

Language, Cultural, and Systemic Barriers to Mental Health Care Among Racial and Ethnic Groups in California: Scope of the Problem and Implications for State Policy

Brief Report

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Executive Summary

The Need for Mental Health Care in California

Psychological distress negatively affects California's population and work force. Sixteen percent of Californian adults reported needing help for a mental or emotional problem in the past year, 13% did less in the previous month because of mental or emotional problems, and 16% were unable to do their work or other activities as well as usual because of a mental or emotional problem. Some populations are particularly affected by psychological distress. A fifth (20%) of both Latinos and African Americans reported not being able to do their work or activities as well as usual because of emotional problems, compared to 15% of Asian/Pacific Islanders and 14% of Whites.

Barriers to Mental Health Care in California

Of the 16% of Californians who reported needing help for an emotional problem in the past year, less than half (42%) received needed mental health services. Race/ethnicity and lack of English language proficiency were significant barriers to care. African Americans, Asian/Pacific Islanders, and Latinos were all about 30% less likely to have gotten care than Whites even when other factors, such as poverty, English language proficiency, and insurance status, were controlled. When other factors were controlled, Californians who did not speak English were almost 80% less likely to have received needed services than those who spoke English.

Lack of health insurance was the most powerful systemic barrier to mental health care among all Californians. Insured adults were twice as likely to have received needed mental health care than those who were uninsured when other variables were controlled. Another significant barrier was not being a US citizen. Citizens were almost one and a fourth times more likely to have received needed mental health care than non-citizens when other factors were controlled.

Among adults with health insurance, lack of mental health coverage was the most powerful systemic barrier to mental health care. Insured adults with mental health coverage were twice as likely to have received care as those without mental health coverage. Among only adults with health insurance, non-citizens were as likely as US citizens to have received needed mental health treatment when other factors were controlled. However, even with insurance coverage, Latinos and African Americans were still significantly less likely to have received needed services than Whites. Insured Latinos were 30% less likely and insured African Americans were almost 40% less likely to have received needed care compared to insured Whites. There was no significant difference between Whites and Asian/Pacific Islanders in this group. Non-English speakers were still at a disadvantage

among insured adults; they were 65% less likely to have received needed services compared to English speakers when other factors were controlled.

Policy Recommendations

According to our policy models, the most effective ways to increase use of needed mental health services for all Californians is to provide health insurance with mental health coverage and to reduce language barriers to care. Among all Californians whose demographics make them highly likely to need mental health care and unlikely to receive it (e.g., poor, non-citizens, high school education, non-English speaking), an estimated 67% would receive care if these two barriers were removed.

Issues of Particular Interest to Latino Californians

Of all racial/ethnic groups, Latinos were the least likely to receive needed mental health care. Only 24% received needed services, leaving approximately 750,000 Latino adults in California who did not receive needed care. Latinos' use of mental health care varied dramatically by English language proficiency. Though a similar percentage of English-only speaking Latinos (17%), bilingual Latinos (14%), and non-English speaking Latinos (18%) reported a need for mental health care, 43% of English-only speaking Latinos received needed services, compared to 34% of bilingual Latinos, and only 8% of non English-speaking Latinos. Barriers to care among Latinos were myriad. Latinos were the racial/ethnic group least likely to have health insurance and, among those with insurance, the least likely to have mental health coverage. Only 71% of insured Latinos had mental health insurance compared to 90% of insured Whites. Even when insurance status and English language proficiency were controlled, Latinos were still less likely to have received needed mental health services compared to Whites. Policy models indicated that removing language barriers and providing insurance with mental health coverage would increase the receipt of needed services from less than a fourth to 45% of disadvantaged Latinos.

Issues of Particular Interest to Asian/Pacific Islander Californians

Asian/Pacific Islanders were the racial/ethnic group reporting the lowest level of psychological distress, as is typically found in mental health research. Only 9% of this group reported needing mental health services within the past year, compared to 16% of Latinos, the group with next lowest level of reported need. However, this may not necessarily reflect the true level psychological distress among this group. Unlike Whites who reported need for mental health care in higher percentages than they reported specific indicators of psychological distress, Asian/Pacific Islanders reported specific

distress in higher percentages than they reported need for mental health care. Though only 9% of Asian/Pacific Islanders reported needing mental health care, 13% reported doing less, and 15% reported not doing their usual work as well in the past month because of mental or emotional problems. Specific distress was even more prevalent among Asians/Pacific Islanders who did not speak English, 18% of whom reported doing less and 22% of whom reported not doing their usual work as well because of a mental or emotional problem.

Asian/Pacific Islanders were less likely than Whites to receive needed services. Non-English speaking Asian/Pacific Islanders were particularly unlikely to receive needed services. Only nine percent of non-English speaking Asian/Pacific Islanders received needed mental health services, compared to 31% of bilingual Asian/Pacific Islanders and 56% of English-only speaking Asian/Pacific Islanders. Policy models indicated that making mental health insurance coverage available and decreasing language barriers would be particularly effective in increasing rates of receipt of needed services among this group, leading to an estimated 97% of disadvantaged Asian/Pacific Islanders receiving needed mental health care.

