

Health Policy Brief

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Uncovering Unique Challenges: Variation in Unmet Mental Health Needs Among Asian Ethnic Groups in California

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“This brief uses 2015–2019 CHIS data to examine the unmet mental health needs among adults across Asian ethnic groups in California.”

SUMMARY: The Asian population is diverse, with a range of experiences, cultural backgrounds, and demographic profiles. However, most research examines Asian ethnic groups as a single, homogeneous group. To better understand the mental health needs of this diverse population, this brief uses 2015–2019 California Health Interview Survey (CHIS) data to examine unmet mental health needs among adults across Asian ethnic groups in California. More than half (51%) of the state’s Asian adults who felt they needed mental health services experienced unmet need for mental health care, with percentages among Asian ethnic groups ranging from 43% of Japanese adults to 61% of Vietnamese adults. And while more than two-thirds (68%) of all Asian adults in the state with

serious or moderate psychological distress had unmet need for mental health care, the percentage among different ethnic groups ranged from less than half (45%) among Japanese adults to more than three-quarters (78%) among Vietnamese adults. These findings emphasize the importance of examining variation within the Asian population by ethnic group to identify and help meet their disparate needs. Policy recommendations that may help improve the mental well-being of Asian ethnic groups include promoting mental health literacy; increasing access to culturally and linguistically appropriate mental health services; and supporting policies on collecting and reporting disaggregated data on Asian ethnic groups.

Mental health is an essential aspect of overall health and well-being. Mental health includes emotional, psychological, and social well-being at every stage of life. According to the Centers for Disease Control and Prevention (CDC), 1 out of 5 adults experiences a mental illness in a given year.¹ Although mental health conditions are experienced across all demographic groups, gaps in care vary by race and ethnicity. Mental health literature suggests that Asian adults nationally have rates of mental illness that are lower than those among non-Latino white adults.² However, Asian adults have higher levels of unmet need for mental health services than non-Latino white adults. In addition, recent data from

California suggest that Asian populations have experienced significant increases in serious psychological distress over time.³ Given the diverse backgrounds and experiences within the Asian population, it is likely that there will be considerable variation in mental health need as well as in unmet need for mental health services in this population.

The Asian population — the fastest-growing racial or ethnic group in the United States over the past decade⁴ — comprises a diverse population with a range of ethnic backgrounds, sociodemographic profiles, and length of residence in the U.S. Despite this variation, most studies combine Asian ethnic groups and treat them as a single population. However,

“Disaggregating data would identify the variations in need for mental health services as well as in unmet need to address the needs of each Asian ethnic group.”

wide variations in mental health need as well as in unmet need for mental health services are likely across the different Asian ethnic groups. Disaggregating data would identify the variations in need for mental health services as well as in unmet need, informing tailored policies for prevention, early intervention, and treatment services to address the needs of each Asian ethnic group.⁵

This policy brief uses data from the 2015–2019 California Health Interview Survey (CHIS) to examine mental health need and unmet need for mental health services among the overall Asian population and seven Asian ethnic groups: 1) Chinese; 2) Filipino; 3) Japanese; 4) Korean; 5) South Asian, such as Bangladeshi, Indian, and Pakistani; 6) Vietnamese; and 7) other Asian ethnicities, such as Cambodian, Burmese, Hmong, Laotian, Malaysian, Thai, and Indonesian, and adults who identify as two or more Asian ethnicities. Measures and ethnic group disaggregation are described in more detail in the Data Source and Methods section at the end of this policy brief. Please note that all data presented in this brief were collected prior to the COVID-19 pandemic.

Variations in Perceived Need and Psychological Distress Among Asian Ethnic Groups in California

Chinese (29%) and Filipino (25%) adults make up more than half of the adult Asian population in California, followed by 12% Vietnamese, 11% South Asian, 9% Korean, and 5% Japanese. The remaining 9% includes those of other Asian ethnicities and those with two or more Asian ethnicities. The exhibits that follow make clear the importance of viewing these ethnic groups separately in terms of mental health and access to care.

