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Factors that Contribute to Disparities in Access to Mental Health Services within Hispanic Adults

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FACTORS THAT CONTRIBUTE TO DISPARITIES IN ACCESS TO MENTAL HEALTH SERVICES WITHIN HISPANIC ADULTS

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

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by

Jasmine Soriano

May 2024

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Approved by:

Dr. Teresa Morris, Faculty Supervisor, Social Work

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ABSTRACT

The focus of this research project was to understand and identify the challenges Hispanic adults face when accessing their mental health services to better understand this concerning issue and help support social workers in bridging that gap in the Hispanic community. The study took place at a mental health clinic in Southern California through virtual interviews for those who chose to participate. This agency provides mental health therapy to individuals 0-21 years of age, but for the purpose of this study, only adults aged 18-21 qualified to participate. The study consisted of twelve voluntary participants from both Hispanic adult clients ages 18-21 who receive mental health services and Hispanic and Non-Hispanic mental healthcare professionals who provide services at a Mental Health Clinic in Southern California. Six of those participants were previous clients, and six were mental health providers. Together they identified four major barriers Hispanic adults face when accessing mental health services. The researcher utilized a post-positivist approach to analyze the data and identify codes and themes which allowed the researcher to make inferences and conclusions about what the codes and themes meant. This research project found four barriers which were categorized as economic factors, sociocultural factors, stigmatization, and geographical factors. The results of this study helped inform mental health professionals of important identifying information regarding service access which was beneficial in making feasible treatment recommendations. On a macro level, the findings of this study had the potential of changing the way treatment recommendations are made, to encourage cultural competency of more agencies, and even allow more individuals to access their mental health services.

ACKNOWLEDGEMENTS

This endeavor would not have been possible without the patience of my research supervisor, Dr. Teresa Morris. A special thank you to my cohort for the endless support and guidance that flourished into friendships. I am beyond grateful for the Distant Pathway Program at California State University, San Bernardino for providing an online MSW program where independent, first-generation women, like myself can continue holding a career while pursuing higher education. Words cannot express how much this program has shaped many aspects of my life. Lastly, thank you to my friends and family who continued to push me towards this milestone.

DEDICATION

I dedicate this study to my younger siblings, Julie, Joanna, Anthony, and Nico, in hopes that they understand that breaking generational barriers is obtainable. I hope they someday understand that being their big sister has been my greatest accomplishment.

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CHAPTER ONE

ASSESSMENT

Introduction

Chapter one describes the focus of this study: factors that contribute to disparities in mental health service access in Hispanic communities. An explanation of the research paradigm used to guide this research is provided as well as the theoretical orientation used to frame the study. To get a better understanding of the concerning issue, a literature review is provided which discusses the current disparity in access to mental health services in low economic communities, the widespread presence, current causes to the issue, impacts, and possible interventions and preventative measures to address the issue. The chapter concludes with an analysis of how the study relates to the practice of social work at both a micro and macro levels.

Research Focus

This research project strived to understand and identify the challenges Hispanic adults face when accessing their mental health services. By deepening this understanding, it helps mental health providers in bridging the gap within the Hispanic community and provide feasible interventions and preventions that help eliminate barriers. More than one in five adults in the United States have a mental health disorder; yet more than half do not receive treatment (Han et al., 2015). However, there are ethno-racial differences in the rates of people accessing those services. Findings from the CDC show that in 2018, Hispanic adults were 50 percent less likely to have received mental health treatment as compared to non-Hispanic whites. In addition, other data shows that 24.4% of adults who receive mental health services are Caucasian adults whereas only 12.6% of them are Hispanic adults who receive mental health services (Terlizzi & Norris, 2021). The National Alliance on Mental Illness (NAMI) defines mental illness as medical conditions that disrupt thinking, feelings, mood, ability to relate to others and daily functioning. According to the NAMI, untreated mental illness can leave individuals with a persistent decline in mental health making it difficult for them to live happy and healthy lives. This study strived to deepen the understanding of why the disparity in accessing mental health services continues to exist to support social workers in bridging that gap in the Hispanic community.

Paradigm and Rationale

This study utilized the post-positivism paradigm. This paradigm focuses on an inductive exploratory approach to objectively understand reality (Morris, 2014). It assumes that data must be collected in a naturalistic setting and that the researcher must actively work to control their influence on reality. The primary purpose of the research project was to deepen our understanding of the factors contributing to the disparity in access to mental health services within Hispanic adults. Since the main goal within post-positivism is a passive understanding of knowledge and deepening the understanding of a particular issue, this paradigm pairs well with the topic of interest (Morris, 2014) because this study is one that has already been explored, therefore future findings can help determine if current barriers still hold truth and to better understand those barriers. The post-positivist approach assumes the value in research, and understands that social reality exists to be measurable, knowledgeable, and difficult to obtain (Bisel et al., 2017).

Literature Review

According to the Centers for Disease Control and Prevention (CDC), 20.3% of adults in the United States received mental health treatment in 2020 (Terlizzi & Norris, 2021). However, there are ethno-racial differences in rates of accessing mental health treatment. While 24.4% of White adults received mental health services, only 12.6% of Hispanic adults received mental health services (Terlizzi & Norris, 2021). With the continued growth of the Hispanic population in the United States, it is crucial to explore what factors are contributing to the disparities in access to mental health services.

Prevalence

Recent findings from the National Latino and Asian Study found that prevalence rates of mental illness in Hispanics continues to rise. Mental illness affects 28.1% of Hispanic men in the US, and about 30.2% of Hispanic women in the US (Alegria et al., 2007). The CDC reports that only half of those affected receive mental health treatment (Terlizzi & Norris, 2021). While 24.4% of White adults with mental illness received mental health services, only 12.6% of Hispanic adults received mental health services (Terlizzi & Norris, 2021).

Contributions to the Causes of Disparities in Hispanic Adults Accessing Mental Health Services

Research has identified several factors that prevent Hispanics from accessing mental health services. These factors range from language barriers, poverty, a lack of cultural competence among providers, clients' legal status, and negative stigma about mental illness (NAMI, 2021).

