Published in final edited form as:

Soc Work Health Care. 2018 April ; 57(4): 267–283. doi:10.1080/00981389.2018.1437104.

Factors associated with the use of social workers for assistance with lifetime and 12-month behavioral health disorders

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Abstract

This study examined the use of social workers for assistance with a behavioral health disorder. Data were from the Collaborative Psychiatric Epidemiology Surveys. The analytic sample included respondents who reported using professional services for assistance with a behavioral health disorder during their lifetime (n=5,585). Logistic regression was used to examine the use of a social worker during the respondent's lifetime or the 12 months prior to the interview. Ten percent of respondents visited a social worker for help with a behavioral health disorder during their lifetime and three percent did so in the 12 months prior to the interview. Women were less likely than men to report using a social worker. Those who visited a social worker tended to also use other professionals for a behavioral health disorder although overall respondents reported visiting social workers less frequently for this reason than other types of professionals.

Keywords

social work; mental health; service utilization

Social workers are a critical component of the behavioral health service delivery system and one of the largest groups of behavioral health service providers (Heisler & Bagalman, 2015; Robiner, 2006) delivering a variety of psychological and substance abuse services to individuals, families and groups. Despite this, extremely little is known about the prevalence with which Americans seek assistance from social workers for behavioral health disorders and the degree to which individuals receive help from social workers in place of or in addition to other service providers. The majority of studies on the utilization of behavioral health services have combined social workers with other providers in categories such as human service providers (Druss et al., 2007; Wang et al., 2005) or non-psychiatrists (e.g. counselors, social workers seen in mental health settings) (Neighbors et al., 2007). Few studies have explicitly investigated the use of social workers for behavioral health disorders. In fact, a search of the research literature found more studies about the use of clergy and primary care physicians for behavioral health issues than about the use of social workers (e.g., Bohnert et al., 2010; Chatters et al., 2017; Olfson, Kroenke, Wang, & Blanco, 2014; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

A recent SAMHSA report to Congress (Hyde, 2013), suggested that future changes to behavioral health care include the integration of behavioral health and primary care, a

greater focus on the use of evidence-based practices, and a more person-centered and recovery-oriented approach to care. All of these fit well with the social work skill set which emphasizes the ability to navigate across multiple systems and levels of care, evidence-based approaches to care, and beginning “where the client is”. In addition, the move toward provision of behavioral health care within the context of community health centers has been found to increase the delivery of both mental health and substance abuse treatment by a range of behavioral health specialists including social workers (Wells, Morrissey, Lee, & Radford, 2010).

Understanding the characteristics of those who use social workers for behavioral health issues can help inform policies and programs moving forward. This is especially important as existing research has found that only a small percentage of those who seek help for a behavioral health problem visit or state a preference for a social worker (Cheng & Robinson, 2013; Hardy, 2014), suggesting that social workers may be underutilized.

Use of behavioral health services

Less than half of those with a behavioral health problem have been found to seek professional help (Neighbors et al., 2007; Wang et al., 2005; Woodward, 2011). This has increased over time from about 20% in the 1990s to 33% in the early 2000s with the greatest increase seen in the use of the general medical sector (Kessler, Chiu, Demler, & Walters, 2005), particularly a reliance on family physicians (Garrido, Kane, Kaas, & Kane, 2011; Han, Gfroerer, Colpe, Barker, & Colliver, 2011; Neighbors et al., 2007, 2008; Wang et al., 2005; Woodward, 2013). Most of this has been attributed to the increased use of medications, specifically antidepressants (Kessler, Demler, et al., 2005; Marcus & Olfson, 2010; M. Olfson et al., 2002) while the proportion of people receiving outpatient psychotherapy has actually declined (Marcus & Olfson, 2010; M. Olfson et al., 2002).

