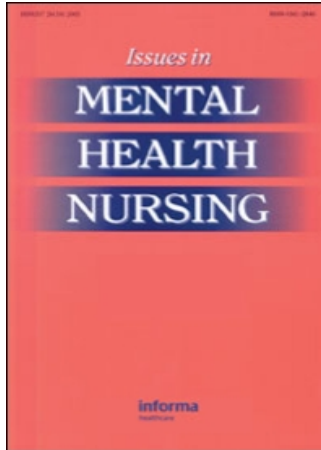


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THE EXPERIENCE OF BLACK CONSUMERS IN THE MENTAL HEALTH SYSTEM - IDENTIFYING BARRIERS TO AND FACILITATORS OF MENTAL HEALTH TREATMENT USING THE CONSUMERS' PERSPECTIVE

Liat Ayalon ^a, Jennifer Alvidrez ^b

^a School of Social Work, Bar Ilan University, Ramat Gan, Israel

^b University of California, San Francisco, California, USA

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THE EXPERIENCE OF BLACK CONSUMERS IN THE MENTAL HEALTH SYSTEM—IDENTIFYING BARRIERS TO AND FACILITATORS OF MENTAL HEALTH TREATMENT USING THE CONSUMERS' PERSPECTIVE

Liat Ayalon, PhD

*School of Social Work, Bar Ilan University,
Ramat Gan, Israel*

Jennifer Alvidrez

University of California, San Francisco, California, USA

Research has shown that relative to Whites, Blacks are less likely to seek outpatient mental health treatment and more likely to seek emergency services. Furthermore, Blacks often terminate treatment prematurely. The goal of the present study was to identify barriers to and facilitators of mental health treatment among Blacks who have a documented need for mental health services. Thirty-four Black mental health consumers were interviewed for this purpose. Comments were categorized into four main categories: (a) barriers to treatment, (b) treatment facilitators, (c) recommendations for improvement of services, and (d) advice to potential consumers. The most common barriers were the importance of family privacy, lack of knowledge regarding available treatments, denial of mental health problems, and concerns about stigma, medications, and treatment. Participants also reported system barriers, such as not receiving appropriate information about services or receiving inadequate, dehumanizing services. Acknowledging the need for mental health services, having a supportive environment, and positive past treatment experiences were identified as treatment facilitators. Community outreach, adequate

follow-up, and coordination of services also were important messages delivered by consumers. The results of this study indicate the importance of educating the general public, not just mental health consumers, about the nature of mental illness and available services.

Research has shown that relative to Whites, Black mental health consumers are less likely to receive outpatient mental health treatment and more likely to receive inpatient and emergency mental health services (Maynard, Ehreth, Cox, Peterson, & McGann, 1997; Pumariega, Glover, Holzer, & Nguyen 1998; Scheffler & Browne Miller, 1991). Furthermore, when Blacks seek services in the formal mental health system, they are likely to have fewer visits and are less likely to adhere to their treatment recommendations than Whites (Lasser, Himmelstein, Woolhandler, McCormick, & Bor, 2002). Research also has shown that relative to Whites, the clinical outcomes of Black mental health consumers are less favorable (Bae, Brekke, & Bola, 2004).

The majority of research to date has focused on barriers to the mental health system. These barriers include sociocultural factors, such as stigma of mental illness (Van Hook, 1999), less familiarity with mental health treatment (Hines-Martin, Usui, Kim, & Furr, 2004), lack of trust in the mental health system (Thompson, Bazille, & Akbar, 2004), concerns about medications (Cooper et al., 2003), folk beliefs (Parks, 2003), and the preference for informal support (Van Hook, 1999). Instrumental barriers, such as the prohibitive costs of treatment and limited availability and access to treatment also have been identified (Bazargan, Bazargan, & Baker, 1998). Yet, financial factors do not fully explain ethnic disparities (Padgett, Patrick, Burns, & Schlesinger, 1994). Lack of ethnic matching and lack of culturally competent services also have been identified as major reasons for lack of participation in treatment and for early termination of therapy among Black consumers (Blank, Tetrick, Brinkley, Smith, & Doheny, 1994; Flaskerud, 1986; Nickerson, Helms, & Terrell, 1994).

