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HOW STIGMA IMPACTS THE UTILIZATION OF MENTAL HEALTH SERVICES AMONG YOUNG ADULTS' WITHIN THREE DIFFERENT ETHNIC MINORITY COMMUNITIES

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

---

by

Ivette Garcia

Melissa Gomez

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May 2023

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ABSTRACT

Mental health is an important aspect of every individual's life. However, regardless of its importance, mental health is a topic that does not get much recognition. It is often simply brushed under the rug and ignored. Consequently, individuals who have mental health diagnoses may or may not choose to seek the necessary assistance. This specifically seems to be the case among adolescents and young adults within various ethnic communities, which may be due to the stigma surrounding mental health in their communities. To illustrate, regardless of the high prevalence rate of mental health issues among the minority youth, many of them still do not utilize the appropriate mental health services. With all that being said, this study questions how stigma influences the utilization of mental health services among young adults' within the Latino/Latinx, African American, and Asian American communities through the descriptive, secondary data analysis of the UCLA Center for Health Policy Research 2021 California Health Interview Survey (CHIS) data. The key hypothesis for this study was that a major factor on whether or not these young adults' speak out and seek help in regards to their mental health is the stigma that their race and ethnicity face. Descriptive analysis was utilized to identify frequencies of variables, quantitative analysis techniques were used to analyze the additional CHIS data, and a multiple logistic regression was conducted in order to identify any significant relationships between the variables. The findings of this research

study indicate that stigma associated with mental health may not be the only factor in determining young adults' utilization of mental health services.

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DEDICATION

To my beloved family: Thank you for always being there for me and continually supporting me through all the good, the bad, and the ugly these past couple of years. I truly would be nowhere without all of you. Siempre estaré muy agradecida de que nunca hayan dejado de creer en mí. Mom, Dad, as always, this is for you!

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Ivette Garcia

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CHAPTER ONE

INTRODUCTION

Problem Formulation

As stated by the Center for Disease Control and Prevention (CDC), "Mental health is important at every stage of life, from childhood and adolescence through adulthood" (Mental Health, 2021). Despite this importance, mental health is something many individuals do not feel comfortable seeking the necessary help for. This specifically seems to be the case among adolescents and young adults within various ethnic communities, which may be due to the stigma surrounding mental health in their communities. For example, as mentioned by DuPont-Reyes, Villatoro, Phelan, Painter, and Link (2020), it's extremely common for adolescents and young adults to experience a mental health stigma within the Latino community.

Mental health concerns is an issue that has been increasing over time, yet, individuals with such diagnoses continue to be hesitant about utilizing the appropriate services. To illustrate, mental health disorders such as anxiety, depression, and behavioral disorders have increased over the years among adolescents and young adults in the Latino community (Caqueo-Urízar, Flores, Escobar, Urzúa, and Irarrázaval, 2020). Additionally, other people of color have shown an increase in vulnerability to mental health disorders due to their constant exposure to racial stigma and discrimination (Swann, Stephens, Newcomb, and Whitton, 2020). Regardless of the high prevalence rate of mental

health issues among the minority youth, many of them still do not utilize the appropriate mental health services. To illustrate, in a study conducted by Green et al. (2020), although 21.4% of young adults in their sample met the criteria for having a mental disorder, only 3.5% of them actually received any treatment.

Studying how stigma impacts the utilization of mental health services among young adults' within three different ethnic minority communities was important for social work for a number of reasons. It gave us the opportunity to better understand just how much stigma and other factors contribute to young adults' non-utilization of services as well as the ability to empower them to seek treatment and actually utilize the services that are available for them. Also, as a result of having done so, future mental health issues may be prevented; early discussion, detection, and prevention are critical during this age period. If not detected and treated in time, mental health problems in youth can often continue, and may even worsen, during adulthood (Caqueo-Urizar et al., 2020). Furthermore, it has allowed us to spread awareness within the three different ethnic minority communities, thus, possibly having decreased reluctance in utilizing mental health services.

It was also important to study the communities *together* as they are all ethnic minorities, therefore, it allowed us to conduct research on just how much of an impact each community's ethnicity has on its young adult's decision to utilize mental health services. Moreover, we recognized some similarities in terms of oppression, stigma, structure, and the challenges they face in accessing

mental health services. With that being said, it was demonstrated that despite any ethnic differences, young adults' in each community share many similar reasons for their little to low utilization of mental health services.

The findings we got from this study contribute to social work practice because we got a better understanding of how stigma and other factors contribute to adolescents and young adults in these communities preferring to keep their mental health issues to themselves and not utilize mental health services. We are now able to focus our efforts on creating more appropriate interventions that will address the *how* and possibly even get them to actually initiate the discussion on their mental health and seek appropriate services. We can now also raise awareness on the issue, normalize mental health, and reduce the stigma in these communities. Additionally, it is possible that with these findings, we may now be able to impede current mental health diagnoses from worsening over time and progressing to other issues.

With all that being said, the question this research project intended to answer is: How does stigma impact the utilization of mental health services among young adults' within the Latino/Latinx, African American, and Asian American communities?

