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African American Community Mental Health Center Service Utilization: A Test of the Cultural Compatibility Hypothesis

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AFRICAN AMERICAN COMMUNITY MENTAL HEALTH CENTER SERVICE UTILIZATION: A TEST OF THE CULTURAL COMPATIBILITY HYPOTHESIS

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ABSTRACT

AFRICAN AMERICAN COMMUNITY MENTAL HEALTH CENTER SERVICE UTILIZATION: A TEST OF THE CULTURAL COMPATIBILITY HYPOTHESIS

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This exploratory study examined whether community mental health centers (CMHCs) in Virginia that had services evaluated as being more compatible with the cultural needs of African Americans attracted a higher percentage of adult African American service users from their catchment areas than CMHCs which were evaluated as being less culturally compatible. The cultural compatibility of 36 CMHCs was assessed via a telephone interview with their clinical directors using a modified version of the Cultural Competence Self-Assessment Questionnaire: Administrative Version (Mason, J., 1995). This study did not find a correlation between CMHCs' cultural compatibility and their success at attracting African American service users. The ways in which the methodological limitations of the study may have contributed to the lack of significant findings are discussed as are ensuing implications for future research on this topic. Also investigated were the types of services used by African and White American CMHC consumers and consumers of other races. Consumers of other races received more emergency care and less outpatient care than did African and White American consumers. Consumers of

other races may have been less assimilated into social service networks and therefore made less use of CMHC services until their problems became severe enough to warrant emergency treatment. The study also found that as the percentage of African Americans on the caseloads of CMHCs increased over the percentage of African Americans in the catchment areas of CMHCs, so did the CMHCs' scores on the cultural compatibility questionnaire. No definitive conclusions were drawn regarding these findings due to the methodological limitations of the study but possible explanations and implications for future research are discussed. Also discussed are ways to improve the existing database of statistics on minority CMHC utilization characteristics in the state of Virginia.

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CHAPTER I

INTRODUCTION

HISTORY OF THE COMMUNITY MENTAL HEALTH MOVEMENT

The community mental health movement can trace its roots to World War II. The federal government first saw a need to address the problem of mental illness at a national level after 1.75 million men were rejected for military service during World War II for having mental and emotional disturbances. This led to the implementation of broad policy and institutional changes at the federal, state, and local levels between the years 1946 through 1981. These changes had a profound effect on how mental health services were delivered.

The policy phase of the community mental health movement at the federal level began in 1946 when Congress passed the National Mental Health Act. This act eventually led to the establishment of the National Institute of Mental Health (NIMH) in 1949. The mission of this new agency was to conduct mental health research and to support training and research in mental health throughout the nation. In 1955, Congress passed the Mental Health Study Act which established the first Joint Commission on Mental Illness and Health. The Commission's purpose was to survey available mental health resources throughout the nation and to make recommendations for combatting mental illness in the United

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Professional Psychology: Research and Practice served as the journal model for this paper.

States. In 1961, the Commission released its final report, "Action for Mental Health," which recommended the establishment of a community mental health network throughout the nation (Smith, Burlew, Mosley, & Whitney, 1978; Vega & Murphy, 1990). The federal Community Mental Health Center program followed in 1963.

The federal Community Mental Health Center program established guidelines for the creation of community mental health centers (CMHCs) throughout the nation. Newly created CMHCs were to provide mental health care for persons in designated geographical zones called catchment areas. These areas were usually drawn along neighborhood lines. The initial goal of the program was to create a network of 2000 centers. Federal money was to be used in the beginning to get the centers started but an increasing amount of funding had to come from local sources with each successive year. Federal legislation also required each community mental health center to provide five essential services: (a) inpatient care; (b) outpatient care including individual, group, or family therapy; (c) partial hospitalization or day-care; (d) emergency care available 24 hours per day; and (e) consultation and education services to community agencies. Community mental health centers (CMHCs) were to serve all ages and treat those suffering from a wide range of mental health problems (Reamer, 1989; Smith et al., 1978, Vega & Murphy, 1990).

The Joint Commission convened in 1955 deemed a federal

CMHC program to be necessary because studies had shown that a large number of Americans in need of mental health care were not obtaining it from the private sector (Reamer, 1989). The poor and minorities, including African Americans, were largely shut out from all but custodial care in state mental hospitals notorious at that time for their poor conditions (Levine, 1981; Smith et al., 1978). Thus, another goal of the CMHC program was the elimination of barriers to receiving care such as patient diagnosis, prognosis, age, sex, race, and ability to pay (Levine, 1981).

President Carter continued the CMHC program under his administration through the Mental Health Systems Act of 1980. He renewed the federal government's commitment to providing high quality mental health care at a reasonable cost to all in need. In its 1978 report to President Carter, a second Joint Commission on Mental Health estimated that nearly 15% of the U.S. population was in need of mental health services. This Commission also renewed the call for CMHCs to meet the needs of those segments of the population that were traditionally underserved by the private mental health sector: children, adolescents, the elderly, and racial and ethnic minorities (Levine, 1981; Vega & Murphy, 1990). With the advent of private insurance for mental health care, CMHCs also came to be seen as the mental health agency of choice for the uninsured.

The last major policy change concerning community mental health care to occur at the federal level took place

in 1980 when President Reagan replaced the Mental Health Systems Act with the Omnibus Budget Reconciliation Act of 1980. This act introduced the Alcohol and Drug Abuse and Mental Health Block Grant programs (Vega & Murphy, 1990). All federal CMHC funds were consolidated into block grants and the total funds available were also reduced. The block grants were then transferred to the states for administration (Surles, R.C., 1990).

As a result of the block grants, CMHC services were no longer organized at the federal level. Each state became responsible for setting its own goals for delivering mental health services to its citizens. Most states designated CMHCs as the agency of choice for caring for the chronically mentally ill. As a result, staff resources were often directed away from other target populations, such as minorities. Many CMHCs also reduced or eliminated their outreach and community education programs because they no longer had a mechanism for being reimbursed for the provision of such services (Vega & Murphy, 1990). The effect block grants had on the provision of CMHC services to minorities is an issue in need of further research.

THE PROBLEM OF AFRICAN AMERICAN UNDERUTILIZATION OF SERVICES

The general consensus of researchers on CMHC service utilization rates in the 1960's and 1970's was that minorities greatly underutilized such services (Acosta, Yamamoto, & Evans, 1982; Smith et al., 1978; Snowden, Collinge, & Runkle, 1982; Vega & Murphy, 1990; Wallen,

1992). This was especially true for African Americans; however, there was no evidence to suggest that low African American utilization rates were due to a naturally low incidence of mental illness within this population (Dohrenwend & Dohrenwend, 1969; Faris & Dunham, 1939; Hollingshead & Redlich, 1958).

Instead, failure of CMHCs to provide services that were congruent with the cultural needs of minorities was often cited as a cause of minority underutilization of services. As James Mason, the developer of the Cultural Competence Self-Assessment Questionnaire noted, "When culture is ignored, barriers to effective service may emerge," (Mason, 1995, p. 3). Wallen (1992), based on her review of the literature on this topic, agreed that cultural barriers were logically suspect as reasons for minority underutilization of services. She noted that economic barriers such as income, level of health insurance coverage, and availability of care had not been found to account for the differences in utilization rates between White Americans and minorities.

Minority mental health specialists made many recommendations concerning how to make CMHC services more compatible with the cultural needs of minorities. They believed that minority consumers' utilization of CMHC services would improve if they found those services to be culturally compatible . One commonly cited proposal for improving African American utilization rates was a call for

an increase in the presence of African American staff at CMHCs. This recommendation was supported by research that found that minority clients preferred to see therapists who were similar to them in terms of cultural background and gender (Matsumoto, 1994). Significantly, one 1980 study found that minority staff presence correlated with an increase in minority client utilization (cited in Snowden, Collinge, & Runkle, 1982).

Other mental health professionals who examined the problem of minority underutilization of services focused their attention on the organization of the community mental health center itself and how it was structured to deliver services. A growing body of literature has developed over the years concerning how agencies can become more culturally competent at delivering services to minority clients. For example, Smith et al. (1978) cited the following seven "agency-client interaction" problems as reasons why minorities underutilized CMHC services in the 1960s and 1970s: (a) a shortage of trained minority mental health professionals, (b) mental health care providers' attitudes towards their minority clients; (c) lack of training of staff to work with minorities, (d) language barriers between clients and staff, (e) manner of referral of minority clients, (f) lack of CMHC involvement in communities served, and (g) failure to include minorities on decision making bodies. Like others before them, Smith et al. argued that a shortage of trained minority mental health professionals to

work in CMHCs was one contributing factor to minority underutilization. However, the authors also focused on six other agency-client interaction problems as needing redress if minority utilization of CMHC services was to be increased.

The second agency-client interaction problem identified by Smith et al. was mental health care providers' attitudes toward their minority clients. They wrote, "the myths and stereotypes these staff persons have learned and exhibit toward minority clients lead to distrust and often inhibit success in the therapy situation" (p. 117).

The third agency-client interaction problem discussed by Smith et al. was the lack of adequate training of CMHC staff for working with poor, urban minorities. The authors thought that the hardships of inner city life were a significant determinant of the behavior exhibited by the minority clients of urban CMHCs and that staff needed to have some understanding of these factors in order to work effectively with minority clients. The authors also cited language barriers between clients and CMHC staff as a fourth agency-client interaction problem needing redress.

The fifth problem that the authors cited was the manner in which minorities were referred to CMHCs for help. They observed that many poor minority clients were not self-referred. Instead, they were referred for treatment by other agencies such as schools, the court system, or welfare authorities. The authors argued that minority clients

referred in this manner may have perceived the CMHC and its staff as part of a coercive, oppressive establishment. Therefore, Smith et al. recommended that every CMHC become a vital part of the community being served.

The sixth agency-client interaction problem cited by Smith et al. was lack of agency involvement in the community being served. Smith et al. made recommendations about how CMHCs could become more integrated into their communities. They reasoned that in order for a CMHC to have an impact on the mental health problems of a community, its personnel had to have a thorough knowledge of the culture and environment of the CMHC's catchment area. They also recommended that CMHCs be physically present in the communities they served and that CMHC staff make full use of the health, economic, and social resources of the community in helping clients.

Finally, the authors stated that a seventh factor that inhibited positive client-agency interaction was failure to include minorities on the CMHC's decision making bodies. Smith et al. recommended that the people selected to serve on such bodies be representative of the clientele served by the CMHC.

Zane, Sue, Castro, and George (1982) also proposed a set of principles for removing organizational barriers to minority utilization of community mental health centers. They listed six necessary factors: (a) congruence between services offered and the needs and cultural patterns of the community mental health center's clients, (b) active

encouragement of utilization, (c) integration and linkage of mental health services with other health and social services, (d) systems of comprehensive and coordinated services, (e) community control of the CMHC through the presence of an active advisory board composed of community representatives, and (f) the development and active dissemination of knowledge among CMHC staff regarding effective practices and systems for working with minority clients.

Zane, Sue, Castro, and George, like Smith et al., argued that minority underutilization of CMHC services had been due in part to the fact that many of the services being offered by CMHC's focused on issues and problems with little relevance to the needs of minorities. Therefore, as a remedy, they proposed that CMHC services be congruent with the needs and culture of the community being served. The authors also recommended that CMHCs actively publicize their services in minority communities because the public generally knew little about the services offered by CMHCs and was rarely educated about these programs and services. Additionally, the authors recommended that CMHC staff improve treatment effectiveness by offering clients linked, comprehensive services. For example, under their model a CMHC therapist would be able to refer a client with medical problems to a public health clinic or refer a client with limited job skills to a vocational rehabilitation agency. The authors hypothesized that this approach would be more

likely to keep clients in treatment because it would address their physical and environmental needs as well as their mental health needs. Also, the authors recommended the implementation of community control of CMHCs. They argued that community control would result in less disparity between the values and goals of program administrators and the citizens of the community. Consequently, CMHC staff would be more likely to offer relevant services. Finally, the authors recommended the dissemination of knowledge to CMHC staff about effective practices for working with minorities. The authors noted that research information about effective community mental health delivery models had yet to be adequately disseminated and implemented among CMHC workers.

Several other authors in the field have also emphasized that training practitioners to work with minorities is essential to improving minority CMHC utilization rates. Vega and Murphy (1990) hypothesized that a limited knowledge base among mental health professionals about the communities and cultural characteristics of minorities contributed to the inability of cultural minorities to receive adequate mental health care. Vega and Murphy noted that both minority and nonminority practitioners received inadequate training in minority mental health issues.

Padilla, Ruiz, and Alvarez (cited in Zane, Sue, Castro, & George, 1982) have also examined the effect of barriers in the service delivery system on minority utilization of CMHC

services. The authors developed a model for making organizational changes in order to improve minority utilization that they called "professional adaption [*sic*]" or adaptation. In their model, professionals adapt their clinical skills, service orientation, and language skills to the specific requirements needed to serve their minority clients. The model consists of five recommended organizational changes: (a) placement of the center within the minority community, (b) hiring bilingual or bicultural personnel, the majority of whom are paraprofessionals originating from the minority community, (c) placing an emphasis on prevention, (d) short-term, crisis-oriented, problem-focused treatment, and (e) community input into program policy.