To date, the majority of research has focused on identifying barriers to service use and almost no attention has been given to the beliefs and attitudes that facilitate access to and use of services. Furthermore, too often research has focused on cross-ethnic comparisons and disregarded within group variations. The goal of the present study was to uncover the experience of Black consumers in the mental health system. Specifically, we were interested in how consumers' experiences are translated into barriers to and facilitators of mental health service use. To gain a

more comprehensive perspective of consumers' experiences, we used qualitative methodology because this method is particularly appropriate in the hypotheses generation stage (Belgrave, Zablotsky, & Guadagno, 2002).

METHODS

Subjects & Setup

Thirty-four seriously mentally ill Black consumers were interviewed as part of a larger study to develop an intervention to reduce stigma about mental illness among seriously mentally ill Black consumers in San Francisco County (Alvidrez, Snowden, & Kaiser, in press). Participants were recruited using flyers posted in mental health clinics and handed out by providers. In addition, recruitment letters were sent to clients who contacted the county centralized intake program for mental health services. Those who self-identified as Black, were over the age of 18, and had self-reported experience with county mental health services (assessment and/or treatment) were eligible to participate in this study. Informed consent was obtained prior to participation, and participants received \$15.

Procedure

As part of the parent study, an open-ended semi-structured interview was conducted to learn about participants' experiences as mental health consumers. The interview was developed based on content and language derived from focus groups conducted with Black medical patients about barriers to mental health treatment (Alvidrez, Areal, & Stewart, 2005). See Table 1 for the interview guide.

Data Collection & Analysis. All interviews were conducted by the Principal Investigator (PI) and a project research assistant. Both interviewers had extensive experience working with public-sector severely mentally ill clients and conducting qualitative interviews. Participants were recruited using flyers posted and distributed by providers in mental health clinics. In addition, recruitment letters were sent to clients who had contacted the county centralized mental health assessment program.

Interviews were audiotaped and transcribed verbatim. Grounded theory methodology guided data analysis (Strauss & Corbin, 1998). Themes were not forced into preexisting categories, but instead new categories were created to reflect the text. A coding book was created based on information gained in the first focus group and then modified based on

TABLE 1. Consumer Interview Guide

Can you tell me about your first treatment experience?
Whose decision was it for you to first get mental health treatment?
What was your first voluntary treatment experience?
How did you come to decide to get treatment?
Did you ever feel bad about yourself for getting mental health treatment? How did you deal with those feelings you had about yourself?
Did you ever get any negative reactions from people for getting mental health treatment? How did you deal with those reactions from other people?
If you had a friend who was afraid to get mental health treatment because of what other people would think, what advice would you give that friend?
If you had a friend who was afraid to get mental health treatment because it would make them feel bad about themselves, what would you tell that friend?
Thinking back, what information about mental health treatment would have been helpful for you to hear about in the beginning?

data from subsequent groups. In the creation of the coding book, themes were compared for similarities and differences and were supported by direct quotes from the text. Each interview was independently coded by the PI and one of four other research team members. All coding decisions were discussed in each PI-team member dyad and consensus was reached through discussion when discrepancies occurred. The first author reviewed the categories and reorganized the coding structure to allow for an analysis of treatment barriers and facilitators.

Comments made by consumers were categorized into four categories: (a) barriers to mental health treatment, (b) facilitators of mental health treatment, (c) recommendations for improvement of services, and (d) advice to other consumers in need of mental health services. These categories were then subdivided to further reflect their unique characteristics. Frequencies of themes within each category were calculated and quotes illustrate each theme.

For each individual, comments that fell into a certain coding category were counted only once. Comments made by participants were allowed to fall into multiple categories. NVIVO 2.0 was used for managing this analysis. This is a computer program that allows for relatively easy navigation and organization of the text and is frequently used in qualitative research.