Language barriers can make treatment difficult and even impossible. The American Psychological Association found that only 5.5% of psychologists in the United States are Spanish speaking, making it difficult for Spanish-only speaking clients to receive treatment (Smith, 2018). Access to care is the first step in any medical treatment or intervention. However, for patients to gain access to care, proficiency in the language spoken by the providers is critically important. Studies have shown that limited language proficiency is likely to lead to a delay in treatment, inadequate care, and misdiagnosis (Ohtani et al., 2015). With the growing populations of immigrants in the United States, the use of multiple languages within communities has also increased.

What we currently know is that poverty is one of the most significant social barriers of accessing mental health services in the United States. 15.7% of Hispanics in the U.S. are considered to live in poverty. This not only makes it more likely for these individuals to have a mental health condition, but it also makes it more likely that they are not insured medically due to their circumstances (NAMI, 2021). Living in poverty often means living paycheck to paycheck or not having a reliable job where they can take time off, making it unlikely for people to be able to take days off work for health service appointments. Additionally, individuals living with an untreated mental illness disorder, often find that their conditions make it harder to escape economic difficulties due to symptoms experienced (e.g. social withdrawal, confused thinking, and/or extreme mood swings get in the way of keeping a job). Employment instability adds a contributing factor that can keep them in a perpetual struggle to make ends meet resulting in an entrapped cycle of poverty (*Poverty and mental health: How counselors can help,* 2023).

Culturally competent care is critical to achieving health equity, particularly in mental healthcare. A lack of culturally competent providers therefore also contributes to disparities in access to mental health services. The American Psychological Association defines cultural competence as the ability to understand, appreciate, and interact with others from different cultures or belief systems (DeAngelis, 2015). Properly understanding a person's cultural influence of their interpretation towards their symptoms is key. Culturally competent social workers and other mental health care providers play an important role in accurately diagnosing and providing treatment interventions.

> "A culturally competent mental healthcare system can help eliminate these disparities by providing culturally sensitive care, reducing biases, and

> addressing systemic barriers to mental healthcare access. As societies become increasingly diverse, cultural competence in mental healthcare is no longer an option, but a necessity that enhances patient outcomes, improves access to mental healthcare, and promotes health equity" (*Cultural competence in Mental Health Care: Why It Matters - Radias Health* 2023).

Competencies shown to work for practitioners working with the Hispanic community are practicing cultural sensitivity and humility, practicing asking before assuming, and knowing about shared values can help practitioners build stronger, more effective partnerships with their clients.

Legal status comes with a lack of knowledge about state or federal policies that can contribute to barriers in accessing mental health services.

> "An estimated 3 million people in California are undocumented, and many legal immigrants such as children, live in mixed-status households where some members don't have legal status. Despite their needs, undocumented immigrants have a hard time accessing mental health care services since Medi-Cal does not cover undocumented adults unless they are pregnant" (Boyd-Barrett, 2019).

People who are undocumented tend to have increased fear and anxiety towards the hostile immigration laws that a misconception of being deported or separated from their families arises if in contact with service providers. There are community-based programs that provide mental health services to undocumented immigrants however many are not aware of these services (Boyd-Barrett, 2019). Though many children of immigrant parents are eligible for the Affordable Care Act, parents are often not aware that their children can qualify (NAMI, 2021).

> “Even without being an immigrant, navigating the mental health system is a challenge. If you add on top of that language barriers, this climate of fear, this anxiety about utilizing services that you worry you may not be eligible for, it really lends itself to incredibly negative impacts on the wellbeing of many of our fellow community members.” (Boyd-Barrett, 2019).

Not only is there a fear of reaching out for medical and mental aid, but there is also a stigma against seeking mental health treatment within the Hispanic community. Mental health stigma is defined as a negative evaluation of those with mental illness and/or those receiving mental health services (DeFreitas, 2018). Two aspects of mental health stigma are perceived stigma and personal stigma. Perceived stigma is defined as believing that society has negative views towards individuals with mental illness. While personal stigma focuses on one’s own beliefs towards mental illness (DeFreitas, 2018). Stigma can prevent individuals from obtaining health services they need by avoidance and denial, which is particularly seen in ethnic minority groups such as Hispanics (DeFreitas, 2018). Stigma often leads to delayed treatment, increased morbidity, and diminished quality of life for those with poor mental health. Therefore, a better understanding of the impacts of stigma across different cultural contexts is critically essential, aiming to inform culturally nuanced strategies to minimize its consequences and contribute to a more equitable and effective psychiatric care system (Ahad, A. et. al, 2023).

Consequences

The consequences of the disparities in access to mental health services within Hispanics can have everlasting effects which lead to untreated mental illness. Untreated mental illness often leads to incarceration, suicide, substance abuse, and homelessness (NAMI, 2021). UCLA Latino Policy and Politics Institute reported a significant rise in homelessness among Hispanics, marking an 8% increase nationally and a 26% increase in Los Angeles County between 2020 and 2022 (Chinchilla et al., 2023). According to the U.S Department of justice, 37% of jail inmates and 14% of federal prison inmates have been previously diagnosed with a mental health disorder (Bronnsen & Berzofsky, 2017). Untreated mental illness can lead to offenses causing incarceration and can elevate the risk of committing suicide while being incarcerated. Studies from the Centers for Disease Control and Prevention (CDC) show that in 2019, suicide was the second leading cause of death for Hispanics, ages 15 to 34.

Interventions/Preventions

According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), focusing on quality mental health treatment with providers that are culturally diverse and competent is one of the biggest steps in addressing the disparity in accessing mental health services in Hispanic adults. As mentioned earlier, cultural competence is the ability to understand, appreciate, and interact with others from different cultures or belief systems (DeAngelis, 2015). Having health providers who are culturally competent can build rapport with clients as those providers can understand the stigmas associated within the client’s culture and can allow individuals to have a safer space to share about their mental health. Placing an emphasis on cultural competency training for employees can benefit agencies and organizations providing richer services and support to their clients. Another prevention technique is providing awareness in communities where many Hispanics reside to spread awareness about mental illness symptoms, and ways to get help (DeAngelis, 2015). Agencies like Mental Health America (MHA) provide resources to the Hispanic communities and other minority groups via the internet. Resources include those such as facts, where to get help, screening tests, and overall issues the Hispanic communities go through in association with mental health (DeAngelis, 2015).

