HHS Public Access

Author manuscript

J Am Geriatr Soc. Author manuscript; available in PMC 2018 May 07.

Published in final edited form as:

J Am Geriatr Soc. 2016 October ; 64(10): 2138–2143. doi:10.1111/jgs.14420.

Barriers to Mental Health Care for an Ethnically and Racially Diverse Sample of Older Adults

Dara H. Sorkin, PhD[*], **Molly Murphy, BSN**[*], **Hannah Nguyen, MSW, PhD**[†], and **Kelly A. Biegler, PhD**[*]

[*]Department of Medicine, University of California, Irvine, Irvine

[†]Department of Human Services, California State University, Dominguez Hills, Carson, California

Abstract

OBJECTIVES—This study examined potential barriers to mental healthcare use of older adults from diverse ethnic and racial backgrounds.

DESIGN—Data were obtained from the 2007, 2009, 2011–12, and 2013–14 California Health Interview Survey (CHIS), a population-based survey representative of California's noninstitutionalized population.

PARTICIPANTS—The total sample consisted of 75,324 non-Hispanic white (NHW), 6,600 black, 7,695 Asian and Pacific Islander (API), and 4,319 Hispanic adults aged 55 and older.

RESULTS—Results from logistic regression analyses that controlled for multiple demographic and health status characteristics revealed ethnic and racial differences in reasons for not seeking treatment and for terminating treatment. Specifically, API and Hispanic adults had greater odds than NHWs of endorsing feeling uncomfortable talking to a professional as a reason for not seeking treatment. Hispanic respondents had lower odds of endorsing concerns about someone finding out than APIs, and APIs and blacks had significantly greater odds of endorsing this concern as a reason for not seeking treatment than NHWs. When asked about reasons for no longer receiving treatment, all respondents, irrespective of race or ethnicity, endorsed that they no longer needed treatment as the most frequent reason for terminating treatment, although specific ethnic and racial differences emerged with respect to perceptions of not getting better, lack of time or transportation, and lack of insurance coverage as reasons for no longer seeking treatment.

CONCLUSION—Understanding how barriers to mental health treatment differ for older adults from diverse ethnic and racial backgrounds is an important step toward designing interventions to overcome these obstacles and improve mental health outcomes.

Address correspondence to Dara H. Sorkin, UCI Department of Medicine, 100 Theory, Suite 120, Irvine, CA 92617. dsorkin@uci.edu.

Conflict of Interest: The editor in chief has reviewed the conflict of interest checklist provided by the authors and has determined that the authors have no financial or any other kind of personal conflicts with this paper.

Author Contributions: Sorkin: study concept and design, data analysis, interpretation of data, drafting of manuscript, revision. Nguyen, Murphy: interpretation of data, drafting of manuscript. Biegler: interpretation of data, drafting of manuscript, revision.

Keywords

mental health; barriers; older adults; racial and ethnic disparities; California Health Interview Survey (CHIS)

Various social, emotional, and physical changes that affect the health and wellness of many older adults accompany the aging process. Although the majority of older adults cope well with these changes and do not have mental health concerns, a significant number of older adults have serious mental health needs that are not a normal part of aging. It is estimated that one in five people aged 55 and older have some type of mental health concern (e.g., anxiety, severe cognitive impairment, depression and other mood disorders),[1] and 4.7% of community-dwelling older adults report having had serious psychological distress in the past year.[2] By 2030, the number of older adults with major psychiatric illnesses will more than double, from an estimated 7 million to more than 15 million individuals.[3] Untreated mental health problems in older adults are associated with poor health outcomes,[4] high healthcare use and costs,[5] complexity of the course and prognosis of many mental and physical illnesses,[5,6] functional disability and cognitive impairment,[6,7] compromised quality of life,[8] and mortality, including higher risk of suicide.[9] As such, the challenge is for health and mental health service providers to outreach to, engage, and retain older adults in mental health care.[10]

Despite the growing burden of mental health need in this population, research suggests that older adults, and in particular racially and ethnically diverse older adults, underuse mental health services or do not seek mental health care.[11] The National Association of State Mental Health Program Directors' Presidential Task Force of Mental Health and Aging notes that elderly adults are the most underserved population in mental health services.[6]

Researchers have identified many barriers that contribute to poor access and inadequate use of mental health services by older adults, including lack of perceived need for care,[12] lack of knowledge about availability of mental health services,[13] stigma,[14] limited availability of affordable services,[15] and difficulty arranging transportation.[15] These barriers may be further exacerbated for ethnic and racial minority older adults who face additional challenges finding adequate care that is consistent with their linguistic, cultural, and personal preferences and values.[16]

