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Barriers and Disparities in Mental Health Care:
Examining Service Utilization among African American Adolescents

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Barriers and Disparities in Mental Health Care: Examining Service Utilization among African American Adolescents

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Emory University, Emory College of Arts and Sciences
2023

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An abstract of
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Abstract

Barriers and Disparities in Mental Health Care:
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Background: Despite high rates of psychological distress among African American adolescents, they remain significantly underrepresented in mental health service utilization. This disparity is influenced by a combination of structural, cultural, and individual-level factors. Guided by Critical Race Theory (CRT) and the Andersen Behavioral Model of Health Services Use, this study explores how individual, community and systemic factors shape mental health service utilization among Black adolescents in the United States.

Methods: This study draws on data from the 2022 National Survey on Drug Use and Health (NSDUH), a cross-sectional survey designed to provide nationally representative estimates of substance use and mental health among the U.S. civilian, noninstitutionalized population aged 12 and older. The 2022 NSDUH employed multimode data collection, with respondents completing the survey either in person or online. This analysis focused on African American adolescents aged 12–17. Key variables were categorized based on the Andersen Behavioral Model's predisposing, enabling, and need factors. Descriptive and bivariate analyses were used to examine sample characteristics and patterns of mental health service use.

Results: While none of the predisposing or enabling factors were significantly associated with mental health service utilization, nearly all need factors showed significant associations with service use. In contrast, for unmet mental health needs, most enabling factors and nearly all need factors were significantly associated. Gender ($p < .0001$) was the only predisposing factor significantly associated with unmet mental health needs.

Conclusions: These findings from this study highlight a critical gap between the mental health needs of African American adolescents and their use of available services. Despite clear indicators of emotional distress, many adolescents still do not access care. This suggests the presence of barriers that go beyond individual willingness or awareness. Addressing these disparities requires culturally responsive strategies that build trust, increase access, and reduce stigma. By informing policy, practice, and community-based approaches, these results emphasize the urgent need for mental health systems to be more inclusive, proactive, and aligned with the lived experiences of Black youth.

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Introduction

Background

Adolescence is a pivotal stage for enhancing health and preventing disease. This stage of life involves significant transitions across various domains: physical, social, emotional, cognitive, and intellectual (Caldwell et al., 2016). While rapid development in these areas offers opportunities for substantial growth, it can also unfold at varying rates, leaving adolescents more vulnerable to risky behaviors and emerging mental health challenges. To effectively support adolescent health and development, those working with youth must have a deep understanding of adolescent growth, environmental influences, and the risk and protective factors that shape well-being (Salam et al., 2016; "Protecting Youth Mental Health: The U.S. Surgeon General's Advisory", 2021).

In particular, adolescence is the period in which both health-promoting and health-impairing behaviors are established. Risk-taking behaviors and unhealthy lifestyle choices during this time are key contributors to future health problems, laying the foundation for long-term morbidity and increased health care use (Vingilis et al., 2006). According to The Health Resources and Services Administration (HRSA), over 5.3 million adolescents, aged 12–17, had a diagnosed mental or behavioral health condition in 2023 (Sappenfield et al., 2024); however, mental illnesses in adolescents frequently remain undiagnosed, partly because adults anticipate turmoil during adolescence (Caldwell et al., 2016). Mental health disorders are a growing concern among U.S. adolescents, with an estimated 1 in 5 teens experiencing a diagnosable mental health condition and 1 in 10 facing significant impairment ("Mental Health Disorders in Adolescents", 2017). Recent data from the HRSA further highlights this trend, estimating that the prevalence of diagnosed mental or behavioral health conditions among adolescents increased

by approximately 35% between 2016 and 2023 (Sappenfield et al., 2024). Despite the availability of effective treatments, only one-third of these adolescents receive the care they need, indicating a significant gap in the use of mental health services ("Mental Health Disorders in Adolescents", 2017). Mental disorders during adolescence are defined as serious deviations from expected cognitive, social, and emotional development, encompassing conditions like anxiety, depression, and developmental delays. When left untreated, these disorders can escalate, leading to detrimental outcomes such as poor academic performance, substance misuse, self-harm, persistent physical illnesses, and suicidal thoughts or behaviors (Lu et al., 2021).

Mental Health in African American Youth

Within this broader context, Black adolescents face unique challenges in mental health. Compared to their White peers, African American teens are disproportionately exposed to environmental stressors, such as under-resourced communities and the emotional toll of racism and prejudice. These factors have been linked to higher rates of anxiety, depression, and other emotional difficulties (Caldwell et al., 2016). According to research conducted since the early 2010s, Black adolescents are increasingly experiencing mental health issues, including depression and suicide attempts (Rose et al., 2012). Between 2007 and 2020, the suicide rate among Black adolescents aged 10 to 17 rose by 144% (Cubbahe & Adams, 2023). Racial and ethnic disparities in mental health outcomes have remained persistent, with nearly 47% of African American respondents in the National Comorbidity Survey-Adolescent Supplement reporting a mental health disorder before the age of 18 (Planey et al., 2019). Similarly, the Youth Risk Behavior Surveillance System indicates that Black students attempt suicide at higher rates than their White counterparts (Centers for Disease Control (CDC), 2023; Planey et al., 2019). Despite these alarming trends, access to mental health care remains a major challenge. Nearly

75% of Black adolescents in need of mental health services do not receive them, and studies show that between 50% and 75% of Black youth in urban areas who require care do not obtain it (Planey et al., 2019). These disparities highlight the critical need to address systemic barriers and improve access to mental health services for Black adolescents.

Racial Disparities in Mental Health

The mental health burden among African American adolescents represents a critical public health issue. While 20–50% of teens generally receive mental health services, nearly three-quarters of Black adolescents do not get the care they need, despite experiencing similar or higher rates of mental health disorders compared to their White peers (Byck et al., 2014; Opara et al., 2022; Planey et al., 2019). These disparities are exacerbated by systemic factors, such as case workers being less likely to refer Black children for mental health services compared to children from other racial groups. These disparities persist even among Black adolescents who are insured and live near mental health professionals (Planey et al., 2019). Research indicates that Black youth in areas with higher proportions of Black residents are still less likely to initiate or sustain mental health service use, despite having greater access to mental health specialists (Cook et al., 2017). Several factors contribute to this gap, including limited access to culturally competent care, negative perceptions of mental health services, and systemic barriers rooted in both historical and contemporary racism (Planey et al., 2019). The consequences of untreated mental health issues among Black adolescents are severe. Research shows that unmet mental health needs during adolescence significantly increase the likelihood of poor health outcomes in adulthood, with the odds of negative outcomes rising by 13 to 52% compared to those who received timely care (Planey et al., 2019). Addressing these disparities is essential for improving long-term health and well-being for African American adolescents.

Theoretical Framework

This research is based on two key frameworks: Critical Race Theory (CRT) and the Andersen Behavioral Model of Healthcare Use. CRT, which emerged as an intellectual and social movement in the 1970s, challenges the idea that racism is merely an individual act of prejudice (Ellingwood, 2021; Ravitch, 2021). Instead, it emphasizes that racism is embedded within societal structures, systems, and institutions. Several core principles of CRT shape my analysis. First, the concept that "racism is endemic" highlights how racial inequality is structurally ingrained, and influences access to resources, including healthcare. Second, CRT's principle of intersectionality shows how race, class, gender, and age intersect, compounding the disadvantages that African American adolescents face when seeking mental health care. Lastly, CRT critiques the assumption that laws and policies are neutral, revealing how they often reinforce systemic racism and perpetuate disparities in mental health care access and outcomes (Graham et al., 2014; Ravitch, 2021). Applying CRT to mental health disparities reveals how structural racism in healthcare contributes to unequal access and suboptimal treatment for African American adolescents. For instance, cultural mistrust, rooted in both historical and contemporary experiences of racism, fosters deep-seated skepticism toward mental health institutions, deterring African American adolescents from seeking services and worsening existing disparities (Breeland-Noble, 2004).

The Andersen Behavioral Model of Healthcare Use complements CRT by offering a framework to examine the factors influencing healthcare utilization (Ford & Airhihenbuwa, 2009; Krzyz et al., 2023). This model categorizes determinants of health service use into three factors: predisposing characteristics, enabling resources, and perceived needs. Predisposing characteristics include demographic and social factors, such as race, social status, and health

beliefs, which can shape healthcare utilization patterns. Enabling resources encompass individual- and community-level factors, such as availability of medical facilities, health insurance, or transportation, that affect access to care. Finally, perceived and evaluated needs relate to how individuals perceive their own health and how medical professionals assess their conditions, determining the extent of care they seek and receive (Chen et al, 2021). Among African American adolescents, these factors can manifest as unrecognized or unaddressed mental health needs, limited access to culturally competent providers, and internalized norms that discourage emotional vulnerability, etc. By applying The Andersen Behavioral model, it would be clearer to identify the interplay between individual, social, and structural factors that create barriers to mental health service utilization, and ultimately inform interventions aimed at improving access and equity in care.

Rationale and Significance of the Health Topic

The significance of this research project lies in its potential to address critical mental health disparities among African American adolescents, a demographic that has historically faced systemic barriers to care. Adolescence is a critical period for mental health, and the increasing rates of mental health disorders among Black youth demand urgent attention. By investigating the barriers to mental health care access, utilization, and treatment outcomes, this research aims to shed light on the unique challenges faced by Black youth in receiving the mental health services they need. Mental health disparities in this population not only perpetuate cycles of poor health and social outcomes but also highlight the broader inequities in the healthcare system. This project will contribute to the growing body of knowledge necessary for advancing health equity and social justice by addressing these longstanding inequities.

This research is also positioned to have a broader impact on policy development and clinical practice. By identifying the key barriers that prevent African American adolescents from accessing mental health care, the findings can inform policies aimed at improving service delivery, expanding access to culturally competent care, and ensuring that mental health interventions are effective for all adolescents, regardless of race. Clinically, the study's insights could lead to more tailored approaches to care that take into account the specific cultural and social contexts of Black youth, fostering trust and engagement with mental health services. Ultimately, this work seeks to create pathways for more equitable mental health care, with the potential to positively affect the lives of African American adolescents and reduce the disparities that contribute to ongoing cycles of disadvantage.

Purpose Statement

This research seeks to address the significant racial disparities in mental health outcomes and service utilization among African American adolescents. Despite growing awareness of the mental health challenges faced by youth, African American adolescents continue to experience disproportionately low rates of service use, even when in need of care. Guided by this concern, the study aims to examine the barriers that African American adolescents face in accessing and utilizing mental health services, including both individual-level factors and systemic barriers. Additionally, this research explores whether addressing these barriers could lead to an increase in mental health service utilization among African American adolescents. By identifying and analyzing these challenges, this research study seeks to answer the following questions:

1. What barriers do African American adolescents face in accessing and utilizing mental health care?

2. Can addressing these barriers increase the utilization of mental health services among African American adolescents?

By shedding light on these barriers, this study aims to contribute to the larger public health goal of reducing health inequities and promoting the well-being of marginalized populations. Mental health disparities are a reflection of broader systemic inequalities that perpetuate poor health outcomes for African American adolescents. This research will investigate the factors behind the underutilization of mental health services, with the aim of identifying pathways to more equitable care and better outcomes for this population. The findings will provide critical insights to support advocacy and inform strategies for building a more inclusive and equitable healthcare system.

Literature Review

Adolescent Mental Health

Adolescence is a critical period for mental health, yet a significant number of U.S. teens struggle with untreated mental health disorders. Approximately half of all adolescents experience some form of mental health issue before reaching adulthood (Algería et al. 2015; Lu et al., 2021). Among these, anxiety, mood disorders, ADHD, and behavioral disorders are most common ("Mental Health Disorders in Adolescents", 2017), often leading to poor academic performance, family conflict, contact with the justice system, risky behaviors, and even suicidality as suicide remains the second leading cause of death for individuals aged 15–24 ("Mental Health Disorders in Adolescents", 2017; Planey et al., 2019; Schwartz, 2009). When left untreated, these issues can affect adolescents long into adulthood, hindering their social mobility, educational attainment, and employment opportunities, and raising their risk for chronic physical health problems (Asari & Caldwell, 2017; Caldwell et al., 2016; Lu et al., 2021).

