UTILIZATION OF MENTAL HEALTH SERVICES AMONG AFRICAN AMERICANS

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B.S., California State University, Sacramento, 2008

PROJECT

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SOCIAL WORK

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SPRING
2010
UTILIZATION OF MENTAL HEALTH SERVICES AMONG AFRICAN AMERICANS

A Project

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Division of Social Work
Abstract

of

UTILIZATION OF MENTAL HEALTH SERVICES AMONG AFRICAN AMERICANS

by

Marshay L. Hunter

Mental illnesses are real and disabling conditions and if left untreated can result in disability and despair for schools, families, workplaces, and communities. Mental illness is a global problem and can affect every human being one or more times during his or her life span. African Americans have a history of using the mental health system, but within that system they have been misdiagnosed, underserved, inappropriately classified, and treated with different methods than their Caucasian counterparts. Despite efforts to reduce barriers to mental health care, African Americans are still among those who underutilize mental health services. In this research study, the factors used to examine the utilization of mental health services included inclination to seek services, barriers pertaining to the utilization of mental health services, and preferences for the utilization of mental health services. These factors were examined with the aim of increasing awareness and providing recommendations to the community and the social work profession.

_____________________, Committee Chair
Serge Lee, Ph.D., MSW

Date
ACKNOWLEDGMENTS

It is truly an honor and a privilege to have traveled this far in my educational journey. My Savior paved the road to my educational journey, but I had to make the choice to stay on that road. The road was bumpy and hard at times, but my Savior knew just how much I was able to handle. I give thanks to my Savior for walking with me to the finish line. Amen.

To my wonderful family, I show you gratitude for your love, understanding, and support over the years. Thank you for walking and growing with me as I embarked on my educational journey. It saddens me to be at the finish line and not have my grandfather there waiting for me to finish up, like he did at the track meet, but I know he is proud because education is the road he wanted me to travel. I have to give it all up to my grandparents (Mae and Joe Hunter) for keeping my feet planted on solid ground and always picking up the pieces. I am privileged to be one of those individuals who was raised by a community of family members (Mom: Carol; Dad: Marvin; grandparents; uncles: Dwight, Jeff, Jason; and aunts). Thank you for your addition to my life. To my sister, cousins, godchildren, and friends: “Dare to dream. Your destiny awaits. Remember that a dream is not enough fulfill it.”

To my teachers and professors, you have prepared and provided me with the tools to accomplish my goal and carry out my passion. From the bottom of my heart, you are appreciated, and I express my thankfulness for giving so selflessly of yourselves to prepare me for the road that awaits.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgments</th>
<th>v</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Tables</td>
<td>vii</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>1. THE PROBLEM</td>
<td>1</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Background of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Research Problem</td>
<td>3</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>3</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>4</td>
</tr>
<tr>
<td>Assumptions</td>
<td>5</td>
</tr>
<tr>
<td>Justifications</td>
<td>6</td>
</tr>
<tr>
<td>Summary</td>
<td>6</td>
</tr>
<tr>
<td>2. REVIEW OF THE LITERATURE</td>
<td>7</td>
</tr>
<tr>
<td>Introduction</td>
<td>7</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>7</td>
</tr>
<tr>
<td>Historical Review</td>
<td>8</td>
</tr>
<tr>
<td>Services Provided by Faith-Based Organizations</td>
<td>10</td>
</tr>
<tr>
<td>Barriers to Service Utilization</td>
<td>12</td>
</tr>
<tr>
<td>Experiences With Treatment</td>
<td>16</td>
</tr>
<tr>
<td>Disparities in Usage of Mental Health Services</td>
<td>22</td>
</tr>
<tr>
<td>Asian American Experience With Mental Health Services</td>
<td>24</td>
</tr>
<tr>
<td>Latino American Experience With Mental Health Services</td>
<td>26</td>
</tr>
<tr>
<td>Summary</td>
<td>29</td>
</tr>
<tr>
<td>3. METHODS</td>
<td>30</td>
</tr>
<tr>
<td>Introduction</td>
<td>30</td>
</tr>
<tr>
<td>Table</td>
<td>Title</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>1.</td>
<td>Table 1.0a Age of Participants</td>
</tr>
<tr>
<td>2.</td>
<td>Table 1.0b Gender of Participants</td>
</tr>
<tr>
<td>3.</td>
<td>Table 2.0 Educational Level of Participants</td>
</tr>
<tr>
<td>4.</td>
<td>Table 3.0a Household Income of Participants</td>
</tr>
<tr>
<td>5.</td>
<td>Table 3.0b Participants’ Residence Location in Sacramento County</td>
</tr>
<tr>
<td>6.</td>
<td>Table 4.0a Participants’ Employment Status</td>
</tr>
<tr>
<td>7.</td>
<td>Table 4.0b Participants’ Employed With Medical/Mental Health Benefits Status</td>
</tr>
<tr>
<td>8.</td>
<td>Table 5.0a Participants’ Comfort With Seeking Medical Care</td>
</tr>
<tr>
<td>9.</td>
<td>Table 5.0b Participants’ Personal Inclination to Seek Mental Health Services</td>
</tr>
<tr>
<td>10.</td>
<td>Table 6.0a African Americans’ Inclination to Seek Mental Health Services Compared to Other Ethnic Groups</td>
</tr>
<tr>
<td>11.</td>
<td>Table 6.0b Reasons African Americans Delay Seeking Mental Health Service</td>
</tr>
<tr>
<td>12.</td>
<td>Table 7.0 Participants’ Awareness of Mental Health Services in Sacramento County</td>
</tr>
<tr>
<td>13.</td>
<td>Table 8.0a Participants’ Disclosure of Participation in Mental Health Services</td>
</tr>
<tr>
<td>14.</td>
<td>Table 8.0b Composition of Participants’ Support Systems</td>
</tr>
<tr>
<td>15.</td>
<td>Table 9.0a Participants’ Preference of Ethnic Background of Treating Clinician</td>
</tr>
</tbody>
</table>
16. Table 9.0b Participants’ Preference of Cultural Aspects Involved in Treatment Approaches.................................................................45

17. Table 10.0 Participants’ Preference for Type of Mental Health Services Utilized If Experiencing Symptoms.................................................................46
Chapter 1
THE PROBLEM

*Introduction*

The United States is home to an array of races, ethnicities, and cultures. Diversity has enriched our nation by bringing new perspectives, global ideas, and productive contributions to all areas of contemporary life. The contributions of minorities and all Americans rest on a foundation of mental health (Surgeon General, 2000). Fundamental to the overall health and productivity of the United States are the mental conditions of individuals. As defined by the Surgeon General of the United States, mental health is the wellspring of learning, thinking, resilience, self-esteem, and communication skills. It is easy to dismiss the value of mental health until problems arise. Mental illnesses are disabling and real conditions; if left untreated they can result in disability and despair for schools, families, workplaces, and communities. According to Snowden, Masland, Ma, and Ciemens (2006), mental illness left untreated acts as a disability that inhibits the individual’s ability to meet daily responsibilities. The cumulative impact of the individual’s “burden” on the community results from the mental illness of its members.

*Background of the Problem*

Mental illness is a global problem and can affect every human being one or more times during his or her life span. It is postulated that in the state of California mental illness affects nearly every family. A general report by the Mental Health Services Act (2004), a statewide mental health service program created by the passing
of Proposition 63, stated that between 5% and 7% of adults and between 5% and 9% of children within any year have a serious mental illness. As a result, it is estimated that more than 2 million adults, seniors, and children in California every year are potentially affected by a mental illness. The California Health and Human Services Agency Department of Mental Health (2007) reported the percentages of ethnic and racial groups among persons served in county mental health programs for fiscal year 2005 to 2006 as the following: 33.5% whites, 21.9% Hispanics, 15.7% Blacks, 0.8% American Native, 4.5% Asian/Pacific Islander, 1.3% other, and 22.2% unknown/not reported.

Disparities in the usage of mental health services among racial and ethnic minority groups are well documented. Although efforts to reduce the barriers to mental health care among racial and ethnic minority groups date back decades, significant disparities in diagnosis and treatment continue to persist. Several factors contribute to these disparities: lack of trust of mental health care providers; language barriers experienced by recent immigrants from non-English-speaking countries; economic barriers, including lack of health insurance, because minorities tend to be on average less wealthy than Caucasians. A majority of the mental health providers are nonminorities, which can create linguistic or cultural barriers (Dobalian & Rivers, 2008). Dobalian and Rivers state that even among those with health insurance, evidence exists that racial and ethnic minorities confront disparities in the use of mental health services. For instance, insured minorities are more likely than Caucasians to be affected by changes in their health coverage, in part due to differences in socioeconomic status. Since mental illness is disabling and when left untreated affects the community, the
impact is a burden on the community. Due to untreated mental illness, ethnic minority communities tend to suffer more than Caucasian communities (Snowden et al., 2006).