DEFINITIONS

Serious Psychological Distress (SPD)

Based on the number and frequency of symptoms reported in the past year, SPD is an estimate of adults with serious, diagnosable mental health challenges such as depression or anxiety that warrant mental health treatment within a population.⁶

Moderate Psychological Distress (MPD)

Based on the number and frequency of symptoms reported in the past year, MPD is an estimate of adults with moderate mental distress — that is, distress that is clinically relevant and warrants mental health intervention within a population.⁷

Perceived Need for Mental Health Services (PN)

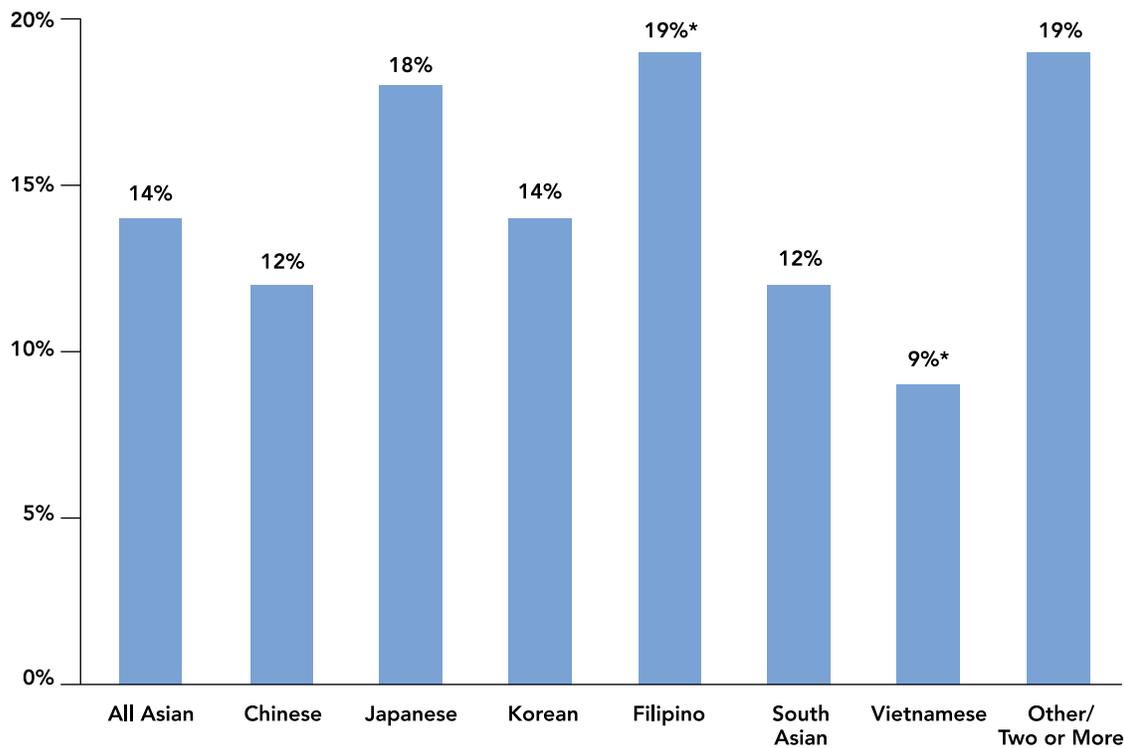
Based on the self-reported need to see a professional for problems with mental health, emotions, nerves, or use of alcohol and/or drugs in the past year, PN is an estimate of adults who felt they had a need for mental health services.

Unmet Need for Mental Health Services

Based on self-reports of not seeing a mental health or medical provider in the past year for mental or behavioral health problems among adults with a perceived need for mental health services or with serious or moderate psychological distress, unmet need is an estimate of adults with an identified need for services who did not receive the care they needed.⁸

Percentage of Asian Adults Ages 18 and Older With Perceived Need (PN) for Mental Health Services, California, 2015–2019

Exhibit 1



*Difference from “All Asian” is statistically significant at $p < .05$. “Other/Two or More” includes Cambodian, Burmese, Hmong, Laotian, Malaysian, Thai, and Indonesian adults, as well as adults who identify as two or more Asian ethnicities.