Despite the prevalence of these disorders, many adolescents do not receive the mental health services they need, with Black youth experiencing some of the greatest disparities in care. Factors like misdiagnosis, negative perceptions of mental health services, stigma, and limited access to culturally competent care contribute to this gap (Caldwell et al., 2016). Research shows that unmet needs as a child have been shown to increase the likelihood of negative health outcomes as an adult by 13 to 52% compared to individuals who do not have unmet needs (Planey et al., 2019). Additionally, Black adolescents are more likely than their White peers to be subjected to disciplinary action for behaviors that may stem from mental health struggles, often being routed into the juvenile justice system instead of receiving therapeutic support. This disparity is influenced by factors such as parental attitudes and beliefs, insurance coverage, and

the availability of culturally competent services (Lu et al., 2021; Planey et al., 2019). However, supportive family and school environments can help mitigate these risks, emphasizing the need for early detection and intervention (Alegria et al., 2015; Caldwell et al., 2016; Planey et al., 2019; Williams et al., 2023). In order to effectively address these disparities and foster resilience in all adolescents, especially those from marginalized households, it is essential to expand access to high-quality, culturally sensitive mental health care (Lu et al., 2017; Williams et al., 2023).

Mental Health Burden among African American Adolescents

African American adolescents face a unique and complex set of challenges in the realm of mental health. As of 2018, Black youth experience behavioral and conduct disorder diagnoses at substantially higher rates than their white peers; yet nearly three-quarters of Black children do not receive the services needed to address these issues (Planey et al., 2019). This limited access to mental health treatment, compounded by the misdiagnosis and overdiagnosis of certain disorders, such as psychotic and disruptive behavioral disorders, and the underdiagnosis of others, like mood and anxiety disorders, has made African American youth an especially vulnerable population (Assari & Caldwell, 2017; Liang et al., 2016; Opara et al., 2021). Despite this, research focused specifically on African American adolescents remains limited. The few nationally representative studies that do exist often fail to account for the diversity within the African American community itself. This lack of targeted research underscores the need for a deeper, more nuanced understanding of the mental health challenges facing African American adolescents (Caldwell et al., 2016).

The mental health landscape for these adolescents is shaped by multiple risk factors, with environmental stressors like racism, discrimination, limited resource access, and exposure to community violence increasing their vulnerability (Lindsey et al., 2013; Opara et al., 2021).

Additionally, historical trauma linked to the mistreatment of Black communities within the U.S. mental health system continues to impact Black adolescents today, contributing to symptoms of psychological distress and a reluctance to seek care (Assari & Caldwell, 2017). This creates a heavy emotional burden and compounds the stress African American adolescents face on a daily basis.

In regard to specific mental health disorders, African American adolescents face elevated risks in some areas. Depression, for instance, shows mixed prevalence findings, with some studies indicating higher rates compared to other racial/ethnic groups, while others show similar levels (Caldwell et al., 2016). Anxiety is also notably prevalent, with national data indicating that African American adolescents may experience anxiety at higher rates than their White peers. Yet, the rising number of Black teenage suicides is arguably the most alarming. According to the CDC, suicide is the third most common cause of death for children aged 10 to 19, with African American and other ethnically diverse youths experiencing the largest rise in suicide rates over the past ten years (Caldwell et al., 2016; Williams et al., 2023). The Emergency Task Force on Black Youth Suicide and Mental Health reports that suicide attempts among Black teenage males have surged by 122% since 1991, while overall suicide attempts among Black adolescents have risen by more than 75% (Williams et al., 2023). These trends highlight an urgent need for a deeper understanding of the factors contributing to this mental health crisis among African American adolescents.

Individual Level Factors Affecting Black Teens' Mental Health

The mental health of Black teens is shaped by a complex web of individual-level factors that interact with broader social, economic, and cultural contexts. These factors do not operate in

isolation; instead, their impact is often influenced by the unique circumstances and experiences of each individual, which can vary widely across different environments. Understanding these personal influences provide crucial insight into how Black adolescents experience and respond to mental health challenges, as well as the ways in which they navigate their mental well-being in the face of various societal pressures.

Age is a critical factor in the mental health of Black teens, as adolescence is a time marked by rapid biological, physical, and social changes. This developmental stage is inherently vulnerable, as teenagers are particularly susceptible to mental health challenges due to the emotional and psychological transformations they experience (Caldwell et al., 2016). Black youth may experience increasingly complicated pressures as they become older as they are faced with increasing responsibilities, expectations around their identities, and considerations of their future roles in society. These challenges can create an environment where mental health struggles may go unrecognized or untreated as the adolescent navigates growing independence and the desire to meet external expectations (Salami et al., 2022).

Gender further shapes the mental health experiences of Black adolescents, particularly for Black teenage boys. While there is limited data on gender differences within this population, existing research suggests that Black boys may experience greater pressure to handle mental health challenges independently. This is often tied to cultural norms around masculinity and self-reliance, which discourage emotional vulnerability and seeking external support. In many cases, the tendency to internalize struggles, such as anxiety, sadness, or stress, can prevent Black teen boys from seeking help, as it becomes ingrained in their identity that strength and vulnerability are mutually exclusive (Lindsey et al., 2017; Williams et al., 2023). This internalized pressure to

"tough it out" can hinder their ability to address mental health issues in a healthy, proactive manner.

Ethnicity adds another layer of complexity to the mental health experiences of Black teens. The diversity within the Black population means that cultural influences can vary widely across different ethnic backgrounds, such as African American, Caribbean, and African immigrants. African and Caribbean Black teens, for example, may have distinct cultural values and experiences that shape how they perceive and respond to mental health challenges (Assari & Caldwell, 2017). These ethnic differences can affect everything from how mental health symptoms are expressed to the willingness to seek help from formal mental health services. As such, culturally specific approaches to mental health care are essential for addressing the unique needs of Black youth from diverse ethnic backgrounds (Jackson et al., 2007; Williams et al., 2007). One factor that can act as a protective influence is a strong sense of ethnic identity. Research suggests that adolescents with a strong connection to their ethnic roots may experience better mental health outcomes, as ethnic identity provides a source of resilience (Williams et al., 2018). This sense of belonging and pride can serve as a positive framework for navigating challenges. However, the relationship between ethnic identity and mental health remains an area of ongoing research, and further studies are needed to fully understand its impact.

Trauma exposure is another significant individual-level factor that deeply affects the mental health of Black teens. Experiences of violence, racism, and discrimination, whether at home, school, or community, can have long-lasting psychological effects on adolescents (Boyd et al., 2022). These traumatic experiences are often linked to heightened levels of anxiety, hypervigilance, and symptoms associated with post-traumatic stress disorder (PTSD). When trauma is left unaddressed, it can create a chronic emotional burden that limits a teen's ability to

process and cope with their feelings. For Black teens, repeated exposure to trauma may not only shape their mental health but also affect how they perceive their own identity and how they relate to others. These experiences of racial discrimination and violence can undermine self-esteem and hinder emotional well-being, making it more difficult for Black youth to seek help or trust the systems that are intended to support them (Harris-Britt et al., 2007). Without adequate resources and support, trauma can become a persistent challenge, influencing both immediate and long-term mental health outcomes.

Together, these individual-level factors play a pivotal role in shaping the mental health experiences of Black teens. Their interactions with societal and cultural forces can create unique challenges that influence how mental health struggles are understood, expressed, and addressed.

Mental Health Service Use among African Americans

While these individual-level factors highlight the unique mental health challenges that Black adolescents face, systemic issues in mental health service access further compound these difficulties, limiting their ability to receive adequate support and care. In one study, African American youth were found to receive significantly less specialty mental health care than their white peers, with lower treatment completion rates (33.5% vs. 45.1%) and, in some cases, spending 50% less time in treatment (Alegría et al., 2011). Furthermore, African American adolescents access fewer mental health services across most sectors, with schools as a key exception. Many Black teens disproportionately enter mental health services through specialized channels, such as the juvenile justice system, at a ratio of 3:1 compared to their White peers. Additionally, disparities persist not only in initial access to care but also in treatment completion and service quality (Cadwell et al., 2016; Williams et al., 2023). Black teens who skip, delay, or

prematurely discontinue mental health treatment face higher risks of negative outcomes, such as academic challenges, family conflicts, juvenile detention, suicidal behavior, or worsening symptoms.

Research suggests that underutilization among African American youth may be influenced by alternative coping mechanisms, such as prayer and religious practices, reluctance to "medicalize" emotional and behavioral issues and financial barriers, such as insurance limitations and the ability to pay out of pocket (Cadwell et al., 2016). However, even when controlling for socioeconomic variables, such as insurance, African American youth continue to show disproportionately low rates of treatment use. Therefore, reducing these racial disparities in mental health care and addressing the effects of unmet mental health needs will require addressing both the barriers and facilitators of mental health service use among African Americans (Planey et al., 2019).

Barriers and Facilitators for Mental Health Service Use

The barriers and facilitators to mental health service use among African American adolescents are shaped by a complex mix of cultural, social, and systemic factors. Barriers are obstacles that prevent individuals from seeking, receiving, or completing mental health care. These can range from personal concerns to broader clinical and systemic issues. For African American adolescents, several barriers have been identified in the literature, including cultural stigma, self-reliance, mistrust of clinicians, limited access to resources, transportation challenges, and economic difficulties (Lu et al., 2021; Planey et al., 2019). These factors not only impede access to care but also affect the quality and continuity of mental health services.

One of the most significant barriers is the stigma surrounding mental health. For many Black adolescents, mental illness is often viewed as a source of shame, with societal expectations emphasizing strength and self-sufficiency (Caldwell et al., 2016; Lu et al., 2021; Planey et al., 2019). This internalized stigma can be particularly powerful, as it discourages open conversations about mental health, further isolating teens who may already feel misunderstood or unsupported. In many Black communities, the fear of being perceived as weak or different exacerbates this stigma, making it even harder for adolescents to reach out for help. Consequently, the silence around mental health struggles can prevent teens from accessing the care they need.

Mistrust of the healthcare system also plays a critical role in deterring Black adolescents from seeking mental health services (Planey et al., 2019; Williams et al., 2023). This distrust is often rooted in both historical injustices, such as the Tuskegee Experiment, and ongoing personal experiences with discrimination or mistreatment. Black teens may fear that mental health providers will not understand their experiences, or worse, that they may be dismissed or misunderstood. This fear can cause them to avoid seeking professional help altogether, believing that their needs will not be taken seriously. Furthermore, skepticism about the effectiveness of mental health treatment compounds these concerns, making it more likely that Black adolescents will turn to informal or alternative coping mechanisms rather than engaging with the formal healthcare system.

In addition to these cultural and social barriers, personal beliefs and attitudes also influence mental health service utilization. For example, many Black adolescents internalize cultural values that emphasize independence and resilience, viewing mental health struggles as personal challenges to overcome rather than issues that require professional intervention (Planey

et al., 2019). This mindset can delay help-seeking behaviors or lead to outright avoidance of treatment. However, when distress becomes overwhelming, particularly when it manifests as poor self-rated health (SRH), it can override these norms and prompt some adolescents to seek support (Lu et al., 2021). In this way, perceived physical or emotional unwellness may serve as a critical point of intervention, offering a window for mental health engagement even within a context of cultural self-reliance.