CHAPTER TWO

LITERATURE REVIEW

Introduction

Mental health is an important aspect of every individual’s life. However, regardless of its importance, mental health is a topic that does not get much recognition. It is often simply brushed under the rug and ignored. Consequently, individuals who have mental health diagnoses may or may not choose to seek the necessary assistance. To illustrate, prevailing reasons for not utilizing mental health services include being uncomfortable sharing personal information, expected absence of use of treatment, social stigma, and the fear of going against community norms (Mokkarala, O’Brien, & Siegel, 2015). With that being said, the following literature review analyzed relevant research looking at how stigma, and other relevant factors, impact the utilization of mental health services among young adults’ within three different ethnic minority communities. It was suspected that a major factor on whether or not they speak out and seek help is the stigma that their race and ethnicity face. To illustrate, the potency of mental illness stigma is one factor as to why some members of ethnic minority groups choose not to solicit or appropriately partake in treatment despite that they would most likely benefit from doing so (Gary, 2005). Therefore, this review looked at the reasoning behind why young adults from various ethnic communities choose not to use mental health services; there was a focus on the stigma that comes with mental health. The subsections examined each ethnicities' reasons

separately and then stated the similarities and differences found across three different ethnicities. The last subsection identified, defined, and applied theoretical perspectives that have guided past research and those that guided this study as well.

Reasons for the Low Utilization of Mental Health Services

Latinos/Latinx

As found by Jimenez et al. (2020), Latinos have a 16.4% lifetime prevalence rate for any depressive disorder and a similar 15.3% one for any anxiety disorder. These statistics may be related to the increase in suicidal ideations, plans, and attempts observed in about the last ten years by young adults in the Latino community. To illustrate, in 2009, about 329,000 Latino young adults had serious suicidal thoughts, 134,000 made a plan, and 74,000 attempted; ten years later about 754,000 had serious suicidal thoughts, 245,000 made a plan while 91,000 attempted (Substance Abuse and Mental Health Services Administration, 2021). The reasoning behind why young adults choose whether or not to discuss mental health and use mental health services may play a significant role in this increase.

There are a variety of reasons as to why individuals from the Latino community ponder whether or not they want to share their experience with mental health and seek the necessary help. Language issues, cultural differences, poverty status, health insurance status, transportation, and lengthy waiting times were identified as barriers that prevented Latino youths from

accessing mental health care (Yeh, McCabe, Hough, Dupuis, and Hazen, 2003). Additionally, other studies still find that Latinos/Latinx continue to face a number of impediments related to mental health. For example, the stigma related with mental health services, fear about legal issues, concerns about racism, and cultural miscommunication all influence the utilization of mental health services (Rastogi, Massey-Hastings, & Wieling, 2012).

It was also mentioned by Parra-Cardona and DeAndrea (2016) that Latinos may experience limitations like having restricted access, language and financial boundaries, and poor health insurance. The National Alliance on Mental Illness (NAMI) provides even further evidence that language, poverty, less health insurance coverage, lack of cultural competence, legal status, acculturation and stigma are all barriers to mental health care for the Latinx community (National Alliance on Mental Illness, 2021). Furthermore, lack of awareness and a negative community attitude also seem to be an issue. For instance, as found by Rastogi et al. (2012), individuals believed that greater mental health awareness would help them since it would influence the community's attitude. Lastly, family bonds are yet another preventative factor to speaking on mental health. "Cohesive familial bonds appear to discourage service use on the part of Latino Americans…" (Chang, Natsuaki, & Chen, 2013).

African Americans

As stated by Asnaani et al. (2010), 8.6% of African Americans are diagnosed with Social Anxiety Disorder, 4.9% with Generalized Anxiety Disorder,

3.8% with Panic Disorders, and a high rate of 12.8% with depression. To make matters worse, it is very common for African Americans to experience disadvantages when receiving and seeking mental health services (Holden & Xanthos, 2009). For example, when receiving mental health services, African Americans are more likely to be given poor quality services or treatment compared to other ethnicities (Holden & Xanthos, 2009). Consequently, this may result in African Americans not wanting to discuss their mental health, nor receive any sort of treatment or services. Additionally, another imperative factor for why African Americans have difficulty talking about their mental health is the financial barrier to both mental health services and treatment (Holden & Xanthos, 2009).

Holden and Xanthos (2009) also stated, "It has been argued that the stigma associated with mental illness in the African American community reduces African Americans' willingness to seek mental health services." This shows that they may not feel comfortable and may feel shame when seeking help for their mental health problems. Furthermore, African Americans may experience cultural mistrust when communicating with their mental health service provider and this can cause them to refuse to receive assistance (Holden & Xanthos, 2009).

Another factor that can cause African Americans to be reluctant about discussing their mental health and seeking services is the poor quality of mental health services that are provided to them. For instance, it is very common for African Americans to face inequality in mental health services, such as

discrimination and racism (Holden & Xanthos, 2009). This will consequently result in African Americans being misdiagnosed and inappropriately prescribed medications for their mental health disorders (Holden & Xanthos, 2009). Therefore, if continued to be provided this kind of treatment and service, it is possible that they become hesitant to seek any type of assistance. Similarly, due to mental health services' lack of understanding their cultural background, African Americans do not want to speak about their mental health with professionals or utilize the appropriate services (Holden & Xanthos, 2009).

Asian Americans

According to Arora and Khoo (2020), Asian American youth experience a high risk of mental health problems, such as low levels of self esteem, social stress, depression, and risk of suicide. Furthermore, it appears that gender and age also play a role in mental health outcomes. For example, female Asian American young adults between the ages of 15 to 24 have a much higher rate of suicide compared to African American and Hispanic females (Arora & Khoo, 2020).