Issues of Particular Interest to African American Californians

Seventeen percent of African Americans reported needing help for a mental or emotional problem. Though these Californians received mental health care at higher rates than Latinos and Asian/Pacific Islanders, perhaps reflecting an absence of barriers related to English proficiency, they still receive care at lower rates than Whites (42% for African Americans vs. 53% for Whites). African Americans were also significantly more likely to have used the emergency room for a mental health problem than other racial/ethnic group; 7% of African Americans used the ER, compared to 2% of both Whites and Asian/Pacific Islanders and 3% of Latinos. Policy models indicate that the most effective area to focus for improving rates of needed mental health service for African Americans is to provide universal health insurance. Insured African Americans were 4 times more likely to have received needed mental health care than were uninsured African Americans.

Issues of Particular Importance for White Californians

Eighteen percent of Whites reported needing help for a mental or emotional problem within the past year, making them the racial/ethnic group with the highest reported mental health need. However, it is not clear whether this indicates that white Californians actually experience the greatest amount of psychological distress or are just more likely to characterize experiences of psychological distress as requiring treatment. Though Whites were the most likely to report a need for treatment, they were the

racial/ethnic group least likely to report any of the specific measures of current psychological distress, which were feeling downhearted and sad, doing less because of an emotional problem, or not doing usual work as well because of an emotional problem within the past month.

Whites were the most likely to receive needed mental health services of all racial/ethnic groups. However, due to current state demographics, the greatest number of adults with an unmet mental health need are White. Forty-seven percent of Whites didn't receive needed mental health services, which translates into an estimated 870,000 Californians.

Policy models indicate that a large number of factors influence Whites' receipt of needed mental health services, including poverty, citizenship, marital status, educational attainment, urban residence, insurance status, and mental health insurance coverage. Insurance status and mental health coverage have a particularly large impact. Having health insurance makes Whites 1.8 times more likely to receive needed mental health services than those who are uninsured and having mental health insurance coverage makes Whites 1.8 times more likely to receive services than those who do not have mental health coverage. Policy models indicated that providing insurance with mental health coverage would increase use of needed services among this group to an estimated 62%.

Issues of Particular Interest to Non-English Speaking Californians

This study shows that limited English language proficiency is a significant barrier to receipt of needed mental health services contributing to disparities across racial/ethnic groups. Approximately 15% of Californians do not speak English, including approximately 40% of Californian's Latino population and 16% of California's Asian/Pacific Islander population. Californians who do not speak English encounter many barriers to care. Almost half (45%) lack health insurance, compared to only 12% of those who speak English very well. Almost half are in poor health, compared to 8% of those who speak English very well. Only half of those who have health insurance have mental health coverage, compared to almost 90% of those who speak English very well. Not surprisingly, this group reports a high level of psychological distress. Almost a fourth (24%) of those who do not speak English reported that they were unable to do their usual work as well because of mental or emotional problems, compared to 15% of those who speak English well. Despite this high level of need, these Californians are not receiving mental health care. Only 9% of those who do not speak English received needed services, compared to 50% of those who speak English very well. For Latinos and Asian/Pacific Islanders, policy models showed that reducing language barriers could dramatically increase receipt of needed mental health services.

Summary

Analyses reveal a high level of unmet need for mental health services. Less than half of Californians who report needing mental health services actually receive them and unmet need is especially high among members of racial and ethnic minority groups. Limited English proficiency further limits use of mental health services, which leads to particularly high levels of unmet need among Latinos and Asian/Pacific Islanders. These patterns of disparity are similar to those seen in national samples, but the diversity of California's population makes these disparities particularly salient. These analyses revealed three barriers that are amenable to policy action. First, improving access to health insurance is likely to reduce unmet need for mental health services for all Californians. Second, improving access to health insurance with mental health coverage is likely to further reduce unmet need. Third, removing language barriers to mental health care is likely to reduce unmet need among the many Latinos and Asian/Pacific Islanders with limited English proficiency. Reducing barriers to mental health care would help millions of Californians, many of whom are poor, disenfranchised, and suffering in silence, and provide residual benefits to employers, families, and the state of California.

Brief Report

Introduction

California is home to approximately 21 million adults, up to 60% of whom are members of racial/ethnic minority groups (US Census Bureau, 2000; California Endowment, 2003). Recent estimates indicate that over three million Californians may need mental health services each year, yet only one third of those may receive needed help (US DHHS, 1999; Little Hoover Commission, 2000). The burden of mental illness falls more heavily on California's diverse racial and ethnic minority groups, yet these groups are particularly likely to have unmet needs for mental health services due to linguistic, cultural, and systemic barriers (US DHHS, 2001; Padgett et al, 1994; Scheffler & Miller, 1989; Fiscella et al, 2002; Chow et al, 2003; Alegria et al, 2002). Untreated mental illness results in unnecessary suffering, unemployment, homelessness, incarceration, and suicide while imposing a tremendous burden on ill individuals, their families, and society at large, costing California billions of dollars each year (Institute of Governmental Studies, 2002).

This study had six goals: (1) Examine the variation in mental health service need across racial/ethnic and linguistic groups; (2) Examine variation in the ways in which different racial/ethnic and linguistic groups report mental health needs; (3) Examine variation in mental health service use across racial/ethnic and linguistic groups; (4) Identify the specific barriers that keep Californian adults from needed mental health services; (5) Determine which barriers are most salient for different racial/ethnic and language groups; and (6) Use predictive policy models to identify the most effective policy options to combat the devastating problem of untreated mental illness for all Californians and for members of California's diverse racial/ethnic and language groups who are in particular need.

