Week 7 Assignment: Research Proposal Assignment

Name

University of New England

Research Proposal: Improving Mental Health for Immigrants and Refugees: Culturally Tailored Interventions to Address Depression

Background

Depression is one of the most urgent yet often overlooked public health crises facing immigrant and refugee populations in the U.S. Nonetheless, disparities persist in diagnosis, access, and treatment among these populations.[1,2] Millions of immigrants and refugees continuously face structural, cultural, and linguistic barriers[3,4,5] that prevent them from receiving timely and effective mental health care and support. These barriers contribute to lower engagement and poorer outcomes as compared to non-immigrant populations.

A growing body of evidence illustrates that culturally tailored mental health services are associated with improved engagement and better outcomes as compared to standard, 'one-size-fits-all' care.[3,4,5,6] These culturally-tailored interventions include language-concordant therapy, the use of community health workers as facilitators, the integration of cultural beliefs and values into treatment, and the incorporation of community-driven adaptations. While studies indicate engagement and depression severity outcomes are promising, there is limited evidence from rigorous trials evaluating their long-term impact among immigrant and refugee populations.[4,7,8]

Purpose:

The purpose of this project is to evaluate whether culturally tailored mental health services improve depression outcomes among immigrant and refugee adults as compared to standard 'one-size-fits-all' care. To achieve this purpose and provide insights into both effectiveness and contextual factors, the study will employ three distinct but complementary designs: A randomized controlled trial (RCT) pilot study, a qualitative content analysis pilot study, and a community-based participatory research (CBPR) pilot study.

Significance and Importance:

Addressing depression disparities among immigrants and refugees is a prerogative for both public health and equity. This study combines rigorous clinical evaluation with qualitative insights and community engagement. Research findings have the potential to generate evidence that directly informs culturally responsive care models, improve engagement and retention during treatment, and reduce the severity of depression among vulnerable populations. Further, findings will not only be relevant to clinical practice, but will also inform policy decisions around resource allocation and delivery of mental health care services.

Key Terms:

- Culturally tailored mental health services: These are services adapted to the patients' language, beliefs, and community context.
- Standard 'one-size-fits-all' care: This defines the current, usual primary care services without cultural adaptation.
- Depression severity: This will be evaluated through Patient Health Questionnaire-9 (PHQ-9) scores taken at baseline, and months 3, 6, 9, and 12. This is a validated screening tool with strong reliability in diverse populations.[9]

Goals:

1. To determine whether culturally tailored services lead to greater reductions in PHQ-9 scores over 12 months as compared to standard care among Latinx immigrants/refugees (quantitative - RCT pilot). We hypothesize that participants in the group receiving culturally tailored services will show a significantly greater mean reduction in PHQ-9 scores at 12 months as compared to those receiving standard care (control group).
2. To identify perceived barriers and facilitators influencing mental health services utilization among Latinx immigrants and refugees, and possible solutions as per the lived experiences of participants (qualitative pilot study).
3. To co-develop and pilot-test a culturally tailored intervention with Latinx immigrant communities that is culturally relevant and feasible (CBPR pilot study). The over-arching objective is to establish a replicable model of culturally-tailored care co-designed with the respective community that can be scaled to other immigrant and refugee populations, albeit with generalizability limitations in mind.

Methods and Procedures

Study Design(s):

1. Quantitative Design (RCT): The study will utilize a randomized controlled trial (RCT) design to evaluate the effectiveness of integrated culturally-tailored behavioral health services (CBT) compared to standard care in reducing depression symptoms among immigrant and refugee populations. This approach will involve comparing outcomes between two parallel groups: one receiving a culturally-tailored cognitive-behavioral therapy (CBT) intervention for Latino adults with depression, and the control group (receiving standard care/non-tailored CBT or usual clinical services).
2. Qualitative Design (Content Analysis): This study will use semi-structured interviews to collect rich narrative data. The goal of these interviews is to gain insights on the experiences of Latinx participants when accessing (or avoiding) mental health care systems, perceived barriers, and their personal views on how accessibility, equity, and effectiveness of mental health services can be improved for their respective communities.
3. CBPR Design (Mixed-Methods Pilot): The pilot study will work collaboratively with Latinx communities, integrating both quantitative outcomes and qualitative feedback. Overall, the aim is to establish a framework that can be adopted (and tailored) for other communities in identification and evaluation of barriers/facilitators, and developing feasible and culturally competent interventions.

