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Barriers to Effective Mental Health Services for African Americans

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Many African Americans—especially the most marginal—suffer from mental health problems and would benefit from timely access to appropriate forms of care. However, few seek treatment from outpatient providers in the specialty mental health sector and those who do are at risk of dropping out. African Americans visit providers in the general medical sector, although they use another hypothesized alternative to specialty care, voluntary support networks, less than other groups. These help-seeking tendencies may reflect characteristic coping styles and stigma, as well as a lack of resources and opportunities for treatment. More should be learned about differences in need according to location, social standing, and cultural orientation so as to identify treatments and programs that are especially beneficial to African Americans.

KEY WORDS: African Americans; mental illness; treatment; coping; help seeking.

The African American population is large—about 12.5% of the U.S. population, not counting a substantial census undercount (Statistical Abstract of the United States, 1999). It is socially and historically unique, because of enslavement and long-term residence in the rural south, followed by migration to industrial centers of the north.

When considered in aggregate, African Americans are relatively poor: In 1998 about 24% of African American families, but only 8% of White families, had incomes below the Federally established poverty line (Statistical Abstract of the United States, 1999). The official poverty rate, however, understates the economic plight of many African Americans. African Americans are more likely than Whites to live in deep poverty—about 14% of Black families, but only 3.5% of White families, reported incomes of less than $5,000 per year (Statistical Abstract of the United States, 1999).

Apart from income, African American families have considerably less total wealth than White families. Considering the value of home ownership and other assets, the median net worth of African American families is only about one tenth that of White families (O'Hare, Pollard, Mann, & Kent, 1991).

While many African Americans continue to live in deep poverty, the African American poverty rate appears to have shrunk: although high, the African American poverty rate has declined in recent years. By the late 1990s, 32% of African American men and 59% of African American women held white collar jobs; the median income of African Americans living in married couple families was 87% that of comparable Whites, and almost 32% of African Americans lived in the suburbs (Thernstrom & Thernstrom, 1997). Thus, in socioeconomic terms, the African American population is polarized.

For many years a dominant African American experience with mental illness and treatment was periodic confinement in psychiatric hospitals (cf. Snowden & Cheung, 1990). Against this backdrop, the effort of the past three decades to bring about equity in mental health care represents beneficial strides. More African Americans who need mental health care are in treatment than ever before, and the Black–White gap in utilization appears to have shrunk. As will be shown, however, many barriers remain.

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The present paper will analyze barriers to receiving appropriate and timely mental health care facing African American populations. From Rogler's five-phase model of help seeking (Rogler, 1989), the paper addresses three major topics: patterns of help seeking, assessment and diagnosis, and assignment to care. The purpose is to identify distinctive features of the African American stance toward mental illness and help seeking, and African American patterns of participation in treatment, in order to increase inclusion and promote a higher quality of care.

EPIDEMIOLOGY

It is useful at the outset to consider issues of need and the possibility of greater mental illness among African Americans than among other groups. Yet studies accepted as providing our best estimates of community need give inconsistent answers. On the Epidemiologic Catchment Area (ECA) surveys, African Americans and Whites proved no different in lifetime and current disorders after adjusting for socioeconomic and demographic differences between the groups (Robins & Regier, 1991). With respect to individual disorders, the data indicated that African Americans were more likely than Whites to suffer from phobic disorder (Zhang & Snowden, 1999) and possibly from panic and sleep disorder (Bell, Dixie-Bell, & Thompson, 1986; Neal & Turner, 1991). Somatization disorder and somatization syndrome also are found more in African American communities than elsewhere (Robins & Regier, 1991; Zhang & Snowden, 1999).

The National Comorbidity Survey, on the other hand, painted a different picture. It indicated that African Americans had *lower* lifetime prevalence of mental illness than Whites (Kessler et al., 1994). Also, African Americans were found less likely than Whites to suffer from a comorbid substance abuse disorder.

Major epidemiological surveys cited above appear to agree that African Americans rates of mental illness are *no greater* than those of Whites. On the other hand, this conclusion ignores differences in the downward drift of African Americans burdened with mental illness away from the general population.

