SMIAdviser
A Clinical Support System for Serious Mental Illness

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An APA and SAMHSA Initiative

AMERICAN PSYCHIATRIC ASSOCIATION

SAMHSA
Substance Abuse and Mental Health Services Administration

Culturally Competent Care for Black American Adults Living with a Serious Mental Illness

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Despite efforts to improve the quality of mental health care nationally, disparities in care for those who are Black Americans continue. The President's New Freedom Commission on Mental Health set goals for eliminating disparities in mental health care[1] and the Diagnostic and Statistical Manual of Mental Disorders-5-TR[2] emphasizes the importance of integrating culture and social context when considering a diagnosis. There is recognition that culturally competent care tailored for this population is imperative and a key component of delivering high quality care.

The 2020 National Survey on Drug Use and Health (NSDUH) provides data indicating that millions of Black American adults struggle with mental illness. Specifically, data from the NSDUH and other studies show that:

- 17% of Black Americans (more than 5.3 million people) reported having a mental illness[3]
- 27% of those (1.4 million people) reported a serious mental illness (SMI)[3]
- The percentage of Black American adults who had Major Depression was highest among those aged 18 to 25[3]
- Black American adults are more likely to endorse feelings of despair, hopelessness, and low self-worth compared to white adults[4]
- Overt racism and racism expressed through microagressions disproportionately affects Black Americans and manifests as stress, anxiety, suicide, and unequal access to treatment[5]

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According to the American Psychiatric Association's Mental Health Disparities for Black Americans guide,[6] these individuals are:

- Less likely to receive guideline-consistent care
- Less frequently included in research
- More likely to use emergency rooms or primary care (rather than mental health specialists)

Overdiagnosing or Misdiagnosing Black Americans

Black Americans are disproportionately diagnosed with schizophrenia with estimates ranging from three to five times more likely to receive this diagnosis compared to white individuals.[7] Black American individuals exhibit a higher tendency to articulate physical symptoms associated with their mental health, rather than directly expressing mental health symptoms. Consequently, healthcare clinicians lacking cultural competence may fail to recognize these physical expressions as potential indications of an underlying mental health condition. Non-Black American mental health professionals' inexperience with various gestures, jargons, and other ways of connecting for Black Americans can result in misconceptions and misdiagnosis.[8] Moreover, in a study conducted on racial disparities, it was reported that perceived honesty from clinicians was lower for Black Americans, a factor that may be related to overdiagnosis and misdiagnosis for this population.[9]

Below are recommendations and guidelines to address these issues.

Conduct a proper assessment. Conducting a proper assessment ensures rapport is being established and the individual feels comfortable providing information to the clinician. This requires the clinician to solicit feedback about the assessment process and acknowledge that the individual is an expert of their experiences. Clinicians must avoid seeking information to confirm their perception of the individual and their presenting issues.[8]

Utilize evidence-based framework for assessments. Clinicians should utilize a contextualized method to conduct culturally competent assessments and diagnostic formulation, encompassing the use of the DSM-5 Outline for Cultural Formulation and Cultural Formulation Interview.[10] A skilled use of cultural knowledge should heighten therapist credibility, increase an individual's engagement, and ultimately improve quality of life.[11]

Adequate supervision is imperative. Proper supervision must be routine to ensure quality professional services are being rendered. Regular supervision for cultural competence is necessary to enhance treatment engagement, professional functioning, and evaluate practical administration of self-awareness, knowledge, and skills. The value of supervision for culturally competent treatment cannot be overestimated to properly address a professional's strengths, weaknesses, and limitations in understanding individuals' cultural backgrounds.[12]

Barriers to Care

Black Americans are 20% more likely to experience serious mental health problems than the general population. Despite the needs, only one in three Black American adults with mental illness receive treatment.[3] Key barriers to care are described below.