Snowden, Collinge, and Runkle (1982) have also identified elements in the service delivery system that they hypothesized must be present to promote minority utilization of CMHC services. They recommended that (a) administrators use a sliding scale to set fees, (b) staff match clients demographically and ethnically, (c) clinics be located within easy reach of the community being served, (d) services be advertised to inform potential clients and favorably dispose them towards service utilization, and (e) centers be organized to create units and procedures more compatible with client lifestyles and values.

Dana, Behn, and Gonwa (1992) also developed a model for structuring CMHC service delivery in order to better serve

minority clients. The authors conducted a comprehensive literature review on the subject of providing culturally competent care to minority clients of social service agencies such as CMHCs. They defined cultural competence as "...an ability to provide services that are perceived as legitimate for problems experienced by culturally diverse persons," (pg. 221). They compiled a 700-item annotated bibliography composed of all the papers they could locate concerning cultural perspectives of mental illness or well-being, descriptions of relevant services, identification of effective service-delivery models, and implications for culturally competent service delivery. They developed a checklist of agency characteristics they believed represented cultural competence based on this literature review. The checklist contains items relating to agency practices, availability of the agency's services, the relationship of the agency to the ethnic communities served, training of agency staff, and cultural competence evaluation activities. Most of the items on the checklist correspond to the service delivery and organizational characteristics recommended for improving African American CMHC utilization rates by the researchers previously discussed in this chapter. For example, the checklist includes items regarding resource linkage; bicultural/ bilingual staff; operation of the agency by the minority community; clients as evaluators of services offered; traditional customs and familial roles incorporated into interventions; use of minority

paraprofessionals; in-service training of staff; flexible hours/appointments/home visits; agency environment reflective of clients' culture; and location of the agency in the minority community.

In summary, a review of the literature suggests that there are six basic organizational principles which CMHCs should incorporate in order to improve African American and other minorities' CMHC utilization rates:

1. Minorities should be on the clinical staff.

2. The centers' services should be easily accessible.

3. There should be integration and linkage of mental health services with other health and social services.

4. Treatment provided should be compatible with the needs and culture of the minority communities being served.

5. Clinical staff should be familiar with cultural variables that might influence diagnosis and treatment of minority clients.

6. Minority clients should be directly involved in determining what services will be offered and in evaluating the quality and effectiveness of those services.

Matsumoto (1994) reviewed research that supports principles four and five as important means of improving African American utilization rates. He found that research indicated that non-White American mental health clients tended to prefer action-oriented therapy rather than non-directive approaches characteristic of psychoanalytic and humanistic therapies. He also reviewed research that showed

that counselors who were judged to be culturally sensitive in regards to their clients were rated as more credible and competent to conduct treatment across racial lines by African American clients.

CURRENT AFRICAN AMERICAN UTILIZATION PATTERNS

Starting in the late 1970s, many CMHCs with minority under-utilization problems began to restructure their organizations to make them more responsive to the needs of their minority clients. In most cases, this meant that the CMHC implemented some or all of the six principles for improving minority utilization summarized in Table 1. Recent utilization studies suggest that these strategies may have been effective. Current trends reveal that African Americans use CMHC services more than is expected in terms of their representation in the population (Broman, 1987; Cheung & Snowden, 1990; Flaskerud & Hu, 1992; Goodman & Siegel, 1978; O'Sullivan, Peterson, Cox, & Kirkeby, 1989; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). For example, Flaskerud and Hu (1992) examined patterns of minority utilization of public mental health services in Los Angeles county between 1983 and 1988. They found that while African Americans made up only 12.8% of the county population they accounted for 20.5% of the client episodes in the mental health system during that time period. White Americans, who composed 44.2% of the population accounted for 43% of the client episodes.

Bacote (1991) is one of several authors who have found

Table 1

Six Principles for Providing Culturally Compatible Community Mental Health Center Services

Principles
1. African Americans on staff
2. Easily accessible services
3. Linkage with health and social services
4. Provision of culturally compatible treatment
5. Staff training
6. African American consumers and community members evaluate and help determine services offered

that instituting a culturally compatible approach to providing community mental health services appears to result in an increase in the rate of African American utilization of CMHC services. Bacote described an Ohio CMHC's outpatient dual diagnosis program established to specifically serve low-income African Americans using a culturally specific model of care. The culturally specific program was established after the CMHC's traditional dual diagnosis program was unable to attract minority clients. Some of the components of the culturally specific program included the use of African American therapists using a form of psychotherapy, NTU therapy, based on an Afrocentric world view; the provision of comprehensive health services to the program's clients; and aggressive outreach efforts. This program was able to attract African American clients while the traditional program could not.

Flaskerud (1986) is one of the few researchers who has examined whether or not any of the different steps proposed for increasing minority utilization of services can be empirically linked to existing minority utilization rates at CMHCs. Flaskerud developed a cultural compatibility scale in order to test the hypothesis that congruence between a CMHC's services and the needs and cultural patterns of its catchment area population leads to greater minority utilization of services. The scale consisted of nine items:

1. Therapists who share the culture (ethnic/racial background) of the clients.

2. Therapists who share the language or language style of the clients.

3. Location of the agency in the client community.

4. Flexible hours and appointments.

5. Provision of or referral to services for social, economic, legal, and medical problems.

6. Use of family members in the therapy process.

7. Use of a brief therapy approach.

8. Use of or referral to clergy and/or traditional healers in the treatment process.

9. Involvement of consumers in determining, evaluating, and publicizing services.

Flaskerud examined the relationship of the presence or absence of these variables to the utilization of services by African American, Mexican American, Filipino American, Vietnamese American, and White American clients at four public CMHCs in a southern California city. She defined utilization in terms of drop-out rates and total number of outpatient visits.

The results of Flaskerud's study did not offer definitive support for the effectiveness of her model for increasing minority utilization of services. None of the nine components of her scale proved to be significantly correlated to drop-out status and neither did the total score for her scale. However, a discriminant analysis of the data conducted to predict drop-out status based on cultural compatibility variables revealed that language match of

therapist and client, ethnic/racial match of therapist and client, and agency location in the ethnic/racial community made the greatest contribution in determining the discriminant score.

Due to the results of the discriminant analysis and a review of the methodological deficiencies of her study, Flaskerud concluded that the effects of a culture-compatible approach on minority utilization needed further investigation. She noted that the CMHCs that she compared scored very similarly on her scale and that a study of centers with more diverse scale scores might produce different results. Furthermore, while the research utilized a pool of 300 subjects, all of these subjects came from four mental health centers, three of which were located in communities where one ethnic group predominated. Additionally, Flaskerud's definition of utilization may have affected the results. The scale she developed or some components of the scale, may be better predictors of how likely minorities will be to initially seek services at a CMHC instead of how likely they are to drop-out of treatment. For example, a 1991 (Hu, Snowden, Jerrell, & Nguyen) study of minority utilization of public mental health services in San Francisco and Santa Clara, California found that there were no differences between different ethnic and racial groups in their levels of use of different services once they were engaged in services. Instead, there were differences in the types of services used by the

different minority groups.

A 1991 study conducted by Sue, Fujino, Hu, Takeuchi, and Zane supports Flaskerud's caution in not dismissing the value of providing culturally compatible services in order to improve minority utilization. The authors specifically examined the effect of matching client and therapist for ethnicity and/or language on services received, length of treatment, and treatment outcomes as measured by the Global Assessment Scale for Asian, African, Mexican, and White Americans using outpatient services in the Los Angeles county mental health system. They found that ethnic match was related to length of treatment for all groups but was only associated with treatment outcomes for Mexican Americans. Ethnic and language match proved to be a significant predictor of length of time in treatment and treatment outcome for clients who did not speak English as their primary language. However, ethnic matching did not lower the odds of African Americans dropping out of therapy. The authors considered their study to offer partial support for the cultural compatibility or responsiveness hypothesis.

O'Sullivan and Lasso (1992) also found some support for the cultural compatibility hypothesis in their examination of Hispanic utilization of CMHC services. They found that Hispanic clients remained in treatment longer if they were served by Hispanic staff and/or a Hispanic CMHC. They defined a Hispanic CMHC as one with all Hispanic staff located in a predominantly Hispanic community. The authors

also found that Hispanic clients who received culturally compatible services had lower drop-out rates and received more individual therapy than those who received services from non-Hispanic personnel and/or agencies.

PROBLEMS ASSOCIATED WITH CURRENT PATTERNS OF AFRICAN AMERICAN UTILIZATION OF CMHC SERVICES

Even though the numbers of African Americans using services has increased significantly in many cases, greater utilization has not always equaled improvement in the way African Americans are treated within the public mental health care system. As the study by Sue, Fujino, Hu, Takeuchi, and Zane (1991) suggested, it may be premature to conclude that the increase in African American utilization rates at CMHCs signals an end to the problems community mental health centers have had in appropriately treating minorities. In general, studies have found that when minorities use outpatient care, they tend to use less of it and are more likely than White Americans to terminate prematurely. In contrast, minorities are more likely than White Americans to use inpatient and emergency mental health services. They are also more likely to be rehospitalized after inpatient treatment and to be admitted involuntarily to mental institutions (Wallen, 1992).

Additionally, as Cheung and Snowden revealed in their 1990 review of national trends in minority utilization of mental health services, improvement in the cultural compatibility of services offered is not the only possible

explanation for the increase in minority utilization rates. At least part of the increase in utilization rates for African Americans can be accounted for by the fact that hospitalization rates are higher for this group than for White Americans and all other minority groups except for Native Americans. Between 1960 and 1970 there was a large overall drop in psychiatric hospital use. However, although the decline in hospital use by White Americans slowed down between 1970 and 1980, it increased for minorities by about 37%. Cheung and Snowden hypothesized that relatively high admission rates for African Americans and Native Americans was primarily responsible for this trend.

In their investigation of an urban and suburban CMHC, Goodman and Siegel (1978) found a similar pattern. Their study revealed that White Americans and African Americans differed significantly in the manner in which the two groups entered the mental health system. At the urban center, more African Americans than White Americans used inpatient services, especially drug abuse services but the two groups did not differ in manner of entry into the suburban center. Goodman & Siegel concluded that the higher utilization of services by African Americans reflected the "true prevalence of symptomatology" (p. 61) of mental illness in this population. The authors' data also indicated that there were other differences between the African American and White American clients of the CMHCs they studied. African Americans seeking help at the two CMHCs were more likely to

be (a) diagnosed as psychotic or retarded, (b) referred by the courts, and (c) admitted as an emergency case.

There are several ways in which these data could be interpreted. There may be bias in the way African Americans are diagnosed that results in their being overdiagnosed as psychotic or retarded. Another possibility is that African Americans have greater numbers of and more severe problems than White Americans utilizing CMHCs. Alternatively, the data may be an indication that African Americans are more inclined than White Americans to wait until their mental health problems are severe before seeking help. The data also suggest that African Americans may be more likely than White Americans to wait until circumstances force the courts to intervene and order them into treatment. A 1991 study conducted by Hu, Snowden, Jerrell, and Nguyen of public mental health service utilization in San Francisco city and County and Santa Clara County in California offered some support for these hypotheses. They found that African Americans were less likely than White Americans to use case management and individual outpatient services but more likely to use emergency services.

Cheung and Snowden (1990) disagree with the opinion that the increase in utilization of public mental health services by African Americans is solely a reflection of the level of symptomatology in this population. They note that despite increases in the hospitalization rates of minorities, there is little evidence of a greater prevalence

of severe mental illness among minority groups. The Epidemiologic Catchment Area (ECA) study funded by the National Institute of Mental Health offers support for this view. The ECA study examined the prevalence of psychiatric disorders among the general population at five sites located across the country: New Haven, Connecticut; Baltimore, Maryland; St. Louis, Missouri; Los Angeles, California; and Durham, North Carolina. The authors of the study concluded that "previously reported racial differences in diagnosis and treatment, which portrayed a picture of consistently greater illness among blacks, do not reflect true variations in morbidity between these racial groups [blacks and whites]" (Bromet & Schulberg, 1989, p. 76).

Some authors explain the relatively high incidence of severe diagnoses among African Americans in the public mental health system by noting the strong correlation between minority status and poverty. Several studies have found that the presence of mental disorders is highest in the most socioeconomically disadvantaged segments of society (Dohrenwend & Dohrenwend, 1969; Dohrenwend, Dohrenwend, Gould, Link, Neugebauer, & Wunsch-Hitsig, 1980; Faris & Dunham, 1939; Hollingshead & Redlich, 1958; Lorion & Felner, 1986). Faris and Dunham (1939) examined the relationship between social class, race, and mental illness in Chicago in the 1930s. They found that the lowest socioeconomic areas of the city had the highest admission rates to Chicago's psychiatric hospital. However, while they found a large

percentage of African Americans and recent immigrant groups living in those areas, the authors did not detect a racial tendency towards developing mental disorders. They concluded that "the nature of the social life and conditions in certain areas of the city is in some way a cause of high rates of mental disorder" (p. 170). Hollingshead and Redlich (1958) also found that while the lowest socioeconomic groups in an urban area near New Haven, Connecticut had the highest rates of mental illness there did not appear to be any racial differences in the rate of mental disorders. Also, like Smith et al. (1978), Hollingshead and Redlich found that authoritative and compulsory methods such as police intervention were often used to induce low socioeconomic status persons to seek mental health treatment. Dohrenwend and Dohrenwend (1969) also found consistently higher rates of mental disorder at the lower socioeconomic levels of society but, like the previous authors, they did not find a difference in the rate of mental disorder between African Americans and White Americans.

