



CHILDREN AND FAMILIES
EDUCATION AND THE ARTS
ENERGY AND ENVIRONMENT
HEALTH AND HEALTH CARE
INFRASTRUCTURE AND
TRANSPORTATION
INTERNATIONAL AFFAIRS
LAW AND BUSINESS
NATIONAL SECURITY
POPULATION AND AGING
PUBLIC SAFETY
SCIENCE AND TECHNOLOGY
TERRORISM AND
HOMELAND SECURITY

The RAND Corporation is a nonprofit institution that helps improve policy and decisionmaking through research and analysis.

This electronic document was made available from www.rand.org as a public service of the RAND Corporation.

Skip all front matter: [Jump to Page 1](#) ▼

Support RAND

[Browse Reports & Bookstore](#)

[Make a charitable contribution](#)

For More Information

Visit RAND at www.rand.org

Explore the [RAND Corporation](#)

View [document details](#)

Limited Electronic Distribution Rights

This document and trademark(s) contained herein are protected by law as indicated in a notice appearing later in this work. This electronic representation of RAND intellectual property is provided for non-commercial use only. Unauthorized posting of RAND electronic documents to a non-RAND website is prohibited. RAND electronic documents are protected under copyright law. Permission is required from RAND to reproduce, or reuse in another form, any of our research documents for commercial use. For information on reprint and linking permissions, please see [RAND Permissions](#).

This report is part of the RAND Corporation research report series. RAND reports present research findings and objective analysis that address the challenges facing the public and private sectors. All RAND reports undergo rigorous peer review to ensure high standards for research quality and objectivity.



Beliefs Related to Mental Illness Stigma Among California Young Adults

Rebecca L. Collins, Elizabeth Roth, Jennifer L. Cerully, Eunice C. Wong

The goal of this report is to examine mental illness stigma and related beliefs among young adults in California. Specifically, we examine whether levels of stigma are higher or lower than those observed in older adults and identify beliefs in this age group that might be the most appropriate targets for intervention to increase early enrollment in care.

The onset of mental illness symptoms occurs by age 24 in three-fourths of all people who experience a mental illness in their lifetime (Kessler et al., 2005), but treatment delay ranges from six to eight years or more (Wang et al., 2005). Failure to seek treatment and treatment delay are especially likely among those with the onset of symptoms at an earlier age (Wang et al., 2005), making adults under age 30 an important target of early intervention efforts. Mental illness stigma (beliefs that people experiencing mental illness are, for example, dangerous, worthless, or cannot recover, as well as unwillingness to work, live, and socialize with affected individuals) is common, and fear of stigmatization has been identified as a barrier to seeking treatment. Thus, reducing stigma among young adults might serve to bring more of them into treatment sooner. However, prior population surveys have found that young persons already report relatively low levels of stigma. In a review of 32 tests of age differences across 18 publications, Angermeyer and Dietrich (2006) concluded that older people have more stigmatizing attitudes than younger ones in the majority of cases. In the interest of guiding policy on stigma reduction, we tested whether this is currently the case among adults residing in California, with the goal of informing California's stigma-reduction efforts.

Method

We surveyed a probability sample of 2,568 California adults ages 18 years and older who were reachable by telephone (landline or cell phone). We initially surveyed a random sample of 2,001 adults in the spring of 2013, and then surveyed additional African American and Asian American adults in the summer of 2013 to enhance the diversity of the sample so that racial/ethnic differences could be tested. This additional sample was drawn from targeted lists of individuals likely to be African American

or Asian American based on a variety of information sources and is not a probability sample. In total, the sample included 1,014 White, 631 Latino, 401 Asian American, and 360 African American individuals, as well as 108 who identified as another race or multiracial (and 54 who did not indicate a race or ethnicity). Participants were allowed to choose the language of survey administration, including English, Spanish, Cantonese, Mandarin, Vietnamese, Hmong, and Khmer. A total of 305 Latino individuals completed the survey in Spanish; 254 Asian Americans completed it in an Asian language.

For the initial random sample of adults, the response rate (completes among known eligibles plus estimated unknown eligibles) was 15 percent and the cooperation rate was 63 percent. The demographic characteristics among those surveyed were similar to population proportions prior to weighting, slightly underrepresenting younger people and minorities. Within the targeted racial/ethnic sample, the response rate was 8 percent and the cooperation rate 66 percent. Although our response rates were low, they were not out of the normal range for recent surveys and do not necessarily indicate bias in the data (Groves, 2006). We applied a weighting procedure to the data so that the results of the survey approximate those of the adult population of California. However, our additional sampling of Asian Americans was focused on Chinese and Southeast Asian subgroups; therefore, the views of Korean, Filipino, Japanese, or other Asian groups residing in California may not be fully represented.

