JP3
Journal of Progressive Policy & Practice
Volume 1 – Issue 1
Fall 2013

Biases, Barriers, and Other Bitter Pills: The Intersection of Mental Health, Poverty, and the African American Community

Guia Calicdan-Apostle, MSSW, DSW
Richard Stockton College of New Jersey

There is wide agreement among researchers (e.g., Barnes, 2008; Chat & Green, 2011; Mulvaney-Day & Earl; Ojelade, McCray, Ashby & Myers, 2011; Safran et al., 2009) that there is mental health disparity between non-Hispanic Whites and minority populations in the United States. The intersection of mental health and poverty, moreover, has been highlighted as a critical concern (Chow, Kim, & Snowden, 2003; Green, Zebrak, Fothergill, Robertson & Ensminger, 2012; Mental Health, 2012). While 27.4% of African Americans live below the poverty level compared with just 9.9% of non-Hispanic Whites (United States Census, 2012), Blacks are 20% more likely to report having severe psychological difficulty; and, poor African Americans are three times as likely as more affluent Blacks to recount psychological distress. Non-Hispanic Whites, nevertheless, are more than twice as likely to receive anti-depressant prescriptions (Mental Health, 2012). This paper examines the recent relevant literature with two aims: (1) to better understand the relationship between mental health and poverty in the African American community, and (2) to identify and unpack the biases and barriers that create inequality in such areas as access to quality care; health policy and practice; service quality; and treatment and intervention. Preliminary solutions are presented.

INTRODUCTION

According to the 2010 U.S. Census, African American or Black children have the highest rate of poverty at 38.2%, while only 12.4% of White children under 18 live in poverty.

The poverty rate is also highest among single parent female-headed families. In the case of Blacks and Hispanics, 31.6% are poor as compared to 15.8% of families headed by single men who are also poor (Reidenbach & Weller, 2010). The recent recession has contributed to the poverty status of African Americans. While our economic state has been characterized by a decrease in household income for most middle and low income families, the economic status of African Americans decreased more than three times faster than Whites from 2000 to 2008. For example, African Americans' household income decreased 1% per year compared to White Americans' decreased income of 0.34% per year (Reidenbach & Weller, 2010). In 2009, the rate of employment of African Americans was 2.1% lower than it was at the beginning of 2001 while White Americans were employed at a rate 1.4% higher than in 2001. Indeed, the poverty rate among African Americans has increased at more than double the rate among non-Hispanic Whites, with 27.4% of all African Americans now living below the poverty level compared with just 9.9% of non-Hispanic Whites (United States Census, 2012).

Poverty is a breeding ground for mental illness. In a 2000 report on the 34.7 million African Americans in the United States (U.S. Census Bureau, 2002), almost 25%, or 7.5 million, had been diagnosed with a mental illness (Davis, 2005). African Americans are 20% more likely to report having severe psychological difficulty than non-Hispanic Whites; and, poor African Americans are three times as likely as more affluent Blacks to recount psychological distress. In addition, a report from the U.S. Surgeon General revealed how the suicide rate among African Americans ages 10 to 14 increased 233%, as compared to 120% of Non-Hispanic Whites from 1980 to 1995. Overrepresented in homeless populations, incarceration, foster care, child welfare systems and serious violent crime (Mental Health: Cultural, 2001), African Americans are at risk for mental health illness. These data further reinforce the severity of mental health challenges affecting the African American community.

The Mental Health Landscape

To comprehend the mental health landscape in the United States, we must understand how mental health disparity is defined. Mental Health Science Group representatives from the National Institute of Mental Health (NIMH) describe mental health disparity within the context of the health status of the general population as the "significant disparity in the overall rate of mental illness incidence or prevalence, morbidity, mortality or survival rates in a health disparity population" (Safran, Mays, Huang, McCuan, Pham, Fisher, McDuffie, & Trachtenberg, 2009, p. 1962). A leading mental health agency, the Substance Abuse and Mental Health Service Administration (SAMHSA), elaborates the definition of mental health disparity in terms of "power imbalances that impact practices influencing access, quality, and outcomes of behavioral health care" (Safran, et al., 2009, p. 1962). As well, if there is a significant disparity in the principal rate of disease incidence, including its prevalence or rate of survival in a specific group of people defined along racial and ethnic lines, for example African Americans as compared with the general US population, this would constitute an elaborate working definition of SAMHSA (Safran, et al., 2009).