Source Population and Sampling:

Target Population: Foreign-born Latinx adults, aged 18–65, diagnosed with moderate to severe depression ($\mathrm{PHQ}-9\ \mathrm{score}\ \geq 10$),[9] and currently receiving health care services through primary care or a mental health clinic.

- Quantitative RCT: Based on a power analysis test with parameters: Cohen's d = 0.50, $\alpha = 0.05$, $1-\beta = 0.80$, to-tailed independent samples t-test; the minimum required sample size is 64 participants per group, for a total of 128 participants. To account for an anticipated attrition rate of 20%, which is commonly observed in longitudinal psychotherapy trials,[10,11] the total participant recruitment target will be 160 participants or 80 per group.

- Qualitative Study: Purposive subsample of 20 participants, drawn from the quantitative cohort.
- CBPR Pilot: Foreign-born Latinx Spanish-speaking adults, aged 18–65, diagnosed with moderate to severe depression ($\text{PHQ} - 9\ \text{score} \geq 10$), recruited in collaboration with CHWs and cultural organizations.

Recruitment Procedures:

- Flyers in clinics, community centers, and cultural events.
- CHW outreach and peer referrals.
- Partnership with faith-based organizations and advocacy groups.

Key Variables and Measurement:

- Independent variable: Type of care (culturally tailored vs. standard).
- Dependent variable: Depression severity (PHQ-9 scores at baseline, 3, 6, 9, and 12 months).
- Qualitative focus: Perceived barriers, facilitators, cultural relevance, participant-identified solutions.

Data Collection Procedures

- RCT: PHQ-9 scores collected at baseline, 3, 6, 9, and 12 months.
- Qualitative Study: Semi-structured interviews (each about 45 to 60 mins long) and focus groups (each with 5 to 8 participants) conducted in either English or Spanish.
- CBPR Pilot: As above RCT and qualitative studies, but developed and adapted collaboratively with community partners.

Analysis Plan

Data Management:

All data will be stored in secure, password-protected databases. Any identifying information such as names and contact information will be kept in a separate, encrypted file from the research data. Participants will be assigned coded identifiers to protect confidentiality. Only authorized members of the research team will have access to identifiable data; and data-sharing agreements will be established with community partners. In addition, audio-recordings of qualitative interviews and focus groups will be transcribed verbatim and de-identified prior to analysis. To prevent loss, data backups will be maintained on secure institutional servers.

Data Analysis:

- Quantitative RCT Data Analysis: Data from the RCT will be analyzed using an intention-to-treat approach to account for all randomized participants; including those lost to follow-up. Descriptive statistics will summarize participant demographics and baseline characteristics. Independent-samples t-tests (two-tailed) will analyze PHQ-9 scores between intervention and control groups at baseline, 3, 6, 9, and 12 months.
- Qualitative Data Analysis: Interviews and focus groups will be analyzed using content analysis as per Erlingsson & Brysiewicz's framework.[12] This will include: (1)

thorough familiarization with the transcripts and hermeneutic spiral, (2) dividing text into meaning units and condensing these meaning units while retaining core meaning, (3) coding, (4) grouping codes into categories, and (5) developing broader themes. NVivo software will be used to support systematic coding and retrieval of data. To enhance credibility, coding will be conducted jointly with academic researchers and trained community co-coders. Intercoder agreement will be assessed, and discrepancies resolved through discussion. To preserve participant perspectives and ensure authenticity, direct quotes will be included in the report.

- CBPR Pilot Data Analysis: The CBPR pilot will integrate both quantitative and qualitative data through triangulation. Quantitative PHQ-9 outcomes will be analyzed descriptively to evaluate preliminary changes in depression severity over the pilot period. Qualitative data from focus groups and interviews with participants, community health workers, and healthcare services providers will undergo content analysis to identify perceived barriers, facilitators, and suggested improvements. Data from both sources will then be iteratively refined into categories/themes to assess convergence or divergence of findings. This integrative approach will allow the pilot to inform refinement of the intervention model and highlight actionable community-driven recommendations.

Dissemination Plan

Findings will be disseminated to academic, clinical, and community audiences. Community partners will receive accessible, bilingual reports and presentations (English and Spanish). In addition, peer-reviewed manuscripts will be submitted to journals focusing on mental health disparities and health equity. Finally, policy briefs will be prepared for decision-makers to inform culturally tailored interventions.

References

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