Twenty-four percent of the weighted final sample consisted of young adults ages 18–29 (unweighted $n = 449$), with the remainder fairly evenly distributed across ages 30–39, 40–49, 50–64, and 65 or older. In the analyses presented here, we compare individuals ages 18 to 29 with all other respondents to the survey (i.e., those 30 and older). For dichotomous (two-category) measures, we use chi-square to test for difference by age; for our continuous measure, we use a t-test.

Our survey measured attitudes, beliefs, and behavior across a variety of domains related to stigma and treatment seeking, drawing on previously validated measures, typically those used in large-population surveys. Using two common survey questions,

or items, we measured stigmatizing beliefs, one about perceived dangerousness (drawn from the Centers for Disease Control and Prevention [CDC] Health Styles survey [Kobau et al., 2010]) and one tapping perceptions of the contributions people with mental health problems can make to society (adapted from the New Zealand “Like Minds” stigma-reduction campaign evaluation [Wyllie and Lauder, 2012]).

We measured respondents’ attitudes with three indicators of social distance. Social distance is a person’s unwillingness to have contact with a person experiencing mental health problems. Participants were asked whether they would be willing to “move next door to,” “spend an evening socializing with,” or “work closely on a job with” someone who has a serious mental illness. The three social contact situations were drawn from a larger set used in the U.S. General Social Survey (Pescosolido et al., 2010) and chosen to represent diverse kinds of interaction, as well as contact that was not particularly intimate and thus more likely to be changeable over time (to maximize our likelihood of observing changes between the survey described here and a follow-up survey conducted one year later). The original survey items use vignettes to describe individuals experiencing sets of symptoms associated with various mental health conditions (e.g., depression, schizophrenia). To make the items briefer, we replaced the vignettes with the phrase: “a person who has a serious mental illness.”

People’s attitudes toward mental illness are not always in line with their beliefs about how the general public views those with mental illness (Reavley and Jorm, 2011). Respondents’ perceptions of others’ attitudes—or, to put it differently, their awareness of stigma—were tapped with two items, one asking whether people are generally caring and sympathetic toward those with mental illness and another asking whether people with mental illness experience high levels of prejudice and discrimination (drawn from the CDC Health Styles survey [Kobau et al., 2010] and adapted from the evaluation instrument for the Irish national stigma-reduction “See Change” campaign [See Change, 2012], respectively).

Stigma is one factor in underutilization of mental health services (Clement et al., 2014). To measure treatment seeking, we asked respondents whether they would seek professional help if they had a serious emotional problem (using an item from the National Comorbidity Survey [Mojtabai, 2007]), with the following response options: “definitely,” “probably,” “probably not,” and “definitely not.” A prior U.S. national survey found that youth ages 15 to 24 were less likely to endorse this item than older persons (Gonzalez, Alegria, and Prihoda, 2005). We also asked respondents whether fear of disclosure would cause them to delay seeking treatment if they had a mental health problem and (to measure more general concealment based on fear of stigma) whether they would conceal the problem from friends and family and/or coworkers and classmates. These three items were adapted from the evaluation instrument for the See Change campaign (See Change, 2012).

Stigma may influence not only whether an individual seeks help, but also whether he or she provides it to others (Jorm et al., 2005). We asked respondents whether they had contact with anyone who had a mental health problem in the past 12 months and, if yes, the extent to which they provided emotional support, linkage to professional treatment, or linkage to community resources/informal support (“not at all,” “a little,” “some,” “a lot”). Items were constructed based on responses to the Australian National Survey assessing how people react when they have contact with someone experiencing mental health problems (termed “mental health first aid” responses; Jorm et al., 2005).

We measured beliefs about recovery because they are often related to stigma (Wood and Wahl, 2006) and are likely to influence treatment seeking and referral. We asked respondents to estimate the number of persons out of 100 who “see a professional for serious emotional problems” (drawing the item from the National Comorbidity Survey [Mojtabai, 2007]) and to express the strength of their agreement or disagreement with the statement “A person with mental illness can eventually recover” (drawn from the CDC Health Styles questionnaire [Kobau et al., 2010]).

