

Center for the Study of Social Organization

**"Just the Type With Whom I Like to Work":
Two Correspondence Field Experiments in an
Online Mental Health Care Market**

**Heather Kugelmass
Working Paper #18, July 2017**



“JUST THE TYPE WITH WHOM I LIKE TO WORK”:
TWO CORRESPONDENCE FIELD EXPERIMENTS IN AN ONLINE MENTAL HEALTH
CARE MARKET

Heather Kugelmass

Abstract

Two correspondence field experiments investigated discrimination in the context of a large online mental health care market. The subjects of these experiments were more than 900 mental health care providers (MHPs) who advertise for clients on a website that enables help-seekers to search for and contact individual providers. Both studies were designed to evaluate the receptiveness of MHPs to black and white help-seekers. In the first study, MHPs were contacted via email by an ostensibly black or white, and male or female, help-seeker requesting an appointment. No racial or gender disparities emerged. In the second experiment, a different set of MHPs received an email from a less educated help-seeker, who was either black or white and whose attempts to contact a therapist were prompted by either a caseworker or an unspecified person. Results from the two studies combined suggest a hierarchy of accessibility: more educated help-seekers are preferred over less educated ones and, among those less educated, black help-seekers with a caseworker are the least desirable. These disparities persisted after controlling for sociodemographic and financial characteristics of the MHPs.

Introduction

There is a growing body of evidence that medical care providers discriminate against prospective patients based on race and indicators of socioeconomic status, such as education. However, discrimination in access to *mental* health care providers (MHPs) has been largely overlooked by researchers. MHPs practice in a society where discrimination is nominally disapproved, but in a market where it is invisible. The field experimental approach employed in this study enables the observation of actual decisions made by real MHPs in a naturally occurring online setting.

Until now, there have been only two studies that have employed a field experiment to examine racial discrimination in access to mental health care providers (Kugelmass 2016; Shin et al. 2016). Both uncovered discrimination. We do not know, however, whether those results are generalizable to a variety of mental health occupations, in various geographic regions, and in a competitive online market.

This paper focuses on the segment of the private mental health care sector that is actively seeking clients online. In each of the two studies described in this paper, the central question is: Do mental health care providers discriminate against black help-seekers based upon receiving an email request for an appointment? What other characteristics of help-seekers (gender, education) or attributes of the MHPs contribute to accessibility rates? To what extent, if any, does the level of racial discrimination depend on the help-seekers' characteristics and the MHPs' attributes?

The subjects are 908 MHPs nationwide who advertise their professional services by posting a profile on PsychologyToday.com. PsychologyToday.com maintains an online directory of profiles (www.therapists.psychologytoday.com) that serves as a marketplace to connect providers to individuals seeking therapists ("help-seekers"). Psychology Today (2016) claims to be "the most in-depth and wide ranging online directory of mental health professionals;" it is therefore an important setting in the private mental health care market. Psychology Today's role in expanding and constraining access to care for different groups is apparent in one of Psychology Today's featured MHP satisfied customer comments: "I already have three new clients and *they're just the type with whom I like to work!*" [emphasis mine].

I conducted two cross-sectional, randomized correspondence field experiments of MHPs' accessibility toward individuals seeking therapy. Both varied the race of the help-seekers. (See Figures 1a and 1b.) Study 1 also assessed the influence of gender. Race and gender were both signaled by the name in the email address and signature. Study 1's help-seekers were intended to be perceived as college-educated, middle class, individuals.

Study 2 was designed to assess the influence of help-seeker race among help-seekers who less educated than those in Study 1. There were two versions of emails. Both contained spelling and punctuation errors that signaled lower educational attainment than Study 1's help-seekers. One mentioned that an unspecified "some-one" [sic] suggested therapy; the other mentioned that it was "my caseworker." The existence of a caseworker implies that the help-seeker has a social need that triggered institutional involvement. This distinction is addressed in further detail later in this paper.

The primary outcome measure for both studies is the accessibility of the MHPs contacted via email, as measured by positive responses to the request for an appointment. A secondary aim of both studies is to analyze how attributes of the MHPs (race, gender, geographic region, and occupation) as well as their financial flexibility (sliding fee scale, free consultation, and health insurance) are associated with their accessibility to help-seekers.

Results show that positive response rates to blacks and whites are equivalent in Study 1, (more educated). In contrast, positive response rates to blacks are lower than whites in Study 2 (less educated). In both studies, some characteristics of mental health care providers predict the likelihood of a positive response, but they do not explain the relationship (or lack thereof) between help-seeker race and provider accessibility. Taken together, these studies reveal that racial discrimination in this online mental health care market is manifested under only some circumstances.

Background and Literature Review

The Landscape of Mental Health Care

Outpatient mental health care in the United States is found in three sectors: general medical, public mental health, and private mental health. Psychologists, psychiatrists, social workers, and other counselors—whether working in the public or private sector—are considered specialists (Pescosolido and Boyer 2010). Specialty care is associated with considerably higher rates of adequate care than the general medical sector (Roy-Byrne et al. 2009; Young et al. 2001).

Of the two sectors in which specialists can be found, the private sector has considerably higher quality. The public mental health care sector is insufficiently funded and lacks the necessary services to support those who need services (National Alliance on Mental Illness 2009). According to a report by the National Alliance on Mental Illness (2009:44), service delivery in most states is mediocre, with a “culture of service delivery that perpetuates stigma and stereotypes...there is little respect for the consumer or acknowledgement of diversity.” Therefore, systematic exclusion from the private sector can have a negative impact on the mental health of the already disadvantaged groups.

Nonetheless, progress has been made toward reducing barriers to entry to the private mental health care market (Corbett 2011) for both help-seekers and for MHPs. During the second half of the twentieth century, the category of “mental health care provider” (MHP) increased considerably. A phrase that once referred to psychiatrists (medical doctors with psychiatric training), now encompasses professionals including psychologists (MHPs with doctoral degrees), clinical social workers, and licensed counselors, among others (Frank and Glied 2006).

According to the Substance Abuse and Mental Health Services Administration (2014), approximately 34 million adults received mental health care in 2013; more than 15 million of those received that care in the outpatient sector. Of those receiving outpatient care, almost 60 percent received care in “the office of a private therapist, psychologist, psychiatrist, social worker, or counselor that was not part of a clinic” (Substance Abuse and Mental Health Services Administration 2014).

The expansive set of MHP occupations, and the increasing number of MHPs overall, ostensibly offers help-seekers a wide variety of options for outpatient care.¹ These options are now readily visible online. The increasing number of MHPs that have begun promoting their practices on the internet has generated a new help-seeking model, wherein “clients shop for therapy much as they would for any online product: by comparing, contrasting, and learning as they go” (Grodzki 2013).

Perhaps the most popular online option for locating MHPs is Psychology Today’s therapist directory (www.therapists.psychologytoday.com). Approximately 100,000 MHPs (American and Canadian, including treatment facilities) have active profiles on it today (Psychology Today 2015). This membership far exceeds those of the many other online therapist search tools in this market, including GoodTherapy.com (10,000 members), APA’s Psychologist Locator (6,000 members), NetworkTherapy.com (4,000 members) and HelpPRO Therapist Finder (5,000 members). To the author’s knowledge, no academic research has been conducted using MHP profile data from PsychologyToday.com.

Bias Among Mental Health Care Providers

¹ According to the May 2016 Occupational Employment Statistics Survey, approximately 108,000 clinical psychologists, 114,000 mental health and substance abuse social workers, and 140,000 other licensed mental health counselors are actively practicing in the United States. However, there is a severe shortage of MHPs in many parts of the country.

The research on doctor-patient relationships finds that stereotypes influence providers' beliefs, perceptions of symptoms, diagnoses, and treatment recommendations (van Ryn and Fu 2003). Their judgments are based on patients' intelligence, education, career demands, personality, and likelihood of non-adherence to treatment recommendations (van Ryn and Burke 2000).

