ABSTRACT

MENTAL HEALTH OUTREACH PROGRAM FOR AFRICAN AMERICANS:

A GRANT PROPOSAL

By

Eddie S. Mack

May 2015

The purpose of this project was to write a grant proposal seeking funding for a community-based mental health-educational outreach program targeting African Americans in Los Angeles County, California. This population underutilizes mental health intervention services despite their high risk of developing mental health abnormities. The California Endowment was chosen as a potential funder due to its commitment to improving the health of Californians; the host agency Alma Family Services, shares in the commitment to early prevention and intervention. The program will provide resource information to reduce barriers to treatment and to increase awareness. The actual submission and/or funding of this grant was not a requirement for the successful completion of this project.

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A GRANT PROPOSAL

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Committee Members:

Janaki Santhiveeran, Ph.D. (Chair)
Jo Brocato, Ph.D.
Thomas Alex Washington, Ph.D.

College Designee:

Nancy Meyer-Adams, Ph.D.

By Eddie S. Mack

B.S.W., 2010, California State University, Long Beach

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CHAPTER 1

INTRODUCTION

Mental health is not often discussed, but it plays a significant role in daily life (Mental Health America [MHA], 2014). The financial health of the United States rests on the foundation of its citizens' mental health. For example, psychological abnormalities are linked to a significant loss in salary and productivity totaling $37 to $14 billion dollars (Graaf, Tuithof, Dorsselaer, & Have, 2012). Furthermore, research has suggested that regulations enacted and designed to counter the adverse effects of common mental disorders on employees will aid in lessening the impact of salary loss and increasing worker's productivity (Graaf et al., 2012). The cost of not attending to mental disorders is significantly larger than employee treatment cost. According to Graaf et al., 2012), the "prevention and treatment" of psychological illnesses may be more financially responsible and "cost effective" (Graaf et al., p. 1877).

Mental health is vital to a person's well-being. Research suggests that persons with mental health issues seek and obtain services at different rates depending on preferences, finances, and accessibility (Barksdale & Molock, 2009). Research also strongly suggests that African Americans prefer utilizing informal mental health care services such as church or friends rather than formal mental health care services more than do Whites (Barksdale & Molock, 2009). African Americans utilize psychiatric services based on their perceived need for services, which varies from individual to

individual and family to family (Barksdale & Molock, 2009). Barksdale and Molock (2009) reported that African Americans utilize formal and informal mental services at half the rate of their White counterparts.

Before 2012, the largest percentage of minorities lived in the following states: Hawaii (77.1%), District of Columbia (64.7%), California (60.3%), New Mexico (59.8%), and Texas (55.2%; U.S. Census Bureau, 2012). In July 2011, an unprecedented event occurred in North America: The majority of children under 1 year old were non-White (50.4%); this estimate is higher than the previous census results from April 1, 2010, which charted this population at 49.5% (U.S. Census Bureau, 2012). Altogether, 36.6% of total North American population in 2011 (about 114 million people) was comprised of minorities, a notable increase from 36.1% in 2010 (U.S. Census Bureau, 2012).

Hispanics comprise the largest minority group; estimates show their numbers to be over 45 million (U.S. Department of Health and Human Services [USDHHS], 2008). The rapid growth of the Hispanic population in North America constitutes 50% of the minority population and by 2050 will constitute 25% of North America's population (U.S. Census Bureau, 2008). The Hispanic population is more less than Whites to use the U.S. mental health care system (Dupree, Herrera, Tyson, Yuri, & King-Kallimanis, 2010; Shobe, Coffman, & Dmochowski, 2009). The above analysis highlights gross disparities in mental health care usage between minorities and Whites.

Some African Americans continue to feel marginalized by the mental health care system due to the lack of shared information or interface between African

Americans and the scientific community. As a result, African Americans hold great suspicion of the health care system and therefore are less likely to use modern medical treatment or to participate in medical research (Briggs, Briggs, Miller, & Paulson, 2011).

Cultural, societal, and socioeconomic elements can undoubtedly influence mental health development in African Americans; these influences can place African Americans at risk of manifesting mental and behavioral abnormalities (World Health Organization [WHO], 2014a). The promotion of mental health care, intervention, and treatment must encompass developing an environment where the parties involved respect the civil rights of the person and where the stated needs of that person are met (WHO, 2014b). Mental health must be viewed as equally important in development as education, compassion, and employment (WHO 2014b).

According to the U.S. Census Bureau (2011b), 42.7 million persons in North America lived below the poverty line from 2007 to 2011. Poverty among African Americans (25.8%) was 10 points greater than that for the total U.S. population. Poverty and mental wellness are linked. For example, a person with a severe psychological illness is more likely to experience poverty, and vice versa (Santiago, Kaltman, & Miranda, 2013). Research suggests that racism and discrimination lead to a lower quality of life for minorities (Danna, Ponce, & Siegel, 2010) African Americans are also adversely affected by low-wage jobs, associated with limited purchasing power, dilapidated housing and neighborhoods, and violence, all to a greater degree than other ethnic groups (Marger, 2008; Sue, Bucceri, Lin, Nadal, & Torino, 2007; Sue,

Capodilupo, & Holder, 2008). As a consequence of experiencing racial discrimination, African American urban youth have an increased risk of developmental mental and behavior challenges (Tobler et al., 2013).

The limited research on psychiatric epidemiology among African American youth has yielded mixed results due to disputed documented cases of disruptive behavior and misdiagnosis. However, African Americans have remained resilient, often enduring racism, discrimination, poverty, and lack of access to services (APA Task Force on Resilience and Strength in Black Children and Adolescents [APA Task Force], 2008; Evans et al., 2012).

Data suggest that many African Americans are hesitant to seek formal professional mental health services because such service is unacceptable to family and friends (Barksdale & Molock, 2009). Some African Americans are deterred from seeking mental health services out of fear of stigmatization (Barksdale & Molock, 2009). To prevent being labeled as “different” or “other,” many African Americans opt not to seek treatment or they delay care. According to the USDHHS Office of Minority Health, African Americans over 18 years old are 20% more inclined to report severe mental illness than Whites (MHA, 2014). African Americans are more likely to use a primary health care practitioner than to obtain care from a formal mental health specialist (Barksdale & Molock, 2009). African Americans seek mental health services based on social and cultural beliefs (Barksdale & Molock, 2009). They have a great need for mental health treatment services just as other groups but are more likely to delay treatment (Baker, Kurland, Curtis, Alexander, & Papa-Lentini, 2007).

The Purpose of the Grant

The purpose of this project is to write a grant application to fund the development of a mental health program that includes outreach, community involvement, and informational services to equip African Americans with resources to sustain mental wellness. The mission of the program is to increase usage of mental health services by the African American community. The proposed program will identify, investigate, and address factors that contribute to underutilization of mental health care services by the target population. The program's aim is to work with an existing community organization that promotes mental health and conducts research. The staff will select a location where workshops and presentations can be conducted and where evidenced-based literature can be disseminated, along with referral information.

Definition of Terms

Black or African American

A person having origins in any of the Black racial groups of Africa (U.S. Census Bureau, 2011a).

Chronic Mental Illness

A mental problem or condition that persists for at least 3 months (Centers for Disease Control and Prevention [CDC], 2014).

Culture

"A combination of common heritage beliefs, values, and rituals that are an important aspect of racial and ethnic communities" (APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008, Cultural Issues section, para. 1).

Mental Health

"A state of well-being in which a person realizes his or her own potential, can cope with the normal stresses of life, can work productivity and fruitfully, and is able to make a contribution to the community" (WHO, 2014, para. 3)

Mental Health Information

A process whereby staff share general or specific information about the availability and usage of mental health services. These efforts are designed to reduce the stigma of mental disorders and to develop community awareness of available mental health resources (Los Angeles County Department of Mental Health, Program Support Bureau, 2010).

Mental Illness

"Refers collectively to all diagnosable mental disorders. Effects of the illness include sustained abnormal alterations in thinking, mood, or behavior associated with distress and impaired functioning" (CDC, 2011, What is Mental Illness section, para. 1).

Background Information

There continue to be great disparities in the utilization of mental health care services between African Americans and their White counterparts. The underutilization of mental health services by the target population is disturbing and disconcerting, because many African Americans in the United States have long encountered poor health outcomes (e.g., heart disease, diabetes), in addition to outside stressors such as discrimination, unresponsive environments, chronic unemployment and/or underemployment, homelessness, underperforming schools, unjust laws that disproportionately

target poor and minority individuals, and lack of access to culturally competent community resources (Copeland, 2006).

Previous attempts have been made to assist Americans with maintaining mental and physical health. In the early 1960s, public mental health facilities rendered mental health services to all persons, regardless of gender, age, or ethnicity (Briggs et al., 2011). However, these early public mental health facilities were ill equipped to provide culturally sensitive intervention to minorities, especially African Americans (Briggs et al., 2011). Furthermore, the public mental facilities of the 1960s paid little to no attention to the needs of oppressed persons regarding their mental and physical health (Briggs et al., 2011).