Statement of the Research Problem

Past and present research reveals that mental illness is prevalent in the United States. Mental illness affects almost every family, regardless of background or age. A diagnosis of a mental illness brings stigma, discrimination, and a lack of support services. Those who become disabled by mental illness deserve the same care that is extended to those who face other kinds of disabilities. Historically, people of African descent have utilized the mental health system, but within that system they have been misdiagnosed, underserved, inappropriately classified, and treated with different methods than were their Caucasian counterparts. Due to stigma and discrimination, minorities are reluctant to seek help for their illness (Parham, 2002).

Purpose of the Study

The rationale of this research study is to examine the utilization of mental health service among African American adults in Sacramento, California, so that recommendations can be made to social workers and other health and human services providers to better serve this population. The researcher conducted a survey study utilizing snowball sampling to recruit participants, which means that prospective participants were African American adults who were relatives, friends, acquaintances, and church members known to the researcher and her family. It is hypothesized that by participating in the research study, the participants could provide a community
perspective regarding utilization of mental health services among African Americans in Sacramento, California.

Theoretical Framework

Sociopsychological and human ecology perspectives are theoretical perspectives that examine communities and assist the researcher in gaining a greater understanding of how they work (as cited by Zastrow & Kirst-Ashman, 2007). According to Zastrow and Kirst-Ashman, community can be defined as a group of people who have something in common with one another that links them and distinguishes them from others who are not a part of the community. The above theoretical perspectives will be used to aid in explaining the utilization of mental health services among African Americans.

The sociopsychological perspective of communities involves how members feel about themselves and interact with each other. Zastrow and Kirst-Ashman (2007) state that an individual’s feelings about their relationship to and with their community are of the upmost importance. Contemporary researchers such as Parham (2002) suggest that African Americans will at first depend on traditional support systems during time of distress. The traditional support systems could include older relatives, elders in the community, or other individuals who are perceived as having gained wisdom. As a result, the sociopsychological perspective aids in explaining how African American minorities could feel inferior to nonminority counterparts, resulting in insufficient care of their mental health needs.

The human ecology perspective of a community pertains to the focus of the relationship of populations to their environments, especially regarding how people and
services are distributed. This perspective emphasizes how populations are distributed within a geographical area and how individuals interact with others in their social environments. A portion of this interaction includes access to resources. In communities, some population groups will inevitably have greater access than will others (as cited by Zastrow & Kirst-Ashman, 2007). Viewing communities from a human ecology perspective assists to focus on the inequalities and problems faced by people who have fewer resources than do others in the community. This perspective also provides a useful assessment tool for understanding why people act as they do within the context of the larger community. Economic and demographic factors are known to contribute to the varying proportions in African American usage of mental health services; for instance, African Americans who are employed but whose employers do not offer health insurance benefits may not utilize such services. In addition to the economic barriers are social attitudes, including cultural mistrust, differences in attitudes and knowledge (Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2000b).

**Assumptions**

The assumptions in this research study include: (a) African Americans, in addition to other minority groups, are in need of mental health services; (b) African Americans are less likely to access mental health services to avoid stigma, discrimination, and the lack of support services; (c) African Americans are less likely to disclose information pertaining to mental health due to fear of being seen as weak by
other African Americans. These assumptions could play a factor in how African Americans seek out mental health services.

**Justifications**

The researcher of this project speculated that this research project will contribute to the social work and health and human services fields because it will provide an understanding of why African Americans underutilize mental health services. The conclusion of this project includes recommendations for improving the delivery and access of mental health services to the African American population.

**Summary**

Chapter 1 of this research project has included an introduction, background of the problem, statement of the research problem, purpose of the research study, theoretical framework, assumptions, and justifications. Chapter 2 includes a review of the literature. Chapter 3 includes the methodology. Chapter 4 includes an analysis of the data obtained from the research survey. Chapter 5 includes conclusions of the findings from the research study, implications and recommendations for social work practice, and suggestions for future research.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

The literature review is organized into eight segments. The first segment presents the definition of relevant terms pertaining to the utilization of mental health services. The second segment provides a brief historical account of the African American experience during slavery. The third segment presents services provided by faith-based organizations in the communities that subsidize services that were difficult to assess by African Americans. The fourth segment discusses the barriers to service utilization. The fifth segment discusses the treatment experience of this group. The sixth segment examines disparities in the usage of mental health services. The seventh segment provides an account of Asian Americans’ experiences when utilizing mental health services. The eighth segment presents the experience of Latino Americans in term of utilizing mental health services.

Definition of Terms

The definition of terms provides conceptualization of frequently used relevant terms pertaining to the utilization of mental health services among African Americans.

Mental health is defined as the ability to function in accord with the nature, aim, and purpose of their creation. Assessing mental health requires that clinicians understand the nature of African people. The role of the clinician is to assist the client to assess his or her degree of functional ability in relation to nature (Parham, 2002).
Mental disorder/mental illness is conceptualized as a clinically significant behavior or psychological syndrome or pattern that occurs in an individual. There is association with present distress or disability or with a significantly increased risk of suffering death, pain, important loss of freedom, and disability. The disorder’s pattern cannot be merely an expected and culturally appropriate response to a particular event. The disorder must be considered a manifestation of a behavioral, biological, and psychological dysfunction in the individual (American Psychiatric Association, 2000).

**Historical Review**

Garretson (1993) reports that during the first portion of the 19th century, families usually took care of their mentally ill relatives at home. Garretson found that there were two reasons behind that responsibility: (1) a lack of available public or private facilities to provide care; and (2) the stigma associated with being mentally ill. As a result of these two factors, families were motivated to keep the mentally ill in the home and hidden. Information pertaining to mentally ill slaves is nonexistent, but as a rule, the slave owners, who absorbed the economic loss of the slaves’ nonproductivity, cared for mentally ill slaves. Free Blacks who became mentally ill were usually very poor, and their families were not in the position to provide care or absorb the economic loss. These mentally ill family members were generally placed in the care of public institutions.

According to Jarvis (2008), during the antebellum period of American history the mental health of African Americans was disregarded on the slave plantations of the Old South. Psychosis among slaves was considered to be rare, because mental illness
was seen to afflict the “civilized” classes that were faced with strains and increased mental activity produced by their civilizations. Jarvis explained that during this period African Americans were viewed as “primitive” people who lacked the mental capacity to engage in the demands of the modern world and were theoretically exempt from psychosis or less likely to become psychotic. Psychosis among slaves came to the attention of physicians when the symptoms were severe and threatened productivity. Symptoms that were quietly endured by the slave went unnoticed, because overseers and slave masters assigned simple routine work that was tailored to the limitations of the affected slaves.

The census of 1840 (Garretson, 1993) for the first time counted residents of mental hospitals and provided comparative statistics of White and Black mentally ill patients. In this report, census information from 15 northern and 15 southern states was used to study the patient population. It was discovered that the number of northern White patients was nearly the same as the number of southern White patients. It was discovered that there were 10 times more Black patients in the North than in the South. In 1842, these statistics were interpreted to mean that the highest state of civilization had the greatest danger of mental problems. It was concluded that slaves were better adjusted than free Blacks were, so slavery must be better for American Blacks (Garretson, 1993).

Study of African Americans with mental illness was possibly sparked by the Great Migration, when large numbers of southern Blacks moved to northern cities after the World War I. The mental health of Blacks in earlier years was unnoticed in the
northern states, possibility due to the small numbers of non-White minorities living in the areas. By 1944, high rates of mental illness in African Americans were no longer confined to the South and became mainstream. Over time, the mainstream study came to focus more on psychosis and the distinction between hospital admission rates and rates of the disorder were distorted (Jarvis, 2008).

In considering the history, Garretson (1993) reported that problems resulted from poor data collection, poor research design, and interpretation of results. The data collection problems originated because of past and current access to mental health services by Black and White patients. Accessibility of mental health care continues to be a problem for the African American population because public mental health facilities continue to be more accessible than private facilities. Problems with interpretation of data collected occurred because, historically, researchers had not taken into consideration communication styles, vocabulary, value systems, or expressions of distress differences by African Americans as compared to Whites.

*Services Provided by Faith-Based Organizations*

According to Taylor, Ellison, Chatters, Levin, and Lincoln (2000), historically, African American communities have a tradition of providing internal human services programs most often in the context of religious institutions. African American churches provided a range of opportunities and resources to African Americans who were inaccessible to or neglected by mainstream institutions. The churches provided community outreach programs, food for the unemployed, free health clinics, child care, and recreational activities. Portrayals of African American life focus on the social and
economic problems and challenges facing this group. That perspective often overlooked the strengths and resources that have assisted Black communities in overcoming obstacles and barriers. Descriptive findings from the aforementioned researchers indicate that Black churches provided services in areas as basic needs of living, health programs, and family services.

Perdue, Johnson, Singley, and Jackson (2006) discussed racial disparities in the mental health system that could be decreased by mental health providers learning to use spirituality as a clinical tool for assessment and treatment. The tendency to explain the experience of mental illness in religious or spiritual terms is common to African Americans; many African American consumers of mental health clinics are influenced by their sense of spirituality when coping with mental illness. The majority of African Americans view mental illness as much a spiritual illness as a physical one. Thus the role of spirituality in the lives of this population and its relationship with mental health care is of great importance when providing treatment.

