Mental Health, Diagnosis, and Treatment: The Effects of Race, Gender, and Class on Access to Mental Healthcare

Hundreds of thousands of people in America struggle with their mental health and do not get the support they need. Nearly 50,000 people died in 2022 from suicide last year in the U.S., making it the eleventh leading cause of death.[1] This does not include attempts or self-harm, so this number only represents a portion of those who suffer from mental illness and are not getting adequate treatment. Despite there being various resources and seemingly lessened stigma around mental illness compared to the last few decades, it is still an important issue.

Disparities in mental health access often correlate with higher suicidality and drug use.[2] Even with many resources for mental health, there are still barriers that make it hard to seek mental health treatment. Race, gender, and class can affect whether and how someone goes about addressing their mental health problem. This research paper examines the effects of race, gender, and class on mental well-being, diagnosis, and access to treatment. Conducting this research should make evident the root of these disparities so they can be addressed to close this gap.

Literature Review

Racial Disparity

Much of the existing research identifies a racial disparity in mental health struggles, the diagnosis of mental health disorders, and access to mental health care. However, there are conflicting conclusions about the impact of race. One study indicated that there are higher rates of mental health problems and use of mental health care among First Nation people compared to white people.[3] In that same study, there were lower

reported mental health problems and use of mental health care in African Americans, Asian Americans, Hispanic/Latino Americans, and other groups.[4] Another study indicated that there is lower mental health for Black Americans in life satisfaction and happiness.[5] Additionally, Black Americans and Latino Americans experience more severe and longer bouts of mental illness than other racial groups.[6] This is partially attributed to various forms of racism, such as discrimination and institutional racism, exhibited through incarceration and aggressive policing.[7]

Race bias exists for mental health problems that include eating disorders, substance abuse disorders, and comorbid mood disorders.[8] Black people are more likely to be misdiagnosed or over diagnosed for substance abuse and underdiagnosed for comorbid mood disorders in Black Americans compared to white Americans.[9] For conduct disorders, Black and Latino adolescents are over diagnosed. White adolescents, on the other hand, were underdiagnosed with conduct disorders despite the case vignettes demonstrating little to no difference.[10] The diagnosis of a client can be strongly influenced by preconceived notions of their racial group.

With conduct disorder, the disruptive behaviors of a child may be interpreted differently based on their race. Different cultural expressions of symptoms can affect the diagnosis of certain disorders. This has been seen with the expression and diagnosis of major depressive disorder.[11] One reason is that most mental health disorders research has been conducted by white researchers on white samples. So, symptoms of mental disorders are typically viewed through a Eurocentric lens that emphasizes emotions over physical symptoms such as fatigue and body aches, which are exhibited more by other cultures.[12]

Studies have found reasons why people who identify with a racial minority group are less likely to get treatment despite having lower mental health rates than white

people.[13] Implicit bias produces worse mental health treatment among Black Americans and other racial minority groups. For example, professionals spend less time evaluating Black Americans and other racial minorities, do fewer procedures, and provide worse quality of treatment than to white Amercians.[14] Additionally, people of color are medicated more than white people, compared to other forms of treatment such as therapy.[15] This could explain why African Americans are less likely to leave treatment before being authorized to do so, or Hispanic Americans are more likely to seek crisis services than other types of treatment.[16]

Perceived need is also important when seeking out treatment. Perceived need could be defined as "a person's awareness that something is wrong, that what is wrong relates to his or her mental health, and that professional assistance is necessary to overcome it."[17] So, someone can know that they have mental health struggles but may not think that it is a disorder or believe it will heal on its own. African Americans are more likely to believe that their mental health issues will improve on their own compared to white Americans.[18] Even with positive views of mental health care, racial minorities still tend to have lower perceived needs and are less likely to seek treatment.[19]

Gender Disparity

Studies have presented evidence that women will find it easier to access mental healthcare.[20] The reason is that women are somewhat socially conditioned to be more in tune with their emotions and mental health. Conversely, men may have a harder time seeking out mental health care due to the stigma that mental health issues have for men, which will be expanded on later in this section.[21]

Gender bias is present in the diagnosis of certain mental disorders. For example, autism spectrum disorders and ADHD have been either over diagnosed in males or

underdiagnosed in females.[22] In fact, for those who did not exhibit symptoms of ADHD, men were two times more likely to be diagnosed with ADHD than women.[23] Gender bias is also found in a few other disorders, such as antisocial and histrionic personality disorders. Still, many other mental health diagnoses did not exhibit gender bias, such as mood disorders.[24]