Results

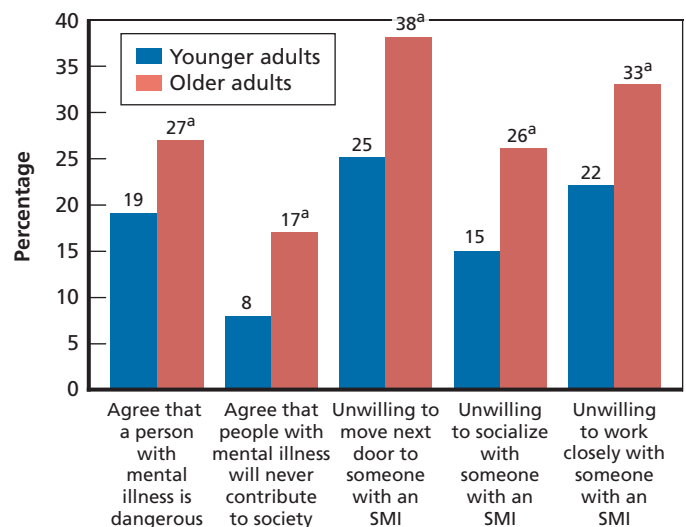
Stigma-Related Attitudes and Beliefs

Relative to other age groups, young adults in California have more positive attitudes and beliefs about people with mental health challenges (see Figure 1).

Awareness of Mental Illness Stigma

Although their own attitudes toward people experiencing mental health problems are relatively positive, young adults are aware of

Figure 1. Fewer Young Adults Hold Stigmatizing Attitudes and Beliefs About Mental Illness Than Older Adults



^aOlder and younger adults differ significantly, $p < 0.01$.

NOTE: SMI = serious mental illness.

mental illness stigma within the broader society. Indeed, younger adults see the general public as more stigmatizing of those with mental illness than do older adults. Only 38 percent of young adults endorsed the item “People are generally caring and sympathetic towards those with mental illness,” while 46 percent of older adults did so ($p < 0.01$). In response to the item “People with mental illness experience high levels of prejudice and discrimination,” 76 percent of young adults agreed or strongly agreed, while 72 percent of older adults did so (a difference that is not statistically significant, $p = 0.11$).

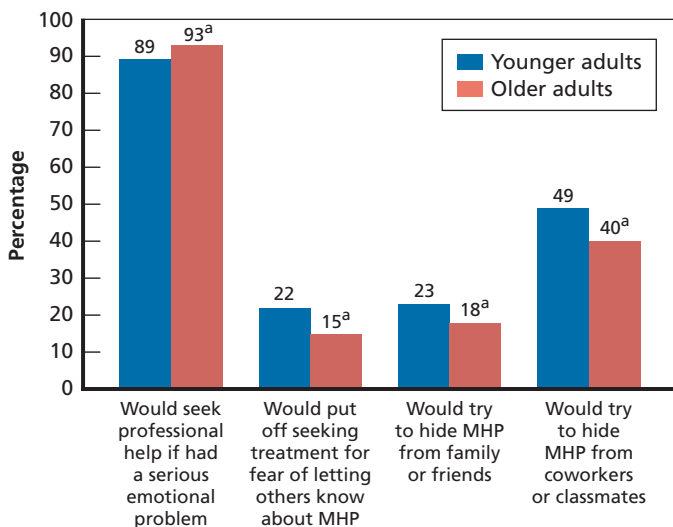
Probable Treatment-Seeking and Concealment

Consistent with this awareness of stigma, young adults showed concern about how they would be perceived should they experience a serious emotional problem. They were slightly less likely than other age groups to say they would seek professional help if they had a serious emotional problem, and somewhat more likely to say they would put off treatment out of fear of others’ finding out and would hide the problem from family, friends, coworkers, and/or classmates (see Figure 2).

Contact with Persons Experiencing Mental Health Challenges

One reason behind the lower levels of stigmatizing attitudes and beliefs held by young adults may be their greater experience with those who have a mental health challenge. Young adults are more likely than older adults to report recent contact with someone who has a mental health problem. Seventy percent said they had interacted with such a person in the past 12 months, while only 60 percent of older adults did so ($p < 0.01$). As shown in Figure 3, among those who reported contact in the past year with

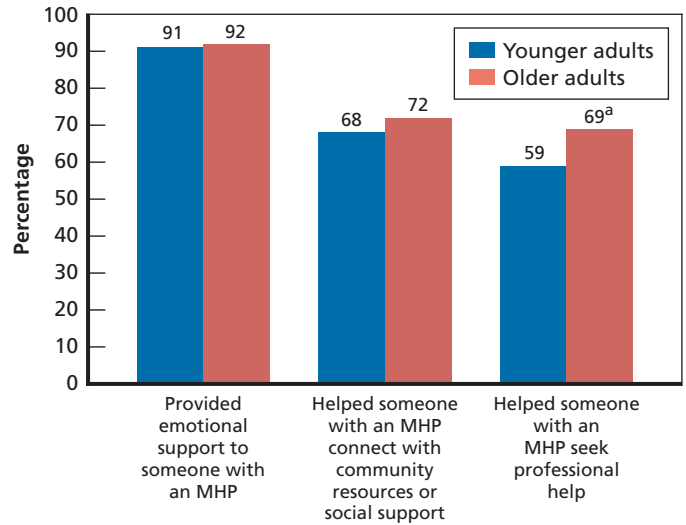
Figure 2. Young Adults Are Less Likely to Seek Treatment and More Likely to Conceal Mental Health Problems Than Older Adults



^aOlder and younger adults differ significantly, $p < 0.05$.