The same patterns have been found in more recent research. Lorion & Felner (1986) discovered that while low socioeconomic groups include disproportionate numbers of women, minorities, and the elderly, "observed differences in the prevalence of [mental] disorders cannot be explained as a function of sex, race, or age" (p. 742).

Cheung and Snowden (1990) agree that although socioeconomic status (SES), as a correlate of minority

status, appears to be related to severe mental illness, they question whether SES is strongly enough correlated with severe mental illness to account for the differences between hospitalization rates of White Americans and minorities. A study by Flaskerud and Hu (1992) lends some support to Cheung and Snowden's position. In their study examining utilization patterns of minorities in the Los Angeles county public mental health system between the years 1983 and 1988, Flaskerud and Hu (1992) did not find a link between socioeconomic status and psychiatric diagnosis. The authors found that while ethnicity had a significant and consistent relationship to diagnosis in both inpatient and outpatient samples, age and socioeconomic status showed no relationship to diagnosis. For example, the authors found that diagnoses of schizophrenia were present in approximately equal percentages among clients of both low and high socioeconomic status. Therefore, they concluded that simply being African American increased one's chance of receiving a diagnosis of psychosis, especially schizophrenia, possibly due to the presence of ethnic stereotyping and bias in the assignment of psychiatric diagnoses.

In his review of three studies which investigated the relationship between race and diagnosis, Matsumoto (1994) also found that racial bias appeared to be a reason why African Americans were more likely than White Americans to receive a diagnosis of schizophrenia. Matsumoto noted as well that there appeared to be cultural differences between

African Americans and White Americans in the expression of symptomatology for these two mental illnesses which were not usually considered by clinicians when they made diagnoses. This is an important issue since psychiatric diagnosis influences the clinical treatment and prognosis of patients.

Windle (1980) proposed another hypothesis to explain why minorities use CMHC services in numbers greater than their proportion of the population. The author observed that minority group members are more likely than White Americans to experience poverty and thereby be limited in the type of mental health services that they could obtain on their own. If one assumes that federally funded CMHCs give services proportional to unmet needs, such centers would be expected to serve minorities at higher rates than White Americans. Windle discovered that, in general, this was indeed true for the 142 federally funded CMHCs on which data was collected. Using data collected for the year 1974, Windle discovered that non-whites had higher CMHC utilization rates than whites. This trend was less marked in the south and far west, in nonmetropolitan areas, and in less affluent catchment areas. Therefore, while most centers served a higher proportion of minorities than whites, many centers had utilization rates that were the reverse of this trend.

Looking now at the question of whether or not African Americans experience utilization problems after entering the mental health system, the data is mixed. Some studies conclude that African Americans drop-out of therapy at

higher rates than White Americans (Cheung & Snowden, 1990; Flaskerud, 1986; Goodman & Siegel, 1978; O'Sullivan, Peterson, Cox, & Kirkeby, 1989; Sue, Fujino, Hu, Takeuchi, & Zane), while others suggest that in general, drop-out rates for minorities have declined (Cheung & Snowden, 1990).

Sue, Fujino, Hu, Takeuchi, and Zane (1991) examined minority utilization patterns at community mental health centers in Los Angeles county. They found that while the percentage of African Americans represented on the patient rolls was greater than their percentage in the county population, they had the least positive results of any of the ethnic groups using CMHC services. African American consumers tended to exhibit relatively little positive change after treatment, terminated treatment more quickly than other ethnic groups, and averaged fewer sessions than other groups.

Cheung & Snowden (1990) caution that many of the existing studies about minority utilization of services did not control for differences in socio-demographic standing and diagnosis. Therefore, it is possible that a closer analysis of the data might reveal that low-income White Americans have CMHC utilization rates similar to low-income African Americans. Additionally, studies have tended not to draw distinctions between types of mental health programs. Utilization rates for African Americans may differ as a function of type of setting and type of service. For example, African Americans may predominate in the substance

abuse programs or emergency services division of a mental health system while being underrepresented in that systems outpatient therapy programs.

Another important issue not adequately considered by many past and current researchers is that comparing races may not be sufficient for developing a clear picture of the adequacy of mental health services for minorities. Underscoring this point are two comprehensive and methodologically-sound national studies conducted at the University of Michigan. These two studies focused on professional help-seeking. The National Survey of Black Americans (NSBA) conducted between 1979 and 1980 looked at a nationally representative cross-section of the adult African American population (Neighbors, 1985). Similarly, the Americans View Their Mental Health (AVTMH) study conducted in 1976 was an area probability sample of the general population of adults living in private homes (Broman, 1987). Both surveys were similarly designed and conducted.

Broman (1987) found that while African Americans were more likely to seek help from mental health sources than White Americans, African Americans more often sought help for economic and physical problems than White Americans. Broman noted that it would be a mistake to assume that only people with mental health problems seek help from mental health sources. Both Broman and Bacote's studies suggest the possibility that a larger number of African Americans than White Americans may utilize mental health services for

problems most directly related to low-economic status. Significantly, Broman found that if he restricted his data analysis to people with mental-health-related problems only, his results then became consistent with previous research findings of under-utilization of mental health services by African Americans. He found that African Americans with emotional and interpersonal problems did not seek help from mental health sources in the numbers that they should based on need.

Neighbors (1985) detailed analysis of the NSBA supports Broman's finding of under-utilization of mental health services by African Americans with mental health problems. In his study, Neighbors focused on African Americans suffering from a mental health problem. He found that only 9% of African American adults with serious personal problems who sought professional help contacted a CMHC, psychiatrist, or psychologist. Instead, most sought help from medical doctors, hospital emergency rooms, and ministers. Utilization of mental health resources was low even for those respondents who believed their problems had almost brought them to the point of a nervous breakdown or who thought of their problems in emotional terms. Of those who indicated that they were at the point of a nervous breakdown, 55% sought professional help. However, 76% of those seeking professional help did not contact a mental health professional or agency. Of those survey respondents who said that they had an emotional problem, only 35% of

those who sought professional help contacted a psychiatrist, psychologist, or CMHC.

Therefore, while African Americans appear to utilize mental health services at rates generally higher than their representation in the population, studies also suggest that those with problems most appropriate to the mental health sector of the health care industry do not use mental health services in the numbers that they should, based on need (Broman, 1987; Neighbors, 1985). In general, according to Neighbors' survey, only 20% of the African Americans estimated to have a mental disorder during any one year utilized mental health services. However, these numbers are generally characteristic for White Americans as well. The 1978 report by the President's Commission on Mental Health concluded that while 15% of the population was in need of mental health services at any given time, only 3% of the national population sought care in the specialized mental health sector (Stefl & Prosperi, 1985). Dohrenwend et al. (1980) estimated similar statistics. In their review of studies published since 1950, they obtained an estimate that 16-25% of the United States population suffered from a clinically significant mental disorder but only 12-18% of that number received treatment from a mental health professional.

In conclusion, while there appears to have been an increase in the number of African Americans utilizing mental health services since the 1970's, there are still several

questions that remain to be answered before we can conclude that CMHCs adequately meet the needs of this population. As summarized in Table 2, five issues warrant further investigation.

1. African American versus White American use of inpatient services. Some studies have suggested that the African American inpatient hospitalization rate is too high.

2. Severity of diagnoses given to African Americans versus White Americans. Some studies have suggested that African Americans receive more severe and more stigmatizing diagnoses than do White Americans despite the fact that there is no evidence of a greater prevalence of severe mental illness within the African American population.

3. Type of therapy African Americans receive in comparison to White Americans. If African Americans are overdiagnosed as having severe mental illnesses, then they may be more likely to receive pharmacotherapy or case management rather than outpatient psychotherapy.

4. African American versus White American drop-out rates. The data are not clear as to whether or not African Americans are more likely to drop-out of treatment early.

5. African American versus White American route of referral to the CMHC. Some studies have suggested that African Americans are more likely than White Americans to be court-referred rather than self-referred for services (Goodman & Siegel, 1978).

Unfortunately, questions two, four, and five could not

Table 2

Utilization Patterns of the African American Community Mental Health Center Patient Population

Area of utilization/ treatment characteristics	Pattern of utilization
Inpatient services	+
Psychotherapy	-
Pharmacotherapy	+
Case management	+
% with a severe diagnosis	+
% that are treatment drop-outs	?
% self-referred	-
% court-referred	+

Note. + = overrepresented; - = underrepresented; ? = representation unknown.

be investigated by the author of the current research because of the significantly limited types of archival data that were available for analysis. The state department of mental health in Virginia did not require its CMHCs to submit detailed racial breakdowns of their caseload characteristics in their quarterly reports to the state. Consequently, many did not track such data and had to conduct special data analyses in order to provide the author with a simple breakdown of the racial distribution of mental health consumers across service categories. Additionally, the state department of mental health did not require its CMHCs to collect data on drop-out rates, manner in which consumers were referred for services, treatment outcomes, or consumer satisfaction with services. Therefore, the author could only focus on questions one and three when investigating African American service utilization characteristics for the current study. Since much of the data that the author would like to have collected was not readily available, the research that was conducted was necessarily exploratory in nature and limited in scope.

CHAPTER II

THEORETICAL FORMULATIONS

HYPOTHESES

The present study was designed to answer two questions. First, it examined whether CMHCs with services judged to be more compatible to African American culture attracted a higher percentage of African Americans from their catchment areas than did centers with services judged to be less compatible. Second, it investigated whether or not there were any significant differences between African Americans and White Americans with regards to the types of services they used. The author hypothesized that CSBs with high cultural competence would tend not to assign African Americans to inpatient and/or case management services more often than to outpatient services and that African Americans would not use emergency services more often than White Americans at the more culturally competent CSBs.

METHOD

The first part of the study focused on assessing the relationship between a CMHC's cultural competence at providing services to African American clients and its effectiveness at attracting African American clients from its catchment area. In Virginia, Community Services Boards (CSBs) operate public community mental health centers. The outpatient clinics of Virginia's 39 CSBs served as the target population for this part of the study. The clinical director or supervisor at each CSB's adult outpatient clinic

was sent an introductory letter (Appendix A) requesting his or her participation in the study. Next, clinical directors/supervisors were interviewed via telephone using the Structured Telephone Interview for the Cultural Competence Questionnaire (Appendix B). Each director was provided with a copy of the questionnaire to follow during the telephone interview. Demographic information about the clinical directors completing the telephone interviews was also collected (Appendix B) via prepared questions after the administration of the Cultural Competence Questionnaire (CCQ). Appendix C (Modlinsky, 1989; U.S. Bureau of the Census, 1994) contains information about date established, jurisdiction served, catchment area size, and catchment area population characteristics for each of the 39 CSBs studied in this paper.

The second part of the study focused on examining whether or not there were any significant differences between the types of mental health services used by African American and White American consumers. Statistics on the types of services used by African American and White American consumers were collected from each individual CSB. All CSBs are required to report standard types of information on their services and patient populations to the state's Department of Mental Health. All CSBs report their information on a quarterly basis using the same format. Therefore, data received from all CSBs can be reliably compiled, analyzed, and compared. The mental health director

of each CSB was sent a letter (Appendix D) requesting that his or her CSB provide the author with unduplicated client data from their fourth quarter reports for fiscal year 1997 for the following four outpatient mental health service categories: (a) emergency services, (b) local inpatient, (c) outpatient, and (d) case management. Each CSB was asked to provide the author with information about how many African American and White American adults used these different services during fiscal year 1997.

INSTRUMENTS

The degree of cultural compatibility of each CSB's services to African American culture was determined using a shortened and modified version of the Cultural Competence Self-Assessment Questionnaire: Administrative Version (CCSAQ) developed by James Mason at the Portland State University Research and Training Center on Family Support and Children's Mental Health (Mason, 1995). Each center's degree of cultural competence was assessed according to its score on the Cultural Competence Questionnaire, a modified version of the CCSAQ. The higher a center's score, the more compatible its services were judged to be with the culture of its African American clients.

The CCSAQ was developed as a tool to help mental health agencies assess their cross-cultural strengths and weaknesses. The data provided by the CCSAQ were designed to provide agency personnel with information needed to develop specific training activities and interventions that would

promote greater competence across cultures between agency personnel and the clients they served. The CCSAQ was designed to be administered to individual personnel at human service agencies and it has also been used to evaluate a worker's preparation for working cross-culturally. Two versions of the CCSAQ were developed. One version was for use with direct service providers and the other was for use with administrative staff. The instrument is a self-report questionnaire which yields one general overall score based on the following six subscales: (a) knowledge of community, (b) personal involvement, (c) resources and linkages, (d) staffing, (e) organizational policies and procedures, and (f) outreach to communities. The 60 items that compose the subscales are presented in a Likert scaling format.

Extensive research was conducted to develop the CCSAQ. The research process began with a comprehensive review of the literature relevant to the delivery of health and human services to minorities. Focus groups were convened to discuss the development of the subscale items on the basis of the literature review. The focus groups were composed of people from the professional service disciplines in mental health as well as special education, maternal and child health, alcohol and drug treatment, and relevant academic disciplines. The CCSAQ author, James Mason, used the recommendations of the focus groups to construct the items of the questionnaire.