The use of behavioral health services has been found to vary in consistent ways across sociodemographic and disorder-related indicators. In general, those who are younger, female, unmarried, white, and more highly educated have been found to be more likely to seek help for a behavioral health problem and more likely to visit professionals who specialize in mental health or substance abuse treatment instead of, or in conjunction with, their primary care physician (Neighbors et al., 2007; Wang et al., 2005; Woodward, 2013). Those with a substance disorder have been found to be more likely to use mental health specialty services than those with a mood or anxiety disorder (Wang et al., 2005; Woodward, 2013).

Use of social workers for a behavioral health problem

Among population based studies to date, social workers as a source of help for behavioral health problems have most often been included within broader categories of mental health specialists (which includes social workers seen in a mental health setting) or human services providers (which includes social workers seen in non-mental health settings) (Dezetter et al., 2011; Druss et al., 2007; Neighbors et al., 2007; Olfson et al., 2002; Wang et al., 2005). One study that examined different types of providers separately found that overall the use of

social workers was low, they were most likely to be visited when they were one of multiple professionals seen for assistance, and they were more likely to be used by those with numerous comorbid behavioral health problems (Woodward, 2013). Overall, a higher proportion of respondents have been found to report visiting mental health professionals than human services professionals (Druss et al., 2007; Neighbors et al., 2007; Wang et al., 2005).

This limited use of social workers may be in part because people do not recognize social work as an option for helping them with a behavioral health problem. In a 2004 nationally representative telephone survey, respondents viewed social work positively overall, but believed them to be less effective in treating behavioral health problems than psychologists or psychiatrists and most appropriate in roles related to child protection (LeCroy & Stinson, 2004). Numerous studies have found social workers to be the professional least likely to be visited for a behavioral health problem (Condie, Hanson, Lang, Moss, & Kane, 1978; Fall, Levitov, Jennings, & Eberts, 2000; Hardy, 2014; Williams, Simon, & Bell, 2015) and in two studies of African Americans, religious leaders were preferred (Hardy, 2014; Williams et al., 2015). It might also have been the case that individuals received help from a social worker for a behavioral health problem, but within the context of a broader health issue or stressful life event (Gadalla, 2007; Price, 2010; Simning et al., 2010; Taylor, Neighbors, & Broman, 1989).

Despite public perception, social workers are estimated to be the most plentiful provider in the behavioral health system (Heisler & Bagalman, 2015). Social workers have been found to provide behavioral health services in a variety of organizations including managed behavioral health care (Reif, Torres, Horgan, & Merrick, 2012), substance abuse treatment (Smith, Whitaker, & Weismiller, 2006), private practice (Smith et al., 2006), and social service agencies (Smith et al., 2006; Taylor et al., 1989). In a survey of members of the National Association of Social Workers (NASW), 71% reported doing work related to substance abuse and treatment including screening and referring clients for treatment; diagnosing or assessing substance disorders; and providing treatment to those with a primary, secondary, or co-occurring substance disorder (Smith et al., 2006). Recent projections from the Bureau of Labor Statistics have estimated that the number of mental health and substance abuse social workers will increase by almost 19% by 2024 (Salsberg et al., 2017).

A basic, generalizable description of who uses social workers for a behavioral health problem is missing from current literature. One recent study that explicitly compared the use of a social worker to the use of other providers found that the association of type of behavioral health disorder, race, education, and marital status with service use was similar for those who used social workers and those who used other providers. Age and gender, however, were significantly associated with the use of other providers, but not the use of social workers (Cheng & Robinson, 2013).

The goal of this study was to provide a comprehensive understanding of the use of social workers for lifetime and 12 month behavioral health disorders. It used data from the Collaborative Psychiatric Epidemiology Surveys (CPES) to examine the association of

sociodemographic and disorder-related variables with the use of social workers for a behavioral health disorder and the degree to which individuals sought assistance from both social workers and other behavioral health service providers.