There is strong evidence of health disparities, i.e., incidence, mortality, prevalence and challenges that African Americans face when compared to White Americans. Research in mental health explains correlations between mental illness and its overrepresentation in high poverty stricken communities (Chow, Jaffee, & Snowden, 2003). Although this trend is complex in scope, poor areas are predisposed to be short of the much needed resources that combat mental

illness. These communities depend on safety net providers. *Safety net providers*, according to the Institute of Medicine, are resources that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable populations (Lewin & Altman, 2000). Serving a high volume of uninsured people, safety nets are hospitals and mental health centers typically designated as the primary and only system of care for poor communities. Sadly, their existence is limited and they have been unable to fully meet the mental health needs of the poor, mostly minority-populated communities they serve. Research, indeed, highlights observable gaps between the demand for and the supply of safety net services specifically in certain subpopulations and services (Felt-Lisk, McHugh & Howell, 2001).

Many African Americans live in areas where there is a propensity for health problems, including mental health issues, to arise. The persistent challenges of population density, inadequate or unaffordable housing, overcrowding, limited access to resources, and high crime rates (Black & Krishnakumar, 1998) help us understand how psychological stress can link race to health (Copeland, 2005). Linking health outcomes with other anxiety and trauma-inducing factors is clearly imperative in the African American community. Several authors (Chadiha & Brown, 2002; Klonoff, Landrine, & Ullman, 1999; Leventhal & Brooks-Gunn, 2003; Mechanic, 2005; Satcher et al., 2005; Williams & Jackson, 2005) affirm Copeland's (2005) assessment that the "prolonged negative impact of racism, discrimination, poverty, substandard housing and neighborhood conditions, insurance status, and insufficient availability of and access to quality health care, have all been linked to poor health outcomes among African Americans" (p. 267).

As a result of the aforementioned factors, several implicit and explicit challenges routinely face U.S. minority groups. Some of the issues that can be observed in high risk communities throughout the nation include increased risk of disability and disease from harmful occupational exposure; biological problems; appropriately addressing diverse cultural values in our educational systems; strained majority-minority social relationships; autonomous institutions within ethnic minority group populations operating at cross-purposes; and deep-seated socioeconomic, ethnic, and familial concerns (Geronimus, 2000; Smedley, Stith, & Nelson, 2003; U.S. Department of Health and Human Services, 2000; U.S. Department of Health and Human Services, 2001b).

The State of Mental Health Institutions

To better understand the mental health landscape, we must explore how catchment areas such as state psychiatric hospitals respond to the needs of the community at-large. These state hospitals provide the highest percentage of inpatient psychiatric services in the United States. They are driven by economic policies that shape the requirements of hospital psychiatric care. From the early 21st century model of long-stay public hospitals, to the more recent acute care management in private or not-for-profit settings, this paradigm shift may have reduced the financial load on federal dollars and commercial insurers by reallocating monies through managed care practices. But stronger policies of short hospital stays and limiting the number of days of treatment and deinstitutionalization seem to be the solutions to the expensive cost of health care services. As more and more mental health hospitals are closing and more community centers emerging in locations not often easily accessible to African American clients with transportation problems (Gary, 2010; Rickles, Domínguez & Amaro, 2010), we can implicitly understand how the seemingly undetectable mental health care pipeline works its way into our communities.

