Perceived Discrimination and African American Mental Health Service Utilization

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Abstract

Introduction: Large disparities in black-white mental health service utilization remain despite access to utilization increasing. Due to the distress caused by discrimination we hypothesized that, experiencing events of perceived discrimination will lead to an increase in utilization. Rates of utilization may be skewed because many studies do not include informal supports such as religious care. **Methods:** We conducted a secondary analysis of the data collected in the Midlife in the United States (MIDUS) series, the Milwaukee samples. Total mental health service utilization was measured by formal utilization (e.g., visiting a psychiatrist, a general practitioner, or a counselor) as well as informal supports which was only measured in terms of religious care. Discrimination was measured by daily, lifetime, and job discrimination. **Results:** Almost 30% of participants reported utilizing some form of service. Discrimination also leads to an increase in likelihood of utilization across all mental health services. **Discussion:** Discrimination is a strong predictor of utilization. Discrimination causes distress that leads individuals to want to receive treatment beyond factors associated with pathology.

Introduction

Mental health is a public health concern with 20% of U.S. adults living with a mental illness (NIH, 2019: Goodwin University, 2021). Mental disorders (25.5%), excluding intellectual disabilities is the second leading reason disabled workers enroll in the U.S. Social Security Disability Insurance Program (Social Security Administration, 2019). Access to mental healthcare services is essential to alleviate mental disorders in the population. Rates of access among African Americans has remained significantly lower than that of Caucasians. As recently as 2019, 23% of white American adults received some form of mental health treatment out of that, 19.1% had taken prescription medication and 10.9% received counseling/therapy in the past 12 months. Compared to 13.6% of black adults that received any treatment, of that 11.1% relied on medication exclusively and 8.1% relied on therapy only (Terlizzi & Zablotsky, 2019). Furthermore, though population-wide access in mental health has increased over time, the gap in access to mental healthcare has grown – rates of access to mental healthcare increased from 16% to 20 % for Caucasians and from 7% to 10% for African Americans from 2004 to 2012 (Cook et al, 2016). It is crucial to better understand rates of mental health service utilization among black Americans and to identify factors among black Americans that are contributing or detracting from the utilization of mental health services.

Formal mental health care services are often underutilized and viewed as ineffective by African Americans whereas, family, friends, churches, and other forms of informal services are sought after (Dana, 2002; Hays & Lincoln, 2017; NAMI, 2009). Formal services are performed by a mental health professional such as a psychiatrist or counselor, whereas informal services are performed by community members like clergy (Hays & Lincoln, 2017). Informal services are often seen as more accessible due not only to geographical location but also due to the relationships built in these settings and their cultural significance. In a 2017 study, 95% of black American respondents were grouped into a class defined by their moderate use of informal service and medical providers and low reliance on mental health professionals (Hays & Lincoln, 2017). There is a close tie to religion in many African American communities. African Americans often turn to religious figures rather than trained professionals when seeking mental health assistance (NAMI, 2009). African Americans in Northern Pennsylvania and central New Jersey that were highly religious tended to have fewer positive attitudes towards professional mental health treatment (Davenport & McClintock, 2020). The higher reliance on informal resources such as church members and medical providers is often due to relationship that has already been built between the individual and the person providing the service. While selecting a clinician or looking for care, African Americans often seek providers that do not present prejudice and show that they understand the effects of racism and discrimination in their daily lives (Dana, 2002). Due to the often-established connection to community resources, there may be a better understanding of the effects of discrimination.

Discrimination could affect rates of mental healthcare utilization among African Americans. According to the American Psychology Association (APA), experiences of discrimination lead to more stress and poorer health outcomes (2016). Because discrimination leads to more stress and poorer health outcomes, it is possible that experiences of discrimination could lead to a greater demand for mental health services. Some studies that have explored the role of discrimination found minimal correlation to mental health (Kessler et al., 1999), this study only utilized data from the original Midlife in the United States (MIDUS) studies which underrepresented African Americans in the original series.

