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Experiences of Accessing Mental Healthcare Among Older Black Women Living in Public Housing

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This is to certify that the doctoral dissertation by

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Walden University
2025

Abstract

Experiences of Accessing Mental Healthcare Among Older Black Women Living in Public Housing

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MA, University of Phoenix, 2014

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

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Abstract

Older Black women living in public housing have been identified as a high-risk group for experiencing barriers to and underutilization of mental health services. Accessing and utilizing mental health care in public housing complexes is challenging due to persistent barriers that discourage residents from seeking treatment. The older adult population, particularly Black women, remains inadequately served and experiences some of the poorest health outcomes, in part because of underreporting of health concerns and limited treatment-seeking behaviors. The purpose of this study was to explore older Black women's experiences of accessing mental health care while living in public housing and to understand their perceptions of the challenges and barriers to care and service use. A sociocultural conceptual model for treatment engagement served as the conceptual framework for this study. Ten Black women aged 55 and older who had lived in public housing for at least six months participated in semistructured interviews. Findings revealed that access to mental health care among older Black women in public housing was marked by limited support, inadequate infrastructure, and social isolation. Participants described navigating fragmented care systems without guidance, often relying on family, primary physicians, or faith instead of structured programs or community resources. The results highlight how systemic neglect, environmental insecurity, and racialized experiences intersect to create major barriers to mental health treatment for these women. Results of this study have the potential to be used for positive social change in raising awareness, creating interventions, and facilitating the development of prevention programs for this specific group.

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Dedication

This research is dedicated to all individuals who have faced challenges when attempting to seek help for mental health issues. To my grandmother and dad (RIP) who encouraged and motivated me to pursue this degree, thank you for your support. I also want to dedicate this research to all people who feel overlooked and those who continue to struggle with accessing mental healthcare. To my committee members, my mom, husband, children, and siblings who have patiently awaited the day of completion. Jehovah God bless the mental health of all.

Acknowledgments

First and foremost, I would like to thank Jehovah God for choosing me to take on this task of making a positive impact in others' lives. The wisdom and gift from Jehovah God have allowed me to move forward in my studies and share with the world a hope for positive social change. To my siblings who spoke of encouragement and continuous support throughout the research process. To all participants who spoke their truth on their experience of accessing mental healthcare. I would also like to thank Walden University and the upmost honor to Dr. Susana Verdinelli, my committee chair who worked so diligently, genuinely, and humbly to ensure that my academic journey was a success. Without your guidance, I could not have done this. Special thanks to Dr. Amy Sickel; Program Director, Dr. Kimberly McCann, Dr. Joann McAllister, Mr. Greg Murphy, and Dr. Melody Moore; your blessings and support are greatly appreciated for the completion of this research.

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Chapter 1: Introduction to Study

Racially and ethnically diverse residents who live at or below the federal poverty level tend to be concentrated in public housing (Lascher et al., 2013). Older adults in public housing are often poor, live alone, and experience multiple medical problems that place them at risk for mental illness (Simning et al., 2012). However, mental health care systems inadequately serve older individuals (Hinds et al., 2018; Simning et al., 2012). This problem is even more complex for older Black women living in public housing, as residents of public housing have some of the poorest health profiles of any group in the United States (Haley et al., 2017). Furthermore, Black women are more likely to experience mental health symptoms and less likely to seek help (Nelson et al., 2020; Ward et al., 2009).

In this study, I explored access to mental health care among older Black women living in public housing. This study aimed to provide a deeper understanding of the challenges and barriers they face in accessing mental health care and utilizing services while living under restricted conditions. Understanding these barriers within the context of public housing has the potential to inform planning and guide more equitable service delivery and culturally competent health care (Memon et al., 2016).

This chapter presents the background of the study, the problem and purpose statements, and the significance of the study. It also outlines the research questions and theoretical framework, followed by a discussion of the study's nature, definitions of terms specific to the research, and an examination of the assumptions, scope, delimitations, and limitations.

Background

Residents who live in public housing are disproportionately racially and ethnically diverse and often live at or below the federal poverty level (Lascher et al., 2013). Older adults living in public housing share distinct characteristics such as living below the federal poverty level, living alone, and/or presenting high levels of medical comorbidity that place them at risk for mental illness (Simning et al., 2012). Mental health care systems insufficiently served the minority older adult population, and residence in public housing influenced health and utilization of healthcare (Hinds et al., 2018; Simning et al., 2012).

The problem was compounded for older Black women living in public housing. First, people living in public housing have some of the poorest health profiles of any group in the United States (Haley, et al., 2017), and they tend to underreport health and mental health problems (Hinds et al., 2018). Second, Black persons typically do not seek professional treatment for mental health problems (Bailey et al., 2011; Hunt et al., 2015; Ward et al., 2013). Third, earlier studies have indicated that Black women tend to experience more mental health symptoms, and depression, and are less likely to seek help.

Mental health services are exceedingly inadequate for low income and ethnic minority individuals, overlooking social and economic problems. Ethnic minorities living in impoverished neighborhoods face a disproportionate burden of illness and are less likely to receive adequate access to health care (Haley et al., 2017). Disparities related to mental health services have been notable among ethnic minorities living in public

housing (Dinwiddle et al., 2013). When addressing disparities in access to mental health services, research concluded that individuals from Black minority ethnic backgrounds need literacy on mental health and feasible support to improve information about services and access in healthcare (Memon et al., 2016). In addressing changes in healthcare use among people who moved into public housing, it was found that health care utilization worsened after people moved into public housing (Hinds et al. 2018), which was attributable to decreased access. The scarcity of resources and inadequacy of access to health services were relevant issues that needed to be addressed (Lake & Spain, 2017).

Numerous studies have addressed issues and barriers related to accessing mental health care among individuals living in low medium and restricted conditions (Alang, 2019, Campbell & Long, 2014; Conner et al., 2010; Dinwiddie et al., 2013; Gaston et al., 2016; Hays & Gilreath, 2017; Lukachko et al., 2015). However, additional research was needed to address issues related to access and service utilization for mental health care among older Black women living in public housing.

Problem Statement

Several factors were identified as barriers to accessing and using mental health services among Black persons. Cristancho et al. (2008) organized the group of barriers into two systems: the system-level barriers and the individual-level barriers. The system-level barriers refer to structural barriers built into the design and access to services, such as inaccessible location, transportation issues, or lack of health insurance or childcare. Individual-level barriers refer to beliefs and experiences of the interpersonal and intrapersonal encounters with the professionals in the health system, and include issues

like trust, internalized stigma, and shame and embarrassment (Ward et al., 2009). Research on mental health services access for Black persons identified religiosity, stigma, culture, race, depression, perceived discrimination, negative perceptions toward the professional mental health system, racism, and residential segregation as systems and individual barriers (Alang, 2019, Campbell & Long, 2014; Conner et al., 2010; Dinwiddie et al., 2013; Gaston et al., 2016; Hays & Gilreath, 2017; Lukachko et al., 2015; Ward et al., 2013).

According to Simning et al. (2011), the high level of psychiatric disorders reported among public housing residents coupled with low health care utilization highlighted a need to better understand mental health care barriers housing residents encountered. Particularly, older Black women in public housing seem to be a high-risk group for experiencing barriers and underutilization of mental health services (Haley et al., 2017). Black women are likely to experience these barriers as well; however, the challenges Black women in public housing faced in accessing mental health services had not been studied.

Purpose of the Study

The purpose of this study was to explore the experience of access to mental health care among older Black women living in public housing. This study also aimed at understanding older Black women's perceptions of their challenges and barriers to accessing mental health care and service use while living under confined conditions. In the context of this study, accessing mental health care refers to an individual's approach in seeking and obtaining services for one's health care needs. Accessing to mental health

care was defined as a function of personal and environmental factors, and the relationship between service user and health care provider (Memon et al., 2016).

The study focused on a specific population as this was one of the most vulnerable groups living in public housing (Haley et al., 2017; Lascher et al., 2013; Simning et al., 2012). Gaining an understanding of the experiences of these women may have the potential to help develop solutions to accessing and receiving mental health services while living in public housing (Memon et al., 2016). The study helped to shed light on individuals' perceptions and experiences of accessing mental health care and highlighted challenges that need to be addressed in a manner that will decrease and eliminate barriers related to accessing and utilizing healthcare. Results of this study have the potential to assist in implementing plans and programs to reduce disparities and challenges related to access health care while living in public housing.

Research Questions

The guiding research questions for this study were:

- RQ 1: What is the experience of accessing mental health care services among older Black women living in public housing?
- RQ 2: What are the barriers to accessing mental health services among older Black women living in public housing?

Conceptual Framework for the Study

The conceptual framework for this study was the sociocultural model for treatment engagement that Copeland and Butler (2007) developed. Described within this model are some of the main factors that include downsides that had a negative impact on

Black women's mental health and should be taken into consideration and addressed to avoid disparities in access to and utilization of mental health services in this population. The factors were grouped into categories of (a) racism and discrimination, (b) socioeconomic status, (c) stress and well-being, and (d) housing and neighborhood conditions. This model helped in understanding how these factors intertwined and affected Black women's access and use of mental health service living in public housing. Copeland and Butler's model is based on Andersen's (1995) widely cited and used behavioral model of access to health services. Andersen's model is considered the most common framework used to understand individuals' access to health care (Derose et al., 2011). Copeland and Butler adjusted the model to represent and target Black women's mental health access. The details of the model are covered in detail in Chapter 2.

This model was a good fit for my study. Research studies on barriers to accessing mental health services in the Black population has consistently supported the relevance of the four factors Copeland and Butler identified (Alang, 2019, Campbell & Long, 2014; Conner et al., 2010; Dinwiddie et al., 2013; Gaston et al., 2016; Hays & Gilreath, 2017; Lukachko et al., 2015; Ward et al., 2013). As seen in the problem statement, barriers for accessing mental health services among Black persons consist of a broad range of system-level and individual-level barriers addressed in Copeland and Butler's theory. This model provided a framework to understanding Black women's perception and experience of accessing, seeking, and utilizing mental health services while living in public housing. Copeland and Butler's model also inspired various aspects of this study's strategy. The research questions were framed to obtain the meaning of women's

experience. The semistructured interview guide was developed to gather participants' experience of access to mental health care services and used the four socio-cultural factors (housing and neighborhood conditions, economic status, racism and discrimination, stress and wellbeing) to explore the phenomenon of access. Analysis of the complexities of barriers to accessing services, including the four sociocultural factors this model identifies, provided a deeper explanation of their experiences. The sociocultural factors are described in greater depth in Chapter 2.

Nature of Study

This study is framed within the qualitative tradition; specifically, the descriptive qualitative research approach was used. Qualitative research is inductive and consistent with gaining an understanding of an event or phenomenon (Merriam, 2002), such as how older Black women living in public housing access to mental health care. The qualitative approach was supported in this project since sparse research had been conducted on older Black women's access to mental health care. This qualitative study used a descriptive qualitative research methodology to examine older Black women's experience of accessing mental health care will living in public housing. The descriptive qualitative approach seeks to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved (Caelli et al., 2003; Sandelowski, 2000). The descriptive qualitative research design was appropriate for this study as it was a descriptive, interpretive, and reflective approach. The descriptive qualitative design involves the interpretation of subjective opinions, attitudes, beliefs, or reflection on their experiences of things in the outer world (Percy et al., 2015). This approach is used to

understand how people interpret, construct, or make meaning from their world and their experiences (Merriam, 2002). This approach was a good fit for my study, as I focused on older Black women's experience of accessing mental health care. Black women 55 and older living in public housing and who accessed mental health services were the participants of this study. Participants partook in a semistructured interview and commented on their experience in accessing mental health care services while living in public housing. The interviews shed light into understanding the challenges and barriers that these individuals encountered while seeking mental health care services.