Moreover, although Asian Americans require a higher level of needs for their mental health and have a much higher risk for suicide, they are less likely to receive services (Arora & Khoo, 2020). As stated by Arora and Khoo (2020), Asian American adolescents' number one cause of death is intentional self-harm or suicide. This may be due to the lack of knowledge about services and resources available to them within their community. For instance, Asian

American adolescents reported that they are less likely to be aware of their schools mental health services (Arora & Khoo, 2020).

Asian American young adults experience barriers that include poor mental health literacy as well as an increase in shame and stigma about their mental health problems. The role of family has also been found to have an impact on seeking mental health services. As stated by Arora and Khoo (2020), a crucial influence on Asian American adolescents' underutilization of mental health services is their family, making it challenging for them to discuss with their parents about mental health problems. Therefore, this shows that Asian Americans may steer away from communicating about mental health with their parents.

Similarities and Differences

Latinos/Latinx and Asian Americans seem to be in agreement about the impact familial bonds have on their decision to speak about their mental health. They both also reported to lack awareness and knowledge of mental health services available to them. Additionally, Asian Americans and African Americans share the fear of feeling shameful when communicating their mental health with others. As for Latinos/Latinx and African Americans, their reasons for being hesitant to share about their mental health seem to have the most resemblance. For instance, as previously stated, both ethnic groups struggle with cultural differences, lack of cultural competency, concerns of racism, cultural miscommunication, and financial limitations when seeking proper mental health

services. Lastly, in regards to similarities, all three ethnic groups reported experiencing the stigma surrounding mental health.

We acknowledge that the cultural and historical experience of Latinos/Latinx, African Americans, and Asian Americans are different, however, they all shared similar experiences with the stigma associated with mental health. All of the aforementioned factors played a role in whether or not these ethnic minority groups shared their mental health experiences and utilized the necessary services to help deal with them. Now, although all these various factors are critical, this specific study concentrated on how *stigma* impacts the utilization of mental health services among young adults' within the Latino/Latinx, African Americans, and Asian American communities.

Theories Guiding Conceptualization

A framework that has guided past mental illness research and was applied to this research is the *Framework Integrating Normative Influences on Stigma (FINIS)*. This framework focuses on the idea that varying levels of social life set the standard expectations that occur during the process of stigmatization (Pescosolido, Martin, Lang, & Olafsdottir, 2008). We applied FINIS to this research question by arranging the previously identified characteristics in a manner that demonstrates how they affect the stigma on mental health. For instance, race and ethnicity as well as age are social characteristics that have an impact on attitudes towards mental health. The strength of a familial bond and a

network’s valence are social network characteristics that also affect how individuals view mental illnesses (Pescosolido et al., 2008).

Another framework that was useful for this research was the Andersen Behavioral Model of Utilization as it has guided the analysis of factors that are linked with individual’s utilization of healthcare services (Phillips, Morrison, Andersen, & Aday, 1998). As stated by Andersen (1995), the phase 4 emerging model “portrays the multiple influences on health services’ use and, subsequently, on health status.” Moreover, this model also incorporates feedback loops that show that outcome affects predisposing factors, perceived services need, and health behavior (Andersen, 1995). Therefore, it was an appropriate framework when attempting to analyze and arrange the aforementioned factors contributing to the utilization of mental health services among young adults’ within Latino/Latinx, African American, and Asian American communities. For example, factors related to health care systems were considered environmental characteristics under this model while health behavior factors included use of health services. Additionally, identified population factors can be arranged as predisposing characteristics, enabling resources, or need factors (Andersen, 1995).

The FINIS is a valuable tool that was utilized to have a better understanding of how mental illness stigma occurs and negatively affects young adults’. Andersen’s Behavioral Model of Utilization was used to gain some insight into how various factors contributed to young adults’ utilization of mental health

services. A better insight on both of these issues made it possible to bring more awareness to the communities that this study focused on. FINIS was of use when attempting to reduce the stigma surrounding mental health, while Andersen's model helped explain the access and use of services for mental health. Thus, the potential reduction of stigma could now possibly increase individuals' willingness to speak up and seek the necessary mental health services.

Summary

Mental health and the stigma surrounding it continues to negatively affect many individuals as it prevents them from discussing their experience and seeking services to help them. It has been found that ethnicity and race play a big factor on young adults' decisions to not speak about their experiences with mental health and utilize the appropriate services. Therefore, this literature review showed some of the factors impacting the utilization of mental health services among young adults' within three different ethnic minority communities. The three ethnicities that we focused on, Latinos/Latinx, African Americans, and Asian Americans, did demonstrate both similarities and differences in their factors. Lastly, the *Framework Integrating Normative Influences on Stigma* and the Andersen Behavioral Model of Utilization were also identified and examined as useful frameworks that helped guide this study.

CHAPTER THREE

METHODS

Introduction

This research study aimed to identify and analyze how stigma contributes to young adults' decision regarding whether or not to utilize mental health services. Furthermore, this study took a look into racial differences in mental health service utilization. This study concentrated on three ethnic minority groups: Latinos/Latinx, African Americans, and Asians. The following chapter will describe the way in which the study was done.