Data source: Pooled 2015, 2016, 2017, 2018, 2019 California Health Interview Survey (CHIS)

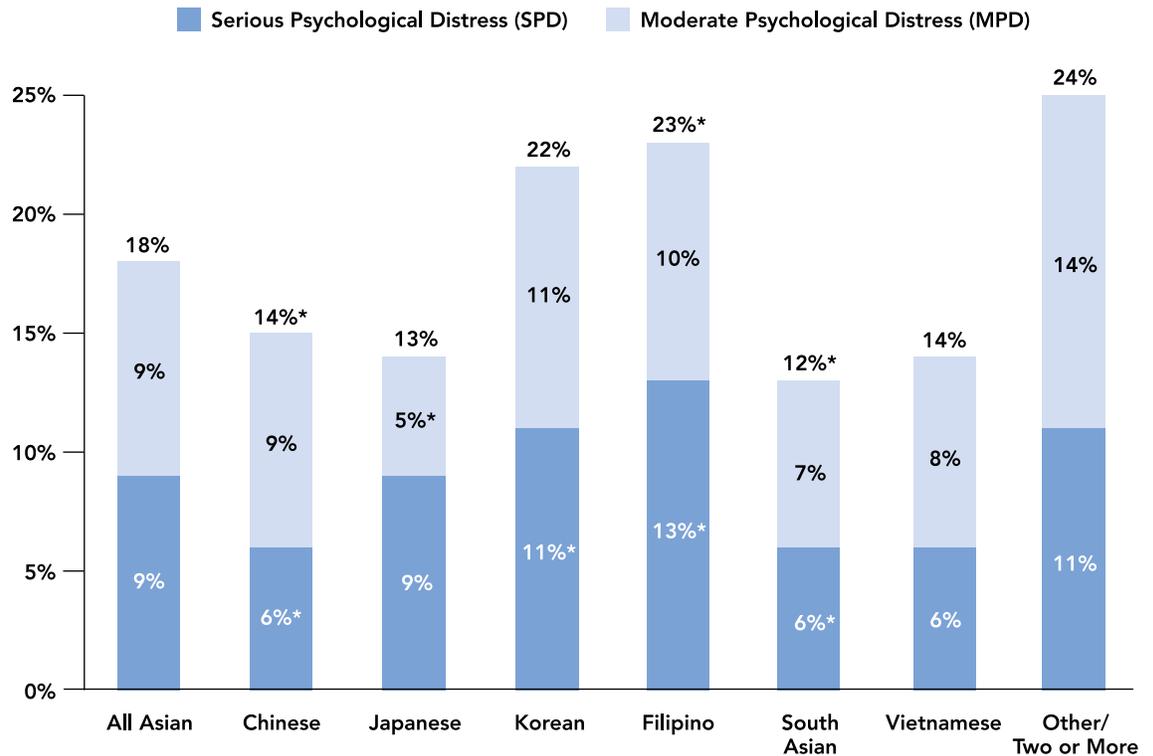
Mental health needs are measured in two different ways: 1) *perceived need*, with individuals asked whether they feel they need help with mental, emotional, alcohol, or drug problems; and 2) *serious or moderate psychological distress*, based on a person’s reporting of symptoms related to depression or anxiety.

Perceived Mental Health Need: Overall, 14% of Asian adults in the state said they had needed help with emotional, mental, alcohol, or drug problems in the past year (Exhibit 1). However, compared to all Asian adults, a larger proportion of Filipino adults said they needed mental health care (19%); conversely, a smaller proportion of Vietnamese adults said they needed care (9%).

“Mental health needs are measured in two different ways: 1) *perceived need* and 2) *serious or moderate psychological distress*.”

Exhibit 2

Percentage of Asian Adults Ages 18 and Over With Serious and Moderate Psychological Distress, California, 2015–2019



*Difference from “All Asian” is statistically significant at $p < .05$.

Note: SPD+MPD may not equal total due to rounding
SPD+MPD differences from “All Asian” are statistically significant at $p < .1$ for Japanese, Vietnamese, and Other/Two

or More. “Other/Two or More” includes Cambodian, Burmese, Hmong, Laotian, Malaysian, Thai, and Indonesian adults, as well as adults who identify as two or more Asian ethnicities.

