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Review Article

Developing and Evaluating Culturally Sensitive Mental Health Interventions: How the Scrutiny of Diversity Equity and Inclusion (DEI) Initiatives Can Affect Treatment

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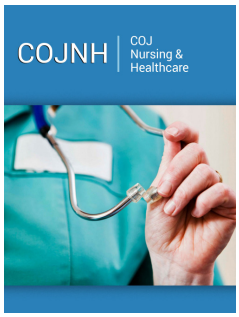

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Abstract

This research aims to investigate and explore the impacts of Diversity, Equity, and Inclusion (DEI) on mental health treatment, within communities. The primary purpose was to examine and explore how beliefs and traditions influence mental health and the utilization of health services. This study used the Bronfenbrenner theory of 1979 [1] which comprises the Microsystem, Mesosystem, Exosystem, and Chronosystems and its components as a lens of data analysis to examine the impact of the scrutiny of DEI on mental health treatment. This study used a "Non-Experimental Descriptive Statistics" "Quantitative Methodology" to analyze current Secondary Data obtained from CDC, MAMI, NCHS, and NIH to investigate and explore the correlations/relationships between Inclusive and Non-Inclusive depression effects in the participants' age groups, sex, and races. The study found that many of the participants experienced some feelings of depression. On average, younger participants reported more experiences of the sentiments of depression than older participants. Additionally, male participants reported more experiences of feelings of depression than female participants. Finally, other and multiple races, non-Hispanic Inclusive 13 out of 58 or 22.4%, and other and multiple races, non-Hispanic Non-Inclusive 8 out of 58 or 0.14% reported more experiencing feelings of depression than other races. The importance of this research study's results and findings needs to be investigated further by public health and public policy decision-makers, which should bring some positive social changes to encourage inclusion when treating patients with mental health needs.

Keywords: Diversity; Equity; Inclusion; Non-Inclusive; Inclusive; Non-Inclusive; Ages; Sex; Race Origin; Experiences; Feelings; Depression; Discriminations

Introduction

This research aims to investigate the impact of Diversity, Equity, and Inclusion (DEI) on mental health care treatment, within communities. This study explores how beliefs and traditions influence mental health and the utilization of health services. In today's interconnected world, grasping the relationship between culture and mental well-being is crucial. Mental health professionals need to appreciate individuals' cultural beliefs to achieve results when providing care to groups. By honoring people's backgrounds, beliefs, and

customs mental health practitioners can build trust, and improve communication with their clients [2-4]. Since various cultures have perspectives on health, this approach ensures that treatment plans are culturally appropriate leading to results and better overall health outcomes. As noted by Griner & Smith [3] an individual's culture can greatly impact their perception of health diagnosis and treatment.

Purpose of the Study

The primary aim of this study is to investigate the impact of Diversity, Equity, and Inclusion (DEI) considerations on healthcare for communities. The research seeks to assist healthcare providers in tailoring their services with a focus on empathy. Cultural aspects play a role in perpetuating the stigma that hinders access to treatment. Recognizing these challenges can aid in developing strategies to lessen stigma and enhance understanding of health concerns and treatment choices. One potential approach may involve integrating therapy techniques that align with clients' cultural beliefs. Moreover, this research could offer insights for policymakers in formulating policies that promote client acceptance of treatment rather than exclusion [5,6]. Additionally, educators must undergo training on empathy to gain a grasp of how culture influences health outcomes.

Community engagement and support play a role in healthcare. Involving the community in understanding how culture impacts health care and prevention is essential for intervention strategies. Overcoming obstacles, like community involvement, is critical. Initiatives focusing on diversity, equity, and inclusion can help tackle challenges related to providing treatment and engaging with individuals. minority populations in need of mental healthcare interventions [7]. While mental health diagnoses as highlighted in DSM 5 are broad, this study will primarily focus on data collected on individuals diagnosed with depression.

Significance of the study

This research contributes to advancing health treatment and policies that improve care in minority communities. People from diverse backgrounds often face obstacles linked to their upbringing, which impact how mental health problems are perceived and treated. Issues like stigma, limited healthcare access, and discrimination worsen these challenges. The study aims to pinpoint barriers and create strategies for aiding these communities. Its discoveries can help policymakers grasp the needs of minority groups better and distribute resources efficiently to tackle inequalities. Additionally, it can guide the implementation of policies that strive to bridge existing disparities. Furthermore, this research will supply insights for healthcare educators specializing in addressing health issues among minority populations to promote equity in healthcare services for these communities. Acknowledging the diversity of backgrounds and experiences is vital for designing health interventions. This involves providing training on competence for healthcare professionals by integrating beliefs and practices into treatment plans while also cultivating relationships with community leaders and members.