Study Design

The purpose of this study was to examine how stigma plays a role in young adults, from different ethnicities, utilizing mental health services available to them. This study was best addressed by a descriptive, secondary data analysis. The data we utilized was from the 2021 California Health Interview Survey (CHIS) conducted by the UCLA Center for Health Policy Research. CHIS is a population-based telephone and web survey of households and it aims to provide these estimates for California's entire population as well as for its major ethnic groups. A strength of the utilization of CHIS data was that it has been collected by a highly regarded research center that is well funded. Additionally, it allowed for the analysis of both a larger and more representative sample size. However, a disadvantage of utilizing CHIS data was that the questions that were

asked were not constructed specifically to our research needs. Moreover, we did not have the opportunity to gain knowledge on participants' own personal experiences since they were restricted to a limited range of answers.

Sampling

As previously mentioned, our sample size was derived from secondary data collected through UCLA's Center for Health Policy Research CHIS. This consisted of data from all 58 counties in California, resulting in a random sample size of over twenty thousand California residents. These twenty thousand participants included a population of approximately 5,861 self-reported Latinos/Latinx, African Americans, and Asians, which are the three ethnic minority groups this study will be focusing on. In addition, we concentrated on the data reported from young adults, aged eighteen through twenty-five.

Data Collection and Instruments

In order to acquire the 2021 CHIS confidential data required for this study, it was necessary for the two researchers conducting this study to write and send the appropriate syntax to the UCLA statisticians. The data was then received once the statisticians ran the syntax and uploaded the output to the researchers' data access center. CHIS participants' demographic data was analyzed; such data included participants' ethnicity, race, gender, education level, employment status, immigrant status, and age. CHIS asked about these demographic factors utilizing various levels of measurements. For example, age was measured at an

interval/ratio level, while immigration status was measured at a nominal level. Furthermore, CHIS participants' experiences with mental health were also examined. These experiences were mainly asked utilizing a 1-5 point Likert scale that corresponded with "all of the time", "most of the time", "some of the time", "a little of the time", and "none of the time" (CHIS, 2021). Some of the items are (a) "About how often during the past 30 days did you feel hopeless?"; (b) "About how often during the past 30 days did you feel so depressed that nothing could cheer you up?"; and (c) "About how often during the past 30 days did you feel worthless?" (CHIS, 2021).

The dependent variables (DV) were the young adults' utilization of mental health services and were measured through a set of questions from the CHIS questionnaire as well. These questions were asked with the same approach; participants had to select "yes" or "no" for whether the statement applied to them. The first dependent variable was (a) "In the past 12 months have you seen your primary care physician or general practitioner for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?"; and the second dependent variable was (b) "In the past 12 months have you seen any other professional, such as a counselor, psychiatrist, or social worker for problems with your mental health, emotions, nerves, <u>or</u> your use of alcohol or drugs?" (CHIS, 2021).

The independent variables (IV) were the stigma on mental health and CHIS's preexisting questions related to stigma were utilized to measure this. For

example, the questionnaire consisted of four reasons people have chosen to not seek mental health help despite believing they might need it. Respondents were required to select “yes” or “no” to each statement with regards to whether or not the statement applied to their reasoning for not seeking professional help. The four items were (a) “You were concerned about the cost of treatment”; (b) “You did not feel comfortable talking with a professional about your personal problems”; (c) “You were concerned about what would happen if someone found out you had a problem”; and (d) “You had a hard time getting an appointment” (CHIS, 2021). Other independent variables included: needing help for emotional/mental or alcohol/drug problems in the past year, work status in the past week, citizenship status, having been born in the United States, highest level of education completed, serious psychological distress, K6 score, poverty level, and insurance coverage for mental health problems.

Procedures

Utilizing a mixed-mode survey, both web and telephone, CHIS randomly sampled California addresses for 2020-2021 (CHIS, 2021). The randomly selected addresses were then sent various invitation letters soliciting that one adult member within each household complete the study via telephone or web through the use of a secure access code (CHIS, 2021). The survey was offered in a variety of languages, such as: English, Spanish, Chinese, Korean, Vietnamese, and Tagalog. As for the specific CHIS data that was utilized for this project, public demographic data was analyzed by the two researchers who

conducted the study while the more confidential mental health details were examined by UCLA statisticians. These statisticians ran the requested analyses within the data access center and sent back completed output to the researchers.

Protection of Human Subjects

Considering that this study was done utilizing a secondary data analysis method, the researchers did not make any direct contact with human subjects. Nonetheless, it should be noted that UCLA's Center for Health Policy Research was sure to follow all proper regulations to guarantee that appropriate measures were in place to ensure the protection and confidentiality of all their survey's participants. To illustrate, upon completion of the survey, all personal contact information such as names, addresses, telephone numbers, and birth dates were separated from participants' responses. In addition, no researcher ever saw the personal contact information and it was automatically destroyed at the end of the survey. The UCLA Center for Health Policy Research was also sure to acquire a Certificate of Confidentiality from the National Institutes of Health to protect their participants' privacy. Furthermore, despite the lack of any identifying information, all CHIS data that was utilized will still be kept on a password protected USB drive that will only be accessible by the two researchers conducting this study. Any and all information stored on the USB drive will be erased after three years of the study being completed.