Data Set

The 2001 California Health Interview Survey (CHIS) was used for all analyses. The CHIS dataset, which contains data on 55,428 adults, is rich in information on the linguistic and cultural diversity of Californians. It was administered in six languages between November 2000 and October 2001. Approximately 12% of adult interviews were conducted in languages other than English (CHIS, 2002). All analyses accounted for the complex sample design and employed CHIS sampling weights to produce accurate population estimates.

Population

The study sample included all adults aged 18 to 64 (n= 43,713 or 86% of the total CHIS sample) who represent the majority of California's population. Main analyses examining barriers to mental health care included only adults who self-reported having a mental health need, as non-use of mental health services for adults without mental health problems does not indicate unmet need.

Racial/Ethnic Groups

Race/ethnicity comparisons focused on California's four largest racial/ethnic groups: African-Americans, Asian/Pacific Islanders, Latinos, and Non-Latino Whites. Forty-nine percent of the sample was White, 31% was Latino, 11% was Asian or Pacific Islander, and 5% was African American. Though the mental health needs of Native Americans/Alaskan Natives are of interest, the available sample was too small for the analyses performed in this study. Similarly, sample size limitations precluded examination of subgroups within the broadly defined Latino and Asian/Pacific Islander groups.

Language Groups

In bivariate analyses, we defined language groups in four different ways to explore the multiple aspects of language relevant to mental health and mental health care. The first definition was based on self-reported English Language Proficiency. The majority of the sample (74%) either reported speaking English only or reported speaking English very well, 11% reported speaking English well, and 15% reported speaking English not well or not at all. The second definition was based on Language Spoken at Home, which had eight categories. Fifty-eight percent of the sample spoke only English at home, 8% spoke Spanish only, 19% spoke English and Spanish, 2% spoke an Asian language only, 2% spoke an Asian language and English, 3% spoke an other language only, and 7% spoke another language and English. The third definition was based on Monolingual/Bilingual Ability, which had three categories delineated by Ponce et al. (2004), and was created from the previous two variables. Fifteen percent of the sample self-reported speaking English "not well or not at all", 27% of the sample reported speaking a language other than English at home, but reported speaking English "well or very well," indicating bilingual ability, and 58% of the sample reported speaking only English. The final definition was based on Language of Interview, indicating the language in which respondents completed the CHIS interview. Though the CHIS was administered in eight languages, the sample sizes for languages other than English and Spanish were too small for analysis. Thus, the original eight categories were combined into three categories; 83% of respondents completed the survey in English, 15% in Spanish, and 3% in another language.

In-depth multivariate analyses indicated that Monolingual/Bilingual Ability was the most descriptive of these four language variables. Thus, all final multivariate analyses were performed using this variable. In these models, interactions were also created between the three categories of Monolingual/Bilingual Ability for both Latinos and Asian/PIs to capture possible differences in the effects of bilingual ability or lack of English fluency by race/ethnicity.

Mental Health Need

Direct Mental Health Need was defined by the CHIS item: “During the last 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, blue, anxious, or nervous?” In bivariate analyses we considered four possible dichotomous measures of indirect mental health need. The first measure, called SF-12 Indirect Mental Health Need, was based on the Mental Component Summary (MCS) score from the SF-12, an extensively validated 12-item health status measure (Ware et al., 1998)¹. We hypothesized that the SF-12 items would be less direct and potentially less stigmatizing than the item inquiring directly about need for mental health services and that adults who were feeling psychological distress yet felt uncomfortable endorsing a direct question about mental health need might still endorse these items. We also hypothesized that the MCS score would be sensitive to differences between race/ethnic groups because the MCS takes some aspects of physical distress into account. Some cultural groups, especially Asians and Hispanics, are more likely to present with physical symptoms of emotional distress (Angel & Thoits, 1987; Marsella, 1982; USDHHS, 2001). Persons with MCS scores less than or equal to 32, the average MCS score observed in an outpatient mental health clinic sample (Adler et al., 2000) were considered to have indirect need for mental health treatment. We also examined responses to the three individual SF-12 items that were obviously related to mental health status as measures of indirect need. The first was Sadness, measured by the question “During the past 4 weeks, did you feel downhearted and sad?” Response options for this question were “All of the time, most of the time, some of the time, a little of the time, or not at all.” Anyone who responded “all of the time” or “most of the time” was considered to be sad. The second was Did Less, which was measured by the yes or no answer to the question “During the past 4 weeks, did you do LESS than you would have liked because of any kind of emotional problem?” The third was Didn’t Do Work As Well, which was measured by the yes or no answer to the question “During the past 4 weeks, did you NOT do your work or other activities as well as usual because of emotional problems such as feeling depressed or anxious?”

After examining the relationships amongst the four indicators of indirect mental health need by race/ethnic and language groups, we chose to use the Didn’t Do Work As Well variable as our primary

measure of indirect need. All four indirect measures yielded similar results, but this variable is particularly relevant for state policy because of its direct link to employment. This item was also endorsed more frequently than any other indirect measure.