Research on the target population has documented preferred treatment methods that many service providers have yet to employ to increase African American involvement in the mental health system (for example, professionals who have the ability to speak to the injustices or triumphs that affect their daily lives) and issues that deter help-seeking behavior on behalf of African Americans such as cultural influences and lack of peer-family-community support (Copeland, 2006).

African Americans and Mental Illness

The prevalence of chronic mental illness within the African American community in particular warrants attention. Available data strongly suggest that African Americans are affected by many factors that contribute to poor mental health outcomes, more so than Whites. Lo, Cheng, and Howell (2014) conducted a multivariate data analysis utilizing data from the 2009 National Health Interview Survey to investigate racial differences in the manifestation of chronic mental illness and the significances of

race in association with the manifestation of particular physiological illness and variables in relationship with community status and health care treatment. The authors found that 28% of the total sample was distinguished by chronic psychological illness, including 3.5% of the African American sample and 2.6% of the White sample. The authors concluded that race had a strong association with chronic type of mental illness.

Lo et al. (2014) reported that "a chronic condition stemming from a mental illness was more likely to be found among African Americans than Whites" (p. 253). Focusing on the 290 participants who coped to having psychological issues, 90% had had their mental illness longer than 1 year. The researchers concluded that race did not have anything to do with a person not having a job or being able to afford health care. However, the study highlighted disparities in respondents: Whites were older, more likely to homeowners, more educated, earned more, were more likely to live with a significant other, and were more likely to insurance, compared to minority individuals such as African Americans.

Many African Americans look at the race or ethnicity of the practitioner as a significant factor in choosing whether to obtain or forgo treatment (Meyer & Zane, 2013). Consumers who were racially matched with a therapist of the same race exhibited better mental health treatment outcomes, increased usage of services, and less likelihood to drop out of treatment.

Perception of Mental Illness

Research suggests that African Americans hold distinct perceptions about mental illness, its causes, and about preferred methods of intervention (Conner et al., 2010). In 1996, the MHA (2014) commissioned a national survey on clinical

depression. The goal of the survey was to investigate barriers to mental health treatment for Americans, their perceptions of mental illness, and their understanding of treatment options. The survey indicated that 63% of African American respondents regarded depression as a result of individual mental and physical weakness, in contrast to 54% of the overall sample. African Americans (56%) held the attitude that depression was linked to the natural aging process of the human body. African Americans perceived that their needs for mental health care services were better met and the intervention was more productive when the provider was of the same ethnic background.

Conner et al. (2010) investigated barriers (cultural and systemic issues) that affected African Americans' perceptions about the United States and the public health systems that preserved its existence. Participants exhibited limited symptoms of mild depression. The data for this study were accumulated via 37 interviews involving adult African Americans, audiotaped and later transcribed. The researchers found that African Americans mistrusted the public health care system in general and the mental health care sector specifically; they attributed these attitudes to the African American experience in North America, which research has suggested can be stressful and affect overall mental health. These cultural viewpoints about mental illness may induce suffering in the African American community as a result of failure to secure care out of fear of being stigmatized and rejected by their community and society as a whole (Conner et al., 2010).

African Americans must cope with racial animus from other African Americans, in addition to grim outcomes with respect to social and economic justice. As a result,

many African Americans hold the perception that mental health should be handled in-house in a culturally accepted manner (Conner et al., 2010). According to Conner et al. (2010), African Americans in their study had difficulty in identifying symptoms of depression. Such failure to understand constitutes mental illness and how to identify signs of mental health is influenced by historical cultural perceptions about mental illness and how to react to and deal with mental illness.

Social Work Relevance

The social work profession has proven its usefulness in resolving individual, familial, and community issues. Social workers provide comprehensive mental and behavioral services to low-income communities and to individuals of all backgrounds. It is paramount that social workers be well versed in environmental factors that may affect human behavior and policy issues. Social workers are likely to encounter persons who are reluctant to seek treatment and who have limited resources. Developing programs and treatment options that incorporate aspects of cultural relevance and modern scientific evidence-based interventions aimed at fostering mental health and combating mental illness is fundamentally crucial.

Cross-Cultural Relevance

Mental health is an essential factor in the process of human development. It is of the utmost importance that individuals and their families be provided adequate services to improve mental health care outcomes for all Americans in a fair and just manner. The mental health care system is not sufficiently equipped to respond to and target issues, which presents as a barrier to mental stability (Briggs et al., 2011). Many studies have identified barriers such as ethnicity, stigma, and insufficient treatment

usage by the target populations (Alvidrez, Snowden, & Kaiser, 2008). Briggs et al. (2011) suggested that African Americans' unemployment and underemployment has been documented as a barrier to adequate comprehensive mental and behavioral health care services. They argued that African Americans are disproportionately and adversely affected by incarceration and are ultimately discriminated against once they are released, including difficulty in obtaining employment that provides mental health care insurance.

African Americans account for 9.6% of Los Angeles County residents and 43.7% account for the Los Angeles County Jail's "serious mental illness" occupants (Patrisse, 2014, p. 1).

CHAPTER 2

LITERATURE REVIEW

This chapter reviews literature about the African American experience in the United States. It explores the disparities in the mental healthcare system. A focus is placed on effective strategies for increasing participation in the mental health care system. Finally, the literature review explores the need for policy changes in the mental health care system, the need for people to flourish, and coping mechanisms utilized by the target population to maintain mental health and hope.

African Americans in the United States

The U.S. Census Bureau (2012) estimated that more than 10 million people resided in Los Angeles County, California, including 9.2% of whom were African Americans. This was not the case because before industrialization and urbanization, when the majority of African Americans resided in the north and south (Wilson, 2005). The homogeneous movement of African Americans from the south to other regions in the United States was due in part to increasing opportunities and hope. The large migration of persons of African descent from southern, northern, rural, and agricultural areas to urban areas produced significant racial color lines in the United States (Wilson, 2005). African Americans' urban population increased from 1910 to 1960 from 27% to 73% in California (Wilson, 2005).

Before migration changed the social fabric in predominately White areas in Los Angeles (Watts, South Gate, and Main), these areas were off limits to African Americans. In fact, racially inspired boundaries restricted non-Whites from around the Central Avenue areas of Los Angeles in the 1940s (Brown, Vigil, & Taylor, 2012). Along with restrictions placed on movement, African Americans had to contend with "White Flight" from "Watts [which was a] predominately White, . . . middle class district of professionals, white collar workers, and government employees" (Brown et al., 2012, p. 215). The mass exodus of the White population had a dramatic effect on the social fabric of these areas. Color lines dictated where resources would be allocated. African Americans accounted for 50% of Los Angeles's newly arrived minority population during the 1940s and 1950s (Brown et al., 2012).

Los Angeles could not absorb the rapid migration of African Americans, and these areas became impoverished. African Americans were more likely than their White counterparts to work night shifts and hold positions where upward mobility was nearly impossible because no African Americans were allowed to occupy a position higher than their White counterpart. This situation perhaps "instill[ed] in them a sense of diminished enthusiasm and self-esteem" (Brown et al., 2012, p. 215).

The migration across the vast American west to Los Angeles, California was challenging, emotional and courageous. Many African Americans migrated out of desperation, under undesirable terms or conditions, and others on short notice. They uprooted their families, in many instances leaving their support systems behind. This factor, in turn, created greater barriers for success after the great migration of limited-

skill African American job seekers. The migration had an impact on every aspect of the traveling African Americans and their families. Once in Los Angeles, the newcomers encountered numerous barriers to social and economic justice. The majority of these newcomers were sharecroppers from the Deep South and victims of Jim Crow segregation laws; they had limited education (Brown et al., 2012).

African Americans' Mental Health

According to the USDHHS (2012), 20% of African Americans reported serious mental illness more readily than Whites. A study commissioned by the MHA (2014) revealed that 17% of African Americans identified fear and a limited understanding of treatment methods as barriers to service.

African Americans are more likely to experience somatization at the rate of 15% compared to White Americans at a significantly less rate of 9% (National Alliance on Mental Illness [NAMI], 2007). In some people, somatization is thought to mask psychiatric symptom distress or full-blown mental illness; somatic symptoms may be a more acceptable way of expressing suffering than psychiatric symptoms (U.S. Office of the Surgeon General, Center for Mental Health Services, & National Institute of Mental Health, 2001).

Somatization dates back to psychoanalytic theories, including clinical studies that described human discomfort displayed through somatic indictors as the result of internalized emotional discomfort of a psychological matter. Somatization was recognized as a defense mechanism in Appendix C of the revised third edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association [APA], 1987). However, somatization would later be deleted from *DSM-IV* (APA,

1994) “as somatization was viewed as a symptom derived from other defenses: A distressing idea or affect is blocked (repression, isolation of affect) and displace[d] onto a physical symptom” (Busch, 2014, p. 421).

Historical Facts About African Americans

African Americans have an extended history in the United States dating back to the 1800s. The 1800s were very stressful times for this population, and many took their own lives. Snyder (2010) asserted that, as suicide increased exponentially, ship captains and everyone in the business of slavery were concerned about the well-being of their cargo on land or on the ocean until the selling date. Several preventative measures were documented and implemented to reduce the suicide rate of captive Africans at sea or on land: Attempted self-murderers were charged with serious crimes; the family of self-murderers could face financial issues; nets were placed around ships to prevent jumping; and forced feeding was instituted with The Speculum Oris (Snyder, 2010).