Definitions

Access (in terms of healthcare): Access to a service, provider, or an institution is defined as the opportunity or ease with which consumers or communities can use appropriate services in proportion to their needs (Levesque et al., 2013).

Black American: A person in the United States who identifies as Black, broadly encompassing Americans of African descent, whether they are descendants of enslaved populations or more recent immigrants from across the African diaspora. While African American remains a common and formal usage, especially in historical or institutional contexts, Black is increasingly favored as a more inclusive and flexible self-identification that reflects diverse experiences and histories (Ridley-Merriweather et al., 2023).

Mental health disparity: Unequal levels of attention directed toward mental health compared with other public health concerns of similar scope; unequal health outcomes between individuals with mental illness and those without; and unequal access, quality, and results of mental health care across different population groups (Safran et al., 2009).

Public housing: The nation's oldest housing subsidy program that plays a crucial role in helping low-income people afford safe, stable housing, and whose units are owned and managed by local public housing authorities (Docter & Galvez, 2019).

Race: A primordial source of identity and intergroup antagonism where people typically have different appearances in terms of skin color, hair texture, and other superficial features (Hirschman, 2004).

Residential segregation: A key aspect of racial inequality, implicated in both intergroup relations and in larger processes of individuals and group social mobility (e.g., separating Black and White neighborhoods; Charles, 2003).

Service utilization: The act of receiving or not receiving mental health services and how individuals (who need assistance) access services (Howard et al., 1996).

Stigma: The co-occurrence of its component-labeling, stereotyping, separation, status loss, and discrimination-and further indicate that for stigmatization to occur, power must be exercised. It is also known as the ways in which people construct cognitive categories and link those categories to stereotyped beliefs (Link & Phelan, 2001).

Assumptions

When considering a plan of action in upholding the integrity of the study, numerous philosophical assumptions were realized. Axiology, epistemology, methodology, and ontology are some assumptions that must be considered when examining qualitative work. An axiological assumption involves values' role in research (Creswell & Poth, 2017) Research is acknowledged as value laden and biases, which can be present at any point of the research process. As the researcher of this study, I was alert

of my own possible bias and its influence on the research design and analysis of the study. In my awareness of potential bias, I refrained from the use of scrutiny, misjudgment, and any forms of unethical misconduct. My attitude in minimizing personal bias influenced the creation of meaning and knowledge that is based primarily on participants' noticeable accounts and experiences.

The epistemological assumption involves the researcher's knowledge of the results of the study and how those claims are accounted for (Creswell & Poth, 2017). In this assumption, researchers collect data while also attempting to get close to the topic of the study. Participants are given a voice by the researcher who represented their views. In this study, I implemented time management in collecting and analyzing data. Older Black women were willing to discuss their perspectives of accessing mental healthcare while living in public housing, authentically and genuinely. Also, some women were open to answering all interview questions in a comfort and secure manner while others experienced a degree of discomfort and unease in sharing their experience and perception on accessing healthcare. Knowledge generated from this study is based on participants' experience that was truthful.

The methodological assumption involves specific methods in a qualitative inquiry and particularly involves inductive reasoning and has a likeness for an emerging and flexible design. (Creswell & Poth, 2017). Details of the context of this study were provided and I (along with the participants) compared questions from experiences. Using a flexible design, I constructed semistructured interviews with an in-depth analysis that

rest focus of the research on the participants' views. The assumption was essential to the meaningfulness of this study.

Ontology involves the nature of reality and those things that exist. Here, reality is subjective and multiple. The ontological assumption of this study centered on the understanding that participants may have different views and perspectives in their experiences of accessing and utilizing mental health care services. An assumption in this study was that women shared a sense of vulnerability to one another's perception while exchanging their perspective and experiences of accessing healthcare. Implications for practicing these ontological assumptions suggested a use of quotes and themes to express participants' voice and offered evidence of different viewpoints (Creswell & Poth, 2017) In alignment with this implication, I furnished a wealthy description of participants' perceptions when reporting on the study's results.

Scope and Delimitations

I collected data from older Black women about their perception of accessing mental healthcare while living in public housing. The study was limited to U.S. residents who were older Black women residing in public housing. Women had some encounter in accessing mental health care while living in public housing. Each participant met criteria including (a) being a Black woman, (b) being 55 years of age or older, (c) living or have lived in public housing for at least 6 months, and (d) having experience with accessing mental health care and service utilization. The study excluded any other race, gender, and age that did not meet the study's criteria. Interviewing provided insight into some of the tenants' experience with accessing healthcare and was useful to housing authority

managers in their planning process for the development of certain programs that are geared towards the safety and well-being of their tenants.

Transferability of the study results were partially limited due to the nature of this qualitative study. The data for this study were gathered from a small homogeneous sample of participants located in a specific geographical area. It was not guaranteed that the outcome of this study was transferable to another location and practice. In this project, the size of the sample was deliberately small and carefully selected, with a focus on generating rich and detailed descriptions within their contexts (Percy et al., 2015), which served as a foundation for continuing more targeted research in future studies. Although the scope of this study was limited to a small and selected sample within a specific context, the rich and thick descriptions facilitated comparisons to other settings and similar populations.

Limitations

A limitation of this study was that it only focused on Black women and their experiences, and other groups such as mental health providers or those working directly in reaching out to this population including people in specific prevention programs involved in understanding Black women's access to mental health care were not included. A more systematic exploration would have brought a broader perspective to the phenomenon under study. A related possible limitation is that the study only targeted older Black women and other people living in public housing could have also faced similar challenges; however, they were not the focus of this study. A barrier to this study was having access to this population and their willingness to consent and remain in the

study until the end. However, I tried to reach out to this population and recruit from different sites.

Significance

Understanding Black women's barriers to accessing mental health services in the context of living in public housing had the potential to translate into planning and direction for more equitable service delivery and culturally competent health care professional practice (Memon et al., 2016). Identifying specific challenges in accessing mental health services provided insight to isolate and remove barriers. Results of this study informed mental health service providers, local authorities, health care services, and community groups about the needs of this population; in turn, these groups disseminated the information and used the information to support the creation of programs and services for this population.

Although previous research identified what barriers Black people seeking mental health services have faced (Alang, 2019, Campbell & Long, 2014; Conner et al., 2010; Dinwiddie et al., 2013; Gaston et al., 2016; Hays & Gilreath, 2017; Lukachko et al., 2015; Ward et al., 2013), the current literature lacked an in-depth exploration of older Black women living in public housing's insight on their journey of accessing mental health services. The increased understanding of the strategies older Black women use and whether certain characteristics promoted steadfastness in seeking services provided better knowledge of what professionals (and society) could do to support positive mental health within the Black community. The implications for positive social change include better

resources and increased visibility of the challenges reported by older Black women living in public housing.

Summary

While a great depth of research and information existed around access and utilization of mental health care services, there was a scarcity of literature regarding older Black women's experience of access to and utilization of services. Older Black women's perspectives on living in public housing and accessing mental health care have yet to be studied through firsthand encounters and no qualitative studies have been found to irradiate this viewpoint. The scarcity of literature surrounding viewpoints of experiences involving access to care and service utilization for older Black women living in public housing justified the exploratory nature of this research. The account of these experiences provided valuable insight into older Black women's challenges of living in confined conditions and barriers associated with such. The sociocultural conceptual model served as the conceptual framework for this study. Semi-structured interviews with Black women 55 years of age or older, living in public housing and having experienced accessing mental health care and service utilization was interviewed. The findings of this investigation were fundamental to implementation of programs and plans to eliminate disparities as well as future research. This chapter provided a common description of the phenomenon of interest while also providing a general account on theoretical support for the purpose of the study and its research questions.

Chapter 2 provides a more thorough synopsis that addressed some of the issues related to Black individuals living in public housing, access of health care and service

utilization, race, stigma, and residential segregation. In Chapter 2, information is discussed on supplemental elements that may affect Black women's experience of accessing mental health care services. Chapter 2 also explores the literature and theoretical foundation of the study while also explaining the methodology for conducting a literature search. Key terminology is defined for understanding of terms and preparation for additional discussion in the preceding chapter.

Chapter 2: Literature Review

While the literature on accessing mental health care among older adult populations had expanded, little was known about the experience and challenges that Black women faced in accessing mental health services while living in public housing. Older adults living in public housing share distinctive characteristics such as receiving a low income, living alone, or presenting high levels of medical comorbidity that place them at risk for mental illness and at a high need for mental healthcare (Simning et al., 2012). The inadequacy of the mental health systems and their service to the minority older adult population and living in public housing influence health and health care utilization (Hinds et al., 2018; Simning et al., 2012).

Accessing healthcare is essential for individuals' health and well-being; however, Black persons typically do not seek professional treatment for mental health problems (Bailey et al., 2011; Hunt et al., 2015; Ward et al., 2013). Older Black women in public housing, particularly, seem to be a high-risk group for experiencing barriers and underutilization of mental health services (Haley et al., 2017; Ward et al., 2009). Several factors have been identified as barriers to accessing and using mental health services among Black persons. The system-level barriers consist of inaccessible location, transportation issues, or lack of health insurance (Cristancho et al., 2008). Individual-level barriers include issues like trust, internalized stigma, and shame and embarrassment (Ward et al., 2009).

The purpose of this study was to explore access to mental health care among older Black women living in public housing. This study also aimed at understanding older

Black women's perceptions on their challenges and barriers to accessing mental health care and service use while living under confined conditions. This literature review includes the sociocultural conceptual model for treatment engagement as related to access of mental health care and treatment-seeking. This section also explores social issues and factors that negatively affect Black women's mental health and should be considered and addressed to eliminate disparities in access to and utilization of mental health services in this population. A discussion about limitations of the current research conclude this section as well as a description of the literature search strategy.

Literature Search Strategy

The published research in relevance to accessing mental healthcare while living in public housing dated back to the 1990s with the magnitude of the studies focusing on access and utilization of mental health care. Amid this research was an insufficient number of studies on older Black women's experiences of accessing mental health care at the time of living in public housing. While there had been growth in investigating mental healthcare access in public housing, more research was needed that specifically explored older Black women's encounter of seeking mental healthcare and an understanding of their need for improvement in accessing care and treatment process.

The search strategy and resources included utilization of the Walden University Library to gain access to assorted databases, which included EBSCO Host, ProQuest, PsycINFO, and Google Scholar. The articles searched were peer-reviewed and most reviewed within the past decade. Applied search terms consisted of keyword searches and the Boolean method to return numerous terms of keywords. The search terms utilized

included access of *healthcare, older Black women and mental health, mental health and public housing, service utilization and mental health, Black Americans and mental health services, Stigma, Race, and Mental Health, Race, ethnicity and mental health access,* and *residential segregation and mental health disparities.* This review provided evidence that there is an increased amount literature on accessing mental healthcare and a scarcity of research that sufficiently explores the experience of older Black women's experience of accessing mental healthcare while living in public housing.

Conceptual Framework

Accessing mental healthcare and service utilization often ignites significant challenges in many areas of an individual's life that can harm both mental and physical aspect. These challenges can be the result of barriers to accessing mental health services in Black populations. The use of a conceptual foundation that offered organization and structure was useful to understanding the experience of accessing and seeking mental healthcare in public housing and how it may have impacted older Black women's lives. Therefore, the sociocultural conceptual model for treatment engagement was applied to this study as a part of the conceptual framework.

The Socio-Cultural Conceptual Model

Copeland and Butler's (2007) sociocultural model for treatment engagement described four main factors that negatively affect Black women's mental health. Copeland and Butler's model is based on Andersen's (1995) extensively cited and used behavioral theory of access to health services, which is considered the most common framework used to understand individual's access to health care (Derose et al., 2011).