While barriers pose significant challenges, there are also key facilitators that can increase the likelihood of African American adolescents seeking and receiving mental health care. Facilitators are elements that make it easier for individuals to access, engage with, and complete mental health services. Social support, positive past mental health experiences, and guidance from mental health professionals all play a significant role in facilitating mental health service use (Lu et al., 2021; Planey et al., 2019).

A strong social support network is one of the most essential facilitators for Black youth in accessing mental health care. Adolescents are more likely to feel at ease with the idea of treatment when friends, family, or community leaders support them in doing so. This support is especially influential when parents actively encourage mental health care, as many Black parents encourage their children to seek support from extended family and trusted community members (Lu et al., 2021; Planey et al., 2019). This encouragement creates an environment where mental health care is seen as an acceptable and valuable resource, rather than something to be avoided or hidden. Additionally, action in the form of providing referrals plays a crucial role in facilitating access to care. Many Black adolescents enter mental health services due to referrals, with parents and schools often leading the way in encouraging their children to seek professional help (Algería et al., 2012; Lu et al., 2021; Planey et al., 2019). In fact, a study found that among

African American adolescents with elevated depressive symptoms who were receiving treatment, nearly 70% had been referred or mandated by their parents (Planey et al., 2019). These referrals can normalize the process of seeking mental health care and provide adolescents with the guidance they need to access appropriate services.

Religion and spirituality, which can sometimes act as barriers due to their association with stigma, can also serve as powerful facilitators. For some Black adolescents and their families, faith plays a critical role in their coping mechanisms (Planey et al., 2019). When mental health providers recognize and respect the role of spirituality in a teen's life; it can help bridge the gap between faith-based beliefs and mental health care. Incorporating spiritual beliefs into treatment can enhance engagement with care, particularly for those who may view religion as an integral part of their healing process.

Geographic location also plays a key role in facilitating access to mental health services. Black adolescents in urban areas are more likely to receive mental health support due to the greater availability of mental health professionals in these regions (Lu et al., 2021; Planey et al., 2019). This access disparity highlights the need to address geographic inequities in mental health care, as those living in rural or underserved areas may face significant challenges in accessing services. Expanding access to mental health professionals and services in these areas is crucial to ensuring that all Black adolescents, regardless of location, can receive the support they need.

The factors that either hinder or facilitate mental health service use among Black adolescents are complex and multifaceted. Addressing these barriers while strengthening facilitators is essential for creating a mental health system that resonates with Black teens and supports their unique needs.

Theoretical Framework

This study's design was guided by the frameworks of the Andersen Behavioral Model of Healthcare Use and Critical Race Theory. Both theories served as a guide for my research's design and analysis as they offer complementary frameworks for investigating and understanding mental health service utilization among African American adolescents. Using these models, my research explores how both systemic inequities and individual-level determinants interact to affect mental health service use. This combined approach allows for addressing the unique challenges African American adolescents face within the healthcare system, as well as to propose targeted strategies that promote equitable access to mental health care.

Core Tenets of Critical Race Theory

Critical Race Theory (CRT) provides a powerful framework to explore the influence of systemic racism and intersectionality on health disparities, particularly within marginalized communities (Graham et al., 2011). This perspective illuminates how racial and ethnic inequities in health access and outcomes are perpetuated by ingrained structures and practices, revealing the root causes of these disparities by unpacking concepts like race consciousness, the social construction of race, and the centrality of marginalized voices in research and practice.

At its core, CRT challenges colorblind ideologies, urging us to recognize the significance of race in shaping social and institutional structures. The tenet of race consciousness argues that dismissing or ignoring race upholds existing inequalities; recognizing race's persistent role in social systems is crucial for understanding and addressing health disparities. Another key CRT principle is *Centering the Margins*, which shifts the focus to the lived experiences of marginalized groups, often excluded from mainstream narratives. By prioritizing these

perspectives, CRT challenges dominant research paradigms and sheds light on the unique challenges faced by communities of color in healthcare access, quality, and outcomes.

CRT also highlights the social construction of race, rejecting race as a biological or fixed category. Instead, race is understood as a socially constructed tool used to maintain power hierarchies and justify discrimination. This perspective is essential for analyzing how racial categories impact healthcare, as the historical and ongoing social construction of race shapes resource allocation, policy development, and treatment practices. Further, intersectionality acknowledges that people have multiple, intersecting identities, such as race, gender, and socioeconomic status, which together shape their unique experiences of oppression and privilege (Bowleg, 2021; Critchlow, 2015). This framework underscores the need to examine how these identities contribute to health disparities.

For this analysis, CRT provides a lens to examine how historical and ongoing forms of discrimination, cultural mistrust, and intersecting identities (like race, gender, and socioeconomic status) impact mental health access and outcomes. Additionally, It supports the justice-oriented approach to your research as CRT calls for an active commitment to social justice and encourages researchers and practitioners to work toward dismantling oppressive systems.

The Andersen Behavioral Model of Healthcare Use

The Andersen Behavioral Model of Healthcare Use provides a comprehensive framework for understanding the various factors that influence individuals' decisions to seek health services, including mental health care (Chen & Gu, 2021; Alkhawaldeh et al., 2023). According to the model, healthcare utilization is determined by three main components: predisposing characteristics, enabling resources, and need factors (Anderson, 1995). This model is particularly

valuable for understanding the disparities in mental health service utilization among Black adolescents. It has been adapted over time to better address the unique needs of vulnerable populations. The original model focused on individual characteristics and immediate resources, but the updated model incorporates broader contextual factors and the social determinants of health, offering a more comprehensive understanding of healthcare utilization, especially for groups facing systemic challenges. This modified framework, referred to as the Behavioral Model for Vulnerable Populations, provides valuable insights into the barriers to healthcare faced by marginalized groups, including racial minorities, low-income individuals, and people in underserved communities (Small, 2010).

The updated model introduces contextual characteristics to encompass community-level influences that go beyond an individual's control, shaping healthcare access in powerful ways. These characteristics include structural elements like socioeconomic conditions, cultural norms, and the organization of healthcare systems, which affect access and utilization by shaping community-wide attitudes and resources for health-seeking. This expanded perspective shows that access to healthcare depends not only on personal resources but also on community conditions that can either promote or hinder help-seeking behaviors (Small, 2010).

In this model, predisposing characteristics are broadened to include community demographic composition and societal health beliefs, highlighting how cultural and demographic landscapes influence personal health decisions. Enabling resources are also reconceptualized, extending beyond individual or family resources to incorporate systemic factors such as health policies, healthcare financing, and community infrastructure like transportation. This broader view of resources recognizes that healthcare access is shaped by the collective structures supporting or limiting community members. Need factors are also expanded in this model,

accounting for both the perceived and evaluated need for healthcare at individual and community levels. This is especially relevant for vulnerable populations, as certain health needs, particularly mental health concerns, may be less visible or prioritized within these groups. The Behavioral Model for Vulnerable Populations places an explicit focus on health equity, aiming to reveal and address disparities by examining how structural inequities restrict access to care. With its emphasis on interventions, this model not only describes healthcare utilization patterns but also guides the design of targeted, actionable solutions that reduce disparities and improve access for underserved groups (Small, 2010).

Methods

Study Overview

This study is an exploratory investigation aimed at addressing disparities and barriers in mental health care. Through an in-depth analysis of the data, the study sought to uncover patterns, identify key factors, and provide insights into mental health service utilization among African American adolescents. By using a combination of descriptive and analytical methods, this approach allowed for a comprehensive exploration of the barriers affecting service utilization.

To operationalize exposures and outcomes, I organized the measures through the lens of the Andersen Behavioral Model of Healthcare Use. By structuring the data in this way, the model helps reveal the complex interplay between structural barriers and individual experiences, offering a clearer understanding of the factors contributing to disparities in mental health care access and utilization.

Study Design

This study is a secondary analysis of data collected for The 2022 National Survey on Drug Use and Health (NSDUH). The NSDUH is a survey conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA). This survey collects data from a large and dispersed sample of the civilian, noninstitutionalized population of the United States aged 12 years or older. The primary purpose of the NSDUH is to measure the prevalence and correlates of substance use and mental health issues in the United States. The survey began in 1971 and was conducted periodically until 1990, after which it has been administered annually. Data were collected through in-person interviews, most of which are administered with Audio Computer-Assisted Self-Interviewing (ACASI).

The NSDUH incorporates youth-specific measures, like the adolescent depression module, to assess mental health issues relevant to this age group. The survey also includes detailed information on mental health service utilization, covering various aspects, such as types of services received, reasons for not seeking treatment, and perceived barriers to access. These data points are crucial for understanding the unique challenges faced by African American adolescents in accessing mental health care.

Population and Sample

NSDUH Sampling Approach

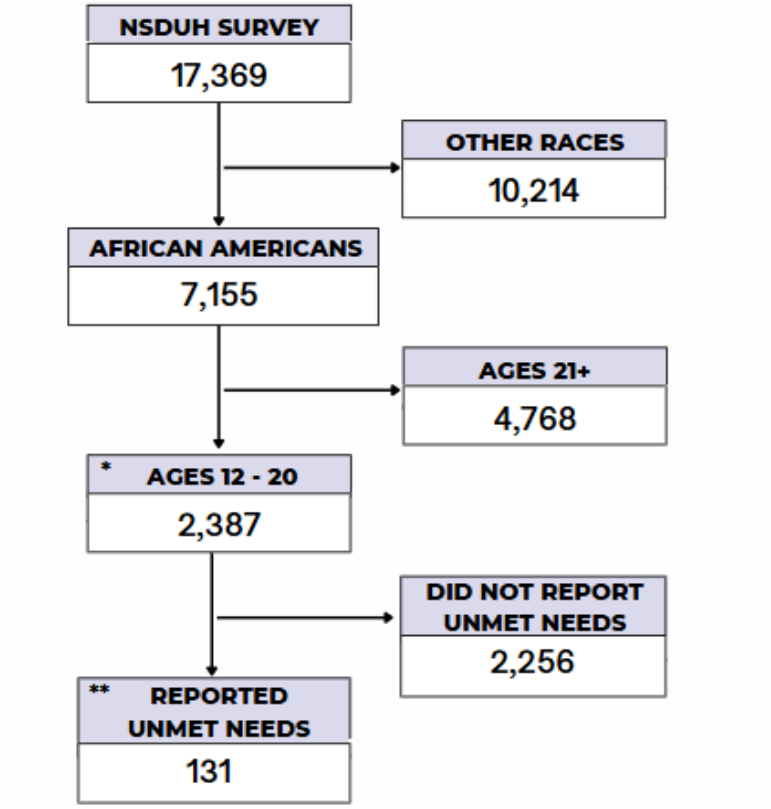
The 2022 NSDUH utilizes a state-based, multistage area probability sample design, which has been implemented for the 2014-2022 NSDUHs. The sample selection process for the NSDUH involves five stages to ensure a representative sample of the target population. First, the U.S. is stratified by states and divided into approximately 750 State Sampling Regions (SSRs). Within each SSR, 48 census tracts are selected as primary sampling units (PSUs) using a size-based probability approach, with minimum dwelling unit (DU) requirements set according to urban or rural classification and state size. Next, a census block group is chosen within each selected census tract, serving as segments for address-based sampling or field enumeration. In the fourth stage, DUs are selected based on factors like target age group sample sizes, eligibility, and expected nonresponse rates. Finally, up to two residents aged 12 or older from each selected DU are chosen for interviews through a random process guided by state and age-specific sampling rates.

The NSDUH sample is designed to be a representative sample of the civilian, noninstitutionalized population of the United States aged 12 or older. The sample size achieved for the 2022 NSDUH is 71,369 individuals.

Secondary Analysis of Sample and Population

This sample consists of 2,388 African American adolescents. According to the World Health Organization, adolescence is the phase of life between childhood and adulthood, from ages 10 to 19. However, there is no universal consensus on when adolescence ends. Some researchers consider it to end at age 18, while others consider it to extend to age 24 (Sawyer et al., 2018; Backes & Bonnie, 2019). For the purpose of this study, adolescents are defined as youth aged 12 to 20 years hence the study population was a sample of African American adolescents, between the ages of 12 and 20. From this sample, an analytic subsample of 131 African American adolescents who reported having unmet mental health needs was identified for further analysis.