Conclusion

In conclusion, mental health rates within Hispanic adults continue to rise and yet Hispanic adults’ access mental health services at a lower rate than White adults (Terlizzi & Norris, 2021). The goal of this study helped understand that gap so that social workers and mental health professionals can better understand the type of interventions being offered and provided to their clients. Another goal of this study was to work in alliance with other research and work that has been done in identifying the factors contributing to the access of these mental health services and using those to identify if those findings still hold true and continue to represent an accurate representation of the challenges Hispanic adults face in mental health services.

Theoretical Orientation

This research was guided by Urie Bronfrenbrenner’s ecological systems theory. This theory adopts the understanding that there are several dynamics within a person’s life which affect their development and interactions (Ceci, 2006). The ecological systems theory focuses on the individual in multiple environments or levels, to get a better understanding of their behavior. These levels are the microsystem, mesosystem, ecosystem, macrosystem, and chronosystem.

The micro system studies a person’s immediate environment such as the home and family relationships. The mesosystem focuses on connections, between home and school, home and work, or home and community. The ecosystem consists of extended family members and neighbors while the macrosystem focuses on socioeconomic status and cultural ideologies. Lastly, the chronosystem includes transitions of major life events such as historical events (marriage, divorce, new home, starting school, etc.).

This theory is appropriate for researching possible factors that contribute to Hispanic adults not accessing mental health services as accessing services is impacted by factors within different levels of their environment. Consideration of external factors such as medical insurance, mental health stigmas, and cultural competence of mental health care providers is just as important as the internal factors to understand the full scope of what is contributing to these disparities.

Potential Contribution of the Study to Micro and Macro Social Work Practice

This study has the potential to contribute towards understanding the inequality in accessibility related to Hispanic adults' mental health services at both micro and macro levels. Understanding these factors allows social workers to make appropriate treatment plans towards this client population based on their accessibility to services. On a micro level, this study explored the individual factors that can contribute to clients not accessing the services given to them. Factors like culture, gender, race, etc. can determine how willing a client is to access mental health services which can guide social workers to understanding why treatment plans might not be working for an individual.

On a macro level, the study helped identify how service providers can make efforts to change practices within their agencies. Macro social workers can target those areas by creating policies and regulations on the implementation of cultural competence amongst service providers and changing training requirements.

Summary

This chapter focused on addressing the focus of this research study - factors that contribute to disparities in access to mental health service within Hispanic adults. An explanation of the research paradigm used to guide this research was provided as well as a discussion of the theoretical orientation used to frame the study. The chapter concluded with an analysis of how this study relates to the practice of social work at both micro and macro levels.

CHAPTER TWO

ENGAGEMENT

Introduction

Chapter two focuses on the engagement stage of the study. It begins with a discussion of the research site and gate keeper. It then details the researcher's self-preparation for conducting the study. The chapter then explores the diversity, ethical, and political issues of the study. Chapter two then concludes with a discussion of the role of technology in this study.

Study Site

The study took place at a mental health clinic in Southern California through a virtual interview for those who chose to participate. This agency provides mental health therapy to individuals 0-21 years of age, but for the purpose of this study, only adults aged 18-21 qualified to participate by verification of identification for age purposes. Services provided at this agency are individual therapy, family therapy, and group therapy. The agency's service providers consisted of a Regional Director, a Clinical Director, a Licensed Clinical Social Worker (LCSW), nine Clinicians who were wither Associate Clinical Social Workers or Associate Marriage and Family Therapists, a Nurse Practitioner, a Registered Nurse (RN), and 2 front office staff; an intake specialist, and a receptionist. The clinic serves individuals aged 0-21 years old who are recipients of Medi-Cal, typically these clients are referred from their doctor, school staff, community members, etc. Clients that are served here are primarily from diverse backgrounds including, Latinos (35%), Asian (1%) and Caucasian (52%) and other populations such as Arabic, etc. (12%). 60% of the clients served are female, 38% are male, 1% identify as "other". 16% of the population are 18–21-year-olds, 84% are 0-17 y/o. The average life cycle of a client is typically 10 months to 1 year.

Engagement Strategies

The gatekeeper is the clinic director and clinicians and the regional director who oversees the clinic. The researcher engaged with gatekeepers at the facility by formally introducing herself and explaining her role, as well as by providing the purpose of the research study and targeted population for interviews and data collection. The researcher then proceeded to take the necessary steps to receive approval from key members at the facility.

The researcher asked the gatekeepers for permission to post flyers in the clinic lobby and send out an email to promote participation within the clinic’s staff members to allow for their collaboration and help them feel like they are a part of the process. After the participants saw the flyers and met interviewee criteria, they contacted the researcher to set up the interview. The researcher then created a zoom link and sent it out to the participant with the confirmed date and time after consent paperwork was signed by the interviewee. The purpose of the study was provided to the interviewees and light conversations were made to build rapport and allow the interviewees to feel comfortable with sharing their answers.

Self-Preparation

Self-preparation was done by conducting an extensive literature review on the disparities in access to mental health services for the targeted population. The researcher also prepared a set of interview questions for both client participants and provider participants, which are listed on Appendices A and B. These sets of questions were brainstormed between the gatekeepers at the site and the researcher. The researcher also turned to friends and family for support by conducting mock interviews on them to get the interviewer comfortable with the interview process, to get a better idea of what can occur throughout an interview, and to collect feedback for the researcher on the interview questions and process. The researcher also prepared by researching data analysis methods and how to properly apply them to the qualitative research conducted.

Diversity Issues

Diversity issues observed by the researcher were gender based. Out of the twelve participants, 8 were female and 4 were male. The difference in sex of the participants can skew the answers provided. For example, the researcher is a 32-year-old female, if she interviews an older male, he might have trouble relating to her or might believe she does not understand because she is too young. A way to address this goes back to the self-preparation of the researcher so that she has the necessary background information for understanding different age groups and genders.

Ethical Issues

There were no ethical issues that arose since the researcher explained to the interviewees and those working with her at the study site that their information will remain confidential and pseudonyms will be used for the study to protect their identity. The researcher reminded each interviewer that their names would not be connected to their answers to provide reassurance. A challenge that arose was obtaining enough participants for the study. During this research process, the study site was transitioning from Medical to private insurance due to a new contract with the county. This was affecting many clients from keeping their current services so there was a reduction in clients the clinic was providing to.