The initial version of the CCSAQ was tested in eight

pilot sites throughout the country to identify the basic psychometric properties of the scale. The pilot sites were the Management Team of the Washington State Division of mental Health, the Children and Youth Services Administration in the District of Columbia, the South Carolina Division of Mental Health, the New York State Office of Mental Health, the Monroe County (New York) Department of Mental Health, the Multinomah County (Oregon) Juvenile Justice Division, the Boys and Girls Aid Society of Oregon, and the California Department of Health-Maternal and Child Health Branch. The pilot testing revealed that the various subscales of the CCSAQ had internal consistency reliability alpha coefficients of .80 or higher, except for the personal involvement subscale which had an average coefficient of .60. Coefficients of .70 are considered to be respectable for new measures (Mason, 1995). The pilot testing was also used to develop normative scores for the various subscales and individual items of the CCSAQ. However, the pilot testing did not involve empirical research on the validity of the CCSAQ as a measure of the cultural competence of human service agencies. No such research had been done at the time the current study was conducted.

Despite the limited amount of research done on the instrument, the CCSAQ was the best measure of a human service organization's cultural competence that this author could identify. The items which comprised the questionnaire

operationalized the six principles most often identified by research as being important for delivering culturally compatible mental health services to the African American community: (a) having African Americans on staff, (b) providing easily accessible services, (c) linking of mental health services with other health and social services, (d) providing culturally compatible treatment, (e) having staff trained for and knowledgeable about working with African Americans, and (f) involving the African American community and consumers in determining and evaluating CMHC services.

However, the CCSAQ had to be modified extensively to suit the design and purpose of the present study. The Cultural Competence Questionnaire (CCQ), the modified version of the CCSAQ used in the current study, was developed by regrouping the CCSAQ's questionnaire items so that they were organized into six subscales corresponding to the aforementioned six principles of providing culturally compatible treatment. The six subscales of the CCQ are: (a) linkage, (b) staffing, (c) training of staff, (d) accessibility, (e) culturally relevant treatment, and (f) community and consumer outreach. Because the CCSAQ questionnaire was too long for telephone administration, not all of its questions were used in the CCQ. The CCQ used only those questions selected by the author of the present study as having the greatest content and face validity in representing the above six principles.

Several additional changes were made to the CCSAQ in

order to adapt it to the unique purposes of this study. First, it was administered via a telephone interview rather than as a written self-report questionnaire in order to increase the participation rate of the targeted subject sample - Virginia's 39 CSB outpatient mental health clinic directors. Therefore, the current author dropped "self-assessment" from the title and renamed the scale the "Cultural Competence Questionnaire." Furthermore, although the questionnaire was originally designed to be used to assess the cultural competence training needs of human service agency personnel, it was not used for that purpose in this study. Instead, the CCQ was used to obtain a numerical measure of the cultural competence of a CSB's adult outpatient mental health unit based on the responses of that unit's clinical director.

Three other general changes were made in adapting the CCSAQ for the present study. Questions were reworded so that they only pertained to African Americans whereas the original scale assessed cultural competence across several racial and ethnic groups. Questions were also reworded to make it clear to the survey respondents that their answers were only to apply to the particular mental health clinic in which they worked and not to the entire CSB. Most CSBs in Virginia have several different programs at different sites with different personnel. Therefore, CCSAQ question 42 which originally read, " Are there people of color on the staff of your agency?" was changed to read, "Are there African

Americans on the staff of your clinic?" Finally, the directions were changed to clarify the nature of the telephone interview and the purpose of the questionnaire.

The author acknowledges that whether or not the CCQ yields measures of cultural competence significantly different from the CCSAQ is a question not addressed by the current research. The author maintains that the CCQ can still serve as an adequate means of measuring a CMHC's cultural competence due to the clarity with which this instrument operationalized the concept. The CCQ can be found in its entirety in Appendix B.

CHAPTER III

ANALYSIS OF THE DATA AND RESULTS

Thirty-one of thirty-nine targeted CSBs participated in the telephone survey resulting in a response rate of 82%. However, because four CSBs had more than one clinic providing adult outpatient mental health care, 36 Cultural Competence Questionnaires were completed.

Of the eight CSBs that did not participate in the study, two refused participation because the study was not endorsed by the Virginia Community Services Board Administration Survey Review Team. One of those CSBs served an urban population in Northern Virginia with a catchment area that was 8% African American. The second CSB served a small rural population with a catchment area that was 27% African American.

As previously mentioned, these two CSBs gave the lack of endorsement of the current study by the Survey Review Team as their reason for not participating. The Survey Review Team is a committee that reviews questionnaires and other survey instruments before they are submitted to CSBs in order to help balance CSBs' capabilities with researchers' needs.

The author sought to obtain the endorsement of the Survey Review Team for the current research. A research proposal was submitted to the Survey Review Team twice. The research design was changed upon the second submission in order to address concerns raised by the Survey Review Team

regarding the original study design. However, after the second submission, the Survey Review Team raised a new set of concerns. The study was once again redesigned to address all but two of the concerns raised.

Due to the limited resources of the author of the current study, two concerns raised by the Survey Review Team could not be addressed. First, the Survey Review Team requested that the research design account for other factors that might affect service utilization such as patient diagnosis and prognosis or the extent to which mental health services similar to those offered by the CSBs were available in each catchment area. Second, the Survey Review Team wanted data demonstrating that the CCQ was a valid measure of cultural competence. The author of the current study did not have the resources needed to make a comprehensive analysis of CSBs' catchment areas in order to obtain measurements of other factors that might have affected African American utilization rates. The state department of mental health did not collect such data. Also, no prior validity research had been done on the CCQ or the measure from which it was adapted. Therefore, the current study was necessarily exploratory in nature.

It is typical in community psychology to proceed with field research despite the difficulty of designing studies that meet the strict methodological standards found in more traditional academic research. Issues concerning how mental health care is delivered in the community which are

investigated in community psychology often require a quasi-experimental approach infrequently used in other areas of psychology. Consequently, community psychology studies are more often exploratory in nature and may not yield findings that meet the strict criteria of .05 significance. In this type of field research, there are often variables that cannot be controlled for and data analyses must often be qualitative rather than strictly quantitative in nature. Therefore, researchers in the field attempt to control for those variables that can have a confounding effect on their data analyses while acknowledging their inability to control for all confounding variables. In the tradition of research in community psychology, the author of the current study acknowledged its methodological limitations and advocated that the research proceed in order to find out what the study could reveal about the effect of cultural competence on African American CSB utilization rates in Virginia. In response, the chair of the Survey Review Team observed that the type of data the author was seeking was available to the public and stated that the Survey Review Team did not have to give final approval for the research to go forward. Therefore, the author proceeded with data collection.

The reasons why the six other CSBs did not participate in the study could not be determined because their clinical directors never responded to written or telephone requests for participation. Five of these CSBs served small to mid-size rural communities with African Americans accounting for

6% to 20% of their catchment area populations. The remaining CSB served one of the largest urban cities in Virginia and had a catchment area population that was 15% African American.

The author cannot definitively state whether or not the addition of eight more Cultural Competence Questionnaires would have had an effect on the results found in the present study. Even if the non-participating CSBs did not respond because they thought they would perform poorly on the CCQ and cast their agencies in a negative light, eight more CCQ results would appear to be too small a number to have much of an impact on a correlational study. Furthermore, because the non-participants did not predominate from one particular region of the state, the current research did have participation from a representative cross-section of the state's CSBs.

The 31 participating CSBs varied in terms of the type of population each served. An equal number (n = 8) served primarily urban or suburban populations. The remaining 20 served primarily rural populations.

Information on the backgrounds of the 36 clinical directors who completed the CCQ via the telephone survey was also gathered. An equal number of men and women participated (n = 18). Most were White Americans (n = 33) while two were African American and one was Asian American. The respondents mean age was 48 years (range 36 - 56). Their professions varied. Most were social workers (n = 17), eight were

psychologists, three were nurses, and the remaining eight were licensed professional counselors. The mean number of years most respondents had worked for their CMHCs was 13 (range 1 - 28). The majority of the responding clinical directors (n = 26) said they were very much involved or sometimes involved (n = 9) in policy formation at their CMHCs.

A Pearson correlation was conducted to determine whether or not there was a correlation between CSB's total CCQ scores and the percentage of African Americans the CSBs attracted from their catchment areas. Data on the African American population from the 1990 census was used to determine what percentage of its catchment area's African American population each CSB attracted. The results of the analysis did not reveal a significant correlation, r = .08, p = .65.

For all CSBs combined, the mean percentage of African Americans attracted from their catchment area populations was 2% (range 0% - 6%). Across CSBs, the mean percentage of White Americans attracted from catchment areas was 1% (range 0% - 3%). These utilization rates are in line with research that found that only 3% of the national population used private or public mental health services (Stefl & Prosperi, 1985).

The mean percentage of the African American catchment area population that utilized CSB services did not vary greatly as a function of type of population served: M = 2%

for urban (range 0% - 6%) and rural (range 0% - %6) CSBs and *M* = 3% for suburban CSBs (range 0% - 5%).

The data were also examined to see if there were any differences in the mean percentage of the African American catchment area population that utilized CSB services as a function of whether or not the CSB offered primary substance abuse treatment. Most CSBs had separate substance abuse and mental health treatment programs and/or clinics but not all. The Survey Review Team thought CSBs that offered primary substance abuse treatment might have higher African American service utilization rates because substance abuse is a prevalent problem in poor African American communities. Therefore, this possible explanation for why some CSBs might have higher African American utilization rates than others needed to be controlled for in the data analyses.

The data were examined to determine the effect of presence of primary substance abuse treatment at the CSBs' adult outpatient mental health clinics on African American service utilization rates. No effect was found. CSBs that offered mental health and substance abuse treatment at the same site drew the same percentage of African Americans from their catchment area populations, *M* = 2% (range 0% - 7%) as did CSBs that did not offer primary substance abuse treatment at their adult outpatient mental health clinics, *M* = 2% (range 0% - 6%).

An analysis of variance was conducted to determine if total CCQ scores varied according to the type of population

served. For all centers, the mean total CCQ score was 70 (range 50 - 103) with the following breakdown: urban centers, M = 77 (range 61 - 103); suburban centers, M = 71 (range 61 - 80); rural centers, M = 67 (range 50 - 99). However, these mean scores were not statistically different from each other, $F(2, 35) = 2.15$, $p > .05$.

An analysis of variance was also conducted to determine if total CCQ scores varied according to whether or not a CSB offered both substance abuse and mental health treatment in the same clinic. No significant difference was found, $F(2, 35) = 1.22$, $p > .05$. The mean CCQ score for CSBs with combined mental health and substance abuse clinics was 70 (n = 19). The mean CCQ score for those that had separate clinics for these two services was 72 (n = 14).

A Pearson correlation was also performed to determine if the percentage of African Americans CSBs attracted from their catchment areas was correlated with the percentage of African American direct care service providers on the staffs of the CSBs. No significant correlation was found, $r = .24$, $p = .16$. However, there was a significant correlation between the percentage of African Americans on the caseloads of the CSBs and the percentage of African American staff at the CSBs, $r = .74$, $p < .001$. Possible reasons for why only one of these correlations proved to be significant is discussed in Chapter IV.

While most of the CSBs surveyed had African Americans on staff, the percentage of African Americans on staff

varied greatly. The mean percentage of African Americans on the direct service staffs of all the CSBs combined was 15% (range 0% - 79%). However, ten CSBs serving suburban or rural populations had no African Americans on their direct service staff. Yet, an analysis of variance did not find a statistically significant difference between the percentages of African Americans on the direct service staffs of CSBs serving urban, suburban, or rural communities, $F(2, 36) = 2.90$, $p > .05$. For urban CSBs, the mean percentage of African Americans on staff was 28% (range 1% - 79%). For suburban CSBs, the mean percentage of African Americans on staff was 13% (range 0% - 43%). For rural CSBs the mean percentage of African Americans on staff was 10% (range 0% - 50%). A few suburban and rural CSBs had relatively large percentages of African Americans on staff which would explain the failure to find a significant difference between urban, suburban, and rural centers despite urban centers having a higher mean percentage of African Americans on staff.

An analysis of variance was conducted to determine if the percentage of African Americans on staff differed between CSBs that did and did not offer primary substance abuse treatment. CSBs with separate mental health and substance abuse treatment clinics had a greater percentage of African Americans on their direct service staffs (M = 17%, range 0% - 50%) than did CSBs that provided these services at one clinic (M = 10%, range 0% - 50%), $F(2, 36)$ =

3.61, $p < .05$.

A standard multiple regression analysis did not reveal a statistically significant correlation between CSBs' mean scores on the six subscales of the CCQ and the percentage of African Americans the CSBs attracted from their catchment areas, $F(6, 36) = .32$, $p > .05$. The dependent variable in the analysis was the percentage of the African American population each CSB attracted from its catchment area. The means of the CSBs' subscale scores served as the predictor variables.

Although no correlation was found between subscale scores and percentages of the African American population pulled from catchment areas, there was variability in mean subscale scores across the different CSBs. Table 3 presents the mean subscale scores for all CSBs combined. Table 4 presents the mean subscale scores as a function of type of population served by the CSBs. Only the Staffing subscale score significantly differed as a function of type of population served. Urban CSBs scored higher on this subscale than did rural CSBs. Mean subscale scores did not vary significantly as a function of combination or separation of mental health and substance abuse treatment services within the CSBs.