Figure 1. Flow Chart of Research Methodology



***Study Sample**
****Study Sub-sample**

Data Collection Procedures

The NSDUH primarily uses in-person interviews and audio computer-assisted self-interviewing (ACASI) to collect data. The 2022 NSDUH utilized a multimode data collection approach, allowing respondents to participate either via the web or through in-person interviews. This approach was implemented in 2020 due to the COVID-19 pandemic and continued in 2022 to maintain comparability.

The NSDUH data were accessed through the Substance Abuse and Mental Health Data Archive (SAMHDA), where the dataset is made publicly available. These data can be downloaded in various formats, including ASCII files and SAS transport files, to accommodate different software programs for analysis. For this study, the data were prepared for secondary analysis by first selecting the appropriate dataset from SAMHDA, based on the variables relevant to the research objectives. After downloading the data, the files were imported into a statistical software program where they were cleaned and formatted for analysis. This preparation involved recoding variables as needed and ensuring that the dataset was properly structured for the specific analyses planned.

Study Measures

Exposures

Predisposing Factors

Age. This reflects the NSDUH's final edited value provided in the dataset, which accounts for potential inconsistencies in age reporting throughout the questionnaire. Respondents initially provide their birthdate early in the survey, but they may revise their age in response to consistency checks across different sections. As a result, the final age value is derived from multiple sources, including the initial and revised age responses, the calculated age based on

birthdate and interview date, the age listed in the questionnaire roster, and the pre-interview screener.

Sex. This was measured as a binary variable based on self-report, with respondents identifying as either male or female.

Enabling Factors

Family Income. The NSDUH captures family income through a series of questions addressing various sources, including employment and government assistance. While it is unclear whether adolescents directly report their family's income or if this information is provided by another household member, the survey calculates several variables related to family income based on these responses. For analysis purposes, the recoded variable of family income was utilized; this includes four categories: *Less than $20,000*, *$20,000–$49,999*, *$50,000–$74,999*, and *$75,000 or More*.

Poverty Level. The NSDUH measures poverty level as a function of family income relative to federally defined poverty thresholds, which consider factors such as age, family size, number of children in the household, and total family income. Being at 100% of the poverty threshold indicates a family income equal to the threshold, while levels below 100% signify living in poverty as defined by the federal government. Conversely, a poverty level above 100% indicates income above the threshold.

Given that NSDUH collects only categorical income data, the survey assigns the midpoint of each income range as the effective family income. However, respondents aged 18 to 22 living in college dormitories are excluded from this calculation, as they are assigned system-missing values. For analysis, the poverty level variable was recoded into three categories: *Living*

in Poverty, Income Up to 2X Federal Poverty Threshold, and *Income More Than 2X Federal Poverty Threshold*.

Covered by Health Insurance. Participants responded to the question, "Is [SAMPLE MEMBER A] currently covered by any kind of health insurance, that is, any policy or program that provides or pays for medical care?" Responses to this question were recorded as either "Yes" or "No," providing a binary measure of health insurance coverage.

Reasons for not getting treatment in the past 12 months. Participants responded to the question, "For each statement, please mark whether or not it was one of the reasons why you did not get [additional] professional counseling, medication, or other treatment for your mental health, emotions, or behavior." Participants could identify various reasons for not seeking or receiving treatment, including cost, lack of insurance coverage, transportation challenges, concerns about privacy, stigma, readiness for treatment, and perceived effectiveness of care. For each issue listed, participants could select "Yes" or "No."

Need Factors

Self-perceived Mental Health Status. Participants were asked whether they experienced mental or emotional problems. Participants could select, "yes" or "no,".

Passive Suicidal Ideation. Participants responded to the question, "At any time in the past 12 months, that is from [DATEFILL] up to and including today, did you seriously think about trying to kill yourself?" Participants could select, "yes" "no," "I'm not sure," "don't want to answer".

Active Suicidal Ideation. Participants responded to the question, "During the past 12 months, did you make any plans to kill yourself?" Participants could select, "yes" "no," "I'm not sure," "don't want to answer".

Past Year and Lifetime Major Depressive Episode (MDE). Respondents were administered age-appropriate depression modules to assess whether they had experienced a major depressive episode (MDE) in their lifetime and in the past year. Only adolescents aged 12 to 17 are included in both variables. These variables indicate whether participants met the criteria for a lifetime and/or past-year MDE based on DSM guidelines. Participants were classified as having experienced a MDE in their lifetime if they met at least 5 of the 9 criteria used to define MDE, with one of the criteria being either a depressed mood or a loss of interest or pleasure in daily activities. If an adolescent did not meet these criteria or if certain key information about their symptoms was missing or unclear, they were classified as not having lifetime MDE. Similarly, the survey captures past year major depressive episodes, with participants being categorized based on whether they met the same criteria within the previous 12 months.

The following variables are among all adolescent respondents who were asked the respective questions and are not confined to those respondents who were ultimately classified as having a Major Depressive Episode (MDE) in their lifetime or the past year.

Outcomes

Health Behavior

Mental Health Service Utilization

The three variables categorized under mental health service utilization for major depressive episodes (MDE) were derived from recoded items specifically administered to youth respondents aged 12 to 17:

Saw/Talked to an MD/Professional for MDE in the Past Year. Participants were asked whether they had seen or talked to a medical doctor or other professional for a Major Depressive Episode (MDE). Participants could select “Yes” or “No.”

Received Treatment/Counseling for MDE in the Past Year. In this variable, adolescents are categorized as having received treatment or counseling for MDE if they saw or talked to a medical doctor or other professional regarding their depression. This includes professionals such as general practitioners, psychiatrists, psychologists, or counselors.

Saw/Talked to a Professional for MDE in the Past Year. This variable indicates whether an adolescent reported seeing or talking to a health professional about MDE within the past year. Adolescents were classified as having seen or talked to a health professional, if they reported consulting with any of the following: a general practitioner or family doctor, other medical doctors, psychologists, psychiatrists, social workers, counselors, or other mental health professionals. If no health professional was consulted, adolescents were classified as not having seen or talked to a health professional.

Unmet Mental Health Care Needs

Thought They Should Be Treated but Did Not Receive or Seek. Participants responded to the question, “During the past 12 months, did you think you should get professional counseling, medication, or other treatment for your mental health, emotions, or behavior?” This question is asked of respondents who did not report receiving any of the treatments in the past 12 months for mental health, emotions, or behavior, and did not report seeking treatment in the past 12 months for mental health, emotions, or behavior. Participants could select, “yes” or “no,” .

Data Analysis

All data were analyzed using SAS 9.4. The dataset was restricted to African American adolescents under the age of 20 to align with the study’s focus. To ensure data quality and accuracy, responses coded as "Yes (unknown receipt of treatment)", "No (unknown receipt of treatment)", "Don't Know", "Bad Data – Logically Assigned", "Refused", "Blank (No Answer)",

and "Legitimate Skip" were set as missing values. Given that this study analyzed a subset of the original full sample, survey weights were applied to account for the complex survey design. Weight calibration was performed to adjust the public-use file (PUF) weights to the full sample totals, reducing bias from substitution and minimizing variance introduced by subsampling. This approach ensured that findings were representative of the target population and preserved the integrity of population-level estimates. Additionally, a subset of the study sample was created consisting of adolescents who reported unmet mental health needs. This subset was used to explore the reasons for unmet needs as reported by these adolescents.

Descriptive statistics, including sample frequencies and weighted percentages, were calculated for all predisposing, enabling, and need factors, as well as the outcome variables. Additionally, bivariate analyses were conducted using Fisher's Exact tests for categorical variables with expected cell counts less than five, ANOVA for categorical variables with more than two levels to examine associations, and a one-way chi-square test to assess the distribution of perceived barriers. These tests were chosen to examine statistical differences across groups and assess associations between predisposing, enabling, and need factors and mental health service utilization outcomes.

Results

Demographics and Descriptive Statistics

The study sample consisted of African American adolescents aged 12 to 20. Approximately 23% were between 12 and 13 years old, 23% were between 14 and 15 years old, 21% were between 16 and 17 years old, and 33% were between 18 and 20 years old. The sample was evenly distributed by gender, with roughly half identifying as male and half as female. Regarding socioeconomic status, 28% reported a family income of less than $20,000, 33% had an income between $20,000 and $49,999, 14% fell within the $50,000 to $74,999 range, and 26% reported a family income above $75,000. Additionally, 36% of the sample were living in poverty, and 63% did not have health insurance (Table 1).

In terms of mental health experiences, 77% reported experiencing mental or emotional difficulties, 23% had experienced a Major Depressive Episode (MDE) in their lifetime, and 17% experienced an MDE in the past year. Additionally, 15% of participants had seriously considered suicide in the past year, while 8% had made plans to do so. Regarding mental health service utilization, 28% saw or talked to a medical doctor or mental health professional for MDE in the past year, 30% received treatment or counseling for MDE in the past year, and 27% reported seeing or talking to a health professional for MDE in the past year. About 8% of the adolescents believed they needed treatment for mental health concerns but did not seek or receive care (Table 1).

Among adolescents who believed they needed mental health treatment but did not seek or receive care, several barriers were identified. The most reported reason was the belief that they could handle their mental health on their own (69%). Additionally, 41% lacked knowledge of where to get treatment, and 40% reported not being ready to start treatment. Concerns about

privacy (38%), stigma (37%), and fear of being committed to a hospital or forced into treatment (40%) were also prevalent. Financial barriers played a significant role, with 26% reporting treatment costs as too high, 17% lacking health insurance coverage, and 11% stating that their insurance did not cover enough (Table 6).

Access-related challenges included difficulty finding a preferred provider (27%), no available openings with a preferred provider (6%), and issues with transportation, childcare, or scheduling (17%). Additionally, 24% reported not having enough time for treatment. Other concerns included fear of being prescribed medication (34%), believing that treatment would not help (41%), and feeling that no one would care (40%). Social and cultural influences were also factors, with 28% reporting that their family, friends, or religious group would oppose treatment. These findings highlight the multifaceted barriers to mental health care access among African American adolescents (Table 6).

Bivariate Analyses

Mental Health Service Utilization

To analyze the relationships between predisposing, enabling, and need factors and mental health service utilization, three types of service use for major depressive episodes (MDE) in the past year were examined. These included: (1) seeing or talking to a doctor/professional for MDE in the past year (Table 2), (2) receiving treatment or counseling for MDE in the past year (Table 3), and (3) seeing or talking to a health professional for MDE in the past year (Table 4). Given the consistent prevalence of need factors across all three service utilization variables, the results are presented together.

None of the predisposing or enabling factors were significantly associated with mental health service utilization. However, all need factors, except for lifetime MDE, were significantly

associated with service use. In terms of internal and external recognition of mental health problems, approximately 94% of adolescents who used mental health services reported experiencing mental or emotional difficulties, compared to 85% of those who did not use services ($p = 0.02$ for "Saw/Talked to a Doctor/Professional for MDE in the Past Year" and "Saw/Talked to a Health Professional for MDE in the Past Year"; $p = 0.01$ for "Received Treatment/Counseling for MDE in the Past Year"). Passive suicidal ideation was reported by 60% of service users and 39% of non-users ($p = 0.01$ for both Saw/Talked to a Professional variables; $p = 0.005$ for "Received Treatment/Counseling in the Past Year"). Similarly, 27% of service users had active suicidal ideation, compared to 20% of non-users ($p < 0.01$ for all mental health service utilization). Additionally, 80% of those who accessed services had experienced an MDE in the past year, while 71% of non-users had also experienced an MDE ($p = 0.009$ for "Saw/Talked to a Doctor/Professional for MDE in the Past Year" and "Received Treatment/Counseling in the Past Year"; $p = 0.01$ for "Saw/Talked to a Health Professional for MDE in the Past Year").