NOTE: MHP = mental health problems.

Figure 3. Past-Year Support Provision to Someone with a Mental Health Problem Among Younger Versus Older Adults



^aOlder and younger adults differ significantly, $p < 0.05$.

NOTE: Percentages given are of those who interacted in the past year with a person with an MHP.

someone who had a mental health problem, nearly all, regardless of age, said they provided emotional support to the individual. Younger and older adults were also about equally likely to provide help connecting with community resources, friends, or family. However, young adults were less likely than older ones to say they assisted the person to obtain professional help.

Recovery Beliefs

Although young adults are relatively reticent to seek treatment or refer others, they have no less confidence in its efficacy. Their beliefs about recovery and professional treatment do not differ from the beliefs expressed by older age groups, estimating that 46 percent of those who “see a professional for serious emotional problems” are helped, compared to an estimate of 47 percent among older adults ($p = 0.55$). Seventy-one percent of young adults agree or strongly agree that “a person with mental illness can eventually recover,” compared to 70 percent of older adults ($p = 0.54$).

Discussion

Rates of mental illness stigma are lower among younger versus older adults in California. Twenty-five percent say they would be unwilling to move next door to someone with mental illness, and nearly as many, about one in five, are unwilling to work closely with someone with mental illness or consider people with mental illness to be dangerous. Changing young adults’ beliefs would increase feelings of social inclusion and acceptance among people living with mental health challenges. Nonetheless, these rates of stigma are about 30 to 50 percent lower than those observed among older Californians. This might be because

societal attitudes have been changing over time and older adults have not “caught up” with new norms, or it may be that attitudes toward people with mental illness become more negative with age. Regardless of the source of the discrepancy, this raises the question of whether it would be an optimal investment of effort and funds to focus stigma reduction on young adults, or whether the same investment would yield greater payoff if groups where stigma is more prevalent were targeted. There may be other reasons for targeting young adults, but in terms of prevalence of the problem being addressed (stigma) our data suggest young adults are a lower-priority group.

The primary rationale for focusing on young adults with mental illness is the desire to increase their rates of enrollment in care, resulting in interventions earlier in life and sooner after diagnosis. Our analyses indicate that young adults who experience mental illness symptoms are slightly less likely to seek care and substantially more likely to delay care. Although survey items are hypothetical, participants’ reports are consistent with U.S. data on treatment-delaying behavior (Gonzalez et al., 2005; Wang et al., 2005). Young adults in California are also more likely to conceal their (hypothetical) illness and they see society as more stigmatizing than do older individuals, even though their own attitudes are more accepting of those with mental health problems. In their report on mental illness stigma in Australia, Reavley and Jorm (2011) find that Australians attribute more stigmatizing attitudes to others than they hold themselves and argue that interventions to reduce stigma should focus on bringing beliefs about public perceptions in line with personal beliefs. Our data suggest that an analogous approach to stigma reduction would be effective in California, at least for young adults. For example, young adults might be provided feedback about their peers’ attitudes toward mental illness, demonstrating that

most young adults hold less-stigmatizing views than commonly attributed to them or to broader society. Recognizing that their peers are accepting might help young adults to reduce their fears of stigma and increase their willingness to seek or refer others to treatment.

Another potentially fruitful method of increasing early enrollment in care is to spread knowledge on where and how to seek help. Seventy percent of young adults interacted with someone in the prior year who had a mental health problem, compared with 60 percent of older adults who did so. But young adults were also much less likely to say they helped the person in question to obtain professional help, and are themselves less likely to seek help. Our findings suggest that this is not due to differential perceptions of treatment or recovery, but rather that young adults know less about where treatment is available or how to obtain it, or are less likely to see treatment as worthwhile given social and monetary costs. Programs such as Mental Health First Aid (MHFA) might help to address these gaps. MHFA trains individuals to identify and respond to people with developing mental health problems or to people in crisis. One of five steps in providing aid is to encourage the seeking of professional help, and MHFA provides information about the types of professionals and help available (e.g., medication, talk therapy). MHFA also provides information about local and national resources to help link individuals to care. A growing evidence base suggests that MHFA is effective in increasing knowledge and rates of intervention, as well as in decreasing stigma (Jorm, 2012). Providing MHFA training to California young adults would improve the chances that they would link others to care, and might also decrease self-stigma and increase their own likelihood to seek care should they need it. Each of these changes would help to address the need to get more young adults with mental health problems in California into care sooner.