Data source: Pooled 2015, 2016, 2017, 2018, 2019 California Health Interview Survey (CHIS)

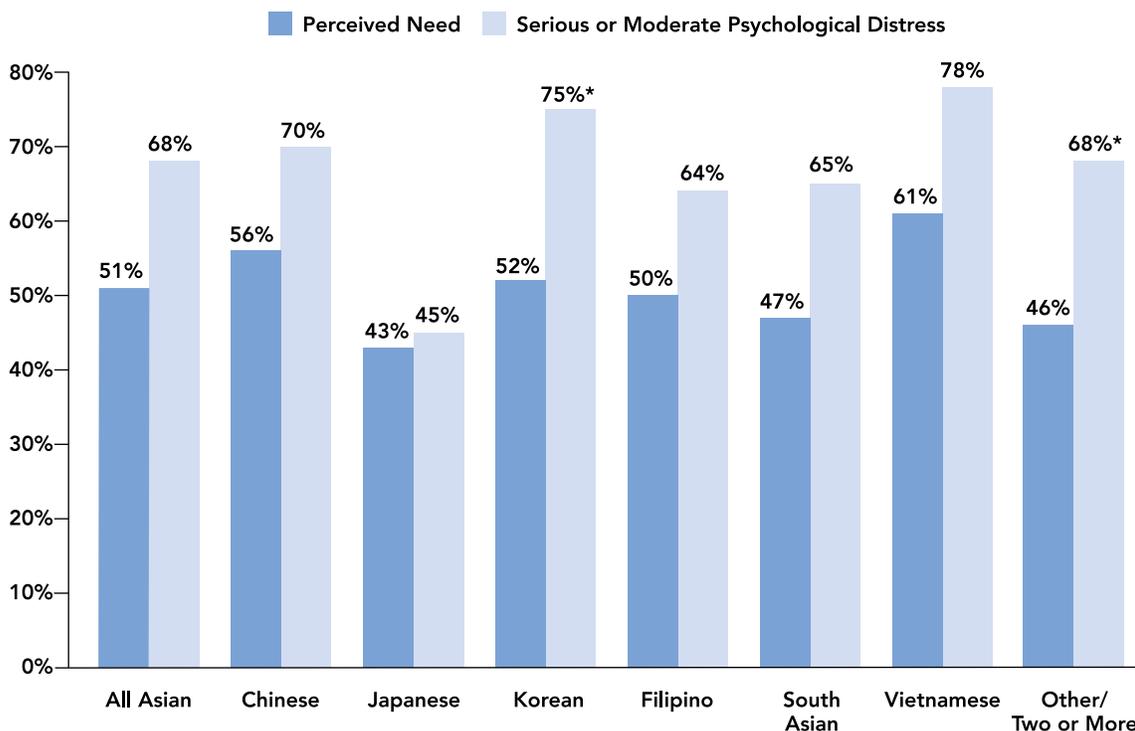
“Asian adults overall were more likely to report symptoms associated with SPD and MPD than they were to have a perceived need for mental health care.”

Psychological Distress: Among Asian adults overall, 9% have serious psychological distress (SPD) and an additional 9% have moderate psychological distress (MPD) (Exhibit 2). However, compared to all Asian adults, Filipino adults were nearly 1.5 times more likely to have SPD (13%), and Chinese and South Asian adults were less likely to have SPD (6% for both groups). Japanese adults were less likely to have MPD (5%).

Perceived Need vs. Psychological Distress: Asian adults overall were more likely to report symptoms associated with SPD and MPD than they were to have a perceived need (PN) for mental health care (18% SPD/MPD in Exhibit 2 vs. 14% PN in Exhibit 1). In particular, this was true for adults identifying as Korean (22% SPD/MPD vs. 14% PN), Vietnamese (14% SPD/MPD vs. 9% PN), and Filipino (23% SPD/MPD vs. 19% PN, $p < .1$).

Percentage of Asian Adults Ages 18 and Over With Unmet Need for Mental Health Care by Perceived Need and Psychological Distress, California, 2015–2019

Exhibit 3



*Difference between perceived need and serious or moderate psychological distress is statistically significant at $p < .05$.

Note: Difference in unmet need for serious or moderate psychological distress between “All Asian” and “Japanese” (68% vs. 45%) is statistically significant at $p < .05$.

“Other/Two or More” includes Cambodian, Burmese, Hmong, Laotian, Malaysian, Thai, and Indonesian, as well as adults who identify as two or more Asian ethnicities.

Data source: Pooled 2015, 2016, 2017, 2018, 2019 California Health Interview Survey (CHIS)

Unmet Need for Mental Health Care

Unmet need is defined as having a need for mental health care but not receiving it. We examined this separately for adults with a perceived need for mental health services and for adults with serious or moderate psychological distress, and then compared the estimates for the two measures to identify Asian ethnic groups most likely to experience unmet need for mental health services.