More recent studies have not only recognized the negative relationship between discrimination and mental health but have also found discrimination to be a significant predictor of utilization (Evans & Sheu, 2018; -Ault-Brutus, 2012). Lifetime discrimination is often depicted as discouragement from further development, unjust denial of a job, bank loan denial, etc. (Williams, 1997). The APA has found that black Americans report experiences of lifetime discrimination at a higher frequency than white Americans (2016). Although black Americans are likely to feel stressed due to experiences of discrimination, they utilize mental healthcare services at a lower rate than white Americans. Previous studies have examined mental health service utilization among African Americans and black Americans but gaps in the literature remain. Regarding utilization, correlates such as socioeconomic status and education level rather than discrimination (Cook et at., 2016). There are conflicting findings concerning discrimination's role in mediating utilization among African Americans (Kessler et al., 1999; Choi et al., 2019). African Americans are often underrepresented in the literature; therefore, the results of these studies are not generalizable, and their results may not be as accurate (DeCoux et al., 2010; Evans & Sheu, 2018).

Present Study

The present study examined rates of mental healthcare utilization among African Americans in the Milwaukee area and correlates of mental health service utilization in this population. Mental health service utilization variables included visiting a Fromal mental healthcare provider and visiting religious leaders for mental health concerns. A potential correlate of mental health service utilization is perceived discrimination. We conducted descriptive analyses of mental health service utilization to add to the literature on rates of mental health service utilization among African American. We also examined the association between lifetime discrimination and several important demographic variables (age, sex, marital status, income, level of education, insurance status, and living with a chronic condition) and utilization of mental healthcare utilization services to provide a greater understanding of possible determinants of mental healthcare utilization among African Americans.

Methods

Data

We conducted a secondary analysis of the data collected by the Midlife in the United States (MIDUS) Milwaukee African American Studies. Two Milwaukee African American samples were conducted in conjunction with the MIDUS 2, Refresher, and MIDUS 3. Each sample is considered a "wave." In this study we analyzed data from MIDUS 2 Milwaukee African American Sample and the MIDUS Refresher Milwaukee African American Samples which comprised two independent samples that completed identical self-report measures.

Participants

Wave 2 consisted of 592 participants and the refresher collected data from 508 individuals a allowing the current study to examine the responses of 1,100 participants. Table 1 shows that 59.9% of participants were female, 25.7% were married, 80.9% had medical insurance, and 82.1% were living with a chronic condition. The average age of participants was 47 years old. Only 25.7% of participants were married. The median household income was $28,000. The mean Kessler score for negative affect was 11.14. The Kessler Psychological

Distress Scale (K6) was developed to evaluate distress to determine cases of serious mental illness from non-cases (Kessler et al., 2003). The K6 scale asks participants 6 questions which are answered on a Likert scale. The range of scores goes from 6 to 30 and scores below 13 often indicate that an individual is psychologically well (Harvard Medical School, 2005). On average, participants experienced 2 events of lifetime discrimination. The demographic variables included, age, sex, marital status, income, level of education, insurance status, and living with a chronic condition and were measured using a questionnaire.

Measures

Mental health service utilization was measured in terms of formal and informal services. In this study, formal services were services provided by a mental health professional such as a therapist, psychiatrist, or general practitioner. The other form of service measured was religious care. Attending one or more sessions with any service provider in the past 12 months was marked by a 1, no attendance was marked by a 0. Discrimination was calculated based on lifetime events of perceived experience of discrimination based on race.

Results

Table 2 displays the rates of utilization for all service types. 27.86% of participants reported the utilization of any service. Rates of utilization are relatively equal across care types. General Practitioners are the most frequently utilized with 16.04% of participants reporting the use of this form of care. GPs were followed by psychiatrists and counselors for formal care, with 11.36% and 11.04% of participants reporting utilization, respectively. Formal care accounted for 21.26% of utilization whereas religious care accounted for only 12.18% of all utilization.