Political Issues

Interviewing social workers is a large part of this study to explore factors that contribute to Hispanic adults not accessing mental health services. Since the researcher is a social work student, there could be a political issue arising that the study is skewed to the defense of social workers or in their favor. To avoid this issue, as a researcher and social work student it was important to be aware of hidden biases and values so that all interviewees felt they had the same opportunity to share. Another challenge that might arise is the interview revealing negative information and/or practices of the study site. If this occurs, the researcher will discuss with the key members the details of these findings and shape it in a form of a learning opportunity for them to make changes if necessary to their practice approach.

Role of Technology

Technology played a large role in the engagement process of this study, and conveniently it made it easier for the researcher to contact key players. Phone calls and emails were used for communication to coordinate in person meetings between stakeholders and the researcher as well as for setting up virtual interviews. Interviews were audio recorded with transcripts and were stored on a password protected computer.

Summary

Chapter two began by discussing the study site and the process used to engage gate keepers at the site. Methods of how the researcher prepared for the case study were provided along with the diversity, ethical, and political issues that arose and how they were overcome. In addition, the role of technology was explored and explained.

CHAPTER THREE

IMPLEMENTATION

Introduction

This chapter provides information on the implementation of the study, how the participants were chosen, the method of data collection, and the data collection process. This is then followed by how data was recorded, managed, and provides the plan for data analysis after collection.

Study Participants

Participants of this study included twelve individuals that consisted of a mixture of former clients between the ages of 18 and 21 years old who were registered to receive mental health services at the identified study site and service providers employed at the study site. The demographics of the participants were 58% Hispanic, 25% White, 8% Asian, and 8% African American as seen below on figure 1.

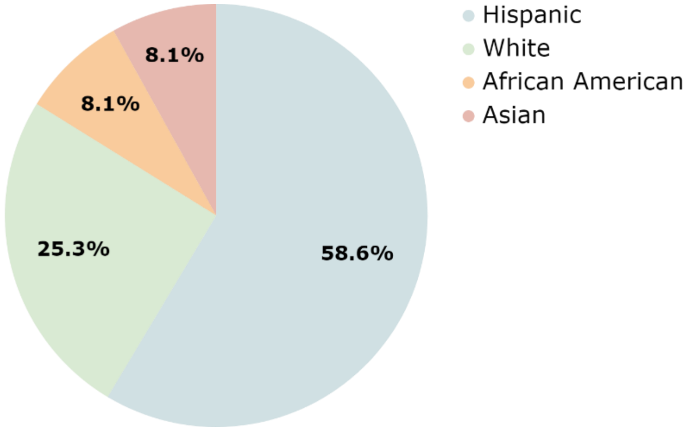


Figure 1. Participant Demographics

Selection of Participants

This study utilized homogenous sampling to collect qualitative data. Homogenous sampling is sampling whose units (e.g., people, cases, etc.) share the same (or very similar) characteristics or traits (e.g., a group of people that are similar in terms of age, gender, background, occupation, etc.) (Morris, 2006). Since the research being conducted was meant to address specific characteristics of the group of interest, homogenous sampling was appropriate to collect qualitative information since this type of sampling looks for participants who can provide the most complete data about the study focus (Morris, 2014). The researcher posted voluntary recruitment flyers at the agency's lobby for clients to have access to. Recruitment emails were sent to agency employees asking for voluntary participation.

Data Gathering

This study focused on collecting qualitative data; therefore, the method for gathering data was one-on-one interviews with participants. Structured interview questions were developed in advance. Questions for patients included those around the topic of their mental health services such as how often they access those services, if they are mandatory or voluntary, if they feel they have trust with the mental health professional, if they are honest with them, and if they feel they are understood. (See Appendix A) For the mental health professionals such as social workers, therapists, and psychologists, questions included those regarding their Hispanic patients on their caseload. Questions included how often those patients on their caseload access their services and come to their appointments, asked if they were bilingual themselves, how they build rapport when there is a language barrier, and what factors they believe prevent a patient from attending their meetings. (See Appendix B)

Phases of Data Collection

The data collection phase was broken down into two parts; the preparation phase which included the literature review followed by the interview process where questions were asked, recorded, and reflected on by the researcher. Preparations for interviews included organizing a list of descriptive interview questions that could potentially be asked during the process as well as rapport building prior to the interview.

During the interview, the researcher engaged with each participant virtually in a private room where answers could remain confidential. Consent was required, in the form of an informed consent document. Once the participant consented to the interview, the researcher asked a few ice breaker questions to help build rapport and make them feel at ease. The researcher proceeded to ask the predeveloped questions (see appendices A and B). These questions were structured in categories of questions at an individual level, cultural level, and organizational level. Once the interview was over, the researcher thanked each participant for participating and let them know that a summary of the research findings would be made available to them and would be contacted when that was completed.

Data Recording

The instrument utilized to record data was a video conferencing platform that could be used through a computer desktop or mobile app and allowed users to connect online for video conference meetings, webinars and live chat. This online interview was recorded through the platform directly which provided the option of providing a video recording and audio transcripts. Audio recordings and transcripts were saved on a password protected computer and assigned a code name**.**

Summary

This chapter described the details of the implementation stage of the study such as study participants and the method used for selecting participants. It then explained how using interviews and surveys as data collection would be appropriate. Data collection and the analysis of data using the top-down method were discussed. Lastly, the chapter outlined the termination and follow-up process.

CHAPTER FOUR

EVALUATION

Introduction

Chapter four is where the study findings were reported and interpreted. In this chapter the data analysis section discussed the methods of coding that were used; open and axial coding to identify themes within the interviewee's answers. The definition of these codes was also explained and demonstrated in the chapter. The researcher interpreted the data to build the theory that Post Positivist researchers seek to discover. This theory is also explained and defined according to the discoveries made by the researcher. Lastly, this theory reported on the implications it has on a micro/macro social work level as well as review the study limitations.