For older adults who initiate treatment, barriers to care pose a continuing challenge to their treatment process and may lead to the premature termination of care.[17] For example, low-income older adults may have difficulty paying for treatment, particularly those who may be required to stay in treatment for a long time. Language differences between providers and consumers may make it difficult for older adults with limited English language proficiency to communicate, leading to frustration and poor communication between doctors and patients.[18] The incongruence between clients' and providers' views about mental health care may further discourage older adults from remaining in treatment if they perceive that providers do not understand and respect their worldviews.[18]

Examination of factors that influence help-seeking behaviors in an ethnically and racially diverse sample of older adults, and whether and how these factors vary between older adults from diverse ethnic and racial backgrounds, has been limited. This study sought to address this gap. The aims of this study were to examine differences in reasons why older adults from diverse ethnic and racial backgrounds do not seek help for mental health concerns, to evaluate treatment status in those who have sought mental health-related care, and to describe reasons for terminating treatment for those who have sought mental health care.

METHODS

Sample

The data for this study came from the 2007, 2009, 2011–12, and 2013–14 California Health Interview Survey (CHIS) Public Use Files and confidential data. The CHIS is a random-digit-dial, telephone-based survey conducted of households representative of California's noninstitutionalized population. Interviews were conducted in English, Spanish, Mandarin, Cantonese, Vietnamese, and Korean. The sample for analyses was restricted to individuals aged 55 and older and consisted of 75,324 non-Hispanic whites (NHWs), 6,600 blacks, 7,695 Asians and Pacific Islanders (APIs), and 4,319 Hispanics. APIs were Chinese (29.1%), Filipino (25.2%), Japanese (11.5%), Vietnamese (12.4%), and Korean (10.3%), and other (11.4%). The majority of Hispanics were Mexican American (~78%), 11% were from Central American, and the rest were from other Hispanic ethnicities or from multiple ethnicities. Additional information about the survey can be found at http://www.chis.ucla.edu.

Measures

Reasons for Not Seeking Treatment—Respondents who reported that they might need to, but did not, see a professional because of problems with mental health, emotion, nerves, or use of alcohol and drugs were asked to respond to the following question, "Here are some reasons people have for not seeking help even when they think they might need it. Please tell me 'yes' or 'no' for whether each statement applies to why you did not see a professional." Possible reasons included cost of treatment, not comfortable talking with professional about personal problems, concerne about what would happen if someone found out, and have a hard time getting an appointment.

Treatment Status and Reasons for No Longer Receiving Treatment—Questions regarding treatment status and reasons for no longer receiving treatment were asked of anyone who had reported seeing a primary care physician or general practitioner for problems with mental health, emotions, or use of alcohol or drugs, or seeing a professional, such as a counselor, psychiatrist, or social worker, for problems with mental health, emotions, or use of alcohol or drugs in the past 12 months. Treatment status was assessed by asking respondents, "Are you still receiving treatment for these problems from one or more of these providers?" The response option was yes or no. If the respondent answered 'no' to the question regarding treatment status, he or she was asked, "Did you complete the recommended full course of treatment?" The response option was yes or no. Respondents who stated that they were no longer receiving treatment were asked, "What is the MAIN

REASON you are no longer receiving treatment?" Responses included got better or no longer needed, not getting better, wanted to handle problem on own, bad experiences with treatment, lack of time or transportation, too expensive, and insurance does not cover.

Covariates—The following standard demographic characteristics were included as covariates in the analyses: age, sex (1 = male, 2 = female), marital status (1 = not currently married, 2 = currently married), nativity (1 = not born in the United States, 2 = born in the United States), and education (1 = high school or less, 2 = some college or more). English language proficiency was dichotomized into two categories according to self-reported responses to the question "Would you say you speak English…" (1 = very well or well, 2 = not well or not at all). Physical health status was assessed by asking participants whether they had been diagnosed with any of four chronic health conditions (high blood pressure, asthma, diabetes mellitus, heart disease). Responses were summed to form a measure of number of chronic health conditions (0 = none, 1 = 1 or 2, 2 = 3 or 4). Mental health need was assessed using the Kessler 6 scale. A score greater than 6 indicates nonspecific psychological mental distress according to the Kessler criterion.[19] Responses were scored and dichotomized (1 = no psychological distress, 2 = psychological distress).