Data Analysis

Descriptive analysis was utilized to identify frequencies of ethnicity, race, gender, education level, employment status, immigrant status, and age. Quantitative analysis techniques were also used to analyze the additional CHIS data. Binary logistic regressions were conducted in order to identify any significant relationships between young adult’s utilization of mental health services (IV) and the stigma on mental health (DV). How stigma influenced participants’ utilization of mental health services was also analyzed as part of this study. All the data was coded, entered electronically, and examined statistically through Statistical Package for the Social Sciences (SPSS).

Summary

This study intended to identify and examine how stigma influences some young adults' utilization of mental health services through the secondary data analysis of the 2021 California Health Interview Survey data. In order to obtain the imperative data that was needed for this research, this was the most effective study design to utilize. CHIS asked a number of demographic questions as well as inquired about the stigmatization of mental health and how much of an impact it has had on participants’ utilization or non utilization of mental health services.

CHAPTER FOUR

RESULTS

Introduction

The information provided in this chapter is data received from the UCLA Center for Health Policy Research, which was obtained from the 2021 California Health Interview Survey (CHIS). Data presented includes demographic variables such as gender and ethnicity as well as binary logistic regressions demonstrating relationships between various aforementioned variables. A presentation of these findings will be reported in this chapter.

Presentation of Findings

Demographics

The sample (N= 1,395) was retrieved from secondary data collected through UCLA's Center for Health Policy Research CHIS and consisted of young adults, aged eighteen through twenty-five, from 58 counties in California. As demonstrated in Table 1, the sample consisted of 768 females (55.1%) and 627 males (44.9%). Table 2 shows that the majority of the participants were Asian (49.0%), followed by White (24.9%), Latino/Hispanic (16.4%), and African American (5.6%).

Table 1. Self-Reported Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MALE	627	44.9	44.9	44.9
	FEMALE	768	55.1	55.1	100.0
	Total	1395	100.0	100.0	

Table 2. Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00 (White)	348	24.9	24.9	24.9
	2.00 (Latino/Hispanic)	229	16.4	16.4	41.4
	3.00 (Asian)	684	49.0	49.0	90.4
	4.00 (African American)	78	5.6	5.6	96.0
	5.00+ (Multi Ethnic)	56	3.9	3.9	100.0
	Total	1395	100.0	100.0	

Binary Logistic Regressions

According to the Omnibus Tests of Model Coefficients (Table 3), the model utilized to run the first binary logistic regression was significant as the p-value was less than 0.001. In other words, with the independent variable the model significantly improved the prediction of the dependent variables over and above the model with the independent variable. For example, in Block 0 the percentage correct was 84.7% (Table 4) while in Block 1 the percentage correct was 92.5% (Table 5), indicating a 7.8% improvement. Additionally, as seen in Table 6, the model is further supported by the Hosmer and Lemeshow Test since a p-value more than 0.05 indicates a good fit and the model’s significance was 0.936.

With that being said, there were significant relationships found between participants' seeking their primary care physician or general physician for problems related to their mental health, emotions, nerves, or their use of alcohol/drugs (DV) and a couple of the independent variables tested. To illustrate, independent variables such as poverty level, ethnicity, and needing professional help with those same problems appeared to predict the dependent variable, especially ethnicity. As seen in Appendix A, poverty level(1) had a significance of 0.016, therefore, it was working with the second group when referred back to the first group. Appendix A also demonstrates that ethnicity was working in many areas; it can be seen that the first ethnicity (White) had a significance of 0.003, the second (Latino/Hispanic) had a significance of 0.001, the third (Asian) had a significance of 0.017, and the fifth (Multi Ethnic) a significance of 0.009. Lastly, as shown in Appendix A, requiring professional help for the problems listed in the dependent variable (mental health, emotions, nerves, or use of alcohol/drugs) had a significance less than 0.001.

Table 3. Omnibus Tests of Model Coefficients (DV #1)

		Chi-square	df	Sig.
Step 1	Step	669.098	47	0.000
	Block	669.098	47	0.000
	Model	669.098	47	0.000

Table 4. Classification Table[a,b] (DV #1)

Observed			Predicted		
			SEEN PCP		Percentage Correct
			1.00	2.00	
Step 0	SEEN PCP FOR MENTAL/ALCOHOL/DRUG PROBLEMS	1.00	0	213	0.0
		2.00	0	1182	100.0
	Overall Percentage				84.7

Table 5. Classification Table[a] (DV #1)

Observed			Predicted		
			SEEN PCP		Percentage Correct
			1.00	2.00	
Step 1	SEEN PCP FOR MENTAL/ALCOHOL/DRUG PROBLEMS	1.00	167	46	78.4
		2.00	59	1123	95.0
	Overall Percentage				92.5

Table 6. Hosmer and Lemeshow Test (DV #1)

Step	Chi-square	df	Sig.
1	2.970	8	0.936

Similarly, for the second independent variable run, the Omnibus Tests of Model Coefficients (Table 7) demonstrated that the model was still significant since the p-value continued to be less than 0.001. Again, each time the model is still improving or, in other words, improvement can be seen in including the variables from the base model. To illustrate, the percentage correct in Block 0 (Table 8) was 80% while in Block 1 it was 94.8% (Table 9), indicating an improvement of 14.8%. Moreover, based on the Hosmer and Lemeshow Test (Table 10) the model continued to be a good fit due to its p-value of 0.882.