Copeland and Butler adjusted Andersen's model to represent and target Black women's mental health access and to understand barriers to accessing mental health services in this population. Research on challenges to accessing mental health services consistently supported the relevance of the four factors (racism and discrimination, socioeconomic status, stress and well-being, and housing and neighborhood conditions) identified by Copeland and Butler (Alang, 2019, Campbell & Long, 2014; Conner et al., 2010; Dinwiddle et al., 2013; Gaston et al., 2016; Hays & Gilreath, 2017; Lukachko et al., 2015; Ward et al., 2013).

Copeland and Butler (2007) addressed a broad range of system-level and individual-level barriers and provides a framework to understand Black women's experience of accessing, seeking, and utilizing mental health services while living in public housing. People may not face barriers in the same way; experiencing barriers may depend on many factors. However, there is a similar context among people living in public housing and issues related to racism, discrimination, housing conditions and socioeconomic status are similar among Black women living in public housing. Thus, Copeland and Butler's conceptual model provided the potential to reveal general dimensions and a means to categorized barriers and obstructive events across older Black women. Even though the type of barrier and response to it were not exactly similar, they likely experienced significant barriers to accessing services. This was useful in the interview question development process and in identifying themes or concepts in the analysis phase to understand the participants' experience. Building on existing knowledge, this conceptual model provided the opportunity to better understand or

interpret older Black women's perception of the personal and contextual barriers as well as built knowledge of patterns that improved care by knowing what to expect.

Literature Review Related to Key Variables and/or Concepts

There are various topics of interest that were merged at the center of this study. This literature section was arranged by describing factors involving mental health care, public housing, and barriers and consequences associated with each. When addressing changes in healthcare use among individuals who move into public housing, researchers hypothesized that all forms of healthcare use would decrease after individuals moved into public housing and suggested that reduced access to healthcare was one reason for the decrease in healthcare services (Hinds et al. 2018). Older Black women, particularly, seem to be a high-risk group for experiencing barriers and underutilization of mental health services in public housing (Haley et al. 2017). In addressing disparities in access to mental healthcare and utilization, findings indicated that people from Black and minority ethnic backgrounds need mental health literacy and practical support, which would help to improve information about services and access to pathways (Memon et al., 2016).

Barriers to Receiving Mental Health Services

Several barriers to using mental health services were identified among Black individuals. A large group of barriers related to perceived discrimination, racism, or race. Another group of barriers related to mistrust to the health system, attitudes, beliefs, and perceptions about receiving mental health services. Yet there was another obstacle related to access, transportation, and geographical location.

Perceived Discrimination and Racism

Through a systematic review, Gaston et al. (2016) explored the differences in the perceptions of mental health services among Black Americans or African Americans, African, and Caribbean Black descent. Older African Americans reported that barriers to treatment were perceptions of depression, racism, discrimination, and negative beliefs. Older African American over 65 reported that mental health services were underutilized while African American women reported that perceptions of mental health were negative, with many participants believing that stigma, lack of confidentiality, and questionable effectiveness of psychotherapy were significant barriers to mental health treatment seeking.

Stigma and racial differences in treatment seeking attitudes and help seeking behaviors among older adults with depression were explored (Conner et al., 2010; Hays et al., 2017). Findings indicated that although perceived public stigma (negative attitudes held by the public) among older adults was high, African American older adults endorsed higher levels of internalized stigma (negative attitudes held by stigmatized individuals about themselves) and less positive attitudes towards seeking mental health treatment than their White counterparts (Conner et al., 2010). A high level of internalized stigma (trust, shame, and embarrassment) was related to more negative attitudes towards seeking treatment; and, in fact, partially mediated the relationship between race and attitudes towards seeking mental health treatment (Conner et al., 2010). Alang (2019) explored the unmet needs for mental health care among Blacks; identifying factors associated with causes of unmet needs, confrontation of racism, and constructive solutions to improving

service use. In terms of mental health and service use, college-educated Black respondents reported a fear of discrimination based on race. Findings highlighted racism as cause for mistrust in mental health systems and the importance of anti-racism education and community-driven practice in decreasing unmet need was emphasized by participants of the study.

Attitudes and Perceptions Towards Mental Health and Services

African American's beliefs about mental illness, attitudes towards seeking mental health services, and cultural beliefs on help-seeking and service use were explored (Campbell & Long, 2014; Ward et al., 2013). Feelings on depression and treatment in Black communities were explored and Black respondents felt that depression was viewed as a White woman's problem and was not an illness that plagued Blacks (Campbell & Long, 2014). Black women were less likely to consult or receive treatment for depression or other mental health issues; or they delayed treatment until the problem became severe (Nelson et al., 2020; Woodward, 2011). Yet, depression was reported as the most common mental illness for both Black males and females (Ward et al., 2013). The lack of trust in the health system revealed the need for mental health literacy and support (Memon, 2016). Education can help improve information about services and access to mental healthcare in the Black community. Anti-racism education and community-driven practice in decreasing unmet needs were identified as factors to decrease barriers to accessing mental health services (Alang, 2019).

Religiosity was a cultural factor associated with the use of mental health services among Black individuals. Lukachko et al. (2015) investigated the relationship between

religiosity and mental health service utilization among African Americans. They hypothesized that greater religiosity would be associated with lower mental health service utilization. Subjective religiosity was significantly associated with a decrease in formal care while African Americans who reported a high degree of religiosity were less likely to utilize professional source of mental healthcare than those who reported a low degree of religiosity. Avent et al. (2015) interviewed senior African American pastors who confirmed that parishioners in their communities tended to seek out daily assistance for mental health consultations including topics on depression, domestic violence, addiction, and other significant mental health issues. Some Black Americans relied more on the use of pray as a coping strategy or seek informal services within the church than consulting with mental health professionals (Harris et al., 2021).

Access, Transportation, and Geographical Location

Accessible transportation is essential to health care utilization (Syed et al., 2013). Transportation became an important barrier to accessing health care providers. There was a relationship between people's poor health and difficulty accessing public transportation. Those who reported transportation as a barrier to access health care were likely to belong to a racial or ethnic minority, and be female, poor, and less educated (Haley et al., 2017).

The concept of residential segregation surfaced to explain the lack of access to health service utilization (Dinwiddle et al., 2013). Isolated neighborhoods had fewer physician offices, medical technology for specific treatment, or specific specialists. Dinwiddle et al., (2013) explored how residential segregation might influence access to psychiatrists. Findings indicated that there was a shortage of psychiatrists in certain areas;

particularly those isolated neighborhoods where there was limited access to mental healthcare.

Living in Public Housing

A review of the barriers that Black Americans experience in accessing mental health services were presented in previous section. However, the problem of accessing mental health services was multiplied for older Black women living in public housing. Individuals who lived in public housing tend to have shown a poor health profile (Haley, et al., 2017). In fact, studies that reported on relocation experiences indicated that those moving from public housing to qualitatively different neighborhoods reported improved mental and physical health in post-relocation (Cooper et al., 2013; Cooper et al., 2015).

People living in public housing is a population disproportionately composed of racial and ethnic minority groups who lack social support and who experience high levels of mental health problems (Cooper et al., 2015; Cotrell & Carder, 2010; Parsons et al., 2011). Unfortunately, public housing does not follow the best health practices for its tenants. Lipman and Manthorpe (2017) examined current practice and policy in 12 housing associations in the United Kingdom. They investigated the needs of older Black and ethnic minority tenants with dementia in housing associations. Results indicated that none of the housing provided adequate dementia care or attended cultural or ethnicity-related needs and preferences. Gonyea et al. (2018) explored how depression related to loneliness in older ethnic minority housing residents in the United States; they found that loneliness explained almost half of the variance in depression. It was evident that

adequate care models addressing social risk factors are needed to meet the needs of the older population.

Elders with disabilities was another group who experienced challenges while living in public housing. White et al. (2019) examined health behaviors and healthcare utilization of African American seniors and seniors living with disabilities in public housing. They collected data from 131 public housing residents. Findings indicated that African American seniors living with disabilities in public housing encountered significant barriers as it relates to health and well-being. Research findings also suggested a need for additional research to assist public housing authorities and public health practitioners providing services that meet the needs of this population.

Hinds et al. (2018) investigated whether a move to public housing affects people's use of healthcare services and reported that general practitioner visits and prescriptions increased while emergency visits and hospitalization decreased over time. While healthcare use changed over time, findings indicated that public housing provided basic needs to a population who had a high burden of disease and who were not able to obtain and maintain housing in the private market.

Living in public housing was challenging for its residents due to several issues such as being in poor neighborhoods with limited access to transportation and other resources. Hagan et al. (2020) explored how residents living in public housing negotiated, endured, and resisted violence. They collected data through in-depth interviews to 44 residents in two predominantly African American public housing communities. Residents narrated distinct yet similarly multilayered and complicated stories of the ways they

endured, were harmed by, and resisted multiple forms of violence reflective of the experience of living in public housing.

Finally, another challenging layer related to living in public housing related to availability. Residential care had not kept pace with the growth of the older population. Frochen et al. (2020) investigated the distribution of residential care in California. They mapped the ratio of beds to older women in Los Angeles and San Diego County and showed geographical disparities in care supply and need in these areas. A better understanding of these geographical disparities in residential care supply and need was needed to plan for residential care facility development in underserved areas.

Summary and Conclusion

In this literature review, I provided an overview of the current pertinent research on living in public housing and barriers to accessing mental health among older Black women. Although research has lengthened on accessing mental healthcare, literature indicated a limited amount of research that discussed older Black women experiences accessing mental health care, or their perceptions on the challenges and barriers of service use while living under confined conditions. Chapter 2 discussed the inadequacy of mental health systems, their services to the minority older adult population and how living in public housing played an essential role in health and health care utilization. In this chapter, the importance of access to care for individual's health and well-being was emphasized and numerous research supported Black people's lack of seeking professional treatment for mental health problems (Bailey et al., 2011; Hunt et al., 2015; Ward et al., 2013).

Barriers to receiving mental health care services in the Black population were identified; and they were perceived as a negative impact on individuals' seeking treatment and living in public housing. However, the challenges Black women in public housing face in accessing mental health services had not been studied. As a result, the focal point of my study was to explore how older Black women living in public housing experienced accessing mental health services and understood the challenges and barriers they experienced in accessing mental health care and service use. As addressed by Copeland and Butler's socio-cultural conceptual model, factors that negatively affected Black women's mental health were considered and addressed to rid of any disparities in access to and use of mental health services. The model also offered organization and structure that was beneficial in exploring older Black women's perceptions on access and utilization of care. Results of the study helped in creating awareness of the needs of this group and helped in developing interventions or prevention programs. The next chapter described the methodology and research design that was used to address the study's goals.

Chapter 3: Research Method

The purpose of this study was to explore access to mental health care among older Black women living in public housing. This study also aimed at understanding older Black women's perceptions on their challenges and barriers to accessing mental health care and service use while living under confined conditions. The study used a descriptive, qualitative approach that consisted of semistructured interviews with older Black women who have experienced obstacles in accessing mental health care and service use while living in public housing. This approach offered an understanding of the challenges and barriers that these individuals encountered while seeking mental health care services. The succeeding sections provided an outline and description of the research design and rationale, the role of the researcher, and elements of methodology and trustworthiness.

Research Design and Rationale

A descriptive qualitative approach was used to explore the following research questions:

- RQ 1: What is the experience of accessing mental health care services among older Black women living in public housing?
- RQ 2: What are the barriers to accessing mental health services among older Black women living in public housing?

The central phenomenon of interest in this study related to accessing mental health care. Specifically, the phenomenon revolved around how older Black women accessed mental health care and service use while living in public housing. Accessing mental health care relates to an individual's approach in seeking and obtaining services

for one's health care needs. Personal and environmental factors and the relationship between service users and health care providers impact the access to mental health care (Memon et al., 2016).