Mental Health Pipeline

The following is an example of how a mental health pipeline could be inadvertently formed in a system that requires action and change. An African American male child who is acting out in class, for example, may have been classified under the Federal Education Act of 2004 (Individuals with Disabilities Education Act) as a child with a learning disability and a comorbidity of typical behavioral problems like anxiety and impulse control disorders under the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). Because of the school's inadequate supply of professionals to make available those interventions that may be appropriate for this child, he may begin to act out in a manner that may not be acceptable to the school or system standards. Cultural competency skills play a huge part in listening and understanding from the child's perspective. If interventions are unavailable in school, however, this child may be referred to community mental health services. Sometimes, the behavior may be deemed so severe that the child is taken to a hospital. Whether or not his behavior is initially controlled through medication, the child will typically be given a few days of stay. The average length of stay in a hospital for a mental diagnosis is 7.5 days. This protocol is for both privately insured and Medicaid recipients. Shortened lengths of stay are monitored by strict standards of "medical necessity" and automatically require frequent review while the patient is in the hospital. When the child is released, two things can happen. He may continue to act out if medication and therapeutic interventions are not followed, or he may continue to recover following a rigorous therapeutic modality. Such actions may be caused by individual perceptions of mental illness which usually become barriers in individuals who perceive mental health and mental illness as dichotomous (Swanson & Ward, 1995). For example, Hines-Martin et al. (2003) found not only that African Americans perceive mental health and mental illness to be dichotomous but also that many experience challenges in initially accessing mental health services.

The state of vulnerability of a child with little or no guidance in navigating through procedures for example could potentially encounter problems with the law, in which case, his next stop could be a local jail. Correctional facilities are not mental hospitals. But according to a 2006 study by the U.S. Department of Justice, mental illness is pervasive in correctional systems. About 56% of state prisoners, 45% of federal prisoners and 64% of local jail inmates have mental health problems (National Alliance on Mental Illness, 2012). The cost of maintaining this school-to-prison pipeline is expensive. Inmates with mental illness alone cost U.S. taxpayers about $9 billion a year, according to the National Alliance on Mental Illness (NAMI). Minority communities disproportionally bear the burden of being caught up in this system. For the African American community in particular, the greatest clinical need seems to be in the areas of improved services following the continuum of care where mental health access is just as pivotal as patient choice of care modalities and methods of recovery.

Earlier, we discussed the prevailing health disparities and addressed the burden of mental illness in the African American community. To more fully appreciate the biases and barriers that create inequality in such areas as access to quality care, health policy and practice, service quality, and treatment and intervention, we identify and unpack the underlying context.

Biases

Minorities, according to former Surgeon General David Satcher, suffer a disproportionate amount of mental illness due to limited access to services relative to the general population,

received lower quality of actual care, and less likely to seek help when they are in distress (Eack & Newhill, 2012). Poverty, stigma, and discrimination are key contributors to these disparities (Rank, 2004; U.S. Department of Health, 2001; Wilson, 2009). Client race was the strongest predictor of admission diagnosis in mental health research (Barnes, 2008). The author discovered that in diagnoses of schizophrenia and mood disorder for clients admitted to state psychiatric hospitals more than half of African Americans had a diagnosis of schizophrenia and were less frequently diagnosed with bipolar and major depressive disorders than were White clients. Mental health practitioners widely agree that it is more challenging to treat the psychopathology of schizophrenia because persons with this issue function less successfully in the community and are further challenged by a rigorous treatment process (Falloon, Boyd, McGill, Razani, Moss, & Gilderman, 1982; Kopelowicz & Liberman, 2003). Because much more is known about bipolar disorders, the treatment process is not nearly as complex and demanding (Grohol, 2006). For African American clients, it seems that this crucial disparity of over diagnosis or misdiagnosis of schizophrenia is a major bias in mental health services.

Minority patients, especially African Americans, are prescribed more psychotropic medications at higher doses, and are more likely to receive injectable medicines (Citrome, Levine, & Ailingham, 1996; Segal, Bola, & Watson, 1996). Involuntary hospitalization is more likely to occur among African Americans than White Americans (Rosenfield, 1984). Non-Hispanic Whites are also more than twice as likely to receive anti-depressant prescriptions (Mental Health and African Americans, 2012). This unequal system of care suggests a major gap in healthcare service delivery and is consistent with earlier research on admission diagnosis of schizophrenia (Barnes, 2008).

The manner in which African American patients are treated in healthcare settings also forms the basis of another bias. When they feel that their provider has been discourteous, African American clients are less likely to return for treatment. Thus they may seek another healthcare provider or change their healthcare plans altogether (Copeland, Scholle, & Binko, 2003).