SAS-Callable SUDAAN release 9.0.2 (Research Triangle Institute, Research Triangle Park, NC) was used to conduct data analyses. Descriptive statistics (e.g., chi-square, analysis of variance) were generated to examine the sociodemographic characteristics of the study sample. Bivariate analyses were then conducted using chi-square tests to examine ethnic and racial differences in study outcomes according to subgroup. Finally, logistic regression analyses were conducted to determine the relationship between race and ethnicity and each of the study outcomes. A priori, other variables that have been linked to ethnic and racial differences in mental health status and use of services, including age, sex, marital status, education, nativity, number of chronic conditions, and mental health need were included in the adjusted models as covariates. For models in which race or ethnicity was significantly associated with the outcome, all pairwise comparisons between all ethnic and racial groups were tested. Two-tailed $P \leq .05$ was considered statistically significant.

RESULTS

The sociodemographic characteristics of the sample are presented in Table 1. NHW (68.9%), API (63.2%), and black (62.0%) respondents had a higher percentage of responders with at least some college degree compared with Hispanic respondents (21.7%). Most NHW (94.5%), black (91.9%), API (89.8%), and Hispanic (79.1%) respondents had some form of insurance coverage. A higher percentage of NHW (91.3%) and black (92.4%) respondents were born in the United States compared with their Hispanic (32.9%) and API (16.3%) counterparts.

There were ethnic and racial differences in some of the reasons for not initiating treatment (Table 2). Although there were no ethnic and racial differences in cost being cited as a reason for not seeking treatment ($F(3,320) = 0.26$, $P = .85$), there were significant ethnic and racial differences in the odds of endorsing whether respondents felt comfortable talking with a professional about their personal problems ($F(3,320) = 2.91$, $P = .03$). Specifically, API

(adjusted odds ratio (aOR) = 2.8, 95% confidence internal (CI) = 1.2–6.4, $P = .01$) and Hispanic (aOR = 2.2, 95% CI = 1.2–4.2, $P = .01$) respondents had higher odds of endorsing feeling not comfortable talking to a professional as a reason for not seeking treatement compared with NHW respondents. There were also significant ethnic and racial differences in the odds of endorsing feeling concerned about someone finding out about a mental health concern ($F(3,320) = 8.99$, $P < .001$). Hispanic respondents had lower odds of endorsing concerns about someone finding out compared with API respondents (aOR = 0.2, 95% CI = 0.1–0.6, $P < .001$, results not shown but available upon request), and both API (aOR = 5.5, 95% CI = 2.2–16.3, $P < .001$) and black (aOR = 3.5, 95% CI = 1.6–7.6, $P = .002$) respondents had significantly higher odds of endorsing this concern as a reason for not seeking treatment compared with NHW respondents. Finally, there was one significant ethnic and racial difference in the odds of endorsing having a hard time getting an appointment as reason for not seeking treatment ($F(3, 320) = 2.64$, $P = .005$), with Hispanic respondents having more than twice the odds of reporting having a hard time getting an appointment compared with NHW respondents (aOR = 2.3, 95%CI = 1.1–4.7, $P = .02$).

Table 3 presents the differences in mental health treatment status and barriers to receiving mental health care according to ethnicity and race, adjusting for sociodemographic and health characteristics. There were no significant ethnic and racial differences in the odds of still receiving treatment for a problem ($F(3,320) = 0.83$, $P = .47$) or in the odds of having completed the recommended full course of treatment ($F(3,320) = 1.34$, $P = .26$).

Of those who were no longer receiving mental health–related care, all four ethnic and racial groups reported that the primary reason for no longer receiving treatment was because they no longer needed it ($F(3,320) = 0.33$, $P = .80$). Ethnic and racial differences emerged for some of the reasons why respondents discontinued treatment. There were significant ethnic and racial differences in the odds of reporting not getting better as the primary reason for no longer receiving treatment ($F(3,320) = 3.44$, $P = .02$). Specifically, black (aOR = 0.2, 95% CI = 0.1– 0.8, $P = .02$) and API (aOR = 0.2, 95% CI = 0.1–0.6, $P = .01$) respondents had lower odds of reporting not getting better as a reason for discontinuing treatment compared with NHW respondents. There were no significant ethnic and racial differences in the odds of wanting to handle the problem on their own ($F(3,320) = 1.71$, $P = .17$) or having had bad experiences with treatment ($F(3,320) = 1.11$, $P = .33$) as the reason for no longer receiving treatment. Hispanic respondents had lower odds of endorsing lack of time or transportation as a significant barrier than NHW respondents (aOR = 0.1, 95% CI = 0.1–1.0, $P = .05$; $F(3, 320) = 2.59$, $P = .05$). There were no significant ethnic and racial differences in the odds of reporting that treatment was too expensive as a barrier ($F(3,320) = 1.83$, $P = .14$), although there were ethnic and racial differences in the odds of lacking insurance as being reported as a barrier ($F(3, 320) = 3.44$, $P = .02$). Specifically, API (aOR = 3.5, 95% CI = 1.1– 11.4, $P = .01$) respondents had higher odds of reporting insurance as a barrier compared with NHW respondents ($F(3,320) = 3.44$, $P = .03$), and Hispanic respondents had lower odds of reporting insurance as a barrier compared with API respondents (aOR = 0.02, 95% CI = 0.01–1.10, $P = .004$, results not shown but available upon request).