Results from qualitative and survey-based studies over the past several decades suggest that MHPs prefer help-seekers who possess "YAVIS" attributes: i.e., young, attractive, verbal, intelligent, and successful (Schofield 1964; Tryon 1986). Along the same lines, Howard and Orlinsky (1972:623) characterize the type of patient favored for traditional individual psychotherapy as one who is "generally college educated...culturally sophisticated, verbal and intelligent" and who "positively value[s] psychotherapy as a cultural form and as a means of help." They contrast that type of patient with another: "working class or lower class status...who for the most part have finished not more and often less than a high school education." They go on to describe this type as "less culturally sophisticated, less verbally communicative...and to contain those of the non-white population who receive therapeutic treatment" (1972:623). Link and Milcarek (1980) set out to quantify Schofield's (1964) and Howard and Orlinsky's (1972) qualitative observations and found that more desirable patients—those who are more communicative, motivated, and competent—did in fact receive more attention from MHPs.²

Because the stereotypes associated with blackness are incongruent with the characteristics of a desirable client, the discretion of MHPs to select their clients may perpetuate racial discrimination in the mental health care sphere. Indeed, a variety of stereotypes about blacks' low intelligence, high hostility, or reluctance to comply with treatment recommendations could lead to avoidance of these help-seekers (Abreu 1999; Dovidio et al. 2008; van Ryn and Burke 2000). A meta-analysis by Boysen (2009) concluded that while explicit (conscious, self-reported) bias among MHPs is rare, implicit (automatic, non-conscious) bias is common. Using priming methods (Abreu 1999) or the Implicit Association Test (Castillo et al. 2007; Katz and Hoyt 2014) and counseling students (Boysen and Vogel 2008; Castillo et al. 2007) or practicing MHPs (Abreu 1999; Katz and Hoyt 2014), these scholars found evidence of anti-black implicit bias, although the relevant stereotypes were often unknown. Geller (1988:124) used survey data in an attempt to better understand the nature of the anti-black stereotypes. He reported that, after controlling for sociodemographic

² The study was conducted in an inpatient setting.

characteristics, black patients were rated by psychiatrists as “less articulate, competent, introspective, self-critical...and psychologically minded.”

Clearly, beliefs about black help-seekers’ lack of education, and the related attributes that it proxies (e.g., communication skills, social class, intelligence), would reduce the appeal of black help-seekers as potential clients. Another set of beliefs that could deter MHPs from accepting black help-seekers are those related to the perceived nature and prevalence of blacks Americans’ social problems, the view that those social problems are of their own making, the assumption that they continue to experience these problems as a consequence of their own lack of effort, and that receipt of publicly financed social services is undeserved (Gilens 1999). Publicly-funded institutions that serve and control socially, socioeconomically, or otherwise disadvantaged individuals tend to employ caseworkers.

Ensign refers to caseworkers as “agents of social intervention” (1990:1). Unlike other intervening agents in the help-seeking process (e.g., family, friends, colleagues), they act in an official capacity, representing a wide range of surveilling institutions (e.g., child protective service agencies), as gatekeepers to the social safety net. Also unlike informal intervening agents, they exist in a hierarchical relationship with their clients in which the client has little or no control (Ensign 1990:109). Informed by Foucault’s conception of power, Ensign (1990) characterizes caseworkers’ relationships with male clients as one in which the caseworker is dominant. The cases that caseworkers supervise converge with stereotypes about African Americans in ways that could make them less desirable to MHPs. For example, that they are likely to be under correctional supervision, abuse substances, or receive welfare benefits.

Like race, gender is an easily recognizable axis of inequality that exists in health care sectors; it can affect clinicians’ perceptions and can mitigate or exacerbate the effects of race (Arber et al. 2006; Chapman, Kaatz, and Carnes 2013; Lewis, Croft-Jeffreys, and David 1990). Some early research on MHPs’ patient preferences suggests that women are favored over men (e.g., Howard and Orlinsky 1972). This preference was partially supported by Kugelmass’s (2016) audit study of psychotherapists. Because in the U.S. men are considerably less likely than women to use mental health care services (Substance Abuse and Mental Health Services Administration 2014), it is possible that a lack of experience with male help-seekers—or a fear of black male help-seekers— influences MHPs’ receptiveness to them.

The studies reviewed thus far have taught us much about bias among providers, but most have investigated general impressions or diagnostic decision-making, not accessibility to help-seekers. Moreover, they are based on survey data, implicit bias tests, or vignette-based experiments, rather than experimentally controlled real-world interactions.

Field Experiments

Field experiments are an ideal method for systematically testing whether otherwise unobservable discrimination has occurred; subjects are unaware that they are being exposed to experimental stimuli. In field experiments of racial discrimination, if the racial minority auditors receive worse treatment than the white auditors over a series of trials, then discrimination is said to have occurred. Correspondence field experiments use a written stimulus, often varying the name of the writer to signal race. In recent years, the ubiquity of online correspondence has resulted in the proliferation of online field experiments to test for racial discrimination in various markets: labor (e.g., Gaddis 2015; Nunley et al. 2015), housing (e.g., Carpusor and Loges 2006; Hanson and Hawley 2011; Hogan and Berry 2011), and product markets (e.g., Besbris et al. 2015; Doleac and Stein 2013). The overwhelming majority of field experiments across markets find evidence of racial discrimination (Rich 2014).

Field experiments of racial or social class-based discrimination in the mental health care sector are rare, and are typically conducted over the phone, not email. Through one such study, Rhodes et al. (2009) found that patients with Medicaid were far less likely than those with private insurance to be offered an appointment by a mental health clinic. Although “Medicaid” is more than just a signal of class—it has sizable financial consequences for the MHP—other research suggests that providers discriminate on the basis of perceived class even among help-seekers with the same private health insurance coverage.

One example of the independent influence of class is a recent phone-based experiment involving three hundred and twenty in-network psychologists for an HMO. These MHPs were called once by a black help-seeker and once by a white help-seeker who was middle class or working class and male or female (Kugelmass 2016). Class was cued primarily through education (vocabulary and grammar), as well as accent and name. The results revealed profound differences in appointment offer rates by help-seeker race and social class, even though insurance status was the same for all help-seekers. After controlling for race, working class help-seekers had odds of

receiving an appointment offer that were a third of middle class help-seekers' odds. Moreover, controlling for class, blacks were less likely to be offered an appointment. In a similar phone-based field experiment, Shin (2016) varied only race and also found evidence of discrimination. Kugelmass's (2016) and Shin et al.'s (2016) studies support the broader body of research pointing toward implicit (non-conscious) negative outgroup biases as one mechanism through which disparities in health care access can emerge.

Market Considerations

The social psychological literature just reviewed provides reason to hypothesize that racial will be observed in the present research. However, some field experimental research driven by economic theories points to market conditions under which discrimination might not occur. Becker (1957), in his seminal book *The Economics of Discrimination*, theorized that market competition reduces the rate of discrimination by increasing the cost of discriminating. This theory is consistent with recent studies showing a relationship between labor market tightness and discrimination. Baert et al. (2013, 2015) demonstrate that ethnic discrimination is less likely to occur when employers have difficulty filling a vacancy. Like employers, MHPs advertise an opening that they are seeking to fill and incur costs if it remains vacant.

The online mental health care market also bears resemblance to product and service markets; some studies of those markets have also found that discrimination is conditional on market competition. For example, a field experiment conducted on eBay (Nunley, Owens, and Howard 2011) found that race-based price differences arise only in low competition markets. These findings are consistent with other field experiments in product markets (e.g., Caminade et al. 2014; Doleac and Stein 2013).

Low search costs for buyers may also reduce discrimination by sellers. In one of several innovative field experiments, Gneezy et al. (2012) investigated discrimination against disabled individuals in the car repair service market. The level of discrimination exhibited by car mechanics was influenced by the mechanics' beliefs about the relative search costs for a disabled versus non-disabled person to locate a mechanic. When the auditors specified that they were collecting price quotes from multiple mechanics, there were no differences in outcomes.

