Disparities in Mental Health Care Utilization and Perceived Need Among Asian Americans: 2012–2016

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Objective: The objective was to examine mental health treatment access disparities between Asians and whites in the United States as well as the role of perceived and objective need and barriers to treatment in these disparities.

Methods: Data are five annual cross-sections (2012–2016) of responses from Asian Americans and whites to the nationally representative National Survey on Drug Use and Health. Multivariate logistic regression analyses adjusting for sociodemographic factors were conducted to compare past-year treatment access rates between Asians and whites across three need subgroups: those with perceived need for treatment, those with past-year serious psychological distress, and those with a past-year major depressive episode. Barriers to treatment were compared between Asians and whites with perceived need.

Results: Asians were less likely than whites to have accessed mental health treatment in the past year in all analyses. Compared with Asians with need determined by structured diagnostic instruments, Asians with perceived need had higher rates of mental health care access, but even among respondents with perceived need, the disparity between whites and Asians remained. Regarding barriers to treatment, only one barrier (not knowing where to go for treatment) was more likely to be reported for Asians than whites.

Conclusions: Differences between Asians and whites in perceived need for mental health treatment do not explain the wide disparities in mental health care access between these two groups. Clinical interventions improving the relevance and fit of mental health care and community-based outreach interventions increasing awareness of available services are needed to improve access to mental health treatment among Asians.

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In the United States, Asian Americans access mental health treatment at less than half the rate of other racial-ethnic groups (1). Prior studies have reported disparities in access and quality of care between Asian Americans and other racial-ethnic groups across different mental health issues (depression [2], anxiety [3], and suicidal ideation [4]) and study methods (5, 6). Although the utilization rate of mental health care is overall lower for racial-ethnic minority groups compared with whites (5, 7, 8), Asian Americans have the lowest rate of mental health care across all racial-ethnic minority groups (2, 5).

One explanation for the wide disparities in mental health treatment utilization is a lower perceived need for treatment among Asian Americans compared with other racial-ethnic groups. In a recent study, after the analyses were adjusted for mental illness, Asians had a 23.3% lower prevalence of perceived need compared with whites and were the least likely to perceive a need for mental health treatment across all racial-ethnic groups (9). Additionally, Asian Americans with suicide attempts perceived less need for help than their Latino counterparts (10, 11). Cultural differences in the understanding of mental illness likely influence perceived need. Asian Americans may conceptualize treatable mental illness as consisting of behaviors that are disruptive to the social group, such as psychotic or hyperactive behavior (12). Emotional distress and other internalizing behaviors would thus be regarded as personal or social problems rather than as treatable conditions.

Asian Americans also tend to somaticize psychological distress as physical symptoms, such as indigestion, poor

HIGHLIGHTS

- Asian Americans with a need for mental health treatment accessed care at lower rates than whites.
- Perceiving a need for treatment did not eliminate the disparity in treatment rates between Asians and whites.
- Culturally sensitive interventions are needed to improve mental health treatment access rates among Asian Americans.

appetite, and heart palpitations (12, 13), and they are more likely to do so than members of other ethnic groups (14, 15). As a result, they may be more likely to seek treatment for physical ailments rather than for underlying psychological issues. Assessing the relative contribution of perceived need to utilization disparities compared with other factors will help develop targeted interventions to improve mental health treatment in this population.

Numerous barriers to mental health treatment seeking have been reported in the literature. Feelings of shame, stigmatization, and an unwillingness to burden others are major contributors to the lack of help-seeking behavior among Asian Americans with mental illness (12). Among young Asian American women with a history of depression and suicide, family and community stigma were identified as factors contributing to a reluctance to seek mental health services (4). Noncultural practical barriers to accessing care, such as cost, language barriers, and lack of knowledge of available resources, also contribute to low utilization rates among Asians (16–19). A study by Kung (16) found that among Chinese Americans, practical barriers to mental health treatment seeking were perceived as being more prohibitive than cultural barriers, with cost being the most highly endorsed barrier after adjustment for socioeconomic status.