Unfortunately, despite this, there was only one significant relationship found between participants' seeing other professionals, such as counselors, psychiatrists, or social workers for problems with their mental health, emotions, nerves or their use of alcohol/drugs (DV) and all of the independent variables tested. The one independent variable that appeared to predict the dependent variable was participants' scores on the K6 Mental Health Assessment. As shown in Appendix B, K6 scores had a significance of 0.012.

Table 7. Omnibus Tests of Model Coefficients (DV #2)

		Chi-square	df	Sig.
Step 1	Step	982.350	47	0.000
	Block	982.350	47	0.000
	Model	982.350	47	0.000

Table 8. Classification Table[a,b] (DV #2)

Observed			Predicted		
			SEEN OTHER PROF.		Percentage Correct
			1.00	2.00	
Step 0	SEEN OTHER PROF. FOR MENTAL/ALCOHOL/DRUG PROBLEMS	1.00	0	279	0.0
		2.00	0	1116	100.0
	Overall Percentage				80.0

Table 9. Classification Table[a] (DV #2)

Observed			Predicted		
			SEEN OTHER PROF.		Percentage Correct
			1.00	2.00	
Step 1	SEEN OTHER PROF. FOR MENTAL/ALCOHOL/DRUG PROBLEMS	1.00	245	34	87.8
		2.00	39	1077	96.5
	Overall Percentage				94.8

Table 10. Homser and Lemeshow Test (DV #2)

Step	Chi-square	df	Sig.
1	3.712	8	0.882

Summary

This chapter presented the results of statistical analyses conducted on data provided by the UCLA Center for Health Policy Research, which was obtained from the 2021 California Health Interview Survey (CHIS). Demographic data such as age, gender, and ethnicity was discussed as well as the results of the binary logistic regressions that were run.

CHAPTER FIVE

DISCUSSION

Introduction

The following chapter will discuss inferences and suggestions that can be thought of in response to the statistical analysis results as well as major similarities and differences to previous literature that can be linked to the findings. In addition, the strengths and limitations of this research study will be addressed. Lastly, the impact of the findings of this study on future research will also be examined.

Discussion

The results from the first binary logistic regression suggests that there is a significant relationship between participants seeing their primary care physician (PCP) or general practitioner for problems with their mental health, emotions, nerves, or their use of alcohol/drugs (DV) and their poverty level (IV) and ethnicity (IV). There also appears to be a significant relationship between seeing their PCP and needing professional help due to those same problems (IV). This is similar to findings from the study conducted by Yeh et al. (2003), that found that poverty status was identified as one of the barriers preventing Latino youths from accessing mental health care. Additionally, the National Alliance on Mental Illness (2021) also provides evidence that poverty is an impediment to mental health care in the Latinx community.

Nonetheless, there are no significant relationships between any other independent variables that were run. To illustrate, contrary to the researchers' beliefs, seeking out their PCP had a non significant relationship with being uncomfortable sharing, appointment availability, serious psychological distress, and citizenship. This differs from the findings of a study conducted by Mokkarala et al. (2015), which found that a prevailing reason for young adults' not utilizing mental health services included not feeling comfortable sharing personal information. It also differs from a study conducted by Rastogi et al. (2012) that found that fear about legal issues influences mental health service utilization.

As for the second binary logistic regression that was run, there is a significant relationship between participants seeing other professionals, such as counselors, psychiatrists, or social workers for problems with their mental health, emotions, nerves or their use of alcohol/drugs (DV) and their K6 Mental Health Assessment score (IV). For example, the higher a participants' score was on the K6 (otherwise, the more distressed they were), the more likely they were to see any of the aforementioned professionals. Similar to the first binary logistic regression, this dependent variable did not appear to have significant relationships with any of the other independent variables. This also differs from previous literature as findings from a study conducted by Parra-Cardona and DeAndrea (2016) found that Latinos may experience limitations like poor health insurance and financial boundaries that prevent them from seeking appropriate mental health services. However, this study found that neither insurance

coverage nor cost of treatment had a significant impact on participants seeking mental health professionals.

Strengths and Limitations

A strength of this research study was that the data was collected and received from a highly regarded, well funded research center. Furthermore, a larger and more representative sample size was able to be analyzed by utilizing this data. As far as limitations go, a huge time constraint was faced as the application process to obtain access to this data was rather time consuming and there was even an additional wait time for the UCLA statisticians to run the provided syntax. Another limitation is that the two researchers who conducted the study were not able to actually see the data until the syntax was run and the output was returned by the UCLA statisticians. This resulted in the researchers being unable to alter or modify the data as necessary. Lastly, the researchers were unable to utilize the majority of questions related to stigma that were included in the CHIS questionnaire due to confidentiality issues.

Future Research

The findings we got from this study allowed us to get a better understanding of how stigma is not the leading factor that contributes to adolescents and young adults in these ethnic minority communities preferring to keep their mental health issues to themselves and not utilize mental health services. Other factors such as ethnicity, poverty levels, and K6 scores also

appear to have a significant impact on these individuals' underutilization of mental health services. Therefore, future research may choose to focus more of their efforts on examining such factors rather than simply concentrating on stigma as the primary factor of mental health services not being utilized as often as they should. Furthermore, a suggestion for any future research on this topic would be to take a more direct approach when gathering the necessary data. For example, if given the opportunity, the researchers believe that a questionnaire with a deeper focus on mental health would have allowed for even further insight on the topic. It is possible for this to be accomplished by creating a questionnaire geared specifically towards any future research questions rather than utilizing data from a pre-existing survey.