The internet facilitates information search and thereby has the potential to reduce racial discrimination in some markets, argue Morton et al. (2003), who analyzed racial differences in

automobile transaction prices. Morton et al. (2003) found that, unlike in offline markets, African American buyers using an online service did not suffer from disparate treatment. They attribute this to the internet's role in reducing search costs for the consumer and reducing cues about the consumer that salespeople could use as signals of willingness to pay. This is notable because MHPs on Psychology Today know that the search costs to help-seekers are negligible: help-seekers simply click the "email" button on a profile, type a short message, and move on to the next MHP who looks suitable.

To whom will mental health care providers sell their services? The economic theory and empirical work just described suggest that in many type of markets, for discrimination to occur, professionals must be willing to forfeit revenue to avoid interacting with undesirable potential clients. MHPs who do not accept interested help-seekers both forfeit potential revenue and incur Psychology Today's monthly advertising cost. By targeting MHPs who pay to advertise their services, I am capturing a population that perceives a tight market—that is, a market in which they need to compete for the clients they consider desirable.

The Present Research

Although it is generally accepted that therapists have implicit negative biases toward black Americans, we know little about the extent to which these biases influence therapists' decisions regarding if and how to respond to help-seekers' requests for care. The two studies presented in this paper contribute to the emerging body of literature on this topic by investigating the decisions of a wide range of MHPs advertising in an online market. This paper asks: Will MHPs be equally responsive and accessible to all help-seekers? There are many attributes of MHPs that could influence if and how they respond. A second aim of this research, therefore, is to analyze how MHPs' sociodemographic characteristics and financial flexibility are related to accessibility toward prospective clients. These are the central inquiries:

1. Study 1 (more educated help-seekers):
 - a. Does the accessibility of mental health care providers depend on help-seekers' (i) race or (ii) gender?
 - b. Does the magnitude of the racial disparity, if it exists, depend on help-seekers' gender?

2. Study 2 (less educated help-seekers):
 - a. Does the accessibility of mental health care providers depend on help-seekers' (i) race or (ii) intervening agent (caseworker versus unspecified)?
 - b. Does the magnitude of the racial disparity, if it exists, depend on whether the help-seeker mentions a caseworker or an unspecified agent as recommending therapy?
3. What sociodemographic and financial characteristics of mental health care providers
 - a. predict access for the populations of help-seekers represented in Study 1 and 2?
 - b. moderate the relationship between their accessibility and help-seekers' race?

For ease of exposition, I refer to the alternative intervening agents in Study 2 as “caseworker” and “unspecified.” The latter is a placebo condition that does not identify who prompted the help-seeker’s decision to pursue therapy; it simply mentions “someone.” Additionally, I refer to all help-seekers in Study 2 as “less educated,” relative to what I call the “college educated” (or “more educated”) help-seekers of Study 1. These are necessarily imprecise terms that represent a complex set of concepts and assumptions about how the help-seekers are being perceived by MHPs.

The studies do not examine MHPs’ responses to objectively defined racial group categories or educational attainment levels. Rather, the studies are designed to investigate how MHPs’ responses vary based on how they *perceive* help-seekers with variable attributes. Due to the deception required for field experiments such as these, we cannot directly measure how the study’s subjects perceive the experimental stimuli. Instead, we must rely on survey-takers’ assessments of race and education level as approximations. The design and survey validation of the experimental stimuli are discussed in the section that follows.

Data and Methods

Sample

The sample was selected from mental health care providers (MHPs) listed on Psychology Today’s online therapist directory. When MHPs first register to be included in the directory, they answer questions to create “profiles.” Most questions are optional, but the typical profile includes the MHP’s address, photo, year graduated, clinical specialties (e.g., depression), client specialties (e.g., elderly), and accepted health insurance plans, among others. In total, MHPs listed on

PsychologyToday.com receive more than 540,000 emails from help-seekers per month (Psychology Today 2015). Help-seekers do not register to use the website; they search anonymously.

In September 2015, the sampling frame was compiled using a web-scraping program customized to extract all data for all MHPs with profiles on PsychologyToday.com. The final sample included only MHPs whom Psychology Today verified were licensed in the United States. I also restricted the sample to psychologists (PhD or PsyD), social workers (MSW, LCSW, or clinical social work/therapist) and licensed counselors (LPC or LMCH).³ I further disqualified MHPs who treat only children, did not include an option to email them, indicated that they were not accepting new clients, had not updated their profiles since 2013 or earlier, or did not include a profile photo.⁴

I imposed two additional exclusionary criteria, with the goal of isolating MHPs who are responsible for selecting their own clientele. First, I excluded any profiles listed as “treatment facilities.” Second, I excluded any MHPs who selected a button labeled “email us” instead of “email me.” These restrictions ultimately resulted in a pool of approximately 30,000 MHPs from which the study samples were randomly drawn. The informed consent requirement was waived by Princeton University’s Institutional Review Board.

Experimental Design

Each study had a 2x2 between-subjects design, with MHPs randomly selected from the eligible sample, and then randomly exposed to one of four possible treatments. (See Figures 1a and 1b.) No MHPs received more than one email and none were subjects in both studies.

[Figures 1a and 1b about here]

Study 1 varied race and gender, with each MHP receiving an email from either a black or a white help-seeker, who was either male or female. Study 1’s MHP sample was stratified by occupation to ensure that equal numbers of psychologists, social workers, and licensed professional counselors were randomly assigned to each experimental condition.

³ This excluded marriage counselors, pastors, and others who did not earn at least one of the degrees listed above. Psychiatrists were excluded due to small sample size. For Study 1, I further excluded any therapists with degrees in multiple categories.

⁴ Ninety-four percent of MHPs post at least one photo to their profile.

MHPs who were subjects in Study 2 received an email from either a black or white male help-seeker, who either mentioned that a caseworker or an unspecified external actor (“someone”) had prompted his search for a therapist. All of Study 2’s help-seekers were ostensibly less educated than those in Study 1, as signaled through poor writing mechanics (spelling, punctuation, etc.). In neither study was education stated explicitly.

Mental health care providers were emailed through their profile pages on Psychology Today. Clicking the “email me” button on an MHP’s profile directs help-seekers to an email form where they are prompted to enter their name, email address, phone number (optional), email subject, and message. A sidebar reads:

Don't be shy. Our therapists are here to help you and are pleased to hear from you. Feel free to ask for what you want... an appointment, a consultation or simply a response to a question. Keep it short, 200 words or less, this is just an initial contact. Remember to double check your return email address or your phone number if you prefer to be called.

Messages were kept as short as possible, which is consistent with the instructions above as well as with most health care field experiments. This meant omitting any unnecessary contextualizing information (e.g., symptoms or backstory). This also decreased the odds that the messages would be memorable or would elicit a response customized to the help-seeker’s specific circumstances. These are examples of the email scripts as they appeared to MHPs.

Study 1:

Your Name: Jill Miller
Your Email: jill.miller795@gmail.com
Your Phone:
Subject: appointment

Message:
Dr. Nadkarni,
Do you have any appointments open? Please let me know. Thank you.
Jill Miller

Study 2:

Your Name: Keyshawn Washington
Your Email: keyshawnwashington470@gmail.com
Your Phone:
Subject: appointment

Message:

Dr barken

[*My caseworker /Some-one*] thinks I should see a therapist I think its a good idea, do you have appointments ? thanks

Keyshawn Washington

The help-seekers' names were used to communicate race, gender and, to a lesser extent, education. In order to maximize the salience of the help-seeker's name, MHPs were exposed to it in three places: the reply-to email address (e.g., jill.miller795@gmail.com), the sender name field of the email form, and the help-seeker's signature in the email message. Following Giulietti et al. (2015), within each study I used two pairs of first and last names to represent each racial category (e.g., Jill Miller and Sarah Long for white females). The results presented do not distinguish between the two names that represented each racial category.⁵

In order to confirm that help-seekers would be perceived as intended, the contents of the email scripts and the names of the help-seekers were pre-tested by survey-takers on Amazon's Mechanical Turk crowdsourcing labor market platform. The intended race of the help-seeker was readily recognized; correct race identification ranged from 85 to 98 percent. In addition, although none of the email prompts directly indicate educational attainment, findings from surveys suggest that the intended level of education was being telegraphed nonetheless. More than 90 percent of survey-takers responded that the help-seeker had received at least some college education, whereas 40 percent of survey-takers presented with the "someone" script, and 30 percent of those presented with the caseworker script, thought the help-seeker had at least some college education. When survey-takers were asked to identify the social class associated with the name and email text combinations to be used in the studies, the modal response for each was consistent with the intended education manipulation. That is, Study 1's help-seekers were most commonly identified as middle

⁵ The differences in outcomes between names within conditions were not statistically significant.

class, Study 2's help-seekers with an unspecified intervening agent were lower-middle class, and Study 2's help-seekers with a caseworker were lower class.

