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Provider Types Utilized and Recency of Mental Health Service Use among African American Emerging Adults

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Abstract

Objective—This study examined factors associated with mental health service utilization among African American emerging adults, specifically, when services were used (recency) and the types of providers utilized (mental health/non-mental health).

Methods—Guided by the Behavioral Model for Vulnerable Populations, secondary analysis of the National Survey of American Life (2001–2003) was conducted. A nationally representative sample of African American emerging adults, ages 18–29 (n=806), were assessed using the Composite International Diagnostic Interview. “Evaluated need” was determined by endorsement for one of four DSM-IV diagnosis types (mood, anxiety, substance use, impulse control). Respondents who reported a need for services for emotional/substance use problems were considered to have a “perceived need”. Those who reported voluntary use of mental health/health services to address these problems were considered to have utilized services.

Results—25% of the sample utilized services in their lifetime, while 9% utilized services in the past 12 months. Females were more likely than males to utilize services in three of the four service use categories (lifetime, mental health sector, and non-mental health sector). Respondents with an evaluated need for services were 2–12 times more likely to have utilized services compared to those without a need.

Conclusions—Little is known about why African American emerging adults underutilize mental health services. These findings indicate that being female and having an evaluated need for services were associated with greater odds of service use among this sample. This suggests the need for additional examination of gender differences in service utilization and greater mental health outreach/education among African American males.

Introduction

More than 23 million US adults ages 18 years and older who experience mental illness fail to utilize mental health (MH) services (1–4). Research indicates being African American (AA) or an emerging adult (ages 18 to 29) are further associated with decreased MH service utilization compared to older AAs or Caucasians of any age (5–9). AA adults utilize outpatient MH services at half the rate of Caucasians (6, 9–10) while emerging adults are less likely than adults ages 26 and older to utilize services with utilization rates of 40% or less versus 62–71%, respectively (5, 7–8, 11–14). Both AAs (4, 9) and emerging adults (14,

15) are more likely to seek MH services from non-MH sector providers such as medical doctors and religious/spiritual advisors.

Gender, need for services, and access to health insurance have been found to influence MH service use among AAs (6, 16-18) and emerging adults (5, 14, 19). Less is known about the factors that facilitate or hinder service use among a specific subset of these groups, AA emerging adults (20-21). This gap in the literature is concerning given AA emerging adults are an especially high-risk group because of combined influences of disproportionate burden of mental illness experienced by AAs (4) and their greater likelihood of experiencing persistent illness once diagnosed (22-23). Compared to older adults, emerging adults of any race/ethnicity are at increased risk for the onset of severe mental illness (7, 19, 24-26) with three-fourths of all lifetime cases of mental illness beginning by age 24 years (8). While few studies have sought to examine specific rates of mental illness among AA emerging adults in particular, complex interactions among age and race have been noted (27). Findings from the Epidemiologic Catchment Area Study indicate AA emerging adults had higher 12-month rates of major depression when compared to other racial/ethnic and age groups (27).

Although the exact prevalence of mental illness among this population is unclear, it does not discount the fact AA emerging adults are at risk for experiencing mental illness, while being less likely than other groups to seek MH services when needed (9, 28). Untreated mental illness often leads to serious personal and societal consequences; many of which are disproportionately experienced by AA emerging adults. This population has lower college graduation rates, and higher rates of homelessness and unemployment when compared to Caucasian emerging adults (29-31). It is noted the disproportional rate of these issues among AAs may be attributed to differences in social positioning and other social determinants compared to Caucasians (27, 32). However, given the potentially cumulative vulnerabilities of the impact of race and age on incidence of mental illness for AA emerging adults and their quality of life (4, 27, 33), it is crucial to examine factors that may increase utilization of MH services among this population.

This study utilized the Behavioral Model for Vulnerable Populations (BMVP; 34) to explore MH service use among AA emerging adults. The BMVP posits that predisposing (e.g., socio-demographic factors), enabling (e.g., resources that facilitate service use), and need (e.g., evaluated or perceived need for services) factors may predict service use among vulnerable populations. This study employed eight predictor variables of service use commonly cited in the literature and drawn from the BMVP. For example, predisposing factors such as being female (17), more educated (17), and employed (35) are associated with increased service use. Enabling factors such as MH insurance coverage (6, 17), higher perceived emotional support (36), and lower perceived racial discrimination (6) have been found to improve the likelihood of MH service use. Having an evaluated need or perceived need for services has been cited as the strongest predictor of service use (37).

To further address the dearth of literature on this topic, this study focused exclusively on AA emerging adults, using a nationally representative sample, to examine within-group differences that may influence service utilization among this group. To date, most research investigating service use provides comparisons by either race/ethnicity or age (1, 8);

therefore, it has been difficult to clearly ascertain the factors that facilitate or hinder service use among this specific subgroup. Thus, this study's objective was to determine the association of predisposing, enabling, and need factors with MH service utilization among AA emerging adults.