Conclusion

This study was conducted to understand the way in which stigma impacts the utilization of mental health services among young adults' within three different ethnic minority communities. Data analysis revealed that, contrary to the researchers' hypothesis, stigma is not necessarily the leading cause of mental health service underutilization by young adults from these communities. Other factors such as ethnicity, poverty level, and distress level also play an important role on whether or not these individuals seek the appropriate services for their mental health needs. Based on the findings of this study and the literature provided, it is evident that there are a number of other factors at play when it

comes to the utilization of mental health services. This should be acknowledged when conducting future research on this topic.

APPENDIX A:

VARIABLES IN THE EQUATION (DV #1)

Variables in the Equation (DV #1)

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B)	
								Lower	Upper
Step 1a	AF81R(1)	3.125	0.832	14.124	1	0.000	22.762	4.461	116.146
	AK1R			3.309	3	0.346			
	AK1R(1)	0.354	0.800	0.196	1	0.658	1.424	0.297	6.835
	AK1R(2)	-0.542	0.348	2.434	1	0.119	0.581	0.294	1.149
	AK1R(3)	0.062	0.272	0.051	1	0.821	1.064	0.624	1.812
	CITIZEN1R			1.968	3	0.579			
	CITIZEN1R(1)	0.332	0.482	0.474	1	0.491	1.393	0.542	3.582
	CITIZEN1R(2)	0.948	0.783	1.467	1	0.226	2.580	0.557	11.959
	CITIZEN1R(3)	-0.113	0.583	0.037	1	0.846	0.893	0.285	2.802
	AH47_R			15.771	22	0.827			
	AH47_R(1)	-1.223	32952.540	0.000	1	1.000	0.294	0.000	
	AH47_R(2)	-17.797	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(3)	-0.530	35131.442	0.000	1	1.000	0.589	0.000	
	AH47_R(4)	-1.653	29373.940	0.000	1	1.000	0.191	0.000	
	AH47_R(5)	-16.579	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(6)	-18.739	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(7)	-18.023	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(8)	-17.822	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(9)	-18.329	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(10)	-17.081	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(11)	-17.793	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(12)	-16.933	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(13)	-16.537	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(14)	-17.983	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(15)	-18.947	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(16)	-18.956	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(17)	-17.065	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(18)	-17.388	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(19)	-17.580	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(20)	-19.463	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(21)	-18.864	20784.152	0.000	1	0.999	0.000	0.000	
	AH47_R(22)	0.181	45248.821	0.000	1	1.000	1.199	0.000	
	DID NOT SEEK PROF HELP: COST OF TREATMENT			0.000	2	1.000			
	DID NOT SEEK PROF HELP: COST OF TREATMENT(1)	22.408	3744.890	0.000	1	0.995	5391658943.461	0.000	
	DID NOT SEEK PROF HELP: COST OF TREATMENT(2)	22.497	4423.541	0.000	1	0.996	5893678175.012	0.000	
	DID NOT SEEK PROF HELP: NOT COMFORTABLE			0.000	1	1.000			
	DID NOT SEEK PROF HELP: NOT COMFORTABLE(1)	-0.027	4372.032	0.000	1	1.000	0.973	0.000	
	DID NOT SEEK PROF HELP: HARD TO GET APPNT			0.000	1	1.000			
	DID NOT SEEK PROF HELP: HARD TO GET APPNT(1)	-0.141	5219.069	0.000	1	1.000	0.868	0.000	
	SERIOUS PSYCHOLOGICAL DISTRESS	-0.010	0.037	0.079	1	0.779	0.990	0.920	1.065
	SERIOUS PSYCHOLOGICAL DISTRESS FOR WORST MONTH PAST YR (K6 SCORE)	-0.037	0.032	1.324	1	0.250	0.964	0.906	1.026

Variables in the Equation (DV #1) Continued

POVERTY LEVEL			12.116	3	0.007			
POVERTY LEVEL(1)	-0.922	0.384	5.749	1	0.016	0.398	0.187	0.845
POVERTY LEVEL(2)	0.416	0.395	1.107	1	0.293	1.516	0.698	3.290
POVERTY LEVEL(3)	-0.293	0.343	0.726	1	0.394	0.746	0.381	1.463
INS COVERS TREATMENT FOR MNTL HEALTH PROBLEMS			3.306	2	0.191			
INS COVERS TREATMENT FOR MNTL HEALTH PROBLEMS(1)	-1.344	0.812	2.738	1	0.098	0.261	0.053	1.282
INS COVERS TREATMENT FOR MNTL HEALTH PROBLEMS(2)	-0.951	0.920	1.069	1	0.301	0.386	0.064	2.345
Ethnicity (White)			27.275	7	0.000			
Ethnicity(1)	-1.120	0.380	8.706	1	0.003	0.326	0.155	0.687
Ethnicity(2)	-1.002	0.302	11.012	1	0.001	0.367	0.203	0.664
Ethnicity(3)	1.563	0.655	5.689	1	0.017	4.775	1.321	17.252
Ethnicity(4)	0.158	0.901	0.031	1	0.861	1.171	0.200	6.850
Ethnicity(5)	-2.484	0.956	6.747	1	0.009	0.083	0.013	0.544
Ethnicity(6)	-0.020	1.271	0.000	1	0.987	0.980	0.081	11.827
Ethnicity(7)	19.085	19566.715	0.000	1	0.999	194321399.025	0.000	
Constant	19.653	20784.152	0.000	1	0.999	342780874.572		