African Americans are overrepresented in high need populations. Because a high proportion of African Americans are incarcerated and confined to mental hospitals, are homeless, and live among the inner-city and rural poor, African Americans with significant mental health needs will be underrepresented in household surveys. By counting members of these high need groups, we might arrive at higher rates of mental illness among African Americans than are revealed in current estimates.

A concentration of mentally ill African Americans among persons confined to mental hospitals and among the homeless is consistent with evidence of an interaction between African American status and socioeconomic status (e.g., Kessler & Neighbors, 1986). Whether because of greater exposure to stress or greater downward social mobility, it appears that poor African Americans suffer from mental disorders at higher rates than poor Whites.

Coping: Activism; prayer; turning to family, friends, and religious figures. Studies of coping methods employed by African Americans indicate a spectrum of strategies, but point to certain marked preferences (Broman, 1996). Respondents to the National Survey of Black Americans (Neighbors & Jackson, 1996) heavily endorsed three strategies that are worthy of note (Broman, 1996).

"Face the problem/do something" was affirmed by more than 87% of the sample. Accompanied by a tendency to minimize any perception of threat (Johnson & Crowley, 1996) this stance has been characterized as "John Henryism," a belief that obstacles can be overcome through heroic striving (Adams, Aubert, & Clark, 1999). John Henryism was formulated to understand the behavior of certain African American males and has been associated empirically with increased diastolic blood pressure.

Other coping strategies arise from the religious orientation of African Americans (on one survey almost 85% of African Americans described themselves either as "fairly religious" or "very religious"; Taylor & Chatters, 1991). Prayer has been found among the most frequent African American coping responses (Broman, 1996); about 78% of African Americans reported that they prayed "nearly every day" (Taylor & Chatters).

Another coping preference frequently attributed to African Americans is a turning to significant others in the community, especially family, friends, neighbors, voluntary associations, and religious figures. According to conventional wisdom, such tendencies express mutual commitment and reflect a helping tradition found in African American communities. With respect to material assistance, the empirical literature supports this view: there is evidence of greater pooling of resources, for example, in African American households and among neighbors (e.g., Saegart, 1989).

On the other hand, African Americans do not appear to be especially likely to receive face-to-face help

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from informal community helpers (voluntary support networks) when their concerns are labeled as problems of emotions and mental health. From a study of help seeking from informal helpers, Snowden (1998) reported that African Americans were less likely than Whites—not more likely—to have turned for assistance to family and friends and religious figures. Nor did Snowden's data support an expectation that informal help was sought as a substitute for mental health treatment. Informal help instead was complement.

Snowden's findings were consistent with those from the few studies reported in the literature comparing African American and White informal help seeking. Rather than direct assistance from informal helpers—acknowledgment and discussion of problems framed in psychological and psychiatric terms—African Americans may prefer indirect assistance, including general encouragement, companionship, and social and spiritual advice (Taylor & Chatters, 1991).

GENERAL HEALTH AND SPECIALTY MENTAL HEALTH SERVICES

Critics have pointed not only to family and friends as sources of assistance preferred by African Americans but also to the general medical sector. Thus, physicians and hospitals have been viewed as alternatives to mental health specialists.

Evidence bears out these contentions. Data from the National Ambulatory Medical Care Survey reveal that among persons with a mental-health-related complaint as the reason for their visit, about 53% of African American visits were made to a primary care physician and 32% to a psychiatrist, compared to 44% of visits by Whites made to a primary care physician and 42% to a psychiatrist (Snowden & Pingitore, in press). The disproportionate use of emergency care by African Americans will be discussed later.

Turning to the specialty mental health sector, data from the ECA and other household surveys (Freiman, Cunningham, & Cornelius, 1994) indicate that African Americans in the community are less likely than Whites to seek outpatient treatment for mental health problems. After controlling for sociodemographic differences and differences in the need for treatment, the odds of African Americans receiving treatment from any source in the community were only .54 those of Whites. If treated, African Americans were far more likely to have been treated in the public sector (Schwartz et al., 1998).