Perdue et al. (2006) added that the African American approach to spirituality is a continuum of turning to God and turning it over to God. Turning to God and turning it over to God includes meditation, prayer, Bible reading, fasting, attending church, and watching or listening to religious materials. Essentially that is a mechanism for coping with any chronic illness. African Americans who utilize this method believe that individuals have only some control in managing their mental health. The clinician is viewed as the healer instrument whom God has provided to do the divine work. It is documented that African Americans who turn it over to God and turn away from mental
health services tend to be low income, elderly, and/or members of fundamental Christian faith who have low material resources, insufficient health insurance, and a complete distrust in the mental health system.

In order to address spirituality as a clinical tool for assessment and treatment, Perdue et al. (2006) recommend utilizing the Spiritual Perspective Scale and the Spiritual Assessment Scale to assess the spiritual needs of clients, including spiritual distress and support. To identify spiritual resources, clinicians can use the spiritual genogram and spiritual ecomap. When conducting the spiritual assessment, it is imperative for the clinician to go beyond probing questions relating to religious preference, such as church attendance, use of prayer, and reading or listening to religious materials. It is more important for the clinician to assess the spiritual practices and beliefs relating to spiritual distress, support, and the management of mental disorder.

*Barriers to Service Utilization*

Ayalon and Alvidrez (2007) conducted a study to uncover the experiences of Black consumers in the mental health system. The focus of the research project was to identify barriers and facilitators of mental health treatment. The study recruited 34 seriously mentally ill Black consumers who were interviewed to develop an intervention that would decrease stigma regarding mental illness among seriously mentally ill Black consumers in San Francisco County.

Ayalon and Alvidrez (2007) categorized the responses of the participants into four categories: barriers to treatment, treatment facilitators, recommendations of service
improvements, and advice to future consumers. The common barriers present included lack of knowledge pertaining to the availability of treatment, denial of the mental illness, importance of upholding family privacy, concerns regarding medications, treatment approaches, and stigma. System barriers were also reported pertaining to receiving inadequate and inappropriate dehumanizing services. Identified as treatment facilitators were recognition of the need for mental health services, positive experience with past treatment attempts, and a supportive environment. The participants’ recommendations included outreach in the community, sufficient follow-up, and service coordination. In terms of advice to future consumers, the participants advised the importance of recognition and acceptance of one’s need for mental health services and ignoring the negative opinions of others. This study proved to be unique because it focused on Black mental health consumers and their unique characteristics without comparing them to the majority culture. The findings from the study presented the importance of educating mental health consumers, in addition to the general public, about the availability of services and the nature of mental illness. The findings can assist in guiding mental health providers toward improving mental health service for Blacks.

Hines-Martin, Malone, Kim, and Brown-Piper (2003) conducted a qualitative study to explore the help-seeking experiences of a sample of 24 African American males and females who sought public mental health services for the first time. The participants were recruited from community outpatient and inpatient settings. The participants identified barriers in terms of mental health services utilization at three
levels: individual, environmental, and institutional. In terms of access to mental health services, the findings suggested the participants experienced stigma, gatekeeper biases, lack of sufficient insurance coverage, and difficulty with conceptualization of their problems. This study illustrates that understanding how individuals think and discuss struggles for problem solving is key in facilitating equitable mental health service usage. The findings recommend for future research that stigma needs more exploration to deconstruct the concept and identify the components that are susceptible to change.

A research article by Thurston and Phares (2008) investigated the influence of parents’ gender, race, and psychopathology on barriers and attitudes toward utilizing mental health services for themselves and their children. Parent participants in the study totaled 194; specifically, the participants were 51.5% African Americans, 50 mothers and 50 fathers; and 48.5% Caucasians, 48 mothers and 46 fathers. The finding displayed that 36.3% had utilized mental health services for themselves in the past. Of the parents who did utilize mental health services, 69.6% were mothers and 68.1% were Caucasian. A total of 19.4% of children in the total sample had utilized services in the past. In addition, 67.6% of the children’s parents had personally utilized services. The overall findings indicated that a greater number of mothers compared to fathers had used mental health services in the past. Another well-established pattern presented by the study was racial differences in the usage of services, such that Caucasian parents used more services than did African American parents. Parents did not differ by gender or race in relation to current psychopathology. In relation to African American and Caucasian parents’ attitudes and barriers to treatment for themselves and their children,
The correlation analysis provided a positive relationship between parents’ barriers and child-related barriers to treatment. The findings presented that parents perceived significantly more barriers for themselves than for their children. Essentially, parents were more able to overcome barriers when seeking services for their children.

Thurston and Phares (2008) propose recommendations that take into account the fact that fathers and minorities utilize services the least. The recommendations include targeting specific barriers to the utilization of treatment by decreasing access barriers, flexibility with mode of treatment delivery, development of strategies to reduce early dropouts, interventions tailored to the needs of the family, and clinicians’ increased cultural sensitivity to clients’ experiences.

African Americans in low-income communities are at a greater risk of exposure to traumatic events and symptoms of posttraumatic stress disorder (PTSD) (Davis, Ressler, Schwartz, Stephens, & Bradley, 2008). Davis et al. set out to (a) examine the frequency of trauma exposure and PTSD symptoms in a sample of low-income African Americans who were seeking out treatment in public hospitals and primary care clinics; (b) examine the reported needs of mental health services in this population as they relate to PTSD symptoms; and (c) examine the barriers to receiving services and the relationship of those barriers to PTSD symptoms.

The results of the study by Davis et al. (2008) displayed that approximately 22% of the 220 participants recruited met the criteria for PTSD. The reported traumas included murders of friends and family, sexual assaults, and attacks with weapons. Out of the 45 participants meeting the criteria for PTSD, 95% were at one time consumers
of mental health services, receiving treatment for depression, anxiety disorder, bipolar disorder, and schizophrenia. Findings from Davis et al. indicate that only 13.3% of the PTSD patients had received PTSD-focused treatment. In relation to the participants’ perceived importance of mental health services and PTSD in their lives, the participants rated family counseling at 21%, mental health care at 31%, individual counseling at 27%, and substance abuse treatment at 13%. The participants as a whole reported barriers to accessing mental health services as family disapproval, negative counseling experiences reported by others, ineligibility for services, community disapproval, and limited finances and transportation.

The data from the study suggest that participants with PTSD symptoms are not receiving PTSD-related treatment and that there is a need for mental health services. Davis et al. (2008) suggest the need for awareness of the high prevalence of traumatic events and PTSD in relation to this population. Possessing awareness of the barriers might assist clinicians in collaborating with patients on solutions to overcome barriers. Future research may determine whether the same barriers are faced by other disadvantaged populations and the degree to which the barriers cause harm.

Experiences With Treatment

Kupfer, Frank, Grochocinski, Houck, and Brown (2005) conducted a study that was intended to compare treatment history and clinical characteristics of African American and Caucasian participants in a bipolar disorder registry. For more than 20 years, it has been recognized that bipolar disorder diagnosis in minority communities has often been overlooked. Both African Americans and Hispanics with bipolar disorder
were at high rates of receiving misdiagnosis due to being young and presenting with psychotic symptoms.

Kupfer et al. (2005) used a sample size of 2,718 to compare history and characterize the overall findings by race. The findings from the bipolar disorder registry displayed that 18.5% of the African Americans reported underemployment or unemployment, compared to 37.5% of the Caucasians. The findings showed 68.8% of the African Americans who participated in the study were on welfare, compared to 37.8% of the Caucasians. Sixty-four percent of African Americans reported attempts of suicide, compared to 49.1% of Caucasians. In the study, 14.4% of African Americans reported interacting with a health professional who considered them to be schizoaffective, compared to 8.7% of Caucasians. African Americans who were diagnosed with bipolar disorder reported at 94.7%, compared to 97.1% Caucasians. In the study, 2.9% of African Americans reported a health professional who considered them to be experiencing hypomania, compared to 9.7% of Caucasians. Fifty percent of African Americans reported a health professional who considered them for comorbid diagnosis, compared to 36.6% Caucasians. The findings suggest that African Americans with bipolar disorder need community and mental health services delivery to reduce barriers to early accurate diagnosis and appropriate treatment. The researchers suggest that community education about the disorder to reduce stigma and professional development efforts of clinicians aimed at providing accurate diagnosis are needed.

Sanders Thompson, Bazile, and Akbar (2004) conducted a study by the means of a focus group on the attitudes and beliefs of 201 African Americans regarding
psychotherapy, psychotherapists, and barriers to treatment. The participants revealed that race should not matter in therapy, but they believed that psychotherapists were insensitive to the African American experience. This was displayed because the psychologist often struggled with how and when to address issues concerning culture, race, and ethnicity affects pertaining to mental health attitudes and therapeutic response.

The focus group is considered a qualitative research strategy that uses a semi-structured format of discussion to elicit an in-depth understanding of the values, beliefs, and attitudes that affect behavior. All of the focus groups in the Sanders Thompson et al. (2004) study were conducted by an African American female psychologist who had at least eight years of experience conducting focus groups; she was assisted by an African American graduate student of counseling. Participants were volunteers who were recruited via posted announcements, advertisements, and newspapers. The group facilitator started the process and moved the discussion along with the aid of questions, but the specific content, including the order of discussion, was driven by the participants’ responses.