By recognizing and respecting these differences we can customize health interventions to better address needs ultimately enhancing their effectiveness and supporting a healthcare system that effectively tackles health issues within communities. Moreover, building trust and connection between therapists and clients through interventions is essential for achieving treatment results. Evaluating the effectiveness of these interventions with a focus on Diversity, Equity, and Inclusion (DEI) is crucial to ensure they cater to the needs of populations. Exploring how DEI assessments impact treatment outcomes can provide insights into how inclusivity and fair practices influence the success of healthcare treatments. This study can help determine whether a closer examination of DEI leads to treatment outcomes that underscore the significance of implementing DEI standards, in healthcare settings. By assessing and refining these approaches healthcare professionals can strive towards providing health services for all individuals.

Theoretical Framework

When creating and assessing health programs, in the realm of Diversity, Equity, and Inclusion (DEI) it is advantageous to apply Bronfenbrenners [1] Ecological Systems Theory. This framework offers insights into the elements that impact individuals within communities. The theory comprises the Microsystem, Mesosystem, Exosystem, and Chronosystems as its components. Bronfenbrenners [1] ecological System Theory encourages professionals to grasp the contexts of individuals by tackling issues concerning health, family dynamics, and community support systems [1]. By examining these connections within DEI endeavors we can assess how they either facilitate or hinder health interventions. Delving into Diversity, Equity and Inclusion (DEI) efforts can provide perspectives on how obstacles or supportive atmospheres influence the accessibility and quality of healthcare services. Policies that promote fairness and inclusivity in healthcare can be scrutinized to evaluate their efficacy in delivering care. Mindful interventions should harmonize with prevailing views on health. Respectfully challenge them. It is crucial to examine DEI initiatives to guarantee they authentically mirror and honor community values rather than enforcing a one-size-fits-all strategy.

When addressing the constraints of Diversity, Equity, and Inclusion (DEI) initiatives in meeting communities' needs within systems it is vital to encourage cooperation among stakeholders, from sectors to address healthcare. To enhance healthcare interventions and assess the success and inclusivity of Diversity, Equity, and Inclusion (DEI) initiatives these efforts must be flexible and adjusted to changing situations. Drawing from Bronfenbrenner's Ecological Systems Theory can help in this regard.

Research questions

What are the influences of the depth of examination on DEI initiatives on the success of attuned mental health interventions?

Hypothesis

This research study hypothesized a single hypothesis.

Alternative hypothesis 1

Hypothesis H1: There are some significant relationships/ correlations between the influences of the depth of examination on DEI initiatives on the success of attuned mental health interventions

Null hypothesis 1

Null hypothesis Ho: There are insignificant relationships/ correlations between the influences of the depth of examination on DEI initiatives on the success of attuned mental health interventions

Literature Review

Stigma has been identified as a barrier that hinders minority communities from receiving healthcare services. Golberstein [8] propose that policy objectives should concentrate on diminishing the stereotypes linked to health conditions. Their research revealed that many health issues remain untreated because of this stigma. Recognizing and respecting the backgrounds and identities of individuals seeking healthcare assistance is vital. These initiatives play a role in understanding how cultural influences impact an individual's health and response to care. By promoting empathy in therapy sessions practitioners can improve the effectiveness of their approaches by tailoring them to each patient's needs. The importance of these efforts is evident in communities where individuals from minority groups may face difficulties in accessing quality healthcare resulting in challenges such as misdiagnosis, underutilization of services, and poorer health outcomes [9]. Research indicates that personalized interventions considering factors can enhance satisfaction levels and overall outcomes for patients from backgrounds. Hence it is essential to incorporate competence into healthcare delivery, for support.

A study conducted by Jordans [10], emphasized the significance of a supportive care system in healthcare treatment. This study underscored the need to address challenges such as stigma to improve outcomes, for individuals navigating health issues. Efforts to promote Diversity, Equity, and Inclusion (DEI) in the healthcare field strive to create an environment where individuals from different backgrounds can access top-notch healthcare services. These programs focus on lessening healthcare disparities by enhancing the skills of providers and fostering environments that value perspectives and lived experiences [11]. Additionally, research has delved into strategies for advancing DEI within the healthcare sector.

Healthcare professionals participate in training programs to improve their expertise. Policies are under review to ensure access to services while community engagement initiatives are being implemented to meet the needs of populations. It is worth noting that studies indicate disparities in health outcomes among minority groups who may experience rates of health issues and potentially receive treatment compared to their White counterparts [12]. Moreno & Chhatwai [13], discovered that DEI efforts in healthcare aim to address these disparities by advocating for fairness and inclusivity in healthcare delivery. The growth of DEI initiatives in healthcare has shown progress over time but has also faced criticism, for not addressing certain considerations related to diversity factors. The recognition of the significance of healthcare services has led to the introduction of Diversity, Equity, and Inclusion (DEI) programs geared towards reducing inequalities despite encountering obstacles along the way.