To cope with the horrors of slavery, many Africans participated in homosocial outings after work or during their free time. They relaxed through game play, roughhousing, and drinking. Lussana (2013) noted that drinking alcohol at various points in U.S. history solidified bonds and played a significant role in American culture. Enslaved men watched over each other whenever possible and, on occasions when an enslaved African and/or African American got too drunk, he was pulled to the side and asked to “get it together” (Lussanna, 2013). Social acceptance is important to human development and, during this epoch, slaves endured unremitting discrimination and segregation along color lines.

Disparities in Mental Health Care

Disparities in the mental health care system continue, largely along racial and ethnic lines. Research indicates that disparities exist in part because minorities are less likely to initiate care from the general health care system (Cook et al., 2014). As a result, minorities are less likely to be diagnosed, treated, or receive referrals to a specialist. Research also reveals that minorities are more likely than Whites to use emergency room services and less likely to get treatment from a primary care physician (Cook et al., 2014).

According to Copeland (2006), the U.S. Surgeon General published in the 1999 *Mental Health Report* findings that highlighted vast inequalities in the U.S. mental health care system. Copeland stated that when African Americans are able to find mental health care services, the services are often substandard in practices and diagnosis.

Jimenez, Cook, Bartels, and Algeria (2013) examined disparities in the mental health care service delivery system utilized by racial and ethnic elderly minority adults in the United States. The authors' study revealed that Whites were more likely than minorities to experience a mental health disturbance and get psychiatric medication refills. In contrast, according to Jimenez el al. (2013), older minorities who experienced an episode were more likely than their White counterparts to have an episode "with only outpatient care visits (no psychotropic medication fills)" (p. 22).

Cook, McGuire, Algeria, and Normand (2011) analyzed data from 2000 to 2007 regarding medical expenditures reported in a panel survey of 511,083 African Americans, Latinos, and Whites. The results revealed that when factors such as physical

ailments presented with mental illness, disparities in the mental health care system increased for some groups. Thus, the authors examined comorbidities and their potential effects on patients with mental ailments and the likelihood that the physician would be familiar with mental illness presented in the form of physical illness. By factoring in comorbidities and adjusting for differences in certain areas, the authors presented results that strongly suggested that treated comorbidities result in better mental and physical health outcomes (Cook et al., 2011). These results are significant for many reasons but in part because minorities have a larger prevalence of comorbidities. When the Latino population was taken into account, mental health care disparities decreased compared to Whites (Cook et al., 2011). The results of this study laid out the case that minorities experience health care issues that may have an impact on them being diagnosed for mental illness because minorities use the emergency room due to a lack of insurance more than Whites, who are likely to have a primary care practitioner.

Black Subgroups and Mental Health Care

According the U.S. Census Bureau (2011a), there were 308.7 million Americans in the United States on April 1, 2010, 13% of whom self-identified as Black alone and 1% of whom self-identified as Black in combination. These persons and those who self-identified as Black with multiple nationalities made up 14% (42 million individuals. To clarify, the classification utilized by the Bureau adds other nationalities under the umbrella of Black or African American: Sub-Saharan African, Kenyan, Nigerian, Afro-Caribbean, Haitian, and Jamaican (U.S. Census Bureau, 2011a).

The African American-Black population in the United States is unique in many aspects in terms of North American experiences, in part due to discrimination or

isolation and difference in length of exposure to U.S. democracy. As a result, the target population's needs are vast and far reaching. Therefore, cultural competency is needed to diagnosis and treat this populations' unique ailments and close the racial and ethnic gaps in mental health care usage.

Studies have revealed that Black immigrants and African Americans are not the same in terms of physical and mental health status (D. R. Williams, Haile, et al., 2007). Unfortunately, little credence is given to the narrative that mental and behavioral ailments manifest differently in Black- African Americans and persons in general (D. R. Williams, Haile, et al., 2007). As a consequence, limited research is available about the diversity of mental challenges that this population encounters in North America (D. R. Williams, Haile, et al., 2007). Moreover, the diversity within the African American population of North America is ignored and categorized as a singular population by the U.S. Census Bureau. Grouping Black Caribbean immigrants with African Americans for counting purposes, as they constitute 4.4% of the North American Black population, ignores the significant cultural history and experiences of each group (D. R. Williams, Haile, et al., 2007).

D. R. Williams, González, et al. (2007) reported in a self-report study that lasted for 2 years and included 3,570 African Americans, 1,621 Blacks of Caribbean descent, and 891 non-Hispanic Whites age 18 or older, African Americans were at a relatively higher risk for chronic depression. Utilizing research data from the National Survey of American Life—an in-person household mental health survey of noninstitutionalized U.S. Blacks—D. R. Williams, González, et al. examined the prevalence and correlation

of mental illness in Caribbean immigrants (Black Caribbeans) and U.S.-born African Americans. The study revealed that Blacks of Caribbean nationality experienced a higher prevalence of mental health issues than U.S.-born African Americans. On the other hand, U.S.-born African Americans had higher substance use rates.

Research has found 10.4% of African Americans, followed by 12.9% of Caribbean Blacks and 17.19% of non-Latino Whites, acquired mental illness in a particular Major Depressive Disorder (MED) during their lifespan (National Institute of Mental Health [NIMH], 2007). It was noted by NIMH (2007), which utilized the study of D. R. Williams, Haile, et al. (2007), that 10.4% of African Americans, followed by 12.9% of Caribbean Blacks and 17.19% of non-Latino Whites, had acquired Major Depressive Disorder (MDD) before they died. The study also revealed that 56% of African Americans reported higher rates of chronic depression, compared to 65% of Caribbean Blacks and 38% of Whites. According to D. R. Williams, Haile, et al., among participants with depression, the rate of chronic depression was highest in Black groups: 56.5% in African Americans and 56% percent in Caribbean Blacks, compared with 38.6% in Whites

Barriers to Mental Health Care

Based on findings reported by Danna et al. (2010), U.S. minorities experience higher levels of health abnormalities. The study identified barriers based on perceived discrimination and the impact of perceived discrimination on persons who self-identified as being discriminated against in the mental health system as it relates to the race-ethnicity and social economic position (SEP). The authors found that social economic status was an important variable in understanding disparities in mental and physical health care in the U.S. health care system after controlling for SEP,

attainability of care, patient requests-needs, or patient choice of clinicians. Danna et al. added that inaccessibility of care for African Americans persisted and noted that inequalities in health care have been researched and widely documented.

Serkin, Ngo-Metzger, and Alba (2010) noted that consumer feelings of abandonment, negative treatment, and feelings of discrimination in the health care process may have an adverse impact on their perceptions of the health care process. The authors suggested that being on the receiving end of negative experiences in the health care system might influence dropout rates, mistrust, and avoidance (Serkin et al., 2010).

According to M. Williams (2011), African Americans avoid obtaining mental health services because of the stigma associated with mental health care. Stigma is a social construct that seeks to mark persons with mental health challenges as inferior or needy, which is stereotypical and adversely affects employment outcomes (Cummings, Lucas, & Dross, 2013). As a result of stigmatization of mental illness in U.S. society, persons with such formal health care needs are less likely to pursue or utilize psychiatric services for mild, chronic, or severe psychological challenges (Smith, 2012).

Alvidrez et al. (2008) revealed that 35% of the participants in their study held a narrow viewpoint about mental illness and felt that the presence of a mild illness such as mild depression or anxiety occurred only in "crazy people."

The profound negative sentiments and biases associated with mental illness have the ability to manifest in persons whose job or career requires that they provide care for others (Smith, 2012). In addition, stigmatization of mental illness has a detrimental

effect on individuals, causing them to withdraw from their social network and/or conceal their mental condition (Calloway, 2006).

Failure to get treatment out of fear of being stigmatized could exacerbate current aliments and affect self-efficacy to achieve. As a result of internalization, socially engineered negative connotations are often attached to mental illness (Calloway, 2006).

Another common barrier to individualized mental health care treatment for many minorities, in particular African Americans, is lack of insurance. Calloway (2006) pointed out that in addition to the many barriers to adequate health care, African Americans encounter issues that add to inequalities: limited health care liability, poor planning of treatment methods for persons with dual diagnosis (co-occurring mental illness and substance use and drugs in combination). Calloway contended that these disparities persist because health care is closely related to financial well-being, dictated by SEP. The author's study included 55 participants, 21% of whom reported that stigma attached to mental health was a concern that limited their motivation to seek help. Some (11%) identified unequal treatment from the health care system as the next barrier to treatment, and 10% reported that confiding in someone about their illness was a significant issue in their view of treatment obtainment behavior (Calloway, 2006).

Mistrust of the health care system in general and the mental health care system in particular causes African Americans to avert the system as a whole. Distrust was recognized as a significant barrier to psychiatric care by minorities (USDHHS, 2001). Distrust of the mental health care system is prevalent among minorities, especially African Americans. Although the mental health care needs of African Americans are

ubiquitous and unique, there is limited scant documentation available with respect to the usage of mental health care services by African Americans (USDHHS, 2001).