Poverty does affect African Americans' chances of receiving specialty outpatient treatment, but not in a straightforward manner. Many of the poor are eligible for Medicaid, which finances considerable mental health care. Data from a representative national sample revealed that African Americans on Medicaid were no less likely than Whites to receive outpatient treatment whereas insured African Americans were considerably less likely (Snowden & Thomas, 2000). More serious disorders found among the poor appear to compel treatment, which is often provided in the public sector where providers are unwilling or unable to avoid African Americans.

Differences also exist after initial barriers have been overcome and treatment has begun. African Americans are more likely than others to leave mental health programs prematurely (Sue, Zane, & Young, 1994) and to receive emergency care (Hu, Snowden, Jerrell, & Nguyen, 1991). These differences might come about because, to a greater extent than among other groups, African Americans participate in treatment through legal involvement and coercion (Akutsu, Snowden, & Organista, 1996; Takeuchi & Cheung, 1998).

Voluntary help seeking has been linked to an African American idiom of distress. Snowden (1999a) correlated the number of African American folk symptoms identified from a previous study as occurring on the Diagnostic Interview Schedule (Heurtin-Roberts, Snowden, & Miller, 1997) with the likelihood of having received mental health care. For anxiety-like and somatization-like symptoms, the association among African Americans was especially strong between symptom distress and having received treatment, whether from a mental health specialist either in private or public practice, from a physician, or in an emergency room.

At the same time, there is evidence of a greater willingness by African Americans to seek mental health care. In a follow-up at the Baltimore site of the ECA, Cooper-Patrick, Crum, Powe, Pratt, and Ford (1999) found an increase by all groups in rates of mental health help seeking. They also found that African Americans were no longer less likely than Whites to seek treatment.

ASSESSMENT AND DIAGNOSIS

Lopez (1989) conducted a comprehensive review of literature on the issue of bias in clinical judgment. He examined judgments of the presence or absence

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of psychopathology and of severity, as well as of tendencies to attribute psychopathology where none was present and to overlook psychopathology, which was in fact present.

With respect to African Americans, the evidence considered by Lopez proved equivocal, as some investigators reported the existence of bias but others reported its absence. The most consistent pattern of findings concerned the possibility of bias in rendering certain particular diagnoses: schizophrenia and the affective disorders.

Schizophrenia and the affective disorders. Over the past two decades, reports in the literature have pointed to racial imbalances in treated samples in diagnosed schizophrenia and in the affective disorders. The pattern is persistent and clear: African Americans prove more likely than Whites to be categorized as schizophrenic and less likely as having an affective disorder.

Several studies illustrate this point. From national data on psychiatric hospital admissions, Snowden and Cheung (1990) reported that African Americans were about 1.8 times as likely as Whites to be diagnosed with schizophrenia and about half as likely to be diagnosed with an affective disorder. Lawson, Hepler, Holladay, and Cuffel (1994) found that African American inpatients were about 1.5 times as likely as Whites to be diagnosed as schizophrenic and only about 0.60 times as likely to be diagnosed with an affective disorder; among outpatients with affective disorders, racial discrepancy was less but for schizophrenia it was greater. Similarly, Hu et al. (1991) found that African Americans were about 1.5 times more likely than Whites to have a diagnosis of schizophrenia and only 0.75 times as likely to have a diagnosis of affective disorder. The latter finding was considered routine and passed without comment.

As they diagnosis patients in clinical practice, do clinicians routinely overdiagnose schizophrenia among African Americans and underdiagnose affective disorders? Several widely cited studies support this conclusion. For example, Loring and Powell (1988) presented 290 psychiatrists with standard case descriptions, varying only the race and gender of the case. When labeled African American, the case was more frequently diagnosed paranoid schizophrenic by both African American and White respondents. From a body of such evidence, reviewers (Lu, Lim, & Mezzich, 1995; Neighbors, Jackson, Campbell, & Williams, 1989; Worthington, 1992) have judged the case for bias to be a strong one.