Because culture and language have considerable influence on how patients obtain and respond to health care services (Copeland, 2005), African American patients are not immune from these influences. Many come from a high level of cultural mistrust where mental illness is stigmatized and where attitudinal responses to individuals with mental illness have been negative (Silva de Crane & Spielberger, 1981). In a similar study, Diala, Muntaner, Walrath, Nickerson, La Veist, and Leaf (2000) uncovers negative and shameful attitudes toward the mentally ill. This may be due to a lack of knowledge about mental health issues and a lack of understanding of the cultural norms that might present a barrier for achieving a more open perspective. How client attitudes manifest in response to patient-professional relationships will require more cultural sensitivity on the part of providers.

Barriers

There are barriers to mental health care in the African American community. For example, race and the diagnosis of schizophrenia are significant issues in the utilization and diagnosis of mental illness. Hospital workers most likely provide diagnoses using unstructured or semi-structured clinical interviews rather than comprehensive structured interviews (Neighbors, 2003) and Black patients are much more likely than White clients to receive a diagnosis of schizophrenia. Although African Americans disproportionately experience socially

overt situations that increase their chances of developing a mental illness, they are less likely to receive diagnosis and treatments via comprehensive structured interviews (Neighbors, 2003).

Decision makers other than mental health professionals, including business owners, neighbors, the public, the police, and the courts, play an important role in assessing mental illness and deciding whether troublesome behavior warrants treatment or punishment (Snowden, 2000; 2001). Perceptions of vulnerability to mental health by these decision makers could impact the appropriate assessment of African Americans who may have acted out but not been clinically diagnosed. Sometimes community members who are detached from African American culture prejudge people because of the way they carry themselves or the way they interact with others. Some communities **awfulize** situations that do not warrant such attention.

Structural barriers to care include lack of transportation, nonexistent or inadequate health insurance, scarcity of providers, long waiting lists, and inconvenient health services locations (Beal, 2004; Frist, 2005; Kennedy, 2005; Owens, Hoagwood, Horwitz, Leaf, Poduska, Kellam, & Ialongo, 2002; U.S. Department of Health and Human Services, 1999; U.S. Department of Health and Human Services, 2001a, 2001b). There appears to be some perceptual barriers regarding African Americans' utilization of health care services. Sometimes, understanding and explaining illness is a challenge for African Americans in places where cultural and social nuances can be much more effective in communicating both the medical realities and the availability of resources. This knowledge dissemination could also include medical office protocols. Sensitivity to the impact of culture and language as well as the manifestation of stigma and negative attitudes in how patients obtain and respond to health care services (Copeland, 2005; Diala et al., 2000; Silva de Crane & Spielberger, 1981) may help decrease the *dropout problem*, which is when individuals attend only one treatment session and fail to receive the full benefit of an intervention.

Bitter Pills

Historically, African Americans have struggled through varying degrees of disenfranchisement, emancipation, enfranchisement, and political and social empowerment. They have engaged in a massive migration from the Rural South to the Urban North, requiring a major shift in thinking about health access and self-determination. Blacks have moved from caste segregation to social desegregation (U.S. Department of Health and Human Services, 2003), a phenomenon of concentrating and staying in areas that they are comfortable navigating and where they are not continually questioned. This bitter pill perpetuates a psychological detachment from other communities. African Americans generally continue to face disparities in mental health access and delivery of services, although there has been a lessening of differences between Black and other veterans (Melfi, Croghan, Hanna, & Robinson, 2000). Interestingly, African Americans have more favorable attitudes than Whites toward mental health services before using them but less favorable attitudes after use (Diala et al., 2000). This clearly demonstrates how important it is for service professionals to exercise cultural competence and sensitivity during initial assessments and sustained client engagement.

Promising Solutions

There are several solutions to the mental health issues that challenge the African American community. The first is to empower the community with the knowledge of mental

health and culturally appropriate practice interventions that are available via service providers. Specifically, discussions should be held regarding perceptions of mental illness. The goal through a community process that appropriately includes service providers and clients is to bridge the culturally nuanced misunderstandings that often exist between clients and workers. Secondly, the teaching of cultural competency should be systematically implemented among mental health providers in order to increase cultural humility. Providing services in a context where the culture of the African American community is prioritized will help solve some of the barriers to mental health care access and quality treatment. Thirdly, while the dropout problem will be assuaged by having a more culturally competent staff, service providers and the African American community as a whole must pointedly educate individuals about the critical benefits of completing interventions and treatments. Fourth, mental health professionals must be very careful when diagnosing persons from cultures and groups that have not been previously tested under a generalized index. While psychometric professionals rely on the premise that test results can be measured from a population under examination against a *normal* population, what is considered normal for one culture may not necessarily apply to another. Fifth, the use of evidence-based interventions in mental health practice should be explored in order to increase the efficacy of practice modalities. Sixth, professionals should consider the use of spiritually-integrated interventions in mental health practice, especially given the historic significance of spirituality in the African American community. Finally, improved feedback regarding client satisfaction and the perception of interventions and services can only increase the relevance of mental health treatment.