Mental Health Service Use

Mental Health Service Use was defined by the CHIS item: “Not counting overnight stays, emergency room visits, or visits for drug or alcohol problems, in the past 12 months, have you seen a psychiatrist, psychologist, social worker, or counselor for emotional or mental health problems?” Got Needed Services was defined by endorsing Mental Health Service Use if a direct mental health need was reported.

Four additional questions were asked of respondents who reported needing help for a mental health problem or visiting a mental health specialist in the past year. These variables were Mental Health Medication, from the question “In the past 12 months, did you take prescription medications, such as an antidepressant or sedative, almost daily for two weeks or more, for an emotional or personal problem?,” Mental Health ER from the question “In the past 12 months, did you receive care in an emergency room for emotional or mental health problems?,” Talk About Mental Health from the question “Did you talk with a health provider about mental health?,” and Delay in Getting Mental Health Services from the question “During the past 12 months, did you have difficulties or delays in getting mental health treatment?”

Control Variables

In multivariate models, other variables that might explain differences in mental health need and mental health service use between California’s racial/ethnic and language groups were controlled. Control variables included in all multivariate analyses were age, living below the poverty level, US citizenship, marital status, gender, health status, education, and living in an urban area. Having health insurance and having mental health insurance were also controlled in service use models. Because mental health insurance coverage was only ascertained for those who had health insurance, all multivariate services use models were run both with and without the mental health insurance variable to test the impact of having health insurance on the entire sample and the impact of having mental health coverage among only those who had health insurance.

Statistical Analyses

For all mental health need and use variables, bivariate and multivariate analyses were run by racial/ethnic and language groups. Due to the large sample sizes, all reported bivariate comparisons

and all multivariate models are significant at the $p < .05$ level unless otherwise indicated. The impact of potential policies on use of mental health services by Californians who need them were examined in a series of models predicting receipt of needed services. Rates of service use were estimated under various scenarios simulated by controlling for different variables, using the general formula:

$$e^{\hat{y}} / 1 + e^{\hat{y}}$$

where \hat{y} is the solution to the logistic regression equation for a certain constellation of variables. By systematically controlling different variables, we estimated the effectiveness of policies targeting particular barriers, holding other predictors constant.

Analyses of mental need and mental health service use revealed three policy-relevant barriers to consider: lack of health insurance, lack of mental health insurance, and limited English language proficiency. Therefore, we tested the policy impact of four potential policy actions that could be taken to address the problem of unmet mental health needs: (1) providing universal health insurance, (2) providing universal health insurance and removing language barriers, (3) providing universal health insurance with mental health coverage, and (4) providing universal health insurance with mental health coverage and removing language barriers. We estimated the maximum impact of these policy actions by examining their effect on Californians who are likely to have a particular need for mental health services, but who are unlikely to receive those services due to other barriers that are less amenable to policy actions, that is Californians who are poor, non-citizens, have only a high school education, and who do not speak English.

Direct Need For Mental Health Services Among California Adults

Table 1 provides a breakdown of direct and indirect need for mental health services by all racial/ethnic and language groups. Sixteen percent of all Californians directly reported a need for mental health services. Of the specific racial and ethnic groups, Whites had the highest percentage of directly reported need (18%), followed by African Americans (17%), and Latinos (16%). Only 9% of Asian and Pacific Islanders reported a direct need for mental health.

Among language skill groups, 17% of those who spoke English very well reported a direct need for mental health care, compared to 11% of those who spoken English well, and 17% of those who spoke English not well or not at all. Among language spoken at home groups, the groups who reported the least amount of direct mental health need were those who spoke Asian languages only (10%) and those who spoke an Asian language and English (9%). The group with the highest percentage of adults reporting direct mental health need was those who spoke only English (18%).

In the multivariate model predicting direct need for mental health services Latinos (OR = .84, $p=.003$), Asians/PI (OR = .54, $p<.001$) and African Americans (OR= .68, $p<.001$) were less likely than Whites to report a direct need for mental health care, even when other potentially explanatory variables were controlled. The impact of English language proficiency on reported mental health need varied by racial/ethnic group when other factors were controlled. Asian/Pacific Islanders who do not speak English were far less likely than Asian/Pacific Islanders who only speak English to report a direct mental health need. Latinos who do not speak English were only slightly less likely to report a direct mental health need than Latinos who only speak English. Interestingly, both bilingual Asian/Pacific Islanders and bilingual Latinos were significantly less likely to report a mental health need than their counterparts who spoke only English.

However, compared to those who speak only English, bilingual adults, in general, were significantly more likely (OR= 1.21, $p=.013$) to report having a mental health problem and adults who do not speak English were even more likely to do so (OR= 2.28, $p=.013$). Being older, married, male, in good health, and not living in an urban environment made one less likely to report having a mental health problem. Having more education made one slightly more likely to report having a mental health problem. When compared to all other groups, Whites were 1.46 ($p<.001$) times more likely to report having a mental health problem.

Indirect Need For Mental Health Services Among California Adults

Far fewer Californians (5%) met the SF-12 Indirect Mental Health Need criteria than reported a direct need for mental health services, and only 4% reported that they were downhearted and sad in the past 4 weeks. However, this does not reflect an absence of psychological distress. Thirteen percent of all Californians reported that they did less in the past 4 weeks because of mental or emotional problems and 16% reported that they didn't do their usual work as well because of mental emotional problems. Thus, it appears that many California adults are suffering from mental health problems that affect their personal and professional lives.