The psychosocial barriers, such as stigma avoidance, negative attitudes toward treatment, and mistrust of the system, have only been correlated with non-Latino white males' lack of access to mental health care, compared to other races.[25] In addition, men are more likely to report "acceptability" as the barrier to mental health care.[26] "Acceptability" as a barrier was a measure of respondents' perceptions of mental health care and their need for it, which can correlate with stigma around getting treatment.[27] This can also be seen as a perceived need. Men have a decreased sense of perceived need than women. Women also have higher rates of accessibility barriers, such as getting transportation, needing childcare, or the service being too far.[28]

Class Disparity

Lower-income people have worse mental health.[29] This can be attributed to financial stress, interactions with the criminal justice system, more crime in high-poverty areas, and more. The mental health of the lower economic class often intersects with other demographic variables, such as race, that can amplify poor mental health.[30] Although the stress from these may not necessarily lead to a diagnosable disorder, there are still services for those who have stress from these factors. However, many cannot or choose not to access these services.

An important part of seeking support for poor mental health is identifying the problem in the first place. People who identify as lower socioeconomic class may not be

aware of their mental health struggles due to a lack of "mental health literacy" compared to those of a higher socioeconomic class.[31] So many are not even aware that they are mentally unwell.

Additionally, low-income individuals and families have less access to mental health services than those who have high incomes.[32] There are a few barriers, such as the "acceptability" barrier, in which respondents thought that they could self-manage their mental health problems or had scheduling problems.[33] Another was "accessibility" barriers, which differed based on gender but were characterized by a lack of transportation and childcare services more so than the middle and upper class.[34] Overall, class affected all these variables in various ways, especially when intersected with race and/or gender.

Intersectionality

These variables cannot only be examined by themselves but also with one another. Demographic identities affect diagnosis rates, accessibility to mental health care, and quality of treatment in unique ways. In terms of reported mental health and perceived need, non-Latino white and African American men were less likely than women to have perceived need of mental health treatment.[35] Additionally, there are more likely to be negative attitudes towards getting mental health treatment, among Asian men.[36] Non-Latino white males are also more likely to have stigma avoidance, and mistrust of the healthcare system, which can deter them from treatment and even recognition that they have a disorder.[37]

In terms of treatment, there is an initial bias in just getting treatment. There are significant differences in appointment offer rates between the middle class versus the working class.[38] From the clients in the middle class, Black respondents received fewer

offers than white respondents.[39] There is a pattern of mistreatment and unmet needs of Black lower-class women in particular.[40] Being a lower-class woman reduces accessibility more so than lower-class men in terms of transportation and childcare.[41] There are so many intersecting aspects to this disparity that could be looked at more intentionally and in depth in future research.

Theoretical Framework

Symbolic interactionism theory examines how daily interactions between individuals and how society is created based on these interactions.[42] A lot of emphasis is placed on symbols and social constructs, such as race, and how they present themselves in these interactions. This will be one of the overarching theories to explain disparity in race, gender, and class in terms of mental health access.

Another major component of disparity in mental health treatment is stigma. Victoria D. Ojeda and Sara M. Bergstresser (2008) references the work of Link and Phelin (2001), which states a four-stage definition of stigma. The stages consist of the idea of established, socially constructed categories in human nature, such as race and class.[43] It also indicates the negative stereotypes associated with certain groups of people, "us" versus "them" mentality, and how discrimination and loss of opportunities arise from this phenomenon. This can explain why people may not get diagnosed correctly with mental health disorders, or if they do, how they could get unfair treatment based on their demographic.

Conflict theory points to fighting for limited resources or opportunities.[44] Although this theory can support ideas of class conflict with competing for mental health resources, it can also apply to racial and gender differences in opportunities as well. Conflict theory examines how there are limited resources, whether that is money or time,

which can deter people from getting mental health care. People in lower socioeconomic status may want to take care of their mental wellbeing, or seek treatment, but may have to direct their attention to having food, clean water, childcare, or paying the bills.