PROGRAM AND TREATMENT ASSIGNMENT

African American overrepresentation in psychiatric hospitals is well established (Snowden, 1999b; Snowden & Cheung, 1990), and has long been considered to raise the specter of cultural misunderstanding and social control more than clinical necessity as factors promoting African American confinement to mental hospitals. Other considerations have come to light, however, implicating more strongly than ever individual and community-level poverty as considerations to bear in mind.

African Americans who are hospitalized tend to experience recidivism; the pattern of repeat use itself helps to explain Black–White differences in hospitalization rates (Leginski, Manderscheid, & Henderson, 1990). The cycling in and out of the hospital often reflects the precarious social position of African Americans suffering from severe mental illness as indicated in high rates of homelessness and incarceration, and as exacerbated by living in stress-enhancing communities (Snowden, 1999a, 1990b).

Financing also plays an important role. Because of poverty African Americans are more likely than Whites to be insured by the Medicaid program. Medicaid coverage is strongly related to the possibility of inpatient treatment: Medicaid recipients were almost three times more likely to be hospitalized as persons covered by private insurance (Freiman et al., 1994). As state Medicaid programs increasingly adopt managed care and psychiatric hospitalization becomes a scarcity, concern with overhospitalization may be transformed into a concern with underhospitalization.

Guideline-Based Treatment in Primary Care

When treated in primary care for mental health problems, the quality of care provided to African Americans may be lower than that provided to Whites. Wang, Berglund, and Kessler (2000) reported that African Americans suffering from depression or anxiety were less likely than Whites to receive care adhering to official practice guidelines. Other investigators found that elderly African Americans were considerably less likely than elderly Whites to receive antidepressant medications (Blazer, Hybels, Simonsick, & Hanlon, 2000).

On the other hand, differences between African Americans and Whites may justify differences in use of medication. Evidence from the growing field of ethnopsychopharmacology indicates that African

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Americans may metabolize antidepressants such that they are more sensitive than others to their effects (Branford, Gaedigk, & Leeder, 1998). The possibility cannot be ruled out that differential prescription practices result from clinical necessity.

Outpatient Psychotherapy

The possibility of racial differences in assignment to individual outpatient psychotherapy has been a source of concern to researchers and activists, owing to a fear that African Americans were considered lacking in sufficient maturity and intelligence to profit from this form of treatment. Updating a number of studies conducted in public mental health systems over the years, Hu et al. (1991) found that African Americans were indeed less likely than Whites to receive individual outpatient therapy, and that those who participated attended 20% fewer sessions. The finding was remarkable for Asian American and Latino clients, who proved *more* likely than Whites to have received individual outpatient therapy.

Assignment to Other Forms of Care

The emphasis on individual psychotherapy has skewed the research base; few studies have sought to understand racial differences in other services and programs. The use of medication with African Americans may give particular cause for concern. Segal, Bola, and Watson (1996) investigated racial differences in the use of antipsychotic medications in four emergency rooms. They reported that African Americans received a far higher dosage than Whites, and that the race-based discrepancy was lower when clinicians were rated to have made a greater effort to engage the client in treatment. Racial barriers appeared to undermine the capacity to establish a successful treatment process and to deliver a high quality of care.

Segal, Bola, and Watson's study was one of the few to examine the process by which decisions about treatment are made. Their assessment of clinical engagement proved valuable in illuminating the underlying process by which race appeared to promote differential treatment.

Hospitals and Emergency Rooms as Usual Sources of Care

The manner by which African Americans enter and participate in mental health services may be determined less by clinical and administrative decision making and more by social structures and community traditions. African Americans make frequent use of psychiatric emergency care. The pattern distinguishes African Americans not only from Whites but also from Asian Americans and Latinos (e.g., Hu et al., 1991).