RESULTS

Demographic and psychosocial characteristics are presented in Table 2. The majority of the sample consisted of males (59%). The

TABLE 2. Demographic and Psychosocial/Clinical Characteristics of the Sample ($N = 34$)

	<i>n (%)</i>
Consumers Demographic Characteristics	
Male	20 (59)
Married	2 (5.9)
High school or less	12 (35)
Not in the job market	20 (58.8)
Current mental health treatment:	25 (73)
Inpatient psychiatric treatment	1 (2.9)
Private therapist/MD clinic	4 (11.8)
VA hospital	1 (2.9)
Community clinic	19 (55.9)
Past mental health treatment:	29 (85.3)
Inpatient psychiatric treatment	14 (41)
Private therapist/MD clinic	7 (20.6)
Residential treatment	17 (50)
Community clinic	7 (20.6)
Jail	5 (14.7)
VA hospital	1 (2.9)
Age	$M = 44; SD = 9.6$
Clinical Characteristics	
Schizophrenia	14 (41)
Bipolar disorder	8 (23.5)
Depression	22 (64.7)
Anxiety	12 (35.3)
Substance abuse	16 (47.1)
Axis II	5 (14.7)
Psychosocial Characteristics	
Mental illness/abuse in the family	27 (79)
Substance abuse	16 (47)
Involuntary treatment	12 (35)
Homelessness	9 (26)
Violent victimization of seriously mentally ill	4 (11)
Criminal justice	4 (11)

average age was 44 ($SD = 9.6$) and the majority of consumers had at least some college education (65%). The majority of consumers were not in the job market (59%) at the time of interview. At the time of interview, 73% of participants reported that they used mental health services. Twenty-nine (85.3%) participants reported receiving mental health treatment in the past. Fourteen participants (41%) indicated that they had had at least one inpatient psychiatric hospitalization, and 17 participants

(50%) indicated that they had received residential treatment in the past. Participants were not asked to provide diagnoses, but most discussed either diagnoses or psychiatric symptoms they experienced over the course of the interview. The most common diagnoses/symptoms reported were depression (65%), followed by substance abuse (47%) and schizophrenia (41%). (This does not sum to 100% because some consumers reported more than one diagnosis.) Participants generally experienced multiple psychosocial problems and stressors, including mental illness of family members, substance use problems, violent victimization, involuntary hospitalization, and incarceration.

Barriers to Mental Health Treatment

Under this category, we identified both psychosocial barriers, such as concerns about using mental health services or lack of perceived need, as well as system barriers, such as characteristics of the mental health system that hamper access to and continued use of mental health services.

Psychosocial Barriers to Mental Health Service Use

Consumers reported a variety of concerns related to mental health treatment. Overall, 29 comments fell into the category of concerns about perceived stigma and the experience of stigma associated with use of services. Participants mentioned the stigma of having a mental illness as a barrier (e.g., “You know, being reared, that, that was, you know, you were blackballed, or you were outcast, if you thought to seek any type of mental health.”), but they also mentioned stigma associated with other concerns, such as the perceived stigma associated with having HIV (“Well, my own negative thing is that I am very secretive when it comes to like, going to get medications, or dropping pills off because, being gay, I’m, I whenever I see gay people at the pharmacy I automatically think that they are getting medications for AIDS or HIV.”).

The importance of personal and family confidentiality as a barrier to seeking mental health treatment was mentioned in 21 unique comments (e.g., “I was very hesitant about telling any of my friends of . . . well, my family, some of my family knew that I’d been hospitalized [for mental illness]. But even to this day a lot of them don’t know. Cuz, I just don’t tell them.”).

Concerns about medications were mentioned in 16 unique comments, such as “Am I going to be on meds forever? . . . And, if so, would that have some kind of a long term effect on me?”

Suspiciousness about treatment and providers was mentioned in 14 unique comments (e.g., “Any time a Black American goes to one of the systems in America, he has suspicions. He has anxieties . . . if you don’t know, you’re going to be afraid.”).

Four comments pertained to the view that God and religious beliefs are incompatible with mental health treatment (e.g., “I would imagine because in my community I don’t think it’s especially . . . you know having my church background, it’s not really looked at in a good light.”).

Five comments concerned the view of treatment as something a White person would seek out but not a Black person; the possibility of ethnic mismatch (i.e., a Black consumer seen by a White professional) was also raised (e.g., “Where I come from, it’s a very black and white place, and . . . But, basically therapy, psychiatrists are for white people and black people [Black men, Black women] should be strong enough to be able to handle their own problems and deal with their own issues.”).

The notion that Blacks underutilize any health services and that underutilization is not specific for mental health was mentioned in five comments (e.g., “And there’s another thing too, another issue. I forget the statistics on this, but you’ll find that Blacks are not real high on the list in terms of wanting to seek any kind of help, medically.”).