Methods

Sample

This study used secondary analysis of data from the Collaborative Psychiatric Epidemiology Surveys (CPES). Data were collected from 2001 to 2003 from three nationally representative surveys – the National Comorbidity Survey Replication (NCS-R), the National Survey of American Life (NSAL), and the National Latino and Asian American Survey (NLAAS). The NCS-R was representative of the U.S. population and included face-to-face interviews with 9,292 residents of English-speaking households who were 18 years or older. The NSAL was representative of blacks in the United States, and the survey was based on a national probability sample of 6,082 African Americans, blacks of Caribbean descent, and non-Hispanic whites. The NLAAS was a nationally representative sample of Latino and Asian populations in the United States, and the survey included 2,554 Latinos and 2,095 Asian Americans. The CPES surveys shared a common set of objectives and instrumentation and were designed so that they can be combined as though they were a single, nationally representative study (Heeringa & Berglund, 2007).

The analytic sample for this study included respondents who reported using professional services for assistance with a behavioral health disorder at any point during their lifetime (N=5,585). The sample included 2,611 non-Hispanic Whites, 1,377 African Americans, 885 Latinos, 283 Asians, and 314 black Caribbeans. Sixty-one percent of the sample was female. The mean age was 39.76 (SD=13.75) and ranged from 18 to 89. After complete description of the study to participants, informed consent was obtained. All three CPES studies were approved by the University of Michigan Institutional Review Board.

Measures

Respondents were given a list of professionals and asked to indicate which ones they had seen in their lifetime “for problems with your emotions, nerves, or your use of alcohol or drugs.” For each professional, they were then asked when they last saw that professional. These items were used to create a dichotomous indicator of visits to a social worker as well as eight other types of professionals (psychiatrist; general practitioner, family doctor, or other medical doctor; psychologist; counselor; other mental health professional; nurse, occupational therapist, or other health professional; religious or spiritual advisor; any other healer) during the respondents’ lifetime and in the 12 months prior to the interview.

Sociodemographic characteristics included race/ethnicity (White, African American, black Caribbean, Latino, Asian), gender, age (18 to 29, 30 to 64, 65 and older), marital status (currently married, previously married, never married), years of education (0 to 11, 12, 13 to 15, or 16 or more), household income in quartiles (\$0 to \$16,999, \$17,000 to \$37,044, \$37,045 to \$66,999, and \$67,000 and higher), region (Northeast, Midwest, South, or West)

and insurance coverage (public vs private). Only one person who visited a social worker did not have insurance and was therefore dropped from the analyses.

Behavioral health disorders were assessed with the World Mental Health Composite International Diagnostic Interview, a structured, lay-administered diagnostic interview based on the definitions and criteria of ICD-10 and DSM-IV (Kessler & Üstün, 2004). On the basis of this assessment, dichotomous measures were created to indicate whether respondents met criteria for any lifetime or 12-month anxiety disorder (panic, agoraphobia, social phobia, generalized anxiety disorder, post-traumatic stress disorder), mood disorder (major depression, dysthymia, bi-polar), or substance disorder (alcohol abuse, alcohol dependence, drug abuse, drug dependence).

Analysis

All analyses were performed with the survey commands in Stata 12.0 (StataCorp, 2011), which accounted for the complex multistage clustered design of the CPES samples. All percentages reported were weighted and frequencies were unweighted. Both unadjusted and adjusted percentages were presented. Adjusted percentages were based on adjusted probabilities from logistic regression and design-corrected Wald tests were presented for testing hypotheses about group differences. Adjusted percentages controlled for age and gender in all analyses. Statistical significance in all analyses was based on 2-sided tests with an alpha of .05. Individually significant odds ratios were discussed only if the multivariate logistic regression model in which they were estimated was significant. This approach minimizes the Type 1 error problem of false positives due to multiple comparisons while also avoiding the Type 2 error problem of not being able to detect true associations of moderate magnitude that is introduced by more conservative methods such as Bonferroni corrections” (Nock et al., 2013, p. 302; Perneger, 1998; p. 11).