The research question helped to examine themes and contexts that pertained to older Black women's experience of access to and service use of mental health care services. The semistructured interview questions were used in a way that monitored distinctive perspectives and feelings of accessing mental health care in public housing. In addition, the theoretical framework of the socio-cultural conceptual model for treatment engagement (Copeland & Butler, 2007) was used to explore some of the main factors that negatively affected Black women's mental health. This model helped in understanding how these factors intertwined and affected Black women's access and use of mental health service while living in public housing.

Research Tradition

The nature of this study was qualitative, and I used a descriptive qualitative research approach (Merriam & Tisdell, 2015; Percy et al., 2015) to specifically address the research questions and goal of this study. Qualitative research is different from quantitative research, particularly in its inductive nature. Qualitative research aims at developing an understanding of an event or phenomenon (Creswell & Poth, 2018). This tradition was a good fit for my study as I aimed to explore in-depth the phenomenon of accessing mental health care among women living in public housing.

Descriptive studies permit understanding of how people interpret, construct, or make meaning from their world and their experience (Merriam, 2002; Percy et al., 2015).

For instance, within a generic qualitative study, researchers could strive to examine a process in a comparable way than is expected in a grounded theory, but without attempting to derive a substantive theory (Lim, 2011). Choosing this tradition helped in providing understanding of older Black women's experiences related to accessing mental health care in public housing.

In this study, the descriptive approach closely related to what the researcher was investigating. In-depth interviews, field observations, and documents were used to respond to clear-cut questions (Patton, 2015). I used in-depth interviews that allowed me to obtain the data that were needed to respond to the research question. I was able to engage with participants and learn of their experiences of accessing care and service utilization, particularly challenges and barriers.

Role of the Researcher

In qualitative research, the researcher is the driving force and instrument for data collection where data is mediated through this human instrument (Denzin & Lincoln, 2003). It is vital for the researchers and participants to build rapport that would help to enrich the study and increase validity. The qualitative researcher needs to describe relevant aspects of self, including any biases and assumptions, any expectations, and experiences that would qualify their ability to conduct the research (Greenbank, 2003). As the instrument in this research study, it was appropriate to analyze potential bias. During the recruiting process, I upheld integrity and eliminated potential biases by not selecting participants who may have had a personal and/or professional relationship with me. Instead, I selected participants within the geographical area that met the criteria of

the study. Having a background and passion for helping individuals with issues involving mental instabilities drew me to this study and I aimed to cause no harm towards self and participants. I kept a personal journal to record personal reactions and reflections for bracketing purposes.

As the researcher and interviewer, it was my duty to control the direction of the interview and to ensure that I was reflexive, conscious, and aware of how my role might have impacted the conversation between myself and the interviewee (McGrath et al., 2018). My role was to outline the research process, lay out the study, and inform participants of their rights to withdraw at any given time. I maintained a professional relationship with participants. Semistructured interviews were conducted and later transcribed. Using a semistructured interview allowed participants the freedom to express their views in their own terms and provided reliable, comparable qualitative data (Cohen & Crabtree, 2006). Data were analyzed and reported. In ensuring data accuracy, it was analyzed to obtain meaning of answers given to suit the research questions. Coding was done based on themes that emerged and ascribed with a focus on their impact on the research questions. My role as the researcher demonstrated that I designed this study with an appropriate strategy that ensured a successful process in answering the research questions.

Methodology

Participant Selection Logic

The participants in this study consisted of 10 Black women who were 55 years of age or older and lived in public housing. Criterion sampling was used as the sampling

strategy in this study. It involved selecting participants or sources of data that met predetermined criteria relevant to the study (Patton, 2002). This sampling was the most suitable approach for this study to ensure that participants met the criteria of the study, and the research questions were not left unanswered.

To be eligible to participate in the interviews, each participant must have met a criterion that included (a) being a Black woman, (b) being 55 years of age or older, (c) living or have lived in public housing, (d) having experience with accessing mental health care and service utilization. Participants of this study were purposefully recruited from a sample of individuals who responded to my invitation of flyers posted in public housing facilities and other locations. More information on recruitment was described under the procedures for recruitment, participation, and data collection section. Additionally, I used snowball sampling. Participants of my study were asked to forward information about this study among other potential participants.

Ten women were selected to participate in semi-structured interviews that ultimately yielded the rich data for this study. A sample size of 10 participants was recommended to reach saturation when using semi-structured interviews (Guest et al., 2006; Guest et al., 2020). Using this sample size also helped in creating a strong coding and minimized the chance of missing codes (Rijnsoever, 2017). Considering these recommendations, I attempted to recruit 10 participants in my study. As expected, saturation was reached with this number of participants. Saturation refers to the point at which no new trends or patterns are emerging from a homogenous sample of participant interviews (Guest et al., 2020; Rijnsoever, 2017). This target sample size was selected

given the likelihood of reaching saturation with this number of homogeneous participants from this specific group of interest.

Instrumentation

Demographic Questions

Each participant was expected to be interviewed for approximately 40-50 minutes to guarantee that all necessary information needed from the participants had been obtained. Before asking the participants questions related to the research study and the specific interview guide, I began by asking them a standard set of demographic questions to get a clear picture of the participants and their context. Appendix displayed the anticipated demographic questions.

Semistructured Interview Guide

A semi-structured interview guide was developed to respond to the research questions (Appendix). The interview's main purpose was to gain an understanding of participants' experiences and their perspective on accessing and utilizing mental healthcare services. I prepared a set of questions for participants; however, a semi-structured interview format allowed the flexibility of creating follow up questions during the conversation. I developed the semi-structured interview questions based on the literature review consulted, previous related studies, and the conceptual framework. I also consulted with my chair, and she reviewed the interview guide and adjusted to fit the goals of the study. Interviews were audio recorded. I built a rapport by connecting with the participants in their context.

Procedures for Recruitment, Participation, and Data Collection

Upon request for approval by the Institutional Review Board (IRB), I began recruiting participants. I sent emails about my study to mental health facilities who had qualifying patients who lived in or have lived in public housing. They were asked to forward the email to potential participants. I was given permission to post flyers about the study at local, public housing facilities, healthcare facilities, and medical plazas. Additionally, potential participants were invited to participate through Facebook forums and organizations that were passionate about and devoted to mental healthcare services. I was given permission from Facebook pages' administrators and organizations that expressed dedication and support to mental health services and public housing reform programs. Email letters and electronic flyers were sent to organizations and Facebook groups with my contact information. Permission to post information pertaining to this study was requested on Facebook sites such as "Mississippi Department of Mental Health," "Mississippi Regional Housing Authority," and Mississippi Association of Affordable Housing Providers.

Interested prospective participants responded to my announcement and invitation by email and phone. At that point, I explained in depth the goals of the study and procedures for participating in the study. I verified that participants met the criterion for participation. After the initial contact, I verified participants' email address to send a consent form. Interested participants who qualified for the study responded by email stating "I consent." After this, I arranged a date and time for an interview. I favored face-to-face interviews that were conducted in a public area. If participants could not meet in

person, I conducted Zoom interviews that were recorded. Upon exit of the study, participants were given the opportunity to ask questions and express their concerns. Participants were also provided with a twenty-five-dollar gift card as a token of appreciation for partaking in the study.

Data Analysis Plan

Thematic analysis was suitable for this study and was a worthy approach for producing original results and analyzing various participants' perceptions (Nowell et al., 2017). According to Braun and Clarke (2006), thematic analysis consists of six phases:

1. Familiarizing yourself with your data: This stage consisted of immersing oneself into the data by using repetitive reading, making notations of ideas, and searching for meaning and patterns pertaining to the data.
2. Generating initial codes: The stages began once the data had been read and familiarized. In this phase, initial codes from the data were produced by working systematically through the entire data set; taking note of interesting aspects in the data items as needed to collect relevant data to each code.
3. Searching for themes: In this stage, all data had been initially coded and collated and was organized and collected into developing themes.
4. Reviewing themes: This stage began once one had devised a set of candidate themes and involved the refinement of those themes. In this stage, it was made known that some themes were not really themes. Data within themes cohered together and consisted of meaning and clear, identifiable distinctions between themes.

5. Defining and naming themes: In this stage, there was satisfaction in the thematic map of the data. Here, I defined and refined the theme that was to be presented for the analysis. Names were provided and the general idea of the story was described more clearly.
6. Producing the report: This is the stage that involved the final analysis and writing of the report. Here is where the scholarly report was created and used to tell the complicated story of the data in a way that convinced the reader of its validity.

Data was gathered from the interviews and analyzed where results were compiled into a report. Ultimately, thematic analysis was a suitable plan that allowed various models of investigation. Excel software was also used for coding during the research process. Results were rendered into a coherent final report. However, not all evidence fitted the pattern of the emerging themes. When this discrepancy surfaced, I documented the negative data to provide a realistic and valid perspective of the phenomenon under study. Conducting negative analysis and critically reviewing conflicting information held the potential to add credibility to the study (Shenton, 2004).

Issues of Trustworthiness

Trustworthiness was fundamental for ensuring quality in this qualitative research study. Credibility, transferability, dependability, and confirmability are considered the qualitative inquirer's equivalents for internal validity, external validity, reliability, and objectivity typically used in quantitative studies. I followed Shenton's (2004) guidelines and recommendations in ensuring trustworthiness.

Credibility

Credibility refers to the congruency of the findings by describing participants' voices. A researcher who addresses credibility responds to the question: How congruent are the findings with reality? (Shenton, 2004). Prolonged engagement, negative case analysis, and peer debriefing were used in this study to ensure credibility. To achieve prolonged engagement, I spent enough time in the field and as expected, I gained an understanding of the phenomenon under study. I proposed conducting several interviews to ensure that saturation was achieved, and the phenomenon of the study was deeply understood.

To ensure that disconfirming or negative information was not neglected in the results of this study, I used negative case analysis. I revised all instances where findings did not fit to understand more extensively why they did not. I revised the analysis until all cases fitted; if they did not fit, I documented disconfirming evidence and provided an alternative explanation as to why they did not fit. Finally, I consulted my dissertation chair across all moments of data collection and analysis. This consultation provided an external perspective that helped me review procedures and analysis and also helped me remain aware of my decision-making throughout the research process.

Transferability

Transferability involves the concept of external validity which is concerned with the extent to which the findings of one study can be applied or transferred to other situations and contexts (Shenton, 2004). Sufficient details of the context of the fieldwork were necessary for readers to be able to decide whether the prevailing environment was

familiar to their context. Based on this, readers should decide whether the findings can justifiably be applied to their settings (Shenton, 2004). To ensure appropriate use of transferability, I utilized a detailed narrative describing all aspects of the study. I provided a rich description of the participants' context and study results. Providing detailed results allowed other readers and researchers to make comparisons in similar situations, events, or contexts. Substantial description of the data collection process, participants' contexts, analysis, and results were provided. Participants' voices were illustrated by using vignettes, which ensured thick and rich description. Based on this, the user of these results was able to make decisions regarding the applicability and transferability of the results.

Dependability

A core aspect of dependability refers to the extent to which similar findings would arise if the study would be replicated (Shenton, 2004). One of the most significant strategies for upholding a study's dependability is to clearly describe all the procedures that are a part of a research project. Within my study, the research design was planned and strategically executed (Shenton, 2004). Describing in detail the interviews and field notes during data gathering helped to avoid and control bias. I documented my steps in the research process to inform readers about the decision-making processes behind each methodological choice and analytical finding. I maintained an audit trail throughout this investigation where each step in the process of data analysis was witnessed by those who were reading about the study and its results.