A further analysis of the data revealed that the percentage of African Americans on the caseloads of the CSBs was greater than the percentage of African Americans in the catchment areas of the CSBs for all but four rural CSBs. The

difference ratio between these two statistics (percentage of African Americans on the CSB's caseload minus the percentage of African Americans in the CSB's catchment area population) was positively correlated with total CCQ scores, $r = .43$, $p = .01$. Table 5 displays the percentage of African Americans on the caseload of each CSB, the percentage of African Americans in the catchment area population of each CSB, and the numerical difference between the two numbers. The difference ratio was also correlated with the percentage of African American staff at the CSBs, $r = .53$, $p = .001$. The difference ratio was not correlated with the percentage of African Americans in CSB catchment areas, $r = -.04$, $p = .83$.

Additionally, a standard multiple regression analysis was conducted to determine if the difference ratio between the percentage of African Americans on the CSBs' caseloads and the percentage of African Americans in the CSBs' catchment areas was correlated with the CSBs' mean subscale scores on the CCQ. A significant result was found, $F(6, 36) = 2.90$, $p = .03$. The linkage subscale had a significant negative partial regression coefficient even though mean linkage subscale scores proved not to be significantly correlated with the difference ratio ($r = -.18$, $p = .15$). This indicated that the linkage subscale served as a suppressor variable for irrelevant variance in the data. Yet, none of the other subscales entered into the regression analysis proved to be significant variables in the regression equation even though four of the subscales were

Table 3

CCQ Mean Subscale Scores for All Community Mental Health Centers

Subscale	*M*	Score Range
Linkage	3.31	2.40 - 4.00
Staffing	2.56	1.00 - 4.00
Training	2.56	1.00 - 4.00
Access	2.67	1.75 - 3.75
Cultural	1.99	1.00 - 4.00
Outreach	2.50	1.40 - 4.00

Table 4

Mean CCQ Subscale Scores and Standard Deviations as a Function of Type of Population Served

	Subscales					
Population	Linkage		Staffing		Training	
Served	*M*	*SD*	*M*	*SD*	*M*	*SD*
Urban**	3.13	.40	3.13	.60	2.88	.60
Suburban	3.38	.52	2.59	.77	2.70	.35
Rural**	3.36	.39	2.33	.80	2.37	.68

Table 4 (continued)

	Subscales					
Population	Access		Cultural		Outreach	
Served	*M*	*SD*	*M*	*SD*	*M*	*SD*
Urban	2.78	.62	2.38	.83	2.83	.60
Suburban	2.53	.54	2.00	.40	2.33	.60
Rural	2.68	.51	1.84	.80	2.43	.59

Note. *ANOVA showed staffing subscale scores significantly different as a function of type of population served, $F(2, 36) = 3.23$, $p < .05$. **Independent samples t-test showed significant difference on the staffing subscale was between the urban and rural centers, $t(26) = 2.55$, $p = .017$.

Table 5

Percentage of African Americans on CSB Caseloads in Comparison to the Percentage of African Americans in CSB Catchment Areas

CSB	AA on Caseload	AA in Population	Difference
1	12%	9%	3%
2	30%	11%	19%
3	40%	13%	27%
4	39%	29%	10%
5	20%	14%	6%
6	27%	16%	11%
7	50%	40%	10%
8	2%	2%	0%
9	39%	33%	6%
10	2%	0%	2%
11	56%	44%	12%
12	60%	39%	21%
13	72%	38%	34%
14	13%	11%	3%
15	5%	4%	1%
16	28%	23%	5%
17	5%	3%	2%
18	5%	3%	2%
19	14%	8%	6%
20	35%	26%	9%

Table 5 (continued)

CSB	AA on Caseload	AA in Population	Difference
21	4%	3%	1%
22	1%	3%	-1%
23	2%	3%	-1%
24	15%	5%	11%
25	60%	41%	19%
26	6%	4%	2%
27	2%	1%	1%
28	60%	49%	11%
29	23%	15%	8%
30	40%	14%	26%
31	28%	14%	14%
32	40%	17%	23%
33	10%	17%	-7%
34	82%	57%	25%
35	8%	6%	2%
36	62%	44%	18%

significantly correlated to the difference ratio. The accessibility (r = .31, p = .03), culturally relevant treatment (r = .35, p = .02), staffing (r = .49, p = .00), and training of staff (r = .40, p = .01), subscales were all positively correlated with the difference ratio between percentage of African Americans on CSBs' caseloads and percentage of African Americans in CSBs' catchment areas. There was not a significant correlation between the difference ratio and the community and consumer outreach subscale.

Finally, individual chi-square analyses were conducted for the 24 CSBs that reported service utilization data in order to analyze the relationship between race of consumers utilizing services and the types of services those consumers received. Except for two CSBs, the analyses revealed that race was not independent of type of service consumers received. Table 6 summarizes the results of these analyses. Table 7 illustrates the distribution of the mean percentages of African Americans, White Americans, and Americans of other races on the caseloads of the responding CSBs across four service categories. Consumers of other races received more emergency treatment (M = 34%) and less outpatient treatment (M = 37%) than did African American and White American consumers. African American and White American consumers were represented in similar proportions across the different service categories. Since the data on the racial characteristics of the consumers using the four services was

Table 6

Results of Chi-Square Analyses for CMHCs for Type of Service and Race of Consumers

Clinic I.D.	Chi-Square Analysis
1	$X^2(6) = 2.47^*$
2	$X^2(4) = 450.87$
3	$X^2(4) = 160.04$
6	$X^2(6) = 48.43$
7	$X^2(6) = 17.16$
8	$X^2(4) = 201.88$
10	$X^2(4) = 1066.88$
11	$X^2(4) = 39.87$
13	$X^2(6) = 55.41$
17	$X^2(6) = 31.88$
18	$X^2(2) = 2.78^*$
19	$X^2(4) = 1039.55$
20	$X^2(6) = 1405.96$
21	$X^2(4) = 1518.77$
24	$X^2(4) = 1891.84$
25	$X^2(4) = 1478.32$
26	$X^2(6) = 59.34$
27	$X^2(4) = 1935.02$
29	$X^2(4) = 2171.28$
32	$X^2(4) = 717.22$
33	$X^2(4) = 21.55$

Table 6 (continued)

Clinic I.D.	Chi-Square Analysis
34	$X^2(4) = 335.21$
36	$X^2(4) = 351.99$
39	$X^2(6) = 17.71$

Note. *Result not significant. All other analyses significant, $p < .05$.

Table 7

Mean Percentages of Racial Groups Utilizing Four Core Services for All CSBs Reporting Data

	Race		
Type of Service	African Americans	White Americans	Other Americans
Case Management	25%	21%	19%
Emergency	25%	29%	34%
Inpatient	3%	3%	2%
Outpatient	47%	48%	37%

provided in aggregate form, further analyses could not be conducted to determine if there was any relationship between racial distribution across service categories and CCQ scores.

CHAPTER IV

DISCUSSION

The results of this study did not disprove the null hypothesis that there is no relationship between cultural competence, as measured by the Cultural Compatibility Questionnaire, and African American service utilization defined as percentage of African Americans attracted from a CSB's catchment area. Even accounting for such factors as type of population served and whether or not a CSB provided both mental health and substance abuse treatment failed to yield significant results. Three major possibilities were considered to explain these non-significant findings. First, there may not have been a relationship between cultural competence of services provided by CSBs and African American service utilization rates for the author to find. Second, the power of the study's design may have been too small to find the link between cultural competence and African American service utilization. Third, the Cultural Competence Questionnaire may not have been an adequate means of assessing cultural competence.

The first possibility considered was that the non-significant results of the study were an indication that there was no relationship between cultural compatibility, at least as operationalized by the CCQ, and a CSB's effectiveness at attracting African American service users from its catchment area. However, many other studies have found links between providing different aspects of

culturally competent community mental health care and various measures of African American service utilization. The presence of African American therapists, using a culturally specific model of care, providing comprehensive health services along with mental health treatment, and outreach to the African American community have all been linked to African American utilization of CMHC services (Bacote, 1991; Flaskerud, 1986; Matsumoto, 1994; Snowden, Collinge, & Runkle, 1982; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Consequently, the author did not think the findings of the current study were an indication that cultural competence of CMHC services did not play a role in African American CMHC service utilization.

The second possible explanation for the study's non-significant findings was that the study did not have sufficient power to detect the phenomenon being studied. Power refers to the chance that one's research design will reject the null hypothesis when it is in fact false (Howell, 1987). Cohen (1992) recommended that all studies have power equal to .80 and he calculated effect sizes and sample sizes needed for research using various statistical tests to reach this level of power.

In order to determine the ideal sample size that should have been used in this study, the author first assumed that cultural competence had a medium effect size. The author made this assumption based on the consideration that there were several other variables that could reasonably be

assumed to have had an effect on why African Americans utilized CSB mental health services. For example, severity of symptoms experienced or court referral for treatment could have influenced why African Americans sought CSB services. Also, Cohen (1992) recommended that exploratory studies assume that the phenomenon being investigated has a medium effect size when no previous research exists to indicate otherwise.

Assuming a medium effect size, the author calculated the sample size the current study would have needed to achieve power equal to .80. According to Cohen, since this study utilized a multiple regression analysis in which there were six variables and significance was set at $p = .05$, the sample size should have equaled 97 subjects. Consequently, the current study lacked sufficient power to have adequate probability of rejecting the null hypothesis.

Finally, the third explanation considered for the non-significant findings of the study was that the instrument used to measure cultural competence did not do so adequately. The psychometric properties of the Cultural Competence Questionnaire (CCQ) were unknown. The CCQ was adapted from an instrument with good reliability but the inter-rater and test-retest reliability of the CCQ itself were unknown. Additionally, the items composing the CCQ were not subtle in nature. Therefore, the participating clinical directors could have easily determined which answers to the various questions on the CCQ would have made their agencies

look more culturally competent and, consequently, been biased to respond in that direction. Furthermore, the CCQ asked very general questions about what type of services a CSB was providing. For example, question one asked whether or not the CSB worked collaboratively with programs that provided employment training. However, the question did not assess how many programs the CSB had contact with nor what was the nature of the collaboration. Therefore, two clinical directors could have rated their agencies the same way on this question while doing very different types of collaborative work with employment programs at their respective agencies. As a result, the CCQ may not have adequately assessed differences in levels of cultural competence among the responding CSBs.

The CCQ may also have been limited in assessing the cultural competence of the CSBs because it was administered as a self-report measure via a telephone interview. While each clinical director was able to provide an overall view of his or her CSB, direct line staff and other administrative staff may have been able to provide a more comprehensive picture of each agency's cultural competence practices if some of them had also been interviewed. If a CSB's rating on the CCQ was the result of the input of more than one staff person at the agency, one could have greater confidence that the cultural competence practices of a particular CSB were being accurately assessed.

While the first major hypothesis of the study was not

supported by the research findings, other data collected were informative. The author obtained information about minority representation on the staffs of the adult outpatient mental health clinics in Virginia.

African Americans were not well represented among the clinical directors who participated in this study. Only two of the 36 clinical directors interviewed were African American and only one other clinical director was from a minority group. Consequently, no data analyses could be performed to examine whether or not there were racial differences in how clinical directors answered questions on the CCQ.

The author was able to examine the data to assess the professional backgrounds of the respondents and found a surprisingly high number of licensed professional counselors (LPCs). Eight of the clinical directors were LPCs. One clinical director noted that many of the direct care staff at his CSB were also LPCs. He thought the same was true for many CSBs in Virginia. Since less training is required to obtain the LPC degree rather than a social work or clinical psychology degree, LPCs could be hired at a lesser rate of pay which would account for the presence of so many LPCs on CSBs' staffs at the expense of having more professionally trained individuals.

The data analyses also revealed that there were differences in how CSBs scored on the staffing subscale of the CCQ based on the type of population the CSB served.

Urban CSBs scored higher than rural CSBs on the staffing subscale of the CCQ. However, CSBs did not differ in the percentage of African Americans they had on staff on the basis of the type of population they served. This disparity may be due to the types of items endorsed on the staffing subscale by the urban and rural CSBs. The staffing subscale assessed for whether or not an agency had African American staff and for how well the agency retained and recruited African American staff. Several rural CSBs reported that they did not have any African American staff and had difficulty recruiting and retaining minority staff. On the other hand, all of the urban centers had African American staff and reported better retention and/or recruitment of African Americans.

There were also staffing differences between CSBs that did and did not offer primary substance abuse treatment. CSBs that did not offer primary substance abuse treatment had a higher percentage of Africans Americans on their staffs than CSBs that did offer primary substance abuse treatment. This is an unexpected finding because substance abuse is a prevalent problem in poor African American communities. Therefore, one would expect treatment programs providing substance abuse treatment to make an effort to hire African American staff since research has shown that minority staff presence correlates with minority service utilization.

Another surprising finding of the current study was

that the percentage of African Americans CSBs had on staff was not correlated with the percentage of African Americans attracted from CSBs' catchment areas. Previous research had found that minority utilization of CMHC services was correlated with minority staff presence (Bacote, 1991; Flaskerud, 1986; Matsumoto, 1994; Snowden, Collinge, & Runkle, 1982; Sue, Fujino, Hu, Takeuchi & Zane, 1991). However, the percentage of African Americans on CSB staffs was positively correlated with the percentage of African Americans on the caseloads of CSBs. In other words, as the percentage of African Americans on the caseloads of CSBs increased, so did the percentage of African Americans on the staffs of the CSBs.

