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African-Americans and Comprehensive Service Use

Matthew T. Theriot, Ph.D.
Steven P. Segal, Ph.D.
Max J. Cowsert Jr., Ph.D.

ABSTRACT: This study examined African-Americans' use of comprehensive mental health services. 248 long-term users of self-help agencies (SHAs) were interviewed about their use of 37 different mental health services from various providers in a six-month period. Multiple regression analysis showed that the homeless and African-Americans were the high users in our sample. A subsequent MANOVA procedure suggested that this may be the result of African-Americans' increased use of SHAs. While African-Americans are low service users in traditional studies focusing on a narrow list of services and providers, this research argues for including SHAs in future studies of African-American service use.

KEY WORDS: self-help agencies; serving African-Americans; consumer-operated services; service utilization; community mental health agencies.

A substantial body of literature details disparities in the use of mental health services between African-Americans and whites living in the United States (Hu et al., 1991; Bosworth et al., 2000; O'Toole et al., 1999;

Matthew T. Theriot is Assistant Professor, College of Social Work, The University of Tennessee at Knoxville. Steven P. Segal is Professor and Director, Mental Health and Social Welfare Research Group, School of Social Welfare, University of California at Berkeley, and Center for Self-Help Research, Public Health Institute, Berkeley, California. Max J. Cowsert Jr., now deceased, is Former Research Associate, Mental Health and Social Welfare Research Group, School of Social Welfare, University of California at Berkeley.

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Address correspondence to Matthew T. Theriot, Ph.D., College of Social Work, The University of Tennessee, Henson Hall, Knoxville, TN 37996-3333.

Vernon & Roberts, 1982; Cooper-Patrick et al., 1999; Sue, McKinney, & Allen, 1976; USDHHS, 2001; Snowden & Cheung, 1990; Howard et al., 1996; Clark, 2001; O'Neill, 2001). An almost equivalent literature explores the influence of predisposing, need, and enabling factors on the use of mental health care services, where ethnicity is viewed as a predisposing factor in mental health service utilization (Andersen, 1968; 1995). Both research literatures, however, focus on a narrow list of services and service providers—usually community mental health center-based outpatient treatment. Communities, however, offer a broad array of biopsychosocial services from multiple service providers including the medical sector, social service agencies, self-help settings, other voluntary and religious-based organizations, as well as informal help sources. Research taking a broader focus on helping that comes from multiple sources in multiple settings may yield a very different picture of African-American service utilization than what has emerged from traditional studies focused on the outpatient mental health agency. This paper considers African-American service utilization of multiple types of behavioral helping from multiple sources. Helping is conceptualized to include all types of biopsychosocial offerings defining a comprehensive services package similar to that offered in a program for assertive community treatment (PACT) approach. The study evaluates differences in such utilization taking into account significant predisposing, need, and enabling factors believed to be important contributors to help seeking behavior (Andersen, 1969; 1995).

Within the help-seeking literature, some argue that need factors, or those conditions for which one seeks specific services, are perhaps the strongest factors impacting help seeking. For example, homelessness (a need factor) has been shown to predict return visits to a primary health clinic (Macnee & Forrest, 1997). Enabling factors, on the other hand, such as access to benefits and care, characteristics of the service system, and close proximity to treatment facilities, have also been found to be more important than other predisposing or need factors in predicting service use and provider choice (Gamache, Rosenheck, & Tessler, 2000). Nevertheless, the predisposing variable *ethnicity*, primarily being African-American, also consistently emerges as a significant factor in service utilization.

When compared to whites, African-Americans receive less or inadequate outpatient mental health care (Hu et al., 1991; Bosworth et al., 2000; O'Toole et al., 1999; Vernon & Roberts, 1982; Cooper-Patrick et al., 1999; Sue, McKinney, & Allen, 1976; USDHHS, 2001). Moreover, when African-Americans do receive outpatient mental health services,

such care is more often provided in an emergency mental health setting or by a primary care physician rather than in an outpatient community mental health setting. These services are usually brief and often considered less desirable than services from other, more specialized settings (Hu et al., 1991; Cooper-Patrick et al., 1999; Howard et al., 1996).