Comparing rates of utilization between Asian Americans with perceived need and those with need identified through structured diagnostic instruments might provide insight into potential explanations for the persistent disparities in mental health care utilization. In this study, we examined rates of past-year mental health treatment usage among Asians and whites across different definitions of need (perceived and clinical) from the National Survey on Drug Use and Health (NSDUH). We hypothesized that after the analyses were adjusted for sociodemographic factors, Asians would have lower mental health treatment utilization rates than whites across all need definitions. In analyses within the Asian racial group, we predicted that those with perceived need would have higher usage rates than those with clinically determined need. Finally, we hypothesized that among respondents with perceived need for mental health treatment, barriers to treatment related to stigma and fear would be endorsed more by Asians than by whites, given that mental illness is often strongly stigmatized in Asian cultures.

METHODS

Data

Data from five annual cross-sections (2012–2016) of the NSDUH were analyzed. The NSDUH is a nationally representative annual survey administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) about substance use and mental health among the civilian noninstitutionalized U.S. population (20). Data from non-Hispanic white and Asian respondents ages 18–64 were included to compare trends between racial groups among the nonelderly adult population and to focus on disparities between Asians and the racial group with the highest level of mental health treatment utilization in the United States (21).

Respondents self-selected their race from the following options: white, black or African American, American Indian or Alaska Native, Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander, Asian, and other. Individuals endorsing more than one race were not included because of small sample size. Individuals age 65 and older were excluded because of the different social and insurance programs available to that age group in the United States. Missing data were imputed by SAMHSA for the public use data set by using standard imputation methods (22). The small remaining sample with missing variables of interest (<1% of the survey population) was excluded. The final sample was composed of 108,404 white and 8,121 Asian nonelderly adults. Institutional review board approval was waived because all survey data used were publicly available.

Stratifying the Sample by Definition of Need

To identify differences in treatment utilization by perceived and clinical need, the sample was stratified according to the following three definitions of need for mental health treatment.

Past-year respondent-perceived need for mental health treatment. Respondent-perceived need was determined by combining participants' responses to a survey question about perceived unmet need ("During the past 12 months, was there any time when you needed mental health treatment or counseling for yourself but didn't get it?") and their responses regarding mental health treatment received in the past year. Participants were considered positive for perceived need if they endorsed perceived unmet need or if they had received mental health treatment in the past year.

Past-year serious psychological distress (SPD). Past-year SPD was measured with the K-6. The K-6 Psychological Distress Scale has high sensitivity and specificity for predicting serious mental illness when using 12 or higher as the cutoff for inclusion in the SPD subgroup (23).

Past-year major depressive episode (MDE). Past-year MDE was measured by using survey items derived from the National Comorbidity Survey Replication (24). Having a lifetime MDE was defined as endorsing at least five of nine symptoms derived from criteria for depression from the *DSM-IV* (25). Participants were then asked whether they experienced these depression symptoms for 2 consecutive weeks or longer in the past year to determine past-year MDE (26).

Treatment Outcome

The outcome of interest was whether participants had received any mental health treatment in the past year,

including inpatient care, outpatient care (primary care or specialty mental health care), or psychotropic medication.

Covariates

Past-year self-reported overall health (excellent, very good, good, or fair to poor) was included to adjust for respondent perceptions of physical and mental health status (27). Sociodemographic variables were chosen because of their significant association with risk of mental illness or access to medical care. These variables included age and sex (28), marital status (29), income (in relation to the federal poverty level; 30), education level (31), insurance status (32), urbanicity (size of metropolitan statistical area; 33), and employment status (34; Table 1).