Data and Methods

This research question is how one's race, gender, and class affect access to mental healthcare. Data was used from the General Social Survey, and for the analysis, the statistical analysis program Survey Documentation and Analysis (SDA) will be used. The General Social Survey (GSS) is "a nationally representative survey of adults in the United States conducted since 1972. The GSS collects data on contemporary American society to monitor and explain trends in opinions, attitudes and behaviors."[45] All the data will be from 2018. The data will be analyzed with Survey Documentation and Analysis (SDA) "a set of programs for the documentation and Web-based analysis of survey data."[46]

The dependent variables that will be used are HLTHMNTL, DIAGNOSD, and MHTREATD. HLTHMNTL asks respondents to rate their mental health, including mood and ability to think. The variables are collapsed into "good" and "bad" mental health. The responses were recoded so that, "Excellent," "Very Good," and "Good" would all be under the category "Well" and the responses "Fair" and "Poor" would be categorized as "Not Well." DIAGNOSD asks respondents if they have ever been diagnosed with a mental health disorder. MHTREATD asks respondents who answered "Yes" to the DIAGNOSD variable if they have ever been treated for a mental health problem.

Table 1: Marginal Frequencies of Self-Reported Mental Health (HLTHMNTL)
Year: 2018
Question: In general, how would you rate your mental health, including your mood and your ability to think?

HLTHMNTL	N	%
Well	2054	89.4%
Not Well	275	10.6%
Total	2329	100.0%

Table 1 shows that 89.4 percent of the total 2329 respondents felt mentally well. The table with the uncollapsed version of this variable in in the Appendix as Table 1a.

Table 2: Marginal Frequencies of Diagnosed Mental Health Problems (DIAGNOSD)
Year: 2018
Question: Have you ever been diagnosed with a mental health problem?

DIAGNOSD	N	Percent
Yes	197	16.3
No	936	83.7
Total	1113	100.0

Table 2 shows that out of 1113 respondents, 16.3 percent have been diagnosed with a mental disorder.

Table 3: Marginal Frequencies of Treatment for Mental Problem (MHTREATD)
Year: 2018
Question: Did you get treatment for your mental health problem?

MHTREATD	N	Percent
Yes	187	95.8
No	10	4.2
Total	197	100.0

Table 3 shows that out of the 197 respondents who state they have been diagnosed with a mental health disorder, 96 percent have sought out mental health treatment.

The independent variables for this paper will be race (RACE), gender (SEX), and socioeconomic class (CLASS).

Table 4: Race (RACE)
Year: 2018

RACE	N	Percent
White	1693	73.8
Black	385	12.4
Other	270	13.8
Total	2348	100.0

Table 4 shows that out of 2348 respondents, 74 percent of participants identified as white, 12.4 percent as Black or African American and that 13.8 percent of the participants identified as another race.

Table 5: Gender (SEX)
Year: 2018

SEX	N	Percent
Male	1052	48.7
Female	1296	51.3
Total	2348	100.0

Table 5 shows that out of 2348 respondents, 51.3 percent of the respondents identified as female and 48.7 percent as male.

Table 6: Class (CLASS)
Year: 2018

CLASS	N	Percent
Lower Class	211	7.6
Working Class	1020	43.5
Middle Class	1019	45.6
Upper Class	83	3.3
Total	2333	100.0

Table 6 shows that out of 2333 respondents, 7.6 percent of the respondents identified as lower economic class, 43.5 percent as working class, 45.6 percent as middleclass, and 3.3 percent as upper class.

Results

In this section, there will be three sets of tables for each independent variable that will indicate the rate of self-reported mental health, diagnosis, and mental health treatment.

Table 7: Self-Reported Rate of Mental Health (HLTHMNTL) by Race (RACE)
Year: 2018

	White	Black	Other
Well	90.2%	86.1%	88.0%
Not Well	9.8%	13.9%	12.0%
Total	100.0%	100.0%	100.0%

N= 2329
Chi-sq= 5.06
P= 0.12

In 2018, 90.2 percent of white respondents report good mental health, 86.1 percent of Black respondents, and 88 percent of respondents identified as some other race. That is a 4.1 percent difference between white and Black respondents. These results follow the hypothesis that white respondents would have better mental health than respondents of color. With p=.12 and chi-sq=5.06, the relationship is not statistically significant.