Whether or not the presence of African American staff caused an increase in the percentage of African American consumers on CSB caseloads could not be answered by this correlational study. Alternatively, it could be that CSBs that had more African Americans on their caseloads felt more pressure from those consumers to hire African American staff. While this study did not provide a definitive answer to these two questions, some possibilities were suggested by the current data.

One possible answer can be found by considering what type of service utilization is represented by the percentage of African Americans attracted from a CSB's catchment area. The percentage of African Americans a CSB attracted from its catchment area may have represented that agency's rate of

African American intakes for the period of time covered by the study. On the other hand, the percentage of African Americans on a CSB's caseload may have been a better measure of the agency's retention and attrition rates for its African American consumers. When considered from this perspective, the positive correlation between percentage of African American staff and percentage of African American consumers may have been an indication that CSBs with higher percentages of African American staff members had better retention and less attrition of their African American consumers. This is only a possibility suggested by the current data. Further research is needed to answer this question definitively.

The issue of what factors may have affected the retention and attrition of African American consumers of services at the different CSBs arose again when the data were reanalyzed using another definition of service utilization. The current research found that as the percentage of African Americans on CSB caseloads increased over the percentage of African Americans in the catchment areas of the CSBs, so did the CSBs' total CCQ scores. In other words, those CSBs rated on the CCQ as being the most culturally competent at providing services to African Americans had the highest percentages of African Americans on their caseloads as opposed to in their catchment area populations. Yet, there was no correlation between CCQ scores and the percentage of African Americans CSBs

attracted from their catchment areas.

National trends would predict that African Americans would be represented on CSB caseloads more than expected in terms of their representation in catchment area populations (Broman, 1987; Cheung & Snowden, 1990; Flaskerud & Hu, 1992; Goodman & Siegel, 1978; O'Sullivan, Peterson, Cox, & Kirkeby, 1989; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). The current study also found that African Americans utilized CSBs' adult outpatient services at rates greater than their proportions in catchment area populations. This trend can be explained by the fact that CSBs in Virginia primarily served poor residents. Since a relatively large percentage of the African American population is poor, one would expect many African Americans to rely on public mental health care.

National trends do not offer an explanation for the correlation found between CSBs' CCQ scores and the proportion of African Americans on their caseloads. However, a consideration of attrition and retention rates of African American CSB consumers might. For example, one possible explanation for these findings may be that as African Americans were represented on a CSB's caseload in increasingly larger proportions than their representation in the community served by that CSB, the more the CSB tried to meet the needs of those African American consumers by making its services more compatible with their culture. This may have resulted in the more culturally competent CSBs having better retention and smaller attrition rates for their

African American consumers. Therefore, they would have proportionally more African American consumers on their caseloads. The lack of a significant correlation between CSBs' CCQ scores and the percentage of African Americans they attracted from their catchment areas may have been because CSBs did not take steps to provide more culturally competent services in order to attract more African American service users.

Support for this hypothesis is offered by the significant positive correlations found between mean scores on the accessibility, culturally relevant treatment, staffing, and training of staff subscales and the difference ratio (the numerical difference between the percentage of African Americans on CSBs' caseloads and the percentage of African Americans in CSBs' catchment areas). Correlation does not prove causation. Yet, the data may be an indication that when a CSB had a caseload with proportionally more African Americans than it had in its catchment area, the agency perceived a need to make its services more accessible and its treatment more culturally relevant to its African American consumers. The consumers may have requested staffing changes themselves. Consequently, the agency may have hired more African American staff and offered its staff training on how to work more effectively with its relatively large percentage of African American consumers. In support of this theory, there was a significant positive correlation between the percentage of CSBs' caseloads that were African

American and the percentage of African Americans the CSBs had on staff. Furthermore, the lack of a significant correlation between the community and consumer outreach subscale and the difference ratio may have been because CSBs were focused more on meeting the needs of the African American consumers they already had on their caseloads rather than trying to reach out to African Americans in their communities. CSB staff may also have thought there was no need to do much outreach to African American communities already disproportionately represented on their agency caseloads. More research will have to be conducted in order to test these hypotheses especially in light of the methodological limitations already discussed with regards to the current study.

Furthermore, there are alternative hypotheses that would also explain why African Americans are represented on CSB caseloads in proportions larger than their representation in the population. Previous research has found that socioeconomic status is an important factor that affects African Americans' utilization of CMHC services. As previously discussed, a relatively large percentage of the African American population is poor and this segment of the African American population would be expected to rely heavily on public mental health care. Also, poor African Americans have been found to use CMHC services for problems most directly related to their low socioeconomic status (Broman, 1987). Such problems might include the

environmental stressors that come along with being homeless or living in a neighborhood with a high crime rate, poor vocational or educational opportunities, and a limited range of medical care. The fact that minority mental health consumers often have significant problems in addition to their mental health problems is an issue often addressed in the literature regarding how to provide culturally competent CMHC services. One of the six principles for providing culturally competent mental health care states that CMHCs will be able to serve their minority consumers better if they provide integration and linkage of mental health services with other health and social services.

The manner in which African Americans were referred for mental health services may also have affected their retention and attrition rates from CSB caseloads. Research has found that more African Americans than White Americans are court-referred for services at CMHCs (Goodman & Siegel, 1978; Smith et al., 1978; Wallen, 1992). African Americans court-referred for services may have remained in treatment at the CSBs in order to avoid going to jail or other court-ordered sanctions rather than because they were responding to the level of cultural competence present at the CSBs. Once court monitoring was discontinued, this same group might have been inclined to drop-out of treatment even if they needed more help and even if the treatment that they had been receiving was provided in a culturally competent manner.

The final major data analysis of this study revealed a relationship between consumer race and type of service received although not in the direction the author anticipated. The review of the literature indicated that African Americans tended to overutilize inpatient services, pharmacotherapy, and case management services and to underutilize psychotherapy. However, the present study did not find a difference between the types of services utilized by African and White Americans. These data must be interpreted cautiously since only a small percentage of CSBs reported the racial characteristics of the consumers who used their four core services.

However, the data analyses revealed that CSB consumers who belonged to the "other" racial category utilized CSB services differently than White and African American consumers. Consumers falling into the "other" racial category received significantly more emergency treatment and less outpatient treatment than did African American and White American consumers. The CSBs that reported this data were from different areas across the state with no one region predominating. These findings may be an indication that racial minorities falling into the "other" category were less assimilated into their communities and into the social service networks in their communities. Therefore, they may have come most often to the CSBs on an emergency basis when the severity of their mental health problems attracted the notice of schools or other social service

agencies. Again, only a small percentage of CSBs reported these data so the results must be interpreted cautiously.

CHAPTER V

CONCLUSIONS

This study's attempt to show a relationship between a measure of cultural competence and African American community mental health center service utilization was unsuccessful. However, although no correlation was found, the methodological limitations of the research prevented the author from concluding that their was no such relationship. Additionally, the study's research design raised several methodological issues that should be addressed in future studies investigating the relationship between cultural competence and African American utilization of CMHCs' services.

Three major possibilities were considered as explanations for the failure of the current study to find support for the hypotheses investigated. First, the original hypothesis regarding the relationship between cultural competence and CMHC service utilization could be incorrect. Second, the research design could have had insufficient power to detect a relationship that did in fact exist. Third, the instrument selected to measure cultural competence could have been unreliable or invalid or both.

One explanation for the failure to reject the null hypothesis is that there is no relationship between the cultural competence of a community mental health center and its ability to attract African Americans or other minorities. This explanation does not appear to be tenable

given the extensive literature and empirical support documenting the relationship between human service organization variables and service utilization patterns of minorities. In fact, the following six basic organizational principles have been repeatedly cited in the literature as being important to providing culturally competent community mental health care: (a) minorities are represented on the clinical staff, (b) services are easily accessible, (c) mental health services are integrated with and linked to other health and social services, (d) treatments provided are compatible with the needs and culture of the minority communities being served, (e) staff are familiar with cultural variables that might influence the diagnosis and treatment of minority clients, and (f) minority clients are directly involved in determining what services will be offered and in evaluating the quality and effectiveness of those services. Bacote (1991); Flaskerud (1986); Matsumoto (1994); Snowden, Collinge, and Runkle (1982); and Sue, Fujino, Hu, Takeuchi, and Zane (1991) are major researchers in this field who found empirical links between the above six principles and various measures of African American service utilization. Consequently, the author of the current study will not assume that there is no relationship between cultural competence and African American CMHC utilization when there is clear and sufficient evidence to the contrary. Therefore, the other two possible explanations for the failure to reject the null hypothesis will now be

considered.

A second explanation for the failure to reject the null hypothesis could be that a relationship between cultural competence of CMHC services and African American service utilization does, in fact, exist but the research design did not have sufficient power to detect it. In order to have achieved power equal to .80, which is considered sufficient to allow most research designs to reject a false null hypothesis, the current study would have needed a sample size of at least 97 CSBs. However, Virginia only had 39 CSBs. Consequently, the current study had a relatively small population pool from which to draw which increased the likelihood that a meaningful relationship between cultural competence and service utilization could have existed and not been detected. With such a small sample size, only an effect size much greater than that suggested by the literature would have resulted in rejecting the null hypothesis. Increasing the sample size used in the current research was not feasible due to the limited number of CSBs within Virginia. Furthermore, conducting a multi-state investigation in order to obtain a larger sample size presented both pragmatic and conceptual issues that were beyond the scope of this investigator. A research design that controlled for differences in how CMHC services were organized, funded, and targeted to consumers would have been necessary in order to compare mental health systems between states. Thus, the lack of power of the current research

remains a real concern and may be responsible for the failure to provide support for the hypothesis investigated. Future studies should assure that they possess sufficient power to correctly reject the null hypothesis.

A third explanation for the failure to reject the null hypothesis could be that the study used an instrument, the Cultural Competence Questionnaire, with unknown psychometric properties to assess cultural competence. Admittedly, this study was exploratory in nature; however, the fact that the reliability and validity of the CCQ had not yet been established was a serious shortcoming. Internal consistency, test - retest, and inter-rater reliability of the CCQ should all be established before the questionnaire is used again.

Additionally, the items composing the CCQ need anchoring and standardization. They are currently very general in nature. Two agencies could provide identical numerical ratings for an item yet have very different ways of implementing the strategy for providing culturally competent care assessed by that item. In order to correct this problem, each of the questions on the CCQ needs further elaboration and specification through the use of behavioral anchors or specific examples. For instance, question 20 asked if a clinic used treatment approaches specific to African American culture. This question could be improved if it also asked what types of culturally specific treatment approaches were used and how often they were utilized.

Also, the CCQ should be administered to more than one

staff person when it is used to obtain a measure of CMHC cultural competence. If a combination of direct service and administrative personnel were administered the CCQ, a more comprehensive and accurate analysis of an agency's cultural competence at serving minorities would be obtained. This strategy of increasing the number of staff and the perspectives represented could help to offset any effect that social desirability might have on how respondents answer items on the questionnaire and thereby increase the validity of the measure.

Another area of concern in attempting to conduct this study was the significantly limited amount of archival data that was available for analysis. As a result, there were several research questions discussed at the end of Chapter I that the author was unable to address. Future research on minority mental health in Virginia will be hampered until more data is made available.

Based on currently available data, it would be difficult to comprehensively assess how well the state's community mental health system meets the needs of its mentally ill African American citizens. The Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) should take the lead role in developing a statewide database of African American CSB service utilization statistics. Trying to collect these statistics from individual CSBs to determine statewide trends would be beyond the means of most researchers. This

responsibility is clearly part of the charge to DMHMRSAS. DMHMRSAS could direct CSBs to maintain service utilization statistics that would allow such variables as types of diagnoses and treatments received, treatment outcomes, drop-out rates, and consumer satisfaction with services to be tracked by race. The Survey Review Team could then play a significant role in advertising the availability of such a database among the research community in Virginia. The Survey Review Team could also solicit studies from researchers interested in investigating the quality of community mental health care provided to African Americans and other minorities in the state of Virginia.

If Virginia's DMHMRSAS and the Survey Review Team were to conduct research on minority mental health, there are a number of sensitive political issues that would need to be considered. For one, CSBs might be reluctant to participate in research if they feared that their funding would be in jeopardy if research findings indicated they were not adequately meeting the mental health care needs of minorities. In order to prevent CSBs from being apprehensive about participating, DMHMRSAS should frame CSB participation in research on minority mental health as a means of improving mental health care for minorities in Virginia. For example, DMHMRSAS could state that research findings would be used to help CSBs set targets and goals for improving their services to minorities.