Cultural Factors

American popular culture is multifaceted and a culmination of many elements. Some identifying features are displayed in various mediums of music, competitive and/or individual sports, cinema, language, and home remedies (Hamlet, 2011). The influence of African Americans for North American popular culture has been broad and significant. However, some cultural beliefs may present barriers that generate individual mistrust of the mental health care system (Hamlet, 2011). The mental health care system has failed in some areas to adapt to the ever-changing demographics of America and to develop, embody, and put into practice culturally sensitive methods (Toffler, 2005). Toffler (2005) asserted that inequality in the mental health care system is rooted in centuries of institutionalized racism, which remain a profound issue. As a result, historical barriers keep many African American from acquiring mental services:

> One is generational: older African Americans are more likely than the youth to be distrustful of doctors. Inequality in access, information, class differences diagnoses and treatment remain. Misinformation [may] lead to destructive consequences, including [failed relationships], imprisonment, and death. (Toffler, 2005, p. 10)

Like many cultural groups, African Americans utilize storytelling to deliver pertinent historical information, including cultural norms, traditions, historical battles, values, and religion to their youth and others members of their community (Hamlet, 2011). Transmission of vital cultural information through communication-language was essential to Africans in their homeland before enslavement. For example, communication allowed tribes on the continent of Africa to communicate with each other

even though many dialects were spoken on the continent. Therefore, to break the narration of events, it was common for captors to attempt to disrupt the communication patterns of the enslaved Africans before and after they arrived at their destination. However, this did not stop the communication flow between Africans. One method of communication that was utilized by Africans was called *Nommo* (effectively used for the purpose of communication in many situations), which traveled with the Africans to America. This genre was rich and infused with body movements, nonverbal communication, and tribal nuances. The slaves used complex communication skills that were recognized only by their authors, employing techniques to deceive captors and convey coded messages. Nommo was such a powerful force during Africa's pre-enslavement era that fathers would not acknowledge or provide their newborn child(ren) an identity (name) or medication or care without accompanying words. However, Nommo was more than words and was viewed by Africans as a living powerful element (Hamlet, 2011).

<u>The Black Church and Mental Health</u>

Mulvaney-Day, Earl, Diaz-Linhart, and Algeria (2011) examined likes and dislikes about interactions with formal mental health care personnel from the perspective of various racial groups. The analysis found variations in terms of expectations and preferences for mental health care treatment providers, delivery techniques, and style of treatment. African Americans were more likely to utilize informal care provided by their religious institution (the Black church). The study, involving 2,107 African Americans, revealed that they preferred informal care from leaders of their church over formal mental health services. This ethnic minority also cited communication and

rapport building as central to mental health care services. The participants were from varying ethnic backgrounds and cultural needs. In a telephone survey of 829 adult primary care clients, African Americans were less likely and Latinos were more likely than non-Latino Whites to regard counseling for a mental illness such as depression to be a legitimate treatment method. The study also explored learned interpersonal and/or cultural perceptions about authority figures within the minority populations that most hinder dialogue with mental health care authority figures. African Americans were more likely than non-Latino Whites to say that talking to a mental health professional about private issues was emotionally too painful (Mulvaney-Day et al., 2011).

The Black church has empowered the African American community for centuries and helped them to conquer seemingly insurmountable challenges (Clardy, 2011). For example, during the era of chattel slavery in North America (c. 1619–1965), most of the Black church sermons centered on their centuries-long bondage. The Black church has continued to support and receive support from the majority of African Americans. In fact, according to the U.S. Religious Landscape Survey conducted by the Pew Research Center's Forum on Religion and Public Life (Pew Research Center, 2015), it was found that African Americans identified religion as a significant aspect of their daily lives and self-identity. The results showed that 87% claimed membership in a religious organization, compared to the overall U.S. average of 83%. Also, 79% of Black respondents reported that religion was important and played a significant role in their lives, compared to 59% of all Northern Americans surveyed. Notably, historical events in U.S. history have placed the Black church at the center of social and political

issues important to this community and progress for the African American community in the United States. "The church [continues to stand] as a rich reservoir of cultural terms and expressions communicated through the sermons of the African American preacher" (Hamlet, 2011, p. 27).

The leaders of these religious institutions are trusted and respected individuals within the African American communities. The Black church social hierarchy system has the preacher (pastor, minster, reverend) at the helm to lead the congregation and support the community. The church affords the pastor-preacher the platform to build coalitions with other organizations and churches (Hardy, 2014).

African Americans have great trust in the Black church's ability to provide appropriate spiritual counseling and mental health care advice and consultation; in many cases it acts as the gatekeeper to interventions in various forms (Allen, Davey, & Davey, 2010).

Some African Americans' inability to cope with painful emotions during treatment resulted in dropout from treatment (McKay, Harrison, Gonzales, Kim, & Quintana, 2002). However, the Black church continues to be a place where African Americans can find solace in times of the mental discomfort, pain, and stress so often visited upon African Americans (Allen et al., 2010). Through sermons and other forms of traditional methods, the church seeks to address its members' unmet needs and support their morale in their interactions with other cultures (Clardy, 2011).

Prayer is also a significant therapeutic coping mechanism used by African Americans to achieve spiritual healing via informal mental wellness. However, the

empowering and encouraging sermons and the charged Black church atmosphere of spirituality and healing, along with an emphasis on prayer to ameliorate mental illness, may not suffice or even may prove to be ineffective (Allen et al., 2010) in that it may cause the individual to hide a diagnosis or disassociate with the social network, religious community, and/or family out of fear of being viewed as different or weak.

In an attempt to address the needs of their members, many Black churches are working diligently to incorporate spiritual and mental health healing to address their congregation's needs. One such Black church is The Potter's House. According to Gibson (as cited in Carrasco, 2005), The Potter's House is unitizing its church to implement support groups to serve the community's health needs. "Here at The Potter's House, we have a full-time Christian Counseling Center that offers individual, family, and group counseling. [This center employs] licensed professionals and paraprofessionals" (p. 4).

Effective Strategies for Increasing Usage of Mental Health Care

African Americans encounter many barriers that contribute to their low rate of participation in the mental and behavioral health care system in North America. Many approaches have been implemented and used successfully to improve African American usage of mental health care. Research has identified that African Americans disproportionally use mental care services as a result of cultural attitudes about mental care. Sixty percent of African Americans in an MHA-commissioned national survey on clinical depression reported internalized negative stereotypes about personal weakness as it relates to psychological abnormalities. The results were significant because they

underscored the greater number of African Americans who hold this viewpoint (54%; MHA, 2014).

Miseducation about mental health care and mental health significantly affects African Americans' understanding of treatment and symptoms related to their mental wellbeing. In the same study on attitudes about mental health and barriers impeding treatment (MHA, 2014), 56% of African Americans stated that depression was common and a part of getting older, which translates to denial of the presence of an illness. Also, 40% cited denial of mental health challenges as a barrier to seeking treatment.

Strategies have been developed and implemented to improve the mental health care system for all Americans in general (NIMH, 2014). MHA of California, in collaboration with NIMH, seeks to provide evidence-based practice mental health care literacy, decrease racial disparities, and expand access for minorities throughout Los Angeles County (NIMH, 2014). In addition, MHA of California seeks to encourage minority participation in policy making statewide by getting the communities involved to participate in shaping mental health care policies (NIMH, 2014)

Other outreach methods commonly utilized to increase support for individuals and families affected by mental challenges and to increase minority usage of mental health care services include the following: (a) meeting the client in the community, (b) educating the community about better mental health practices, (c) facilitating educational workshops and presentation on better mental health practices, (d) providing hotline assistance for crisis or emergency, (e) providing brochures, (f) providing one-on-one mental health care professional services by a practitioner as needed, and (g)

working with religious institutions and mental health care professionals (Singh, Shah, Gupta, Coverdale, & Harris, 2012).

Just as important, community outreach must encompass strategies to capture older adult African American populations for which mental illness is extremely prevalent. For example, Nyunt, Ko, Kumar, Fones, and Ng (2009) examined barriers that older adults encounter in acquiring mental health care treatment from professionals. In addition to psychological deficits, the study found that older adults with mental health challenges were more likely to have to contend with physical ailments, which may restrict both mobility and activities of daily living. These issues, in contrast, may affect their ability to access and utilize psychological services from qualified mental health care professionals, thus, impeding mental health intervention. The study results showed that implementing community outreach activities associated with rapport building, providing referrals as needed, providing mental health education and literature, providing case management assistance, and rendering services in a community environment increased usage of formal health care professionals by participating older adults in Singapore. The robust outreach effort to provide resources to older adults in the Singapore study had 4,436 partakers, 370 (8%) of whom displayed signs of mental illness, including 214 (57.8%) with diagnosed psychological illness(s). Before the outreach efforts were conducted, treatment inquiries came from 10.3% from this population. The outreach activities of the Community-Based Early Psychiatric Interventional Strategy (CEPIS) program in Singapore successfully referred 73.8% to mental health treatment (Nyunt et al., 2009).