Some experts believe that efforts to support DEI often fall short due to challenges such as constraints, lack of enforcement, and superficial implementation [13]. The assessment of DEI programs currently emphasizes their efficacy and results. While these principles garner backing, ongoing dialogues center on the strategies to realize these objectives in healthcare services. Moreno & Chhattwai [13] highlighted that despite endeavors towards DEI in health services; specific tactics are vital for attaining these goals. They stress that with DEI initiatives and policies in effect, persistent disparities in mental health outcomes indicate a call for action. Concerns also arise that DEI endeavors may sometimes come across as checkboxes without fostering change. Experts suggest a strategy involving the evaluation and fine-tuning of (DEI) approaches, heightened community involvement in decision-making processes, and a dedication to instigating change. DEI initiatives within the healthcare sector aim to improve care provision. While progress has been made continuous scrutiny underscores the need for strategies ensuring that these initiatives genuinely cater to all individuals including those from marginalized communities.

In the healthcare field, research has delved into how Diversity, Equality and Inclusivity (DEI) initiatives affect access, to health outcomes, care, and overall success. Prior studies have pointed out the limitations of diversity, equity, and inclusion efforts in healthcare. For example, a study conducted by Gee & Ford [14] investigated the influence of DEI programs on health disparities among minority ethnic groups. Their results indicated that tailored interventions could enhance access to healthcare services and decrease disparities in treatment outcomes. Additionally, Holden et al. [15] discovered that healthcare models rooted in DEI principles notably improved the quality of care for minorities resulting in satisfaction levels and increased engagement.

Nevertheless, not all studies align on the impact of DEI initiatives. Metzl & Hansens [16] research in 2014 shed light on the deficiencies of programs that overlook disparities. Their findings suggested that while DEI efforts can enhance healthcare professionals' skills, they may disregard factors like status and systemic racism that affect care quality. This critique underscores the necessity for strategies that extend beyond individual-level interventions. A study conducted by Williams [17] in 2018 explored the effects of stress resulting from experiences on well-being. The findings revealed that despite attempts to encourage Diversity, Equity, and Inclusion individuals from marginalized communities continue to face stress due to discrimination and bias. It seems that while initiatives promoting Diversity, Equity, and Inclusion have advantages they may not completely tackle all health concerns associated with inequalities.

Gaps in Research

There has been a growing body of literature dedicated to examining Diversity, Equity, and Inclusion (DEI) efforts and their

impact on health. However, there are still research gaps that need to be addressed. One significant gap is the lack of exploration into the long-term effects of DEI programs on health outcomes. Current studies often only offer a snapshot of the effects without considering their lasting consequences. Research needs to delve into the enduring impacts of DEI initiatives and identify the factors that contribute to their success or failure [18]. Another area that warrants investigation in DEI research is intersectionality. While many studies focus on how DEI initiatives impact groups there a need is to explore how different aspects of identity such as race, gender, sexual orientation, and socioeconomic status within these initiatives can influence health treatment outcomes. This approach could shed light on how multiple facets of identity play a role, in shaping results [19]. Many existing research studies tend to concentrate on the outcomes of these programs without delving into their real-world implementation processes. It is crucial to understand the components of DEI initiatives to identify strategies and potential challenges that could hinder their effectiveness. Additionally capturing the perspectives of individuals who benefit from DEI initiatives through investigations is vital. While numerous studies often examine the viewpoints of healthcare professionals and institutional achievements.

However, it remains important to grasp the viewpoints and contentment of individuals accessing healthcare services through DEI initiatives. Previous research has highlighted the advantages of DEI initiatives in healthcare. Nonetheless, there are deficiencies in existing studies. Bridging these information voids by conducting research that incorporates methodologies, assessments of implementation strategies and input, from service recipients will contribute to advancing our comprehension of the impacts of prioritizing DEI on health results.

Research Design

This comprehensive and complicated research study selected quantitative "Non-Experimental Research Descriptive Statistics" as a lens of collected secondary data analyses as the option of methodology. The reason why this quantitative approach methodology was selected over others such as real experiments or quasi-experiments is that we could not do any experiments on already inclusive or non-inclusive (secondary data) in the DEI participants' analyses. Hence this methodology was selected over others because it perfectly fitted the purpose of this research study as supported below.

Methodology

This study used a Quantitative Research Study using "Non-Experimental Research Descriptive Statistics" to calculate the significant differences between dependable and independent variables. Since secondary data was used to collect data in this study, an experimental research study or quasi-experiment research study was not selected hence this selection [20-22].

Data Collections

Three itemized secondary data statistics were collected from the Center for Disease Control and Prevention CDC among others [23-25]. This research study concentrated on the collected secondary data analyses of DEI associative effects of the use of "Inclusive or Non-Inclusive" DEI by measuring "Experiences Feelings of Depression" which was centered on the sex, age groups, and races' originalities of the participants.