DISCUSSION

Although it is well established that there are ethnic and racial disparities in access to and use of mental health care,[20] there is a considerably smaller body of work examining the mental health-seeking behaviors of older-adult minorities, a growing yet understudied group. This study examined ethnic and racial differences in the barriers that older adults face in their attempts to access mental health services and remain in care. Using a population-based sample of ethnic and racially diverse older Californians, the findings evidenced ethnic and racial differences in reasons for not seeking treatment and for terminating treatment. Specifically, API and Hispanic respondents were more likely than NHW respondents to report concerns about not feeling comfortable talking to a professional as a reason for not seeking treatment. API and black respondents were more likely than NHW respondents to report concerns about having someone find out, and Hispanic respondents were more likely than NHW respondents to report difficulty obtaining an appointment. Although there were no significant ethnic and racial differences in whether respondents were still receiving treatment or completed the recommended full course of treatment, there were specific ethnic and racial differences with respect to perceptions of not getting better, lack of time or transportation, and lack of insurance coverage as reasons for no longer seeking treatment. Specifically, black and API respondents were less likely than NHW respondents to report not getting better as a reason for no longer receiving treatment. Hispanic respondents were less likely than NHW respondents to report lack of time and lack of insurance coverage as a reason for no longer receiving treatment.

These ethnic and racial differences in reasons for not seeking treatment and for discontinuing treatment warrant further discussion. For Hispanics, mental health conditions are often perceived as a weakness and burden on the family.[21] Furthermore, prior work has shown that low-income insured and uninsured Hispanic immigrants,[22] whether English or non-English speaking,[23] tend to underuse mental health care because of logistical barriers, such as a lack of time because of work and family obligations or difficulties making appointments in communities where there are few mental health providers available.[24] Nevertheless, when they are able to access care, treatment completion and efficacy has been shown to improve with providers who are concordant in language and culture.[25]

Black respondents reported concerns about someone finding out and talking to a professional about their mental health problems, which may result from cultural stigma toward mental health[26] and the lack of racially concordant mental health providers.[27] In the last decade, the American Medical Association estimated that black professionals accounted for fewer than 3% of mental health clinicians.[28] Consistent with previous literature,[29] black respondents were less likely to terminate treatment because of perceived ineffectiveness than NHW respondents, and cost did not emerge as being a greater burden for black respondents than for other ethnic and racial groups.

Asian and Pacific Islander respondents also responded overwhelmingly that their reasons for not seeking treatment were related to not feeling comfortable talking to a professional and concerns about someone finding out, which is supported by a well-established research on the stigma associated with seeking out mental health services in this population.[30] An

additional notable reason for no longer receiving treatment was related to lack of insurance coverage. Given that a large majority of older API adults are foreign born, many lack insurance or have limited insurance that excludes mental health benefits. Insurance changes that result from the Affordable Care Act are likely to ameliorate this problem, but may still be inadequate to address difficulties in understanding and navigating the complex mental healthcare system.

Several study limitations should be noted. First, because the CHIS is conducted over the telephone, and therefore requires the technology, mobility, and cognition to participate in a telephone conversation, it is likely that the poorest, the most-isolated, and the most severely untreated mentally ill potential respondents were omitted from the study. Furthermore, many older adults, especially those with mental illness, may reside in treatment facilities, group homes, and other residential settings where their telephone access is limited. It is likely that the findings underestimate the degree to which ethnically and racially diverse older adults would endorse these barriers.