Keyes (2007) argued that psychological health and illness are contingent on the individual's ability to flourish in society, which is significant and beneficial for making mental care nationally better for everyone. Kayes underscored the significance of social involvement and the benefits to society as a whole as long as the process of "flourishing" continues. For example, adults of sound mind without the existence of mental illness for 365 days flourished as indicated by completing more workdays than before, staying at work for longer hours, and having greater confidence within themselves and their social environment. This improvement included greater self-efficacy, increased motivation to achieve clearly defined goals, and greater willingness to work through adversity. The study subjects' commodities risks were low and their activities of daily living were not a significant issue; the flourishing individuals had lower utilization of health care. Sadly, according to Keyes, (2007),

> the prevalence of flourishing is barely 20% in the adult population, indicating the need for a national program on mental health promotion to complement ongoing effort to prevent and treat illness. Findings reveal a Black advantage in mental health as flourishing and no gender disparity in flourishing among Whites. (p. 95)

More important, Keyes reported significant empirical findings that suggest that the mental health care system in its entirety (i.e., research and services rendered) as it currently operates in American needs drastic transformation in order to improve the national mental health care system. The author suggested that the U.S. government's policies that dictate methods of direct or indirect intervention to lower mental illness must encompass strategies that target physical as well as mental wellness to obtain a new vision in U.S. health care policies that promote the safekeeping and advancement

of health in order to assist individuals and families with living healthier and longer lives.

These findings underline the underpinning historic inequalities in health care that affect African Americans' healthy human development and longevity. For example, African Americans live 7 to 8 years less than Whites, a factor that can be linked directly to health care disparities, violent environments, untreated illnesses, and a lack of psychoeducation about available mental health practices (Briggs et al., 2011).

Chapter Summary

As do other minorities in the United States, African Americans encounter unprecedented ongoing historical barriers to health care equality. African Americans have languished behind their White counterparts for centuries in seeking and obtaining formal mental intervention health care services. Furthermore, there is scant research informing members of the scientific and African American community about the impact of ongoing historical barriers to appropriate formal mental care. The viewed literature alludes to many cultural, access, and institutional systemic barriers to this population's aspirations, access, and motivation to seek and/or complete treatment sessions with a formal culturally sensitive mental health care professional team. Mental health research and strategies are needed to promote prevention for the purpose of understanding and addressing concerns that adversely affect African Americans' access to care. Identified barriers include mistrust of the health care system (i.e., cultural disconnect between providers and consumers), stigma, inadequate or lack of health care coverage, and scant knowledge about locations of treatment care centers and options. Cultural factors that

serve as obstacles to utilization of mental health care services include religious beliefs, beliefs about mental health care professionals, perceptions of psychological aliments.

CHAPTER 3

METHODOLOGY

The information presented in this chapter describes the methods utilized to gather information about funding the proposed outreach program. Also included is pertinent information about the target population. A summary of the criteria used for choosing a funding source and the requirements needed for the grant are included. The chapter addresses in part the needs of the target population.

The Target Population

This outreach program's target population is the African American community in the Los Angeles County area. This grant program will focus on minors, adolescents, and adults coping with psychiatric illness who qualify for comprehensive behavioral mental health services at Alma Family Services. The program's purpose is to provide psychoeducation to normalize mental health and to destigmatize mental illness in the African American community. The program will make available treatment options for the target population, material about interventions available for individuals with mental health issues, and resource information.

Host Agency

Alma Family Services (Alma) was identified as the host agency for this outreach program. Alma was established in East Los Angeles, California, by parents from the community in 1975. Because of its success, Alma has opened other service centers in

the Los Angeles area. Alma continues to play a significant role in providing a high level of quality services to the community and surrounding areas. Since its inception, Alma has provided a range of quality community-based integrated support and comprehensive services: assisting children with special needs, substance use programs, comprehensive behavior health programs, adult and child therapeutic service case management, and mental health services. Alma's mission is to promote the quality of life of individuals with a mental illness and individuals with a developmental disability and their families. Alma is a strong advocate for the rights of persons with mental and developmental disabilities (Alma Family Services, 2014).

Alma was designated for implementation of this program because of its many integrated mental health services. These services and programs meet the requirement to provide the target population quality mental, behavioral, and supportive services. Before services are rendered for any form of treatment, a complete comprehensive assessment is performed. For persons who require psychotropic medication support, Alma employs psychiatrists who evaluate and diagnose clients for medication support. Alma provides psychiatric consultation for individuals, families, or significant others regarding the importance of medication adherence and side effects. Case management services are also provided to those who need additional services and referrals outside the realm of what Alma offers its clients (Alma Family Services, 2014).

Alma uses a multidisciplinary approach to integrated services to provide quality therapeutic treatment. Alma's trained therapists collaborate with other practitioners such as Licensed Clinical Social Workers (LCSWs) and psychiatrists to develop a

mutually agreed-upon plan to treat the client's psychological, developmental, and social needs. Along with these services, Alma offers family and peer support groups, services for children and adolescence, all founded on evidence-based practice (Alma Family Services, 2014).

Alma outreach programs inform and educate the community about the importance of mental health. Alma has invested in resources for prevention and early intervention services. Alma's many locations make the agency a prime candidate for this proposed grant program. The agency agreed to participate in this project.

Methods of Identifying and Selecting Potential Funding Sources

An extensive search was conducted to identify potential sources for funding this mental health outreach endeavor. An Internet grant search was utilized to accumulate information about funding sources using Google, Yahoo, and California Grant Watch. This writer accessed several databases, such as EBSCO, for this purpose. Key terms utilized to assist with finding a potential funding source for this grant proposal were *outreach program*, *African American*, and *mental health*. Multiple websites and foundations were considered for funding. Information from the following websites was utilized for the purpose of this grant: The Foundation Center (2014), the California Endowment (2011), California Grant Watch (n.d.), and Grants.gov (n.d.).

The Foundation Center (2014) was previewed for the purpose of funding this program and proved to be an invaluable source of information on available funding. More than 500 foundations support this foundation. It connects change agents to the resources needed to affect various agencies in the United States. This foundation offers

a wealth of information and acts as a guide for fund seekers. Furthermore, the Center provides a robust database of available funding sources.

During the search for the most qualified potential funding source, this writer was conscious of the requirements, limitations, eligibility, availability, and feasibility, which were the minimum standards for grant securement. The inquiry into the above funding providers produced three funders that were considered for this grant proposal.

The first of the three potential funding sources identified for consideration was the Ben and Stella Weingart Foundation. The Weingart Foundation is interested in addressing the needs of low-income children, youth, and adults by supporting nonprofit organizations that provide comprehensive services in the area of health, education, human services, and homelessness in southern California. The Weingart Foundation's aim is to support organizations that are committed to assisting communities where access to services is limited. The foundation places an emphasis on the need to provide quality services to individuals with a disability by providing more access to resources for the economically disadvantaged (Weingart Foundation, 2014).

The second source reviewed as a possible funder for this grant project was the James M. Cox Foundation. Cox Foundation grants are intended to provide funding to nonprofit agencies in its communities. The Cox Enterprise and its companies support the community through partnerships, volunteerism, and providing financial support. The Foundation's mission is to design programs that preserve the environment; empower individuals, families, and communities; and promote diversity and inclusion. The Cox Foundation emphasizes the importance of early childhood education and

empowering families and individuals for success through education and supporting the health and well-being of individuals in the communities where their companies are featured. The Cox Foundation is partnered with African American and Latino communities to promote diversity in the work place.

The third potential funding source identified for this grant program was The California Endowment (2011), whose goal is to provide grants to nonprofit organizations that target the underserved population of California. To receive these funds, the organization must promote healthy living, education, and prevention of disease. In order to reach a broad range of consumers, The California Endowment promotes starting new programs that prioritize diversity in the health care professions, environmental health, healthy aging, and mental health. Grant funds can be utilized to encourage and recognize leaders who are working to promote wellness within the community by informing the community of health care issues.

Criteria for Selection of Actual Funding Source

It was paramount that the potential funding source for this program meet the minimum criteria set by the proposal. This program needed a funding source that shared the same aspirations as the host agency and the neighboring community. It was important that the funder have a history of service to underserved communities of California and have an interest in increasing access to mental health services in California. The amount of funding offered had to meet the criteria set for the project grant in order to provide the funds needed to mount an effective response to the plight of the mentally challenged in Los Angeles County. Also taken into consideration was the funder’s desire to serve the geographical location where the target population is concentrated.

Likewise, the application deadline and the population that the funder wanted to serve had to align with the population that the program was designated to serve at large.

Description of the Funding Source

The California Endowment was selected for this project because it recognizes the need to expand access to quality health care for underserved communities in California. The goal is to support improvement in mental health education and prevention through outreach. The desire of the foundation is to diversify and strengthen the health care work force correlates with the goals of the proposed mental health outreach and psychoeducation program.

The California Endowment was selected for a variety of reasons for funding this program. One of the reasons was that The California Endowment was compatible with the program's agenda and goals. The California Endowment would be able to provide sufficient funding for this endeavor for approximately 1 fiscal year. The California Endowment is one of the leaders in California with regard to funding programs that aim to expand mental health services to underserved communities in Los Angeles County.