The author is aware that any initiative to conduct

research on the quality of community mental health care provided to African Americans and other minorities in Virginia would be politically sensitive in nature. CSB directors and officials at DMHMRSAS might fear that negative results could lead to charges of racism and neglect from the minority communities in Virginia. One way to deal with this concern would be to involve minority members of the professional community and minority citizens of Virginia in designing a research program. Groups like the Virginia Association of Black Psychologists and the Virginia Association of Black Social Workers along with their counterparts in the Asian, Hispanic, Native American, and immigrant communities could be tapped for their expertise. Each CSB's catchment area could be surveyed to obtain the assistance of leaders of the minority community as well as ordinary citizens and mental health consumers in the minority community. If such steps were taken, minority professionals and community members would be able to play a role in planning and prioritizing goals for research about minority mental health care in Virginia. They would also be able to help with conducting such research and developing and instituting policy initiatives to be undertaken as the result of the findings of such research. CSB directors and DMHMRSAS officials would be much less likely to face charges of racism and neglect if the minority community were to feel a sense of ownership of the research being undertaken in their communities and a sense of trust that the results of

such research would be used to improve the quality of mental health care provided to their communities.

The author's experiences with the clinical directors who participated in this study were encouraging. Their reactions indicated that there was a willingness at the CSB level to participate in research studies examining minority mental health issues. Most of the clinical directors who participated in this study expressed interest in its findings and several said that completing the CCQ made them think about how they might better serve their minority consumers. A few commented that the issue of cultural compatibility was a timely one because their catchment area population was becoming more diverse. The majority of these clinical directors helped to determine policy at their agencies so their positive reception to this study suggested that many of them might be open to implementing possible policy recommendations that might ensue from research on minority mental health care in Virginia.

Despite its methodological limitations, the current study provided some additional information that suggested other areas in need of further research. One such area is African American representation on the staffs of Virginia's CSBs. Research has found that the presence of African American staff is an important factor affecting African American CMHC service utilization. However, African Americans were not well-represented among CSB clinical directors and rural agencies reported that it was very

difficult for them to attract African American staff. More research is needed to determine what policy initiatives could be undertaken to help rectify these problems. Salary structure, recruitment efforts, and factors affecting staff retention and promotion should all be investigated in future research on how to improve the representation of African Americans on the staffs of Virginia's CSBs.

Factors that may affect the retention and attrition of African American consumers of CSBs' mental health services might also be promising areas for future study. Trends suggested by the data indicated that the presence of African American staff and the level of an agency's cultural competence at providing services might have a beneficial effect on African American consumers' retention and attrition rates. However, these trends in the data must be interpreted cautiously. The CCQ, which was used to assess cultural competence, had several limitations previously discussed in Chapter IV. Also, the study did not control for other variables that might have affected African American retention and attrition rates such as socioeconomic status and manner of referral for services. Future research on African American retention and attrition should clarify how CSBs classify their active cases. This would enable researchers to determine whether or not African Americans were listed as active cases even if they were not being currently treated in order to artificially inflate their numbers on CSBs' caseloads. Also, recidivism might account

for the high percentage of African Americans on some CSB caseloads if those agencies used intake numbers to count their African American consumers. Therefore, as was done in the current research, future studies should request unduplicated client statistics.

Also, research on African American attrition and retention rates should use longitudinal designs. These statistical trends only become evident over time. Longitudinal designs would enable researchers to investigate whether or not community mental health centers' CCQ scores vary over time with increasing and decreasing proportions of African Americans on their caseloads.

Additionally, future research could attempt to find ways to control for several other variables that affect African American service utilization. Level of education, diagnosis, prognosis and availability of private mental health care or not-for profit private mental health care are variables that might affect African American CSB service utilization rates. Also, socioeconomic status and manner in which consumers were referred for services should be controlled for since these two variables also affect why African Americans seek out and continue to use CMHC services. These variables would be difficult to control for unless the statewide database and research initiative previously discussed were developed.

Finally, more research is needed to address how other minorities are faring in the community mental health system in Virginia. The data analyses of the current study revealed

several trends suggesting that minorities who are not African American utilized emergency services more than other racial groups and utilized outpatient services less. More research should be conducted to determine if better outreach efforts are needed in order to adequately meet the mental health needs of Virginia's other minority groups.

In closing, the comments made by clinical directors who participated in this study underscore the fact that this nation is becoming more culturally diverse. Our public institutions must respond to this increasing diversity if they are to serve their citizens well. Many CSB clinical directors in Virginia appear to be interested in and open to ideas about how this might be accomplished.

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APPENDIX A

INTRODUCTORY LETTER

A. Michelle Marsh
3636 16th St. N.W. Apt. B607
Washington, D.C. 20010
_____ _____, 1998
month day

Director of Clinical Services
_____
Name of CMHC
_____
Street Address
_____, VA _____
City Zip Code

Dear _____:
Name of Clinical Director

I am a graduate student in clinical psychology at the Virginia Consortium for Professional Psychology. Currently, I am conducting research for my dissertation. I am writing to request your participation in a brief telephone survey that should not last longer than 5-10 minutes.

I am investigating factors associated with African Americans' utilization of community mental health centers' services in Virginia. I have enclosed a copy of the questions that I would ask you to answer during the telephone interview. Completion of the survey will not require advance preparation on your part and the results of the survey will not be used to identify you or your agency by name.

I am also requesting information about the total number of people who sought services at your adult outpatient mental health clinic or clinics during fiscal year 1997. Specifically, I am interested in what percentage of that number were White Americans, what percentage were African Americans, and what percentage were of other races.

I shall contact you three to seven days after you receive this letter to follow-up and arrange a time to conduct the brief phone survey. I hope that you will be able to participate and I thank you in advance for considering my request.

Sincerely,

A. Michelle Marsh, BA
VCPP

APPENDIX B

CULTURAL COMPETENCE QUESTIONNAIRE: STRUCTURED TELEPHONE INTERVIEW

This questionnaire is designed to assess the cultural competence of community mental health centers in their work with African American service users. Please answer the questions in terms of how they relate to the current practice of your outpatient mental health program or service unit only, not the entire CSB. Your responses are strictly confidential and will not be used to identify you or your agency by name.

(I. LINKAGE)

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH NOT AT ALL, BARELY, FAIRLY WELL, OR VERY WELL.

1. Does your mental health outpatient clinic(s) work collaboratively with programs that provide employment training?

   NOT AT ALL..1 BARELY..2 FAIRLY WELL..3 VERY WELL..4

2. Does your clinic work collaboratively with programs that provide educational opportunity?

   NOT AT ALL..1 BARELY..2 FAIRLY WELL..3 VERY WELL..4

3. Does your clinic work collaboratively with programs that provide housing?

   NOT AT ALL..1 BARELY..2 FAIRLY WELL..3 VERY WELL..4

4. Does your clinic work collaboratively with programs that provide alcohol and/or substance abuse treatment?

   NOT AT ALL..1 BARELY..2 FAIRLY WELL..3 VERY WELL..4

5. Does your clinic work collaboratively with programs that provide public health services?

   NOT AT ALL..1 BARELY..2 FAIRLY WELL..3 VERY WELL..4

(II. STAFFING)

6. How well has your clinic been able to retain African Americans on staff?

   NOT AT ALL..1 BARELY..2 FAIRLY WELL..3 VERY WELL..4

PLEASE ANSWER THE FOLLOWING QUESTION WITH NONE, A FEW, SOME, OR MANY.

7. Are there African Americans on the staff of your clinic?

NONE....1 A FEW....2 SOME....3 MANY....4

PLEASE ANSWER THE FOLLOWING QUESTION WITH NONE, A LITTLE, SOME, OR A LOT.

8. Does your clinic emphasize active recruitment of African Americans?

NONE....1 A LITTLE....2 SOME....3 A LOT....4

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH NOT AT ALL, SELDOM, SOMETIMES, OR OFTEN.

9. Does your clinic hire or sponsor practicums or internships for African American students or interns?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

(III. TRAINING OF STAFF)

10. Does your clinic provide training that helps staff work with African Americans?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

11. Do your clinical staff routinely discuss, either formally or informally, barriers to working across cultures with African Americans?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

12. Do clinical staff routinely discuss, either formally or informally, their feelings about working with African American consumers?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

13. Do clinical staff routinely share agency or practice-based "success stories" involving African Americans?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

14. Do clinical staff attend workshops or seminars regarding how to work effectively with African American consumers?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

(IV. ACCESSIBILITY)

15. Does your clinic out-station staff in African American communities?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

16. Does your clinic provide or facilitate child-care for consumers?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

17. Does your clinic provide or facilitate transportation (such as bus tickets or ride-sharing) for consumers?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

18. Does your clinic allow for access after regular business hours (such as through message-beeper or agreements with crisis-providers)?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

(V. CULTURALLY RELEVANT TREATMENT)

19. Does your clinic use assessment instruments specific to African American culture for diagnosis?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

20. Does your clinic use treatment approaches specific to African American culture?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

21. Does your clinic specifically consider African American culture in service plans?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

22. Does your clinic review case practice on a regular basis to determine relevancy to the African American community?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

(VI. COMMUNITY AND CONSUMER OUTREACH)

23. Does your clinic offer workshops on mental health issues as they relate to African Americans?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

24. Does your clinic involve African American consumers and/or community members in determining what type of services the clinic will offer?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

25. Does your clinic involve African American consumers and/or community members in evaluating the services the clinic offers?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

26. Are African Americans depicted on clinic brochures or other clinic media?

NOT AT ALL...1 SELDOM...2 SOMETIMES...3 OFTEN...4

PLEASE ANSWER THE FOLLOWING QUESTION WITH NOT AT ALL, BARELY, FAIRLY WELL, OR VERY WELL.

27. How well do you assure that the African American community is aware of your program and the services and resources you offer?

NOT AT ALL..1 BARELY..2 FAIRLY WELL..3 VERY WELL..4

(CULTURAL COMPETENCE SCALE DEMOGRAPHIC INFORMATION)

NOW I WOULD LIKE TO ASK YOU QUESTIONS ABOUT YOURSELF. THESE ARE FOR RESEARCH PURPOSES ONLY AND WILL NOT BE USED TO IDENTIFY YOU.

1. What sex are you? a. Female b. Male

2. What race are you?
   a. Asian/Pacific Islander
   b. Black/African American
   c. Hispanic- or Latino-American
   d. Native American/American Indian
   e. Caucasian/White American
   f. Other (specify)_____

3. How old are you? Age:_____ Years

4. What is your professional affiliation?

   a. Social Worker
   b. Psychologist
   c. Physician
   d. Psychiatrist
   e. Nurse
   f. Case Manager
   g. Other (specify)_____
   _____

5. What is your position with the agency? _____

6. How many years have you been with the agency? _____

7. How many years of experience do you have in administration? _____

8. How many years of experience do you have in direct service? _____

9. To what extent are you involved with the analysis or formation of agency policy?

   1.Very much 2.Sometimes 3.Very rarely 4.Not at all

10. Which type of population is primarily served by your clinic?

    a. urban b. suburban c. rural

11. How many full or part-time direct care providers (therapists, case managers, psychiatrists, etc.) do you have on staff? _____

12. How many of them are African Americans? _____

NOW I WOULD LIKE TO ASK YOU ABOUT THE RACIAL CHARACTERISTICS OF THE ADULTS SEEN DURING FISCAL YEAR 1997 AT YOUR OUTPATIENT MENTAL HEALTH CLINIC OR CLINICS.

13. How many adults were seen at your clinic(s) during fiscal year 1997? _____

14. How many of them were African Americans? _____

15. How many of them were White Americans? _____

16. How many of them were of other races? _____

17. Finally, does your CSB have separate mental health and substance abuse treatment clinics? _____

THAT CONCLUDES THE SURVEY. DO YOU HAVE ANY QUESTIONS OR COMMENTS THAT YOU WOULD LIKE TO MAKE?

_____
_____
_____
_____
_____
_____

WOULD YOU LIKE TO RECEIVE A BRIEF, ONE PAGE SUMMARY OF THE RESULTS OF THIS STUDY? YES_____ NO_____

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.