Statistical Analyses

First, in bivariate analyses, we used chi-square tests to compare treatment rates, need, overall health, and sociodemographic factors between whites and Asians. Next, we estimated a series of multivariate logistic regression models, testing whether treatment rates differed between whites and Asians among the three different need subgroups, adjusting for the health and sociodemographic variables described earlier. The predictive margins method was used to convert the regression coefficients into more easily understandable predicted rates of mental health treatment for each racial group, after covariate adjustment in the logistic regression models (35).

Secondary analyses assessed barriers to treatment among only those with perceived unmet need. Multivariate logistic regression models compared whites with Asians on the endorsement of each barrier, after adjustment for the covariates described earlier.

All statistical analyses were conducted in Stata, version 15.1 (36). To account for the complex survey design and to make results nationally representative, NSDUH sampling weights and variance estimation variables were used during analyses (26).

TABLE 1. Treatment, need, and sociodemographic characteristics among white and Asian respondents to the 2012–2016 National Survey on Drug Use and Health

	Whites (N=108,404)		Asians (N=8,121)		
Variable	N	%	N	%	p
Received any mental health treatment in the past year	20,630	19.0	468	5.8	<.001
Perceived need in past year	24,648	22.7	661	8.1	<.001
SPD in past year[a]	17,524	16.2	907	11.2	<.001
MDE in past year[b]	10,494	9.7	451	5.6	<.001
Age					
18–25	40,470	37.3	3,262	40.2	<.001
26–34	21,471	19.8	1,904	23.5	
35–49	30,163	27.8	2,241	27.6	
50–64	16,300	15.0	714	8.8	
Sex					<.005
Male	50,852	46.9	3,881	47.8	
Female	57,552	53.1	4,240	52.2	
Overall health					<.001
Excellent	26,724	24.7	2,420	29.8	
Very good	45,152	41.7	3,273	40.3	
Good	27,246	25.1	2,002	24.7	
Fair to poor	9,282	8.6	426	5.3	
Marital status					<.001
Married	46,755	43.1	3,767	46.4	
Widowed	1,442	1.3	65	.8	
Divorced or separated	11,980	11.1	338	4.2	
Never been married	48,227	44.5	3,951	48.7	
Income					<.005
Living in poverty	16,366	15.1	1,598	19.7	
Income up to 200% FPL[c]	19,944	18.4	1,396	17.2	
Income >200% FPL	72,094	66.5	5,127	63.1	
Education					<.001
Less than high school	10,728	9.9	441	5.4	
High school graduate or some college	64,623	59.6	3,447	42.5	
College graduate	33,053	30.5	4,233	52.1	
Insurance					.026
Any	94,837	87.5	7,195	88.6	
Uninsured	13,567	12.5	926	11.4	
County type					<.001
Large metropolitan	40,162	37.1	5,288	65.1	
Small metropolitan	40,681	37.5	2,252	27.7	
Not metropolitan	27,561	25.4	581	7.2	
Employment status					.047
Full-time	62,577	57.7	4,255	52.4	
Part-time	19,391	17.9	1,456	17.9	
Unemployed	6,330	5.8	410	5.1	
Other	20,106	18.6	2,000	24.6	

[a] SPD, serious psychological distress.
[b] MDE, major depressive episode.
[c] FPL, federal poverty level.

RESULTS

Asian respondents had higher educational achievement, were more likely to reside in urban metropolitan statistical areas, and were less likely to be divorced compared with whites (Table 1). Asians also had lower household incomes but slightly higher rates of health insurance coverage. They perceived less need for mental health treatment and had lower rates of SPD and MDE in the past year compared with whites.