Reporting a direct need for mental health services involves two evaluative judgments. The first is determining whether you are experiencing emotional distress. The second is determining whether emotional distress indicates a need for mental health care. When individuals do not report having a mental health service need, it is not clear whether they are not experiencing any emotional distress or whether they are experiencing emotional distress, but do not feel that it is best addressed by mental health services. In previous studies, racial/ethnic groups have been found to vary in the way they assess emotional distress and this variation was also observed in the CHIS data. Though Whites were

the most likely to report direct need for mental health treatment, they were also the least likely to report any of the specific current measures of emotional distress considered alternative indirect measures of mental health need. The most dramatic difference was seen in reports of not doing as well at work due to an emotional problem. Fourteen percent of Whites reported not doing work as well because of emotional problems, compared to 15% of Asian/Pacific Islanders, and 20% of African Americans and Latinos.

In multivariate models, only Latinos were significantly less likely ($p=.047$; $OR=.800$) than Whites to report having an indirect mental health need according to SF-12 cut off scores. African Americans and Asian/Pacific Islanders were equally likely as Whites to endorse this indirect measure of mental health need. Bilingual adults were 1.6 times more likely to report an indirect need and non-English speakers were 3 times more likely to report an indirect need. Among Asian/Pacific Islander groups, non-English speakers were the most likely to report an indirect need. Among Latinos, bilingual speakers were the most likely to report an indirect need.

As for the other indirect measures, those who didn't speak English were significantly more likely ($OR= 1.48$, $p=.045$) to report feeling sad, doing less ($OR= 1.32$, $p<.001$) and not doing work as well as usual because of a mental or emotional problem ($OR=1.35$, $p=.004$) than were those who spoke only English. Bilingual adults were also significantly more likely ($OR=1.30$, $p<.001$) to report not doing work as well as usual because of a mental or emotional problem. No racial/ethnic group was significantly more or less likely than Whites to report any of these measures of psychological distress.

Concordance of Indirect and Direct Need

Though only 9% of Asians/PI directly reported needing help for a mental or emotional problem in the past year, 15% didn't do their usual work as well in the past month once as well because of one. Sixteen percent of Latinos and 17% of African Americans reported needing help, while 20% of both groups reported not working as well because of a mental health problem. Whites showed the opposite pattern. Though 18% of Whites directly reported a mental health problem, only 14% didn't do their usual work as well because of one. Though not all these adults conceive of their problems as needing the advice of a mental health professional, they are clearly in emotional pain.

In multivariate models predicting those who weren't doing work as well as usual because of emotional problems, but did not report having a mental health problem, African Americans were significantly more likely ($OR=1.62$, $p<.001$) and Asian/Pis were marginally more likely ($OR=1.25$, $p=.056$) than Whites to have reported a symptom of emotional distress without reporting a mental

health problem. Bilingual adults (OR=1.42, $p<.001$) and those who do not speak English (OR=1.41, $p=0.03$) were also significantly more likely to have not reported a need for help while endorsing this symptom of emotional need.

Use of Mental Health Services Among California Adults

Table 2 shows use of mental health services by racial/ethnic and language groups. Regardless of directly reported need for mental health services, Whites were the most likely to talk with a mental health professional; 11% of all White respondents used mental health services. Asians and Latinos were the least likely to talk with a mental health professional, with 4% and 5% respectively receiving specialty mental health services. Those who spoke English well were far more likely to use services than those with less English proficiency; 10% of those who spoke English very well talked with a mental health professional, compared to 4% of those who spoke English well, 2% of those who didn't speak English well or not at all.

Receipt of Needed Services

Less than half (42%) of Californians who directly reported needing services received them. Though fewer members of minority racial/ethnic groups reported needing mental health services, those minorities who reported needing mental health care were far less likely than Whites to receive it. Fifty-three percent of Whites received needed services, compared to 42% of African Americans, 31% of Asians, and 24% of Latinos. The importance of English language skills is dramatically clear. Fifty percent of those who spoke English well received needed mental health services, compared to 9% of those who do not speak English well or at all. This language breakdown was seen within racial/ethnic groups as well. Among Latinos, 43% of English-only speakers received needed services, compared to 34% of bilingual speakers, and 8% of non-English speakers. Among Asians, 56% of English-only speakers received services compared to 31% of bilingual speakers, and only 9% of non-English speakers.

Table 3 highlights the significant variables in the multivariate models predicting receipt of needed services. In the model including all Californians, African Americans (OR=.618, $p<.001$), Asian/Pacific Islanders (OR=.696, $p=.034$), and Latinos (OR=.683, $p=.007$) were all significantly less likely to have received needed care than Whites. Being unable to speak English made one almost 80% less likely to have gotten care compared to those who spoke English when other factors were controlled. There was no significant interaction between race/ethnicity and language ability. Asian/Pacific Islanders and Latinos appeared to experience similar language barriers.