Sanders Thompson et al.’s (2004) study revealed that the participants were not negative toward seeking mental health-related services, but they had attitudes and beliefs that negatively affected seeking treatment. Participants were more comfortable with the idea of obtaining counseling rather than psychotherapy, which they associated with the label “crazy.” Suicide thoughts or attempts, schizophrenia, depression, drug and alcohol abuse, rape and acts of violence against women and children, and grief were considered serious reasons to seek mental health treatment, as opposed to daily
stressors. Despite acknowledgment of the identified reasons to seek treatment, the participants noted that stigma, cost, and knowledge of available resources affected treatment seeking.

In a study that examined racial differences in attitudes toward professional mental health services and the usage of services, Diala, Muntaner, Walrath, Nickerson, LaVeist, and Leaf (2000a) found that African Americans displayed more need for services but at the same time experienced more negative attitudes about mental health services and were likely not to use the services again in comparison to their Caucasian counterparts’ usage and needs. These negative attitudes displayed implications for follow-up and the outcome of the mental illness. Factors that contributed to the negative attitudes regarding continued usage of mental health services included how services were structured or organized, delivery of services, lack of professionals who resembled clients, and access to quality services in the community, including difficulties in locating and traveling. The study reported that African Americans who received services from racially different providers faced clinicians’ underdeveloped interracial skills and discrimination, which negatively influenced the negative attitudes and the notion of not using the mental health services again.

When examining African Americans’ use of mental health services, Snowden (1999) conducted a study that examined racial differences in the use of mental health services in general medical and specialty mental health. Data came from institutional and household surveys and permitted an estimation of services used in the general population and in samples of persons confined in prisons, jails, and mental hospitals.
The findings from the study supported those from previous community surveys that indicated that African Americans are underrepresented in the mental health treatment world. The finding suggest the importance of adjusting any racial difference observed in services that are used to account for clinical and sociodemographic differences between Caucasians and African Americans and of sampling widely to reach portions of the populations.

Snowden (1999) reported that racial disparities in the utilization of mental health services were present but were apparent less in uncontrolled than in controlled analysis. Before adjustments were made for covariates and weighing of the data, the African American population showed less than did Caucasians in seeking help from therapists in private sectors, from mental health centers, and from physicians. African Americans displayed no difference from Caucasians in terms of the use of public sector therapists, but they used emergency services more than Caucasians. In accounting for this difference, it was apparent that the location of the private sector and their willingness to serve African Americans has to be taken into account.

Evidence from this study displayed that African Americans who have undergone treatment for mental illness are more likely than Caucasians to be in jails, prisons, and mental hospitals and are more likely to become homeless. The African American poor are likely to reside in areas that are impoverished and crime ridden and that offer little margin to absorb the social disability that comes along with mental illness and adds to the downward spiral of social mobility (Snowden, 1999).
Smith and Wermeling (2007) proposed that African American women have the greatest need for mental health services when compared to other ethnic groups but often receive ineffective services. The underlying issues presented that educational level and professional status are permitting African American women to become more upwardly mobile. Therefore, the balance of occupation, family, and community responsibilities increases their susceptibility to physical and mental health problems. Despite the generality that African Americans have negative attitudes toward professional counseling, African American women will seek out services if the problems become severe enough.

The researchers sought to conduct a study on the preference of African American women toward counseling services. An analysis of variance was conducted at .05 level of significance, utilizing individual or group counseling services and African American or Caucasian counselors as independent variables and the anticipated satisfaction as the dependent variable. The results of the study provided that counselor ethnicity has a greater influence on anticipated satisfaction much more than the delivery of services. The results indicated that racial and ethnic counselor preference is present not just with low-income African American population but is also present in upwardly mobile African American women as well (Smith & Wermeling, 2007).

Smith and Wermeling (2007), based on their study, suggest that because African American women who are seeking services could prefer African American providers, the hiring practices among mental health and counseling agencies should be vigilant and proactive in increasing the number of counselors within mental health agencies with an
ethnic background. The mere presence of African American counselors within the agencies could make professional counseling more striking and accessible for upwardly mobile African American women with the financial resources to choose their preferred counseling services.

Disparities in Usage of Mental Health Services

Sue and Chu (2003) presented that disparities exist in the access to and quality of mental health care among ethnic minorities. Ethnic minorities collectively experience a greater disability from mental disorders than do non-Hispanic Whites. The greater disability has been attributed to provisions of services rather than to inherent differences. In addition, cultural factors experienced by minority group member can increase and decrease the risk for developing mental disorders.

Carpenter and Chernoff (as cited in Sue and Chu, 2003) reported that the National Institute of Mental Health funded a study from a nationally representative sample of about 4,000 African Americans, 1,500 Black Americans of Caribbean descents, and 1,500 non-Whites. Participants were interviewed in face-to-face meetings and were asked questions regarding their lives and experiences of religion, health problems, employment, mental health, employment, and psychological resources. In relation to mental health, the survey requested information on medication usage, psychological problems, formal and informal help-seeking, and impairment. The initial findings from the study presented lower rates of mental disorders among African Americans in relation to non-Hispanic Whites. In terms of lifetime prevalence, rates were found to be lower for major depression, social phobia, panic disorders,
agoraphobia, generalized anxiety disorder, and dysthymia. Thus, lower rates of mental disorders were discovered for African Americans. Compared to the mental health findings, the African American population on average was worse off than the general population on almost every other societal and health indicator, including infant mortality and crude death rates. Despite the physical health of African Americans, the results of this study suggested that African Americans might have a lower rate of mental illness than non-Hispanic Whites.

In another study Richardson, Anderson, Flaherty, and Bell (2003) examined disparities in mental health services provided to a population in high need compared to services provided by substance abuse treatment wards, primary care, and specialty mental health clinics providing services to Caucasian and African American patients seeking out treatment for major depression. The findings from the study displayed that the hypothesis of no racial/ethnic differences in the provision of mental health psychotherapy, pharmacotherapy, and counseling was not confirmed. Bivariate and multivariate evidence of racial differences in the provision of pharmacotherapy and psychotherapy was discovered. Racial differences were discovered in the provision of mental health care after controlling for other factors. In addition, the researchers discovered that African Americans were more likely to receive mental health services from substance abuse clinics than from primary care and mental health specific clinics. On the other hand, Caucasians were more likely to use the services from mental health-specific clinics.
Due to the findings, the researchers suggest further research on racial disparities in mental health care be expanded beyond comparisons between primary care and psychiatric settings to include substance abuse treatment facilities. In addition, the study suggests that controls should be entered for diagnosis and other factors, such as site of services provision, due to the apparent disparities in services provided across sites for patients of other races (Richardson et al., 2003).

Asian American Experience With Mental Health Services

In a 1998 article, Herrick and Brown explored the reasons for underutilization of mental health services among Asian Americans residing in the United States. Herrick and Brown pointed out Asian Americans are considered the fastest-growing minority in the United States. Similar to other minorities in the United States, this group has experienced discrimination in the form of stereotyping and racism. The stereotyping includes the perception that Asian Americans do not experience mental illness and do not participate in the services offered by the mental health system as much as Caucasians, African Americans, and Latinos. In addition, Asian Americans are considered as the “model minority”: they are the most educated minority and have higher-paying jobs than other minority groups in the United States.

Other researchers pointed out that the mental health of all immigrants, including Asian Americans, reflects an interplay between their migration experience and the experience of assimilation; individual hardiness; their attachment to their own culture group, including the extent of their social support from family and friends; and their experience of acceptance in this country (Hurh & Kim, 1990; Kessler & Neighbors,
The researchers revealed the contributing factors to the underutilization of mental health services to the support of a tight knit family dynamic, use of indigenous healers or spiritual leaders, stigma and shame that reflects poorly on the family, lack of access to culturally appropriate services, and not being identified in demographic studies (Herrick & Brown, 1998).

Herrick and Brown (1998) make suggestions to improve mental health services. The suggestions include the involvement of indigenous healers on the treatment team to enhance the incorporation of Eastern and Western strategies for helping the client; the integration of a family-focused treatment plan rather than an individual-focused treatment plan because of the individual’s dependence on the family for support; beginning medications with lower dosages and gradually increasing the dosage to an appropriate therapeutic window to avoid uncomfortable side effects; and teaching consumers and families about therapeutic options to assist with compliance and inclusion in the decision-making process.

Atkinson, Lowe, and Matthews (1995) conducted a study with the purpose of investigating the relationship among Asian American gender, acculturation, and willingness to seek personal and academic counseling. Due to past utilization, it was hypothesized that Asian Americans were more willing to go to counseling for academic problems than for personal problems, but the difference was less for those who scored high on acculturation than those who scored low on acculturation. Earlier research revealed that gender was a factor, and it was hypothesized that female participants were
more willing to seek counseling for personal and academic reasons than were male participants.