APPENDIX C

A PROFILE OF VIRGINIA'S 39 COMMUNITY SERVICES BOARDS

1. Alexandria Community Services Board

   Date CSB Established: March 25, 1969

   CSB Size: 15 square miles

   Jurisdiction Served: City of Alexandria

   CSB Catchment Area Population:
   - 113,509 Total
   - 26,077 African American = 23%
   - 69,939 White American = 62%
   - 17,493 Other = 15%

2. Alleghany Highlands Community Services Board

   Date CSB Established: December 8, 1981

   CSB Size: 452 square miles

   Jurisdictions Served: County of Alleghany and the Cities of Clifton Forge and Covington

   CSB Catchment Area Population:
   - 24,077 Total
   - 2,089 African American = 9%
   - 21,770 White American = 90%
   - 218 Other = 1%

3. Arlington County Community Services Board

   Date CSB Established: November 23, 1968

   CSB Size: 26 square miles

   Jurisdiction Served: County of Arlington

   CSB Catchment Area Population:
   - 174,603 Total
   - 19,254 African American = 11%
   - 115,792 White American = 66%
   - 39,557 Other = 23%

4. Blue Ridge Community Services Board

   Date CSB Established: January 20, 1969

   CSB Size: [851] square miles

Jurisdictions Served: Counties of Botetourt, Craig, Roanoke and the Cities of Roanoke and Salem

CSB Catchment Area Population:
233,234 Total
29,761 African American = 13%
199,913 White American = 86%
3,560 Other = 1%

5. Central Virginia Community Services Board

Date CSB Established: April 18, 1969

CSB Size: 2,103 square miles

Jurisdictions Served: Counties of Amherst, Appomattox, Bedford, Campbell, and the Cities of Bedford and Lynchburg

CSB Catchment Area Population:
215,538 Total
41,584 African American = 19%
171,416 White American = 80%
2,538 Other = 1%

6. Chesapeake Community Services Board

Date CSB Established: June 24, 1969

CSB Size: 341 square miles

Jurisdiction Served: City of Chesapeake

CSB Catchment Area Population:
180,577 Total
52,431 African American = 29%
122,782 White American = 68%
5,364 Other = 3%

7. Chesterfield Community Services Board

Date CSB Established: August 11, 1971

CSB Size: 442 square miles

Jurisdiction Served: County of Chesterfield

CSB Catchment Area Population:
234,088 Total
32,755 African American = 14%
192,849 White American = 82%
8,484 Other = 4%

8. Colonial Community Services Board

Date CSB Established: January 5, 1971

CSB Size: 286 square miles

Jurisdictions Served: Counties of James City and York and the Cities of Poquoson and Williamsburg

CSB Catchment Area Population:

115,360	Total
18,561	African American = 16%
92,314	White American = 80%
4,485	Other = 4%

9. Crossroads Community Services Board

Date CSB Established: December 6, 1973

CSB Size: 2,816 square miles

Jurisdictions Served: Counties of Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward

CSB Catchment Area Population:

87,283	Total
34,626	African American = 40%
52,032	White American = 60%
625	Other = 0.7%

10. Cumberland Mountain Community Services Board

Date CSB Established: June 7, 1972

CSB Size: 1,513 square miles

Jurisdictions Served: Counties of Buchanan, Russell, and Tazewell

CSB Catchment Area Population:

107,024	Total
1,763	African American = 2%
104,333	White American = 97%
928	Other = 1%

11. Danville-Pittsylvania Community Services Board

Date CSB Established: October 31, 1972

CSB Size: 1,018 square miles

Jurisdictions Served: County of Pittsylvania and the City of Danville

CSB Catchment Area Population:
109,961 Total
36,511 African American = 33%
72,590 White American = 66%
860 Other = 1%

12. Dickenson County Community Services Board

Date CSB Established: June 24, 1982

CSB Size: 332 square miles

Jurisdiction Served: County of Dickenson

CSB Catchment Area Population:
17,683 Total
74 African American = 0.4%
17,520 White American = 99%
89 Other = 0.5%

13. District 19 Community Services Board

Date CSB Established: September 18, 1973

CSB Size: 1,880 square miles

Jurisdictions Served: Counties of Dinwiddie, Greensville, Prince George, Surry, Sussex and the Cities of Colonial Heights, Emporia, Hopewell, and Petersburg

CSB Catchment Area Population:
161,576 Total
70,845 African American = 44%
86,449 White American = 53%
4,282 Other = 3%

14. Eastern Shore Community Services Board

Date CSB Established: July 26, 1971

CSB Size: 696 square miles

Jurisdictions Served: Counties of Accomack and Northampton

CSB Catchment Area Population:
45,361 Total
17,892 African American = 39%
26,715 White American = 59%
754 Other = 2%

15. Fairfax-Falls Church Community Services Board

Date CSB Established: January 15, 1969

CSB Size: 407 square miles

Jurisdictions Served: County of Fairfax and the Cities of Fairfax and Falls Church

CSB Catchment Area Population:
910,837 Total
73,440 African American = 8%
682,182 White American = 75%
155,215 Other = 17%

16. Goochland-Powhatan Community Services Board

Date CSB Established: April 12, 1982

CSB Size: 558 square miles

Jurisdictions Served: Counties of Goochland and Powhatan

CSB Catchment Area Population:
33,987 Total
9,131 African American = 27%
24,683 White American = 73%
173 Other = 0.5%

17. Hampton-Newport News Community Services Board

Date CSB Established: February 23, 1971

CSB Size: 124 square miles

Jurisdictions Served: Cities of Hampton and Newport News

CSB Catchment Area Population:
318,755 Total
119,988 African American = 38%
183,169 White American = 57%
15,598 Other = 5%

18. Hanover County Community Services Board

Date CSB Established: May 31, 1972

CSB Size: 465 square miles

Jurisdiction Served: County of Hanover

CSB Catchment Area Population:
71,543 Total
7,790 African American = 11%
62,848 White American = 88%
905 Other = 1%

19. Harrisonburg-Rockingham Community Services Board

Date CSB Established: March 24, 1972

CSB Size: 871 square miles

Jurisdictions Served: County of Rockingham and the City of Harrisonburg

CSB Catchment Area Population:
93,926 Total
3,311 African American = 4%
88,566 White American = 94%
2,049 Other = 2%

20. Henrico Area Community Services Board

Date CSB Established: July 9, 1969

CSB Size: 620 square miles

Jurisdictions Served: Counties of Charles City, Henrico, and New Kent

CSB Catchment Area Population:
247,116 Total
55,887 African American = 23%
182,026 White American = 73%
9,203 Other = 4%

21. Highlands Community Services Board

Date CSB Established: October 31, 1972

CSB Size: 578 square miles

Jurisdictions Served: County of Washington and the City of Bristol

CSB Catchment Area Population:
65,693 Total
1,881 African American = 3%
63,362 White American = 96%
450 Other = 1%

22. Loudoun County Community Services Board

Date CSB Established: May 20, 1969

CSB Size: 517 square miles

Jurisdiction Served: County of Loudoun

CSB Catchment Area Population:
108,116 Total
8,321 African American = 8%
93,319 White American = 86%
6,476 Other = 6%

23. Middle Peninsula-Northern Neck Community Services Board

Date CSB Established: February 28, 1974

CSB Size: 2,039 square miles

Jurisdictions Served: Counties of Essex, Gloucester, King and Queen, King William, Lancaster, Mathews, Middlesex, Northumberland, Richmond, and Westmoreland

CSB Catchment Area Population:
124,176 Total
32,740 African American = 26%
89,750 White American = 73%
1,686 Other = 1%

24. Mount Rogers Community Services Board

Date CSB Established: September 21, 1972

CSB Size: 2,217 square miles

Jurisdictions Served: County of Bland, Carroll, Grayson, Smyth, Wythe and the City of Galax

CSB Catchment Area Population:
116,270 Total
2,994 African American = 3%
112,434 White American = 96%
842 Other = 1%

25. New River Valley Community Services Board

Date CSB Established: July 1, 1969

CSB Size: 1,473 square miles

Jurisdictions Served: Counties of Floyd, Giles, Montgomery, Pulaski and the City of Radford

CSB Catchment Area Population:
155,235 Total
6,995 African American = 5%
142,973 White American = 92%
5,267 Other = 3%

26. Norfolk Community Services Board

Date CSB Established: March 9, 1969

CSB Size: 53 square miles

Jurisdiction Served: City of Norfolk

CSB Catchment Area Population:
241,426 Total
98,954 African American = 41%
128,477 White American = 53%
13,995 Other = 6%

27. Northwestern Community Services Board

Date CSB Established: June 25, 1974

CSB Size: 1,624 square miles

Jurisdictions Served: Counties of Clarke, Frederick, Page, Shenandoah, Warren and the City of Winchester

CSB Catchment Area Population:
170,008 Total
7,127 African American = 4%
160,346 White American = 94%
2,535 Other = 2%

28. Piedmont Community Services Board

Date CSB Established: October 31, 1972

CSB Size: 1,572 square miles

Jurisdictions Served: Counties of Franklin, Henry, and Patrick and the City of Martinsville

CSB Catchment Area Population:
132,581 Total
26,270 African American = 20%
105,418 White American = 79%
893 Other = 1%

29. Planning District 1

Date CSB Established: July 28, 1972

CSB Size: 1,393 square miles

Jurisdictions Served: Counties of Lee, Scott, Wise and the City of Norton

CSB Catchment Area Population:
91,698 Total
1,289 African American = 1%
89,756 White American = 98%
653 Other = 1%

30. Portsmouth Community Services Board

Date CSB Established: April 22, 1969

CSB Size: 29 square miles

Jurisdiction Served: City of Portsmouth

CSB Catchment Area Population:
103,464 Total
50,966 African American = 49%
50,215 White American = 49%
2,283 Other = 2%

31. Prince William County Community Services Board

Date CSB Established: November 21, 1968

CSB Size: 347 square miles

Jurisdictions Served: County of Prince William and the Cities of Manassas and Manassas Park

CSB Catchment Area Population:
278,481 Total
34,062 African American = 12%
219,428 White American = 79%
24,991 Other = 9%

32. Rappahannock Area Community Services Board

Date CSB Established: June 9, 1970

CSB Size: 1,406 square miles

Jurisdictions Served: Counties of Caroline, King George, Spotsylvania, and Stafford and the City of Fredericksburg

CSB Catchment Area Population:
202,499 Total
30,362 African American = 15%
165,246 White American = 82%
6,891 Other = 3%

33. Rappahannock-Rapidan Community Services Board

Date CSB Established: October 30, 1972

CSB Size: 1,998 square miles

Jurisdictions Served: Counties of Culpeper, Fauquier, Madison, Orange, and Rappahannock

CSB Catchment Area Population:
124,059 Total
17,691 African American = 14%
104,133 White American = 84%
2,235 Other = 2%

34. Region Ten Community Services Board

Date CSB Established: February 3, 1969

CSB Size 2,179 square miles

Jurisdictions Served: Counties of Albemarle, Fluvanna, Greene, Louisa, Nelson and the City of Charlottesville

CSB Catchment Area Population:
176,380 Total
30,458 African American = 17%
140,628 White American = 80%
5,294 Other = 3%

35. Richmond Behavioral Healthcare Authority

Date CSB Established: April 28, 1969

CSB Size: 60 square miles

Jurisdiction Served: City of Richmond

CSB Catchment Area Population:
201,480 Total
115,200 African American = 57%
82,377 White American = 41%
3,903 Other = 2%

36. Rockbridge Area Community Services Board

Date CSB Established: October 14, 1982

CSB Size: 1,147 square miles
Jurisdictions Served: Counties of Bath, Rockbridge and the Cities of Buena Vista and Lexington

CSB Catchment Area Population:
37,374 Total
2,116 African American = 6%
34,888 White American = 93%
370 Other = 1%

37. Valley Community Services Board

Date CSB Established: June 15, 1971

CSB Size: 1,418 square miles

Jurisdictions Served: Counties of Augusta and Highland and the Cities of Staunton and Waynesboro

CSB Catchment Area Population:
104,041 Total
7,552 African American = 7%
95,457 White American = 92%
1,032 Other = 1%

38. Virginia Beach Community Services Board

Date CSB Established: June 20, 1969

CSB Size: 259 square miles

Jurisdiction Served: City of Virginia Beach

CSB Catchment Area Population:
430,295 Total
63,915 African American = 15%
330,018 White American = 77%
36,362 Other = 8%

39. Western Tidewater Community Services Board

Date CSB Established: December 1, 1971

CSB Size: 1,333 square miles

Jurisdictions Served: Counties of Isle of Wight and Southampton and the Cities of Franklin and Suffolk

CSB Catchment Area Population:

107,621	Total
47,175	African American = 44%
59,502	White American = 55%
944	Other = 1%

APPENDIX D

DATA REQUEST LETTER

A. Michelle Marsh
3636 16th St. N.W. Apt. B607
Washington, D.C. 20010
_____ ___, 1998
month day

Director of Mental Health Services
_____
Name of CSB
_____
Street Address
_____, VA _____
City Zip Code

Dear _____:
Name of Clinical Director

I am a graduate student in clinical psychology at the Virginia Consortium for Professional Psychology. I spoke to you in December 1997 about my dissertation research. I am writing to request some additional information about the adult mental health services of your Community Services Board.

I am investigating factors associated with African Americans' utilization of community mental health centers' services in Virginia. I would like to get statistics regarding how many African American and White American adults and how many adults of other racial categories used the following services at your CSB during fiscal year 1997: (1) local inpatient, (2) emergency, (3) outpatient, and (4) case management services. I am interested in mental health unduplicated client characteristics only.

I will contact you by phone three to seven days after you receive this letter to follow-up and collect these statistics. However, if you prefer, you can mail them to me at my address above. I hope that you can provide me with this information and I thank you for considering my request.

Sincerely,

A. Michelle Marsh, BA
Virginia Consortium for
Professional Psychology

VITA

Alicia Michelle Marsh received her B.A. in psychology from Princeton University in 1989. She graduated with honors and went on to pursue graduate work in clinical psychology at the Virginia Consortium Program in Clinical Psychology. The Virginia Consortium Program in Clinical Psychology is located at building 3300 South/Suite 201; 397 Little Neck Road; Virginia Beach, Virginia 23452. Ms. Marsh expects to receive her doctoral degree in clinical psychology in August, 1999.

Ms. Marsh completed her predoctoral internship in clinical psychology at Howard University Hospital in Washington, D.C. in 1993. After internship, she completed a two-year clinical psychology postgraduate fellowship at Howard University Hospital. The fellowship provided specialized training in providing psychological services to seriously mentally ill adults living in community residential facilities in Washington, D.C.

After completion of the fellowship and through the present, Ms. Marsh has worked as a case manager at Coates & Lane Enterprises in Washington, D.C. Coates & Lane Enterprises operates community residential facilities (CRFs) for mentally ill adults. As a case manager, Ms. Marsh provides psychological services to help residents of the CRFs stay out of long-term treatment at psychiatric hospitals and remain in the community.