Asians were significantly less likely than whites to have received any mental health treatment in the past year (Table 1). These disparities were also significant when the data were stratified by those with perceived need, SPD, and MDE. Among white and Asian participants, rates of past-year

TABLE 2. Percentage of survey respondents with perceived or clinical need for mental health care who received no mental health treatment in the past year, by race[a]

Need definition	Whites (N=108,404)			Asians (N=8,121)		
	Total N	No treatment N	No treatment %	Total N	No treatment N	No treatment %
Perceived need	24,648	4,018	16.3	661	193	29.2
SPD in past year[b]	17,524	8,916	50.9	907	711	78.4
MDE in past year[c]	10,494	4,423	42.1	451	329	73.0

[a] Data are from the 2012–2016 National Survey on Drug Use and Health. All Asian-white differences significant at p<.05 level.
[b] SPD, serious psychological distress.
[c] MDE, major depressive episode.

mental health treatment utilization were highest among those with perceived need compared with those in other need definition groups (Table 2).

After adjustment for health and sociodemographic factors, the analyses showed that Asians were significantly less likely to receive mental health treatment in the past year in the overall sample (Table 1) and in subgroups defined by each of the need definitions (Table 3). Compared with whites with perceived need, Asians with perceived need were less likely to have received mental health care in the past year (odds ratio [OR]=0.57, 95% confidence interval [CI]=0.44–0.75). Asians with past-year SPD (OR=0.32, 95% CI=0.25–0.42) and past-year MDE (OR=0.31, 95% CI=0.21–0.45) were also less likely to have received mental health care in the past year. Among respondents reporting perceived need for mental health care, 87.1% of whites received mental health care in the past year, compared with 80.0% of their Asian counterparts ($p<0.001$) (see online supplement). Among those with past-year SPD, 53.3% of whites received past-year mental health treatment compared with 28.9% of Asians ($p<0.001$). Among those with a past-year MDE, 70.0% of whites received mental health treatment in the past year compared with 35.3% of their Asian counterparts ($p<0.001$).

After adjustment of the analyses for sociodemographic factors, two barriers to treatment were endorsed at significantly different rates between Asians and whites with perceived unmet need. Asians were less likely than whites to endorse cost as a treatment barrier (OR=0.63, 95% CI=0.43–0.94, p=0.024), and Asians were more likely than whites to endorse not knowing where to go for treatment (OR=1.61, 95% CI=1.09–2.39, p=0.017) (see online supplement]).

DISCUSSION

The findings from this study demonstrate that significant disparities in mental health treatment utilization exist for Asians across both respondent-perceived need for mental health treatment and need as determined by structured psychiatric diagnostic instruments. These disparities persisted after controlling for sociodemographic factors, even within the population endorsing perceived need for mental health treatment. Greater than half of whites with SPD went without mental health treatment in the last year. The rate of treatment utilization was even lower among Asians: three in four Asians with SPD did not receive any mental health treatment in the past year. Although rates of mental health treatment were highest among Asians with perceived need, there was still a significant disparity with whites, demonstrating that racial differences in perception of need did not fully explain the disparity in treatment utilization.

Rates of mental health treatment for Asians were greater when the need for treatment was recognized by the patient. Interventions to improve mental health treatment rates among Asians could target culturally informed views of mental health to improve perceived need among Asians. Increasing recognition of emotional disturbances as medically treatable may be especially important in this population (12). Partnering with Asian-American communities to develop culturally relevant interventions that integrate the Western philosophy of mental health care with existing Asian cultural views may help Asian Americans recognize when treatment is needed.

Stigma is a key contributing factor in whether Asian Americans seek mental health care. Stigma-related barriers, such as "Concerned neighbors or community would have a negative opinion" and "Didn't want others to find out about needed treatment," were measured; they were not endorsed significantly more by Asians with perceived need for mental health treatment than by whites with perceived need, despite prior studies suggesting that stigma plays a large role in unmet need for Asians (4, 37–41). This finding could represent a shift in how mental health treatment is perceived in the Asian-American community, or it could be due to a lack of nuance in the questions within the survey that were meant to capture stigma. Stigma within Asian communities may manifest more as shame within the family and a need to "save face" (4, 16) than as concern over the negative opinions of neighbors or community members as posed by the survey questions. Future research conducted within Asian populations should take these cultural factors into account to better capture the social and cognitive processes that prevent Asians from seeking care.