1. **Socioeconomic factors and mental health disparities make treatment options less accessible.** The United States Census Bureau in 2020 reported that 10.4% of Black American adults (more than 4.5 million people) in the U.S. had no form of health insurance.[13] Black American adults living below the poverty line are twice as likely to report serious psychological distress than those with more financial security.[14] Black Americans also have a higher risk for exposure to homelessness and violence. All these aspects contribute to worse mental health outcomes, especially when symptoms go untreated.
2. **Stigma around mental health in Black American communities prevents individuals from seeking professional help.** Mental Health America conducted a survey which found that 63% of Black Americans believe that depression is a personal weakness.[15] Black Americans may encounter feelings of shame related to SMI and harbor concerns regarding potential discrimination stemming from their diagnosis.
3. **Lack of representation among mental health professionals leaves Black Americans with extremely limited choices of clinicians.** According to the American Psychiatric Association, only 2% of psychiatrists and 4% of psychologists in the United States are Black Americans.[16] This makes it difficult for individuals to find representation in mental health care. Historically, Black Americans found that non-black clinicians are less likely to include them in their own treatment plan and more likely to minimize their declared symptoms.
4. **Clinician bias can impact diagnosis for Black Americans.** Several research studies report clinicians have been susceptible to information-gathering biases that influenced the diagnostic process, resulting in searching for data to confirm the diagnosis while disregarding conflicting information, and crafting conclusions based on assumptions about ethnicity.[17]
5. **Psychopharmacological interventions are more limited for Black Americans.** Black Americans receive less medication due to cultural bias, socioeconomic status, and lack of insurance.[5] There is evidence that Black Americans experiencing depression who do not have insurance receive fewer antidepressants than those insured, but even among the insured, Black Americans received fewer medications as compared to white individuals.[18] Black Americans are found more likely to engage in alcohol use, smoking (marijuana), prescription pain reliever misuse, and illicit drug use when managing mental illnesses.[4]

6. **Lack of recognition or support of alternative coping approaches to mental health symptoms.** Older Black Americans adults identified prayer as their most frequently used therapeutic treatment intervention along with natural home remedies, familial support, and consulting religious advisors.[19] Older Black Americans who utilized religious coping strategies such as prayer were found to have higher quality of life and decrease in depressive symptoms.[20]

Drop-Out Rates

Black Americans are less likely to remain in mental health treatment when compared to their white counterparts or other ethnic minority groups.[21]

1. Treatment dropout among Black Americans typically takes place during the beginning phases of treatment; therefore, clinicians should prioritize building rapport and strong therapeutic alliance during triage, or if possible, during the time of referral.[22]
2. Increased treatment dropout has been found to be due to perceived racism, desire for non-traditional therapy modalities, religious coping, or inability to connect with a clinician's description of mental health illness and symptoms.[22]

Culturally Competent Treatment

It is critical to establish cultural competence within your treatment program(s). Here are some steps you might take to better support Black Americans in your care:

1. **Commit to the core competencies of multicultural care.**
   a. Awareness – Awareness of one's own assumptions, values, and biases.
   b. Knowledge – Understanding the worldview of culturally diverse individuals.
   c. Skills – Identifying culturally appropriate resources to assist with symptom management and behavioral modification.[10]
2. **Diversify your team by employing, coaching, and providing mentorship to Black American mental health clinicians who exhibit intercultural competencies.**
   Recruit this workforce population and establish a resource hub within your program to ensure that professionals grow their core competencies.
3. **Directly address the racism Black Americans experience by confirming mental health clinicians fully support anti-racism and embed this stance in their practices.**
   Include this as part of the interview process and job descriptions as well as routinely train and discuss policies around anti-racism and cultural competency.

4. Collaborate with Black American wellness organizations, community service agencies, and scholars to construct and implement culturally appropriate interventions. This will ensure that your organization is addressing common issues members of your community face, increases visibility towards efforts, and demonstrates commitment to making change on a larger scale.

5. Reconceptualize access to mental health services using a socio-cultural framework. You can start by asking individuals in your care about any socioeconomic barriers that might make continuing in treatment difficult.

6. Participate in trainings that help you recognize your unconscious bias and other factors that may play a role in misdiagnosis or inadequate care. Identifying your biases will help reduce the likelihood that they may negatively impact your care for Black American individuals. View this article on Psychiatry Online to learn more about the role implicit bias plays in mental health treatment.

7. Address stigma by offering evidence-based information to family and friends of Black Americans to eliminate common myths associated with serious mental illness. By educating the individual and their community you build allyship and acknowledge the importance of having open conversations about SMI. Providing resources and education about SMI increases the number of supports the individual has and the likelihood they will continue with care. Find more resources on SMI Adviser's website.

8. Integrate patient centered care and consider racial identity when formulating a treatment plan. This could mean incorporating faith, spirituality, and community involvement into treatment. Many Black Americans often view the church as a supportive family unit. Evidence suggests that spirituality often contributes to the resiliency in navigating society entrenched oppression and discrimination.

9. Focus on prevention and early intervention by making educational resources available to Black American individuals and their families. Share resources about mental health wellness that include the importance of regular checkups for physical and mental health, sleep hygiene, exercise, and diet. You may also provide materials on self-care and mental wellbeing that consider Black American life experiences.

10. Emphasize strong therapeutic alliance between clinicians and those in their care. Focus must be placed on the individual-clinician interaction and how cultural meaning is attributed to certain behaviors and the treatment context.[11] Routinely involve individuals in their treatment plan and encourage consistency by listening and adjusting when necessary.