The use of the term "caseworker" was modeled after Olah et al.'s (2013) use of "welfare worker" to signal low socioeconomic status in their field experiment of discrimination among Canadian medical professionals. The mention of a "caseworker" (relative to "someone") was intended to add a component of social need and institutional involvement to the otherwise education-oriented cue. When survey-takers were presented with the "caseworker" script, and prompted to speculate about why the writer needed a caseworker, they typically alluded to legal trouble, substance abuse, disability, or the need for public assistance.

Variables

Accessibility. The main dependent variable is MHP accessibility, which was operationalized as a positive response to the request for an appointment. Each MHP response was assigned one of the following mutually-exclusive categories. For analyses, the codes were collapsed into a binary variable: category 1 and 2 ('1') versus all other categories ('0'). Categories 1 and 2 open the door to further interaction and promote the potential for an appointment. Categories 3, 4, and 5 impede timely access to an appointment.

Categories:

- 1) Explicitly affirmed appointment availability (e.g., "Yes, I have appointments")
- 2) Requested/offered to speak on phone (e.g., "What is a good time to discuss on the phone?")
- 3) Requested additional information without reference to appointment or call (e.g., "What is your insurance?")
- 4) Offered waitlist or referral (e.g., "I'm not taking new clients this month, but I can put you on a waitlist.")
- 5) Rejected the help-seeker without offering waitlist or referral (e.g., "I'm not taking new clients.")

Responsiveness (email reply). This is a dichotomous dependent variable that is of secondary interest to accessibility. Help-seekers' primary concern is mental health care, not a callback; however, this variable represents an interim step that may contribute to disparities in rates of positive response.

Help-seeker Race. Studies 1 and 2 manipulated the race of the help-seekers (black=1, white=0), cued by racially distinctive names. In Study 1, first and last names were adopted from an experiment by Abascal (2015), who selected racially-identifiable middle class names. In Study 2, names were selected from New York State birth records; their selection was informed by a combination of mother's race and mother's education.

Help-seeker Gender. Study 1 manipulated the gender of the help-seekers (female=1, male=0), cued by gender-specific names. All help-seekers in Study 2 were male.

Intervening Agent. Study 2's help-seekers mention that either "my caseworker" (=1) or "someone" (=0) thinks the help-seeker should see a therapist. I refer to the latter as an unspecified intervening agent.

*Mental Health Care Provider Attributes.*⁶

Sociodemographic. Gender, state, and occupation were available in the web-scraped profile data. Seventy-one percent of MHPs with profiles on Psychology Today are female. I collapsed states into the four Census regions. Twenty-one percent of MHPs reside in the Northeast, 16 percent in the Midwest, 29 percent in the South, and 34 percent in the West. This paper focuses on three categories of occupations: psychologists (PhD or PsyD), social workers (MSW, LCSW, or clinical social work/therapist) and licensed counselors (LPC or LMCH). Approximately one-quarter of MHPs on Psychology Today fit into each of those three occupational categories, with another quarter composed of assorted other occupations (e.g., marriage counselors, pastoral counselors, art therapists). MHP race is not included in profile data; it was inferred from profile photos. Research assistants coded phenotype. Then their codes were collapsed into three categories: white (88 percent), black (5 percent), or other race (7 percent).

Financial flexibility. Financial variables shed light on how the MHPs are experiencing market competition and what types of clients they consider acceptable. I include three dichotomous financial variables. First is whether or not the MHP checked a box indicating that she offers a

⁶ I considered two additional attributes: (a) the number of years that the MHP has been practicing and (b) session cost. Because these fields are not mandatory, including those variables in regression models decreases the sample size. Neither was statistically significant, so they are excluded from the models presented.

sliding scale fee. Second is whether or not the MHP checked a box indicating that she offers a free consultation. Third is whether or not the MHP accepts at least one insurance plan; MHPs have the option of choosing from a list of dozens or entering their own. Each of these three indicators of financial flexibility is present for 60-65 percent of MHPs on PsychologyToday.com.

Results

Analytic Approach

Except where otherwise indicated, the outcome variable is a positive response to the request for an appointment. This variable was composed by collapsing the five possible response categories into two, as previously described. Table 1 presents the percent of responses in each of the five possible categories for each study. Robustness checks that consider different formulations of the dependent variable, comprised of various combinations of the categories, produce results patterned similarly to those presented in this paper.

Figures 2 and 3 present the unadjusted positive response rates with the associated confidence intervals. I conduct Bonferroni-adjusted pairwise comparisons between each of the experimental conditions within each study to determine which help-seekers significantly differ.

The models presented in Tables 2 and 3 were estimated using logistic regression. Results are reported as odds ratios, which were obtained by exponentiating the logit coefficients. All variables in the models are categorical or dichotomous and each has a reference category with an odds ratio of 1.0. For each study, the regressions are conducted in stepwise fashion to mirror the three sets of explanatory variables—help-seeker characteristics, MHP sociodemographic attributes, and MHP financial flexibility.⁷

[Table 1 about here]

Study 1 (more educated)

The comparison of positive responses across race and gender appear in Figure 2. Seventy-two percent of all MHPs who were contacted either explicitly replied that they had available

⁷ I analyzed results including and excluding the five percent of replies (n=35/739) that were signed by an individual other than the MHP contacted (e.g., an administrative assistant). Because the results were very similar, all observations are included in the analyses presented here.

appointments or suggested a phone call. Rates are indistinguishable for black and white, female and male; the four conditions ranged from 70 to 73 percent. The results presented in Figure 2 are supported within the logistic regression framework. (See Model 1 in Table 2.) No significant effects were found for help-seeker race or gender, nor was there an interaction between the two.

[Figure 2 about here]

Model 2 introduces a series of sociodemographic attributes of mental health care providers. The gender and race of the MHP were not significant predictors of accessibility, but geographic region and occupation were. MHPs in the south were, *ceteris paribus*, less likely to respond positively than MHPs in the northeast (OR=0.48, $p<.05$). In addition, when help-seekers contacted a licensed counselor, they had odds of a positive response that were more than twice what they would have received from a psychologist (OR=2.32, $p<.001$).

Model 3 adds another set of explanatory variables: sliding scale fee, free consultation, and insurance. MHPs who accept insurance were considerably less likely to respond positively as those who do not (OR=0.57, $p<.01$). The other two financial variables were not associated with accessibility. The coefficients for each help-seeker remained essentially unchanged across all three models, indicating that the MHP sociodemographic attributes or finances were not concealing underlying race or class-based disparities.

[Table 2 about here]

Study 2 (less educated)

Figure 3 makes apparent sizeable differences by race and intervening agent. Among white men who mentioned that “someone” (i.e., not a caseworker) suggested he see a therapist, 65 percent received a positive response, while 55 percent of otherwise identical black men did. Men who mentioned a “caseworker” fared worse on average and racial differences were more pronounced: almost 61 percent received a positive response, but only 36 percent of blacks did. After applying a Bonferroni adjustment to the confidence intervals, I find significant pairwise differences between blacks with a caseworker and the three other groups: whites without a caseworker ($p<.01$), whites with a caseworker ($p<.05$), and blacks without a caseworker ($p<.10$).