Lack of problem recognition and denial of mental health problems were mentioned in 25 unique comments as barriers to treatment (e.g., “At that time, back then, I didn’t really think I had a problem, you know, I mean I was functioning, you know, I guess I was, you know, working every day and so forth. I didn’t admit to, you know, I needed help.”).

Not knowing what services existed or what treatment would involve and incongruence between consumers’ expectations and what they received from providers also were mentioned as barriers to treatment in 16 unique comments (e.g., “In the hospital is when I first started taking meds. So, I did that for quite some time, but I never . . . and it was really confusing because I didn’t know what to expect. I didn’t know why I was talking to this person, I didn’t know, like, if they were supposed to tell me how to make my life better, or what.”).

System Barriers

Participants also cited barriers to getting in the door (i.e., accessing the mental health system). Two main themes were identified as barriers to mental health services. Eight unique comments discussed the fact that appropriate information about and referral for mental health treatment were not provided (e.g., “Had they told me I was depressed, I needed some medication, I needed to talk to a mental health specialist or a psychiatrist or any I think I would have thought about it considerably.”).

Instrumental limitations that prevented access to the mental health system were mentioned in four comments (e.g., “Well, somebody told me about B___ drop-in center, but, um, I haven’t had like the bus fare to get over there.”).

Barriers inside the mental health system (i.e., continued care in mental health services) were also cited by participants. The most common barrier to active participation in the mental health system, identified in nine unique comments, was described as receiving irresponsible, inadequate, or incompetent treatment:

Probably 7th grade, like I had to go to group therapy at school and that made me feel a little weird, because when I told the teacher ... the therapist at school, you know, what was going on with me and how I felt, she’s like, “Where’d you hear that?” You know ... and just sort of devalued what I’d actually said. I was just like — things aren’t good, things aren’t ... you know ... I’m supposed to be young and things aren’t bright and things aren’t fun and blah, blah, blah, and she’s just like ... I guess she thought I was reading from a text book or something because she says just like, “You couldn’t of thought of that yourself.”

Seven comments addressed the issue of the provider not explaining or listening (e.g., “The importance of taking the medication, to help the symptoms. That would have been the first thing that didn’t nobody tell me. They just told me to take something. They didn’t tell me the importance of why I should take what they take.”).

Five comments described the experience of not being treated as a person (e.g., “I’m used to a doctor when we’re talking to have eye contact, you know, not with his head down. I don’t think the man knew what I looked like.”).

Facilitators of Mental Health Treatment

Facilitators to mental health treatment were divided into two major categories: factors that promote access into the mental health system and factors that promote continued use of services.

Factors that Promote Access into Mental Health Treatment

Making the decision to enter mental health treatment was a one category described by participants, with four main themes identified under this category. The most common reason for entering treatment was the consumers’ acknowledging their high levels of need, when symptoms became too bothersome or to the point of suicidality or mental health rehospitalization. One respondent said, “I mean, it wasn’t like

there was choice for me really, it's just like 'You've been in General [for psychiatric hospitalization], you have some treatment, this is what you do.' It's not even a question of should I do it or not . . . it's just, this is what has to be done." This theme was identified in 22 unique comments.

Compliance with a referral made by a mental health provider, family members, or friends was identified as a reason to enter treatment in 11 comments:

Well, basically she [social worker] said, you know, get the support that I really need, you know, that I didn't have. It would be good to go to groups and one-on-one with psychiatrist. Also, take the meds. Because the meds do help people throughout their pregnancy and depression, with their depression. I listened to her.

Nine comments addressed the issue of needing someone to talk to in order to increase self-understanding (e.g., "After I lost my mother then I felt like, you know, I didn't really have anybody, 'cause we don't have a large family. It's very small. And a lot of my life, you know, felt like empty. So, you know, I need, needed support.").

Five comments acknowledged checking treatment out and liking it:

So, it [mental health referral] made me skeptical, but still I was looking for certain things, and I thought maybe this might be a way to find it, in areas you least expect, so to speak. So, that's what I did. I went to him, and his first name was [name withheld] as a matter of fact, and which mine is [name withheld] too. So, it shows I had something in common with the man, and after talking to him for about an hour, I felt fairly decent that I would come back. I didn't know whether I was going to be cured or not, or get a hold on some of my problems. I was still a little inhibited.