Unmet Mental Health Service Need

Several factors were significantly associated with the outcome of reporting unmet needs. Among predisposing factors, sex was the only significant variable. Approximately 74% of female adolescents who thought they needed treatment did not receive or seek care, although 54% of female adolescents did not report unmet needs ($p < 0.0001$). For enabling factors, both total family income and poverty level showed significant associations. Among those who reported unmet needs, 17% had family incomes less than $20,000; 33% had incomes between $20,000 and $47,999; 13% had incomes between $50,000 and $74,999; and 37% had incomes of $75,000 or more ($p = 0.0002$). Comparatively, among those who did not report unmet needs,

29% had family incomes below $20,000; 33% between $20,000 and $47,999; 13% between $50,000 and $74,999; and 24% had incomes of $75,000 or more. Poverty level also demonstrated a clear gradient. Among those with unmet needs, 20% were living in poverty, 30% were living at twice the federal poverty threshold, and 49% were living at three times the poverty threshold ($p < 0.0001$). In contrast, among those without unmet needs, 39% were living in poverty, 25% at twice the threshold, and 37% at three times the threshold (Table 5).

Most of the perceived barriers to care were significantly associated with reporting unmet need. Specifically, these included structural barriers such as the cost of treatment (21%, $p = <.0001$), lack of health insurance (11%, $p = <.0001$), and insufficient insurance coverage (10%, $p <.0001$). Provider-related issues also emerged, with 23% reporting difficulty finding a preferred provider ($p < .0001$) and 3% noting that there were no available openings with their preferred provider ($p < .0001$). Logistical challenges were also significant, including trouble with transportation, childcare, or scheduling (16%, $p < .0001$), and not having enough time for treatment (16%, $p < .0001$). Psychosocial concerns played a major role as well. About 11% reported fear of "bad things happening" if they sought treatment ($p <.0001$), and 75% believed they could manage their mental health on their own ($p <.0001$). Related concerns included stigma and fear, with 41% worried about what others might think ($p = 0.014$), 40% afraid of being committed or forced into treatment ($p = 0.017$), and 41% believing that no one would care ($p = 0.001$). Emotional readiness and doubt also emerged as barriers as 47% reported they were not ready to start treatment ($p = 0.01$), and 45% did not think treatment would help ($p = 0.033$). Additionally, 34% were concerned about disapproval from family, friends, or religious groups ($p <.0001$), and 36% worried they would be told to take medication ($p <.0001$). (Table 6).

Among need factors, all variables except for self-perceived mental health status were significantly associated with unmet service need (all p-values < 0.0001). Notably, 46% of those who reported unmet needs had experienced passive suicidal ideation, compared to 6% of those without unmet needs. Additionally, 22% of those with unmet needs reported active suicidal ideation, compared to 4% without unmet needs. Lifetime MDE was reported by 69% of those with unmet needs versus 12% of those without, and past-year MDE was reported by 58% of those with unmet needs compared to 8% of those without (Table 5).

Discussion

Summary of Study

The main objective of this study was to examine the barriers that prevent African American adolescents from accessing and utilizing mental health services, with particular attention to how these barriers shape treatment outcomes. The ultimate goal of this research was to identify not only who is being left behind, but also why, and what can be learned from these gaps to inform strategies that advance mental health equity.

Key Results

The results of this study highlight critical insights into the relationship between mental health needs and service utilization among African American adolescents. A central finding was the significant disconnect between adolescents' perceived need for mental health care and their actual use of services. Despite the presence of clinical need factors, such as major depressive episodes (MDE) and suicidal ideation, many adolescents did not seek or receive care. This suggests that while need factors can influence recognition of mental health challenges, they do not necessarily lead to help-seeking behavior. These findings are consistent with prior research, which shows that adolescents experiencing acute symptoms are often aware of their mental health needs (Samargia et al., 2006). However, despite the presence of perceived need, many adolescents still did not engage with services, indicating a persistent gap between recognition and action. This gap points to the potential influence of additional psychosocial and structural barriers that extend beyond individual symptom severity.

The study also revealed that adolescents who reported unmet mental health needs experienced notably higher levels of emotional distress. Compared to their counterparts who did not report unmet needs, these adolescents had significantly higher prevalence of passive and

active suicidal ideation and were highly represented among those who experienced MDE in both the past year and across their lifetime. This finding supports the idea that perceived unmet need reflects not just subjective concerns but is often grounded in real, serious mental health challenges. The strong association between distress and unmet need reinforces the urgency of addressing barriers to care, as unaddressed needs may reflect more severe underlying conditions that could worsen over time without intervention (Planey et al., 2019; Wang et al., 2007).

Socioeconomic factors added another layer of complexity to these findings. Adolescents from higher-income households and those living three times above the federal poverty level were highly represented among those who reported unmet needs, whereas those living in poverty were less represented in both the unmet need and no-reported-unmet-need groups. Given the higher prevalence of lower-income youth in the overall sample, this pattern may reflect a lower likelihood of recognizing or reporting unmet mental health needs among this group. This aligns with existing literature documenting how socioeconomic disparities affect not only access to care, due to factors such as insurance coverage, affordability, and transportation (Anyigbo et al., 2024; Lu et al., 2019), but also perceptions of mental health needs and expectations of treatment (Assari and Caldwell, 2017; Lu et al., 2019).These findings suggest that perceived unmet need may be shaped not only by actual access but also by broader expectations of care and cultural understandings of what constitutes a treatable condition.

Gender also emerged as a notable factor. Female adolescents were highly represented among both those who reported unmet needs and those who did not, suggesting a complex relationship between gender and mental health perception. Prior research has shown that girls are often more likely to acknowledge and experience emotional distress (Demkowicz et al., 2025; Thomsen et al., 2024; “US Teen Girls Experiencing Increased Sadness and Violence”, 2023).

However, this study demonstrates that this recognition does not necessarily translate into higher rates of service utilization. The distribution of females across both perceived need categories may reflect previous research indicating that Black females are more likely to have unrecognized or unmet mental health needs (Prichett et al., 2023). In contrast, the underrepresentation of male adolescents in both categories may point to distinct but overlapping challenges: lower recognition of mental health needs and underutilization of services. Existing research shows that Black adolescent males access mental health services at disproportionately lower rates than their male peers from other racial groups (Williams et al., 2023). Additionally, stigma may play a significant role in shaping how young Black males perceive and interpret their emotional struggles, potentially leading them to minimize or dismiss the need for professional help altogether (Lindsey et al., 2017; Thomas et al., 2011; Williams et al., 2023). In this context, their limited presence in both the perceived need and service use categories in this sample may reflect a broader issue of non-recognition and underutilization. Altogether, these patterns reflect layered dynamics and highlight the need for more gender-responsive and culturally grounded approaches to mental health outreach. A gender-informed approach to prevention and intervention must acknowledge that Black adolescents do not experience or respond to mental health challenges in the same way. These findings emphasize that strategies must be responsive to the specific ways Black adolescents experience, interpret, and respond to mental health challenges. They suggest the presence of additional, intersecting barriers specific to Black girls and boys, and point to a bidirectional relationship between gender, mental health awareness, and access to services that warrants further exploration.

Finally, the most frequently reported barrier to care was the belief that mental health challenges could be managed independently. This was the only barrier a clear majority of

adolescents identified as a reason for not seeking care, showing the largest margin of identification among all perceived barriers. While several other barriers were significantly associated with unmet need, most respondents did not perceive them as obstacles, highlighting self-reliance as a uniquely prominent concern. The prominence of this barrier aligns with broader research findings, suggesting that self-reliance is a commonly reported reason for non-use of services among Black adolescents (Williams et al., 2023). It underscores a deeply rooted personal or cultural tendency to manage distress independently, which may delay or prevent engagement with professional support. This finding aligns with cultural narratives emphasizing self-sufficiency, particularly within Black communities (Hadjiyanni, 2019). Ideologies such as the "strong Black female/male" promote personal resilience and discourage reliance on external mental health services (Bauer et al., 2021; Castelin and White, 2022; Giscombe et al., 2020; Johnson et al., 2024). These narratives may contribute to the internalization of stigma surrounding mental health care among adolescents and reinforce hesitation to seek help, even when distress is significant.

Collectively, these findings suggest that mental health service utilization is shaped not only by structural access but also by internal beliefs, socioeconomic context, and social identity. The study sheds light on the multifaceted nature of access to care, revealing that service use is influenced by a complex interplay of cultural, psychological, and systemic factors. A deeper understanding of these intersecting influences is essential for developing interventions that are both accessible and culturally relevant to the lived experiences of African American adolescents.

Strengths

This study centers the experiences of African American adolescents, an underserved population that is often overlooked in mental health research despite experiencing

disproportionate mental health challenges and disparities in access to care. By focusing specifically on this group, the study brings visibility to a critical gap in literature and supports efforts to better understand the unique factors shaping mental health service utilization within this population.

Additionally, this research is grounded in two well-established theoretical frameworks, which provided a strong foundation for shaping the research questions, guiding the analytic approach, and interpreting findings. The results illustrate how intersectionality, a construct in CRT, manifests in the overlapping effects of race, gender, and age on mental health service utilization among Black adolescents. While these disparities underscore the value of an intersectional lens when examining access and utilization, the persistent gap between need and service use reflects CRT's assertion that traditional systems are not race-neutral and often fail to equitably serve Black communities. At the same time, the clear associations between perceived need and service utilization align with the Andersen Behavioral Model's emphasis that need factors play a central role in health behavior. It is plausible that with a larger, more representative sample of African American adolescents, and more detailed measures of enabling and predisposing factors specific to their lived experiences, additional components of the model could emerge as significant. Together, these frameworks offered a structured lens for understanding the interaction between individual, social, and systemic influences on perceived need and service use.

A key strength of the study is the use of nationally representative data from the National Survey on Drug Use and Health (NSDUH). The large sample size and broad geographic coverage enhance the generalizability of the findings and allow for greater confidence in applying the results to African American adolescents across the United States. The analysis also

accounted for the NSDUH's complex survey design through the application of weights and appropriate data handling procedures. This ensured that population estimates were as accurate and unbiased as possible and that statistical conclusions were reflective of the broader adolescent population.

Finally, as an exploratory study, this research contributes to filling important gaps in literature by highlighting patterns in perceived unmet need and identifying potential barriers to care. These findings can inform future research and intervention design aimed at reducing disparities and improving mental health outcomes for African American youth.

Limitations

Several limitations should be considered when interpreting the findings of this study. First, there is the potential for response bias with the NSDUH data, particularly given the sensitive nature of topics related to mental health. Adolescents may have misunderstood certain questions, struggled to accurately recall past experiences, or responded in ways they believed to be more socially acceptable. Such factors could introduce inaccuracies into self-reported data, potentially affecting the reliability of some responses. Additionally, the cross-sectional design of the NSDUH data presents another important limitation. While the study was able to identify associations between variables, directionality cannot be determined, which limits the ability to draw conclusions about causality or long-term effects.

The relatively small sample size of African American adolescents further restricted the analysis, limiting the statistical power and constraining the ability to explore more detailed subgroup differences. Missing data also posed challenges such as skipped questions, refusals to answer, and uncertainty about specific responses led to additional reductions in the already limited sample. The non-significant associations between predisposing or enabling factors and

mental health service utilization could be reflection of the limitations of the particularly small number of adolescents reporting mental health service use. In addition, small cell sizes in certain parts of the analysis reduced variation in key variables, which may have contributed to unstable or less reliable p-values, reducing the likelihood of detecting significant associations. As a result, many p-values were excluded from the statistical tables, and those that remain should be interpreted with caution.