Table 8: Diagnosis of Mental Disorder (DIAGNOSD) by Race (RACE)
Year:2018

	White	Black	Other
Yes	19.0%	12.0%	5.3%
No	81.0%	88.0%	94.7%
Total	100.0%	100.0%	100.0%

N= 1133
Chi-sq= 19.49
P= 0.00

In 2018, 19 percent of white respondents stated that they were diagnosed with a mental disorder, with 12 percent of Black respondents and 5.3 percent of respondents who identified as some other race. That is a 7 percent difference between white and Black respondents. These results follow the hypothesis because white respondents are diagnosed with a mental disorder more than non-white people. With p=0.00 and a chi-sq=19.49, the relationship is statistically significant.

Table 9: Treatment of mental health problem (MHTREATD) (out of those who reported a diagnosis of a mental disorder) by race (RACECEN1)
Year:2018

	White	Black	Other
Yes	96.3%	88.7%	100.0%
No	3.7%	11.3%	00.0%
Total	100.0%	100.0%	100.0%

N= 197
Chi-sq= 2.7
P= 0.15

In 2018, 96.3 percent of white respondents diagnosed with a mental disorder were able to get treatment, along with 88.7 percent of Black respondents and 100 percent of respondents who identified as some other race. That is a 7.6 percent difference between white and Black respondents. This follows the hypothesis that white respondents would

have better access to mental health treatment than non-white respondents. With p=0.15 and chi-sq=2.7, the relationship is not statistically significant.

Table 10: Self-Reported Rate of Mental Health (HLTHMNTL) by Gender (SEX)
Year: 2018

	Male	Female
Well	86.1%	82.6%
Not Well	13.9%	17.4%
Total	100.0%	100.0%

N= 5949
Chi-sq=13.24
P= 0.01

In 2018, 86.1 percent of men reported good mental health, while only 82.6 percent of women reported good mental health. That is a 3.5 percent difference between male and female respondents. This follows the hypothesis of men reporting better mental health than women, but not by much. With a p-value=0.01 and a chi-sq=25.80, the relationship is statistically significant.

Table 11: Diagnosis of Mental Disorder (DIAGNOSD) by Gender (SEX)
Year:2018

	Male	Female
Yes	12.6%	19.9%
No	87.4%	80.1%
Total	100.0%	100.0%

N= 1,133
Chi-sq= 10.97
P= 0.01

In 2018, 12.6 percent of men and 19.9 percent of women reported having a diagnosed mental health disorder. That is a 7 percent difference between male and female respondents. This follows the hypothesis that women are more likely to be diagnosed with a mental health disorder than men. With a p-value of 0.01 and a chi-sq of 10.97, this relationship is statistically significant.

Table 12: Treatment of mental health problem (MHTREATD) by Gender (SEX) Year: 2018

	Male	Female
Yes	94.4%	96.7%
No	5.6%	3.3%
Total	100.0%	100.0%

N= 197
Chi-sq= 0.61
P= 0.48

In 2018, 94.4 percent of men report getting treatment for their mental health disorder, along with 96.7 percent of women. That is only a 2.3 percent difference between male and female respondents. This follows the hypothesis because women reported higher access to mental health treatment than men. With a p-value=.48 and chi-sq=0.61, the relationship is not statistically significant.

Table 13: Self-Reported Rate of Mental Health (HLTHMNTL) by Class (CLASS)
Year: 2018

	Lower Class	Working Class	Middle Class	Upper Class
Well	62.8%	83.3%	89.1%	89.6
Not Well	37.2%	16.7%	10.9%	10.4%
Total	100.0%	100.0%	100.0%	100.0%

N=5944
Chi-sq= 244.97
P= 0.00

In 2018, lower class respondents reported the lowest rate of mental health, with only 62.8 percent of them feeling mentally well; the working class reported 83.3 percent, the middle class reported 89.1 percent, and the upper class reported 89.6 percent. There is a 26.5 percent difference between lower-class and upper-class respondents. This follows the hypothesis that the lower-class respondents would have the worst reported mental health compared to the other classes. With a p-value= 0.00 and a chi-sq= 244.97 the relationship is statistically significant.

Table 14: Diagnosis of Mental Disorder (DIAGNOSD) by Class (CLASS)
Year:2018

	Lower Class	Working Class	Middle Class	Upper Class
Yes	21.2%	19.8%	12.7%	11.0%
No	78.8%	80.2%	87.3%	89.0%
Total	100.0%	100.0%	100.0%	100.0%

N= 1,125
Chi-sq= 11.32
P= 0.04

Twenty-one-point two percent of lower-class respondents were diagnosed with a mental health disorder, following 19.8 percent of working-class respondents, 12.7 percent of middleclass respondents, and eleven percent of upper-class respondents. There is a 10.2 percent difference between lower-class and upper-class respondents. This does not follow the hypothesis because the lower-class respondents were more likely to be diagnosed with a mental health disorder. With the p-value=.04 and a chi-sq=11.32, the relationship is statistically significant.