This theme of inadequate care and limited service use by African-Americans was recently highlighted with the publication of "Mental Health: Culture, Race, and Ethnicity," a report from the Office of the Surgeon General of the United States (USDHHS, 2001) and by the National Association of Social Workers Executive Director Elizabeth Clark in her call for social workers to address and overcome these disparities (Clark, 2001; O'Neill, 2001). While research addressing African-American service use often focuses on community mental health center-based outpatient services, the Surgeon General's Report identifies four major sectors that provide mental health care. These sectors include *the specialty mental health sector*, *the general medical and primary care sector*, *the human services sector* and *the voluntary support network* (p. 33; USDHHS, 2001). However, in discussing African-American service utilization, the Report only addresses the first three sectors and fails to look beyond the traditionally formal system of service provision. It does concede that African-Americans may make extensive use of alternative, or complementary, treatments for their mental health problems. Yet, the nature and type of these alternative treatments are not clearly defined.

This narrow focus is somewhat surprising for two distinct reasons. First, the gold standard of care for the seriously mentally ill is a comprehensive approach employed within the framework of the program for assertive community treatment (PACT). PACT is credited with providing effective treatment leading to reduced use of psychiatric hospitalization (Essock, Frisman, & Kontos, 1998; McGrew et al., 1995), reduced homelessness (Lehman et al., 1999), maintained employment (Becker et al., 1999), cost-effectiveness, and consumer satisfying care (Essock, Frisman, & Kontos, 1998; McGrew et al., 1995; Drake & Burns, 1995; Burns & Santos, 1995). Nonetheless, PACT has not been shown to improve the quality of life of minority groups (Phillips et al., 2001). Second, the Report does not recognize the recent proliferation of mental health self-help agencies and their important contributions to care. Often incorporated as voluntary agencies and run by former and current mental health consumers, these agencies now represent a new trend in the organized delivery of mental health services to agency members. More importantly, these mental health self-help agencies claim to serve

those populations that are not well served in more traditional mental health settings (Segal, Silverman, & Temkin, 1995a). For this reason, the omission of mental health self-help agencies from previous discussions of service providers and service use, especially African-American service use as described in the Surgeon General's Report, perhaps results from the absence of data on such utilization. This paper will help address this gap in the literature by addressing the importance of predisposing, need, and enabling factors in predicting the use of a comprehensive list of thirty-seven services provided at a variety of organizational settings including self-help agencies, social service agencies, community mental health centers, and medical settings. In this framework, a situation is created wherein individuals have the opportunity to choose the services and providers that they feel will best meet their needs. In essence, then, consumers are able to develop their own "PACT-like" comprehensive service model of care.

METHODS

Subjects and Study Sites

Utilizing four urban, client-run self-help agencies in the San Francisco Bay area, 310 long-term users of self-help were interviewed by mental health professionals or former mental health clients trained by the Center for Self-Help Research in Berkeley, California. Interview subjects included agency clients as well as agency staff and volunteers (who were also clients). "Long-term" use was defined as those persons who had visited their respective agency at least 12 times during the previous three-month period. In the month before the baseline interview, respondents visited the agencies an average of 16.6 times (Segal, Silverman, & Redman, 2000). Six months following this baseline interview, a follow-up interview was administered to 248 respondents. Our analysis measures service use at follow-up and, as a result, includes only those persons completing a follow-up interview. A more detailed outline of agency and client characteristics may be found in Segal, Silverman, and Temkin (1995a).

Criterion Measure: Comprehensive Service Use

Our Comprehensive Service Use Scale (see Table 1) is designed to incorporate those services typically provided in a PACT model of care, such as that reported by Phillips and associates (Phillips et al., 2001). Their list outlines 37 different services offered to the client, family and relatives, and PACT team members. Organized into nine areas, the types of service in this model are "Rehabilitative Approach to Daily Living Skills," "Family Involvement," "Work Opportunities," "Entitlements," "Health Promotion," "Medication Support," "Housing Assistance," "Financial Management," and "Counseling" (Phillips et al., 2001). Similarly, our list is also a collection of 37 diverse services. Services included in our list were matched based on category rather than on individual service type and an additional service category was added, "Social Activities." The

TABLE 1

Comprehensive Service Use Scale

Support Services/Living Skills
1. A meal or groceries
2. A bus pass or bus voucher
3. A place to take a shower
4. Free clothing
5. Free personal items (comb, soap, etc.)
6. Use of a telephone
7. A mailing address
8. A place to do laundry
9. A place to store stuff

Advocacy Services/Entitlements
10. Help dealing with government benefits
11. Help protecting patient rights in a mental health facility
12. Help getting services from a state agency or another social service agency
13. Help in accessing health care

Vocational Services/Work Opportunities
14. Help finding a Job
15. Placement in a sheltered workshop or supported employment setting
16. Training to develop a job skill

Housing Assistance
17. Help finding a short-term place to stay
18. Help dealing with landlord problems
19. Help finding a long-term place to stay
20. Help with rent or move-in costs
21. Placement in a board and care or other group living situation