References

1. US Department of Health and Human Services. Achieving the promise: Transforming mental health care in America: final report. 2003.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). American Psychiatric Publishing; 2022. https://www.psychiatry.org/psychiatrists/practice/dsm
3. Substance Abuse and Mental Health Services Administration. 2020 National Survey on Drug Use and Health: African Americans. July 2022. https://www.samhsa.gov/data/sites/default/files/reports/slides-2020-nsduh/2020NSDUHAfricanAm Slides072522.pdf.
4. Mental Health America. Black and African American Communities and Mental Health. Accessed March 2023. https://www.mhanational.org/issues/black-and-african-american-communities-and-mental-health
5. Noonan AS, Velasco-Mondragon HE, Wagner FA. Improving the health of African Americans in the USA: An overdue opportunity for social justice. Public Health Reviews. 2016;37(1). https://doi.org/10.1186/s40985-016-0025-4
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental disorders (5th ed). American Psychiatric Publishing; 2013.
7. Schwartz RC, Blankenship DM. Racial disparities in psychotic disorder diagnosis: A review of empirical literature. World journal of psychiatry. 2014;4(4): 133–140. https://doi.org/10.5498/wjp.v4.i4.133
8. Danzer G., Rieger S. M., Schubmehl S., Cort D. (2016). White psychologists and African Americans' historical trauma: Implications for practice. Journal of Aggression, Maltreatment & Trauma, 25(4), 351–370. https://doi.org/10.1080/10926771.2016.1153550
9. Eack SM, Bahorik AL, Newhill CE, Neighbors HW, Davis LE. Interviewer-perceived honesty as a mediator of racial disparities in the diagnosis of schizophrenia. Psychiatr Serv. 2012;63:875–880.
10. Fung K, Lo,T. An integrative clinical approach to cultural competent psychotherapy. Journal of Contemporary Psychotherapy. 2016; 47(2), 65–73. https://doi.org/10.1007/s10879-016-9341-8
11. Huey S.J, Tilley J L, Jones EO, Smith CA. The contribution of cultural competence to evidence-based care for ethnically diverse populations. Annual Review of Clinical Psychology. 2014; 10(1), 305–338. https://doi.org/10.1146/annurev-clinpsy-032813-153729
12. Hook JN, Watkins CE, Davis DE, Owen J, van Tongeren DR, Marciana JR. Cultural humility in psychotherapy supervision. American Journal of Psychotherapy. 2016; 70(2), 149–166. https://doi.org/10.1176/appi.psychotherapy.2016.70.2.149

13. Keisler-Starkley K, Bunch LN. Health Insurance Coverage in the United States: 2020. United States Census Bureau, U.S. Department of Commerce; 2021. https://www.census.gov/content/dam/Census/library/publications/2021/demo/p60-274.pdf
14. National Center for Health Statistics. Health, United States, 2017: With special feature on mortality. 2018.
15. Ward EC, Wiltshire JC, Detry MA, Brown RL. African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. Nursing research. 2016; 62(3), 185–194. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4279858/
16. O'Malley L. Addressing the lack of black mental health professionals. INSIGHT Into Diversity. 2021; December 17. https://www.insightintodiversity.com/addressing-the-lack-of-black-mental-health-professionals/
17. de Haan AM, Boon AE, de Jong JT, Vermeiren RR. A review of mental health treatment dropout by ethnic minority youth. Transcultural Psychiatry. 2017; 55(1), 3–30. https://doi.org/10.1177/1363461517731702
18. Jung K, Lim D, Shi Y. Racial-Ethnic Disparities in Use of Antidepressants in Private Coverage: Implications for the Affordable Care Act. Psychiatric Services. 2014; 65(9): 1140– 1146. https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300182
19. Chatters LM, Taylor RJ, Jackson JS, Lincoln KD. Religious coping among African Americans, Caribbean blacks and Non-Hispanic whites. Journal of Community Psychology. 2008; 36(3): 371–386. https://doi.org/10.1002/jcop.20202
20. Mouzon DM. Chronic stress, coping, and mental health among older African Americans. Journal of Aging and Health. 2022; 34(3), 347–362. https://doi.org/10.1177/08982643221085805
21. Summers LTM, Abrams LP, Harris HL. Identifying barriers and access to mental health care for African Americans. African Americans and Mental Health. 2021; 13-21. https://doi.org/10.1007/978-3-030-77131-7_2
22. Wintersteen MB, Mensinger JL, Diamond GM. Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents? Professional Psychology Research and Practice. 2005; 36(4), 400–408.