APPENDIX B:

VARIABLES IN THE EQUATION (DV #2)

Variables in the Equation (DV #2)

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B)	
								Lower	Upper
Step 1a	AF81R(1)	20.566	1910.828	0.000	1	0.991	854756926.549	0.000	
	AK1R			2.519	3	0.472			
	AK1R(1)	-1.303	0.866	2.261	1	0.133	0.272	0.050	1.485
	AK1R(2)	0.130	0.398	0.108	1	0.743	1.139	0.522	2.485
	AK1R(3)	-0.013	0.335	0.002	1	0.969	0.987	0.511	1.905
	CITIZEN1R			2.096	3	0.553			
	CITIZEN1R(1)	0.587	0.571	1.057	1	0.304	1.799	0.587	5.509
	CITIZEN1R(2)	0.376	0.782	0.231	1	0.631	1.456	0.314	6.749
	CITIZEN1R(3)	0.706	0.690	1.045	1	0.307	2.025	0.523	7.839
	AH47_R			24.887	22	0.303			
	AH47_R(1)	-0.016	33755.335	0.000	1	1.000	0.984	0.000	
	AH47_R(2)	-17.053	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(3)	1.946	35766.993	0.000	1	1.000	7.002	0.000	
	AH47_R(4)	1.362	30718.102	0.000	1	1.000	3.905	0.000	
	AH47_R(5)	-16.229	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(6)	-18.605	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(7)	-15.302	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(8)	-14.920	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(9)	-16.063	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(10)	-15.971	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(11)	-15.748	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(12)	-16.295	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(13)	-16.661	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(14)	-15.299	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(15)	-16.014	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(16)	-14.514	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(17)	-16.559	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(18)	-15.783	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(19)	-14.322	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(20)	-16.977	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(21)	-16.829	21727.751	0.000	1	0.999	0.000	0.000	
	AH47_R(22)	1.109	45689.933	0.000	1	1.000	3.031	0.000	
	DID NOT SEEK PROF HELP: COST OF TREATMENT			0.000	2	1.000			
	DID NOT SEEK PROF HELP: COST OF TREATMENT(1)	37.497	6035.069	0.000	1	0.995	19272605922908	0.000	
	DID NOT SEEK PROF HELP: COST OF TREATMENT(2)	33.149	3518.878	0.000	1	0.992	24907309501120	0.000	
	DID NOT SEEK PROF HELP: NOT COMFORTABLE			0.000	1	1.000			
	DID NOT SEEK PROF HELP: NOT COMFORTABLE(1)	-1.640	5724.297	0.000	1	1.000	0.194	0.000	
	DID NOT SEEK PROF HELP: HARD TO GET APPNT			0.000	1	1.000			
	DID NOT SEEK PROF HELP: HARD TO GET APPNT(1)	-0.604	4988.479	0.000	1	1.000	0.546	0.000	
	SERIOUS PSYCHOLOGICAL DISTRESS	0.024	0.045	0.270	1	0.603	1.024	0.937	1.119
	SERIOUS PSYCHOLOGICAL DISTRESS FOR WORST MONTH PAST YR (K6 SCORE)	-0.097	0.038	6.341	1	0.012	0.908	0.842	0.979

Variables in the Equation (DV #2) Continued

POVERTY LEVEL			3.024	3	0.388			
POVERTY LEVEL(1)	0.445	0.454	0.958	1	0.328	1.560	0.640	3.799
POVERTY LEVEL(2)	-0.364	0.457	0.637	1	0.425	0.695	0.284	1.700
POVERTY LEVEL(3)	0.085	0.399	0.046	1	0.831	1.089	0.498	2.382
INS COVERS TREATMENT FOR MNTL HEALTH PROBLEMS			6.714	2	0.035			
INS COVERS TREATMENT FOR MNTL HEALTH PROBLEMS(1)	15.465	1910.828	0.000	1	0.994	5202957.051	0.000	
INS COVERS TREATMENT FOR MNTL HEALTH PROBLEMS(2)	16.840	1910.828	0.000	1	0.993	20577844.324	0.000	
Ethnicity			10.213	7	0.177			
Ethnicity(1)	0.606	0.444	1.864	1	0.172	1.832	0.768	4.371
Ethnicity(2)	0.345	0.343	1.008	1	0.315	1.411	0.720	2.766
Ethnicity(3)	-0.799	0.596	1.797	1	0.180	0.450	0.140	1.446
Ethnicity(4)	1.544	0.967	2.548	1	0.110	4.684	0.704	31.180
Ethnicity(5)	-0.270	1.314	0.042	1	0.837	0.764	0.058	10.033
Ethnicity(6)	-1.800	1.234	2.130	1	0.144	0.165	0.015	1.854
Ethnicity(7)	-0.288	2.338	0.015	1	0.902	0.750	0.008	73.211
Constant	-1.063	21811.614	0.000	1	1.000	0.346		

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