There was a positive association between lifetime discrimination and the utilization of any form of cares, $\chi^2(1) = 13.42$, $p < .001$, OR = 1.09, 95% CI = [1.007-1.172] (see Table 3). These results are similar across formal service types. **(Table 6)**.

Overall, formal care had a positive relation with experiences of lifetime discrimination, $\chi^2(1) = 11.32$, $p < .001$, OR = 1.12, 95% CI = [1.049-1.202] (Table 4). Religious care also had a positive relationship with lifetime discrimination, $\chi^2(1) = 4.53$, $p = .010$, OR = 1.09, 95% CI = [1.007-1.172] (Table 5).

Additionally, negative affect was a correlate had a very significant relationship with the utilization of mental health services. The utilization of formal care had a significant positive relationship with negative affect, $\chi^2(1) = 56.83$, $p < .001$, OR = 1.14, 95% CI [1.099-1.179] (Table 4). There was a similar positive relationship between negative affect and religious care, $\chi^2(1) = 20.96$, $p = .001$, OR = 1.09, 95% CI = [1.05-1.139] (Table 5). This overall positive relationship is seen between negative affect and the utilization of any form of service, $\chi^2(1) = 67.61$, $p = < .001$, OR = 1.14, 95% CI = [1.106-1.183] (Table 3).

Discussion

In the current study, we investigated rates and correlates of mental health service utilization among African Americans located in Milwaukee, Wisconsin. Black Americans are utilizing a variety of mental health care resources, including formal and religious care. Religious care accounted for a low portion of care utilization compared to all forms of formal care. As we expected, experiences of discrimination had a significant positive relationship with service utilization across all service types, including religious care, when adjusted for other relevant correlates. A 2008 study found a higher reliance on informal supports alone than formal supports alone (Woodward et all., 2008). The results of the present study contradict those that found no correlation or a negative correlation between discrimination and utilization. A study found gender and evaluated need to be significant predictors of utilization whereas discrimination was not (Williams, 2014). Burgess et al. made the distinction between U.S.-born and African-born black Americans and found that U.S.-born black Americans had a more significant negative correlation between discrimination and utilization (2008). The results of this study show that experiences of lifetime discrimination still have a significant relationship with utilization when adjusting for negative affect.

The results of our study indicate that the relationship between discrimination and utilization is more complex. Other studies have suggested that racial identity moderates the impact of discrimination on utilization (Richman, 2007). Depending on an individual's nationality and/or ethnicity, there would not be the same historical relationship to acts of racial discrimination. Without the historical connection, racism may affect an individual less.

There are several important limitations to this study. First, the data used to conduct the present study was sourced from a cross sectional study with data being collected over a variety of years from different participants each time. Due to the nature of the original study, a causal relationship could not be determined. Data on stigmas surrounding the discussion of mental health and receiving mental healthcare was not collected. Also, participants were not asked about feeling discouraged from receiving care. Both factors could also be influenced by discrimination and reveal a more complex patter.

Based on the results of the present study, it is evident that African Americans do use a variety of mental health resources at a relatively equal rate with GP being most frequently utilized. In order to get more individuals to see a psychiatrist or counselor, practitioners will have to be more conscious of the experiences of racial minorities, particularly black Americans. If a practitioner is prepared to discuss issues surrounding race, black clients maybe more comfortable meeting with mental health professionals.

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Table 1: Participant Demographic Characteristics				
Correlate	**n**	**Mean**	**sd**	**Median**
Age	1100	47.6	12.3	47
Sex	1100			
Female	659 (59.9%)			
Male	441 (40.1%)			
Income	1093	40,023.13	42,693.27	28,000
Marital Status	1100			
Married	283 (25.7%)			
Unmarried	817 (74.3%)			
Insurance	1099			
Insured	889 (80.9%)			
Uninsured	210 (19.1%)			
Chronic Conditions	1100			
No Chronic Condition	197 (17.9%)			
Has Chronic Condition	903 (82.1 %)			
Negative Affect	1095	11.14	5.1	10
Daily Discrimination	1004	2.23	2.57	1
Lifetime Discrimination	926	2.38	2.55	`2