Table 15: Treatment of mental health problems (MHTREATD) by Class (CLASS)
Year: 2018

	Lower Class	Working Class	Middle Class	Upper Class
Yes	91.5%	97.2%	95.6%	84.7%
No	8.5%	2.8%	4.4%	15.3%
Total	100.0%	100.0%	100.0%	100.0%

N= 197
Chi-sq= 2.93
P= 0.4

Ninety-one-point five percent of lower-class respondents report having treatment for their mental health disorder, along with 97.2 percent of working-class respondents, 95.6 percent of middle-class respondents, and 84.7 percent of upper-class respondents. There is a 6.8 percent difference between lower-class and upper-class respondents. This does not follow the hypothesis, with the upper-class respondents having the least reported treatment for their mental health disorder, while the working class has the highest reports of treatment. With a p-value= 0.4 and a chi-sq= 2.93, the relationship is not statistically significant.

Discussion

Race

The self-reported status of mental health (HLTHMNTL) showed some variance across race but not much, with Black respondents having the lowest percentage of mental health reported as "Well," with respondents who responded as some other race with the highest percentage. These results supported part of the hypothesis: it was assumed that white respondents would have better mental health overall than people of color, but it

turns out that respondents in the “Other” category reported the best mental health. Of course, these results do not allow us to differentiate between Latino people, Asian people, and others, and the differences are small.

This study speculates that the difference in reported mental health could be differences in opportunity and prejudice. Black Americans are more likely to face racial prejudice on a day-to-day basis than white ones. They are also more likely to live in low-income areas with fewer opportunities and more crime and violence. This difference in lived experience can contribute to lower mental health in Black Americans than in white Americans. For the respondents who are of some other race, they are more likely to face racial prejudice than the white respondents, but in this study, differences in opportunity, income, and other factors that could contribute to each race’s lived experiences were not examined.

Examination of the diagnosis of mental health disorders (DIAGNOSD) produced statistically significant results showing a strong correlation between race and diagnosis of mental health disorders. The results follow the hypothesis that white people would more likely get a diagnosis for a mental health disorder than people of color. This disparity could represent access to a doctor or some other health professional who has the expertise to diagnose them. This can also be reflective of the different cultural ways people could express poor mental health symptoms. Diagnostic criteria in America are typically based on Eurocentric views of mental health that mostly rely on emotions or feelings and antisocial characteristics. People of other cultures might exhibit mental disorder symptoms in more physical ways, such as fatigue and body aches. It is interesting to point out that despite Black respondents having lower mental health, they had lower mental disorder diagnoses. Although poor mental health doesn’t always correspond with the

presence of a mental disorder, such as general stress, it is interesting to see this incongruence. This could be reflective of more trust in the healthcare system among white people to get tested for a disorder. This can also be representative of possible stigma differences in the racial community. The percentage of those diagnosed within the "Other" race category aligns with the previous results of having slightly higher rates of good mental health. The combination of these results could be evidence of stigma in various racial communities that is not represented in the results.

Race did not predict differences in the reported treatment of a mental health problem (MHTREATD), but there was still an eight percent difference between those who have sought out treatment among white and Black respondents. This difference was not statistically significant. The difference could be because Black people tend to have worse experiences in healthcare than white people.[47] This is where the theory of symbolic interactionism can be useful in understanding why people of certain groups are less likely to seek treatment.

When people of color experience discrimination or microaggressions in interactions during treatment, this creates a poor impression of mental health treatment for them. It may make them wonder if those interactions mean the treatment is not meant for people who identify with a race other than white. This phenomenon can be intensified by others around them who also share poor experiences with mental health professionals. Studies show that if Black people get treatment for mental health care, it is often due to a crisis, and they leave treatment before being authorized to do so.[48] This can lead to a sense of mistrust of healthcare and be compounded by other factors, such as stigma or lack of resources, that result in them relying on self-care methods rather than professional treatment.