The Atkinson et al. (1995) study revealed that the participant’s level of acculturation and type of problem did not significantly influence the willingness to see a counselor. The Asian American women in this study were not more willing to see a counselor than were Asian American men. The participants were found to underutilize psychological and psychiatric counseling services and to overutilize career counseling and academic services. This suggests that mental health services delivery factors such as accessibility of services, availability of culturally similar counselors, and self-fulfilling biases of the service providers may account for the patterns of services utilization found among this population.

*Latino American Experience With Mental Health Services*

It is expected that by the year 2030, the Latino population will total more than 73 million, which would comprise about 20% of the U.S. population (U.S. Census Bureau, 2004, as cited in Añez, Silva, Paris, & Bedregal, 2008). Añez et al. explored the need to develop culturally and linguistically mental health services to address the diverse need of the Latino American population. Data reveals that there are only 29 Latino mental health providers for every 100,000 Latinos in the United States, compared to an estimated 173 Caucasian providers available for every 100,000 Caucasians in the country (U.S. DHHS, 1999, as cited in Añez et al.). Those discrepancies are of great concern considering that Latinos in the United States have increased mortality and morbidity rates, suicide rates, school dropout rates, alcohol and
illicit substance use rates, and HIV infection rates (Centers for Disease Control and Prevention Office of Minority Health, 2005; Martinez, DeGarmo, & Eddy, 2004; Substance Abuse and Mental Health Services Administration, 2005; all cited in Añez et al., 2008). Añez et al. offer suggestions for improving the challenged mental health system. The first improvement is to face the challenge of engaging a high-need and underserved population. The second improvement is to identify the disparities contributing including stigma, poverty, cultural and linguistic barriers, lack of bilingual staff, and the lack of empirically supported treatments that resemble Latinos’ needs.

Shattell, Hamilton, Starr, Jenkins, and Hinderliter (2008) conducted a community-based participatory research. This type of research bridges the gap between academic research and real-life situations of communities and offers suggestions for addressing issues. The methods used were a purposeful design that included contacting agencies to locate individuals who might be interested in participating in this study. The study identified the factors that affect the Latino population’s access, usage, and concept of mental health services at individual, organizational, and community levels. The individual-level factors included health benefits related to mental illness and care, unethical or suspicious providers, immigrant status and acculturation, financial factors, and cultural gender roles. The organizational-level factors pointed out issues related to access to care and the cost, immigrant status and acculturation, insufficient bilingual providers, and culturally sensitive care. The community-level factors included the travel distance between available resources and the need to provide resources closer in the community and immigrant status and acculturation.
In an article by Garcia and Saewyc (2007), the researchers conducted a study on the health-related perceptions of Mexican-origin immigrant adolescents with the effort of informing a design for culturally and developmentally appropriate mental health services. The researchers pointed out that rates of suicide, depression, and anxiety are high among Latino adolescents in the United States; many such youth are immigrants. During the immigration period, the adolescents are at risk of developing mental health problems. In addition, limited research is available that presents mental health problems among immigrant Latino adolescents.

Garcia and Saewyc (2007) utilized focus ethnography to research the health-related experiences and perceptions of immigrant Latino adolescents. This type of focus was chosen because it provides an understanding of the context of the environment and culture. Fourteen adolescents were recruited from September 2003 to September 2004 from two community settings: a bilingual public charter school and a neighboring Catholic church. The data came from one-to-one semi-structured interviews and a visually narrative project coded and analyzed inductively. The results of the research revealed that the adolescents were willing to describe mental health experiences about themselves and others. It was apparent that a gap existed between recognizing mental health problems and identifying or accessing professional help to promote a healthy mental status. Due to this evident gap, the researchers propose suggestions to professional helpers that might meet the needs of adolescent Latinos or the general Latino population. Suggestions include the professional helpers emphasizing education,
awareness, intervention, barriers, and cultural competence when in contact with the Latino population, especially the adolescents.

Summary

In this chapter, the relevant literature of the topic was reviewed. The themes of discussion in this chapter included definition of relevant terms, a brief historical account of the African American experience, services provided by faith-based organization, barriers to service utilization, treatment experience of this group, disparities in the usage of mental health services, an account of Asian Americans’ experiences in utilizing mental health services, and the experiences of Latino Americans in utilizing mental health services. Chapter 3 presents the research methodology of the utilization of mental health services among African Americans.
Chapter 3
METHODS

Introduction

This chapter presents the research design, sampling design, and instrument used in this study. The chapter includes the preparation for data analysis. The considerations utilized for the protection of human subjects are discussed. The chapter also includes the delimitations of the study. The chapter concludes with a summary.

Research Design

This research project utilized the exploratory design, quantitative in nature. The exploratory design is appropriate for this research project, as mental health utilization by African American adults in Sacramento County is not yet well understood. Currently, it is unclear as to the reasons African American adults do not fully utilize mental health services that are available to all adult residents in Sacramento County. Exploratory research is a strategy used when information is lacking pertaining to the topic under study (Marlow, 2005).

To reiterate, the purpose of this research study was to examine the utilization of mental health services among African Americans so that recommendations can be made to social work and other health and human services providers in Sacramento County to improve services to better serve the African American population. Participants in the research study provided the researcher with valuable insights as the basis on which to make recommendations to increase the utilization of mental health services among this population.
Sampling Design

Participants for this research project were African Americans 18 years of age or older. The sample size for the research study consisted of 31 participants. The researcher used snowball sampling to recruit participants, which means that participants were African American adults who are relatives, friends, acquaintances, and church members known to the researcher and her family. Rubin and Babbie (2008) define the term snowball as “the process of accumulation as each located subject suggests other subjects” (p. 343).

The participants for this research study were recruited by telephone calls, e-mail, and referrals. Relatives, friends, acquaintances, and church members showed willingness to be participants in this research study as evidenced by their acceptance and completion of the research questionnaire. Relatives and church members were more inclined to provide referrals to conduct the research study with their coworkers and acquaintances. Individuals who were referred to the researcher by relatives and church members did not provide any additional referrals for others to participate in the research study. Friends and acquaintances sparingly provided additional referrals to participants in this research study. A majority of the friends and acquaintances who participated in this research study reported this as their first opportunity to participate in an activity that warrants their input on a pertinent topic to the African American community. In order to uphold confidentiality, participants were provided with the opportunity to complete the research questionnaire in their considered comfort arena. Comfort arenas included the participant’s home, work office, coffee shop, and the researcher’s home.
Instrument

This research study utilized a survey questionnaire developed by the researcher (see Appendix B). The survey questionnaire was designed to be completed in 15 to 20 minutes and consisted of 35 questions total with a mixture of closed-ended and open-ended questions. Marlow (2005) points out that closed-ended questions give the respondents limited categories to choose as answers. Open-ended questions allow the respondents to create a response. Twenty of the 35 developed questions were closed-ended. Five of the 35 developed questions were closed-ended but supplied the “other” option to specify the answer. Eight of the 35 developed questions were closed-ended and allowed the participant to explain his or her rationale. Two of the 35 developed questions were open-ended.

The survey questionnaire was constructed to allow respondents to provide input on an array of questions. Respondents answered demographic questions pertaining to age, gender, income, educational level, household composition, and location of residence. Respondents reported on usage of supportive services including medical and mental health services either from personal or secondary experiences. Respondents also answered questions regarding mental illness, discrimination, and recovery.

Marlow (2005) presents that quantitative data collection instruments are most easy to test for reliability and validity. The instrument was not pretested for reliability and validity coefficient. After the construction of the research questionnaire to test for ambiguity and error, a pretest was administered to three individuals who were representative of the population and to the researcher’s project adviser. Due to their
administrative role, the three pretesters were not included as participants in the actual research study.

Data Analysis

Upon completion of the data collection procedure, all the raw data was entered into the statistical programming package SPSS. The variables of the data collected representing the questions asked were entered in columns in the Variable View window of SPSS, and the respondents’ answers to the questions were entered in the Data View window. The name of each variable was entered row to row. Labels were assigned to variables that received abbreviated names, and a value label was assigned for each code pertaining to the particular variable. To bring meaning to the data collected, the method utilized to analyze the data was descriptive statistics. Descriptive statistics procedure summarizes the sample or the relationship (Marlow, 2005).

Protection of Human Subjects

As required by California State University, Sacramento, the researcher obtained approval from the Committee for the Protection of Human Subjects at California State University, Sacramento, Division of Social Work Committee for the Protection of Human Subjects. The researcher completed a “Request for Review by the Sacramento State Committee for the Protection of Human Subjects Application.” The application had a total of eight questions that were required for completion. Within the allotted questions, the researcher proposed the following: who would comprise the research subjects; recruitment methods; maintenance of informed consent; privacy and safety of the subjects; summary of the purpose, design, and procedures; description of the
research questionnaire; explanation of considered risk associated with participation of the subjects. The questions on the application pertaining to description of physical procedures and utilization of drugs or pharmaceuticals did not apply to this research proposal.

Once the researcher filled out the application, it was submitted to the researcher’s project advisor Dr. Serge Lee, who provided feedback and approval. After Dr. Lee approved the application packet, it was submitted to the Division’s Institutional Review Board (IRB). Later in the submission process, the researcher was contacted via e-mail with the information that this research proposal and survey questionnaire were approved by the Social Work Committee for the Protection of Human Subjects at “minimal risk,” approval number 09-10-041, expiring in January 2011. The research proposal was approved at “minimal risk” because some of the questions included in the survey questionnaire could cause discomfort or trigger psychological conditions.