Data Interpretation

The researcher utilized a post-positivist approach to analyze the online interviews that were recorded through the platform directly. Since the platform provided the option of video recording with audio transcripts. Audio recordings and transcripts were saved on a password protected computer, the researcher was able to review audio transcripts and identify codes and themes which allowed the researcher to make inferences and conclusions about what the codes and themes meant. Open coding involves techniques to conceptualize data at a basic level and in small components. In other words, data is broken down into tiny components to later be brought together during axial coding. Axial coding is where connections between the open codes are reviewed and are used to create larger codes or themes. The researcher began by reviewing the interview transcripts from the online platform utilized and using open coding to find words, fragments, and sentences that were answered by participants to further analyze. Next, by using axial coding, the researcher linked the connections between the open codes to further develop common themes. The data findings demonstrated that the most reported barriers were economical and stigmatization, followed by sociocultural factors and geographical factors.

Open Coding

The open codes identified were language, cultural competence, social support, religion, insurance, income, employment, location, distance, transportation, stigma, awareness, and therapy readiness. These open codes then emerged into four identified themes later defined and discussed: economic barriers, sociocultural barriers, stigmatized barriers, and geographical barriers.

Language. “Language” refers to the method of communication spoken by the interviewees and their fluency with it. It also includes the fluency of their service provider to determine if they can communicate utilizing the same language. If there were differences in the languages spoken, translation methods were also included in this code. This code emerged when interviewee #1 mentioned that their parents only spoke Spanish, but his therapist only spoke English. This interviewee mentioned the use of a translator app during family therapy which he reported to not be personable and caused parents to disengage and opt out of therapy. Multiple service provider interviewee's reported phrases such as "I am the only Spanish speaking clinician; therefore, I am overloaded caseload wise" or "There are very few Spanish speaking therapists here" to help explain the demand of Spanish speaking clients in comparison to the number of therapists able to speak Spanish. The most common languages reported within the interviewees were English and Spanish. Only two interviewees out of the twelve reported "Language not being an issue" within their treatment.

Cultural Competence. "Cultural Competence" refers to knowledge, respect, and understanding of cultures other than one's own. This code emerged from the responses of those interviewees identified as service providers. Common verbiage and phrases included "I did not get enough training on cultural competency", "the training I received was online and not interactive", "I do not feel I was set up for servicing the demographic population this clinic services", and "cultural competency is an area of need". Interviewee #7 mentioned cultural competency training as "just being another training to check off" and elaborated by stating that implementation of it is not followed up on.

Social Support. "Social support" refers to support accessible to an individual through social ties to other individuals, groups, and the larger community. It also includes a network of family, friends, neighbors, and community members that is available in times of need to give psychological, physical, and financial help. Examples of responses provided by interviewees were “I don’t tell my family or friends I come to therapy”, “I ask my parents not to mention my mental health to my family”, and “I don’t talk about these things with others”. Interviewee #2 elaborated that his parents were often judged and insulted by family members for taking him to therapy. This interviewee mentioned “my parents do not have the social support for my health”. Social support was demonstrated to not only affect the client directly but their family as well.

Religion. “Religion” refers to the beliefs, practices, and attitudes of individuals regarding anything holy, sacred, or absolute. For this code, interviewee’s responses included “common misconceptions” within their religion regarding mental health. Examples of this were “mental health services are not a thing; they expect prayers to do the work”. Interviewee #2 shared that her parents do not tell their church friends about therapy due to the criticism about the validity of mental health itself.

Insurance. “Insurance” refers to support and coverage for medical or mental health expenses. This code emerged from the number of interviewees reporting having Medi-Cal as a primary source of insurance. Responses shared the difficulty in “finding providers”. Three interviewees also shared knowing at least one other individual who did not qualify for health insurance and not treating their mental health services. Half of the interviewees reported to have “been affected by the change in policy”. When asked to elaborate and after speaking to the study site gatekeepers, it was discovered that the clinic used as the study site lost their contract with the county therefore were no longer able to accept Medi-Cal recipients. All six client interviewees reported to be Medi-Cal recipients and having to look for services elsewhere. The other six provider interviewees reported that the clinic shifted to private insurance which most of their current population did not have.

Employment. “Employment refers to earning wages or salary for a service. This code was mostly reported to affect the client’s parents. Since the population of clients interviewed were young adults ages 18-21, some reported to “live with parents”, therefore lack of employment for their parents affected them directly. Four of the six client interviewees reported that at least one parent was unemployed.

Location. “Location” refers to the geographic area of the study site and how it affects clients and providers from accessing it. This code emerged after a couple of provider interviewees reported a “local shelter” to cause traffic and loitering of unhoused people near the study site entrance. Phrases such as “It scares off people from approaching the clinic” or “clients always file a complaint about the groups of unhoused people in the parking lot”. Client interviewees reported phrases such as “my mom gets scared of something happening to me when coming to therapy” or “I see the police there often which gives me anxiety”.

Distance. “Distance” refers to the commute it takes clients to get to the study site. Common phrases answered during this portion of the interview were answers such as “it’s two cities away from me, so my mom complains”, “it's not too far but traffic makes things worse and causes me to miss appointments". One interviewee said that he took the city bus which took him an hour and a half to get to therapy.

Transportation. "Transportation" refers to the access and availability of getting to the identified study site by vehicle, bus, bike, on foot, etc. One interviewee reported utilizing the city bus as a means of transportation. Four interviewees reported relying on others for a ride. One interviewee reported using Uber services and having to pay for a ride to his services. All six-client interviewees reported that "transportation was a stressor for them getting to the study site".