Factors that Promote Continued Use of Mental Health Services

Resources that facilitate use of mental health services were cited as a factor that promoted the continued use of mental health services. Twenty-seven comments addressed the issue of having an environment that supports mental health service use (e.g., "And then the next thing I know, I ended up in the hospital. A friend of mine, boyfriend, took me. They saw what was going on with me and admitted me.").

The theme of having mentally ill peers and family was identified as a resource in 11 comments (e.g., "I went to therapy this week, but you know, there's a lot of people who seek out support in my life one way or another.").

Having a provider who actively tries to connect the consumer to the mental health system also was mentioned as a facilitator in ten unique comments, as in this example:

Well, Doctor [name withheld] told me that in order for me to get better—because I was telling him my problems, and then after I went to see him he told me that I had to keep up with my appointments and make sure that I take my medication as it was prescribed, and I had been going to him for like ten years, so he was so like a comfort to me which gave me some encouragement to go, ‘cause probably I would have never gone.

Only two comments indicated that ethnic matching was helpful (e.g., “Well, as a Black man to a Black person, I can talk to you and have my articulation, my dictation, and all my words.”), but six comments stated that ethnic matching was not necessary (e.g., “If you know you’re drowning you don’t care, you know, you don’t care— race, religion, nothing, you just want to get out, you know, and it doesn’t matter. Once you get out, then I’ll worry about that, but right now I’m drowning, and that’s how I felt.”).

Personal attitudes that increase one’s likelihood to use mental health services was also cited by participants as helpful to promoting continued mental health treatment. Acknowledging the need for services was identified as a treatment facilitator in 28 unique comments (e.g., “I just knew I needed help, you know, I knew that. And it had been going on for years, you know, and I said to myself, ‘Well, this is time now to get some help.’ I’m just going to go through the steps, you know, until I can get some help.”).

Twenty comments addressed the issue of ignoring others’ responses as a strategy that helped participants stay in treatment:

Just that, if there are people out there that, that need mental health services and they want to get them, and they’re like afraid of what their friends may think or their family might think, they should put that aside and think about themselves, because without the ability to, to think and be comfortable, then we’re no good for nobody else.

Telling oneself that there is nothing to be ashamed of was identified in 14 comments (e.g., “It’s not that you’re being, like you’re really crazy or anything, it’s just getting help, you know, in a program.”).

The realization that others also used mental health services was identified in nine unique comments as a facilitator to remaining in treatment as evidenced by this comment:

So, I used to think something was wrong with having to see the therapist or psychiatrist, but I don't feel that way now. I think everybody, even my old therapist was seeing a therapist, you know, so I mean, you know. It's no problem.

Personal Behaviors that Promote Use of Mental Health Services

Personal behaviors that were identified as facilitating participation in treatment varied widely, with the majority of comments (15 comments) acknowledging the issue of becoming proactive in one's care (e.g., "Right, I mean, if you just sit there and say, 'Well, I'm just gonna sit here,' you're not gonna get that help.").

Telling only certain people about their mental illness or identifying a new support system with which they felt comfortable sharing their use of mental health services were mentioned in 12 comments (e.g., "I'll tell people that under the right circumstances I tell 'em that I do have a problem.").

Four comments suggested that not telling anyone about mental health use was helpful (e.g., "I didn't have a lot of shame or guilt around it [receiving mental health services]. I hid it, but I didn't have a lot of shame or guilt around it.").

Four additional comments acknowledged telling every one about mental illness as helpful:

I tell everybody. No, at first I didn't, the first time. You know, with my previous primary doctor. I did not. No, I did not, because I, I, I thought it was, you would be an outcast, or you would be labeled, but this round, you know, 'cause that was the primary doctor, I sought an actual licensed psychologist this time.

The theme of not accepting negative attitudes about mental health use was identified as a treatment facilitator in four unique comments as described by this participant:

Yeah, because I mean that's their opinion. That's their opinion without any experience or without or in denial if there's, if they're in some stress related mode, you know. So, I just let them share that, because if I entertain their negativism, well, then I'm just as worse as the medical world, you know, in labeling them or, you know. Do you . . . does that make sense?"