As professionals who uphold social justice, we must continually address the impact of mental health disparities and poverty where clients are potentially harmed. Given the historic and contextual challenges that the African American client too often embodies, indeed, the ancient Hippocratic admonishment to *do no harm* can wisely and constructively be extended to ***do no more harm*** (Marks, Lamb & Tzioumi, 2009). This kind of holistic appreciation of the various biases and barriers that complexly convolute issues of mental healthcare access, policy and practice, intervention and treatment, and service quality is critical to truly addressing client needs and producing improved outcomes.

REFERENCES

Barnes, A. (2008). Race and hospital diagnoses of schizophrenia and mood disorders. *Social Work*, *53*(1), 77-83.

Beal, A. C. (2004). Policies to reduce racial and ethnic disparities in child health and health care. *Health Affairs,* 23, 171-179.

Black, M., & Krishnakumar, A. (1998). Children in low-income urban settings: Interventions to promote mental health and well-being. *American Psychologist, 53, 635-645.*

Chadiha, L. A., & Brown, G.W. (2002). Contributing factors to African American women caregivers' mental well-being. *African American Research Perspectives*, 8(1), 72-83.

Chat, R., & Green, K. E. (2011). Multiculturally sensitive mental health scale (MSMHS): Development, factor analysis, reliability, and validity. *Psychological Assessment*, *23*(4), 876-887. DOI: 10.1037/a0023710.

Chow, J. C.-C., Kim, J., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health, 93*(5) 803-811.

Citrome, L., Levine, J., & Allingham, B. (1996). Utilization of depot neuroleptic medication in psychiatric inpatients. *Psychopharmacology Bulletin*, 32, 321-326.

Copeland, V. C. (2005). African Americans: Disparities in health care access and utilization. *Health and Social Work*, 30(3), 265-70.

Copeland, V. C., Scholle, S. H., & Binko, J. (2003). Patient satisfaction: African American women's views of the patient-doctor relationship. *Journal of Health and Social Policy*, 17(2), 35-48.

Davis, K. (2005). *Decreasing discrimination and stigma associated with mental illness in the African American community.* Retrieved May 15, 2013, from http://promoteacceptance.samhsa.gov/update/archive/march2005.aspx

Diala, C., Muntaner, C., Walrath, C., Nickerson, K. J., La Veist, T. A., & Leaf, P. J. (2000). Racial differences in attitudes toward professional mental health care and in the use of services. *American Journal of Orthopsychiatry*, *70*, 455-463.

Eack, S & Newhill, C. (2012). ***Racial disparities in mental health outcomes after psychiatric hospital discharge among individuals with severe mental illness***. Social Work Research, 36: 41-52.

Falloon, I., Boyd, J., McGill, C., Razani, J., Moss, H., & Gilderman, A. (1982). Family management in the prevention of exacerbations of schizophrenia — A Controlled Study. *New England Journal of Medicine*. DOI: 10.1056/NEJM198206173062401.

Felt-Lisk, S., McHugh, M., & Howell, E. (2001*). Study of safety net provider capacity to care for low-income uninsured patients.* Retrieved November 27, 2013 from: http://www.mathematica-mpr.com/PDFs/safetynet.pdf

Frist, W. H. (2005). Overcoming disparities in U.S. health care. *Health Affairs*, 24, 445-451.

Gary, K. (2010, July). *Perceptions of psychiatric services held by older African-American males*. Retrieved November 27, 2013 from: http://www.vcu-projectempowerment.org/documents/facts_file_issue3.pdf

Geronimus, A.T. (2000). To mitigate, resist, or undo: Addressing structural influences on the health of urban populations. *American Journal of Public Health*, 90, 867-872.