Implications

The findings of this study illuminate critical implications for mental health equity among African American adolescents. A central insight is the notable disconnect between the recognition of mental health needs and subsequent utilization of services. Despite awareness of emotional distress and the presence of serious conditions such as major depressive episodes and suicidal ideation, many adolescents did not seek or receive care. This gap highlights the limitations of awareness-based interventions and underscores the need to address the broader systemic, cultural, and psychological barriers that hinder help-seeking behavior. Efforts to improve mental health service utilization must therefore move beyond increasing awareness and consider the structural and interpersonal factors that influence follow-through. Interventions should incorporate strategies to reduce cultural stigma, rebuild trust in mental health systems, and acknowledge the role of self-reliance not solely as an individual coping mechanism but as a socially and historically constructed survival strategy, particularly within the context of structural racism and collective resilience.

In addition, the study's findings challenge simplistic assumptions about the role of gender and socioeconomic status in shaping access to care. The presence of unmet needs among adolescents from higher-income households and the high representation of female adolescents

across both ends of the perceived need spectrum suggest that service utilization patterns are shaped by complex and intersecting social identities. These dynamics point to the need for more targeted and contextually sensitive approaches that reflect the lived experiences of diverse youth populations, rather than one-size-fits-all models.

This research also reinforces the value of grounding public health inquiry in robust theoretical frameworks. The application of Critical Race Theory and the Andersen Behavioral Model of Health Services Use provided essential tools for interpreting how broader structural and cultural forces shape individual-level outcomes. These frameworks enabled a deeper understanding of how institutionalized inequities and social determinants of health intersect to produce disparities in perceived need and access to care. By exploring adolescent mental health within these broader contexts, this study contributes to a more comprehensive and equity-focused understanding of service utilization.

Future Directions

This study lays the groundwork for a number of potential future research directions. There is a clear need for longitudinal research to better understand how unmet mental health needs in adolescence impact health and well-being into adulthood, particularly within African American communities. Understanding these long-term dynamics is critical for designing timely interventions that can disrupt cycles of unaddressed distress and structural disadvantage.

There is also value in expanding and strengthening quantitative analyses to improve the validity of findings. For instance, combining multiple years of NSDUH data could increase the sample size of African American adolescents, enhancing statistical power and allowing for more meaningful subgroup analyses. However, this also points to a broader need for data systems that more deliberately and consistently capture the experiences of marginalized populations. Possible

investments in targeted data collection efforts that center African American youth using larger and more representative samples would strengthen the evidence base and support more tailored public health responses.

In addition, while this study was exploratory in nature and did not establish causality, the observed associations, such as the role of self-reliance, offer valuable starting points for future research. There is a need to develop interventions that directly address specific barriers, such as internalized stigma or culturally rooted beliefs about independence, as this could possibly lead to increased service utilization among Black adolescents.

Furthermore, future research should incorporate qualitative methods to further explore the complex barriers identified in this study. Deeper inquiry is needed to understand why perceived need often does not translate into action, and how beliefs about self-management of mental health arise and persist. For instance, it remains unclear whether adolescents believe they can handle their mental health challenges alone because they prefer to or because they feel they have no viable alternatives. Similarly, the dual representation of African American girls in both unmet and unacknowledged need categories calls for a deeper exploration of gendered expectations and cultural pressures that shape their decision-making processes. Such qualitative work would provide richer context and inform more culturally grounded interventions that resonate with the lived realities of African American adolescents.

Conclusion

This study sheds light on the persistent disconnect between mental health needs and service utilization among African American adolescents, highlighting critical gaps that demand urgent attention. While the findings reveal important patterns related to perceived need, distress, socioeconomic status, gender, and cultural barriers such as self-reliance, they also point to the

deeper structural and systemic inequities that shape access to care. These disparities are not merely statistical, they represent real experiences of young people navigating a mental health system that has historically failed to recognize, prioritize, or affirm their needs.

Achieving mental health equity requires more than increasing access. It demands a transformation of systems to reflect the realities of those most affected. This includes recognizing the cultural context, structural barriers, and psychological dimensions that influence how African American adolescents experience and respond to mental health challenges. Solutions must be informed not only by data, but by the voices and lived experiences of youth themselves. Ultimately, this research is a call to action. The ongoing gap between mental health need and care among African American adolescents signals a failure of existing systems to provide equitable, trustworthy, and culturally grounded support. In order to move toward a more just and inclusive future, there must be a commitment to redesigning mental health systems in ways that honor youth voices, reduce disparities, and ensure that no young person is left to face their struggles alone.

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Tables

Table 1: Characteristics of African American Adolescents (N=2,387)

	Analytical Sample N (Weighted Percent)	95% CI
Age		
12 - 13 years old	555 (22.8%)	(20.1, 25.6)
14 - 15 years old	619 (23.0%)	(20.7, 25.3)
16 - 17 years old	560 (20.8%)	(18.2, 23.5)
18 - 20 years old	653 (33.3%)	(30.5, 36.1)
Sex		
Female	1182 (49.8%)	(47.3, 52.4)
Male	1205 (50.2%)	(47.6, 52.7)
Covered by Health Insurance		
Yes	53 (37.4%)	(1.3, 3.6)
No	83 (62.6%)	(3.1, 5.1)
Total Family Income		
Less than $20,000	735 (27.7%)	(25.1, 30.4)
$20,000 - $49,999	789 (32.8%)	(30.1, 35.4)
$50,000 - $74,999	315 (13.8%)	(11.5, 16.1)
$75,000 or More	548 (25.7%)	(22.9, 28.5)
Poverty Level		
Living in Poverty	914 (36.3%)	(33.2, 39.4)
Income Up to 2X Fed Pov Thresh	642 (26.2%)	(23.3, 29.0)
Income More Than 3X Fed Pov Thresh	830 (37.6%)	(34.2, 40.9)
Mental or Emotional Difficulties		
Yes	550 (76.6%)	(20.5, 26.1)
No	126 (23.4%)	(5.2, 9.0)
Passive Suicidal Ideation		
Yes	218 (14.6%)	(9.8, 14.8)
No	1224 (85.4%)	(68.7, 75.0)
Active Suicidal Ideation		
Yes	127 (8.3%)	(5.2, 9.5)
No	1373 (91.7%)	(77.8, 84.4)

Lifetime Major Depressive Episode (MDE)		
Yes	379 (23%)	(20.0, 26.0)
No	1297 (77%)	(74.0, 80.0)
Past Year Major Depressive Episode		
Yes	274 (16.8%)	(13.7, 19.9)
No	1393 (83.2%)	(80.1, 86.3)
Saw/Talked to a MD/Professional for MDE in the Past Year		
Yes	108 (28.3%)	(21.7, 35.0)
No	268 (71.7%)	(65.0, 78.3)
Received Treatment/Counseling for MDE in the Past Year		
Yes	116 (29.6%)	(22.7, 36.6)
No	261 (70.4%)	(63.4, 77.3)
Saw/Talked to a Health Professional for MDE in the Past Year		
Yes	104 (27.4%)	(21.1, 33.7)
No	271 (72.6%)	(66.3, 78.9)
Thought they should be treated for MH but did not seek/receive		
Yes	131 (7.8%)	(5.9, 9.7)
No	1594 (92.2%)	(90.3, 94.1)

The following tables look at: Mental Health Service Utilization for MDE among Adolescents Under the age of 18 by Characteristics of African American Adolescents Under the Age of 18
(Weighted Percent, Standard Error, *p*-values)

Table 2:

	Saw/Talked to an MD/Professional for MDE in the Past Year				
	Yes (Weighted N= 220,065)[1]		**No (Weighted N =556,717)[2]**		
	Weighted Percent	**Standard Error**	**Weighted Percent**	**Standard Error**	***p*-value**
Age					.655
12 - 13 years old	28.7	6.9	32.4	5.0	
14 - 15 years old	38.1	5.2	26.9	4.0	
16 - 17 years old	33.2	7.7	40.8	5.1	
Sex					.901
Female	72.3	6.4	70.9	4.1	
Male	27.7	6.4	29.1	4.1	
Covered by Health Insurance					.455
Yes	100.0	0.0	13.9	4.0	
No	-	-	86.1	4.0	
Total Family Income					.838
Less than $20,000	26.2	6.5	23.7	3.2	
$20,000 - $49,999	24.6	7.3	26.4	3.7	
$50,000 - $74,999	19.3	5.6	17.7	3.3	
$75,000 or More	29.8	5.7	32.2	4.1	

Poverty Level					.586
Living in Poverty	27.8	6.3	29.4	4.2	
Income Up to 2X Fed Pov Thresh	30.0	6.5	29.6	4.0	
Income More Than 3X Fed Pov Thresh	42.2	8.0	41.0	4.7	
Mental or Emotional Difficulties					.022*****
Yes	94.2	5.5	85.0	4.0	
No	5.8	5.5	15.0	4.0	
Passive Suicidal Ideation					.013*****
Yes	59.7	7.7	39.0	6.3	
No	40.3	7.7	61.0	6.3	
Active Suicidal Ideation					.0003*****
Yes	27.0	5.3	19.7	4.9	
No	73.0	5.3	80.3	4.9	
Lifetime Major Depressive Episode (MDE)					.560
Yes	100.0	0.0	97.8	2.0	
No	-	-	2.2	2.0	
Past Year Major Depressive Episode					.009*****
Yes	79.2	6.9	71.1	4.4	
No	20.3	6.9	28.9	4.4	

Notes

[1,2] Weighted frequencies within the categories of Mental Health Service Utilization for MDE vary due to some missing data on the demographic, predisposing and enabling factors.

***** Statistically significant at α <0.05 (two-tailed test)

Table 3:

	Received Treatment/Counseling for MDE in the Past Year				
	Yes (Weighted N= 230,674)[1]		No (Weighted N = 547,864)[2]		
	Weighted Percent	**Standard Error**	**Weighted Percent**	**Standard Error**	***p*-value**
Age					.638
12 - 13 years old	30.4	6.6	32.0	5.1	
14 - 15 years old	37.6	4.9	26.7	4.0	
16 - 17 years old	32.0	7.4	41.3	5.2	
Sex					.713
Female	73.2	6.0	70.5	4.2	
Male	26.8	6.0	29.5	4.2	
Covered by Health Insurance					-
Yes	100.0	0.0	13.9	4.0	
No	-	-	86.1	4.0	
Total Family Income					.976
Less than $20,000	25.3	6.2	24.0	3.3	
$20,000 - $49,999	24.3	7.0	26.9	3.7	
$50,000 - $74,999	19.3	5.4	17.5	3.3	
$75,000 or More	31.1	5.5	31.6	4.1	
Poverty Level					.491
Living in Poverty	27.5	6.1	30.0	4.2	
Income Up to 2X Fed Pov Thresh	28.6	6.1	30.0	4.0	
Income More Than 3X Fed Pov Thresh	43.8	7.7	40.0	4.7	

Mental or Emotional Difficulties					.012*
Yes	94.5	5.3	84.6	4.1	
No	5.5	5.3	15.4	4.1	
Passive Suicidal Ideation					.005*****
Yes	61.4	7.3	38.0	6.5	
No	38.6	7.3	62.0	6.5	
Active Suicidal Ideation					.0002*****
Yes	26.8	5.1	19.6	5.0	
No	73.2	5.1	80.4	5.0	
Lifetime Major Depressive Episode (MDE)					-
Yes	100.0	0.0	97.7	2.1	
No	-	-	2.3	2.1	
Past Year Major Depressive Episode					.011*****
Yes	80.0	6.5	70.7	4.5	
No	20.0	6.5	29.3	4.5	

Notes

[1,2] Weighted frequencies within the categories of Mental Health Service Utilization for MDE vary due to some missing data on the demographic, predisposing and enabling factors.