Four comments discussed the use of antisocial strategies as a means to overcome negative experiences associated with revealing one's mental health service use (e.g., "Very few people would act negatively to my face if they knew my background. I'm not an easy guy if you didn't like

what I like [chuckle]. I can be very hard on you—mentally, physically, and spiritually. Believe me.”).

Positive treatment experiences that promoted the use of mental health services were divided into two main themes. The most common (23 comments) was having been in a treatment that helped (e.g., “Yeah, I think mental health program, man, is a benefit to people not just Black people, but all people and I mean, it helped me tremendously.”). Twelve comments addressed establishing a relationship with a provider as a positive treatment experience, as this participant described:

Yes, where you can actually vent, you know, to say what’s on your mind. That’s one thing I like about a place, like when you have a lot of racing thoughts, to just, just let it out, exactly how you feel. And then after that one hour session, it’s like a burden or a weight lifted off of me when I leave out of there, and it’s a good feeling.

Recommendations for Improving Mental Health Services

When asked about their recommendations for improving mental health services, four major themes were identified. Twenty-seven comments discussed the issue of providing more education about mental health treatment and available services. This comment is illustrative:

Maybe what a therapist and a psychiatrist, what their . . . or psychologist.. what their roles are. And what exactly they do. And what I should expect out of being with them. Because I was just, at first, told to go, and really didn’t know. I didn’t know I really don’t talk to psychiatrist so much.

More community outreach was identified in 11 comments (e.g., “Well, they need, like, more programs that’s dealing with, you know, what you’re dealing with now. I’m glad you’re doing this study ‘cause I’m glad you’re putting this out there. And that’s to let other African Americans know that there is help.”).

Nine comments addressed the issue of having a more personalized/normalized approach to treatment (e.g., “You know, take the person, hear the person out, research it, think about it, apply it to theory, then come up with a plan, and I think it’ll be more effective.”).

Better treatment coordination and follow-up was discussed in four comments (e.g., “I feel like my doctor should have let them [mental health practitioners] know what was going on, you know. Yeah, yeah, yeah, what was going on. Just pick an appointment for me, you know what I mean. I probably didn’t want to face it, you know. I got to call them some kind of way.”).

Advice to Other People Who May Need Mental Health Services

Four major themes fell into this category. “Just doing it” and getting some help were the most frequent themes, identified in 30 categories (e.g., “If you can get good help and keep your appointments, take your medication, you know, those two things I know work.”).

The importance of recognizing and accepting one’s need for mental health services was discussed in 23 unique comments, as described by this participant:

Try to make—I mean, if it’s a person who clearly needs mental help, mental health help, I would try to make them see how bad their life is now, or what they’re going through, how difficult it is, as opposed to what it possibly could be like, and what can happen if you allow people to help you. And, try to also let them know that there are so many people who either get mental help or need it.

Ignoring others’ negative opinions and sharing one’s experiences selectively were mentioned in 19 of the comments (e.g., “I would tell them just try to, get into the mental health system, that you have friends in there. Don’t worry about other people that’s not in it, just find friends that’s in there like I have.”).

DISCUSSION

This study is unique because of its focus on Black mental health consumers and their unique characteristics; there is no attempt to compare this group to the majority culture. Findings can guide the efforts of mental health providers toward the improvement of mental health services for Blacks. Consumers were able to identify both facilitators and barriers to mental health service use. They also were able to use their own experiences in the mental health system and to suggest ideas for improvement of services as well as ideas for other potential consumers who may face similar challenges. Our discussion is guided by the major themes identified in the interviews.

Psychosocial Barriers to Mental Health Treatment

Many consumers acknowledged the presence of psychosocial barriers to mental health service use. The most commonly identified barriers were perceived stigma, lack of problem recognition, and concerns about the confidentiality of treatment. Consumers also mentioned their lack of knowledge about mental health services, concerns about medications,

and suspiciousness about the mental health system as other barriers to service use.

A major concern mentioned by consumers was perceived or experienced stigma. In contrast to past research that focused primarily on stigma of mental illness as a barrier to mental health service use (Van Hook, 1999), the present study suggests that stigma is a multidimensional construct; while some may not approach the mental health system because of the stigma associated with being perceived as a mentally ill consumer, others are concerned about being stigmatized as HIV patients, being stigmatized because of their race, or because they are homeless. Thus, in order to facilitate access to treatment a "one size fits all approach" cannot be adapted, but instead, we should fit our intervention to the particular stigma concerns mentioned by the consumer.