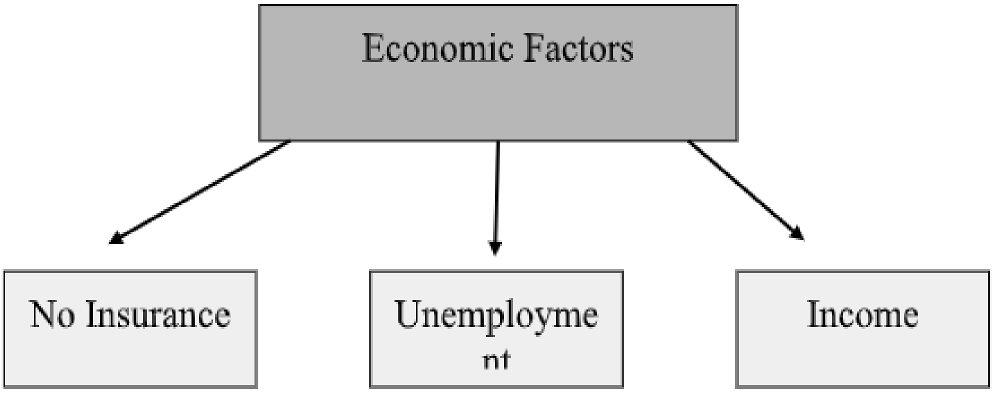
Stigma. "Stigma" refers to a set of negative and often unfair beliefs that a society or group of people have about something. Twelve out of twelve interviewees reported at least one stigma they have experienced or have heard a client tell them about their mental health services. Stigmas reported included comments like "they think I'm crazy being I take medication for my mental health", "I was taken to a psychiatric hospital, and I was too embarrassed to return to school because of people making fun of me", "they don't understand", "I'll be judged and laughed at", and "Boys don't go to therapy".

Awareness. "Awareness" refers to the knowledge and understanding of mental health, its challenges, supports, and how it affects an individual. Interviewees shared comments about the "disconnect between mental health and older generations". When asked to elaborate, interviewees referred to these older generations as their parents or other adults in their lives.

Therapy Readiness. "Therapy readiness" a client's positive attitude/preparedness for potential change and entering a therapeutic relationship. Both client and provider interviewees reported phrases such as "I'm in therapy because my parents are forcing me to", or "I'm in therapy because I live in a group home". Comments like these were followed by comments of "Therapy was not my idea". Other phrases included 'clients have shared that they don't believe in therapy and are here because they believe they have to".

Axial Coding

As mentioned above, the open codes then emerged into the following themes/connections of barrier types preventing these individuals from accessing or wanting to access a service. Figure 2 demonstrates a visual representation of the breakdown of the axial codes.



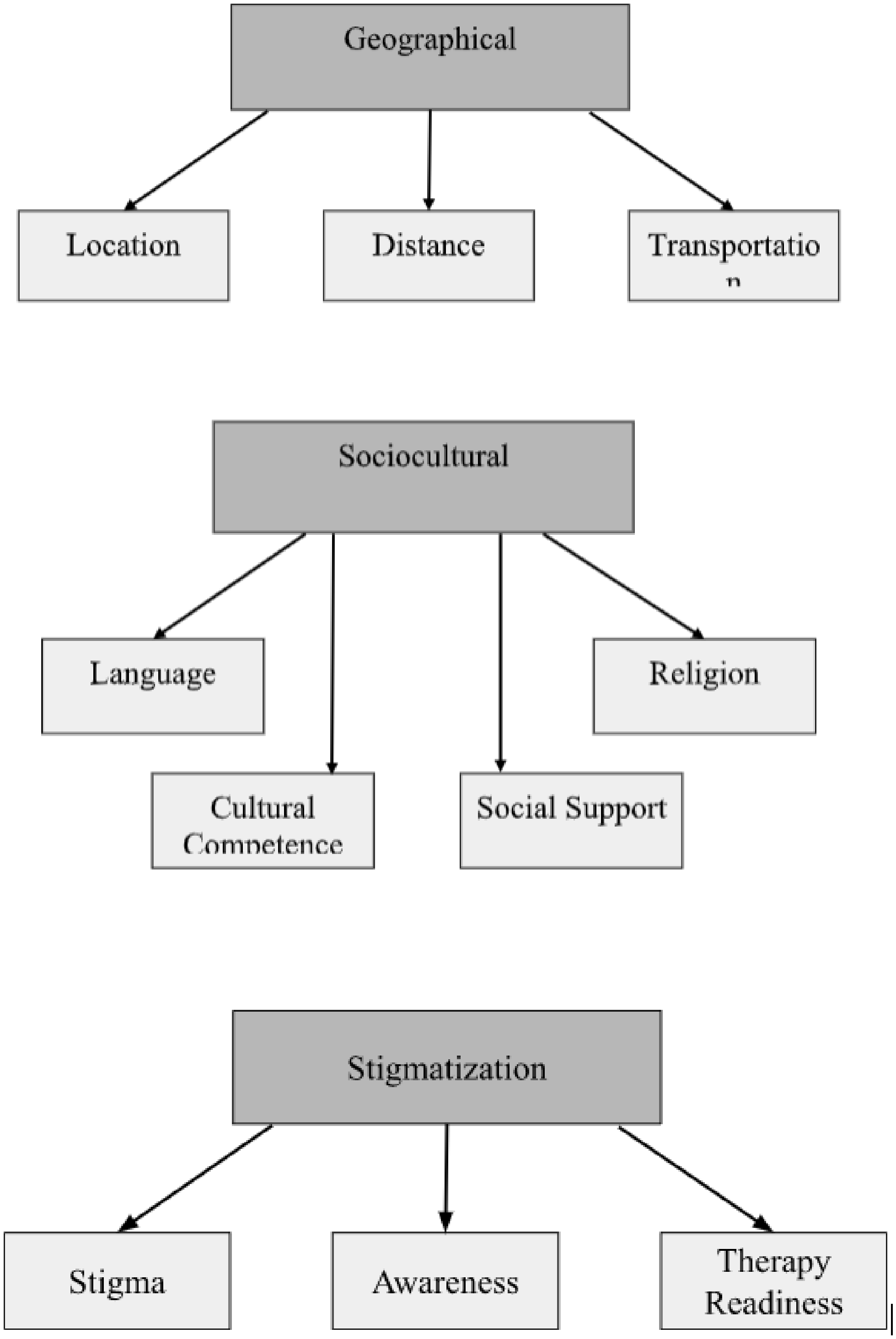


Figure 2. Axial Coding Breakdown

Selective Coding

Once the open and axial codes turned into connections, themes and theories arose. The researcher found that four major themes affected how Hispanic adults accessed their mental health services: economical, geographical, sociocultural and stigmatization. The researcher ended her data analysis by using the process of selective coding. According to Morris (2006), “Selective coding is the process of integrating and refining the categories and their dimensions to develop theory” (p. 116).