Software of Data Analyses

The selected secondary data were fed into Statistical Package for Social Sciences (SPSS) Version 27, and the collected data were crunched, and the results and findings are shown below as the results and findings of the research study. The statistical analysis software was set at 0.005 or 95% as statistical or insignificant differences between the correlations/relationships between DEI-inclusive and non-inclusive participants.

Results and Findings of the Research Study

Table 1-7 & Figure 1-6.

Table 1: Data Analyzed Statistics about DEI Inclusive or Non-Inclusive Statistics.

Statistics				
		Percentage of Adults Age 18 and Older Who Experienced Feelings of Depression, by Living Alone or Living With Others and Sex	**Percentage of Adults Age 18 and Older Who Experienced Feelings of Depression, by Living Alone or Living With Others and Age Group**	**Percentage of Adults Age 18 and Older Who Experienced Feelings of Depression, by Living Alone or Living With Others and Race and Hispanic Origin**
N	Valid	42	22	58
	Missing	16	36	0
Mean		2.4286	2.3182	6.1207
Std. Error of Mean		0.17755	0.24073	0.33461
Median		3	2	7
Mode		1.00a	1	7
Std. Deviation		1.15067	1.12911	2.54832
Variance		1.324	1.275	6.494
Skewness		-0.019	0.172	-0.416
Std. Error of Skewness		0.365	0.491	0.314

Kurtosis	-1.451	-1.356	-0.816
Std. Error of Kurtosis	0.717	0.953	0.618
Range	3	3	9
Minimum	1	1	1
Maximum	4	4	10
Sum	102	51	355

Table 1 showed the mean of 2.24, for sex, 2.32 for age group, 6.121 for race and ethnicities, 1.151 for sex standard deviation, 1.13 for age group, and 2.55 for ethnicities.

a: Multiple modes exist. The smallest value is shown.

Table 2: Showed 100% cumulative percent frequencies' levels for adults 18 and older sex groups living alone with no missing items.

Percentage of adults age 18 and older who experienced feelings of depression, by living alone or living with others and sex.					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Adult Males 18 years or older included	13	22.4	31	31
	Adult Females 18 years or older included	7	12.1	16.7	47.6
	Adult Males 18 years or older not included	13	22.4	31	78.6
	Adult Females 18 years or older not included	9	15.5	21.4	100
	Total	42	72.4	100	
Missing System		16	27.6		
Total		58	100		

Table 3: Showed 100% cumulative percent frequencies' levels for adults 18 and older age groups living alone with no missing items.

Percentage of Adults Age 18 and Older Who Experienced Feelings of Depression, by Living Alone or Living With Others and Age Group					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Adults between the ages of 18 to 29	7	12.1	31.8	31.8
	Adults between the ages of 30 to 44	5	8.6	22.7	54.5
	Adults between the ages of 45 to 64	6	10.3	27.3	81.8
	65 and older	4	6.9	18.2	100
	Total	22	37.9	100	
Missing System		36	62.1		
Total		58	100		

Table 4: Showed 100% cumulative percent frequencies' levels for adults 18 and older race and Hispanic origin groups living alone with no missing items.

Percentage of Adults Age 18 and Older Who Experienced Feelings of Depression, by Living Alone or Living With Others and Race and Hispanic Origin					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Asian, non-Hispanic Inclusive	3	5.2	5.2	5.2
	Asian, non-Hispanic Non-Inclusive	3	5.2	5.2	10.3
	Black, non-Hispanic Inclusive	6	10.3	10.3	20.7
	Black, non-Hispanic Non Inclusive	4	6.9	6.9	27.6
	White, non-Hispanic Inclusive	6	10.3	10.3	37.9
	White, non-Hispanic Non Inclusive	4	6.9	6.9	44.8
	Other and multiple races, non-Hispanic Inclusive	13	22.4	22.4	67.2
	Other and multiple races, non-Hispanic Non Inclusive	8	13.8	13.8	81
	Other and multiple races, non-Hispanic Inclusive	7	12.1	12.1	93.1
	Other and multiple races, non-Hispanic Non Inclusive	4	6.9	6.9	100
	Total	58	100	100	

Table 5: Showed One-Sample Statistics with means of 2.42, 2.32, and 6.12 with the standard deviations of 1.15, 1.13 and 2.55.