[Figure 2 about here]

Odds ratios from a logistic regression (not displayed) in which race and intervening agent were the only covariates revealed that blacks had odds of receiving a response that were less half that of whites (OR=0.49, $p<.01$). Furthermore, an email from a help-seeker who mentioned a caseworker had odds of eliciting a positive response that were 40 percent lower than an email from a help-seeker who did not mention one (OR=0.60, $p<.05$).

Table 3 emphasizes the dramatic and persistent preference exhibited for white men with an unspecified agent relative to black men with a caseworker. Even after the introduction of MHP sociodemographic (Model 2) and financial (Model 3) characteristics, the odds of the latter receiving a positive response is less than a third of the odds of the former ($p<.001$). The odds for white men with a caseworker and white men with an unspecified agent fell in between the two and also remained constant across models.

Although the disparities were unaltered by MHP attributes, two attributes predicted accessibility on average. First, MHPs in the western U.S. were less likely to offer appointments than those in the northeast (OR=0.44, $p<.05$). Second, the willingness to offer a sliding scale fee was associated with greater odds of an appointment offer (OR=1.85, $p<.05$).

[Table 3 about here]

Responsiveness (reply rate)

In this study, receipt of a positive response is the primary outcome of interest. Nonetheless, I conducted supplementary analyses to provide additional perspective on the non-response cases. Across all conditions, the overall reply rate was 85 percent for Study 1 and 74 percent for Study 2. MHPs replied with impressive speed: 93 percent of Study 1 MHPs who replied at all did so within 24 hours, as did 89 percent of those in Study 2. Unsurprisingly, among those MHPs who indicated accessibility, the 24-hour reply rates were even higher.

In Study 1, there were no significant differences in responsiveness by race or gender, which is consistent with Study 1's results for accessibility. Reply rates for men and women, black and white, ranged from 82 to 89 percent.

Study 2 reply rates were patterned similarly to the positive response rates. Among the MHPs who received an email from a less educated help-seeker with an unspecified agent, 82 percent replied to the white man and 69 percent to the black man. Emails that mentioned a caseworker elicited 81 percent and 63 percent reply rates, respectively. Logistic regression results show significant main effects of race ($OR=.44, p<.01$), but not of the intervening agent.

Discussion

Summary

This field experiment explored whether American mental health care professionals in private practice exhibit racial discrimination toward individuals seeking care. A large, dynamic online market that enables MHPs to advertise to help-seekers provided an excellent setting to study this phenomenon.

Overall, the MHPs in this study were quite responsive to help-seekers' requests for appointments compared to other studies of similar populations (Demboisky 2016; Kugelmass 2016; Rhodes et al. 2009; Shin et al. 2016). The high reply rates and speed with which MHPs replied provides evidence that the vast majority of MHPs with profiles are active on the website. Furthermore, it is consistent with the expectation that transaction costs online are lower than those that require connecting on the phone. It is also highly suggestive that these MHPs perceive themselves to be in a competitive market.

Do mental health care providers discriminate against black help-seekers? It depends. MHPs exhibit equal accessibility toward black and white help-seekers perceived to be college educated. However, racial disparities do emerge when lower education is cued. Moreover, together these studies strongly suggest that, on average, more educated help-seekers are favored over less educated help-seekers (72 versus 61 percent positive response). Overall, the least desirable help-seekers are those with low education level accompanied by a level of social need that triggered a caseworker's involvement (48 percent positive response).

It is important to note that these analyses cannot offer a precise estimate of the difference between putatively "more educated" help-seekers of Study 1 and the "less educated" help-seekers of Study 2 because the studies were designed and conducted independently. One potentially influential difference between Study 1's and Study 2's stimuli is that the shadow of an intervening agent in

Study 2, regardless of whether or not that agent was an institutional agent, could be interpreted as a marker of diminished internal motivation. This marker might give MHPs pause because unmotivated clients are less desirable to them (see e.g., Levinson 1969),

In addition, the analyses did not identify characteristics of MHPs that predicted the observed racial disparities in Study 2, or the lack of disparities in Study 1. However, the results do highlight how variation among MHPs—in terms of geography, occupation, and financial flexibility—can contribute to accessibility rates, independent of help-seeker race.

Study 1 (more educated)

The results of Study 1 are consistent with economic theory that associates market competition with reduced racial discrimination. Viewed in this light, the MHPs in this study are not necessarily revealing that black clients are equally preferred to white clients, but that rejecting black clients is not worth lost revenue potential. Perhaps, in a market that MHPs perceive to be competitive, blackness alone would not be sufficient to disqualify a help-seeker.

The sizable effects of MHPs' occupation and insurance status are consistent with a market-based explanation for variation in accessibility. Licensed counselors—who have fewer years of education and less prestige—were more likely to express accessibility. Furthermore, more educated help-seekers were less likely to receive a positive response from MHPs who accept insurance than those who require out-of-pocket payment. MHPs on insurance panels are likely more attractive to help-seekers, and therefore likely receive more inquiries, which may afford them the opportunity to be more selective.

That said, non-market forces may be partly responsible for the finding that Study 1's MHPs do not discriminate against black prospective clients while those in Kugelmass's (2016) and Shin's (2016) field experiments do. For example, it may be the nature of the stimulus itself; that is, racially-accented speech may trigger implicit bias in a way that written communication does not.

Study 2 (less educated)

The results of Study 2 challenge the common perception that MHPs behave in an egalitarian way, as professional norms and codes of ethics dictate (American Counseling Association 2014; American Psychological Association 2010). *Ceteris paribus*, black men were less likely than white men to receive a positive response to their inquiry. Moreover, mentioning a caseworker is

associated with lower accessibility for both black and white men. The caseworker stimulus and race stimulus appear to operate independently, but cumulatively. It may be that men who are black, not well-educated, and have a caseworker suffer from three strikes that disqualify them from being suitable clients.⁸ Indeed, those three characteristics are culturally incongruent with psychotherapy's traditional standing as a luxury for the privileged.

There are several pathways through which mention of a "caseworker" could be reducing accessibility. Clearly, it communicates a level of social need that exceeds that of patients in the desirable "worried well" category; this need could be related to severe mental health issues or to unrelated sources of disadvantage, such as physical disability. Alternatively, it could imply the existence of stigmatized circumstances (e.g., parole) or administratively burdensome circumstances (e.g., custody disputes) that MHPs might seek to avoid even if mental health need is mild. It could also imply institutional coercion into therapy, which signals a lack of commitment to the therapeutic process. (The phrase "I think its a good idea" was included to mitigate that potential signal.)

Even independent of the needs or motivations of the help-seeker, there are two key reasons that MHPs would be averse to the intervention of an agent who, in most cases, works for a public institution that financially supports the provision of social services to those in need. First is that publicly financed services signals a low-income client, which poses a financial risk. Second is that the MHPs in this study—those in solo private practice—might be disinclined to collaborate with any agent of the state with enforcement authority, even if the role of that third party agent is to advocate for the client.

Lastly, it is possible that the lower odds of appointment offers to the help-seekers mentioning a caseworker, relative to those mentioning an unspecified agent, is mediated by the lower levels of education and/or social class attributed to those with a caseworker. Whatever the mechanism, it is striking that simply the mention of the involvement of a public sector helping professional (i.e., a caseworker) reduces access by the magnitude observed, particularly for black help-seekers.

The disparity between black and white help-seekers in the unspecified agent condition, although not statistically significant, is worth briefly addressing. The unspecified "someone" is intentionally ambiguous, thereby activating implicit racial biases. In this condition, MHPs make assumptions not only about the help-seeker, but also about this unspecified external actor. MHPs

⁸ Study 2 did not vary gender. Further research is needed to determine whether the same patterns would be observed for female help-seekers.

might assume that when the help-seeker is black, the “someone” is more likely to be an agent deployed by a public institution or other authority than she is to be a member of the help-seeker’s personal or professional social network.