Many participants mentioned concerns about family and personal privacy as barriers to mental health treatment. This finding could explain past research that found greater use of informal support and under-use of formal support among Blacks (Van Hook, 1999). In their recommendations for improvement of the mental health system, participants mentioned the importance of educating the public about treatment confidentiality. They also recommended educating the general public about the nature of treatment and about available services. In the present study, many participants had been consumers in the mental health system for many years prior to actually learning how to navigate the system and prior to receiving an appropriate follow-up referral. Thus, better outreach and increased educational efforts should be the priority of public health interventions.

Lack of problem recognition and denial of the problem also were frequently mentioned as barriers to mental health service use. These were not solely reported at the personal level, but also at the family and peer level, reemphasizing the importance of educating entire communities and not only directing our educational efforts toward potential mental health consumer. This recommendation is reemphasized by the fact that many participants identified their family and peer support as a major contributor to their use of mental health services.

Similarly to previous research (Hines-Martin et al., 2004; Thompson et al., 2004), many consumers reported suspiciousness about the mental health system and about mental health providers. Concerns about being controlled, harmed, or abused by the system and its providers were frequently mentioned by consumers. These concerns have probably been fueled by the collective experience of Blacks in the United States as well as by the fact that many of the consumers in our study

reported receiving incompetent or inadequate treatment by their mental healthbreak providers.

System Barriers

The two most common system barriers to accessing mental health services were a lack of an adequate explanation about mental health services and a lack of follow-up. Instrumental barriers, such as not having financial means to access services also were identified. Many participants reported high levels of need and minimal personal resources to even access services, but once services were accessed, they often were of poor quality. The majority of consumers did not have other options for mental health services and did not have the personal resources to fight for their rights to receive appropriate services. Interestingly, the need for culturally competent services or for ethnic matching was almost absent in these interviews. Thus, ethnic matching or cultural competence are not “cure all” phrases and cannot replace competent, understanding, and caring treatment.

Facilitators of Mental Health Services

Similar to previous research (Sussman, Robins, & Earls, 1987), perceived need was identified as a major component leading to the decision to enter and continue with treatment. Receiving a referral from a mental health provider or from family members or friends also led many consumers to therapy. This suggests once again the importance of active follow-up and treatment coordination as well as outreach and community education in this population.

Many consumers argued that ignoring others’ opinions, talking about mental illness with only certain people, or finding new support systems that understand and perhaps experience similar struggles were helpful in facilitating their decision to continue with their care. The importance of being proactive in one’s care also was articulated by many consumers and is likely an important suggestion given the many system inadequacies reported by consumers.

Many of the consumers in this study reported life-long experiences of substance abuse, involuntary treatment, mental illness or abuse in their family, victimization by society, homelessness, and frequent encounters with the criminal justice system. These findings emphasize once again the importance of treatment coordination and adequate case management when working with seriously mentally ill ethnic minorities (Miranda, Azocar, Organista, Dwyer, & Areal, 2003).

Limitations

The present study has several limitations. This is a secondary analysis of a larger study designed toward developing an intervention to reduce stigma. This larger goal likely had influenced data collection and analysis. Furthermore, we conducted member check for the overall intervention development, but not for the specific themes presented in this paper. Another limitation is the use of a convenience sample. Potentially, our sample is more invested in and attuned to mental health issues and is not representative of the general population. In addition, the participants in this study were more educated than what is generally reported in the literature and this might have impacted their decision about using mental health services. Last, the use of qualitative techniques is not as standardized as the use of paper and pencil techniques. However, to overcome these limitations, interviewers had extensive prior experience in interviewing techniques, and analysis was conducted by several reviewers in multiple steps.

CONCLUSION

Our study sheds light on both barriers to and facilitations of mental health services in an underserved population of Black mental health consumers. The study is unique because it allowed consumers to express their experiences without assuming a priori what these experiences are. This methodology is particularly important in the hypotheses generation stage. Given the fact that, to date, the majority of research on Black mental health consumers compares their experiences to Whites with little attempt to understand the unique experiences of Blacks in the mental health system, this study provides an important contribution by shedding some light on intragroup variability. The focus on facilitators of mental health use rather than solely on barriers also is a unique aspect of this study.

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