References

- Angermeyer, M. C., and S. Dietrich, "Public Beliefs About and Attitudes Towards People with Mental Illness: A Review of Population Studies," *Acta Psychiatrica Scandinavica*, Vol. 113, No. 3, 2006, pp. 163–179.
- Clement, S., et al., "What Is the Impact of Mental Health–Related Stigma on Help-Seeking? A Systematic Review of Quantitative and Qualitative Studies," *Psychological Medicine*, 2014, pp. 1–17.
- Gonzalez, J. M., M. Alegria, and T. J. Prihoda, "How Do Attitudes Toward Mental Health Treatment Vary by Age, Gender, and Ethnicity/Race in Young Adults?" *Journal of Community Psychology*, Vol. 33, No. 5, 2005, pp. 611–629.
- Groves, Robert M., "Nonresponse Rates and Nonresponse Bias in Household Surveys," *Public Opinion Quarterly*, Vol. 70, No. 5, 2006, pp. 646–675.
- Jorm, A. F., "Mental Health Literacy: Empowering the Community to Take Action for Better Mental Health," *American Psychologist*, Vol. 67, No. 3, 2012, p. 231.
- Jorm, A. F., et al., "Mental Health First Aid Responses of the Public: Results from an Australian National Survey," *BMC Psychiatry*, Vol. 5, No. 1, 2005.
- Kessler, R. C., et al., "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry*, Vol. 62, No. 6, 2005, pp. 593–602.
- Kobau, R., et al., "Attitudes About Mental Illness and Its Treatment: Validation of a Generic Scale for Public Health Surveillance of Mental Illness Associated Stigma," *Community Mental Health Journal*, Vol. 46, No. 2, 2010, pp. 164–176.
- Mojtabai, R., "Americans' Attitudes Toward Mental Health Treatment Seeking: 1990–2003," *Psychiatric Services*, Vol. 58, 2007, pp. 642–651.
- Pescosolido, B. A., J. K. Martin, J. S. Long, T. R. Medina, J. C. Phelan, and B. G. Link, "A Disease Like Any Other? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence," *American Journal of Psychiatry*, Vol. 167, No. 11, 2010, pp. 1321–1330.
- Reavley, N. J., and A. F. Jorm, "Young People's Stigmatizing Attitudes Towards People with Mental Disorders: Findings from an Australian National Survey," *The Australian and New Zealand Journal of Psychiatry*, Vol. 45, No. 12, 2011, pp. 1033–1039.
- See Change: The National Mental Health Stigma Reduction Partnership, "Irish Attitudes Towards Mental Health Problems," 2012. As of August 7, 2014:
http://www.seechange.ie/wp-content/themes/seechange/images/stories/pdf/See_Change_Research_2012_Irish_attitudes_towards_mentl_health_problems.pdf
- Wang, P. S., et al. "Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry*, Vol. 62, No. 6, 2005, pp. 603–613.
- Wood, A. L., and O. F. Wahl, "Evaluating the Effectiveness of a Consumer-Provided Mental Health Recovery Education Presentation," *Psychiatric Rehabilitation Journal*, Vol. 30, No. 1, 2006, pp. 46–53.
- Wyllie, A., and J. Lauder, *Impacts of National Media Campaign to Counter Stigma and Discrimination Associated with Mental Illness*, Auckland, New Zealand: Phoenix Research, June 2012.

Acknowledgments

The RAND Health Quality Assurance process employs peer reviewers. This document received rigorous technical reviews by Joshua Breslau and Donna Farley, which served to improve the quality of this report. In addition, members of the Statewide Evaluation Experts (SEE) Team, a diverse group of California stakeholders, provided valuable feedback on a draft of the report.

RAND Health

This research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at <http://www.rand.org/health>.

CalMHSA

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and Early Intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

© Copyright 2014 RAND Corporation

www.rand.org



The RAND Corporation is a nonprofit institution that helps improve policy and decisionmaking through research and analysis. RAND focuses on the issues that matter most, such as health, education, national security, international affairs, law and business, the environment, and more. As a nonpartisan organization, RAND operates independent of political and commercial pressures. We serve the public interest by helping lawmakers reach informed decisions on the nation's pressing challenges. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. **RAND**® is a registered trademark.