Results

Of the 5,585 respondents who visited some sort of professional service provider for a behavioral health disorder, 10.8% (n=665) visited a social worker during their lifetime and 2.9% (n=166) visited a social worker in the 12 months before the interview. The demographic description of respondents is in Table 1.

There were no significant differences in visits to a social worker by race/ethnicity or gender (Table 2). In terms of behavioral health disorders (Table 3), controlling for age and gender a higher proportion of those who visited a social worker at some point during their lifetime met criteria for all of the lifetime disorders that were assessed, with the exception of alcohol abuse, compared to those who did not visit a social worker. Among those who reported visiting a social worker in the 12 months prior to the interview, only agoraphobia, posttraumatic stress disorder, and drug abuse were significant. For most disorders there was little difference between the unadjusted percentages and those adjusted for age and gender. The one exception was drug abuse for which the adjusted percentages were lower.

Table 4 presents data on the use of other professionals for assistance with a behavioral health disorder. In general in terms of lifetime visits to a professional, a higher proportion of those

who visited a social worker also saw a psychiatrist, a psychologist, a counselor, another mental health professional, a nurse, or a religious or spiritual advisor. Two exceptions were visiting a family or other doctor and visiting a healer. Respondents who reported seeing a social worker in the 12 months prior to the interview also reported seeing another mental health professional, a nurse, or a religious spiritual advisor.

Finally, regression results (Table 5) show that adults aged 65 and older were less likely to have visited a social worker during their lifetime. Those who had never been married, met diagnostic criteria for agoraphobia, and had 2 or more mental disorders were more likely to visit a social worker during their lifetime for assistance with a behavioral health disorder. In terms of use of a social worker in the 12 months prior to the interview, women were less likely than men to use a social worker while those who met criteria for agoraphobia or posttraumatic stress disorder were more likely to report visiting a social worker.

Discussion

Despite the substantial number of social workers in the behavioral health workforce, social workers appear to be among the least utilized service providers along with nurses, healers, and other unspecified mental health professionals. Our results are consistent with previous findings in this regard (Cheng & Robinson, 2013; Hardy, 2014) and may be related in part to the fact that, although this and similar studies focus on adults, the majority of social workers provide services to children and adolescents and, among those, many work in schools (Robiner, 2006).

Similarly, our findings could also be associated with a limited understanding of the social work profession and, in particular, social workers' role in mental health care (LeCroy & Stinson, 2004; Williams et al., 2015). The overwhelming association of social work with child welfare and homeless services, two highly stigmatized populations, may, at worst, increase the perceived stigma associated with the profession as a whole and, at best, limit the public's perception of social workers as a potential source of behavioral health treatment.

At the same time, the lack of knowledge about social work raises questions about the ability of respondents to accurately identify when they are receiving services from a social worker. This may be especially true in certain settings. In an emergency room, for example, titles such as case manager may apply to social workers or nurses depending on their role and patients may or may not recognize the difference. In social service agencies, similar tasks may be done by social workers, counselors, or other types of professionals.

In general, a higher proportion of those with a lifetime or 12-month disorder saw a social worker for assistance and those who saw a social worker were more likely to have two or more disorders. Furthermore, those who saw a social worker also saw another type of professional. This is consistent with previous research on help-seeking in general (Wang et al., 2005; Woodward, 2013) and the use of social workers in particular (Cheng & Robinson, 2013). Individuals with more severe and complex disorders, such as dual diagnosis of both mental and substance use disorders tend to be more likely to use services. These individuals often have contact with a range of professionals over time including potential contact with

multidisciplinary teams. They are also more likely to receive services in hospital and community mental health settings where social workers are involved in behavioral health care. As part of a team, social work plays an important role in addressing the constellation of biopsychosocial issues individuals with complex physical and behavioral health challenges face. Not only can social workers provide counseling, but they can help manage medications and provide case management to link clients to housing, income, and social support services. Social workers working in emergency rooms have been found to save medical providers time (Gordon, 2001) and provide care that is outside the scope of practice of other providers (Moore et al., 2016). There is also some evidence that social workers in primary care settings improved patient outcomes and lowered costs particularly for those patients managing multiple physical and behavioral chronic conditions (McGregor, Mercer, & Harris, 2016).