To determine the story of the study, the researcher developed a selective coding chart to visually display the commonalities and differences reported within the data, which led to connections and statements about the study. The data confirmed that the four themes being economic factors, stigmatization factors, sociocultural factors, and geographical factors continue to hold truth and hinder the accessibility of mental health services amongst Hispanic adults. What this means is that current mental health care strategies are not working as well as we wish they were. With the identified barriers, mental health providers can better evaluate how to target these barriers directly while providing care.

Implication of Findings for Micro and Macro Practice

This study has shed some light on the types of barriers that Hispanic adults face when trying to access mental health services. From a micro social work perspective, mental health providers now have the key factors resulting in lack of service, therefore they can directly switch their treatment approach accordingly. Examples of this could be doing personal development to gain insight on stigmatization and sociocultural factors of the population they directly serve, they can take it upon themselves to learn another language, not only making them more qualified for future positions in social work but helping them provide adequate care.

A key part of macro social work is taking a step back and identifying factors that negatively impact the well-being of the constituents within an organization. Since we know that socioeconomic, geographical, stigmatization, and economical factors are affecting the community, Macro social workers can help advocate and create programs specifically designed to diminish these barriers or also change current program's structure and policy for ensuring their clinicians are receiving adequate training to address these barriers for their clients.

Summary

Chapter four unveiled the data analysis section of this study. The researcher interpreted the data and used visual charts to explain the theory built on a post-positivist perspective. The researcher discovered four main barriers preventing Hispanic adults from accessing their mental health services: economic factors, sociocultural factors, stigmatization, and geographic factors. The researcher also explained and defined the discoveries made. As well as report on the implications it has on a micro/macro social work level.

CHAPTER FIVE

TERMINATION AND FOLLOW UP

Introduction

Chapter five discusses the termination process that the researcher implemented in a post-positivist perspective. This chapter also describes the method in which the researcher chose to communicate the study findings to the research site and the study participants. The researcher did not pursue an ongoing relationship with the study participants and that decision is explained in this chapter.

Termination of Study

The termination of the study was very open from the beginning of the project during each interview conducted. The study site gatekeeper was also front loaded with this information. Key players were thanked for their willingness to allow the researcher to conduct a study at their site. They were debriefed on what to expect such as a summary of the research findings and a timeframe for when to expect it. Upon completion of the research study, a final report was created and submitted to the university as a graduate study research paper.

Communication of Finding to Study Site and Study Participants

As stated previously, this study was conducted from a Post Positivist perspective. This study committed to report findings back to the study site and to the study participants via an electronic poster that was sent out to study site gatekeeper and participants. The poster was presented at California State University, San Bernardino during, “poster day”. The study participants and the gatekeeper were invited to attend the event. The study findings were also typed into an official typed document. Upon approval, the study will be in the John M. Pfau library at California State University, San Bernardino. A full copy of the study was provided to the gatekeeper, as a method of gratitude for their participation in the study.

Ongoing Relationship with Study Participants

Due to confidentiality, there will not be an ongoing relationship with study participants clients themselves. However, there will be an ongoing relationship. with those clinicians who participated in supporting this study since the researcher is employed by this organization. The researcher perceives this project to be a very valuable learning experience that could be used by anyone looking to be an effective social worker.

Dissemination Plan

Results and reports will be shared through email to the study site. When the thesis is published and recorded in CSUSB library, access may be given to the study site to retrieve the study. Otherwise, a copy will be emailed as an attachment.

APPENDIX A

QUALITATIVE MEASURING INSTRUMENT FOR CLIENTS

Individual Level

1) Transportation concerns
    - Do you experience any transportation challenges?
    - How far is the clinic from your home? Do you think it's too far?
2) Fear of therapy
    - Do you worry about sharing in therapy?
    - Do you feel ready to work on your mental health?
3) Childcare
    - Does childcare affect whether you can make it to your mental health appointments regularly?
4) Knowledge/understanding of mental health.
    - How strong would you rate your understanding of mental health?
    - How strong would you rate the importance of mental health services (e.g. going to therapy?)

Cultural Level

1) Therapist’s cultural awareness
    - Do you feel your therapist has knowledge/understanding about your culture?
    - Is your therapist understanding of missed sessions due to cultural events?
2) Therapist language fluency
    - Is your therapist able to fluently communicate with you?
    - Is it considered “normal” to have mental health services in your culture?
3) Mental health stigma
    - Are there negative views towards mental health that prevent you from wanting to access your services?
4) Religion
    - Is your therapist understanding of missed sessions due to religious events?
    - Are there negative views towards mental health that prevent you from wanting to access your services?

Organization Level

1) Appointment time availability
    - Does lack of appointment availability interfere with getting an appointment?
2) Therapist Qualifications
    - Do you feel your mental health provider is qualified to provide services? (e.g. working with interns)

APPENDIX B

QUALITATIVE MEASURING INSTRUMENT FOR PROVIDERS

Cultural Level

1) Therapist’s cultural awareness
   - ❖ Do you feel clinicians at this location have an understanding/awareness of the client's culture?
2) Therapist language fluency
   - ❖ Are you bilingual?
   - ❖ Do you feel there are enough Spanish speaking clinicians servicing the clinic?
3) Mental health stigma
   - ❖ Have clients shared stigmas interfering with them coming to session?
4) Religion
   - ❖ Do you feel client’s religious views are taken into consideration when recommending services/interventions?
   - ❖ If a known religious event is coming up and is on the day you have a session with a client, do you offer to reschedule or skip because of the event?

Organization Level

1) Appointment time availability
   - ❖ Do you think clinician availability interferes with having clients attend their session?
2) Therapist Qualifications
   - ❖ Do you feel confident in servicing the client?
3) Clinic location
   - ❖ Do you think having the location downtown affects client accessibility to the clinic?
   - ❖ Do you think being behind a homeless shelter affects clients coming in? (e.g. being afraid, or considering it a “bad area”)
4) Workload/Support Staffing
   - ❖ Do you feel your workload is too high?
   - ❖ Do you feel you have time/energy to manage your caseloads?
   - ❖ Do you feel you have staff support in understanding Hispanic cultural backgrounds if you do not have firsthand knowledge?
5) Training
   - ❖ Do you feel there is enough training to prepare you to work with Hispanic clients?
   - ❖ Which type of training would you like to see more of?