Confirmability

The qualitative investigator's comparable concern to objectivity is the concept of confirmability. Steps must be taken to ensure as far as possible that the work's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher (Shenton, 2004). Confirmability was promoted through triangulation which helped to reduce the effect of research bias (Shenton, 2004). In this study, an audit trail, which allowed any observer to trace the course of the research step-by-step via the decision made and procedure described (Shenton, 2004), was used. Research work included a reflective journal that allowed the researcher to write down notes and for reasoning purposes that increased consciousness to potential bias. Committee members also assessed interview questions as needed to reduce research bias. Once data was collected and analyzed, I shared a 1–2-page summary of results with participants. Information was sent to participants' email address

Ethical Procedures

The researcher had an obligation to ensure that participants' well-being was safeguarded throughout the research process since research could present risks to participants (Munhall, 2012; Polit & Beck, 2010). Safeguarding participants' well-being involved adhering to the standard ethical principles which included protecting participants from harm, confidentiality, informed consent, and voluntary participation (Scott, 2013). In improving the study's ethical protocol, I carefully considered my decisions to ensure safety and integrity for all parties involved in my research. For

example, to obtain approval from the institution, I reported sufficient information regarding the study, as described in APA Ethical Code of Conduct 8.01 (APA, 2017).

IRB approval number for this study is # 11-29-23-0744848. Prior to my research, I provided the Institutional Review Board (IRB) with adequate information about the study. IRB approval made certain that I administered the study with ethical integrity while also ensuring that the appropriate steps were taken to protect the rights of the older Black women participants. To protect the older Black women participants, the researcher-maintained confidentiality by safeguarding personal information that was not disclosed in the study. In terms of treatment of data, participants' information was confidential having no names in the write-up. A number was designated for each participant to protect their identity and privacy (e.g., Participant 1, Participant 2, Participant 3, etc.) and to also avoid any discomfort or unease.

A copy of the informed consent was given to participants and was in accordance with APA Ethical Code of Conduct 8.02 which explained the purpose of the research, expectations, and participants' rights to decline or withdraw from the study (APA, 2017). Before signing the informed consent, I discussed the form with each participant to ensure that they understood all the elements included in the informed consent. All data was safely secured for the protection of participants. Electronic files were stored, and password protected. My dissertation committee and I have access to data. Participants understood that if they dropped out of the study, all their information would be terminated.

As APA (2017) suggests, psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation. To avoid coercion, the researcher did not provide participants with gift cards until the study had ended.

Summary

This chapter discusses the selection and implementation of the qualitative research design that was used for the purposes of this study. The chapter offered an explanation on how the research tradition pertained to this study in answering research questions regarding older Black women's experience of accessing mental health care services while living in public housing. This chapter also addressed the role of the researcher, the design and methodology of the study, and potential bias that was commonly seen in qualitative research. Within the qualitative tradition, the descriptive approach was outlined. The reasoning for this approach was noted, describing the key features that fitted with the goals of this investigation. The participants' criteria for participation, the recruitment, data collection, the ethical consideration, and data analysis methods were presented. In this chapter, the importance of trustworthiness and its vital role in ensuring quality in a qualitative research study was seen. When considering trustworthiness, Chapter 3 also discussed its components of credibility, transferability, dependability, confirmability and their role in the research process. Having described the methodological outline for this project, the following chapter focused on the study's findings and results.

Chapter 4: Results

The purpose of this study was to explore older Black women's experiences of accessing mental health care services while living in public housing. Individuals who currently live in or have previously lived in public housing were considered for participation in this study. Participants were interviewed to address the primary research questions:

- What are the experiences of accessing mental health care services among older Black women living in public housing?
- What are the barriers to accessing mental health care services among older Black women living in public housing?

In this chapter, I present the study setting and demographic information representing the participants. Additionally, I describe the data collection and analysis procedures, provide evidence of the study's trustworthiness, and conclude with the results.

Study Setting

I gathered participants for this study by posting flyers via email, social media, and public housing facilities, which provided me with a list of potential candidates. Housing management spoke with potential candidates to determine their interest in participating. Those who were interested received my contact information and shared their own for follow-up, while others reached out directly via email to express interest. Participants who expressed interest were sent a copy of the consent form via email for review and to confirm their consent to participate. Once participants replied "I consent" and agreed to the study, I scheduled interview times that were convenient for them.

In the data collection strategy for this project, I had originally planned to conduct only face-to-face interviews but later added Zoom as an additional method of collecting data because some participants were unable to attend in person due to location conflicts. After revising my data collection plan and obtaining approval for this change from the IRB, I began conducting the interviews. All interviews were scheduled within 1 to 2 weeks of participants expressing interest in the study. Upon completion of the interviews, I provided participants with $25 gift certificates, either by email or in person. Participants also received a copy of their transcribed interviews for review and to suggest any changes. All participants confirmed agreement with the data collected.

Demographics

As planned for the purposes of the study and recruitment, all 10 participants interviewed were women. Although the study aimed to select a purposeful sample of participants with similar experiences, recruitment also sought to include a variety of demographic categories. Participants were Black and between the ages of 50-59, 60-69, and 70 and over (see Table 1). The participants also varied in terms of their relationship status at the time of data collection. Participants in this study were single (n = 6), separated (n =2), divorced (n = 1), and widowed (n = 1). The participants' educational level ranged from eighth grade to high school graduate and/or equivalency credential. The participants also reported on the total number of years that they lived in public housing. Half lived in public housing for 10-20 years. The participants also responded to the number of children they have.

Table 1

Participants' Demographics

	Age	Relationship Status	Educational Level	# of years lived in Public Housing	# of children
Participant1	56	Single	8th grade	16	3
Participant2	73	Separated	10th grade	14	3
Participant3	69	Widow	10th grade	30+	1
Participant4	66	Single	10th grade	66	3
Participant5	56	Single	11th grade	19	2
Participant6	66	Separated	12th grade	45	2
Participant7	63	Single	11th grade	5 or 6	3
Participant8	67	Divorced	12th grade/GED	12	3
Participant9	56	Single	12th grade	15,16	3
Participant10	55	Single	11th grade	8	1

Data Collection

Data for this study consisted of interviews with participants. Interviews were conducted over a 4-month period, beginning in December 2024 and concluding in March 2025. I began each interview by asking participants demographic questions. All interviews were recorded using a Zoom recorder. Some interviews were conducted via Zoom, while others were conducted face-to-face in conference or meeting rooms at public housing facilities, with a Zoom recorder used to capture data during the interview process. After each interview, the recordings were transferred to a password-protected iPad. The interviews varied in length: three lasted over 12 minutes, while seven lasted up to 11 minutes, with an average interview time of approximately 10 minutes.

An unanticipated circumstance during the data collection process involved software issues, in which several participant interviews were permanently deleted by Zoom management. These data were unrecoverable. As a result, I had to recruit

additional participants and redo interviews to ensure sufficient data. After contacting potential participants, I was able to conduct replacement interviews and continue with the data collection process.

Data Analysis

According to the thematic analysis approach, generating initial codes begins once the data has been read and familiarized, taking note of interesting aspects in the data items as needed to collect relevant data for each code (Braun & Clarke, 2006). Data analysis for this study took place over several phases. Each interview was transcribed after being uploaded to my iPad. While playing the audio files, I first used handwritten notes for further understanding and later transferred the information into a Microsoft Word document. Each participant was assigned a number, and transcriptions were saved accordingly. Participants were given the opportunity to review their transcriptions for accuracy and were asked to inform me of any inaccuracies they noticed. No participants requested changes. Once I confirmed the accuracy of the transcriptions, I began the process of coding the data. While listening to the interviews again, I noted recurring or salient codes. I further familiarized myself with the data (Braun & Clarke, 2006) through repeated reading and by searching for meaning and patterns.

In analyzing the interviews, I recorded initial line-by-line codes in the center column and placed more developed codes that captured participants' experiences in the left-hand column. Codes were grouped into categories or themes, and the interview data were analyzed to identify consistencies. Themes emerging from the data sources were compared with those identified in the interviews. When consistent themes appeared

across the data set, I determined that the themes were credible and that saturation had been reached.

For organizational purposes, I created a coding template in Microsoft Word, which was used to code each transcription (see Table 2). Each coding document was titled "Interview Number_Coding (date)." The interview transcriptions were copied into the left column of each document, the middle column was used for line-by-line coding, and the right column was used to identify emerging codes.

Table 2

Coding Example

Text	Line by Line Coding	Focused
LizaX: How prepared do you think that you are in accessing mental health services?		
Interview4: Somewhat prepared	Participant felt somewhat prepared to accessing mental health services.	Lack of Preparedness and Awareness
LizaX: Do you think that the housing facility is prepared to access mental healthcare services for its tenants?		
Interview4: I really don't think that they are.	Participant think housing facilities are not prepared to help tenants with accessing mental health services.	Lack of Preparedness and Awareness
LizaX: What would you do if you needed to access mental health services and treatment? What procedures would you take?		
Interview4: My family	When referring to mental health services, the participant finds support in the family system	Family Reliance

At the end of the coding table, I created an area titled Codebook where my observations of the interviews were noted. The codes were then identified. For example,

when a participant described herself as “somewhat prepared,” I developed a working definition of the code titled lack of preparedness and awareness. When new or unique codes appeared in this study, definitions were based on participants’ insights into the notions they were describing. For example, in defining how safe participants felt when accessing mental health care, I used participants’ own words as a basis for naming and defining emerging codes.

The process of abstraction began once all codes were listed and defined. During this process, codes were grouped together based on similarities in the themes expressed. One of the themes identified across the interviews was limited support and resources in public housing. This theme was defined through multiple instances in which participants expressed concerns about the lack of programs and policies to support tenants’ access to mental health care services. After creating this theme, I reviewed the interviews and located all codes that related to the overarching theme (Attride-Stirling, 2001). Defined codes were copied from the previous section of the coding document and pasted under the identified theme to reference which codes comprised the overarching theme throughout the data analysis process.

In thematic analysis, each interview is considered individually, and meaning is generated by analyzing participants’ perceptions (Norwell et al., 2017). During the process of comparing shared beliefs and experiences across interviews, I reviewed and refined previously identified themes. At this stage, it became clear that some themes were not distinct and were either removed from the data set or merged with other themes for presentation in the analysis (Braun & Clarke, 2006). For example, I initially grouped

participants' concerns about transportation barriers with concerns about the lack of local resources and services. After further review and immersion in the data, I determined that these concerns should be separated into two overarching themes.

Once all transcripts were coded and themes finalized, I created a single document to capture the themes from all interviews. This codebook included three columns (see Table 3). The left column contained each theme and its definition, the middle column recorded the number of times each code appeared in the data, and the right column listed the interviews in which the themes appeared. A sample of the codebook is presented in Table 3.

After creating the full codebook, I considered the codes and themes that appeared most meaningful to participants and examined their relationship to the research questions (Braun & Clarke, 2006). During this process, I searched for recurring experiences and noted those that were more unique to individual participants. Analyzing the data first as individual interviews, then by sections, and finally across participants allowed me to reassemble the data into key, participant-informed themes that addressed the research questions (Attride-Stirling, 2001; Braun & Clarke, 2006).

Table 3

Example of Transcription Code Book

Theme	Number of Times Code Appeared in Data	Interviews where Themes Appeared
Limited Institutional Support and Access Infrastructure: Public housing environments lack structured systems, programs, transportation, and policies to support tenants' access to mental healthcare.	9	Interview 1, Interview 2, Interview 3, Interview 4, Interview 5, Interview 7, Interview 8, Interview 9, Interview 10

Negative Case Analysis

All the cases reviewed in this study through thematic analysis consistently yielded the key findings of this research. However, there was a small discrepancy in the details of one participant's explanation. Out of the 10 participants, one participant reported a different experience from the others because she had access to transportation and outside support programs that assisted with accessing mental health care services where she lived. She explained, "We have all of that. Yes, transportation and ramp along with doorbell necessities. I do not know where the transportation for mental health comes from, but we have it" (Interview 6). Although the participant stated that the housing facility had support programs and that she had lived there for over 40 years, she noted that she had not received any training on access to care. Unlike the others, this participant believed that the housing facility was supportive when seeking help for mental health care.