Methods

Sample

This study analyzed data from the National Survey of American Life (NSAL). It is a multi-stage, integrated national household probability sample of 6,082 English-speaking African American, Afro-Caribbean, and non-Hispanic Caucasian adults, aged 18 years and older residing in the continental US. Data was collected between February 2001 and March 2003 and focused on mental disorders and formal/informal service use among racial/ethnic minority groups (27, 38). This study was approved by the Institutional Review Board (IRB) at the University of Michigan. A determination of exemption was later obtained from Washington University in St. Louis' IRB. Further details of the NSAL can be found elsewhere (27). For the purposes of this study, a subset of the AA respondents from the original NSAL adult interviews was analyzed: emerging adults ages 18 to 29 (n=806).

Measures

Mental health service utilization—Respondents were asked if they ever in their lifetime saw any professionals for problems with their emotions, nerves, or use of alcohol or drugs; if they ever talked to a medical doctor or [any] other professional about their problems with the specific disorder (e.g., depression, panic disorder, substance use, attention deficit/hyperactivity disorder,); and a series of questions that asked about previous mention of talking to a professional (e.g., psychiatrist, family doctor, social worker, counselor, religious/spiritual advisor) about MH. Lifetime and past 12 months use were assessed. Those who reported having used MH services in their lifetime were asked which of the following professionals they have ever talked to: MH sector (psychiatrists, psychologists, psychotherapists, social workers, counselors, and MH nurses) and non-MH sector (family doctors, any other medical doctors, any other health professionals, religious or spiritual advisors, and any other healers).

Independent Variables—The author examined the following socio-demographic correlates of MH service utilization: gender, education (11 years, 12 years, 13-15 years, 16+ years), and employment status (employed, unemployed, not in labor force). Respondents indicated having private (e.g., through individual/family's employer), public (e.g., any federal government health insurance programs), or no MH insurance. Perceived emotional support was determined using three items asking how often your family members (other than spouse or partner): make you feel loved and cared for, listen to you talk about your private problems and concerns, and express interest and concern in your well-being. Respondents' answers ranged from very often, fairly often, not too often, and never. These answers were reverse coded to generate a scale of perceived emotional support, with higher scores indicating higher levels of perceived emotional support. Cronbach's alpha for this 3-item index is 0.74. Perceived racial discrimination was assessed using the Major Experiences

of Discrimination scale (39). Respondents were asked if they had ever experienced nine major episodes of discrimination (e.g., being unfairly discouraged by a teacher from continuing your education, being unfairly fired, being unfairly stopped, searched, questioned, physically threatened or abused by the police). For each of the nine discrimination events experienced, respondents were asked to identify one main reason for the discriminatory experience. Reasons included ancestry/national origins, gender, race, age, height or weight, and shade of skin color. For this study, the variable of interest was whether the respondent identified race as the primary reason for any discriminatory experience. This variable was coded into a dichotomous variable with a value of 1 indicating the respondent had experienced at least one discriminatory experience based on race versus no racial discriminatory experiences (value=0). Cronbach's alpha for this item is 0.67.

Evaluated need was determined using the World Health Organization-Composite International Diagnostic Interview (WHO-CIDI), a comprehensive, fully-structured interview designed to be used by trained lay interviewers for the assessment of mental disorders according to the definitions and criteria of the DSM-IV (27). Consistent concordance between the CIDI and the Structured Clinical Interview for DSM-IV has been shown in individual and aggregate level analyses (40). Respondents' were asked questions about physical and emotional well-being in their lifetime (e.g., "have you ever in your life had an attack of fear or panic when all of a sudden you felt very frightened, anxious, or uneasy?"). If they answered yes to specific screener questions, respondents were asked additional questions about the specific disorder to further determine if they met the DSM-IV criterion for the disorder. If the respondent met the criterion for a particular disorder, he/she was considered "endorsed" for the disorder.

Endorsement of at least one DSM-IV diagnosis type was then grouped into one of four categories: *mood disorders* (major depressive episode, dysthymia, mania, bipolar I and II), *anxiety disorders* (agoraphobia without panic disorder, agoraphobia with panic disorder, panic disorder, panic attacks, social phobia, generalized anxiety disorder, posttraumatic stress disorder, separation anxiety disorder, and adult separation anxiety), *substance use disorders* (alcohol abuse and dependence and drug abuse and dependence), and *impulse control disorders* (any binge eating, attention deficit/hyperactivity disorder, and oppositional defiant disorder).

Perceived need was assessed by one item asking, "Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your emotions or nerves or your use of alcohol or drugs?"