With regard to financial flexibility, the availability of a sliding scale fee—which indicates openness to working with low socioeconomic status clients on an ongoing basis—predicts accessibility. This finding suggests that a lack of financial flexibility by MHPs may contribute to difficulties that such help-seekers have accessing care—even when they contact MHPs who are actively searching for clients.

Conclusion

These studies tested for the presence of discrimination exercised by private outpatient care MHPs in an online market; they might not be generalizable beyond that setting. Moreover, we cannot draw conclusions about rates of discrimination even in that particular market because the measurements presume a help-seeker who randomly selects MHPs. As Becker (1957) and Heckman (1998) emphasize, there is an important distinction between true labor market-level discrimination and the discrimination observed with a group of randomly selected employers. This sort of adjustment of search behaviors by minorities could arise in non-labor markets as well. The present research cannot determine the extent to which help-seeker preferences and help-seeking behaviors would change the magnitude of the observed discrimination. That would depend, in part, on how effectively help-seekers can predict which MHPs would be most receptive to them.

Nonetheless, this research contributes to our understanding of the conditions under which racial discrimination does and does not occur in a private mental health care market. By employing an email-based field experimental approach, the studies were able to examine otherwise invisible provider-side responses. Efforts to combat disparities must arise from an appreciation of the scope of the problem and the circumstances under which it is suppressed or reinforced. This research has the potential to help mental health care providers, educators, and consumer advocates as they strive to increase access to care for all.

References

- Abascal, Maria. 2015. "Us and Them: Black-White Relations in the Wake of Hispanic Population Growth." *American Sociological Review* 80(4):789–813.
- Abreu, José M. 1999. "Conscious and Nonconscious African American Stereotypes: Impact on First Impression and Diagnostic Ratings by Therapists." *Journal of Consulting and Clinical Psychology* 67(3):387–93.
- American Counseling Association. 2014. *ACA Code of Ethics*. Alexandria, VA: American Counseling Association. Retrieved March 2, 2016 (counseling.org/ethics).
- American Psychological Association. 2010. *Ethical Principles of Psychologists and Code of Conduct*. Washington, D.C.
- Arber, Sara et al. 2006. "Patient Characteristics and Inequalities in Doctors' Diagnostic and Management Strategies Relating to CHD: A Video-Simulation Experiment." *Social Science & Medicine* 62(1):103–115.
- Baert, Stijn, Bart Cockx, Niels Gheyle, and Cora Vandamme. 2013. *Do Employers Discriminate Less If Vacancies Are Difficult to Fill? Evidence from a Field Experiment*. Forschungsinstitut zur Zukunft der Arbeit. Retrieved December 7, 2015 (http://trafficlight.bitdefender.com/info?url=http%3A//papers.ssrn.com/sol3/papers.cfm%3Fabstract_id%3D2214896&language=en_US).
- Baert, Stijn, Bart Cockx, Niels Gheyle, and Cora Vandamme. 2015. "Is There Less Discrimination in Occupations Where Recruitment Is Difficult?" *ILR Review* 68(3):467–500.
- Becker, Gary S. 1957. *The Economics of Discrimination*. United States: University of Chicago Press.
- Besbris, Max, Jacob William Faber, Peter Rich, and Patrick Sharkey. 2015. "Effect of Neighborhood Stigma on Economic Transactions." *Proceedings of the National Academy of Sciences* 112(6):4994–98.
- Boysen, Guy A. 2009. "A Review of Experimental Studies of Explicit and Implicit Bias Among Counselors." *Journal of Multicultural Counseling and Development* 37(4):240–49.
- Boysen, Guy A. and David L. Vogel. 2008. "The Relationship between Level of Training, Implicit Bias, and Multicultural Competency among Counselor Trainees." *Training and Education in Professional Psychology* 2(2):103–10.
- Caminade, Juliette, John A. List, Jeffrey A. Livingston, and Jeffrey Picel. 2014. "When the Weak Become Weaker: The Effect of Market Power on Third Degree Price Discrimination." *Unpublished Manuscript*. Retrieved December 16, 2015 (http://works.bepress.com/jeffrey_livingston/11).
- Carpusor, Adrian G. and William E. Loges. 2006. "Rental Discrimination and Ethnicity in Names." *Journal of Applied Social Psychology* 36(4):934–952.
- Castillo, Linda G., Daniel F. Brossart, Carla J. Reyes, Collie W. Conoley, and Marion J. Phoummarath. 2007. "The Influence of Multicultural Training on Perceived Multicultural Counseling Competencies and Implicit Racial Prejudice." *Journal of Multicultural Counseling and Development* 35(4):243–55.

- Chapman, Elizabeth, Anna Kaatz, and Molly Carnes. 2013. "Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities." *Journal of General Internal Medicine* 28(11):1504–10.
- Corbett, Alan. 2011. "Silk Purses and Sows' Ears: The Social and Clinical Exclusion of People with Intellectual Disabilities." *Psychodynamic Practice* 17:273–89.
- Dembosky, April. 2016. "Single Mom's Search for Therapy Foiled by Insurance Companies." *State of Health*. Retrieved June 3, 2016 (<https://ww2.kqed.org/stateofhealth/2016/05/23/single-moms-search-for-therapist-foiled-by-insurance-companies/>).
- Doleac, Jennifer L. and Luke C. D. Stein. 2013. "The Visible Hand: Race and Online Market Outcomes." *The Economic Journal* 123(572):F469–92.
- Dovidio, John F. et al. 2008. "Disparities and Distrust: The Implications of Psychological Processes for Understanding Racial Disparities in Health and Health Care." *Social Science & Medicine* 67(3):478–86.
- Ensign, Russell Lee. 1990. "Learning the Rhetoric of Social Intervention: A Case Study of Discursive Formation in the Training and Practice of Odhs Children Services Caseworkers." Ohio University. Retrieved July 4, 2017 (<https://philpapers.org/rec/ENSLTR>).
- Frank, Richard G. and Sherry A. Glied. 2006. *Better but Not Well: Mental Health Policy in the United States since 1950*. JHU Press. Retrieved October 31, 2014 (http://books.google.com/books?hl=en&lr=&id=GCtnAs7wCTMC&oi=fnd&pg=PR9&dq=better+bu+t+not+well+frank+glied&ots=oy7H-yAs8J&sig=AjHAGc6gvYpIH6QQPpKN43u_s8Y).
- Gaddis, S. Michael. 2015. "Discrimination in the Credential Society: An Audit Study of Race and College Selectivity in the Labor Market." *Social Forces* 93(4):1451–79.
- Geller, J. D. 1988. "Racial Bias in the Evaluation of Patients for Psychotherapy." Pp. 112–34 in *Clinical guidelines in cross-cultural mental health*, edited by L. D. Comas-Diaz and E. E. H. Griffith. New York: Wiley.
- Gilens, Martin. 1999. *Why Americans Hate Welfare: Race, Media, and the Politics of Antipoverty Policy*. University of Chicago Press.
- Gneezy, Uri, John List, and Michael K. Price. 2012. *Toward an Understanding of Why People Discriminate: Evidence from a Series of Natural Field Experiments*. National Bureau of Economic Research. Retrieved December 5, 2015 (<http://www.nber.org/papers/w17855>).
- Grodzki, Lynn. 2013. "Shopping for Therapy: Yesterday's Patients Are Today's Educated Consumers." *Psychotherapy Networker*, September 18. Retrieved February 3, 2015 (<http://www.psychotherapynetworker.org/magazine/currentissue/item/2242-shopping-for-therapy/2242-shopping-for-therapy?start=6>).
- Guilietti, Corrado, Mirco Tonin, and Michael Vlassopoulos. 2015. *Racial Discrimination in Local Public Services: A Field Experiment in the US*. Munich, Germany: CESifo. Retrieved October 18, 2015 (http://www.cesifo-group.de/ifoHome/publications/working-papers/CESifoWP/CESifoWPdetails?wp_id=19172131).