One-Sample Statistics				
	N	Mean	Std. Deviation	Std. Error Mean
Percentage of adults age 18 and older who experienced feelings of depression, by living alone or living with others and sex	42	2.4286	1.15067	0.17755
Percentage of adults age 18 and older who experienced feelings of depression, by living alone or living with others and age group	22	2.3182	1.12911	0.24073
Percentage of adults age 18 and older who experienced feelings of depression, by living alone or living with others and race and Hispanic origin	58	6.1207	2.54832	0.33461

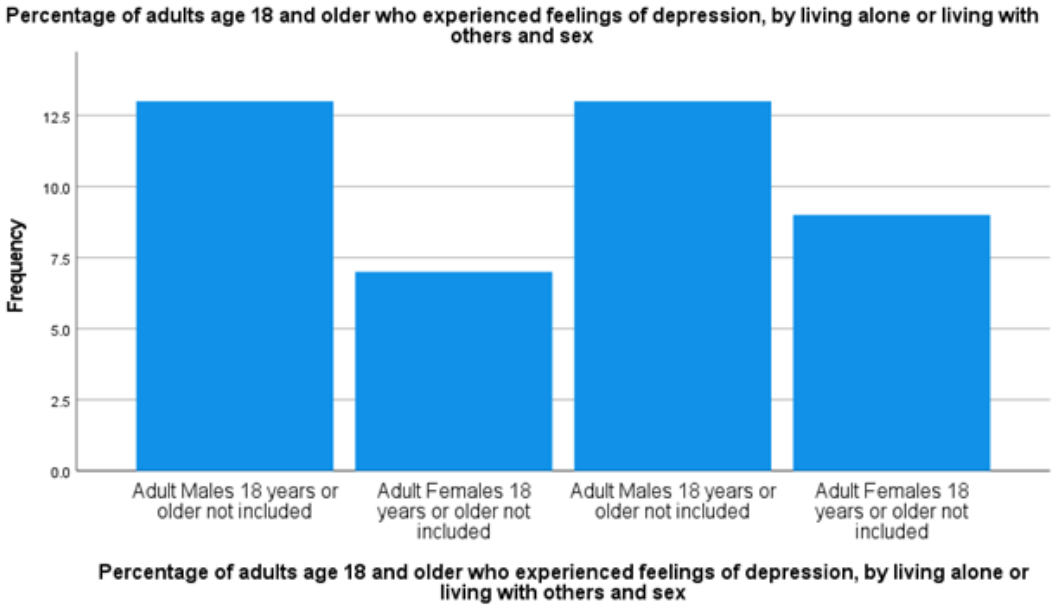

Figure 1: Percentage of age 18 and older sex levels who experienced feeling of depression due to inclusive or non-inclusive in their living arrangements.

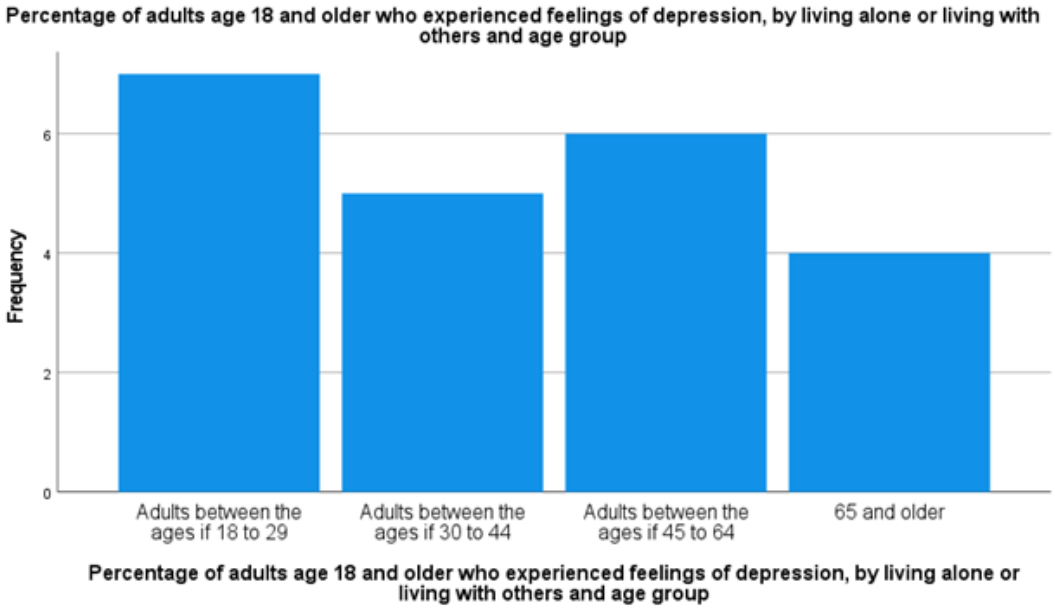

Figure 2: Percentage of age 18 and older levels who experienced feeling of depression due to inclusive or non-inclusive in their living arrangements.

Table 6: One-Sample Test with means of 2.42, 2.32, and 6.12 and statistical significant differences of .000, .000, and .000 or 100% statistical significant differences between the groups.