In addition to number of disorders, type of disorder was associated with visiting a social worker, specifically meeting criteria for posttraumatic stress disorder or agoraphobia. Posttraumatic stress disorder is particularly likely to be comorbid with other disorders (Santucci, 2012) which may contribute to the greater likelihood that these individuals visit a social worker for behavioral health care. The use of social workers for assistance with these disorders, however, may also be related to the nature of social work services. For example, the person-centered strengths-based approach of social work may be particularly suited to working with individuals suffering from post-traumatic stress disorder (Joseph, 2004; Rowe, 2017) through the concept of post-traumatic growth which posits that trauma can be a starting point for increased levels of positive functioning (Joseph & Murphy, 2014).

In terms of agoraphobia, social workers regularly do home visits as part of their services unlike most other behavioral health service providers, which may be necessary for those with agoraphobia given their difficulty leaving the house. This ability to provide services in the home increases access to behavioral health services for clients who might not otherwise be able to access it (Dore & Zuffante, 2015).

Although differences in behavioral health service use by age, gender, race/ethnicity, and socioeconomic status are well documented (Bogner, de Vries, Maulik, & Unützer, 2009; Neighbors et al., 2007; Wang et al., 2005), we found limited demographic differences associated with the use of a social worker. Interestingly, contrary to most previous research on help-seeking from both professional and informal sources, women in this study were less likely than men to report visiting a social worker. This may be due, in part, to the higher proportion of men in the sample who met criteria for a substance disorder compared to women. Much of the available data on the behavioral health workforce combines data on mental health and substance abuse service (Hyde, 2013) making it difficult to identify the proportion of social workers providing substance abuse treatment specifically and what share of addictions treatment service providers social workers represent. However, a 2006 NASW report found that while just 3% of active licensed social workers reported addictions as their primary practice (compared to 37% in mental health), a higher proportion of masters-level social workers in addictions are men (30%) compared to those who work in mental health (19%) and compared to the social work profession over all (18%) (Whitaker, Weismiller, & Clark, 2006). This may in part reflect gender differences in the client base.

Furthermore, social workers in behavioral health clinics and social service agencies, two of the settings where they are most likely to see clients with addictions, are also more likely to see men (compared to private practice where 74% of social workers report a caseload that is predominantly women) (Whitaker et al., 2006). A third of respondents in the current study saw a social worker in the context of private practice and over sixty percent of those were female which may also contribute to gender differences found in this study. Social workers in private practice overwhelmingly work with individuals (Lord & Iudice, 2012) while in other settings social workers may do more group work which is a common modality for substance abuse treatment in particular.

Conclusion and Limitations

The findings of this study should be considered within the context of several limitations. First, given evidence of the public's general lack of knowledge about social work, the use of self-report of visits to a social worker is a limitation of this study that may result in underreporting the use of social workers for a behavioral health disorder. Second, only one person in this sample of service users did not have any health insurance and three-quarters had private insurance. This is somewhat different than the U.S. population at the time this data was collected. Given that insurance coverage may influence where respondents reported going for services this may limit the generalizability of our results. Finally, although the CPES remains one of the only nationally representative surveys that provide comprehensive population data on mental health and mental health service use, the data are now over a decade old. There have been changes in behavioral health care and insurance coverage over this time that may make our results less applicable today.