Evidence of Trustworthiness

The quality of this study was maintained throughout the processes of data collection and analysis. Prior to initiating the study, and as discussed in Chapter 3, the works of other scholars (Shenton, 2004) were consulted to establish the qualities of trustworthiness. In addition to engaging with established standards of quality for qualitative inquiry, efforts were undertaken to ensure credibility, transferability, dependability, and confirmability in the present research.

Credibility

As instructed by the selected methodology and existing literature, the goal of this study was to gain insight into older Black women's experiences with accessing mental health care services while living in public housing. Each step of the study was designed to allow participants' experiences to guide the findings while safeguarding both credibility and transferability (Shenton, 2004). In addition, several aspects of the research were informed by existing literature on access to mental health care and the barriers associated with seeking help. Recurring discussions about the voluntary nature of participation during the recruitment process further strengthened credibility and helped to minimize potential bias (Shenton, 2004). To ensure the accuracy of the data, I repeatedly listened to each recording while reviewing the transcripts. Participants were also invited to review their transcripts to provide corrections or suggestions.

Transferability

In addition to previously described strategies that influenced credibility and transferability, it was essential to describe unique characteristics of each participant so that other advocates working beside this issue can determine reasoning of the study's findings as applied to individuals which they are working with (Shenton, 2004). Participants' information was collected during the interview process and explanations were provided in both words and figures so that the reader gained a better understanding of the people who have shared their experiences. Cautiousness was considered throughout the data collection process where I paid close attention to the context of the participants' experiences. Clarification was also used for any struggle of understanding

participants' testimonies. Throughout each effort, I was able to achieve a rich description of participants' experience promoting transferability of this research study (Mills et al., 2010).

Dependability

To increase the dependability of this study, each step of the research was described in detail, with clear evidence of empirical support and researcher decision-making. A comprehensive audit trail was maintained to ensure organization and accessibility of the data analysis throughout the study (Shenton, 2004). A deviation from the original data collection strategy was explained earlier in this chapter and documented with the IRB. By providing the rationale for considering both face-to-face and Zoom interviews, it is anticipated that future studies on this topic will also take into account data collection methods that allow a wider range of participants to share their experiences.

Confirmability

To ensure the trustworthiness of this study's findings, it was essential to work diligently to maintain fairness throughout the research process. The purpose of the study was to explore Black women's experiences with accessing mental health care, while also examining the challenges and barriers they encountered. This required the use of strategies that optimized confirmability. Peer review was incorporated during coding and data analysis, with feedback from the dissertation committee serving as validation of the findings. Researcher notes were maintained to document feelings and interpretations related to the data. By engaging in a reflective thought process at each stage of the

dissertation, potential biases that could compromise objectivity were carefully monitored (Braun & Clarke, 2006).

Results

The analysis of participant interviews revealed four interrelated themes that describe the challenges and coping strategies experienced by older Black women living in public housing as they attempted to access mental health care. The first theme, limited institutional support and access infrastructure, reflected the lack of structured programs, transportation, and staff assistance, leaving participants without reliable systems to guide them in seeking help. The second theme, environment, safety, and race as barriers to mental health care, highlighted how unsafe living conditions, racial discrimination, and cultural stereotypes combined to discourage help-seeking and amplify psychological distress. The third theme, limited awareness and isolation in navigating mental health care, underscored participants' lack of knowledge and training alongside their social disconnection, which forced many to cope alone or in silence. Finally, the fourth theme, reliance on external or informal support systems, captured the ways participants turned to family, trusted doctors, and personal faith to fill the void left by unresponsive housing authorities. Together, these themes illustrate the systemic, environmental, and social barriers that hindered access to mental health care, while also revealing the informal networks of resilience on which participants depended.

Theme 1: Limited Institutional Support and Access Infrastructure

The first theme was dominant across interviews, and it referred to the absence of structured programs, transportation, and staff support to facilitate access to mental health

services for women living in public housing. Participants consistently reported little to no awareness of available resources, few established procedures to follow when seeking care, and a lack of guidance from housing staff. This deficit left many residents uncertain of how to proceed in times of need, with some relying solely on primary care doctors or family members rather than receiving systematic assistance from housing authorities.

The first component of this theme highlights the lack of programs and procedures to guide tenants. Several participants explained that they had never received flyers, brochures, or any form of instructions on how to access mental health services. Participant 1 noted, “No, we don’t even have a hotline number to call in case we need to access mental healthcare services.” Similarly, participant 5 remarked, “We don’t have any procedures. We have to do that on our own.” These statements reflect the overwhelming sense of being left to navigate a complex healthcare system without institutional support.

The second aspect of this theme concerns the lack of transportation and accessibility, which served as a major barrier. Without designated transportation services, participants often found it difficult to travel to appointments or mental health facilities. As participant 5 expressed, “They use their bus for other things. They could transport us, but they don’t.” Others echoed that reliable transportation would make them feel safer and more confident in seeking care.

The third dimension relates to inadequate housing staff support. Participants repeatedly described housing staff as unhelpful or absent when they attempted to reach out for guidance. Participant 10 explained her frustration: “I tried to reach out to the

housing facility, but they had no answer for me. They don't have anything. No transportation or anything." These responses illustrate the sense of abandonment residents felt when trying to engage with housing management about mental health needs.

Taken together, these narratives depict a structural vacuum where tenants are forced to manage their mental health concerns independently, often without awareness of available options or any tangible support from housing authorities. The lack of institutional guidance, combined with the absence of transportation and unresponsive staff, perpetuates an environment in which access to mental health care remains severely constrained.

Theme 2: Environment, Safety, and Race as Barriers to Mental Health Care

Topics related to the second theme include living in unsafe environments, experiencing racial discrimination, and encountering cultural stereotypes. Participants expressed concerns about neighborhood violence and personal safety, noting that such conditions discouraged them from seeking help. Participant 5 expressed, "I don't feel safe at all. That's why my windows be closed." Participant 1 explained, "We really can't talk to anyone because the neighborhood that we're in, no one wants to help. They just pass us by." Participants frequently cited that the geographic and social environment influenced their access to care, as Participant 5 described: "Because it's kind of rough."

Several participants shared experiences of the emotional toll of living in neglected, unsafe, and under-resourced housing. They noted that these conditions contributed to emotional exhaustion and worsened their mental health. Participant 10

reported, “It is very stressful. We don’t have any public help.” Participant 1 added, “It’s hard to sleep because it isn’t safe.”

Coupled with unsafe environments, participants described a heightened sense of insecurity linked to racial discrimination. They reported that such experiences shaped how they navigated access to mental health care, while poor housing conditions amplified psychological distress and contributed to feelings of neglect. Participant 1 recalled, “They only want to help their kind.” Participant 5 explained, “The first barrier is that I’m Black.” In the same vein, Participant 5 reflected, “It could be because they think all of us are the same.”

Some participants described perceived racism and discrimination when attempting to seek help, stating that such experiences discouraged them from pursuing further assistance. Perspectives on the influence of the neighborhood varied. Participant 8 felt that the neighborhood itself had little effect on her ability to access services, explaining: “I don’t think so due to the fact that if you need mental health, no matter what neighborhood you’re in it should be provided. So, I don’t think that it would be the neighborhood. I think that it would be the housing authority itself.” Other participants, however, reported different experiences. Participant 1 reiterated, “We really can’t talk to anyone because of the neighborhood that we’re in,” while Participant 10 concluded, “It plays the biggest role.”

Overall, this theme highlights that participants perceived significant barriers associated with their environment, safety, and race, which hindered their ability to seek and access mental health care services. These barriers were not experienced in isolation

but intertwined, creating cumulative challenges that left participants feeling unsupported and vulnerable in their pursuit of care. As a result, many participants expressed that systemic neglect, unsafe surroundings, and racial discrimination collectively reinforced their sense of exclusion from essential mental health resources.

Theme 3: Limited Awareness and Isolation in Navigating Mental Health Care

The third theme that was generated from the data combines participants' limited awareness of mental health resources with their experiences of social disconnection and isolation when seeking care. Together, these elements reveal how the absence of knowledge, training, and supportive community dialogue left participants unprepared and alone in navigating mental health concerns.

Many women expressed a limited understanding of how to access mental healthcare, what steps to take, or who to contact in times of need. None of the participants reported receiving any formal orientation or training related to mental health services. Participant 8 explained, "I wouldn't know much about it," while others echoed that no guidelines, brochures, or procedures were available to guide them. This lack of awareness left residents uncertain and unprepared, compounding their difficulty in seeking care.

The absence of peer discussion and housing staff engagement reinforced feelings of isolation. Several participants stated that mental health was never a topic of conversation in their communities. As participant 5 expressed, "We don't talk about mental health down there… I don't think they're concerned about our well-being as far as mental health." This silence not only limited opportunities for peer support but also

created a sense of abandonment, as tenants felt their concerns were dismissed or overshadowed by administrative priorities such as rent collection.

Without community or institutional support, participants often relied on family, doctors, or faith as their primary coping strategies. Several participants described managing stress through prayer or by enduring it alone. As Participant 8 shared, “I just have to deal with it alone.” Others echoed similar sentiments: “I just pray” (Participant 5), “I did a lot of praying” (Participant 9), and “I just pray about it” (Participant 10). While these strategies provided some comfort, they also underscored the absence of systemic or communal support for addressing mental health needs.

This theme demonstrates how limited awareness and preparedness, combined with pervasive social disconnection, intensified participants’ vulnerability in accessing mental health care. The lack of institutional guidance left them uncertain about where to turn, while the absence of open dialogue within their housing communities reinforced isolation. Consequently, participants were left to depend on individual coping mechanisms, primarily faith and family, rather than benefiting from coordinated support systems that could have promoted access and well-being.

Theme 4: Reliance on External or Informal Support Systems

In the absence of institutional assistance or clear pathways to access mental health services, participants described turning to family members, trusted doctors, or their own personal experiences to seek help and understand mental health care. This theme reflects how women often filled the gap left by unresponsive housing authorities through

informal networks and personal connections that were perceived as more reliable and supportive.

This theme included two primary areas: family and community networks, and reliance on primary care providers. When reporting on their support systems, participants frequently mentioned family as the first point of contact during a mental health crisis. For example, Participant 7 explained, “I will contact my family first and let them find someone.” Similarly, Participant 2 simply stated, “I rely on family,” while Participant 4 added, “My family.” Participant 9 elaborated further, saying, “I would contact family or a mental health person.” These accounts reveal that family ties were viewed as a central source of support, both emotionally and practically, when navigating the stress of seeking mental health services.

In addition to family, participants also expressed dependence on doctors and health professionals, whom they often viewed as more trustworthy than housing staff. Participant 1 explained, “My first step would be to contact my primary doctor and get guidance.” Participant 3 echoed this sentiment with, “My doctor,” while Participant 6 emphasized, “Some kind of healthcare provider.” Participant 10 described her reliance by stating, “I would definitely contact a mental health provider.” In some cases, participants contrasted their trust in doctors with their distrust of housing staff. Participant 5 declared, “It sure wouldn’t be no housing,” while Participant 10 reported, “It doesn’t do any good because it’s like they’re not listening.” These responses reflect a pattern where housing management was not considered a viable or trustworthy option for support.

Across the data, most participants displayed a clear sense of untrustworthiness toward housing staff and a strong reliance on external systems of support. This pattern was evident across all ten interviews and consistently demonstrated that tenants turned outward, rather than inward to their housing environment, for guidance and help. The first component of this theme, family and community networks, highlighted the deep reliance on kinship ties and interpersonal support when facing mental health challenges. The second component, primary care dependency, underscored the participants' trust in doctors and medical providers as credible sources of information and assistance in contrast to the silence or neglect they experienced from housing staff.