Green, K. M., Zebrak, K. A., Fothergill, K. E., Robertson, J. A., & Ensminger, M. E. (2012). Childhood and adolescent risk factors for comorbid depression and substance use

disorders in adulthood. *Addictive Behaviors*, *37*(11), 1240-1247. DOI: 10.1016/j.addbeh.2012.06.008.

Grohol, J. (2006). The differences between bipolar disorder, schizophrenia and multiple personality disorder. *Psych Central*. Retrieved on December 18, 2012, from: http://psychcentral.com/lib/the-differences-between-bipolar-disorder-schizophrenia-and-multiple-personality-disorder/000633

Hines-Martin, V., Malone, M., Kim, S., & Brown-Piper, A. (2003). Barriers to mental health care access in an African American population. *Issues in Mental Health Nursing*, 24(3), 237–256.

Kennedy, E. M. (2005). The role of the federal government in eliminating health disparities. *Health Affairs*, 24, 452-458.

Klonoff, E. A., Landrine, H., & Ullman, J. B. (1999). Racial discrimination and psychiatric symptoms among blacks. *Cultural Diversity & Ethnic Minority Psychology*, 5, 329-339.

Kopelowicz, A., & Liberman, R. (2003). Integration of care: Integrating treatment with rehabilitation for persons with major mental illnesses. *Psychiatric Services 2003.* DOI: 10.1176/appi.ps.54.11.1491.

Leventhal, T., & Brooks-Gunn, J. (2003). Moving to opportunity: An experimental study of neighborhood effects on mental health. *American Journal of Public Health*, 93, 1576-1582.

Lewin, Marion Ein, and Stuart Altman (Eds). *America's Health Care Safety Net*. Washington, DC: National Academy Press, 2000.

Marks, S., Lamb, R., & Tzioumi, D. (2009). Do no more harm: The psychological stress of the medical examination for alleged child sexual abuse. Journal of Paediatrics and Child Health, 45(3), 125-132. DOI: 10.1111/j.1440-1754.2008.01443.x.

Mechanic, D. (2005). Policy challenges in addressing racial disparities and improving population health. *Health Affairs*, 24, 335-338.

Melfi, C. A., Croghan, T. W., Hanna, M. P., & Robinson, R. L. (2000). Racial variation in antidepressant treatment in a Medicaid population. *Journal of Clinical Psychiatry*, *61*, 16-21.

Mental Health and African Americans (2012, August 31). Retrieved September 1, 2012, from the U.S. Department of Health & Human Services website: http://minorityhealth.hhs.gov/templates/content.aspx?ID=6474

Mental Health: Cultural, Race, Ethnicity. Surgeon General's Report. US Department of Health and Human Services, Office of the Surgeon General, SAMHSA. 2001.

Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General (2001, August). Rockville, MD: US Department of Health and Human Services; 2001.

Mulvaney-Day, N. E., Earl, T. R., Diaz-Linhart, Y., & Alegría, M. (2011). Preferences for relational style with mental health clinicians: A qualitative comparison of African American, Latino and Non-Latino White patients. *Journal of Clinical Psychology*, *67*(1), 31-44. DOI:10.1002/jclp.20739

NAMI, 2012 Retrieved from: http://naminorthsideatlanta.org/wp-content/uploads/2012/08/The-NAMI-N%E2%80%99Sider-AUG-2012.pdf

Neighbors, H. W., Trierweiler, S.T., Ford, B. C., & Muroff, J. R. (2003). Racial differences in DSM diagnosis using a semi-structured instrument: The importance of clinical judgment

in the diagnosis of African Americans. *Journal of Health and Social Behavior*, 43, 237-256.

Ojelade, I., McCray, K., Ashby, J. S., & Meyers, J. (2011, Fall). Use of Ifá as a means of addressing mental health concerns among African American clients. *Journal of Counseling & Development 89*(4), 206-212.

Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P.J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41,731-738.

Rank, M. R. (2004). *One nation, underprivileged: Why American poverty affects us all.* New York**:** Oxford University Press.