Statistical analysis

Bivariate logistic regressions were conducted. Separate multivariate logistic regressions were constructed to assess the independent associations of each predictor variable to MH service use by recency and provider types utilized. All analyses were performed with the survey command in Stata 12.1/SE (41), which accounted for the complex multi-stage clustered survey design of the NSAL sample, unequal probabilities of selection, nonresponse, and post-stratification to calculate weighted, nationally representative

population estimates and standard errors. All percentages reported were weighted for the NSAL-only sample.

Results

As shown in Table 1, the mean age was 23.5 years, the majority (66%) were women, and nearly three-fourths (72%) were employed. Nearly half (44%) were high school graduates while less than one-tenth (8%) were college graduates. Forty-seven percent of the sample endorsed at least one type of DSM-IV diagnosis in their lifetime while 28% of the sample endorsed at least one type of DSM-IV diagnosis in the past 12 months. Conversely, only 5% of the sample perceived a need for MH services in the past 12 months.

After adjusting for all other variables, gender, educational attainment, and need were found to increase the likelihood of MH service utilization (Table 2). Among respondents who had utilized services in their lifetime, women were twice as likely as men to utilize services (Odds ratio [OR] = 1.9). Having an evaluated need was significantly associated with increased likelihood of service use compared to those who did not have a need (OR = 8.7). For past 12 month utilization, respondents with an evaluated need were 12 times more likely to have utilized services compared to those without an evaluated need (OR = 12.3).

Women were almost twice as likely as men to have utilized MH sector providers (OR = 1.7), while those with an evaluated need were three times more likely to have utilized providers in the MH sector than those without an evaluated need (OR = 3.4). Being female (OR = 3.1), having some college (OR = 9.1), and having an evaluated need (OR = 102.9) was significantly associated with increased likelihood of utilization of non-MH sector providers.

Discussion

This study sought to assess the association of predictor factors with MH service utilization by recency and provider types utilized. Results indicated being female, having some college, and having an evaluated need were associated with increased likelihood of utilizing MH services. These results were consistent with previous literature which found, among AAs (17) and emerging adults (42), women were more likely than men to utilize services in general and more formalized MH services. This gender difference in service use could potentially be explained by prior literature that found AA emerging adults who were men were more likely to rely solely on informal support when seeking assistance (43). Higher educational attainment, including year in college (44), has been associated with greater likelihood of receiving MH services among AA emerging adults (17). It is possible this study's results reflect respondents who were currently in college and utilizing services as well as those who may be more open to seeking services based on insight gained while in college. Consistent with previous literature (16, 35, 37), evaluated need was significantly associated with every MH utilization category. This finding indicates that among this sample of AA emerging adults, those individuals who needed services were, to some extent, utilizing them.

This study found that employment status and MH insurance coverage were not significantly associated with increased odds of any MH service utilization. While the majority of this

sample was employed, almost half (48%) did not have MH insurance coverage. Previous research of the association of employment with MH service use has been contradictory (11), while having health insurance coverage has been found to be a strong predictor of service utilization among AAs in general (6, 17, 45). Although these factors have been found to be associated with service use among other populations, this study's results support prior findings that need is, in fact, the strongest predictor of service use (16, 37).

Unlike previous literature which found higher perceived emotional support was directly related to increased mental health service use (36, 46), this study found perceived emotional support was not significantly associated with service utilization. It is possible respondents in this sample felt their need for services was mitigated by support from family members; thus, no longer requiring the need for formal MH services (47). Perceived racial discrimination also failed to be associated with service use among this population. This finding could be influenced by the respondents' age (e.g., had not yet applied for a housing lease/mortgage), their failure to perceive or have had an experience of racial discrimination, or failure to attribute an event of discrimination to race.

These results should be considered in light of several limitations. First, the NSAL has a cross-sectional design which hinders the ability to make causal inferences about the factors that may be related to MH service utilization among this population. It is possible additional factors that were not asked or were beyond the scope of this study may further impact service use among AA emerging adults. Second, only individuals who were non-institutionalized, including college students living on campus, at the time of the survey were interviewed (27). It is possible those individuals could provide additional information about service utilization among this population. Third, the smaller subgroup analysis (e.g., respondents who utilized non-MH sector providers) led to wide confidence intervals and may have generated unreliable results (48-49). This highlights the fact that despite having a large sample size, examining subsets of service use can have some of the same limitations of smaller studies (27). Lastly was the issue of recall (e.g., recalling symptomology or speaking to any professional about a problem). Most responses were retroactive reports that happened more than a year ago and reliability of the details of the problem or service utilization may be subject to potential recall bias (50-52).