Needs Assessment

The purpose of the grant problem statement was to highlight the need for mental health services and mental health education in the African American community. The program is needed due to the stigma and lack of awareness in the Black community about the significance of getting treatment for an illness. Research has suggested that only one third of African Americans with mental challenges utilize available psychological services (Cheng & Robinson, 2013). To further highlight the mental health services used by this population, information was gathered from multiple databases at

California State University, Long Beach, for the purpose of understanding the needs of this population to include in the grant proposal.

An in-depth analysis of this population's utilization of health services dates back to a grim past when this population and other people of color were used as test subjects. Many African Americans view U.S. mental health services and/or health care services in general with skepticism from past involvement with government officials who used institutional discrimination and put the safety of test subjects last for the purpose of experimentation (Snowden, 2001). This grant application writer thoroughly examined literature from current and past governmental sites such as the U.S. Census Bureau, NAMI, NIGH, and the Los Angeles County Department of Mental Health. Each one was used to put into perspective the past and present magnitude of the problem that this grant project is designed to address. The information was fundamental in producing a program to address the needs of this target population.

Grant Requirements

The California Endowment (2011) allocates grants to nonprofit organizations that seek to expand health services to underserved communities in California. However, to receive funding from this foundation, the organization must be classified as tax exempt under Section 501(c)(3) and have a registered status with the Internal Revenue Service. This grantor is ongoing and accepts applications year around. All information necessary to produce a successful proposal is on the website, along with all required documents. The website provides the issues that the foundation prioritizes for funding. The documents required to apply for funding considerations are information about the organization's mission and activities, region and population to be served, explanation of

how funds are to be used, a cover letter with a proposal summary, budget line items, program agenda goals and objectives, target population, a time table for starting the program, and a method of evaluation of the project.

CHAPTER 4

GRANT APPLICATION

Organizational Information

Alma Family Services was chosen because of its multifaceted approach for providing mental health services to families and individuals. For more than 2 decades, Alma has provided a range of multilingual community-based services to persons who qualify. For example, Alma provides substance abuse counseling and case management. In addition, Alma provides family counseling, peer and family support, individual psychotherapy, and socialization training programs. Alma's skilled staff provides a welcoming atmosphere where consumers are treated with integrity and care. Alma provides its staff with the essential education, training, and skills to provide competent and coherent treatment (Alma Family Services, 2014). Alma shares partnerships with other well-respected providers such as the Department of Mental Health (DMH), the Department of Children and Family Services (DCFS), and donors, all of whom mandate that Alma provide comprehensive mental and behavioral health services in order to remain solvent and answerable to clients. Hence, the agency's commitment to its community and emphasis on integrative services and prevention makes Alma tailored for the proposed program (Alma Family Services, 2014).

Proposal Information

In 2012, the U.S. Census Bureau estimated that more than 10 million people resided in Los Angeles, California. African Americans made up 9.3% of the estimated population count (U.S. Census Bureau, 2012). According to a study conducted by the National Urban League (2012), from 2000 to 2010 the Black population alone grew from 34,658,190 to 38,929,319, an increase of more than 4 million African Americans-Blacks in a decade. The study tracked race in combination populations, Blacks alone or in combination, and found in 2000 that this population was 36,419,434, and in 2010 increased to 42,020,743 (U.S. Census Bureau, 2010; National Urban League, 2014). According to Profile American Forum on the Black population, a study conducted by the National Urban League in partnership with the U.S. Census Bureau (2012) arrived at the conclusion that minority populations would continue to grow at astronomical rates, surpassing the growth of the Caucasian population. By 2050, minorities will constitute approximately half of the U.S. population. According to the *National Health Care Disparities Report* (USDHHS, Agency for Healthcare Research and Quality [AHRQ], 2009), the U.S. Census Bureau estimated in 2007 that there were 38 million Blacks-African Americans, 45.5 million Latinos-Hispanics, and nearly 13.4 million Asians in the United States.

Minority subgroups are more likely than Caucasians to live in poverty and have limited education. According to the *National Health Care Disparities Report* (USDHHS, AHRQ, 2009), poverty can have a fundament effect on mental health. In addition, minorities with fewer financial resources and residing in urban areas may have greater access to treatment than minorities with similar financial means and reside in

rural and remote areas because of "less adequate access to care, more limited availability of skilled care providers, lower family incomes, and greater societal stigma for seeking mental health treatment" (USDHHS, AHRQ, 2009, p. 66). However, the care that some low-income residents of urban areas may receive may not address the complex issue of dual diagnoses, which is common among persons with mental health challenges and who may also have issues with substance use.

According to the National Alliance of Mental Health (NAMI, 2014),

> recent scientific studies have suggested that nearly one-third of people with all mental illnesses and approximately one-half of people with severe mental illnesses including bipolar disorder and schizophrenia, also experience substance abuse. Conversely, more than one-third of all alcohol abusers and more than one-half of all drug abusers are also battling mental illness. (p. 1)

Also, for minorities that reside in sparsely populated rural communities, assistance for mental health issues may not meet their needs because of a lack of assimilation and culturally aware practitioners. Furthermore, they may have to contend with fewer practitioners, fewer jobs, and inadequate health care insurance (USDHHS, AHRQ, 2009, pp. 66-67).

The U.S. Surgeon General's 2001 report (USDHHS, 2001) noted that the quality of service that minority consumers receive is highly based on service location and the fact that at these facilities African Americans are treated by a practitioner may not have adequate experience in working with this population and therefore may not provide adequate diagnosis and treatment (USDHHS, 2001). Facilities where consumers seek mental health treatment may lack competent practitioners who understand the interrelationship between mental health and culture.

The relationship between African Americans and the U.S. public health care system generally has been one of mistrust mainly because research studies in the past that involved persons of color were conducted with malice and deceit toward African Americans (Carmack, Bates, & Harter 2008). One such unethical practice inflicted on African Americans took place in Tuskegee, Alabama. Using deceit, the U.S. government funded and conducted research trials on low-income African Americans. The study involved more than 200 African Americans infected with untreated syphilis while 201 were left disease free and utilized as the control group. The researchers told the participants that they were receiving treatment for their ailment, but no such treatment was rendered. As a result, hundreds of African Americans died from an illness that could have been cured.

In addition to mistrusting the health care system, African Americans encounter many barriers to adequate health care. For example, scores of African Americans currently live below the poverty line, which affects their mental health status (USDHHS, 2012). Poverty has historically continued to plague this community, resulting in generational homelessness, stress, and economic deprivation, along with poor physical and mental health.

The number of low-income children residing in America has grown significantly since 2007 to 22%. African Americans who live below the federal poverty line are less likely to receive treatment for mental challenges and low-income adults are less likely to have insurance to cover costs of mental health services (Santiago et al., 2013).

African Americans encounter issues of accessibility to integrated mental health services in addition to being accepted as a person with mental challenges by peers, family, society, and friends because of lack of education and the stigma associated with a mental health diagnosis. These issues have been thoroughly discussed for the purpose of this program and barriers that adversely affect other minority groups' access to adequate care have been highlighted.

Stigma is a very convoluted social construct that affects many aspects of society's mental health care consumers. Cummings et al. (2013) noted that stigma is multifaceted and encompasses social ideas and feelings such as dislikes, misunderstandings, intolerance, and discrimination toward persons with mental challenges; the authors noted that feelings espoused by others may manifest within persons with mental challenges (i.e., self-loathing).

African Americans in the United States encounter unprecedented obstacles in almost every facet of their lives. The majority of these obstacles are institutionalized because of discrimination and negative viewpoints about African Americans. Calloway (2006) stressed that stereotypes, obstacles, and negative perceptions attributed to African Americans are rooted in the social construct of racism. These obstacles collectively present significant challenges for African Americans, especially in the arenas of learning, economics, and cultural, mental, and physical health, to create classism and produce inequality in the health care system for African Americans (Calloway, 2006).

Current research highlights the significant increase in the African American population in the United States. Studies have underscored the impact of mental illness

on African Americans and the rate at which they receive treatment and the duration of that treatment. A push to mobilize this community and society as a whole in an effort to destigmatize and dispel the negative connotations placed on abnormalities of the mind would benefit society as a whole. Research indicates that the stigma associated with mental illness is a well-established social construct; therefore, a new social construct about mental health needs to be introduced. Outreach also must address the need to increase the number of minorities that work in these helping profession in general and in particular mental and behavioral health. According to NAMI (2007), African Americans in the United States have low employment in professions that provide intervention and treatment for mental and behavior, such as social workers (4%) and psychiatrists and psychologists (2%), which may constitute a barrier for many to seek treatment because of a lack of shared similarities with African American consumers.

Proposed Program

The purpose of the proposed program is to educate and bring awareness to the African American population about the importance of utilizing formal mental health services. The program is designed to foster communication between the African American population and mental health professionals. By bridging this gap, this grant application writer is hopeful that greater knowledge about the culture of this population in question will encourage more African Americans to seek mental health care services, thereby eliminating the stigma that this population places on persons with mental health challenges.