APPENDIX C

ENGLISH INFORMED CONSENT

PROJECT: Identifying barriers for Hispanic adults (18-21yrs) in accessing their mental health services

PURPOSE: The study in which you are being asked to participate is meant to identify the barriers that Hispanic adults face in accessing their mental health services. This study is being conducted by Jasmine Soriano under the supervision of ________________, California State University, San Bernardino. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

DESCRIPTION: A virtual interview will be scheduled upon consent. You will meet through zoom and the researcher will ask questions about your mental health services. Answers will be saved on the computer without the real name of the participant.

PARTICIPATION: Participation is voluntary, and you do not have to answer any questions you do not wish to answer. You may skip or not answer any questions and can freely stop the interview at any time.

CONFIDENTIAL: The study will be confidential meaning the responses collected will be saved using a random name/number that will not connect the participant to the response. Virtual interviews will not be recorded, participants' responses will be entered on a computer document. Data will be destroyed 3 years after the project has ended.

DURATION: The duration of the interview will be one 30–40-minute interview.

RISKS: Potential risks are minimal (e.g. feeling uncomfortable answering some of the questions related to mental health services) but participants have the option of skipping any questions that make them feel uncomfortable and can stop the interview at any time.

BENEFITS: Participants will not have any direct benefits in the study, however, the information found will contribute to our knowledge in this area of research.

CONTACT: If you have any question regarding this study, please contact Jasmine Soriano (626|) 784-8895 or at jasmine-soriano@olivecrest.org

RESULTS: The results of this study will be presented at California State University, San Bernardino.

CONFIRMATION STATEMENT: I understand that I must be 18 years of age or older to participate in your study, have read and understand the consent document and agree to participate in your study.

Signature: ______________________________ Date: _________________

APPENDIX D

SPANISH INFORMED CONSENT

PROYECTO: Identificación de barreras para adultos hispanos (18-21 años) para acceder a sus servicios de salud mental.

OBJETIVO: El estudio en el que se le pide que participe tiene un objetivo en identificar las barreras que enfrentan los adultos hispanos para acceder a sus servicios de salud mental. Este estudio está siendo realizado por Jasmine Soriano bajo la supervisión de la ________________, California State University, San Bernardino. Este estudio ha sido aprobado por la Junta de Revisión Institucional de la Universidad Estatal de California, San Bernardino.

DESCRIPCIÓN: Se programará una entrevista virtual con el consentimiento. Se reunirá a través de Zoom y el investigador le hará preguntas sobre sus servicios de salud mental. Las respuestas se guardarán en la computadora sin el nombre real del participante.

PARTICIPACIÓN: La participación es voluntaria y no tiene que responder ninguna pregunta que no desee responder. Puede omitir o no responder a cualquier pregunta y puede interrumpir libremente la entrevista en cualquier momento.

CONFIDENCIAL: El estudio será confidencial, lo que significa que las respuestas recopiladas se guardarán con un nombre/número aleatorio que no conectará al participante con la respuesta. Las entrevistas virtuales no se grabarán, las respuestas de los participantes se ingresarán en un documento informático. Los datos serán destruidos 3 años después de que el proyecto haya finalizado.

DURACIÓN: La duración de la entrevista será de una entrevista de 30-40 minutos.

RIESGOS: Los riesgos potenciales son mínimos (por ejemplo, sentirse incómodo al responder algunas de las preguntas relacionadas con los servicios de salud mental), pero los participantes tienen la opción de omitir cualquier pregunta que los haga sentir incómodos y pueden detener la entrevista en cualquier momento.

BENEFICIOS: Los participantes no tendrán ningún beneficio directo en el estudio, sin embargo, la información encontrada contribuirá a nuestro conocimiento en esta área de investigación.

CONTACTO: Si tiene alguna pregunta sobre este estudio, comuníquese con Jasmine Soriano (626|) 784-8895 o jasmine-soriano@olivecrest.org

RESULTADOS: The results of this study will be presented at California State University, San Bernardino.

DECLARACIÓN DE CONFIRMACIÓN: Entiendo que debo tener 18 años o más para participar en su estudio, he leído y entendido el documento de consentimiento y acepto participar en su estudio.

Firma:_______________________________ Fecha:________________________

APPENDIX E

IRB APPROVAL LETTER

CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

May 30, 2023

CSUSB INSTITUTIONAL REVIEW BOARD
Administrative/Exempt Review Determination
Status: Determined Exempt
IRB-FY2023-269

Teresa Morris Jasmine Soriano
College of Social & B Sciences, Users loaded with unmatched Organization affiliation.
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Teresa Morris Jasmine Soriano:

Your application to use human subjects, titled “FACTORS THAT CONTRIBUTE TO DISPARITIES IN ACCESS TO MENTAL HEALTH SERVICES WITHIN HISPANIC ADULTS” has been reviewed and determined exempt by the Chair of the Institutional Review Board (IRB) of CSU, San Bernardino. An exempt determination means your study had met the federal requirements for exempt status under 45 CFR 46.104. The CSUSB IRB has weighed the risks and benefits of the study to ensure the protection of human participants.

This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses. Investigators should consider the changing COVID-19 circumstances based on current CDC, California Department of Public Health, and campus guidance and submit appropriate protocol modifications to the IRB as needed. CSUSB campus and affiliate health screenings should be completed for all campus human research related activities. Human research activities conducted at off-campus sites should follow CDC, California Department of Public Health, and local guidance. See CSUSB's COVID-19 Prevention Plan for more information regarding campus requirements.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission webpage. Failure to notify the IRB of the following requirements may result in disciplinary action. The Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have completed your study.

- Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.
- Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implemented in your study.
- Notify the IRB within 5 days of any unanticipated or adverse events experienced by subjects during your research.
- Submit a study closure through the Cayuse IRB submission system once your study has ended.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval number IRB-FY2023-269 in all correspondence. Any complaints you receive from participants and/or others related to your research may be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

King-To Yeung

King-To Yeung, Ph.D., IRB Chair
CSUSB Institutional Review Board

KY/MG

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