testing and ultimately to refinement (see Barrera & Castro, 2006). These advances in the conceptualization of cultural adaptations have led to an increase in the evidence of when, how, and for whom cultural tailoring is appropriate.

Studies have described specific empirical cultural adaptations of psychological interventions. For example, several researchers have found that culturally adapted or tailored cognitive behavioral therapy (CBT) is efficacious and effective for treating depression in racial/ethnic minorities (Gelman, López, & Foster, 2006; Kohn, Oden, Muñoz, Robinson, & Leavitt, 2002; Miranda, Chung, et al., 2003; Muñoz & Mendelson, 2005). Others have described tailoring as varied as inclusion of cultural elements in psychoeducational pretreatment engagement for Black American families (Breland-Noble, Burriss, & Poole, 2010); inclusion of spirituality in interpersonal therapy with Black American women (Boyd-Franklin, 2010); culturally informed family therapy with Latino clients (Santisteban & Mena, 2009); and conceptualization of Asian American cultural issues in treatment approaches designed to reduce disparities in utilization of health care services (Sue & Zane, 2011).

IMPLICATIONS FOR CULTURALLY TAILORED MENTAL HEALTH PRACTICE

All these approaches to cultural tailoring have yielded promising evidence that a variety of groups can benefit from psychological interventions when attention is paid to appropriate adaptation. This raises important implications for cultural tailoring, both practice and research:

1. Clinical mental health counselors and other mental health care providers can lead efforts to enhance culturally competent mental health care delivered in primary care settings by educating clinicians on how to recognize the relation between cultural identity and mental illness and of cultural factors that impede treatment-seeking and utilization (see Betancourt et al., 2003).

2. Providers should develop multidisciplinary collaborative treatment teams to produce models of care, with enhanced liaison consultation services and roles that involve other medical professionals in follow-up and care management.
3. Providers can improve efforts to tailor treatment in primary care, including clinic-specific and treatment-specific evaluation of techniques. These tailoring efforts should allow for alterations on the basis of individual outcomes with regard to case conceptualization, as well as on the basis of clinic or population service delivery outcomes.
4. Providers can become involved in policy-related efforts to change the organization of health care systems and managed care so that cultural tailoring and multidisciplinary teams are incorporated into treatment settings, given the complexity and cost associated with effective intervention models.
5. Providers can consider mental health care models (coordinated, co-located, or integrated; see Aitken & Curtis, 2004; Alvarez et al., 2014; Blount, 2003; Vogel et al., 2014) that situate the mental health provider in primary care offices, consulting with or alongside primary care physicians.

IMPLICATIONS FOR CULTURALLY TAILORED RESEARCH

Based on this brief review of the literature, we offer two major implications for future research on cultural tailoring of counseling interventions, particularly for diverse mental health providers (e.g., mental health counselors, psychologists, psychiatric nurses, family therapists, and social workers) working in primary care settings:

1. As recommended by Whaley and Davis (2007), demand for empirically supported treatments, and the need to move beyond efficacy trials to effectiveness studies that establish the external validity of treatment, should be paired with the need for empirical support for culturally-adapted treatment. Therefore, researchers should conduct effectiveness studies in which cultural tailoring is a specific treatment factor to be evaluated.
2. Investigators should draw from the literature that recommends distinct stages of cultural tailoring and investigate methods both for psychotherapeutic engagement and to increase psychotherapeutic outcomes for diverse groups. As Lau (2006) pointed out, both selective and directed cultural adaptations are necessary, both of which require empirical evidence (p. 297). Evidence for selective cultural adaptations would provide information about the fit of empirically based treatments to specific racial, ethnic, and cultural communities. Evidence for directed adaptations would give providers specific data-

driven modifications to treatment. To give the field direction, researchers should investigate both dimensions of cultural tailoring.

Our review implies that the growing research base on cultural adaptations to treatment should inform culturally tailored practice. There is already evidence of the utility of cultural tailoring for both treatment engagement and treatment outcomes. Future research can point mental health practitioners toward what works and for whom, and offer adaptations they can consider for both objective barriers to treatment (e.g., language, accessibility, and delivery of services) and subjective barriers (e.g., attitudes toward, beliefs about, and perceptions of treatment). All these areas may reduce the significant and persistent racial/ethnic disparities in mental health care and offer promise for mental health providers in primary care settings to address this problem.

CONCLUSION

Our primary goal here has been to provide diverse mental health care providers with knowledge about the treatment provided to racial/ethnic minorities, methods to improve it, and ways to reduce the disparities that lead to significant rates of untreated mental illness among these populations. The most important issues for providers are to (a) recognize factors that underlie disparities in mental health treatment; (b) understand how conceptualizations of cultural competence are evolving, and (c) use and contribute to the literature on cultural tailoring as a way to improve mental health treatment rates for racial/ethnic minority groups in primary care settings.

The significant differences in mental health treatment by race and ethnicity that have persisted despite attention to the health disparities over several decades is an indictment of the mental health care system in the United States. All possible tools for eliminating disparities must be explored. Although we highlight the importance of what can be learned from the literature on cultural competence and cultural tailoring, we also recognize that a comprehensive, multipronged approach is necessary, one that incorporates multiple determinants of such disparities in care as access, acceptance, availability, and mental health care coverage. As mental health care providers, we should approach the current situation with some degree of outrage, but also with determination to move forward the efforts for change.

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