Prior to receiving the survey questionnaire, each participant was provided with a consent to participate form that required a signature to identify approval for participation (Appendix A). The consent to participate form explained that participation in this research study was voluntary, participation could end at any time, and there would be no compensation provided. The consent form also explained the basis for conducting this study, time parameters, and risk associated. Contact information to Sacramento County Adult Mental Health Services Adult Access Team and Child and Family Mental Health Services was provided on the consent form in the event of psychological distress. In order to protect the participant’s confidentiality, the research
questionnaire did not include identifying information such as name, Social Security number, or address. The completed research questionnaires were kept in a locked box at the researcher’s home and were destroyed in May 2010. In the event participants had additional questions, contact information for the researcher and research adviser was included on the consent form.

**Delimitation**

The researcher used relevant articles, journal articles, and research study results to compile information to report on this topic. The research survey participants included African American adults residing in Sacramento County. The research study is limited to the perspective of 31 African American participants.

**Summary**

This chapter explained the research design, sampling design, and instrument used in this research study. The considerations utilized for the protection of human subjects and delimitations were discussed. The following chapter will displays and reports the analyzed data.
Chapter 4

RESULTS

Introduction

This chapter presents the results from the research study. The results presented in this chapter examine the utilization of mental health services among African Americans. Presentations from the findings display demographic information pertaining to the participants in the study. Specifically, information obtained from the research project explained the following: level of comfort in seeking medical care, personal inclination to seek mental health services, inclination of the population to seek services compared to other ethnic groups, reasons African Americans delay seeking mental health services, knowledge of mental health services in Sacramento County, disclosure of participation in mental health services, composition of the support system, preference of ethnic background of treating clinician, preference of cultural aspects included in the treatment approach, and type of services one would select if experiencing symptoms related to a mental illness.

Demographics

Gender and age

Table 1.0a and 1.0b display the frequency distributions of age and gender of the research participants. Findings indicate that the participants’ ages ranged from 19 to 64 years of age. Male participants accounted for 38.7% and female participants accounted for 61.3%.
Table 1.0a

Age of Participants

<table>
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<th>Age</th>
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<th>Valid Percent</th>
<th>Cumulative Percent</th>
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Table 1.0b

Gender of Participants

<table>
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<th>Gender</th>
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</tr>
</tbody>
</table>

Educational Level of Participants

Table 2.0 present the findings in terms of the research participant’s educational level. Of the participants, 19.4% had received at least a high school education, 38.7%
reported a community college educational level and 41.9% reported a university educational level.

Table 2.0

**Educational Level of Participants**

<table>
<thead>
<tr>
<th>Valid</th>
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<th>Frequency</th>
<th>Percent</th>
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<td></td>
</tr>
</tbody>
</table>

**Household Income of Participants**

Table 3.0a displays the household income of the research participants. The findings displayed that 25.8% of the research participants’ income ranged from $8,000 to $20,000; 22.6% of the participants’ income ranged from $32,000 to $44,000; 22.6% income was more than $68,000, and 9.7% of the research participants’ income was under $8,000, between $12,000 and $32,000, or between $56,000 and $68,000.

Table 3.0a

**Household Income of Participants**

<table>
<thead>
<tr>
<th>Valid</th>
<th>Under $8,000</th>
<th>Frequency</th>
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<tr>
<td></td>
<td>$12,000-$32,000</td>
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<td>9.7</td>
<td>9.7</td>
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</tr>
<tr>
<td></td>
<td>$32,000-$44,000</td>
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<td>22.6</td>
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<tr>
<td></td>
<td>$56,000-$68,000</td>
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<tr>
<td>Over $68,000</td>
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<td>Total</td>
<td>31</td>
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</table>
Participants’ Residence Location in Sacramento County

Table 3.0b displays the residence locations of the research participants. Of the research participants, 74.2% resided in the south area of Sacramento County and 16.1% resided in the north area of Sacramento County.

Table 3.0b

<table>
<thead>
<tr>
<th>Residence Location</th>
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</tr>
<tr>
<td>Total</td>
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<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Employment With Medical/Mental Health Benefit Status

Table 4.0a and 4.0b display the findings pertaining to employment and benefit status. Of the research participants, 80.6% reported being employed, 19.4% were unemployed, 71.9% of the research participants reported employment with benefits, and 12.9% reported employment with benefits not offered by their employers.

Table 4.0a

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25</td>
<td>80.6</td>
<td>80.6</td>
<td>80.6</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>19.4</td>
<td>19.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.0b

*Participants’ Employed With Medical/Mental Health Benefits Status*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Yes</td>
<td>22</td>
<td>71.0</td>
<td>71.0</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>4</td>
<td>12.9</td>
<td>83.9</td>
</tr>
<tr>
<td></td>
<td>Not Apply</td>
<td>5</td>
<td>16.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Purpose of the Study*

To reiterate, the purpose of this research study was to examine the utilization of mental health services among African Americans so that recommendations can be made to social work and other health and human services providers in Sacramento County to improve services and better serve the African American population. The researcher was interested in gaining insight on mental health services utilization by African American adults in the greater Sacramento County region. The research participants were asked to report their level of comfort in terms of seeking medical care, personal inclination to seek mental health services, African Americans’ inclination to seek services compared to other ethnic groups, reasons African Americans delay seeking mental health services, knowledge of mental health services in Sacramento County, disclosure of participation in mental health services, composition of the support system, preference of ethnic background of treating clinician, preference of cultural aspects included in the treatment approach, and type of services one would select if experiencing symptoms related to a mental illness.
Participants’ Comfort With Seeking Medical Care

Table 5.0a displays the research participants’ comfort level toward seeking medical care: 41.9% of the research participants “feel comfortable,” 41.9% “feel extremely comfortable,” and 16.0% “feel somewhat comfortable” in seeking medical care.

Table 5.0a

Participants’ Comfort With Seeking Medical Care

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel somewhat comfortable</td>
<td>5</td>
<td>16.1</td>
<td>16.1</td>
</tr>
<tr>
<td>I feel comfortable</td>
<td>13</td>
<td>41.9</td>
<td>58.1</td>
</tr>
<tr>
<td>I feel extremely comfortable</td>
<td>13</td>
<td>41.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Participants’ Personal Inclination to Seek Mental Health Services

Table 5.0b displays that 90.3% of the research participants reported “yes,” 6.5% reported “no,” and 3.2 % reported “don’t know” in terms of their personal inclination to seek mental health services if experiencing symptoms.

Table 5.0b

Participants’ Personal Inclination to Seek Mental Health Services

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Yes</td>
<td>28</td>
<td>90.3</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>6.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Don't Know</td>
<td>1</td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
African Americans’ Inclination to Seek Mental Health Services Compared to Other Ethnic Groups

Table 6.0a presents that 58.1% of research participants reported that African Americans are less likely to seek mental health services compared to other ethnic groups, and 35.5% reported they are unsure whether this population is less likely to seek services compared to other ethnic groups.

Table 6.0a

African Americans’ Inclination to Seek Mental Health Services Compared to Other Ethnic Groups

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>18</td>
<td>58.1</td>
<td>58.1</td>
<td>58.1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>6.5</td>
<td>6.5</td>
<td>64.5</td>
</tr>
<tr>
<td>Don't know</td>
<td>11</td>
<td>35.5</td>
<td>35.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Reasons African Americans Delay Seeking Mental Health Services

Table 6.0b displays the potential reasons African Americans delay or are reluctant to seek mental health treatment. The table presents that 35.5% of the research participants reported that this population delays or is reluctant to seek services due to feelings of shame; 35.5% reported delays or reluctance due to lack of insurance coverage; 22.6% reported delays or reluctance due to lack of knowledge of available resources, and 3.2% reported delays or reluctance due to stigma and discrimination.
Table 6.0b

*Reasons African Americans Delay Seeking Mental Health Services*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling of shame</td>
<td>11</td>
<td>35.5</td>
<td>35.5</td>
<td>35.5</td>
</tr>
<tr>
<td>No insurance coverage</td>
<td>11</td>
<td>35.5</td>
<td>35.5</td>
<td>71.0</td>
</tr>
<tr>
<td>Stigma/discrimination</td>
<td>1</td>
<td>3.2</td>
<td>3.2</td>
<td>74.2</td>
</tr>
<tr>
<td>Unaware of available resources</td>
<td>7</td>
<td>22.6</td>
<td>22.6</td>
<td>96.8</td>
</tr>
<tr>
<td>Not Apply</td>
<td>1</td>
<td>3.2</td>
<td>3.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

*Participants’ Awareness of Mental Health Services in Sacramento County*

When inquiring about the participants’ level of awareness regarding mental health services that are available in Sacramento County, 51.6% of the participants revealed an unawareness of the mental health resources available in the county where they reside, and 48.4% revealed an awareness of the mental health resources available. Of those who reported an awareness of the mental health resources available, many had had some type of involvement with the health and human services or related field. Table 7.0 displays this data.