Despite these limitations, this study provides an investigation of individuals' use of social workers for a behavioral health disorder that is unique in current literature. We found that although social workers are an important aspect of the behavioral health workforce they are utilized by only 1 in 10 of the respondents in this nationally representative sample. The majority of people who saw social workers also sought help from other professionals including psychiatrists, psychologists, clergy, and family doctors. Clearly this is an area where more research is needed. Future research should further examine the quality and outcomes of behavioral health services provided by social workers.

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Table 1:

Demographic description of respondents who reported ever visiting a social worker (n=665)

	Lifetime (n=665)		12-month (n=166)	
	n	%	n	%
Age				
18–29	269	36.9	62	41.1
37–64	367	59.6	98	55.3
65 and older	29	5.6	6	3.6
Sex				
Female	422	55.7	108	53.5
Male	243	44.3	58	46.6
Race/ethnicity				
White	310	81.7	81	83.3
African American	167	9.6	34	6.6
Black Caribbean	41	0.6	10	0.3
Latino	107	6.9	33	8.3
Asian	24	1.3	6	1.5
Education				
0–11	139	14.8	46	18.8
12	186	30.2	16	30.9
13–15	183	26.1	39	25.6
16 or more	157	29	35	24.7
Marital status				
Currently married	299	46.8	64	33.4
Previously married	153	22.7	47	29.8
Never married	213	30.5	55	36.7
Household income				
\$0 to \$16,999	204	21.7	65	28.1
\$17,000 to \$37,044	147	20.2	39	18.6
\$37,045 to \$66,999	141	25.2	30	31.8
\$67,000 and higher	173	32.9	32	24.5
Region				
Northeast	197	26.9	46	19.7
Midwest	162	25.7	36	21.1
South	177	23.3	44	29.8
West	129	24.1	40	29.3
Insurance				
Public	185	22.5	75	68.9
Private	360	77.5	67	31.1

	Lifetime (n=665)		12-month (n=166)	
	n	%	n	%
Location saw social worker				
Private office			53	31.2
Social service agency			41	21.8
Psychiatric outpatient			33	17.5
Substance abuse outpatient			11	8.9
Emergency room			16	7
Church			8	5
Drop-in center			8	4.3
Other			38	17.7

Table 2:Use of social worker by race and gender (n=5,585)^a

Lifetime use of social workers (n=655)					12 month use of social workers (n=166)					
	n	%	Adjusted % ^a	F	p	n	%	Adjusted % ^a	F	p
Race/ethnicity										
White (n=2,611) (ref)	310	10.6	10.7	1.22	.304	81	8.4	8.0	.50	.735
African American (n=1,377)	167	12.3	11.9			34	7.4	7.1		
Black Caribbean (n=314)	41	13.9	12.6			10	4.8	4.4		
Latino (n=885)	107	10.4	9.3			33	10.0	9.1		
Asian (n=283)	24	8.9	8.1			6	8.7	8.4		
Total (N=5,470)	649	10.7				164	8.5			
Gender				3.11	.080				3.65	.058
Male (n=1,931) (ref)	243	12.2	11.9			58	11.1	10.5		
Female (n=3,654)	422	9.9	10.1			108	7.2	7.0		
Total (N=5,585)	665	10.8				166	8.6			
Race/ethnicity by gender										
White male (n=969)	127	12.1	12.0	1.94	.051	35	11.3	10.7	.89	.549
White female (n=1,642) (ref)	183	9.6	9.9			46	6.7	6.5		
African American male (n=405)	63	15.5	15.1			12	8.9	8.5		
African American female (n=972)	104	10.6	10.2			22	6.6	6.4		
Black Caribbean male (n=106)	14	16.1	15.0			3	3.6	3.4		
Black Caribbean female (n=208)	27	11.3	10.1			7	6.1	5.3		
Latino male (n=302)	26	8.2	7.1			6	8.1	7.2		
Latino female (n=583)	81	11.9	11.0			27	11.1	10.3		
Asian male (n=112)	8	9.5	8.7			1	8.5	8.6		
Asian female (n=171)	16	8.5	7.7			5	8.8	8.3		
Total (N=5,470)	649	10.7				164	8.4			

^aUnweighted frequencies and weighted percentages are presented.^bPercentages adjusted for age.