Not having health insurance was the most powerful systemic barrier to mental health care among all Californians. Insured adults were twice as likely to have received needed mental health care than those who were uninsured when other variables were controlled. Another significant barrier was not being a US citizen. Citizens were 1.22 times more likely to have received needed mental health care than non-citizens when other factors were controlled. Other factors that made one more likely to have received services were being older, not being married, and living in an urban area.

Multivariate models were run separately for each racial/ethnic group to identify specific predictors of receipt of services for different groups. Having health insurance was associated with receipt of services in all groups, though the impact of insurance varied by group. Insured Asian/Pacific Islanders were 2.28 times more likely to receive services than their uninsured counterparts. Insured African Americans were 3.97 times more likely to receive services than uninsured African Americans. Insured Latinos were 2.37 times more likely to receive services than uninsured Latinos. Insured Whites were 1.8 times more likely to receive services than uninsured Whites. Among Asian/Pacific Islanders and Latinos, not speaking English was associated with significantly less receipt of services. Non-English speaking Asian/Pacific Islanders were 90% less likely and non-English speaking Latinos were 85% less likely to receive needed mental health services compared to their English-only speaking counterparts. Interestingly, citizenship was only a significant predictor of receipt of mental health services for Whites.

Table 4 highlights the significant variables in the models predicting use of mental health services among those with health insurance, allowing us to test the specific impact of mental health coverage, which was ascertained only for respondents with health insurance. Among all Californians with insurance coverage, Latinos (OR=.699, $p=.002$) and African Americans (OR=.623, $p=.025$) were still significantly less likely than Whites to receive needed mental health services. Insured Asians did not differ significantly from Whites. Non-English speakers were still at a disadvantage compared to English-only speakers; they were 65% less likely to have received needed services compared to English speakers when other factors were controlled. Not having mental health coverage was a powerful systemic barrier to mental health care. Insured adults with mental health coverage were twice as likely to have received care as those without mental health coverage. Among the insured, US citizens were not more likely to have received needed mental health treatment when other factors were controlled.

In the models predicting receipt of needed services among the insured within specific racial/ethnic groups, mental health coverage was significantly predictive of service use in all groups

except African Americans. The impact of mental health coverage was strongest among Asian/Pacific Islanders; those with mental health coverage were 9 times more likely to receive needed services than those who did not have mental health coverage. Latinos and Whites with mental health coverage were both 1.7 times more likely to receive services than their counterparts who had health insurance but lacked mental health coverage. Among those with health insurance, Latinos who did not speak English were still 70% less likely to receive needed services compared to those who spoke only English, but Asian/Pacific Islanders who did not speak English were not less likely to receive services compared to those who spoke only English.

Race/ethnicity and lack of English proficiency also appear to be significant barriers to use of medication for mental health problems among those who report needing care. Forty-two percent of Whites who reported needing help for a mental health problem used medication for an emotional problem within the past year, compared to 18% of Asian/Pacific Islanders, 22% of Latinos, and 33% of African Americans. Forty percent of those who speak English only used medication for a mental health problem, compared to 28% of bilingual Californians and 16% of those who do not speak English. It is not clear whether these differences reflect variation in access to medications, or whether they reflect differences in preferences for medication treatment or a combination of these factors.

The same general pattern of service utilization was seen in speaking about mental health with a health professional, which can constitute either treatment for a mental health problem or a pathway to receiving specialty mental health services. Here the differences between English speakers and non speakers is also dramatic, with 42% of people who speak English well talking about their mental health with a health care provider, compared to 28% of those who speak English well, and 11% of those who do not speak English well or do not speak English at all.

African Americans were more likely than other racial/ethnic groups to have used the psychiatric emergency room (ER), with 7% of those who needed care reporting use of the psychiatric emergency room, compared to 3% of Latinos, 2% of Asian/Pacific Islanders and Whites. Non-English speaking Asian/Pacific Islanders were more likely to use the ER than other Asian/Pacific Islander groups, with 6% of those who said they needed care reporting use of the psychiatric emergency room, compared to 0% of those who speak only English and 1% of bilingual speakers. Interestingly, Latinos who speak only English were more likely to use the ER than those who didn't speak English or who were bilingual; 5% of English-only speaking Latinos used the ER, compared to 3% of bilingual, and 2% of non English speaking Latinos.

Interestingly, despite their apparent greater access to care, Whites were more likely to report having difficulties or delays getting mental health services than were other racial/ethnic groups. Ten percent of Whites reported having a problem getting services, compared to 7% of Latinos and African Americans and 5% of Asians. Those who spoke English very well were also more likely to report having a difficulty or delay getting mental health services than those who didn't speak English.