The program is also designed to highlight the significance of diversity in the mental health professions. For the program to be successful, members of the

community must invest in the idea of changing the culture of stigma associated with a mental health diagnosis. Only then will African Americans with mental health issues feel comfortable in disclosing their diagnoses and seeking treatment.

To reduce the beliefs associated with mental illness, the community must also be educated. Persons with vested interest will lead the charge in their community in reaching and educating individuals with a mental illness who may be reluctant to seek treatment. Community leaders such as heads of religious organizations and the human service sector often have significant influence and can spark interest among residents.

Training will be provided to participants in the outreach program. This training will consist of guest speakers, graphic presentations, group discussions, activities, workshops, and one-on-one consultations with mental health practitioners. Community members will be trained on how to identify someone who is having mental health issues and provided with the skills needed to be competent assets for the program. The training curriculum will encompass learning about treatment options and availability and accessibility of services. After the training, community members will be provided with informational pamphlets to distribute.

Goals

Goal 1 is to inform the African American population living in Los Angeles County and the surrounding areas about the significance of obtaining formal mental health treatment, early family intervention, and family support for the mentally challenged. To achieve this goal, members of the community will have the opportunity to participate in informative dialogue with mental health professionals twice a month for 1 hour. The atmosphere at Alma will promote dissemination of best mental and behav-

ioral health care practices, treatments, and recovery. The information provided will include evidence-based psychoeducational literature such as treatment options, common symptoms awareness, coping, and early prevention techniques for families and consumers. Outreach will be conducted in libraries, community-recreation centers, churches, barbershops, and beauty parlors where many African Americans frequent and congregate. Rapport building will provide the outreach team the platform to build a unique working relationship with these entities stationed within and around the target population. The objective is to provide this community with mental and behavior health knowledge for 1 calendar year. The presentations and dialogue will be conducted in English and Spanish. The expected outcomes are the following:

1. The African American community will acquire greater knowledge of mental health and mental disorders.

2. The African American community will be successfully linked to mental health and community resources.

Goal 2 is to provide support to African Americans in Los Angeles County and the surrounding areas through working collectively with ministers, preachers, business owners, and institutions that share similar interest in expanding awareness about recovery, treatment options, and resources for the duration of this program. Through community outreach activities, the target population will be provided information via oral and various other media. Written material will be made available regarding mental health diagnosis and treatment options at community events, churches, and other places of worship. Educational mental health material will be displayed in these and other

locations in the form of brochures, leaflets, and in-group sessions. The community outreach workers will be delegated the task of manning designated locations other than churches where large populations gather (e.g., community events) and disseminating mental health information. The expected outcomes are the following:

1. Stigma associated with mental illness will be reduced within the community where outreach is conducted and psychoeducational material is dispersed.

2. Community participation will allow for input on community activities such as workshops and presentations.

3. Working with the surrounding private and public institutions will promote mental health awareness and also assist with educating the community.

Goal 3 is to address the needs of African American consumers and their families by requiring case managers to connect them to resources to support mental and behavioral health. The case managers will empathically guide consumers and/or their families through the intake process. After the intake process, the case managers will engage the consumers in biopsychosocial assessment to determine needs. The linking process will be guided by the assessment results. The case managers will keep the consumers and/or their family abreast of treatment options and other services needed to produce positive treatment outcomes and retention.

Work Plan

Weekly 1- to 3-hour training sessions will be provided via oral or graphic presentations detailing mental and behavior mental health literature. Two training sessions will be provided per group. Group 1 will consist of staff training and questions and answers. Group 2 will consist of community member participation and questions

and answers. The two groups will alternate on a weekly basis. Both training sessions will be facilitated by a skilled practitioner. Group 1 sessions will be attended only by staff, and Group 2 sessions will include community outreach members to identify mental illness in persons in need of services. Learning material will be provided to educate attendees about better behavioral and mental health practices. Appendix A contains the timeline for this program.

Adding to the Positive Outcomes of the Funder

The California Endowment's objective is to provide needed resources to economically challenged communities in southern California. Through its Building Healthy Communities initiative, people are educated, housing opportunities are provided, and access to family-focused human services and prevention are expanded. This proposed program and the Endowment's goal is to provide access to and improve the quality of human services for Californians in Los Angeles County. This proposed program was created to address the needs of the underserved population of Los Angeles, as identified by the Endowment's Building Healthy Communities initiative, which seeks to improve multiple outcomes regarding human development. Two outcomes underscored for improvement are prevention and healthy behavior in low-income communities. The target population was selected because research results indicate that 7% of African Americans are at risk of developing depression. African Americans who live in urban communities are more likely than White Americans to overindulge in alcohol. This population is more likely to receive unequal mental health treatment and is less likely to be treated by a practitioner of the same ethnicity (Calloway, 2006). African Americans are more likely to be economically challenged and experience violence or

homelessness and are less likely to have medical or mental health insurance (NAMI, 2014).

The proposed project supports the potential grantor's effort to provide community members with a platform to discuss appropriate health care issues and factors that impede healthy living. The proposed program seeks to work with other like-minded entities to provide the best information to the community regarding mental health and treatment options. One of the many goals of this grant shared with the potential grantor is to increase the usage of formal mental health services by African Americans in Los Angeles by providing knowledge and awareness about treatment options while promoting healthy behavior and self-care in underserved communities.

Target Population

The proposed outreach program seeks to reach African Americans, 18 and over, who may be experiencing mental health issues and who qualify for services from Alma Family Services. The program seeks to utilize outreach as a tool for educating African Americans about treatment options, availability of services, and cultural competence in the medical and mental health profession. Outreach will consist of psychoeducation workshops, training, brochures, radio advertisements, and door-to-door engagement with community members.

Budget Narrative

The required funds to finance this proposed outreach and awareness program for 1 calendar year are estimated at $242,098. The estimated cost to operate this program includes the cost of staffing and nonpersonnel expenditures (see Appendix B for the line-item budget).

Personnel

The Program Manager position will be occupied by a seasoned social work professional with a master's degree in social work from an accredited college. The position tenure will be 1 calendar year. The annual salary for this position will be $51,000 (not to exceed 1 year). The person selected for this position will be in charge of multiple functions of the program's day-to-day activities within the community. The Program Manager is also charged with training and supervising staff, which includes but is not limited to community outreach workers and a case manager in order to achieve work objectives in respect to the proposed program. The Program Manager will also be charged with planning, organizing, and evaluating outcomes. The Program Manager will supervise all elements of the program, which consist of outreach and psychoeducational efforts. He or she will have the job of coordinating the workshops and presentations; coordinating outreach activities; and purchasing needed materials for trainings, workshops, and presentations. He or she will also coordinate events for advancing the mental health agenda through engaging the target population in surrounding communities.

The Case Manager will be employed to provide consumers with referrals and staff support from within the organization. The position will require a person holding a bachelor's degree with an emphasis in social work. The annual salary for this position will be $31,000 for full-time employment for the duration of the program. Other tasks included are intake, psychosocial assessment, linking clients to community resources, and providing assistance as needed in other areas of the program. The Case Manager

will ensure that the consumers and staff are collaborating to produce the best outcomes for the client and agency.

Two Community Outreach Workers will conduct community outreach to advance the stated agenda of the program. The Community Outreach Workers will be required to hold a high school diploma and have some experience working with persons with mental challenges. Outreach workers must have great communication and people skills. Each worker will be employed on a full-time basis for 1 calendar year at an hourly rate of $11; thus, each earn $22,880. Training on appropriate outreach techniques will be provided, along with information about the target population.

Full-time employees will receive full employee benefits, including dental, medical, and psychological care. Benefits at 33% for the full-time work force will equal $42,160. This total has been factored into the direct program cost. However, the program reserves the right to increase or decrease the benefit package based on the current health care system.

A systematic evaluation will be funded for the purpose of tracking outcomes. Evaluation of the program will take place throughout the duration of the program. The evaluation will consist of monitoring and assessing the program's effectiveness. This systematic task will occur periodically during the duration of the program to improve its implementation and effectiveness. The evaluation will be conducted by a skilled independent evaluator who will be paid $5,500 for services rendered.

Nonpersonnel

Nonpersonnel costs for the duration of 1 calendar year for this proposed program will be $25,000. Office supplies (pens, pencils, ink, and other office supplies)

will cost $1,500. Utilities will include telephone, Internet, and fax service estimated at a cost of $2,400. Office space is needed to conduct treatment in the form of talk therapy (psychoeducation) and training seminars and presentations, at an estimated $900 per month or $10,800 for the duration for the program. Curricula for learning better mental health practices will be provided by respected authorities on mental health and self-care. The materials needed for the educational development of staff and community members will cost $7,000, which will include but not be limited to exercise material, healthy coping literature based on the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V; APA, 2013), trauma-focused cognitive behavioral therapy literature, play therapy literature, suicide ideation, assessment and diagnostic literature, cultural competency literature, screen material for comorbidity, talk therapy material, Attention Deficit Hyperactivity Disorder (ADHD) training material, strength-based approach material, material to reduce mental health stigma, and presentations on various treatment modalities for staff. When possible, materials and/or literature will be purchased with video and/or exercise material for learning. All materials and/or exercises utilized for staff and community training will be evidence based and approved by the host agency and mental health outreach program practitioners and community participants.