Asians with a perceived need for treatment had higher treatment utilization rates than Asians in other clinical need categories but lower utilization rates than whites with perceived need. Intervening on perceptions of need would thus not be sufficient to reduce disparities in treatment rates, and a better understanding of other barriers is necessary. In our analyses of barriers to care endorsed by people with perceived need, Asians were more likely to endorse "not knowing where to go," perhaps a byproduct of relative social isolation or lack of connection to mainstream health care agencies.

Past research has shown that Asian students seeking mental health treatment reported a lack of social support

(40), and older Asian-American adults were less willing than adults of other races to discuss mental health issues with anyone (42). A lack of social support may make seeking care more difficult because consulting with friends and family is often an important step in the pathway to treatment (43). Not knowing where to go might also be a consequence of a lack of referrals by clinicians. Asians are more likely to describe their mental distress in terms of physical symptoms or other symptoms that do not correspond with traditional definitions of mental illness (44, 45); therefore, mental illness may go underdetected, resulting in a lack of referrals and treatment (46).

Although Asians endorsed cost less frequently than whites, it was the most highly endorsed barrier to care for Asians after adjustment for insurance status and income level. The cost of mental health care is a widely acknowledged structural barrier for patients (47) and has been reported previously as a barrier to treatment seeking among Asians (16). Although cost is only one of many contributing factors to the wide disparities in mental health treatment utilization, our findings suggest that insurance reform and other structural changes that decrease the cost of treatment will contribute to the reduction of Asian-white disparities in mental health treatment utilization.

TABLE 3. Association between past-year mental health treatment and sociodemographic characteristics among white and Asian respondents to the 2012–2016 National Survey on Drug Use and Health, by need definition[a]

	Past-year perceived need		Past-year SPD[b]		Past-year MDE[c]	
Variable	AOR[d]	95% CI	AOR[d]	95% CI	AOR[d]	95% CI
Race (reference: white)						
Asian	.57	.44–.75***	.32	.25–.42***	.31	.21–.45***
Overall health (reference: excellent						
Very good	.92	.81–1.05	1.24	1.08–1.42**	1.47	1.21–1.77***
Good	.92	.79–1.07	1.58	1.36–1.84***	1.73	1.44–2.08***
Fair to poor	.94	.77–1.14	2.02	1.67–2.45***	2.32	1.88–2.87***
Age (reference: 18–25)						
26–34	1.43	1.27–1.62***	1.51	1.30–1.74***	1.32	1.11–1.57**
35–49	2.19	1.87–2.58***	1.87	1.65–2.12***	1.61	1.38–1.89***
50–64	4.01	3.21–5.01***	2.17	1.80–2.61***	1.70	1.34–2.16***
Sex (reference: male)						
Female	1.02	.92–1.14	1.60	1.45–1.77***	1.56	1.37–1.76***
Marital status (reference: married)						
Widowed	1.57	.91–2.72	.81	.54–1.19	.75	.48–1.17
Divorced or separated	1.04	.88–1.24	1.44	1.24–1.67***	1.31	1.10–1.55**
Never been married	.84	.73–.97*	1.10	.97–1.24	.97	.81–1.15
Income (reference: living in poverty)						
Income up to 200% FPL[e]	.99	.83–1.17	1.04	.90–1.20	1.15	.95–1.38
Income >200% FPL	1.16	.99–1.34	1.09	.96–1.24	1.15	.98–1.34
Education (reference: less than high school)						
High school graduate or some college	1.27	1.06–1.53*	1.33	1.15–1.54***	1.29	1.04–1.60*
College graduate	1.25	1.01–1.56*	2.18	1.84–2.58***	2.29	1.78–2.92***
Insurance (reference: none)						
Any	2.18	1.91–2.48***	1.75	1.53–2.01***	1.82	1.55–2.14***
County type (reference: large metropolitan)						
Small metropolitan	1.08	.96–1.22	1.04	.93–1.16	1.07	.93–1.23
Not metropolitan	1.20	1.03–1.39*	.97	.85–1.10	1.00	.85–1.18
Employment status (reference: full-time)						
Part time	1.14	.99–1.32	1.50	1.32–1.70***	1.38	1.17–1.62***
Unemployed	1.18	.97–1.42	1.40	1.19–1.65***	1.66	1.35–2.04***
Other	1.57	1.35–1.82***	2.05	1.81–2.32***	2.26	1.91–2.67***