Table 2: Rates of All Service Utilization	
Correlate	**Utilization in Percent**
Psychiatrist	11.36
GP	16.04
Counselor	11.04
Formal Care	21.26
Religious Care	12.18
Any	27.86

Table 3: Anova Test for Any Care with OR and 95% CI				
Correlate	**ChiQ**	**df**	**OR**	**95% CI**
Intercept			0.13	[0.059-0.282]
Negative Affect	67.61***	1	1.14	[1.106-1.183]
Lifetime Discrimination	13.42***	1	1.12	[1.056-1.196]
Age	5.12*	1	0.98	[0.969-0.998]
Sex	0.31	1	0.91	[0.640-1.279]
Married	0.68	1	0.84	[0.55-1.268]
Income	0.02	1	1	[0.999-1]
Education				
High School Diploma			0.91	[0.606-1.371]
Bachelor's Degree	3.63	3	1	[0.787-2.999]
Professional Degree			0.77	[0.311-1.791]
Insurance	7.87	1	1.89	[1.208-3.039]
Chronic	8.45	1	2.11	[1.267-3.682]
Sample	1.83	1	0.79	[0.557-1.112]

n = 1100; Chi-square statistics reflects likelihood ratio chi-square values for the association between correlates and the utilization of any service; *** p = 0, ** p = 0.001, * p = 0.01, . p = 0.05, ' ' p = 0.1,   p = 1

Table 4: Anova Test for Formal Care with OR and 95% CI				
Correlate	**ChiQ**	**df**	**OR**	**95% CI**
Intercept			0.046	[0.017-0.117]
Negative Affect	56.83***	1	1.14	[1.099-1.179]
Lifetime Discrimination	11.32***	1	1.12	[1.049-1.202]
Age	0.03	1	0.99	[0.983-1.014]
Sex	0.44	1	0.878	[0.595-1.288]
Married	2.03	1	0.713	[0.442-1.134]
Income	2.64	1	0.99	[0.999-1]
Education				
High School Diploma			0.83	[0.543-1.294]
Bachelor's Degree	2.96	3	1.43	[0.679-2.926]
Professional Degree			1.03	[0.397-2.503]
Insurance	20.64***	1	3.46	[1.97-6.425]
Chronic	8.69**	1	2.53	[1.344-5.219]
Sample	0.82	1	0.84	[0.572-1.227]

n = 1100; Chi-square statistics reflects likelihood ratio chi-square values for the association between correlates and the utilization of formal care; *** p = 0, ** p = 0.001, * p = 0.01, . p = 0.05, ' ' p = 0.1,   p = 1

Table 5: Anova Test for Religious Care with OR and 95% CI				
Correlate	**ChiQ**	**df**	**OR**	**95% CI**
Intercept			0.06	[0.028-0.192]
Negative Affect	20.96***	1	1.09	[1.05-1.139]
Lifetime Discrimination	4.53*	1	1.09	[1.007-1.172]
Age	8.72**	1	0.98	[0.951-0.99]
Sex	0.02	1	0.97	[0.622-1.499]
Married	2.43	1	1.51	[0.897-2.497]
Income	1.39	1	1	[0.999-1]
Education				
High School Diploma	1.35	3	1.25	[0.731-2.232]
Bachelor's Degree			1.28	[0.492-3.148]
Professional Degree			1.82	[0.612-4.94]
Insurance	1.5	1	0.72	[0.431-1.226]
Chronic	2.38	1	1.67	[0.877-3.397]
Sample	0.26	1	0.97	[0.623-1.491]

n = 1100; Chi-square statistics reflects likelihood ratio chi-square values for the association between correlates and the utilization of religious care; *** p = 0, ** p = 0.001, * p = 0.01, . p = 0.05, ' ' p = 0.1,   p = 1