Overall, theme 4 shows that participants developed their own informal systems of support to compensate for the absence of institutional programs or reliable assistance within public housing. By leaning on family and community relationships, and by placing trust in doctors, participants sought to bridge the gap left by housing authorities who were perceived as unhelpful or uninterested in their mental health needs. This reliance on external or informal networks reflects both resilience and vulnerability: while family and doctors offered crucial support, the lack of dependable institutional backing perpetuated feelings of abandonment and reinforced the difficulty of securing consistent access to mental health care.

Summary

The analysis of the data revealed themes that directly addressed the central research questions guiding this study. The overarching questions that guided this asked, What is the experience of accessing mental health care services among older Black

women living in public housing and What are the barriers of accessing mental health care among older Black women while living in public housing?

The findings revealed that the experience of accessing mental health care was defined by a lack of institutional support and infrastructure, limited awareness, and feelings of social isolation. Participants consistently reported the absence of structured programs, transportation, and staff guidance, which left them uncertain of how to seek or maintain care. Many described relying instead on family members, primary doctors, or personal faith to fill the gaps, while housing staff and community networks were largely absent or unhelpful. This reflected an experience in which participants were forced to navigate mental health care independently, often without adequate information, preparation, or supportive dialogue.

The barriers that emerged from the data further reinforced these difficulties. Unsafe housing environments, neighborhood violence, and racial discrimination compounded the challenges of seeking care and contributed to emotional exhaustion. Participants described feeling unsafe in their communities, noting that experiences of racism and cultural stereotypes discouraged them from engaging with available services. In addition, social disconnection and the lack of peer discussion about mental health amplified a sense of abandonment, leaving participants to cope alone or depend solely on informal networks.

Taken together, the themes demonstrate that the women in this study experienced mental health care access as fragmented, uncertain, and unsupported, with barriers rooted in structural neglect, environmental conditions, racialized experiences, and weak

community ties. These findings underscore how systemic and social disadvantages intersect to shape the ways older Black women in public housing approach, experience, and often struggle to obtain mental health services. In the next chapter, the findings of this study are analyzed in relation to current literature, limitations are acknowledged, and implications for future research are discussed.

Chapter 5: Discussion, Conclusions, and Recommendations

A review of existing scholarship on older Black women's perceptions of and barriers to accessing care revealed a gap in understanding the impact of seeking mental health services within the context of public housing (Alang, 2019; Campbell & Long, 2014; Conner et al., 2010; Cooper et al., 2013; Cooper et al., 2015; Gaston et al., 2016; Haley et al., 2017; Harris et al., 2021; Hinds et al., 2018; Memon et al., 2016; Nelson et al., 2020; Syed et al., 2013; Ward et al., 2013; Woodward, 2011). To address this gap, the present study was designed to explore the experiences of older Black women in accessing mental health care while living in public housing. A descriptive qualitative approach was employed to capture participants' perspectives and to provide an in-depth understanding of the structural, social, and personal factors shaping their access to services.

The analysis of the data revealed themes that directly addressed the central research questions guiding this study. The findings showed that participants' experiences of accessing mental health care were marked by limited institutional support, inadequate awareness of available resources, and persistent feelings of isolation. Barriers were further compounded by unsafe housing environments, community violence, and racial discrimination, all of which discouraged help-seeking and heightened psychological distress. Participants often compensated for these systemic gaps by relying on family, trusted doctors, or personal faith, underscoring the absence of reliable institutional support. Taken together, the findings indicate that access to mental health care among older Black women in public housing is fragmented and uncertain, shaped by structural neglect, environmental risks, racialized experiences, and limited community support.

Interpretation of the Findings

The findings of the current study confirm and expand existing knowledge about older Black women accessing mental health care services while living in public housing. Each of the themes identified in this study aligns with findings reported in the literature. By comparing these results to the broader understanding of Black women's processes of accessing mental health services and the barriers associated with them, the study offers direction for future research and practice.

Theme 1: Limited Institutional Support and Access Infrastructure

This theme reflected participants' accounts of the inadequate support provided within public housing environments and the need for a more structured system to facilitate access to mental health care. Participants consistently described housing staff as offering little to no guidance, often leaving them to navigate services on their own. The absence of reliable transportation was also emphasized as a major barrier, further limiting access. Several participants expressed vulnerability and frustration as they recounted how unhelpful and neglectful housing staff had been in their efforts to obtain care, reinforcing the perception that institutional support was absent when it was most needed.

The participants' description of the process of accessing mental healthcare in public housing is consistent with the literature. Participants in this study experienced risk and contextual factors that contributed to their desire to access mental healthcare services, including an absence of mental health literacy and supportive assistance (Memon et al., 2016), no access to transportation (Haley et al., 2017; Syed et al., 2013;

Cristancho et al., 2008), and limited access to mental health services (Dinwiddie et al., 2013).

These findings parallel prior research showing that unmet need for care is strongly associated with transportation barriers and neighborhood disadvantage, particularly among African American adults in public housing environments (Haley et al., 2017). In addition, studies with Black and minority ethnic communities emphasize the role of low mental health literacy, stigma, and poor communication with providers as persistent barriers to engagement with services (Memon et al., 2016). Together, these insights suggest that structural obstacles, such as limited transportation and fragmented service provision, intersect with cultural and informational gaps to restrict older Black women's ability to obtain timely and effective mental health care.

Theme 2: Environment, Safety, and Race as Barriers to Mental Health Care

Participants described how unsafe housing environments, community violence, and racial discrimination discouraged them from seeking mental health services. Living conditions often produced fear and emotional exhaustion, while negative experiences with racism and stereotypes reinforced feelings of neglect and exclusion. Although some participants minimized the role of neighborhood influences, most reported that unsafe surroundings and discriminatory treatment created significant barriers to accessing care and contributed to heightened psychological distress. Consistent with Hagan et al.'s (2020) account of living in public housing and the environmental concerns associated with these settings, participants in this study described multiple challenges related to their daily living conditions. They expressed fears about their personal safety while residing in

under-resourced neighborhoods and reflected on the ways they attempted to resist and navigate community violence. Their narratives align with Frochen et al.'s (2020) investigation of residential care, which highlighted how geographical disparities significantly affect the availability of services. In a similar way, participants in this study noted that both geography and the broader social environment played an important role in shaping their ability to access mental health care, frequently acknowledging that location and neighborhood conditions were central to whether services felt attainable.

The literature has also identified racism and discrimination as persistent barriers to mental health treatment seeking (Alang, 2019; Conner et al., 2010; Gaston et al., 2016; Hays et al., 2017). Echoing these findings, participants described direct experiences of racism while living in public housing and reported how these encounters undermined their willingness and ability to pursue care. Several women explained that they were overlooked, dismissed, or not taken seriously because of their race, which discouraged them from further engagement with health providers. They also described the emotional toll of residing in neglected and unsafe housing, noting that the stress and exhaustion of such conditions compounded their mental health struggles (Campbell & Long, 2014; Ward et al., 2013). Despite these ongoing challenges, none of the participants reported receiving adequate or appropriate mental health treatment to address these difficulties (Nelson et al., 2020; Woodward, 2011).

Theme 3: Limited Awareness and Isolation in Navigating Mental Health Care

Participants reported having little awareness of how to access mental health services and described never receiving formal training, orientation, or educational

resources that could guide them toward appropriate care. This lack of knowledge left many women uncertain about what steps to take, who to contact, or where to turn in moments of need. Alongside this limited awareness, participants experienced significant social isolation. Conversations about mental health rarely occurred within their housing communities, and interactions with housing staff were described as neglectful or dismissive. As a result, participants often managed stress and emotional strain on their own or relied on informal coping strategies such as prayer. These patterns reinforced a cycle of disconnection, where inadequate information combined with limited community dialogue left women to navigate mental health challenges independently, without the benefit of institutional or peer support.

The findings of this study concur with existing literature that highlights the inadequacy of mental health literacy in public housing units and its influence on health care utilization (Hinds et al., 2018; Simning et al., 2012). Participants consistently reported limited awareness of how to access mental health services and a lack of formal training or resources to guide them. These experiences align with prior research showing that residents of public housing frequently face gaps in knowledge and preparedness that restrict their ability to engage effectively with care systems. Similar to the observations of Haley et al. (2017), participants also described being less likely to receive adequate access to health care services while living in public housing. They explained how the scarcity of resources and the limited availability of structured services mirrored the systemic inequities identified in prior work, such as the analysis provided by Lake and Spain (2017).

Findings from this study also coincide with literature suggesting that Black individuals are less likely to seek professional help for mental health concerns (Bailey et al., 2011; Hunt et al., 2015; Ward et al., 2013). Participants' narratives echoed these findings, pointing to a lack of social support and community engagement as factors that heightened their vulnerability to stress and mental health problems (Cooper et al., 2015; Cotrell & Carder, 2010; Parson et al., 2011). In the absence of institutional or peer support, many women turned to personal coping strategies, particularly prayer. Their reliance on prayer as a means of managing distress aligns with prior studies documenting faith-based coping as a common strategy among marginalized populations (Harris et al., 2021; Lukachko et al., 2015). Collectively, these parallels reinforce the congruency between the present study and the broader body of scholarship, emphasizing that structural limitations, inadequate literacy, and weak support networks intersect to limit the ability of older Black women in public housing to pursue professional mental health services.

Theme 4: Reliance on External or Informal Support Systems

Participants described a strong dependence on family members, trusted doctors, and personal faith when navigating mental health concerns, largely due to the absence of reliable institutional support within public housing. Family was often the first line of contact in times of crisis, providing both emotional comfort and practical assistance. Many women emphasized that they would turn to relatives before seeking professional services. Alongside family, primary care physicians and other medical providers were viewed as more trustworthy and responsive than housing staff, who were widely

perceived as unhelpful or uninterested in residents' well-being. In addition, faith and prayer emerged as common coping mechanisms, offering participants a sense of resilience in the face of limited resources. Taken together, these accounts highlight how women relied on informal networks and external systems to fill the void left by inadequate housing support, reflecting both the creativity and vulnerability involved in seeking care outside of formal structures.

Participants' perceptions of access to care and their reliance on informal supports concur with existing literature that highlights the shortcomings of public housing in promoting health and well-being (Cooper et al., 2015; Cotrell & Carder, 2010; Lipman & Manthorpe, 2017; Parson et al., 2011). These studies emphasize that public housing environments often lack structures that encourage best health practices for tenants, leaving residents to depend on personal networks and coping mechanisms rather than organized systems of care. Similar findings are reflected in research showing that individuals in public housing may experience decreased or disrupted healthcare utilization patterns, partly due to structural inadequacies in housing settings that limit access to consistent services (Hinds et al., 2018).

The literature further indicates that barriers extend beyond structural shortcomings to include cultural and social dynamics that shape help-seeking behavior. Stigma, mistrust, and perceived discrimination have been documented as reasons African Americans are less likely to pursue professional counseling, with many relying instead on family, friends, and religious communities (Gaston et al., 2016). Consistent with these patterns, participants in this study described leaning on faith, prayer, and family as their

first response to distress rather than turning to housing staff or formal mental health providers. This reliance is congruent with findings from Harris et al. (2021), who demonstrated that religious coping continues to serve as a central and culturally acceptable strategy for many African Americans when facing psychological stress. Such evidence reinforces that older Black women in public housing are not only navigating gaps in structural support but are also drawing upon cultural practices and informal networks to manage mental health challenges.