The outreach material will consist of educational and informational dialogue with current researched evidence-based behavioral and mental health literature. The production and replication of informational leaflets, pamphlets, brochures and other

printable materials are estimated to cost $7,000. Four computers at $1,500 each and two printers at $200 each will be purchased.

Other Costs

Administration overhead will be calculated at 15% of the total budget, or $31,578.

Evaluation

The evaluation of this mental health and community outreach program will be conducted throughout the funding year in stages. The Program Manager will be charged with assessing the performance, integrity, and effectiveness of the program and its employees internally. In order to evaluate the success of this program, the consumers' data will be utilized to track usage of services by consumers and their families. The outreach program will engage consumers and their families and community members through weekly community and staff educational mental health presentations at various locations where outreach staff will be present. At these locations (churches, family centers, Urban League, Masjids, and community health fairs), mental health workshops will consist of information about better mental and physical health practices, along with identification tools. For the purpose of assessing and tracking consumers' satisfaction and knowledge throughout the duration of the program, participants will be directed to take surveys about mental health in the form of pretest and posttest at every presentation. In addition, outreach workers will work with the religious communities and other institutions in a similar manner to assess and track through surveying consumers' experiences and knowledge about mental health before the outreach effort and afterwards. The information delivered at community events in the form of brochures and leaflets

will be tracked and analyzed through a collection process. The Case Managers will provide monthly logs of consumers' treatments, attendance, progress, dropout rates, referrals, and completion rates to the Program Manager. The Program Manager will meet with the independent evaluator monthly to discuss objectives and progress of the program. The information obtained by the Program Manager will be presented to staff for feedback and discussion. The outreach program will remain in good standing with the funder through monthly consultation and outcome updates.

CHAPTER 5

LESSON LEARNED

Grant Application Writing Process

The grant application writing process requires dedication, commitment, reliance, and patience. The grant application writer learned how to locate and utilize fundamental information retained from literature pertinent to the subject matter in order to present a substantial argument for this program. A needs assessment was conducted to determine the target population's needs and strengths. For example, this task took the form of researching the topic and analyzing literature from many sources. The grant application writer acknowledges the significance of professional writing and communications in transferring knowledge about mental and behavioral health.

Host Agency Selection

The location and choice of the host agency involved time and knowledge about the chosen agency and strategy. The grant application writer considered several communities and host agencies to serve the target population. The writer spoke to representatives and gathered information about the agency to formulate an outreach program that met the merits of the host agency. As a result of this experience, the writer learned the significance of choosing a host agency whose goals, objectives, philosophy, and services are closely aligned with the needs of the target population.

Funding Sources Viewed

The grant application writer conducted an extensive search for a funder whose goals and objectives were similar to those of the proposed outreach program. A variety of informative literature essential in building an argument for this much-needed program was attained by way of Internet search results, using terms such as *outreach program*, *health care usages + African Americans*, *mental health + the Black Church*, and *African Americans and mental illness*. Second, the writer employed a search for potential funders viewing multiple online websites and located three funders, each of which received significant consideration. The final agency was chosen by the writer because it supports goals and objectives similar to those of the proposed program, which encompasses mental and physical health.

Personal Development

The knowledge attained from this process has enlightened and educated the writer about the importance of self-care and mental health. Self-care provided the writer the energy to focus on the task of grant application writing. The grant application writing process was foreign and thought by the writer to be difficult, time consuming, and challenging. Fortunately, the writer was able to gather strength and courage from cohorts and colleagues to overcome seemingly insurmountable barriers. The writer gained knowledge about the writing process and how to utilize statistics to strengthen a position. Just as important, the writer learned how to construct, mark, and develop programs. The information gained as a result of this process has increased the writer's knowledge on the subject exponentially. This knowledge will be utilized for the betterment of the mental and health care delivery systems in the United States.

Implications for Social Work Practice

The knowledge and understanding of the grant application writing process is fundamental to nonprofits and similar institutions. The funds awarded by foundations to begin or expand a program in part determine the direction and the services provided by the program. As a result, the social worker must be astute to consumers' current needs in order to advocate for funding through grant application writing or policy change. Grant application writing provides the social worker with another medium to voice the needs of the community being served by a foundation in hopes of funding. The art of grant application writing is a descriptive depiction of the realities that shape and affect the lives of consumers in order to provide services that alleviate the obstacles faced by the population in need. That is, grant application writing underscores consumers' challenges as well as strengths in order to change self- and community perceptions and receive funding to increase services that may allow continuance or creation of programs for those who qualify.

Conclusion

Before embarking on the challenge of grant application writing, this writer was unaware of the great effort needed to formulate a coherent needs assessment that would benefit the target population. The information gathered through research, internships, coursework, social work literature, encounters with health and behavior health care consumers, and talking with others provided this novice grant application writer and master of social work candidate with the wherewithal to produce an adequate, ardent request for a greater response to issues affecting Americans in the mental health sector in the United States.

The social work Code of Ethics (National Association of Social Workers, 2015) mandates that social workers engage in similar knowledge attainment to enhance the practitioner's knowledge about the barriers that impact the social services system (economically and culturally). The material gathered from researching the subject matter and experience in the field of social work have increased this writer's knowledge about building programs, deadlines, budget cuts, implementation, and outcomes that will increase exponentially. Indeed, the knowledge gained from the grant application writing process exposes the reader to valuable material to address issues plaguing society. The funding provided by foundations supports human services and social work causes. Research obtained for the purpose of granting application writing allows the social worker to read current best practices about the issues in question in order to establish needed information to produce a strong argument.

APPENDICES

APPENDIX A

TIMELINE

TIMELINE

Month 1

- Hire Program Manager
- Hire Case Manager (Program Manager)
- Hire two outreach workers (Program Manager)
- Hire external program evaluator (Program Manager)
- Recruit Social Worker X 2 (MSW) Intern (Program Manager)
- Hold training for program staff
- Create learning materials for presentations, lectures, and distribution

Month 2

- Resume training
- Program Manager delegates outreach tasks
- Program Manager promotes the benefits of outreach in underserved communities in grant writing to funders seeking funding to broaden and lengthen the duration of the program
- Prepare\equip location for staff and group sessions

Month 3

- Begin community outreach
- Host community presentations and gather community input at first meeting
- Implement and address community concerns about the outreach activities
- Host community events and provide oral and written material (brochures and pamphlets)
- Outreach Team will make literature and provide information about the new program available at shores, clinics, parks, churches and other surrounding areas to increase awareness and turnout.
- Begin assessments, consumer and family placements, and referrals and link clients to needed services related to mental and behavior health conduct by the case manager
- All staff meetings held twice monthly to discuss concerns and to provide supervision and input from the program manager on the effectiveness of the outreach and recruitment activities and treatment process

Months 4 and 5

- All staff meetings will continue twice monthly, as will staff and community meetings
- Meeting duration for both groups will be 45 minutes and 15 minutes reserved for Q & A at site location.

- Outreach/presentations and/or meetings conducted in the field (community center, churches, temples duration will be determined by the event agenda
- Outreach will continue until the end of the program or funds are depleted
- Staff and Outreach workers will continue to disseminate literature about the program's mission wherever appropriate (i.e., churches, community gatherings, counseling meeting) where information will be provided orally or materially by trained staff
- Individuals and/or family members will continue to be placed in treatment programs and linked or transferred to mental health providers
- The case manager will continue to address consumers' concerns or needs and keep staff abreast of the current client versus staff dynamic
- Program manager will continue to preside over all staff meetings and provide guidance to staff and oversee the day-to-day operations of the outreach program activities and mission attainment
- All staff meetings will provide the staff an opportunity to identify and address concerns or issues to improve the program

Months 6 and 7

- Program manager and independent evaluator present current outcome data during mid-term staff meeting for quality control purpose
- Continue to provide quality service to the community
- Contingent on the mid-term evaluation will program improvement be considered

Months 8 and 9

- Continue monitoring outcome for modification

Months 10 through 12

- Begin close-out of programs internally (psychoeducation) and externally (presentation and workshops in the community)

APPENDIX B

LINE-ITEM BUDGET

LINE-ITEM BUDGET

Expenses (365 days)

Personnel		**$175,420**
Program Manager (MSW)—FTE = 100%	51,000	
Employee Benefits (@ 33%)	16,830	
Case Manager (BSW)-FTE	31,000	
Employee Related Benefits @ 33%	10,230	
Community Outreach Worker X 2-FTE @ $ 11\hr	45,760	
Employee Benefits (@ 33%)	15,100	
Independent Evaluator	5,500	
Nonpersonnel		**35,100**
Office Supplies	1,500	
Rent ($900/mo.)	10,800	
Utilities ($200/mo/)	2,400	
Printing	7,000	
Training	7,000	
Equipment ($1,500/computer) x 4 ($200/printer) x 2	6,400	
Total Direct Costs		**210,520**
Indirect Costs		
Administrative Overhead (15% of total budget)		**31,578**
Total Program Cost		**$242,098**

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