- Hanson, Andrew and Zackary Hawley. 2011. "Do Landlords Discriminate in the Rental Housing Market? Evidence from an Internet Field Experiment in US Cities." *Journal of Urban Economics* 70(2):99–114.
- Heckman, James J. 1998. "Detecting Discrimination." *The Journal of Economic Perspectives* 12(2):101–16.
- Hogan, Bernie and Brent Berry. 2011. "Racial and Ethnic Biases in Rental Housing: An Audit Study of Online Apartment Listings." *City & Community* 10(4):351–72.
- Howard, Kenneth I. and David E. Orlinsky. 1972. "Psychotherapeutic Processes." *Annual Review of Psychology* 23(1):615–668.
- Katz, Andrew D. and William T. Hoyt. 2014. "The Influence of Multicultural Counseling Competence and Anti-Black Prejudice on Therapists' Outcome Expectancies." *Journal of Counseling Psychology* 61(2):299.
- Kugelmass, Heather. 2016. "'Sorry, I'm Not Accepting New Patients': An Audit Study of Access to Mental Health Care." *Journal of Health and Social Behavior* 57(2):168–83.
- Levinson, Daniel. 1969. "Distress in the City -- and in the Mental Health Field." Pp. 85–98 in *Distress in the City*. Cleveland: Case Western Reserve University Press.
- Lewis, Glyn, Caroline Croft-Jeffreys, and Anthony David. 1990. "Are British Psychiatrists Racist?" *The British Journal of Psychiatry* 157(3):410–415.
- Link, Bruce and Barry Milcarek. 1980. "Selection Factors in the Dispensation of Therapy: The Matthew Effect in the Allocation of Mental Health Resources." *Journal of Health and Social Behavior* 21(3):279.
- Morton, Fiona Scott, Florian Zettelmeyer, and Jorge Silva-Risso. 2003. "Consumer Information and Discrimination: Does the Internet Affect the Pricing of New Cars to Women and Minorities?" *Quantitative Marketing and Economics* 1(1):65–92.
- National Alliance on Mental Illness. 2009. *Grading the States: The State of Public Mental Health Services Across the Nation*. Arlington, V.A.: National Alliance on Mental Illness. Retrieved December 20, 2014 (http://www.nami.org/Content/NavigationMenu/Grading_the_States_2009/Findings/NAMI_GTS09_Findings.pdf).
- Nunley, John M., Mark F. Owens, and R. Stephen Howard. 2011. "The Effects of Information and Competition on Racial Discrimination: Evidence from a Field Experiment." *Journal of Economic Behavior and Organization* 80(3):670–79.
- Nunley, John M., Adam Pugh, Nicholas Romero, and R. Alan Seals. 2015. "Racial Discrimination in the Labor Market for Recent College Graduates: Evidence from a Field Experiment." *The B.E. Journal of Economic Analysis & Policy* 15(3):1093–1125.
- Olah, Michelle E., Gregory Gaisano, and Stephen W. Hwang. 2013. "The Effect of Socioeconomic Status on Access to Primary Care: An Audit Study." *Canadian Medical Association Journal* 185(6):E263–69.
- Pescosolido, Bernice and Carol A. Boyer. 2010. "Understanding the Context and Dynamic Social Processes of Mental Health Treatment." Pp. 420–38 in *A Handbook for the Study of Mental Health: Social*

Contexts, Theories, and Systems, edited by T. L. Scheid and T. N. Brown. Cambridge; New York: Cambridge University Press.

Psychology Today. 2015. "Psychology Today Media Kit."

Rhodes, Karin V., Teri L. Vieth, Hallie Kushner, Helen Levy, and Brent Asplin. 2009. "Referral Without Access: For Psychiatric Services, Wait for the Beep." *Annals of Emergency Medicine* 54(2):272–78.

Rich, Judith. 2014. "What Do Field Experiments of Discrimination in Markets Tell Us? A Meta Analysis of Studies Conducted since 2000." *IZA Discussion Papers* (No. 8584). Retrieved December 6, 2015 (http://trafficlight.bitdefender.com/info?url=http%3A//papers.ssrn.com/sol3/papers.cfm%3Fabstract_id%3D2517887&language=en_US).

Roy-Byrne, Peter P., Jutta M. Joesch, Philip S. Wang, and Ronald C. Kessler. 2009. "Low Socioeconomic Status and Mental Health Care Use among Respondents with Anxiety and Depression in the NCS-R." *Psychiatric Services* 60(9):1190–97.

van Ryn, Michelle and Jane Burke. 2000. "The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients." *Social Science & Medicine* 50(6):813–28.

van Ryn, Michelle and Steven S. Fu. 2003. "Paved with Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health?" *American Journal of Public Health* 93(2):248–55.

Schofield, William. 1964. *Psychotherapy: The Purchase of Friendship*. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Shin, Richard, Lance L. Smith, Jamie C. Welch, and Igeoma Ezeofor. 2016. "Is Allison More Likely than Lakisha to Receive a Call Back from Counseling Professionals? A Racism Audit Study." *The Counseling Psychologist*.

Substance Abuse and Mental Health Services Administration. 2014. *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved (<http://www.samhsa.gov/data/sites/default/files/NSDUHmhr2013/NSDUHmhr2013.htm#2-4>).

Tryon, Georgiana Shick. 1986. "Client and Counselor Characteristics and Engagement in Counseling." *Journal of Counseling Psychology* 33(4):471–74.

Young, Alexander S., Ruth Klap, Cathy D. Sherbourne, and Kenneth B. Wells. 2001. "The Quality of Care for Depressive and Anxiety Disorders in the United States." *Archives of General Psychiatry* 58(1):55–61.