Table 3.

Use of social worker by DSM-IV disorders (n=5,585)^a

	Lifetime service use (n=5,585)						12 month service use (n=1,893)									
	Visited social worker (n=665)			Did not visit social worker (n=4,920)			Visited social worker (n=166)			Did not visit social worker (n=1,727)						
	n	%	Adjusted % ^{a,b}	n	%	Adjusted % ^{a,b}	F	P	n	%	Adjusted % ^{a,b}	n	%	Adjusted % ^{a,b}	F	P
Disorders ^c																
Panic disorder	107	14.5	14.6	515	8.8	8.8	11.3	.001	26	12.7	13.3	181	9.7	9.7	1.2	.279
Agoraphobia	72	10.0	10.2	260	3.8	3.8	23.8	<.001	19	11.4	11.4	93	3.7	3.7	11.0	.001
Social phobia	196	29.3	28.5	973	18.2	18.2	11.6	<.001	39	23.1	21.7	316	15.9	15.6	2.1	.150
GAD	87	13.7	14.2	530	9.9	9.9	5.7	.018	10	6.7	6.8	140	7.6	7.7	.14	.711
PTSD	168	24.1	24.0	722	12.0	12.0	26.2	<.001	43	22.7	23.5	198	11.1	10.8	11.5	<.001
MDD	252	37.6	37.4	1583	29.2	29.2	7.3	.008	46	30.2	29.7	449	23.7	23.1	2.4	.128
Dysthymia	59	7.3	7.6	264	5.1	5.1	4.6	.033	16	8.2	8.9	107	5.7	5.7	1.8	.187
Bipolar I and II	55	9.0	8.3	195	3.3	3.3	30.2	<.001	15	9.2	8.0	85	5.1	5.0	1.5	.218
Alcohol abuse	87	13.4	12.3	502	10.7	10.8	1.09	.298	6	4.4	3.2	31	2.1	1.9	1.4	.241
Alcohol dependence	94	16.6	15.2	423	8.5	8.6	13.8	<.001	10	6.2	4.9	56	3.7	3.7	.43	.512
Drug abuse	130	20.2	17.7	632	12.2	12.4	12.8	<.001	4	7.1	4.5	28	1.4	1.3	4.7	.032
Drug dependence	81	11.3	9.8	265	5.3	5.4	13.0	<.001	6	2.3	1.6	19	1.1	1.1	.45	.502

^aUnweighted frequencies and weighted percentages presented^bPercentages adjusted for age and gender.^cLifetime disorder for lifetime use of social worker and 12-month disorder for 12-month use of social worker

GAD=Generalized Anxiety Disorder; PTSD=Post Traumatic Stress Disorder; MDD=Major Depressive Disorder

Table 4.Use of other professionals by use of social worker (n=5,585)^a

	Lifetime						12 month					
	Visited social worker (n=665)			Did not visit social worker (n=4,920)			Visited social worker (n=166)			Did not visit social worker (n=1,727)		
	n	%	Adjusted % ^b	n	%	Adjusted % ^b	n	%	Adjusted % ^b	n	%	Adjusted % ^b
Psychiatrist	379	59.1	60.0	1659	29.9	29.9	80	39.7	39.3	518	26.5	26.9
Psychologist	273	43.9	42.7	1223	27.4	27.5	38	20.8	19.1	300	17.3	17.2
Counselor	346	53.6	49.9	1307	29.7	30.1	59	37.0	32.5	277	17.1	16.5
Other mental health	110	16.5	16.5	232	4.5	4.4	26	15.0	14.4	86	4.2	4.2
Family or other doctor	289	44.4	48.4	2208	47.5	47.0	77	47.0	52.3	833	52.1	53.0
Nurse	97	15.6	15.6	154	2.7	2.7	20	9.6	10.3	46	2.4	2.5
Religious/spiritual advisor	184	30.8	30.5	853	16.1	16.1	33	26.8	24.5	326	17.1	16.3
Healer	37	4.8	4.5	168	3.2	3.3	10	6.6	6.4	92	5.4	5.2

^aUnweighted frequencies and weighted percentages presented.^bPercentages adjusted for age and gender.