One-Sample Test						
Test Value = 0						
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Percentage of adults age 18 and older who experienced feelings of depression, by living alone or living with others and sex	13.678	41	0	2.42857	2.07	2.7871
Percentage of adults age 18 and older who experienced feelings of depression, by living alone or living with others and age group	9.63	21	0	2.31818	1.8176	2.8188
Percentage of adults age 18 and older who experienced feelings of depression, by living alone or living with others and race and Hispanic origin	18.292	57	0	6.12069	5.4506	6.7907

Table 7: Showed the One-Sample Effect Sizes Cohen's d samples and Hedges' correction at 1.15 versus 1.17, 1.13 versus 1.17, and 2.55 versus 2.58 no corrections of samples' sizes are needed.

One-Sample Effect Sizes					
		Standardizer[a]	Point Estimate	95% Confidence Interval	
				Lower	Upper
Percentage of adults age 18 and older who experienced feelings of depression, by living alone or living with others and sex	Cohen's d	1.15067	2.111	1.56	2.653
	Hedges' correction	1.17227	2.072	1.531	2.604
Percentage of adults age 18 and older who experienced feelings of depression, by living alone or living with others and age group	Cohen's d	1.12911	2.053	1.3	2.79
	Hedges' correction	1.17154	1.979	1.253	2.689
Percentage of adults age 18 and older who experienced feelings of depression, by living alone or living with others and race and Hispanic origin	Cohen's d	2.54832	2.402	1.889	2.908
	Hedges' correction	2.58248	2.37	1.864	2.87

a: The denominator used in estimating the effect sizes.

Cohen's d uses the sample standard deviation.

Hedges' correction uses the sample standard deviation, plus a correction factor.

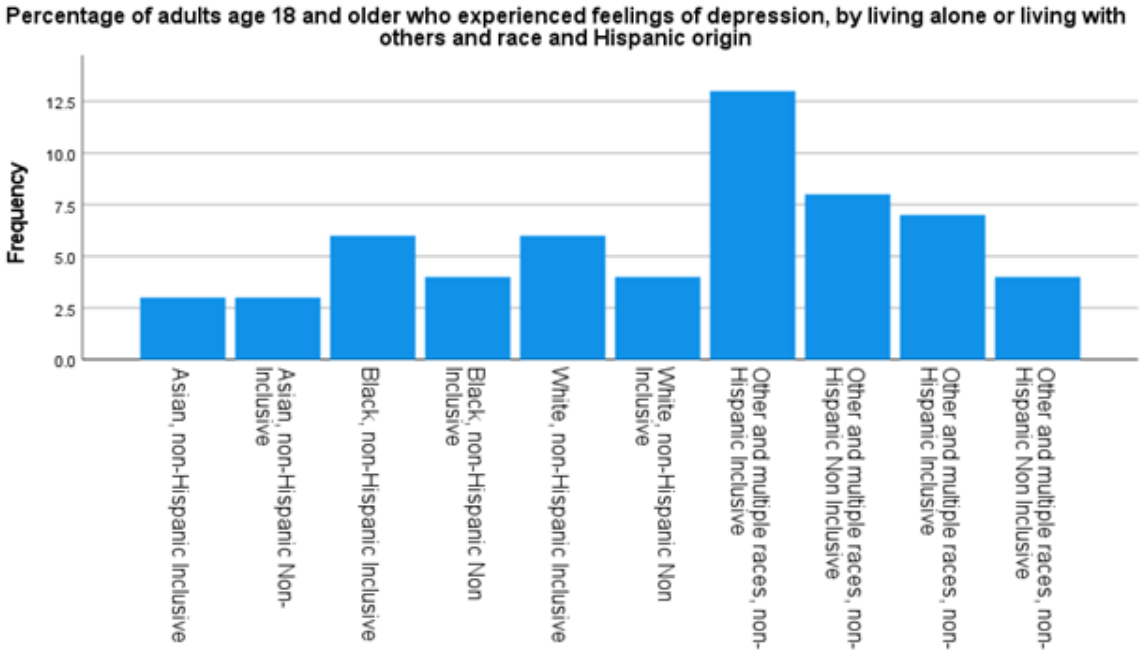

Figure 3: Percentage of age 18 and older race and Hispanic origin who experienced feeling of depression due to inclusive or non-inclusive in their living arrangements.