Living Skills/Financial Management/Counseling
22. Representative payee or conservator for money management
23. Help in managing own money
24. Training in skills such as cooking or use of public transportation
25. Training or help in keeping home in good condition
26. Help in learning to get along better with people
27. Help in coping with psychological problems
28. Help in how to better shop for things
29. Help in improving appearance

TABLE 1 (*Continued*)

Social Activities
30. A place to drop in and hang out
31. Recreational activities such as parties, picnics, sports, or swimming

Health Care/Health Promotion
32. Visit doctor for physical health reasons
33. Visit a dentist
34. Stay overnight in a non-psychiatric hospital

Medication Support
35. Medication review with physician
36. Speak with doctor about changing dose or frequency of medication
37. Speak with doctor about changing medication

"Counseling" section was removed since these services were included under other headings. Likewise, to enhance our focus on the individual consumer, we have not included services that are provided to family or team members. This deletes the "Family Involvement" category from our list.

Since a multi-disciplinary team provides services in a formal PACT model, our list must also consider a variety of providers. Health care and medication support are medical services and, as a result, they are exclusive to a medical setting. All other services were provided either by a self-help agency, a community mental health center, a social service agency, or another formal organization. Services provided by family, relatives, or friends are excluded. Respondents were asked at follow-up if they had received each service in the period since the first interview and, if so, they were asked to specify provider. Services received from more than one agency type were marked for each provider. For our primary regression analysis, service utilization was measured without regard for provider or the number of times each service was received. This creates a 37-point scale that measures adherence to our comprehensive service model. Higher numbers on this scale reflect a higher level of service use. Further analysis will then explore the use of these services with an emphasis on agency type.

Independent Measures

Predisposing Factors. Fifteen predisposing, need and enabling variables were included in this analysis (see Table 2 for a complete variable list). All of these variables were created directly from respondents' answers to specific questions asked during the baseline interview. The eight predisposing variables were chosen to measure the importance of those pre-existing conditions affecting the use of services. These variables were selected to both control for basic demographic information as well as further test those findings reported in the help seeking research. The predisposing factors are ethnicity (African-American vs. other; 69% African American in our sample), gender (72.9% male), age ($\bar{x}$ = 38.9 years, standard deviation ± 8.31), and completed years of education ($\bar{x}$ = 12.58 years, s.d. ± 2.24). Other predisposing factors to be considered include being homeless within the previous five years (72.5%), childhood physical abuse (32.9%), childhood sexual abuse

TABLE 2

Regression Model Predicting Total Service Use (n = 228)

Independent Variables	*Beta Coefficient*	*Significance*	*95% Confidence Interval*	
Predisposing Variables				
African-American	2.474	.016**	.458,	4.49
Male	0.523	.605	–1.47,	2.51
Age	–0.026	.636	–.132,	.081
Education	0.031	.879	–.367,	.429
Homeless in Past Five Years	1.658	.110	–.378,	3.69
Physically Abused in Childhood	1.169	.278	–.949,	3.29
Sexually Abused in Childhood	1.382	.296	–1.22,	3.98
Lived Away from Home in Childhood	–1.186	.187	–2.95,	.580
Need Variables				
Currently Homeless	2.781	.003**	.962,	4.60
BPRS	–0.003	.951	–.082,	.077
Major Mental Disorder	1.242	.150	–.511,	3.31
Lifetime Diagnosis of Substance Abuse	1.359	.183	–.678,	3.53
Enabling Variables				
Weekly Attendance at Self-Help Agency	–0.019	.951	–.632,	.594
Organizational Empowerment Scale	–0.013	.917	–.261,	.234
MAPES	0.004	.955	–.147,	.155

Adjusted R^2 = .082
F = 2.348
Sig. = .004

**p < .05.

(16.5%), and living away from home before the age of eighteen years (foster homes, on one's own, in a group home, or with the juvenile authority; 60%).

Need Factors. Four need variables address immediate deficits or undesirable conditions for which the person might seek help: homelessness, severity of behavioral symptomology, major mental disorder, and substance abuse disorder. Specifically, respondents were identified as currently homeless if they reported living in a shelter, on the streets, or in their car. The level of literal homelessness in our sample is 40.8%. The level of psychological disability (if any) for each respondent was measured with the Overall & Gorham Brief Psychiatric Rating Scale (BPRS; $\bar{x} = 40.8$, s.d. $\pm$ 11.20; Overall & Gorham, 1962). And, the presence of a major mental disorder (27.5%) and/or a lifetime diagnosis of substance abuse (75.7%) were determined through the administration of the Diagnostic Interview Schedule (DIS). A diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or major depression was considered a major mental disorder (MMD), and all diagnoses were compiled into a single binary variable reflecting the presence of a MMD or not. Lifetime dependence on any substance included in the DIS survey was similarly coded into a single binary variable.