Unmet need by PN: More than half (51%) of all Asians with a perceived need for mental health services experienced unmet need for mental health care. Within the different ethnic groups, the proportion experiencing unmet need ranged from 43% of Japanese adults to 61% of Vietnamese adults (Exhibit 3).

Unmet need by SPD/MPD: More than two-thirds (68%) of all Asian adults with serious or moderate psychological distress experienced unmet need for mental health care. This proportion ranged from less than half (45%) of Japanese adults to more than three-quarters (78%) of Vietnamese adults (Exhibit 3).

Difference in Unmet Need by PN vs. by SPD/MPD: Asian adults overall with a perceived need for mental health services had statistically significant lower unmet need (51%) than those with serious or moderate psychological distress (68%) (Exhibit 3). Within the different ethnic groups, statistically significant differences between these two measures of unmet need were found among those who were Korean (52% vs. 75%), “other/two or more” Asian ethnicities (46% vs. 68%), Filipino (50% vs. 64%, $p < .1$), and South Asian (47% vs. 65%, $p < .1$).

“Asian adults with a perceived need for mental health services had significantly lower unmet need than their counterparts with serious or moderate psychological distress — in particular, Korean, ‘other/two or more’ Asian ethnicities, Filipino, and South Asian.”

“The Asian population is growing in California, and the diversity within that population means there are important variations in mental health need and unmet need across Asian ethnic groups.”

Policy Recommendations

The Asian population is growing in California, and the diversity within that population means there are important variations in mental health need and unmet need across Asian ethnic groups. The following recommendations could help improve the mental well-being and access to mental health care for all groups within this diverse population.

Promote mental health literacy both generally and for specific Asian ethnic populations. Asian adults overall and Filipino, Korean, and Vietnamese adults in particular were more likely to report symptoms associated with SPD and MPD than to say they needed mental health care. Promoting mental health literacy in all Asian communities can help increase knowledge about mental health and available services, and it can also help to reduce stigma about mental health problems and seeking care. Furthermore, we found higher levels of unmet need among those with SPD/MPD than those with PN among Asian adults overall and in particular among Filipino, Korean, and South Asian adults and those identifying as “other/two or more” Asian ethnicities. These findings suggest that increasing mental health literacy could help increase the utilization of services and reduce the gaps in care. Existing evidence shows that positive attitudes toward mental health care, higher mental health literacy, and more perceived need were significant predictors of using mental health services.⁹ Strategies that mental health advocacy groups and mental health service providers can employ to help promote mental health literacy include:

- **Increase access to and availability of translated mental health literacy materials.** Limited English proficiency can create barriers to accessing information and increasing knowledge about mental health, particularly among immigrant groups. Availability of in-language materials and Asian-language media could help reduce barriers to care due to language. Materials should be disseminated across a variety of platforms, such as ethnic newspapers, radio, and television, with printed materials placed in spaces that have high Asian population density.
- **Engage in constant conversations with ethnic community organizations.** The level of stigma attached to mental health and related services use can vary across different Asian ethnic groups and can be a barrier to care.¹⁰ More consistent conversations with a diverse group of cultural, ethnic, and nationality organizations are needed to identify strategies for incorporating cultural concerns and beliefs (e.g., stigmas, shame, denial, family pressures and influences, family pride, and educational competitiveness) and expectations (e.g., traditions, customs, and practices) into the development of mental health care systems.
- **Partner with community and faith-based organizations.** Ethnic minority–serving religious organizations (e.g., churches, mosques, temples, and gurdwaras) can be important partners in developing protocols for health promotion programs/activities that address cultural and religious norms. Such organizations can also provide information on mental health in the context of community events and religious services, and they can be helpful as well in such efforts as free mental health screening, culturally tailored health coaching, and referral to care.¹¹

Increase culturally sensitive and linguistically appropriate mental health services. Tailored outreach and services are needed for specific Asian ethnic groups. Vietnamese, Korean, and Chinese adults in particular had high rates of unmet need for mental health care. Policy recommendations for federal, state, and local policymakers include:

- ***Implement the National Culturally and Linguistically Appropriate Services in Health and Health Care Standards (National CLAS Standards) in agencies at state and local levels.***¹² The National CLAS Standards provide practical guidelines for improving the quality of health care services, and they advance health equity for diverse communities by providing a framework to help health care organizations introduce and sustain culturally and linguistically appropriate services.
- ***Create and support educational and employment pathways for a more diverse mental health workforce.*** Community health workers can be crucial members of the mental health workforce in Asian communities. More efforts are needed to support higher education opportunities for mental health workers, including scholarships, training, workforce development, and employment advancements.
- ***Integrate mental health care in primary care settings.*** Because stigma is attached to mental health and service use among some Asian communities,¹³ making mental health care services available in primary health care settings could increase the likelihood that individuals who would not seek mental health care from a specialist would still receive needed care.
- ***Promote trauma-informed care.*** Training and awareness about the historical and political trauma related to Asian immigration and anti-Asian xenophobia must be considered in culturally sensitive services.

Support Policies on Data Disaggregation for Asian Ethnic Groups. Disaggregated data on Asian ethnic groups can inform equity-based policies to address unmet need for mental health care and variations in need among Asian ethnic groups. Suggested policy recommendations for federal, state, and local policymakers include:

- ***Improve accessibility and reporting of disaggregated data on Asian ethnic groups in the health care system.*** Assembly Bill 1726, requiring disaggregated data collection, passed the California State Assembly and was signed into law in 2016. This bill expands to include, but is not limited to, additional Asian ethnic groups — Bangladeshi, Hmong, Indonesian, Malaysian, Pakistani, Sri Lankan, Taiwanese, and Thai — to make California’s collection practices align with that of the U.S. Census Bureau.¹⁴ Making data more publicly accessible and nuanced will provide evidence for advocates and community members for requesting more equitable state policies and funding for culturally appropriate services for vulnerable and often marginalized Asian ethnic groups.¹⁵
- ***Advocate for federal policies on data disaggregation for Asian ethnic groups.*** Existing research suggests that data disaggregation at a federal level, as done with other ethnic communities — for example, American Indians and Alaska Natives (AIAN) — would help to identify barriers to accessing health care and services within Asian communities and encourage efforts to develop tailored policies.¹⁶ A more formal, systematic, and nationwide collection of disaggregated data on Asian ethnic groups would provide more accurate representation and information.

Data Sources and Methods

This policy brief presents pooled data from the 2015, 2016, 2017, 2018, and 2019 California Health Interview Survey (CHIS), conducted by the UCLA Center for Health Policy Research (CHPR). We used data collected in interviews with 11,071 Asian adults, sampled from every county in the state. All analyses presented in this brief include replicate weights to provide confidence interval estimates and statistical tests that account for the complex survey design.

For our analyses, we disaggregated data on Asian ethnic groups to the extent possible based on sample size and statistically stable estimates. For instance, the sample sizes for South Asian ethnic groups were too small to be disaggregated into individual ethnic groups. For a better understanding of the unique experiences of all Asian ethnic groups, future research needs to produce further disaggregated analyses.

Perceived need for mental health services was measured with one question: “Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your mental health, emotions, or nerves or your use of alcohol or drugs?” A “yes” response was coded as a perceived need for mental health services. Serious psychological distress in the past year (SPD) was defined as having a score of 13 to 24 on the Kessler-6 (K6), a validated measure designed to estimate the prevalence of diagnosable mental disorders within a population.⁶ Moderate psychological distress in the past year was measured by using a K6 score of 9 through 12 — a clinically relevant level.⁷ Unmet need for mental health services was measured with two questions: “In the past 12 months, have you seen 1) your primary care physician or 2) a mental health professional for problems with your mental health, emotions, or nerves or your use of alcohol or drugs?” A “no” response to both among those with SPD, MPD, or a perceived need (PN) for mental health services was coded as the individual’s having unmet need for mental health services.

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The California Health Interview Survey covers a wide array of health-related topics, including health insurance coverage, health status and behaviors, and access to health care. It is based on interviews conducted continuously throughout the year with respondents from more than 20,000 California households. CHIS interviews were offered in English, Spanish, Chinese (both Mandarin and Cantonese), Vietnamese, Korean, and Tagalog. CHIS is designed with complex survey methods requiring analysts to use complex survey weights in order to provide accurate variance estimates and statistical testing. CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Public Health, the California Department of Health Care Services, and the Public Health Institute. For funders and other information on CHIS, visit chis.ucla.edu.

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Endnotes

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