Table 7.0

*Participants’ Awareness of Mental Health Services in Sacramento County*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Yes</td>
<td>15</td>
<td>48.4</td>
<td>48.4</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>16</td>
<td>51.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>31</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Participants’ Disclosure of Participation in Mental Health Services

Table 8.0a presents that 83.9% of research participants reported they would inform others of their participation in mental health-related services, and Table 8.0b presents that 63.1% of the support system would be family members and 12.9% would be mental health providers.

Table 8.0a

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26</td>
<td>83.9</td>
<td>83.9</td>
<td>83.9</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>9.7</td>
<td>9.7</td>
<td>93.5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>2</td>
<td>6.5</td>
<td>6.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 8.0b

Composition of Participants’ Support Systems

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>19</td>
<td>61.3</td>
<td>61.3</td>
<td>61.3</td>
</tr>
<tr>
<td>Friends</td>
<td>2</td>
<td>6.5</td>
<td>6.5</td>
<td>67.7</td>
</tr>
<tr>
<td>Mental health providers</td>
<td>4</td>
<td>12.9</td>
<td>12.9</td>
<td>80.6</td>
</tr>
<tr>
<td>No one</td>
<td>2</td>
<td>6.5</td>
<td>6.5</td>
<td>87.1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3</td>
<td>9.7</td>
<td>9.7</td>
<td>96.8</td>
</tr>
<tr>
<td>Family, friends, other consumers of mental health</td>
<td>1</td>
<td>3.2</td>
<td>3.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Participants’ Preference of Ethnic Background of Treating Clinician

The findings in Table 9.0a indicate that 77.4% of the research participants reported not having a preference for the ethnic background of the treating clinician, and Table 9.0b indicates that 58.1% of the participants would prefer their cultural aspects beliefs to be included within the treatment approaches.

Table 9.0a

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Yes</td>
<td>7</td>
<td>22.6</td>
<td>22.6</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>24</td>
<td>77.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 9.0b

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Yes</td>
<td>18</td>
<td>58.1</td>
<td>58.1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>4</td>
<td>12.9</td>
<td>71.0</td>
</tr>
<tr>
<td></td>
<td>Don't Know</td>
<td>9</td>
<td>29.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Participants’ Preference for Type of Mental Health Services Utilized if Experiencing Symptoms

Table 10.0 presents the findings related to the type of mental health services participants might utilize if experiencing symptoms. Of the participants, 35.5% revealed they would seek services from a private practice agency; 16.1% reported seeking
services from a church or relating to spirituality; 16.1% reported seeking services from a psychiatric hospital; and 12.9% of participants revealed they did not know the type of services they would seek out.

Table 10.0

Participants’ Preference for Type of Mental Health Services Utilized If Experiencing Symptoms

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-help groups</td>
<td>2</td>
<td>6.5</td>
<td>6.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Private practice</td>
<td>11</td>
<td>35.5</td>
<td>35.5</td>
<td>41.9</td>
</tr>
<tr>
<td>Community-based agency</td>
<td>1</td>
<td>3.2</td>
<td>3.2</td>
<td>45.2</td>
</tr>
<tr>
<td>Spirituality/church</td>
<td>5</td>
<td>16.1</td>
<td>16.1</td>
<td>61.3</td>
</tr>
<tr>
<td>Psychiatric hospital</td>
<td>5</td>
<td>16.1</td>
<td>16.1</td>
<td>77.4</td>
</tr>
<tr>
<td>Would not seek treatment</td>
<td>1</td>
<td>3.2</td>
<td>3.2</td>
<td>80.6</td>
</tr>
<tr>
<td>Don't know</td>
<td>4</td>
<td>12.9</td>
<td>12.9</td>
<td>93.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>6.5</td>
<td>6.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Summary

This chapter presented the results from the research survey. Chapter 5 provides conclusions of the finding from the research study, implications and recommendations for social work practice, and suggestions for future research.
Chapter 5

CONCLUSIONS

Introduction

This chapter summarizes the major finding from this research study. It includes a summary and discussions of the factors that attributed to the utilization of mental health services among African Americans. The chapter also discusses the implications for social work practice as well as recommendations and suggestions for future research.

Summary

As discussed in chapter 3, the participants in the study provided insight on mental health service utilization by African American adults in the greater Sacramento County region. Major findings from this research study included that participants’ inclination to seek services, barriers to the utilization of mental health services, and preferences on the utilization of mental health services appear to display as consistent and inconsistent with previous research studies. The discussion section below further elaborates on the major findings of this study as they relate to the consistent and inconsistent factors with previous research studies.

Discussion

The researcher examined a variety of different factors attributed to the utilization of mental health services among African Americans, including personal inclination to seek mental health services. Findings from the research study revealed that participants would seek mental health services when experiencing a mental illness.
The overall findings indicate that 80.6% \((N = 31)\) had attended or graduated from a community college or university. The majority of the participants were employed with medical/mental health benefits and reported preferring to seek mental health services in the private practice arena as the primary means and within spirituality as the secondary means. That proved to be consistent with the previous studies that indicated that African Americans turn to God for spiritual help to a larger degree than to modern medicine and mental health services. In addition, the literature presented that this group of people are usually low income, elderly, members of Christian faith with low material resources, insufficient health insurance, and distrust in the mental health system (Perdue et al., 2006; Taylor et al., 2000).

A significant finding from this study that displayed to be inconsistent with literature pertained to the inclination to seek out mental health services. Of the respondents, 90.3% \((N = 31)\) reported that they would seek mental health services in the greater Sacramento region, compared to 6.5% \((N = 31)\) who reported that they would not, and 3.2% \((N = 31)\) reported not knowing. This is in contrast to Thurston and Phares (2008), who indicated that African American parents were less likely to overcome barriers to seek out services for themselves but were more able to overcome barriers and would be willing to seek mental health services for their children.

Another finding that appeared significant for this sample group was related to mental health services utilization of African Americans seeking services compared to other ethnic groups and reasons that African Americans delay seeking mental health services. Examining this relationship more closely, it was found that 58.1% \((N = 31)\)
reported that African Americans are less likely to seek mental health services compared to other ethnic groups. The participants attributed delay in seeking services to feelings of shame, lack of insurance coverage, lack of knowledge of available resources, stigma, and discrimination. Those reports present to be consistent with previous studies that indicate that African Americans were not negative towards seeking mental health services but had attitudes and beliefs that negatively affected seeking services when compared to their Caucasian counterparts. The barriers identified from those studies were stigma, cost, knowledge of available resources, access to services, delivery of services, and lack of professionals who resembled clients (Sanders Thompson et al., 2004; Diala et al., 2000a; Ayalon and Alvidrez, 2007; Hines-Martin et al., 2003).

The factors pertaining to the disclosure of participation in mental health services and the composition of a support system appeared as another significant factor. Findings presented that 83.9% (N = 31) would disclose to others their participation in mental health services. The composition of the support system would include family, reported by 61.3% (N = 31) of the participants. Those findings present to be inconsistent with previous studies that pertain to disclosure of participation in mental health services and support systems. Previous literature indicated that barriers to accessing services were attributed to upholding family privacy, family disapproval, and community disapproval; due to those standards, African Americans withhold from disclosing of their involvement in mental health services (Davis et al., 2008; Ayalon & Alvidrez, 2007).
Another relevant factor pertained to the preference of the ethnic background of the treating clinician: 77.4% ($N = 31$) of the participants reported not having a preference for ethnic background of the treating clinician, 58.1% ($N = 31$) reported having a preference for their cultural aspects being involved in treatment approaches, and 29% ($N = 31$) reported not knowing. Those results are consistent with the Sanders Thompson et al. (2004) study that African American participants revealed that race should not matter in therapy, but the psychotherapists were believed to be insensitive to the African American experience. Essentially, the therapists struggled with issues concerning culture, race, and ethnicity. In contrast, Smith and Wermeling’s (2007) study displayed that upwardly mobile African American women with financial resources to choose their counseling services have indicated that racial and ethnic preference does matter in terms of a clinician. That is inconsistent with the research participants of the current study because a majority of the women who were wealthy with financial means reported that ethnicity of the treating clinician did not matter but having their cultural aspects involved in the treatment approaches was important.

The final factor that presented to be significant involved the research respondents’ report pertaining to their awareness of mental health services in Sacramento County. Of the respondents, 51.6% ($N = 31$) revealed an unawareness and 48.4% ($N = 31$) reported an awareness of the services available in Sacramento County. The majority of the respondents who reported an awareness of the services available in Sacramento County were employed or had involvement with the health and human service field. Those findings were consistent with previous literature that reported
African Americans are unaware of the mental health services that should be available in the community and to all citizens (Ayalon & Alvidrez, 2007; Sanders Thompson et al., 2004).