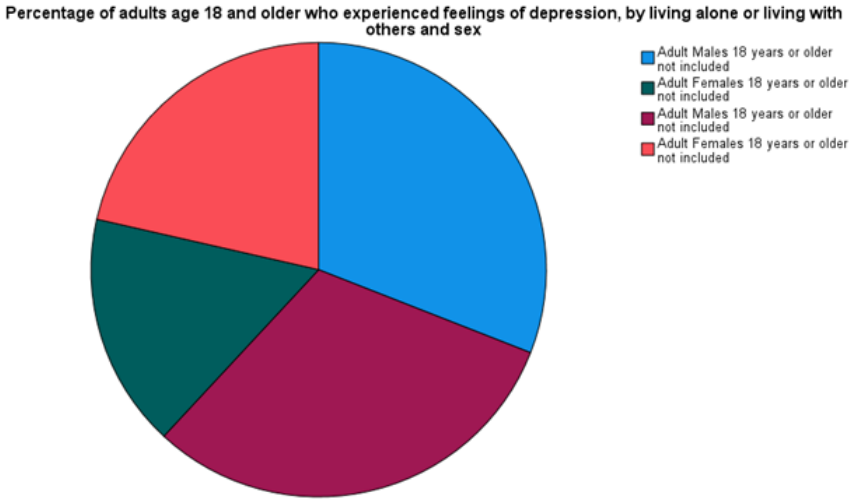

Figure 4: Color-Coded Pie Chart of the Percentage of age 18 and older sex levels who experienced feeling of depression due to inclusive or non-inclusive in their living.

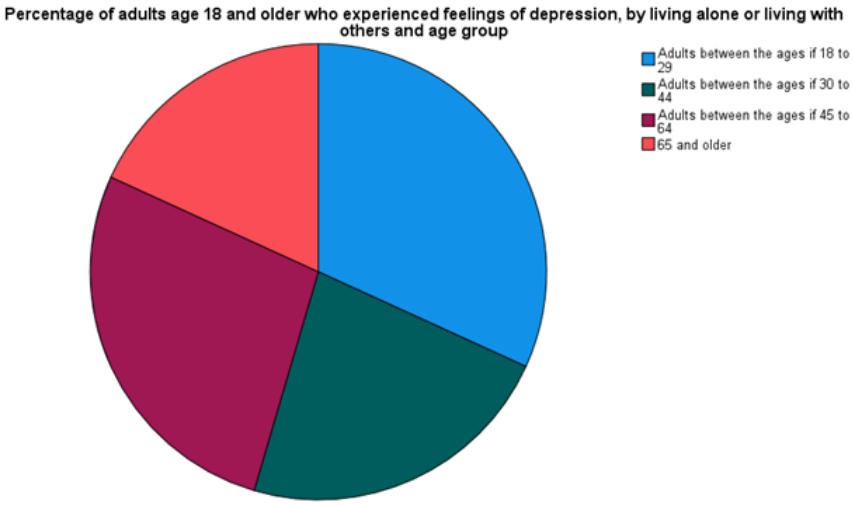

Figure 5: Color-Coded Pie Chart Percentage of age 18 and older levels who experienced feeling of depression due to inclusive or non-inclusive in their living arrangements.

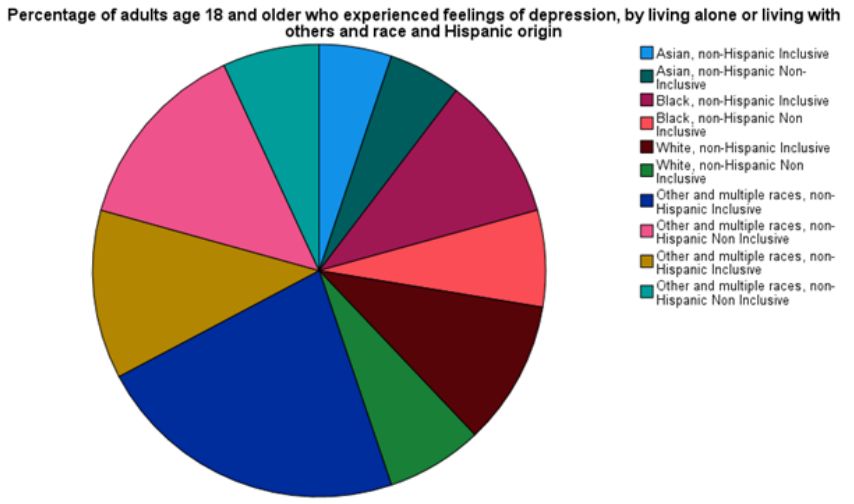

Figure 6: Color-Coded Pie Chart Percentage of age 18 and older race and Hispanic origin who experienced feeling of depression due to inclusive or non-inclusive in their living arrangements.