***** Statistically significant at α <0.05 (two-tailed test)

Table 4:

	Saw/Talked to a Health Professional for MDE in the Past Year				
	Yes (Weighted N= 211,626)[1]		No (Weighted N = 560,914)[2]		
	Weighted Percent	**Standard Error**	**Weighted Percent**	**Standard Error**	***p*-value**
Age					.525
12 - 13 years old	27.5	6.7	32.3	5.0	
14 - 15 years old	39.2	5.3	26.8	4.0	
16 - 17 years old	33.3	7.8	40.9	5.1	
Sex					.613
Female	73.1	6.5	70.3	4.1	
Male	26.9	6.5	29.7	4.1	
Covered by Health Insurance					-
Yes	100.0	0.0	13.9	4.0	
No	-	-	86.1	4.0	
Total Family Income					.967
Less than $20,000	26.9	6.7	23.7	3.3	
$20,000 - $49,999	24.0	7.3	26.8	3.8	
$50,000 - $74,999	20.1	5.9	17.5	3.3	
$75,000 or More	29.0	5.7	31.9	4.1	
Poverty Level					.505
Living in Poverty	28.5	6.6	29.3	4.2	
Income Up to 2X Fed Pov Thresh	29.6	6.5	29.9	4.1	
Income More Than 2X Fed Pov Thresh	41.8	8.4	40.7	4.6	

Mental or Emotional Difficulties					.022*****
Yes	94.2	5.5	85.0	4.0	
No	5.8	5.5	15.0	4.0	
Passive Suicidal Ideation					.011*****
Yes	59.6	8.1	38.8	6.3	
No	40.4	8.1	61.2	6.3	
Active Suicidal Ideation					.0006*****
Yes	25.3	5.7	19.7	4.9	
No	74.4	5.7	80.3	4.9	
Lifetime Major Depressive Episode (MDE)					-
Yes	100.0	0.0	97.8	2.0	
No	-	-	2.2	2.0	
Past Year Major Depressive Episode					.018*****
Yes	78.4	7.2	71.4	4.4	
No	21.6	7.2	28.6	4.4	

Notes

[1,2] Weighted frequencies within the categories of Mental Health Service Utilization for MDE vary due to some missing data on the demographic, predisposing and enabling factors.

***** Statistically significant at α <0.05 (two-tailed test)

Table 5: Unmet Mental Health Service Needs by Characteristics of African American Adolescents (Weighted Percent, Standard Error, *p*-values)

	Yes (Weighted N= 302,717)[1]		No (Weighted N = 3,584,475)[2]		
	Weighted Percent	**Standard Error**	**Weighted Percent**	**Standard Error**	***p*-value**
Age					.292
12 - 13 years old	14.2	3.8	21.7	1.5	
14 - 15 years old	12.1	2.9	20.8	1.3	
16 - 17 years old	39.8	6.4	20.0	1.4	
18 - 20 years old	33.9	6.3	37.5	1.5	
Sex					<.0001*****
Female	73.7	6.7	53.6	1.7	
Male	26.3	6.7	46.4	1.7	
Covered by Health Insurance					.721
Yes	10.6	5.4	36.4	5.1	
No	89.4	5.4	63.6	5.1	
Total Family Income					.0002*****
Less than $20,000	17.1	5.9	29.4	1.6	
$20,000 - $49,999	32.9	7.0	32.9	1.5	
$50,000 - $74,999	13.1	4.4	13.6	1.3	
$75,000 or More	37.0	5.5	24.2	1.4	
Poverty Level					<.0001*****
Living in Poverty	20.1	6.5	38.8	1.7	
Income Up to 2X Fed Pov Thresh	30.9	6.4	24.6	1.5	
Income More Than 3X Fed Pov Thresh	49.0	6.3	36.6	1.8	

Mental or Emotional Difficulties					.479
Yes	72.3	11.9	72.4	4.2	
No	27.7	11.9	27.6	4.2	
Passive Suicidal Ideation					<.0001*****
Yes	46.3	9.4	6.4	1.4	
No	53.7	9.4	93.6	1.4	
Active Suicidal Ideation					<.0001*****
Yes	22.3	7.9	4.4	1.2	
No	77.7	7.9	95.6	1.2	
Lifetime Major Depressive Episode (MDE)					<.0001*****
Yes	68.8	7.4	12.1	1.4	
No	31.2	7.4	87.9	1.4	
Past Year Major Depressive Episode					<.0001*****
Yes	57.9	7.3	7.6	1.4	
No	42.1	7.3	92.4	1.4	
Saw/Talked to a MD/Professional for MDE in the Past Year					1.0
Yes	5.5	3.8	7.4	4.0	
No	94.5	3.8	92.6	4.0	
Received Treatment/Counseling for MDE in the Past Year					1.0
Yes	5.5	3.8	7.4	4.0	
No	94.5	3.8	92.6	4.0	

Saw/Talked to a Health Professional for MDE in the Past Year					.440
Yes	0.4	0.4	7.4	4.0	
No	99.6	0.4	92.6	4.0	

Notes

[1]Weighted frequencies within the categories of Mental Health Service Utilization for MDE vary due to some missing data on the demographic, predisposing and enabling factors.

***** Statistically significant at α <0.05 (two-tailed test)

Table 6: Factors Affecting Mental Health Service Utilization Among African American Adolescents with Unmet Mental Health Needs (N=131)

	Analytic Sub-Sample N (Weighted Percent)	95% CI	Standard Error	*p*-value[1]
Treatment Cost Too Much				<.0001*****
Yes	37 (20.5%)	(16.6, 34.3)	6.7	
No	89 (79.5%)	(65.7, 93.4)	6.7	
No Health Insurance Coverage for Treatment				<.0001*****
Yes	11 (11.4%)	(0, 24.4)	6.3	
No	113 (88.6%)	(75.6, 100)	6.3	
Health Insurance Did not cover enough				<.0001*****
Yes	12 (9.9%)	(0, 21.8)	5.8	
No	10 (90.1%)	(78.2, 100)	5.8	
Lack of Knowledge of where to get treated				.792
Yes	66 (40.6%)	(28.5, 52.7)	5.9	
No	63 (59.4%)	(47.3, 71.5)	5.9	
Could not find a Preferred Provider				<.0001*****
Yes	38 (23.0%)	(13.9, 32)	4.4	
No	89 (77.0%)	(68, 86.1)	4.4	
No Opening with Preferred Provided				<.0001*****
Yes	5 (2.7%)	(0, 6.3)	1.8	
No	120 (97.3%)	(93.7, 100)	1.8	
Issues with transportation, childcare or getting appointments at times that worked				<.0001*****
Yes	23 (15.6%)	(7.1, 24)	4.1	
No	104 (84.4%)	(76, 92.9)	4.1	

Not Enough Time for Treatment				<.0001*****
Yes	28 (16.1%)	(8.9, 23.3)	3.5	
No	98 (83.9%)	(76.7, 91.1)	3.5	
Worried about Privacy				0.476
Yes	59 (45.6%)	(29.7, 61.5)	7.7	
No	67 (54.3%)	(38.5, 70.3)	7.7	
Worried about People's Opinions				0.014*
Yes	51 (41.0%)	(28, 54.1)	6.3	
No	79 (59.0%)	(45.9, 72)	6.3	
Worried about Loss of Home, Job, Children, etc.				<.0001*****
Yes	13 (11%)	(1.4, 20.6)	4.7	
No	117 (89%)	(79.4, 98.6)	4.7	
Not Ready to Start Treatment				0.010*
Yes	49 (46.8%)	(33.4, 60.2)	6.5	
No	78 (53.2%)	(39.8, 66.6)	6.5	
Thought could handle MH by themselves				<.0001*****
Yes	99 (75.6%)	(61.1, 90)	7.0	
No	30 (24.4%)	(10, 38.9)	7.0	
Thought family, friends or religious group would oppose				<.0001*****
Yes	37 (33.7%)	(20.3, 47.1)	6.5	
No	92 (66.3%)	(52.9, 79.7)	6.5	
Afraid of being committed to a hospital or forced into treatment against will				0.017*
Yes	51 (40.0%)	(26.2, 53.9)	6.7	
No	78 (60.0%)	(46.1, 73.8)	6.7	

Thought would be told to take medication				0.0005*****
Yes	45 (35.5%)	(23.7, 47.3)	5.7	
No	85 (64.5%)	(52.7, 76.3)	5.7	
Did Not think it would help				0.033*
Yes	51 (45.2%)	(32, 58.4)	6.4	
No	75 (54.8%)	(41.6, 68)	6.4	
No One would Care				0.001*
Yes	45 (40.9%)	(29.1, 52.6)	5.7	
No	81 (59.1%)	(47.4, 70.9)	5.7	

Notes

[1]P-values were calculated using one-way chi-square tests comparing the distribution between adolescents who identified each reason as a barrier and those who did not

***** Statistically significant at α <0.05 (two-tailed test)

The following tables look at: Mental Health Service Utilization by Factors Affecting Mental Health Service Utilization Among African American Adolescents Under the Age of 18 with Unmet Health Needs (Weighted Percent, Standard Error, *p*-values)

Table 7:

Saw/Talked to a MD/Professional for MDE in the Past Year Received Treatment/Counseling for MDE in the Past Year					
	Yes (Weighted N = 7943)		**No (Weighted N= 144,037)** [1]		
	Weighted Percent	**Standard Error**	**Weighted Percent**	**Standard Error**	***p*-value**
Treatment Cost Too Much					-
Yes	-	-	17.1	4.7	
No	100.0	0.0	82.9	4.7	
No Health Insurance Coverage					-
Yes	-	-	11.8	3.7	
No	100.0	0.0	88.2	3.7	
Health Insurance Did not cover enough					-
Yes	-	-	5.6	3.8	
No	100.0	0.0	94.4	3.8	
Lack of Knowledge of where to get treated					.614
Yes	53.4	30.8	37.2	4.5	
No	46.5	30.8	62.8	4.5	
Could not find Preferred Provider					1.000
Yes	53.4	30.8	22.9	4.5	

No	46.6	30.8	77.1	4.5	
No Opening with Preferred Provided					-
Yes	53.4	30.8	-	-	
No	46.6	30.8	100.0	0.0	
Issues with transportation, childcare or getting appointments at times that worked					.549
Yes	53.4	30.8	11.4	3.9	
No	46.6	30.8	88.6	3.9	
Not Enough Time for Treatment					1.000
Yes	53.4	30.8	17.0	3.9	
No	46.6	30.8	83.0	3.9	
Worried about Privacy					1.000
Yes	86.6	10.0	53.8	5.2	
No	13.4	10.0	46.2	5.2	
Worried about People's Opinions					.357
Yes	92.9	4.5	38.5	4.5	
No	7.1	4.5	61.5	4.5	
Worried about Bad Things Happening					.396
Yes	53.4	30.8	5.3	2.1	
No	46.6	30.8	94.7	2.1	
Not Ready to Start Treatment					1.000
Yes	59.7	29.4	44.1	4.7	
No	40.3	29.4	55.9	4.7	

Thought could handle MH by themselves					.141
Yes	59.7	29.4	81.4	4.3	
No	40.3	29.4	18.6	4.3	
Thought family, friends or religious group would oppose					1.000
Yes	53.4	30.8	28.2	4.2	
No	46.6	30.8	71.8	4.2	
Afraid of being committed to a hospital or forced into treatment against will					.614
Yes	53.4	30.8	50.5	4.7	
No	46.6	30.8	49.5	4.7	
Thought would be told to take medication					1.000
Yes	53.4	30.8	41.9	4.0	
No	46.6	30.8	58.1	4.0	
Did Not think it would help					.342
Yes	53.4	30.8	59.5	4.7	
No	46.6	30.8	40.5	4.7	
No One would Care					.615
Yes	53.4	30.8	41.3	5.0	
No	46.6	30.8	58.7	5.0	

Notes

[1]Weighted frequencies within the categories of Mental Health Service Utilization for MDE vary due to some missing data on the enabling factors.