Implications for Social Work Practice

To reiterate, the goal of the researcher was to bring awareness to social workers and other health and human services providers of the importance of mental health among a minority group that has been long suffering with mental illness and in the mental health system. The purpose of the research project was to examine the experiences of the African American populations in term of their utilizing of mental health services. It is the hope of the researcher that from this research project awareness and understanding will be gained to aid in better servicing this population. At a micro-level of practice, social workers and other health and human services providers can use the information presented in this research project to work with the persons they are individually assessing for needs and the development of collaborative intervention plans. On a mezzo-level of practice, social workers and other health and human services providers can utilize the information presented to educate themselves on the historical and current barriers faced by this minority group to aid in working with small groups. At a macro-level of practice, social workers and other health and human services providers can utilize the findings from the research study to advocate for social and economic justice at the agency and legislative levels.
Recommendations

The information contained in this research project was acquired from relevant literature and a sample of the African American population. The intent was to bring awareness and understanding to aid social workers and other health and human services providers in being competent helpers in serving this population. The following contains a listing of recommendations for social workers and other health and human services providers to explore and utilize when working with the African American population:

1. Providers must be properly trained to conduct accurate diagnoses of mental illness.

2. Providers must be culturally competent in African American cultural aspects and history.

3. Mental health consumers should act as collaborative partners with providers to develop and carry out treatment plans.

4. Mental health agencies should develop programs that are appropriate for providers to service African American consumers.

5. Mental health agencies should integrate cultural aspects and spirituality within the treatment approaches.

6. Mental health agencies should be centrally located within the community to reduce accessibility barriers.

Conclusion

Previous studies have been done pertaining to the utilization of mental health services among African Americans. The reports displayed that mental illness is a
disabling condition when left untreated. Despite the fact that disparities in the usage of mental health services among minority groups is well documented, significant disparities in diagnosis and treatment continue to persist, and as a result African Americans continue to underutilize mental health services. The intent of this study was to contribute to the social work field of study. Recommendations for future research pertaining to the utilization of mental health services among African Americans should include recruitment of a larger sample of the population to provide a greater representation of the experiences; the larger sample will present with an array of different experiences. Exploration of the internal help such as religion will determine the relevance of support it provides to this population. Also, with social workers and other health and human services providers having an awareness of this pertinent issue that affects African Americans and other minority groups, further research can be performed to advocate for programs and treatment approaches that meet the needs of African Americans and other minority groups.
APPENDIX A

Consent Form
Consent to Participate in Research

You are being asked to participate in a research study, which will be conducted by Marshay L. Hunter, a graduate student at California State University, Sacramento, Division of Social Work.

The purpose of this study is to examine the utilization of mental health services among African Americans so that proper recommendations can be made to health and human services providers in Sacramento to improve the current services to better serve African Americans. If you agreed to serve as a participant in this research project, you will be asked to respond to a set of questions that will take approximately 15 to 20 minutes of your time.

This is a voluntary based research study. There will be no compensation for participating in this research study for the participants, researcher, or California State University, Sacramento. As a participant in this research study, you will provide valuable insights that will assist social workers and mental health practitioners better serve the African American population.

In order to serve as a participant, I ask that you voluntarily consent to the research project by agreeing to the following statements: (1) That your participation is voluntary; (2) No inducement will be provided to you; (3) You can withdraw your participation at anytime; and (4) The questionnaire may cause discomfort or trigger psychological condition as certain questions may appear personal. During participation, if the researcher observes that you are experiencing discomfort she will end the study for your safety. After participation in the study and any of the conditions stated above exist, you may seek professional help from Sacramento County Adult Mental Health Services Adult Access Team (916) 875-1055 or Child and Family Mental Health Services (916) 875-7070.

The information gathered from this study is for educational purposes and may become available to the public. No information will be used in the research study to identify you. Information will be kept confidential and stored in a lock box at the researcher’s home. The research study will be completed in May 2010 and the data will be destroyed.

If you have any additional questions about this research study, you may contact my Thesis Advisor, Dr. Serge Lee, at California State University, Sacramento at (916) 278-5820 or by email at leesc@csus.edu. The researcher can be contacted by email at marshayhunter@yahoo.com.

Your signature below indicates you have read this page and agree to participate in the research study.

Signature of Participant  Date
APPENDIX B

Survey Questionnaire
Mental Health Services Utilization by African American Adults

Purpose: The researcher is interested in gaining insight on mental health services utilization by African American adults in the greater Sacramento County region. The research questionnaire below will require about 15 to 20 minutes of your time. Please respond to the following questions to the best of your abilities. In case a particular question does not pertain to yourself or your knowledge of mental health services utilization please kindly disregard that question.

1.) How old are you?_____

2.) Please mark your gender?

   ____ Male
   ____ Female
   ____ Transgender/Transsexual

3.) Please mark your highest level of schooling?

   ____ No Formal Education
   ____ Elementary
   ____ High School
   ____ Adult School
   ____ Vocational
   ____ Community College
   ____ University

4.) What is your family’s annual household income?

   ____ Under $8,000
5.) Including yourself how many people currently reside in your household?

____ 1-2
____ 2-3
____ 3-4
____ 4-5
____ Over

6.) What part of Sacramento County do you currently reside?

____ South
____ North
____ East
____ West

Other (please specify)_____________________________________________

7.) Are you currently employed?

____ Yes
____ No (If no, skip to # 9)

8.) If you are currently employed does your employer offer health benefits/insurance?

____ Yes
9.) If you are not currently employed do you have health benefits/insurance?

_____ Yes
_____ No

10.) Based on the following options, when feeling ill, where do you go to seek medical care for your illness? (Please check all that apply)

_____ Clinics (Free or sliding scale payment option)
_____ Regular physician
_____ Hospitals
_____ Home remedies
_____ Spirituality/church

Other (please specify) __________________________

11.) How comfortable are you in seeking medical care for yourself?

_____ I do not feel comfortable at all
_____ I feel somewhat comfortable
_____ I feel comfortable
_____ I feel extremely comfortable

12.) When receiving medical care do you have a preference on the ethnic background of your treating physician?

_____ Yes
_____ No
_____ Don’t know
13.) Do you believe that mental illnesses is a condition that disrupts the individual’s behaviors such as cognitive functioning, ability to relate to others, feelings, and mood?

_____ Yes
_____ No
_____ Don’t know

14.) Do you believe that mental illnesses affects people because of their gender?

_____ Yes
_____ No
_____ Don’t know

15.) Do you believe that mental illnesses affects people because of their upbringing?

_____ Yes
_____ No
_____ Don’t know

16.) Do you believe that mental illnesses affects people because of their ethnicity?

_____ Yes
_____ No
_____ Don’t know

17.) Do you know someone very close to you that has participated in a mental health treatment program such as individual or group counseling before?

_____ Yes
_____ No
_____ Don’t know
18) If yes to the previous question what type of mental health services? (Check all that apply)

_____ Self-help groups
_____ Private practice
_____ Community-based agency
_____ Spirituality/church
_____ Emergency room
_____ Psychiatric hospital

Other (Please specify)_____________________________

19.) If you experienced symptoms of a mental illness would you seek treatment?

_____ Yes
_____ No
_____ Don’t know

20.) If you were participating in mental health services would you have a preference on
the ethnic background of the treating clinician?

_____ Yes
_____ No
_____ Don’t know

21.) If yes to the above question please specify why?

_________________________________________________________________

22.) While participating in mental health services would you prefer your treating
clinician to include your cultural beliefs into the treatment approaches?
23.) If you experienced symptoms of a mental illness where would you seek treatment?

_____Self-help groups
_____Private practice
_____Community-based agency
_____Spirituality/church
_____Psychiatric hospital
_____Would not seek treatment
_____Don’t know

Other (Please specify)______________________________________________________

24.) If you were participating in mental health services would you feel supported enough to tell friends, family, or others?

_____Yes
_____No
_____Don’t know

25.) If no or I don’t know to the above question please specify why?

________________________________________________________________________

26.) If you were participating in mental health services who would comprise your support system?

_____Family
27.) If you sought out treatment for mental illness would you accept prescribed medications as a treatment approach?
   _____ Yes
   _____ No
   _____ Don’t know

28.) Do you think African Americans who are mentally ill are discriminated against by mental health services providers?
   _____ Yes
   _____ No
   _____ Don’t know

29.) If yes to the above question please briefly explain your reasons?

________________________________________________________________________

30.) Do you think recovery from a mental illness is possible?
   _____ Yes
   _____ No
   _____ Don’t know
31.) Listed below are some potential reasons why African American adults who are mentally ill may delay or are reluctant to seek mental health treatment. Please rank the below based on your personal view. Use “1” as the primary reason, “2” as the secondary reason, “3” as the third reason, “4” as the fourth reason, “5” as the fifth reason, “6” as the sixth reason.

_____ Feeling of shame
_____ No insurance coverage
_____ Stigma/discrimination
_____ Lack of transportation
_____ Unaware of available resources
_____ Lack of cultural sensitive clinicians

Other (please specify)__________________________

32.) Do you believe African Americans are less likely to seek treatment for mental illness than other ethnic groups?

_____ Yes
_____ No
_____ Don’t know

33.) If yes to the above question please explain why?

__________________________________________________________________

34.) Are you aware of the mental health services Sacramento County has to offer?

_____ Yes
35.) If yes to the above question to the best of your knowledge please list mental health services that Sacramento County offers?

________________________________________________________
REFERENCES