Conclusions

This study's findings suggest several general conclusions. Additional MH outreach and education is needed, particularly among AA emerging adults who are men. Among this sample, men were consistently less likely to have utilized services compared to women, despite having similar lifetime evaluated need (42% versus 48%, respectively). Additionally, only 5% of the sample perceived a need for services. Creative solutions incorporating social media outlets such as Facebook and Twitter (53-54) may be more appropriate avenues for improving understanding of mental illness and its symptomology among this population, particularly given their age and access to technology. Additionally, research indicates racial/ethnic- and gender-matching in professional relationships may increase service utilization among AA emerging adults who are male (43, 55). This information is relevant to primary care physicians and other professionals who are often the first point of contact for this

population. It may be necessary to make every effort to match these individuals with a provider who is racially/ethnically similar or male to increase the chances of service utilization and retention.

Similarly, outreach and education needs to incorporate individualized and culturally-targeted materials (56-57). Targeted materials may be helpful in reducing stigma by normalizing mental illness and providing “real-life” and relevant information specifically related to AA emerging adults (56, 58-59). Finally, it is important to incorporate available informal resources (43) that are already being utilized by this population in order to improve the likelihood of use of more specialized services, as needed (31, 50, 60). Local organizations such as churches, beauty salons/barber shops, and community centers have been found to be effective venues for outreach and services among this population (57, 60-61).

AAs, in general, experience a disproportionate burden related to mental illness (4). More specifically, AA emerging adults could be adversely affected by cumulative vulnerabilities related to race, social positioning, age, and mental illness, which may further contribute to their being at particular risk for experiencing a poorer quality of life (33). Despite these potentially bleak outcomes, AA emerging adults often have some of the lowest MH service utilization rates compared to Caucasian emerging adults as well as older AAs and older Caucasians (27-28). This study examined predisposing, enabling, and need factors associated with MH service utilization among AA emerging adults in hopes of enhancing our understanding of the relationship between specific predictor variables and service use among this population. While females and individuals with an evaluated need for services are more likely to utilize services, additional work, both in practice and research, needs to be conducted to increase awareness of MH symptomology among AA emerging adults in general, and service utilization, particularly among males and those experiencing mental illness.

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Table 1

Sample characteristics of 806 African American Emerging Adult respondents drawn from the National Survey of American Life

Characteristic	N	% ^a
Age (M±SD)	23.5±3.5	
Gender		
Female	531	65.9
Male	275	34.1
Education		
Some high school (HS)	186	23.1
High school (HS) graduate	356	44.2
Some college	196	24.3
College graduate	68	8.4
Employment status		
Employed	581	72.1
Unemployed	135	16.8
Not in labor force	90	11.2
Mental health insurance coverage		
Private	231	31.3
Public	133	18.0
None	375	50.7
Perceived emotional support (M±SD)	9.99±2.2	
Perceived racial discrimination (1 event)	257	31.9
Evaluated need		
Lifetime	372	47.1
Past 12 months	219	27.7
Perceived need	38	5.1
Mental health service utilization		
Lifetime	200	24.8
Past 12 months	74	9.2
Mental health sector	79	9.8
Non-mental health sector	33	4.1

^a All percentages are weighted for the NSAL-only sample

Multivariate analysis of the association of predictor variables with mental health service utilization (recency and provider types utilized)

Table 2

Variable	Lifetime use			Past 12 month use			Mental health sector			Non-mental health sector		
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Gender (reference: male)												
Female	1.9***	1.3-2.8	1	.4-2.3	1.7*	1.0-3.0	3.1*	.97-8.6				
Educational Attainment (reference: some HS)												
HS graduate	.8	.5-1.4	.9	.3-2.9	.8	.4-1.5	3.9	.61-6.1				
Some college	1.4	.7-2.5	.9	.2-3.6	.9	.5-1.7	9.1*	.8-11.0				
College graduate	1.1	.4-3.1	1		.9	.3-2.6	1.9	.28-4.1				
Employment status (reference: employed)												
Unemployed	1	.5-1.8	.7	.2-2.8	.87	.3-2.6	2.8	.66-4.1				
Not in labor force	1.2	.5-2.8	1.1	.3-3.9	1.6	.6-4.4	.7	.28-2.8				
Mental health insurance coverage (reference: private)												
Public	1	.5-2.1	.6	.2-2.1	.7	.3-1.8	2.2	.75-2.6				
No insurance	.5	.5-1.4	.6	.2-1.6	1	.5-2.2	1.1	.58-1.6				
Perceived emotional support	1	.9-1.1	1	.7-1.3	1	.9-1.1	1	.78-1.1				
Perceived racial discrimination (reference: no discrimination)												
1 racial discrimination event	.9	.5-1.6	.8	.3-2.6	.8	.3-1.8	1.2	.52-3.3				
Evaluated need (reference: no need)												
Endorsed	8.7***	4.8-15.5	12.3***	3.7-40.6	3.4**	1.5-7.9	102.9***	12.5-846.0				
Perceived need ^d (reference: no)												
Yes			1.5	.4-5.3								

* p value .05,

** p value .01,

*** p value .001

^d Perceived need was only included in past 12 month use analysis