Policy Solutions

We compared the impact on use of needed health services for all Californians and for Californians of specific racial and ethnic groups under four policy conditions: (1) providing health insurance, (2) providing health insurance and minimizing language barriers, (3) providing health insurance with mental health coverage, and (4) providing health insurance with mental health coverage and minimizing language barriers. We considered the effect of these policy solutions on the percentage of Californians who would receive needed care, focusing specifically on those Californians who are likely to be in need of mental health services but who are unlikely to receive them because they are poor, in poor health, have limited education, and, in the case of the entire group and Latinos and Asian/Pacific Islanders specifically, do not speak English. The results of the policy models are presented in Table 5. The estimated percentages of all disadvantaged, non-English speaking Californians who would receive needed mental health services under the first policy condition—providing health insurance—is 17%. This policy solution is most effective for African Americans. An estimated 60% of disadvantaged African Americans would receive needed mental health services if they had health insurance. Policy condition 2—minimizing language barriers as well as providing health insurance—increases the percentage of disadvantaged Latinos estimated to receive care to 40% and the percentage of disadvantaged Asian/Pacific Islanders to 37%. Disadvantaged Asian/Pacific Islanders appear to be particularly responsive to having insurance with mental health coverage. Under policy condition 3—providing insurance with mental health coverage—an estimated 93% of disadvantaged Asian/Pacific Islanders would receive care. The policy condition that would result in the provision of the most needed services to the most disadvantaged Californians is policy condition 4—providing health insurance with mental health coverage and minimizing language barriers. Under this policy condition, 67% of disadvantaged Californians would receive needed mental health care.

Conclusions

Analyses of the CHIS data reveal a high level of unmet need for mental health services. Less than half of Californians who report needing mental health services actually receive them. Unmet need is especially high among members of racial and ethnic minority groups. African Americans, Latinos

and Asian/Pacific Islanders are all less likely than Whites to receive needed mental health services. Limited English proficiency dramatically limits use of mental health services, which leads to particularly high levels of unmet need among Latinos and Asian/Pacific Islanders. These patterns of disparity are similar to those seen in national samples, but the diversity of California's population makes these disparities particularly salient for the state.

While a wide range of cultural, language and systemic barriers contribute to the observed disparities, these analyses revealed three barriers that are amenable to policy action. First, improving access to health insurance is likely to reduce unmet need for mental health services by all Californians. Second, improving access to health insurance with mental health coverage is likely to further reduce unmet need. Third, removing language barriers to mental health care is likely to reduce unmet need among the many Latinos and Asian/Pacific Islanders with limited English proficiency.

Further investigation of the role of cultural factors in mental health service utilization is also warranted. It is not clear from the CHIS data whether differences in service use are due solely to access barriers. Our analyses do indicate that Asian/Pacific Islanders are less likely than members of other racial/ethnic groups to report need for mental health services and that Asian/Pacific Islanders and African Americans are more likely than Whites and Latinos to report significant emotional distress but not report need for mental health services. These results suggest that cultural differences in definitions of mental illness or strategies for dealing with emotional distress also affect utilization patterns. These factors cannot be fully explored in the CHIS data, but may provide additional avenues for improving mental health care for all Californians.

Though mental health programs are currently threatened by budget cuts, the mental health needs of California's diverse public are great. If barriers to care were reduced, millions of Californians, many of whom are poor, disenfranchised, and suffering in silence, would be helped, providing residual benefits to employers, families, and the state of California.

End Notes

¹The SF-12 component scores are computed using standardized scoring algorithms. Scoring of the CHIS SF-12 data was challenging because 4 of the 12 items were administered using non-standard versions of the SF-12 response scales. In the original SF-12, items 9-11 employ a 6-point response scale that ranges from 1=all of the time to 6=none of the time. The CHIS version employed a 4-point version of the response scale for these items from November 2000 to April 2001 that omitted response option 1 (all of the time) and response option 3 (a good bit of the time). In April 2001, response option 1 was added to the CHIS version, yielding a 5-point response scale. In the original SF-12, item 12 employs a 5-point response scale that ranges from 1=all of the time to 5=none of the time. The CHIS version used the response scale used for items 9-11 for item 12. In our scoring, we recoded all of the option 1 responses to be equal to option 2 for items 9-12, because it was not possible to determine which respondents would have chosen option 1 had it been offered prior to April 2001. We then used the standard SF-12 scoring algorithms. Although mean values on the two summary scores (the Mental Component Summary (MCS) and the Physical Component Summary (PCS)) were approximately equal to the mean values observed in population samples used in the validation of the SF-12, the scores we computed from the CHIS data are not directly comparable to other SF-12 scores because the standard response options were not consistently used for four of the 12 items. However, CHIS respondents' SF-12 scores are comparable to the scores of other CHIS respondents.

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Table 1. Need For Mental Health Services Among California Adults by Racial/Ethnic and Language Groups

		Unweighted N	% of Total Sample	% Direct Mental Health Need	% SF-12 Indirect Mental Health Need	% Sadness	% Did Less	% Didn't Do Work As Well
All Californians		43,713	100	16	5	4	13	16
Race/Ethnicity								
	Latino	10,942	31	16	5	5	15	20
	Asian/PI	3,495	11	9	4	5	13	15
	African American	2,047	5	17	6	5	16	20
	White	25,679	49	18	5	3	11	14
	Other Race	2,271	4	21	8	5	17	20
English Language Proficiency								
	Very Well	35,917	74	17	5*	3	12	15
	Well	3,581	11	11	6*	4	15	17
	Not Well or Not at All	4,936	15	17	5*	8	16	24
Language Spoken at Home								
	English Only	29,991	58	18	5	3	12	14
	Spanish Only	2,734	8	17	5	5	16	24
	Spanish and English	6,590	19	16	6	4	15	19
	Asian Lang Only	608	2	10	6	11	18	22
	Asian Lang and English	677	2	9	3	3	13	13
	Other Lang	1,345	3	15	6	5	15	19
	Other Lang and English	2,470	7	13	5	4	14	16
Monolingual/Bilingual Ability								
	English Only	29,991	58	18	5*	3	12	14
	Any Language + English	9,493	27	14	5*	4	14	17
	Any Lang Not English	4,931	15	17	5*	6	16	24
Interview Language								
	English	49,509	89	17	5*	3	12	15
	Spanish	5,073	9	17	6*	5	15	23
	Other	846	2	11	6*	12	19	23

*Group differences not statistically significant.