Table 8

Saw/Talked to a Health Professional for MDE in the Past Year					
	Yes (Weighted N= 1061)		**No (Weighted N= 146,677)[1]**		
	Weighted Percent	**Standard Error**	**Weighted Percent**	**Standard Error**	***p*-value**
Treatment Cost Too Much					-
Yes	-	-	16.8	4.6	
No	100.0	0.0	83.2	4.6	
No Health Insurance Coverage					-
Yes	-	-	11.6	3.6	
No	100.0	0.0	88.4	3.6	
Health Insurance Did not cover enough					-
Yes	-	-	5.5	3.8	
No	100.0	0.0	94.5	3.8	
Lack of Knowledge of where to get treated					-
Yes	-	-	36.6	4.2	
No	100.0	0.0	63.4	4.2	
Could not find Preferred Provider					-
Yes	-	-	22.5	4.3	
No	100.0	0.0	77.5	4.3	

No Opening with Preferred Provided					-
Yes	-	-	-	-	
No	100.0	0.0	100.0	0.0	
Issues with transportation, childcare or getting appointments at times that worked					-
Yes	-	-	11.2	3.8	
No	100.0	0.0	88.8	3.8	
Not Enough Time for Treatment					-
Yes	-	-	16.7	3.8	
No	100.0	0.0	83.3	3.8	
Worried about Privacy					-
Yes	-	-	54.6	5.0	
No	100.0	0.0	45.4	5.0	
Worried about People's Opinions					1.000
Yes	47.1	24.9	39.6	4.5	
No	52.9	24.9	60.4	4.5	
Worried about Bad Things Happening					-
Yes	-	-	5.2	2.0	
No	100.0	0.0	84.8	2.0	
Not Ready to Start Treatment					1.000
Yes	47.1	24.9	43.3	4.3	
No	52.9	24.9	56.7	4.3	

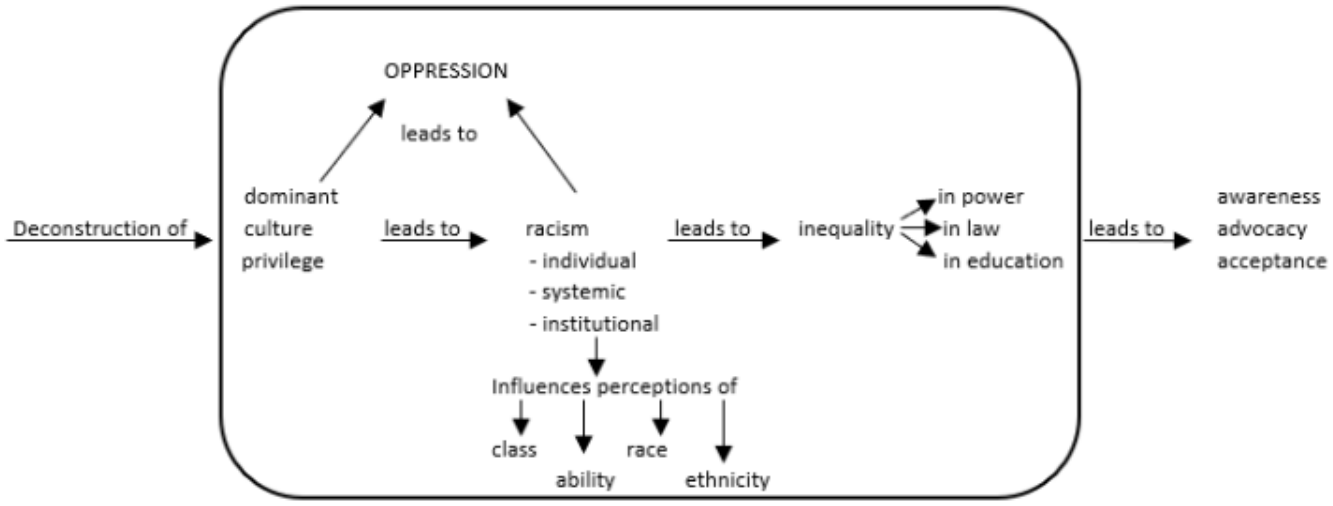
Thought could handle MH by themselves					.328
Yes	47.1	24.9	79.8	4.4	
No	52.9	24.9	20.2	4.4	
Thought family, friends or religious group would oppose					-
Yes	-	-	27.7	3.9	
No	100.0	0.0	72.3	3.9	
Afraid of being committed to a hospital or forced into treatment against will					-
Yes	-	-	49.6	4.7	
No	100.0	0.0	50.4	4.7	
Thought would be told to take medication					-
Yes	-	-	41.1	3.9	
No	100.0	0.0	58.9	3.9	
Did Not think it would help					-
Yes	-	-	58.4	4.9	
No	100.0	0.0	41.6	4.9	
No One would Care					-
Yes	-	-	40.4	5.0	
No	100.0	0.0	59.6	5.0	

Notes

[1]Weighted frequencies within the categories of Mental Health Service Utilization for MDE vary due to some missing data on the enabling factors.

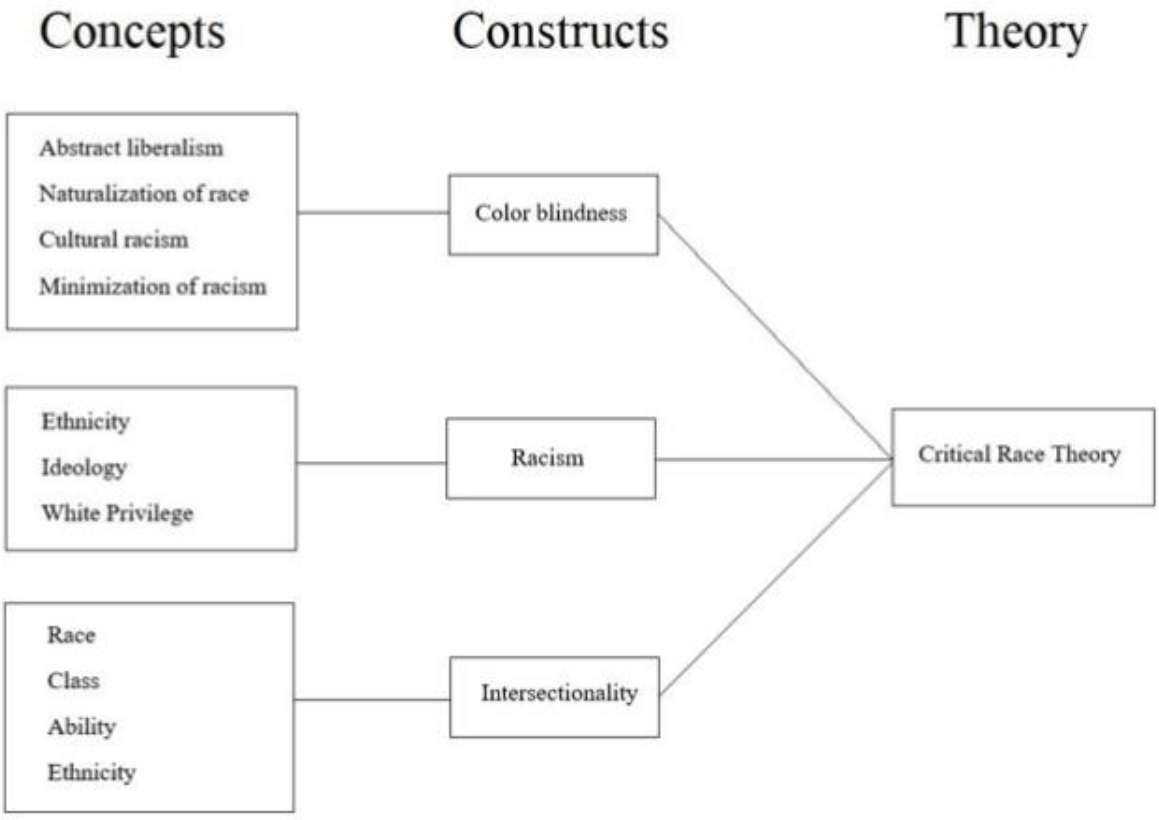
Appendices

Appendix A. Model of Critical Race Theory



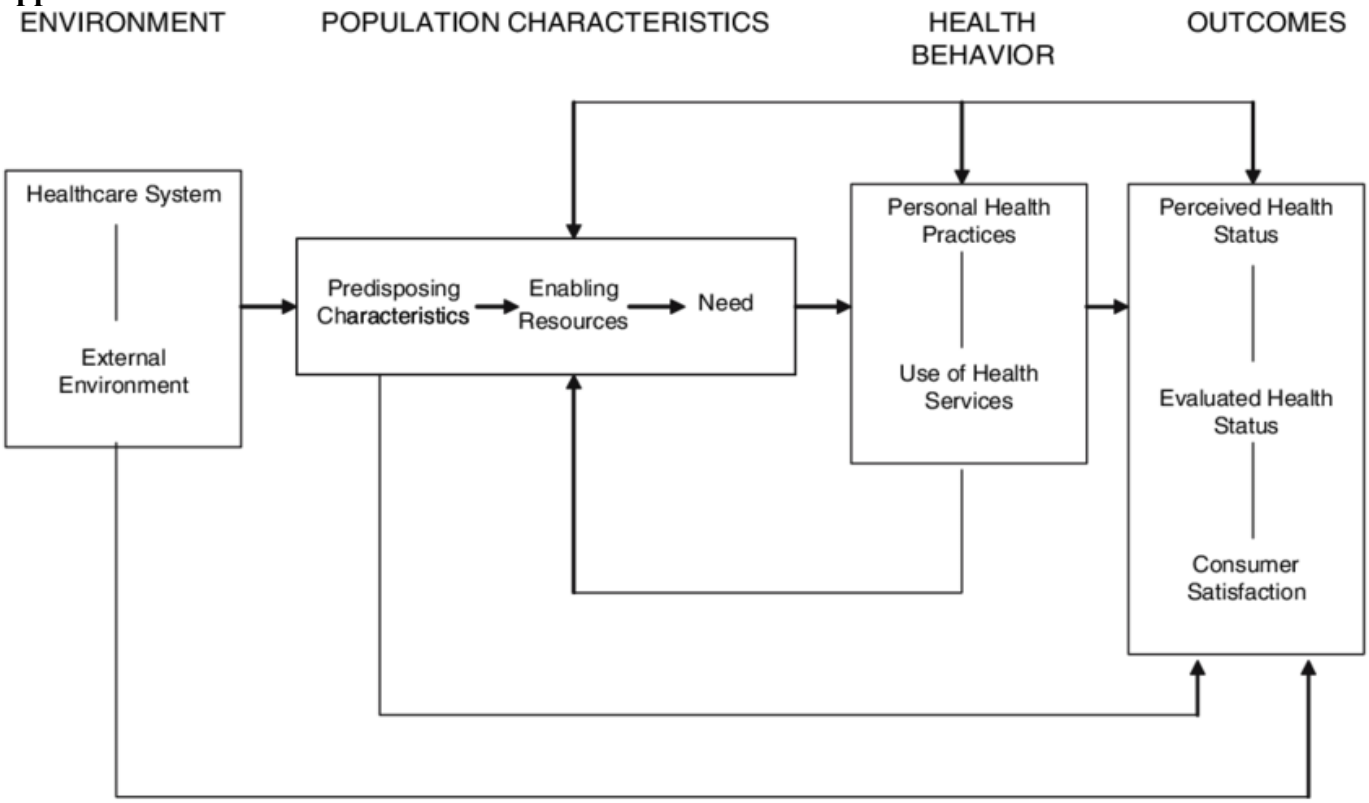
(Movius, n.d.)

Appendix B. CRT Concepts and Constructs



(Movius, n.d.)

Appendix C. Anderson's Behavioral Model of Health Service Use



(Davey & Watson, 2008)