Figures and Tables

Figure 1a. Study 1 experimental design

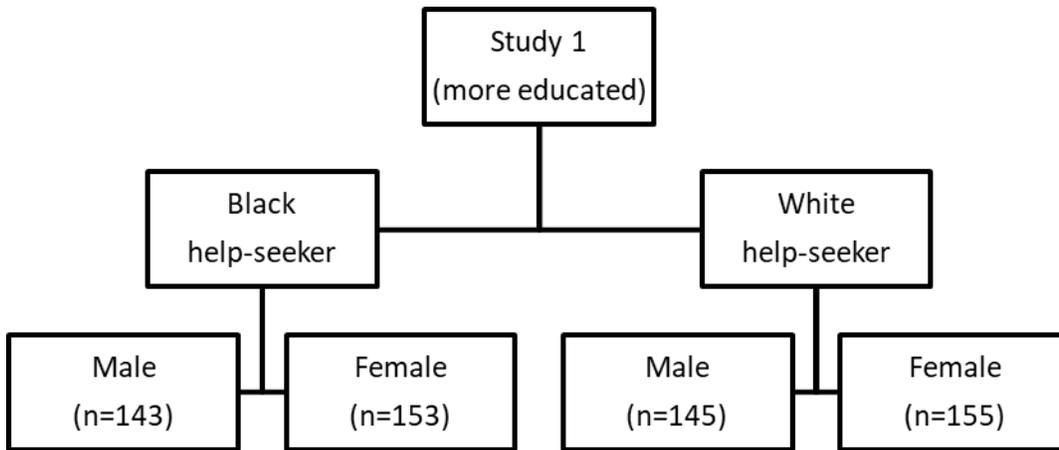


Figure 1b. Study 2 experimental design

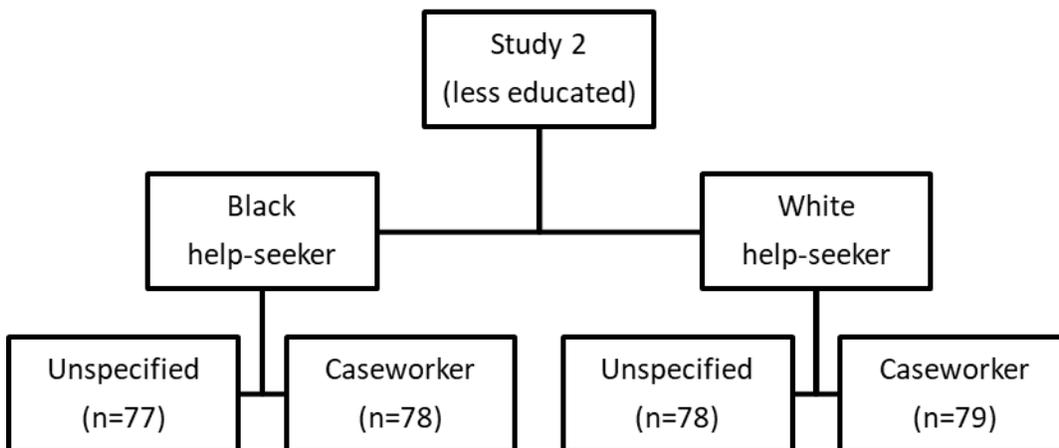
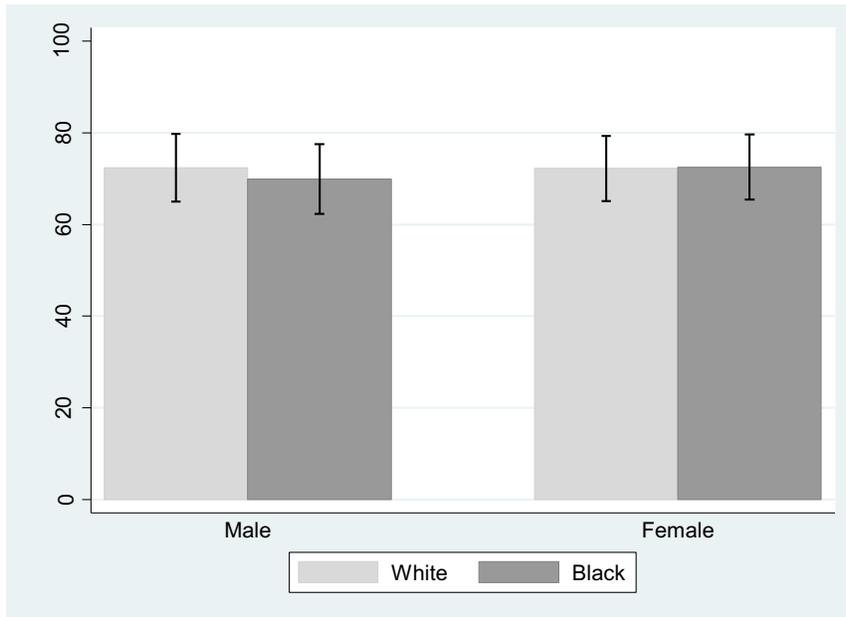
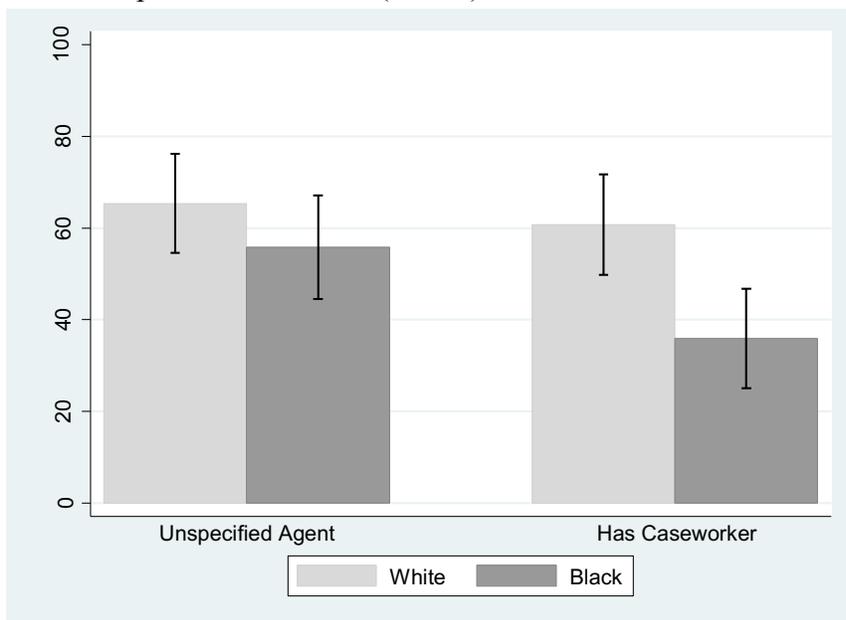


Figure 2. Study 1: Percentage of email inquiries from college educated help-seekers that elicited a positive response from MHPs (n=596)



Note: There are no statistically significant differences by help-seeker race or gender. Unadjusted 95% confidence intervals are displayed.

Figure 3. Study 2: Percentage of email inquiries from less educated help-seekers that elicited a positive response from MHPs (n=312)



Note: There are significant main effects of race and class. Black men with a caseworker received significantly fewer positive responses than the other groups. Unadjusted 95% confidence intervals are displayed.

Table 1. Response categories for Study 1 (more educated) and Study 2 (less educated)

	Study 1 % (n=596)	Study 2% (n=312)
Appt offer	64.9	47.4
Call offer	6.9	7.1
Screening question	5.0	5.8
Waitlist or referral	5.7	5.1
Rejection	2.9	8.3
No response	14.6	26.3

Table 2. Study 1 odds ratios from logistic regression predicting a positive response from a mental health care provider to a college educated help-seeker (MHP) (n=596)

	Model 1		Model 2		Model 3	
<i>Help-seeker race*gender</i>						
black male	0.89	(0.23)	0.89	(0.24)	0.88	(0.24)
white female	0.99	(0.26)	1.01	(0.27)	1.03	(0.27)
black female	1.01	(0.26)	1.02	(0.27)	0.99	(0.26)
<i>MHP sociodemographics</i>						
race (ref. white)						
black			0.99	(0.46)	1.07	(0.50)
other non-white			1.16	(0.65)	1.28	(0.72)
female			0.76	(0.16)	0.78	(0.17)
occupation (ref. PhD/PsyD)						
social worker			1.41	(0.31)	1.43	(0.33)
licensed counselor			2.32***	(0.57)	2.38***	(0.59)
region (ref. northeast)						
midwest			0.91	(0.28)	0.96	(0.30)
south			0.57*	(0.15)	0.56*	(0.15)
west			0.74	(0.20)	0.66	(0.18)
<i>MHP financial flexibility</i>						
sliding scale fee					1.26	(0.26)
free consultation					1.37	(0.28)
accepts any insurance					0.57**	(0.12)

* p<.05, ** p<.01, ***p<.001

Logit coefficients are exponentiated. Standard errors are in parentheses. The help-seeker reference group is white male.

Table 3. Study 2 odds ratios from logistic regression predicting a positive response from a mental health care provider to a less educated help-seeker (MHP) (n=312)

	Model 1	Model 2	Model 3
<i>Help-seeker race*agent</i>			
black w/ unspecified	0.67 (0.22)	0.61 (0.21)	0.62 (0.22)
white w/ caseworker	0.82 (0.27)	0.75 (0.26)	0.83 (0.30)
black w/ unspecified	0.30*** (0.10)	0.28*** (0.10)	0.29*** (0.10)
<i>MHP sociodemographics</i>			
race (ref. white)			
black		1.19 (0.70)	1.09 (0.65)
other non-white		2.64 (1.94)	2.31 (1.72)
female		0.65 (0.18)	0.66 (0.19)
occupation (ref. PhD/PsyD)			
social worker		1.21 (0.36)	1.14 (0.34)
licensed counselor		1.56 (0.50)	1.44 (0.47)
region (ref. northeast)			
midwest		1.16 (0.47)	1.28 (0.53)
south		1.31 (0.46)	1.46 (0.53)
west		0.48* (0.17)	0.44* (0.16)
<i>MHP financial flexibility</i>			
sliding scale fee			1.85* (0.49)
free consultation			1.55 (0.41)
accepts any insurance			1.03 (0.28)

* p<.05, ** p<.01, ***p<.001

Logit coefficients are exponentiated. Standard errors are in parentheses. The help-seeker reference group is a less educated white male who does not mention “someone” but not a “caseworker” (i.e., agent is unspecified).