Table 2. Mental Health Services Use Among California Adults by Racial/Ethnic and Language Groups

		Mental Health Service Use	Got Needed Services	Talked about Mental Health with Provider	Delay in Getting Mental Health Services	Used Medication for MH Problem	Mental Health ER
Definition of Sample		All CHIS respondents	Respondents reporting direct need for MH services	Respondents reporting direct need for MH services and/or Visit to MH Specialist in Last Year			
All Californians		8	42	36	9	34	3
Race/Ethnicity							
	Latino	5	24	23	7	22	3
	Asian/PI	4	31	19	5	18	2
	African American	9	42	38	7	33	7
	White	11	53	45	10	42	2
	Other Race	11	49	45	13	36	7
English Language Proficiency							
	Very Well	10	50	42	10	38	3
	Well	4	29	28	9	23	2
	Not Well or Not at All	2	9	11	5	16	2
Language Spoken at Home							
	English Only	11	51	43	10	40	3
	Spanish Only	2	9	10	6	17	2
	Spanish and English	5	29	28	8	24	3
	Asian Language Only	2	12	14	4	21	7
	Asian Language and English	4	37	27	11	26	1
	Other Language	8	44	35	7	28	3
	Other Language and English	7	44	28	8	26	3
Monolingual/Bilingual Ability							
	English Only	11	51	43	10	40	3
	Any Language + English	7	41	33	9	28	3
	Any Lang Not English	2	9	11	5	16	2
Interview Language							
	English	9	49	41	10	37	3
	Spanish	2	10	10	5	16	1
	Other	1	9	11	5	18	4

Table 3. Odds Ratios of Significant Barriers to Getting Needed Mental Health Treatment for All Californians and by Specific Race/Ethnicity Groups

	All	Latino	Asian/PI	Black**	White
Linguistic Barriers					
Speak English Only	-	-	-	-	-
Bilingual	*	*	*	4.75	*
Don't Speak English	0.21	0.15	0.10	-	-
Cultural Barriers					
White	-	-	-	-	-
Black	0.62	-	-	-	-
Asian/PI	0.70	-	-	-	-
Latino	0.68	-	-	-	-
Other Races	*	-	-	-	-
Systemic Barriers					
Citizenship	1.22	*	*	*	1.72
Health Insurance	2.10	2.37	2.30	3.97	1.84
Poverty	*	*	*	*	1.51
Other Variables					
Age	1.01	1.02	1.03	*	*
Married	0.78	*	*	*	0.75
Good Health	*	*	2.80	*	*
Education	*	1.03	*	*	1.12
Urban Environment	1.27	*	*	*	1.27
Being Male	*	0.61	*	*	*

* Not statistically significant.

** This model is marginally significant (p=.0517). All others are significant at p<.001

Table 4. Odds Ratios for Significant Barriers to Getting Needed Mental Health Treatment for All Californians and by Specific Race/Ethnicity Among Californians With Health Insurance

	All	Latino	Asian/PI	Black	White
Linguistic Barriers					
Speak English only	-	-	-	-	-
Bilingual	*	0.31	*	7.84	*
Don't Speak English	0.35	*	*	-	-
Cultural Barriers					
White	-	-	-	-	-
Black	0.62	-	-	-	-
Asian/PI	*	-	-	-	-
Latino	0.70	-	-	-	-
Other Races	*	-	-	-	-
Systemic Barriers					
Citizenship	*	*	*	*	1.60
Mental Health Coverage	1.98	1.73	9.02	*	1.76
Being Poor	1.77	*	*	*	2.50
Other Variables					
Age	1.01	1.02	1.02	*	*
Married	0.80	*	*	*	0.75
Good Health	0.78	*	2.68	*	*
Education	1.10	1.10	*	*	1.10
Urban Environment	*	*	*	*	*
Being Male	*	0.59	*	*	*

* Not statistically significant.

Table 5: Results from Policy Models Predicting Receipt of Mental Health Services for Californians in Need¹

	All Californians	Latinos	Asians/Pacific Islanders	African Americans	Whites
% Predicted to Receive Services with Health Insurance	17	9	6	60	45
% Predicted to Receive Services with Health Insurance + Removal of Language Barriers	49	40	37	60	45
% Predicted to Receive Services with Health Insurance Including Mental Health Coverage	42	20	93	32	62
% Predicted to Receive Services with Health Insurance Including Mental Health Coverage + Removal of Language Barriers	67	45	97	32	62

¹ Californians in need were defined by those who are not citizens, poor, in poor health, and have only a high school education. In the models predicting receipt of services for all Californians, for Asian/Pacific Islanders, and for Latinos, Californians in need were defined by those who also did not speak English. The model assumes that everyone is of average age for that group, unmarried, male, and does not live in an urban environment.