African American emergency psychiatric care can be viewed from a broader perspective of African American involvement in general medical care. African Americans visit the emergency room more than others for problems in health care (e.g., Snowden, Libby, & Thomas, 1997) and for some, because of a lack of insurance and a lack of health care providers in the community willing to provide routine treatment, the emergency room becomes a usual source of health care (Lewin-Epstein, 1991). Reliance on emergency care might help to explain other features of African American utilization: repeated, crisis-oriented treatment might preclude participation in regular outpatient treatment and facilitate entry into the psychiatric hospital. A tendency toward emergency psychiatric care might represent continuation of an approach taken toward treatment received in the general medical sector.

IMPROVING AFRICAN AMERICAN ACCESS

Perhaps because of a history of self-reliance and mistrust of mental health providers, many African Americans appear to deny mental health problems. When symptoms appear they may be acknowledged more readily if understood as traditional, folk based disorders, and if self-reliance and prayer are considered in response. Thus among African Americans and Whites surveyed in primary care settings, African Americans more often rated spirituality as a determinant of help seeking and a desirable component of treatment (Cooper-Patrick et al., 1998).

Mental illness retains considerable stigma and seeking treatment is not always encouraged. One study (Cooper-Patrick et al., 1995) found that a feeling of embarrassment about seeking treatment was a more significant barrier for African Americans than for Whites. Support from significant others and fellow community members may be sought but only indirectly, in the form of reassurance, companionship, and advice defined in other than mental health terms.

Structural factors also must be considered. Low rates of insurance coverage and lack of a usual source

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of health care limit the options of African Americans seeking treatment.

In thinking about the African American population, it is important to avoid overgeneralization. Age and gender are important to consider along with socioeconomic differences because their strong association with help seeking. Diverging sociohistorical experiences and circumstances of living separate African American women and men (e.g., Snowden, in press), as well as African Americans elders and young adults. These differences suggest that gender-based and age-based interactions should be considered by researchers and possibly gender- and age-sensitive outreach strategies formulated. There is reason to believe also that differences in acculturation (Snowden & Hines, 1998) as well as regional and urban–rural differences (Snowden & Thomas, 2000) should be taken into account.

To improve African American access there appears to be a need for more and better public education, emphasizing that services and programs are available and that recipients are better off than those who abstain. Active outreach into African American communities, engaging opinion leaders and gatekeepers of the community, is also necessary.

Another response to improve African American access focuses on increasing the awareness of personnel providing mental health care. When presenting themselves for treatment, African Americans may express their complaints in terms of physical complaints and of symptoms associated with anxiety. Such complaints may or may not be properly taken at face value; they sometimes reflect a more general language of distress. Special caution should be exercised to guard against error in prescribing psychotropic medications and in making the diagnosis of schizophrenia and affective disorders, whether attributable to misunderstanding or bias. Clinical assessors should remember, in general, the dual nature of potential bias: he or she may attribute mental illness where it does not exist, or may fail to detect it where is does exist.

A number of problems in access appear to be associated with extreme poverty and adverse conditions affecting African American individuals and communities in distress. The repeated use of emergency care, perhaps serving as a usual source of care for problems in health and mental health, may require both structural interventions to create more appropriate points of contact, as well as change in community norms to promote their use.

There is much we do not yet know that is necessary for a comprehensive and effective response. The socioeconomic polarization of African Americans has received insufficient attention among researchers and advocates concerned with access. Many needs of the poorest African Americans are likely to be defined by the problems of severe and persistent mental illness. Long-term disability associated with these conditions may be exacerbated by the a lack of family resources and by a social environment in the poorest black areas that accentuates various forms of distress. High rates of homelessness and incarceration partly attest to high levels of unmet need among poor African Americans.

Finally, it is important to bear in mind the purpose of promoting improved access: to suffer less from troubling symptoms and to have restored one's capacity for successful day-to-day living. It is important to promote participation in mental health treatments and programs insofar as they achieve these objectives.

At present we know disconcertingly little about effectiveness and cost-effectiveness of programs and treatments as they are routinely practiced in the community. We have even fewer answers to questions about the possibility of differential impact on the basis of race (Snowden, 1996). About these issues and others, more research is needed toward a comprehensive understanding of delivery of mental health services to African American populations.

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