Enabling factors address issues of access, availability, and facilitation of comprehensive service utilization. Enabling factors in the model explore the SHA's role in promoting such service utilization. The number of days per week that one visits the SHA is a measure of accessibility. (The average member attended the agency 4.14 days per week (s.d. $\pm$ 1.44).) The Organizational Empowerment Scale ($\bar{x} = 4.81$, s.d. $\pm$ 3.89; $\alpha = .84$; Segal, Silverman, & Temkin, 1995b) measured the role of client involvement in service decisions as a factor enabling comprehensive service use. The Mutual Assistance Program Environment Scale (MAPES) assessed the SHA social climate as an enabler of such services utilization. MAPES scores yielded a mean of 37.5 (s.d. $\pm$ 6.08, $\alpha = .91$).

Data Analysis

Primary Analysis. The predisposing, need, and enabling variables are the independent variables in a multiple regression model to predict the use of services in our 37-point Comprehensive Service Use Scale. The model was run using a basic block "enter" method. This method allows for all fifteen independent variables to be entered and considered together without giving preference to any one variable. All variables in the model are reported in Table 2 although only those variables with a $p < .05$ are discussed as significant results. Individuals with missing information for any of the categorical variables were excluded listwise and not included in the regression analysis.

All continuous variables included in the regression equation were tested for normality and all generated both skewness and kurtosis values that fall within an acceptable range for inclusion in the analysis (George & Mallery, 2001). The values for each variable are as follows: age = .580 (skewness) and .527 (kurtosis); education = .280 and 2.55; BPRS = .945 and .990; weekly attendance at SHA = .094 and –.317; organizational empowerment scale = .507 and –.796; MAPES scale = –.162 and –.367.

Secondary Analysis. Significant predictors of service utilization in the regression model were then analyzed using the SPSS/GLM multivariate analysis of variance procedure. These tests are intended to further elaborate on the factors associated with service use in the regression model by identifying differences in the specific service providers from whom they sought services. This analysis includes five dependent variables that summarize the total number of services received from either a self-help agency, a community mental health center, a social service agency, a general medical setting, or an other, unspecified agency. The independent variables, taken from the primary regression model, include the interactions. Differences in mean service use are considered significant at the .05 level after a Bonferroni adjustment for multiple comparisons.

RESULTS

Table 2 summarizes the variables predicting service use assessed at six months after the baseline interview in the regression model (N = 228). Among the predisposing variables, African-American status is associated with higher service utilization than the other groups (African-American $\bar{x}_{\text{services used}} = 11.94$ [s.d. ± 6.91] vs. Other $\bar{x}_{\text{services used}} = 9.12$ [s.d. ± 5.38]). Likewise, from four need factors, current homelessness is associated with increased service utilization (Homeless $\bar{x}_{\text{services used}} = 12.88$ [s.d. ± 6.65] vs. Not Homeless $\bar{x}_{\text{services used}} = 9.60$ [s.d. ± 6.20]). No enabling variables are significant.

Pulling the two significant predictor variables from this regression model, the subsequent MANOVA (N = 235) made comparisons between African-Americans, the currently homeless, and the interaction of these two variables. The MANOVA main effects and interaction effect were significant: the African-American effect: Wilks' Lambda = .937, F = 3.03, df = 5,227, p = .011; the homelessness effect: Wilks' Lambda = .857, F = 7.58, df = 5,227, p < .0001; the interaction effect: Wilks' Lambda = .898, F = 5.13, df = 5,227, p < .0001. As summarized in Table 3, African-Americans used significantly more services from a self-help agency and significantly fewer services from a community mental health center. The homeless, on the other hand, received more services from a self-help agency, a social service agency, and other agencies. Furthermore, the homeless used more services from a community mental health center and fewer services from a general medical setting at a level that approached significance for both. Regarding the interaction term, there were two significant service providers for those persons who are both African-American and homeless—a self-help agency and a social service agency.