Gender

For self-reported mental health, there is a statistically significant difference, although the percentage difference is about three percent between those who say they are mentally well versus those who say they are mentally unwell. This difference goes back to Link and Phelan's (2001) theory on stigma around mental health. There is a general unwillingness by men to show vulnerability because society has put a negative label on seeking mental health care or having mental health issues, and men don't want to be discriminated against for that.[49] So, although the men in this study mostly said that they are mentally well, there probably were more who felt unwell.

The relationship for diagnosis of a mental health disorder (DIAGNOSD) with gender was significantly significant, with a seven percent difference between males and females. This paper hypothesized that women were more likely to get diagnosed with a mental health disorder than men, once again due to stigma. There is a stigma for men to feel emotions, but also for being labelled with a mental health disorder. Although women experience this as well, it is more present in a man's experience.

The treatment of a mental health problem by gender was not statistically significant, nor was there much of a percentage difference between sexes.

Class

The relationship between economic class and self-reported mental health (HLTHMNTL) is large and statistically significant. The lower economic class reported the lowest rate of mental health, with only 62.8 percent of respondents in that category feeling well. Between the lower economic class and the working class, the two smallest percentages, there is a twenty percent difference. This represents a significant gap in mental health. It is evident that the lower economic class is suffering from mental health

struggles the most. This can be attributed to many factors. One would be a lack of resources and opportunities. Many in poverty struggle to find or keep stable jobs, which can lead to poor mental health. In urban areas, the lower economic class is typically made up of mostly racial minorities, which can indicate intersecting hardship of a lack of opportunity and everyday racism in the media or by cops in their neighborhood. The lower economic class is more likely to have been in the criminal justice system or know someone who has or is imprisoned, which can correlate with poor mental health and generational poverty. There is a myriad of factors that may have led to these results, and they should be further examined.

The relationship between class and the diagnosis of a mental disorder (DIAGNOSD) is large and statistically significant. The lower economic class has higher rates of mental health issues than other classes but only has a small difference in diagnosis. Poor mental health can be due to stress and other daily occurrences that are more likely to happen to those in a lower socioeconomic class. That being said, along with stigma, there are other reasons as to why someone with a disorder may not have been diagnosed. One part could be attributed to conflict theory and the lack of resources. For example, a lower-class individual may not have enough money to go to a doctor and seek diagnostic testing. They may also not have time due to working multiple jobs, overnights, or may not be able to afford childcare to make that appointment. There could also just be a lack of priority put on mental health because they need to figure out housing, food, schooling for their kids, and other necessities that hold priority daily. People with more income are less likely to have to juggle these priorities as they have more resources.

Lastly, there is no statistically significant relationship between the treatment of a mental health problem (MHTREATD) and class. Although upper-class respondents were more likely to say yes to a mental health disorder, they are least likely to seek treatment. It could be assumed that because they have more resources, they would be more likely to seek treatment than the other classes. But once again, stigma has a huge role in this, especially in the upper classes. People in the upper class might be more in the public eye or have a general reputation among their peers that they want to uphold, which could be deeply affected by openly seeking treatment for their diagnosis. So, despite having the resources to do so, many may choose not to because of this social factor.

Conclusion

This paper examined how race, gender, and class affect the mental well-being, diagnosis, and access to treatment for respondents. It found the most statistically significant evidence mainly in how class affects these variables. There was a significant correlation between race and diagnosis. There is also a correlational relationship between gender, mental well-being, and diagnosis. Men are less likely to report poor mental health or have a mental health diagnosis compared to women. As good as this sounds, men are still committing suicide at four times the rate of women, which indicates that this disparity needs to be looked at more closely. Class clearly plays a significant role in mental health disparities, with the lower economic class suffering from the lowest rates of good mental health and a small number of diagnoses despite having the highest poor mental health rates. However, it also examined a trend of people in the upper class not seeking treatment for their diagnosis in comparison to the other classes, which raises some questions.

Overall, there are some trends here based on demographic information, and more research needs to be done on a variety of factors, including races outside of “white” and “Black”, along with age and geographical location. It would also be beneficial to examine reasons behind not seeking treatment, especially concerning stigma and access to resources.

Appendices

Table 1a: Marginal Frequencies of Self-Reported Mental Health Year: 2018

Question: In general, how would you rate your mental health, including your mood and your ability to think?

HLTHMNTL	Value	N	%
Excellent	1	478	20.8%
Very Good	2	905	40.2%
Good	3	671	28.3%
Fair	4	232	8.7%
Poor	7	43	1.9%
Total		2329	100.0%

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