Conceptual Framework

Copeland and Butler's (2007) socio-cultural model for treatment engagement was used as the conceptual framework for this study. The model outlines four interrelated socio-cultural factors, (a) racism and discrimination, (b) socioeconomic status, (c) stress and well-being, and (d) housing and neighborhood conditions, that shape disparities in access to and utilization of mental health services among Black women. Rooted in Andersen's (1995) behavioral model of access to health services, Copeland and Butler's adaptation contextualizes the unique barriers faced by Black women by situating their mental health engagement within environments marked by systemic inequities. This framework provided a lens to analyze how older Black women living in public housing perceived and experienced barriers to care and how they relied on informal supports when formal systems fell short.

The first factor, racism and discrimination, was reflected most clearly in participants' descriptions of how race and stereotypes influenced their interactions with institutions and providers. In alignment with the model, participants reported feeling

overlooked or dismissed on the basis of being Black, with some recounting direct experiences of discriminatory treatment when attempting to access services. These accounts illustrate how systemic racism reinforced mistrust of housing staff and shaped women's help-seeking behaviors. The findings support Copeland and Butler's assertion that discriminatory practices exacerbate psychological distress and contribute to disengagement from formal care pathways.

The second factor, socioeconomic status, emerged in participants' accounts of financial limitations and restricted opportunities to access services. Several women described struggling with the costs of medication or transportation, while others emphasized the absence of affordable or publicly supported programs. These findings parallel Copeland and Butler's emphasis on the constraining role of socioeconomic conditions, particularly for women whose housing environments lacked resources or structured guidance. Participants' reliance on family and primary care providers rather than on formal institutional supports underscores how socioeconomic disadvantage curtailed their engagement with mental health services.

The third factor, stress and well-being, was evident in participants' reports of chronic strain linked to unsafe environments, lack of institutional support, and the constant negotiation of barriers to care. Participants described the psychological toll of living in unsafe neighborhoods, feeling socially isolated, and navigating systemic neglect. Copeland and Butler's model suggests that such sustained stress diminishes well-being and reduces the likelihood of sustained engagement with care. Consistent with the framework, participants turned to coping strategies such as prayer and spirituality to

manage distress, underscoring both resilience and vulnerability in the absence of coordinated mental health resources.

The fourth factor, housing and neighborhood conditions, was strongly represented in the data. Participants consistently linked unsafe surroundings, neglected housing conditions, and lack of staff responsiveness to barriers in seeking care. The absence of structured programs or transportation reinforced their sense of abandonment and compounded the risks associated with living in under-resourced environments. This finding supports Copeland and Butler's assertion that neighborhood conditions are not merely contextual but actively shape access and engagement with mental health care.

Taken together, the findings of this study are consistent with Copeland and Butler's (2007) socio-cultural model. Participants' narratives aligned with all four factors, demonstrating how racism, socioeconomic disadvantage, stress, and neighborhood conditions intersected to create significant obstacles to accessing care. At the same time, the reliance on family, trusted doctors, and spirituality revealed adaptive responses that filled the void left by inadequate institutional support. These results suggest that while the socio-cultural model captures key dimensions of access, older Black women's lived experiences highlight the compounding nature of these barriers and the critical role of informal support networks in sustaining psychological well-being within restrictive environments.

Limitations of the Study

Reasonable efforts were made to ensure accuracy and trustworthiness in this study, which sought to identify the experiences of accessing mental health care among

older Black women living in public housing. One limitation of the study related to the shift from conducting only face-to-face interviews to also including Zoom interviews. This change was necessary to accommodate participants who felt more comfortable with a virtual format. The adjustment also addressed challenges of proximity, as some participants were unable to attend in-person interviews. Without incorporating Zoom, potential participants might have been excluded, which could have further delayed the data collection process.

Although Zoom interviews expanded access, they also created limitations. The virtual format restricted the researcher's ability to observe participants' facial expressions and body language, which could have provided additional context for interpretation and analysis. Another challenge arose when some participants who had initially expressed interest in the study later opted out, failing to respond to follow-up communication. These withdrawals required the recruitment of additional participants, which led to delays and prolonged the completion of the interview process.

Another limitation of the study was related to the interview questions and the lack of probing when participants provided brief answers. In several instances, participants responded with simple "yes" or "no" answers, and the absence of follow-up questions limited the richness of the data collected. For example, when addressing issues of awareness and training for mental health services, participants often gave minimal responses. Probing further by asking questions such as why transportation programs were not available or whether housing facilities had ever offered such services could have yielded more detailed and meaningful insights.

A further limitation concerned the focus of the study population. The research concentrated specifically on older Black women and their experiences of accessing mental health care while living in public housing. While this group represents one of the most vulnerable populations within this context (Haley et al., 2017; Lascher et al., 2013; Simning et al., 2012), the exclusive focus may have excluded the perspectives of other residents in public housing who might share similar challenges. A more systematic exploration that included a wider range of tenants could have offered a broader perspective on the phenomenon under study.

Recommendations

Results of this study revealed that older Black women living in public housing had little to no knowledge or experience in navigating access to care. The findings indicated that older women lacked both institutional support and appropriate protocols when attempting to access mental health services and treatment. For many participants, the process of accessing care was associated with negative outcomes, largely stemming from the absence of resources and tools needed to increase awareness and strengthen mental health literacy.

One participant reported a somewhat different experience, noting that her housing unit had programs designed to promote awareness and training for tenants. However, she explained that no formal training had ever been offered and that tenants rarely took advantage of the resources that were available. This discrepancy highlights the need for further research to better understand the experiences of women who technically have access to mental health care services but do not fully utilize them.

Participants also discussed the importance of spirituality, particularly prayer, as a way of managing stress while living in public housing under restricted and challenging conditions (Harris et al., 2021). Several women described how they struggled with the stress of living in neglected environments and with the lack of access to mental health professionals. While participants shared how prayer helped them cope, it is recommended that additional research explore the broader relationship between religiosity and lower utilization of formal mental health services (Lukachko et al., 2015). A more specific and thorough examination of spirituality, including how it functions at different times and in different circumstances, could provide a richer understanding of its role as a coping mechanism. A qualitative approach would be particularly suitable for such an investigation.

Finally, as noted in the limitations section, this study specifically targeted older Black women living in public housing. Future research should broaden the scope to include a more diverse population of tenants in order to provide a more comprehensive understanding of experiences with access to care. Studies conducted within community agencies and resource centers may also help to illuminate how such organizations support older Black women in navigating healthcare services and treatment, while offering more enriched and relevant data.

Implications

The major problem contributing to older Black women's challenges and barriers to accessing mental health services is the lack of awareness, preparedness, and willingness of housing staff to support tenants as they seek help. Public housing

complexes in most communities tend to operate in the same manner, with little to no emphasis on mental health literacy (Memon et al., 2016). Residents often do not know which steps to take to access care, and this lack of direction has contributed to participants' failure to receive or pursue assistance while living in public housing. Many women also described experiences of unfair treatment within their housing units, including perceptions of being overlooked or persecuted. These realities point to the need for coordinated action by social service agencies, community organizations, faith-based institutions, government agencies, and local officials to introduce policies and laws that address the needs of at-risk populations. There is also an urgent need for local, city, and state leaders to review enforcement procedures and public housing protocols to ensure that tenants receive appropriate guidance and support when seeking mental health care.

Policy and prevention efforts should focus on identifying individuals who are most at risk and who face barriers while attempting to seek care and treatment. Women who have shown resilience in help-seeking should also be supported through clear guidelines and resources that create trust and encourage continued engagement with services. Intervention efforts, such as mental health workshops and community-based training, should be made accessible to reduce barriers and mitigate the risks associated with lack of care. Older Black women, in particular, should have opportunities to develop an understanding of what mental health is and how to access services when needed. Counselors and clinicians specializing in mental health could implement culturally responsive counseling models that take into account the psychosocial experiences of Black women living in public housing. By doing so, clinicians can better understand the

long-term effects that arise from barriers to care and the psychological toll of seeking help in unsupportive environments. The findings of this study may further provide justification for clinicians to advocate for and develop such targeted programs.

This study also suggests that the challenges older Black women face while living in public housing heighten their risk for mental health problems and contribute to broader societal concerns. The coping strategies participants described often lacked effectiveness, failing to address underlying issues or provide sustainable relief. These findings highlight the need for social change through training initiatives for housing staff, advocates, and educators, ensuring that they are better prepared to guide residents in accessing mental health services. Local and city governments should take proactive measures to create rehabilitative systems for at-risk populations and reduce the barriers that prevent vulnerable residents from engaging in care.

Finally, the results of this study have the potential to contribute to the existing body of literature on the social and psychological risk factors influencing older Black women's perceptions of and access to mental health services. By expanding knowledge in this area, the findings may enrich ongoing practices and inform new procedures that enhance mental health programs and provide more effective support for women living in public housing.

Conclusion

This study examined the experiences of accessing mental health care services among older Black women living in public housing, as well as the challenges and barriers they encountered in doing so. The results revealed factors contributing both to help-

seeking resilience and to low mental health literacy related to service utilization. Older Black women emerged as a high-risk group that consistently underutilizes available mental health services within public housing settings. Conversations with participants highlighted the significant stress they experienced while attempting to navigate care, further underscoring the vulnerability of this population.

The study also indicated that limited support from housing staff and a lack of mental health awareness contributed to participants' ongoing struggles and their hesitancy to seek help. In the absence of institutional guidance, women adopted personal coping strategies to manage their mental health challenges. One of the primary strategies described was the use of prayer, which participants identified as a source of strength and comfort. Prayer provided a framework for managing stress and offered a meaningful way to cope with the daily difficulties of living in public housing.

There is an urgent need for further studies that examine the impact of structural, social, and cultural factors on older Black women's access to mental health services. The findings of this research contribute evidence of the negative effects of public housing conditions on mental health care access. They also highlight the potential for community-based programs, interventions, and preventive measures to play a critical role in reducing risks and eliminating barriers. By addressing these systemic challenges, future research and practice can support the development of more equitable and effective mental health services for this vulnerable population.

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Appendix: Interview Guide

Demographic Questions:

1. What is your age?
2. What is your ethnicity?
3. What is your marital status?
4. What is your highest educational level?
5. How many years have you lived in public housing?
6. How many years, (if any) since you moved from public housing?
7. Do you have children? If so, how many?

Interview Questions:

RQ1- What is the experience of accessing mental health care services among older Black women living in public housing?

- How prepared do you think you are in accessing mental health care services?
    - Probe: How prepared do you think your housing facility is in accessing mental health services for its tenants?
- What do you think you will do if you need to access mental health services and treatment?
    - Probe: What are the procedures you were told to follow in terms of accessing mental health care services?
- Do you think you have the awareness to access mental healthcare if necessary?
    - Probe: if so, what makes you feel prepared? If not, what do you need or what will help to prepare you in accessing healthcare?
- What conversation do you have with housing management and/or other tenants about the possibility of accessing mental health care?
    - Probe: What procedures, if any, does your housing facility/management implement in case of an incident that requires you to access mental health care? (i.e., certain feeling of anxiety, depression, suicidal thoughts, endangerment to self and/or others)

RQ2- What are the barriers of accessing mental health services among older Black women living in public housing?

- How safe do you feel in accessing mental healthcare while living in public housing?
    - Probe: What types of concerns, if any, do you have in terms of certain barriers to accessing mental health care in public housing?
- What contributes to your feelings or perspective of these barriers, if any?
- What would make you feel safer in in terms of reducing possible barriers associated with accessing healthcare while living in public housing?

    - Probe: Are there guidelines and procedures implemented by public housing management that assist in eliminating some of the barriers that you may experience while accessing mental health care?
- What kind of awareness and/or training have you received, if any, for accessing mental health care in public housing?
    - Probe: What was the process used to raise awareness for accessing mental health care in public housing?
    - Probe: How well do you think the process prepared you for accessing mental health care?
    - Probe: What would make you feel safe in terms of accessing mental health care while living in public housing?
- In what ways were you supported by the housing management/facility while accessing mental health care services?