Reidenbach, L., & Weller, C. E. (2010, January 15). *The state of minorities in the economy*. Retrieved November 27, 2013 from the Center for American Progress website: http://www.americanprogress.org/issues/race/report/2010/01/15/7131/the-state-of-minorities-in-the-economy/

Rickles, N., Dominguez, S., & Amaro, H. (2010). *Perceptions of healthcare, health status, and discrimination among African-American veterans*. Retrieved November 27, 2013 from: http://iris.lib.neu.edu/cgi/viewcontent.cgi?article=1023&context=bouve_fac_pubs

Rosenfield, S. (1984). Race differences in involuntary hospitalization: Psychiatric vs. labeling perspectives. *Journal of Health and Social Behavior*, 25, 14-23.

Safran, M. A., Mays Jr., R. A., Huang, L., McCuan, R., Pham, P., Fisher, S., McDuffie, K. Y., & Trachtenberg, A. (2009). Mental health disparities. *American Journal of Public Health*, *99*(11), 1962-1966.

Satcher, D., Fryer, G. E., McCann, J., Troutman, A., Woolf, S. H., & Rust, G. (2005). What if we were equal? A comparison of the black-white mortality gap in 1960 and 2000. *Health Affairs*, 24, 459-464.\

Segal, S. P., Bola, J. R., & Watson, M. A. (1996). Race, quality of care, and antipsychotic prescribing practices in psychiatric emergency services. *Psychiatric Services*, 47, 282-286.

Silva de Crane, R. D., & Spielberger, C. D. (1981). Attitudes of Hispanic, Black, and White university students toward mental illness. *Hispanic Journal of Behavioral Sciences, 3,*241-255.

Smedley, B. D., Stith, A.Y., & Nelson, A. R. (Eds.), Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003). Unequal treatment: Confronting racial and ethnic disparities in healthcare. Washington, DC: National Academies Press.

Snowden, L. R. (2001). Barriers to effective mental health services for African Americans. *Mental Health Services Research*, 3(4), 181-187.

Snowden, L. R., & Thomas, K. (2000). Medicaid and African American outpatient mental health treatment. *Mental Health Services Research, 2,* 115-120.

Swanson, G.M. & Ward, A.J. (1995) Recruiting minorities into clinical trials: toward a participant-friendly system. *Journal of National Cancer Institute.* 87 (23), pp. 1747-59.

U. S. Department of Health and Human Services, Health Resources and Services Administration. (2001a). Cultural competence works. Rockville, MD: Author.

U.S. Census Bureau (2002). *Census 2000 profile*. Retrieved April 27, 2009, from http://www.census.gov/prod/2002pubs/c2kprof00-us.pdf

U.S. Department of Health and Human Services [HHS]. (2003). Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the surgeon general. Rockville, MD: Author.

U.S. Department of Health and Human Services. (1999). Mental health: A report of the surgeon general. Rockville, MD: National Institutes of Health, National Institute of Mental Health, Center for Mental Health Services and Substance Abuse and Mental Health Services Administration.

U.S. Department of Health and Human Services. (2000). NIH strategic plan to reduce and ultimately eliminate health disparities. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, Office of Minority Health.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race and ethnicity—A supplement to mental health: A report of the Surgeon General.* Rockville, MD: Author, Substance Abuse and Mental Health Services Center for Mental Health Services.

U.S. Department of Health and Human Services. (2001b). Mental health: Culture, race, and ethnicity--A supplement to mental health: A report of the surgeon general. Rockville, MD: National Institutes of Health, National Institute of Mental Health, Center for Mental Health Services and Substance Abuse and Mental Health Services Administration.

United States Census Bureau. (2012, May 22). About poverty – highlights – U.S. census bureau.http://www.census.gov/hhes/www/poverty/about/overview/index.htmlMental Health

Williams, D. R., & Jackson, P. B. (2005). Social sources of racial disparities in health. *Health Affairs*, 24, 325-334.

Wilson, W. J. (2009). Toward a framework for understanding forces that contribute to or reinforce racial inequality. *Race and Social Problems, 1,* 3—11.

Correspondence regarding this article should be addressed to: Dr. Guia Calicdan-Apostle, Assistant Professor of Social Work, School of Social and Behavioral Sciences, Richard Stockton College of New Jersey. *Email*: Guia.Calicdan-Apostle@stockton.edu