Interpretations of the Results and the Findings of the Study

The study found that there were some significant relationships/correlations between the influences of the depth of examination on DEI initiatives on the success of attuned mental health interventions. For example, the means between sexes, ages, and races were 2.43, 2.32, and 6.12 collectively and the standard deviations were 1.15, 1.13, and 2.55 (Table 1). The study found that 13 out of 42 or 31% of inclusive males above 18 years reported experiencing feelings of depression and 13 out of 42 or 31% of non-inclusive participants also reported forms of depression. On the contrary hand, inclusive females above 18 years reported experiencing feelings of depression in 7 out of 42 or 17% and 9 out of 42 or 21.4% of non-inclusive participant females also reported forms of depression (Table 2). Also, the study found that 7 out 22 or 32% of adults between the ages of 18 to 29 reported experiencing feelings of depressions, in adults between the ages of 30 to 44, 5 out of 22 or 23%, adults between the ages of 45 to 64, 6 out of 22 or 27.3% and 65 and older 4 out of 22 or 18.2% reported experiencing feelings of depressions (Table 3). In terms of race, the study found that Asian, non-Hispanic Inclusive 3 out of 58 or 0.052% and Asian, non-Hispanic Non-Inclusive 3 out of 58 or .0052 reported experiencing feelings of depression [26-30]. Among Black, non-Hispanic Inclusive 6 out 58 or 10.3% and Black, non-Hispanic Non-Inclusive 4 out of 58 or0.069% reported experiencing feelings of depression. Other and multiple races, non-Hispanic Inclusive 13 out of 58 or 22.4%, and other and multiple races, non-Hispanic Non-Inclusive 8 out of 58 or 0.14% reported experiencing feelings of depression [30-37]. The study found that this population reported experiencing feelings of depression than other populations in this research study (Table 4 & Figure 1-6). All the results and findings of this DEI's complicated and comprehensive DEI's research study found, demonstrated, pinpointed, and stipulated that this DEI research study showed some statistical significant differences between all participants in all areas about the DEI project's classifications and inclusive and non-inclusive such as "Ages, Races, and Sexes" about who actually experienced some feelings of depression and who did not during this comprehensive DEI's research study (Table 1-7 & Figure 1-6).

As to answer this critical research question as pinpointed and shown below;

Alternative hypothesis 1a

Hypothesis H1: There are some significant relationships/correlations between the influences of the depth of examination on DEI initiatives on the success of attuned mental health interventions.

Null hypothesis 1

Null hypothesis Ho: There are insignificant relationships/correlations between the influences of the depth of examination on DEI initiatives on the success of attuned mental health interventions.

The research study found that there was an overwhelming overall of One-Sample Test Sig (2-Tailed) of .000, .000, and .000 or 100% relationships/correlations between dependent and independent variables. This demonstrated that there was evidence of experiencing feelings of depression across the board. As such, the study ACCEPTED the Alternative 1 and REJECTED the Null Hypothesis 1 that "There are some significant relationships/correlations between the influences of the depth of examination on DEI initiatives on the success of attuned mental health interventions." Above all, the denominator is used in estimating the effect sizes. Cohen's d uses the sample standard deviation. Hedges' correction uses the sample standard deviation, plus a correction factor was not needed due to their statistically significant closeness of the collected raw secondary data statistics (Table 6 & 7).

Conclusion and Discussions of the Research Study

This comprehensive and complex DEI research study sheds some fundamental bright light on what the limitations of DEI were based on the collected and analyzed secondary data. The study found that the younger males and females reported experiencing feelings of depression more than the older males and females. The study further found 100% correlations/relationships between the study's dependent and independent variables. For example, every participant in this research study reported some form of feelings of depression, which indicated that more needs to be done as to accommodate all DEIs' components. As the theoretical framework selected and used as a lens of data analysis in the research study stipulated "DEI efforts must be adaptable and responsive to evolving circumstances. Leveraging Bronfenbrenner's Ecological Systems Theory can improve healthcare interventions…evaluate the effectiveness and inclusivity of DEI programs with care" (p. 2).

In conclusion, this research has fundamental lessons learned and insights gained for all public as well as to private health practitioners about the limitations of DEI's implementations. The study also showed that for DEI to be effective, efficient, and proficient in any environment the theoretical components of Leveraging Bronfenbrenner's Ecological Systems Theory should and must be holistically implemented to become successful. The study also shed some valuable light on the successes and failures associated with "Inclusive versus Non-Inclusive" in any treatment or learning setting. This was the case because some participants who were classified as "Inclusive" in this research study and those who were classified as "non-inclusive" showed statistically insignificant indifferences between the two groups. The percentage of age 18 and older race and Hispanic origin experienced feelings of depression due to being inclusive or non-inclusive in their living arrangements. Other and multiple races non-Hispanic accounted for the most and Asians accounted for the least. The younger participants experienced the feeling of depression more than the older participants regardless of their classifications. The male participants experienced the feeling of depression more than the female participants regardless of their classifications. The importance of these research results and findings needs to be investigated further by public health and public policy decision-makers which should bring some positive social changes to all participants of DEI. While DEI scrutiny is a current topic of discussion, long-term studies need to be conducted to study the implications of the scrutiny of inclusion and diversity in mental health treatment.

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