[a] Data are from the 2012–2016 National Survey on Drug Use and Health. The analyses were adjusted for overall health, age, sex, marital status, income, education level, insurance status, county type, and employment status.
[b] SPD, serious psychological distress.
[c] MDE, major depressive episode.
[d] AOR, adjusted odds ratio.
[e] FPL, federal poverty level.
*p<.05, **p<.01, ***p<.001.

The implementation of culturally sensitive and specific interventions are needed to improve Asian Americans' utilization of care. Evidence shows that culturally targeted interventions are more effective than more generalized interventions (48) in linking Asians to treatment. Developing outreach programs with community health workers is one way to increase awareness of available treatments within racial-ethic communities (49). A pilot study of a community intervention to increase awareness of mental health issues among older Chinese Americans

showed an increase in intention to consult a mental health professional for psychiatric symptoms postintervention (50).

Within communities heavily populated by Asian Americans, having clinics specifically focused on addressing their unique health concerns will likely improve treatment rates and outcomes; patients receiving treatment at ethnicity-specific mental health programs in Los Angeles were found to be more likely to stay in treatment over time (18). Integration of mental health treatment and primary care within these clinics may be an effective way to improve utilization (51). Unfortunately, many intervention studies examining the mental health treatment of racial-ethnic minority groups have few Asian participants, and results show less improvement in Asian engagement in mental health treatment compared with members of other races (52). Innovative interventions are thus needed.

This study has several limitations. First, the analysis lacks detailed information about the specific ethnic backgrounds or immigration statuses of respondents. Mental health treatment usage rates have been found to vary depending on ethnic group and immigrant status (53, 54), the nuances of which are lost when Asians are treated as a monolithic group. Second, the reliability of self-reported measures of need and treatment may be weakened by recall bias and by feelings of shame for reporting mental illness. Third, although racial differences in measures of external stigma (e.g., "Concerned neighbors or community would have a negative opinion"; "Didn't want others to find out about needed treatment") were investigated in this article, a more nuanced scale of "loss of face" (55) was not assessed. Future studies should assess the role of loss of face as a variable explaining the Asian-white disparity in mental health care utilization. Finally, the survey is available only in English and Spanish. Given that our population of interest was Asian Americans, these data may not fully reflect the experiences of members of this community whose primary or preferred language is not English or Spanish. Therefore, our results may be conservative given that language incongruity is a barrier to mental health treatment.

CONCLUSIONS

Health care systems should strive to improve the cultural sensitivity of their mental health care to better serve Asian-American patients. Training in cultural competency and implicit biases (56) and in asking questions such as those proposed in the Outline for Cultural Formulation in the *DSM-5* (57) that better elicit cultural explanations of mental illness should be provided to clinicians to improve detection and referral to treatment for Asian Americans with mental illness. Pipelines within clinical training programs that include more members of racial-ethnic groups may prove beneficial.

Outreach conducted in Asian communities could improve awareness of mental illness and make care more accessible for those in need. Peer outreach in particular may be helpful, and health centers should consider recruiting community-specific volunteers to encourage information dissemination. Future research should explore the meaning of mental illness and treatment in different Asian subcultures within the United States and develop patient-centered care models based on these cultural understandings.

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