DISCUSSION

Many results from our primary and secondary analyses are consistent with reports from the literature. First, current homelessness emerges as a strong predictor of high service use. This finding is further strengthened because it does not draw exclusively on a sample of homeless persons. Consequently, we are able to better evaluate the impact of homeless status on service utilization rather than simply assuming that such status is important. This benefit also allows for subsequent comparisons between the homeless and the housed to detail specific differences in agency use. Likewise, the use of numerous service provid-

TABLE 3

MANOVA Pair-Wise Comparisons of Total Services Received from Different Agency Providers (N = 235)*

Agency	*Afr.-American Main Effect Afr.-Am.(Mean)-Other(Mean) Difference (SE) Sig.*+	*Homeless Main Effect Homeless(Mean)-Not Homeless (Mean) Difference (SE) Sig.*+	*AA & Homeless Interaction Effect AA & Homeless(Mean)-Not(Mean) Difference (SE) Sig.*+
Self-Help Agencies	1.40 (1.13) .006	1.44 (1.13) .003	1.52 (1.13) .000
Community Mental Health Centers	–1.15 (1.07) .028	1.12 (1.07) .088	1.02 (1.07) .808
Social Service Agencies	–1.16 (1.12) .202	1.77 (1.12) .000	1.43 (1.12) .002
Other Agencies	–1.19 (1.10) .073	1.25 (1.10) .020	1.06 (1.10) .542
Medical Setting	–1.03 (1.07) .680	–1.13 (1.07) .074	–1.13 (1.07) .069

*All five service providers were included as dependent variables in a single Multivariate Analysis of Variance (MANOVA) using SPSS' GLM Procedure. The independent variables were African-American (AA), Currently Homeless, and the Interaction of these two variables. Statistical assumptions for the procedure were met. The test may be considered robust based on Box's Test for Equality of Covariance Matrices ($p = .524$; Tabachnick & Fidell, 1996). Based on the significance of Levene's Tests for Equality of Error Variances and to meet normality assumptions, the five dependent variables were entered into the equation in their natural log form. The MANOVA main effects and interaction effect were significant: the African-American effect: Wilks' Lambda = .937, $F = 3.03$, $df = 5,227$, $p = .011$; the Homeless effect: Wilks' Lambda = .857, $F = 7.58$, $df = 5,227$, $p < .001$; the Interaction effect: Wilks' Lambda = .898, $F = 5.13$, $df = 5,227$, $p < .001$.

+ p-value significant at $\alpha \leq .05$ with a Bonferroni adjustment for multiple comparisons.

Chart and footnote design from Segal, Hardiman, and Hodges (2002).

ers further supports the notion that the homeless are generally high users across multiple settings.

The most important results of this study, however, concern African-Americans' use of services both in the aggregate and in agencies beyond the traditional mental health center. Regarding total service use, two points must be noted that are in contrast with both the Surgeon General's Report and other research. Specifically, African-Americans do not use less services and, more importantly, African-Americans instead use more total services even after controlling for a number of other potential factors. Furthermore, the greatest differences in service utilization appear to be driven by the higher use of self-help agencies. Therefore, one may speculate on two possible conclusions. First, African-Americans use less or receive less services from the more traditional mental health agencies because these agencies do not meet their specific needs or wants. Or, it may simply be that African-Americans are not, as commonly believed, low users of mental health care services. Rather, they receive such treatment in an environment that is relatively new, unique, and previously unresearched—the self-help agency.

An immediate critique of this study might question this emphasis on the importance of mental health self-help agencies. The argument may be made that, in a sample of long-term users of self-help agencies, one would expect the use of self-help services to be high. However, the counter to such a criticism reminds that, even in such a sample, African-Americans still utilize a significantly higher number of self-help services than their fellow self-help agency members. To better address this critique, though, this study should be replicated with members of other mental health or social service agencies who may also use self-help services. Additional research should also look at service use among new members of self-help agencies as well as at self-help agencies in other geographic locations. Finally, our research uses a comprehensive service model of care built around a PACT framework and not an actual PACT program. For this reason, research should still aim to test the effectiveness of such programs on ethnic minority groups and diverse populations.

CONCLUSION

This study shows that African-Americans use self-help agencies at a higher level than comparison groups do. For this reason, future discussions of African-American service utilization must consider the role

of self-help agencies in meeting the mental health care needs of this traditionally under-served or under-utilizing population. It is no longer adequate to state that African-Americans use fewer services at mental health and social service agencies and then add, as the Surgeon General's Report does, that "African-Americans are thought to make extensive use of alternative treatments for health and mental health problems" (p. 65; USDHHS, 2001). Instead, given the proliferation of formal self-help agencies, attention must be given to those service providers beyond the traditional mental health center, social service agency, or general medical setting. Self-help agencies must be included in future discussions of service utilization and, as a result, future research must aim to elaborate on the role of these agencies to both include and serve a diverse population.

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