Table 5:

Logistic regression predicting use of social worker

Variable	Lifetime (n=4,196)		12-month (1,375)	
	OR	95% CI	OR	95% CI
Race/ethnicity				
White	Ref		Ref	
African American	1.10	.78 – 1.56	0.98	.39 – 2.45
Black Caribbean	1.10	.47 – 3.03	0.38	.09 – 1.55
Latino	0.94	.60 – 1.47	0.80	.46 – 1.39
Asian	0.26	.05 – 1.41	n.s.	
Sex				
Female	0.78	.57 – 1.07	.56 [*]	.32 – .97
Male	Ref		Ref	
Age ^{††}				
18–29	Ref		Ref	
37–64	1.01	.79 – 1.29	0.93	.56 – 1.56
65 and older	.31 ^{**}	.14 – .65	0.63	.16 – 2.49
Education				
0–11	Ref		Ref	
12	1.07	.69 – 1.65	1.27	.52 – 3.12
13–15	0.87	.59 – 1.29	0.87	.35 – 2.19
16 or more	1.26	.80 – 1.96	1.29	.48 – 3.50
Marital status [†]				
Currently married	Ref		Ref	
Previously married	1.26	.79 – 2.02	1.22	.54 – 2.80
Never married	1.82 ^{**}	1.23 – 2.68	2.01	1.04 – 3.89
Household income				
\$0 to \$16,999	Ref		Ref	
\$17,000 to \$37,044	0.87	.47 – 1.64	0.79	.29 – 2.14
\$37,045 to \$66,999	0.76	.46 – 1.25	0.89	.34 – 2.34
\$67,000 and higher	1.14	.69 – 1.90	0.69	.27 – 1.76
Region				
Northeast	1.50	1.07 – 2.12	0.81	.48 – 1.37
Midwest	1.25	.84 – 1.86	1.00	.28 – 2.01
South	Ref		Ref	
West	1.11	.70 – 1.75	0.67	.25 – 1.79
Insurance				
Public	1.28	.80 – 2.07	1.18	.57 – 2.43
Private	Ref		Ref	
Disorder				
MDD	1.00	.70 – 1.44	1.59	.57 – 2.43

Variable	Lifetime (n=4,196)		12-month (1,375)	
	OR	95% CI	OR	95% CI
Panic	.96	.64 – 1.42	.61	.24 – 1.53
Agoraphobia	1.80 **	1.19 – 2.72	2.95 *	1.23 – 7.12
Social phobia	1.07	.72 – 1.61	.93	.52 – 1.64
GAD	.88	.63 – 1.22	.75	.23 – 2.40
PTSD	1.55	.96 – 2.49	3.01 **	1.55 – 5.85
Dysthymia	.99	.62 – 1.58	.73	.30 – 1.81
Bipolar I and II	1.63	.98 – 2.70	.75	.19 – 2.96
Alcohol abuse/dependence	1.03	.57 – 1.85	.70	.25 – 1.97
Drug abuse/dependence	.94	.52 – 1.68	2.87	.53 – 15.60
Number of disorders [†]				
None	Ref		Ref	
One	1.83	.92 – 3.67	1.67	.83 – 3.34
2 or more	2.37 **	1.27 – 4.44	1.29	.43 – 3.86

*
p<.05,

**
p<.01,

p<.001

[†]Wald chi-square significant at p<.05 for lifetime

^{††}Wald chi-square significant at p<.01 for lifetime