In sum, many of the important findings of this study suggest that the difficulties that ethnic and racial minority adults face persist into later life. The socioeconomic and interpersonal challenges of being an ethnic minority with mental health problems has been called a double stigma.[14] The older adult population thus faces a triple stigma, layering on the generational taboo that inhibits the seeking of mental health services and fortifies structural barriers to care. Because older adults are less likely to see specialists,[16] primary care providers bear the burden of mental health screening and treatment. Along with expansion of mental health services and coverage under the Affordable Care Act, perhaps the greatest need that this study illustrates is for healthcare providers to be trained to provide culturally competent mental health care for older minority adults, improving access to mental health services.

Acknowledgments

This research was supported by the National Institute of Mental Health (R01 MH091221, D.H. Sorkin, PI) and the National Center for Advancing Translational Sciences (UL1 TR0001414, D. Cooper, PI).

Sponsor's Role: The funding agency was not involved in the design, methods, subject recruitment, data collection, analysis, or preparation of the manuscript.

References

1. Centers for Disease Control and Prevention. The State of Mental Health and Aging in America Issue Brief 1: What Do the Data Tell Us?. Atlanta, GA: National Association of Chronic Disease Directors; 2008.
2. Han B, Gfroerer JC, Colpe LJ, et al. Serious psychological distress and mental health service use among community-dwelling older U.S. adults. Psychiatr Serv. 2011; 62:291–298. [PubMed: 21363901]
3. U.S. Census Bureau. [Accessed March 4, 2011] 2012 National Population Projections: Summary Tables [on-line]. Available at https://www.census.gov/population/projections/data/national/2012/summarytables.html
4. Garber CE, Greaney ML, Riebe D, et al. Physical and mental health-related correlates of physical function in community dwelling older adults: A cross sectional study. BMC Geriatr. 2010; 10:6. [PubMed: 20128902]

5. Bock JO, Luppa M, Brettschneider C, et al. Impact of depression on health care utilization and costs among multimorbid patients—from the Multi-Care Cohort Study. PLoS ONE. 2014; 9:e91973. [PubMed: 24638040]
6. World Health Organization. [Accessed March 18, 2016] Mental Health in Older Adults Fact Sheet, 2015 [on-line]. Available at http://www.who.int/mediacentre/factsheets/fs381/en/
7. Barry LC, Murphy TE, Gill TM. Depressive symptoms and functional transitions over time in older persons. Am J Geriatr Psychiatry. 2011; 19:783–791. [PubMed: 21873834]
8. Adelman RD, Tmanova LL, Delgado D, et al. Caregiver burden: A clinical review. JAMA. 2014; 311:1052–1060. [PubMed: 24618967]
9. Fiske A, Wetherell JL, Gatz M. Depression in older adults. Annu Rev Clin Psychol. 2009; 5:363–389. [PubMed: 19327033]
10. Roehr B. US geriatric mental health workforce needs to expand, says Institute of Medicine. BMJ. 2012; 345:e4686. [PubMed: 22782905]
11. Karlin BE, Norris MP. Public mental health care utilization by older adults. Adm Policy Ment Health. 2006; 33:730–736. [PubMed: 16220240]
12. Mackenzie CS, Pagura J, Sareen J. Correlates of perceived need for and use of mental health services by older adults in the collaborative psychiatric epidemiology surveys. Am J Geriatr Psychiatry. 2010; 18:1103–1115. [PubMed: 20808105]
13. Yeatts DE, Crow T, Folts E. Service use among low-income minority elderly: Strategies for overcoming barriers. Gerontologist. 1992; 32:24–32. [PubMed: 1740252]
14. Gary FA. Stigma: Barrier to mental health care among ethnic minorities. Issues Ment Health Nurs. 2005; 26:979–999. [PubMed: 16283995]
15. Gum AM, Iser L, Petkus A. Behavioral health service utilization and preferences of older adults receiving home-based aging services. Am J Geriatr Psychiatry. 2010; 18:491–501. [PubMed: 21217560]
16. Sorkin DH, Pham E, Ngo-Metzger Q. Racial and ethnic differences in the mental health needs and access to care of older adults in California. J Am Geriatr Soc. 2009; 57:2311–2317. [PubMed: 19943830]
17. Damron-Rodriguez AWS, Kington R. Service utilization and minority elderly: Appropriateness, accessibility, and acceptability. Gerontol Geriatr Educ. 1995; 15:45–64.
18. Barrio C, Palinkas LA, Yamada A, et al. Unmet needs for mental health services for Latino older adults: Perspectives from consumers, family members, advocates, and service providers. Community Ment Health J. 2008; 44:57–74. [PubMed: 18026876]
19. Kessler RC, Andrews G, Colpe LJ, et al. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychol Med. 2002; 32:959–976. [PubMed: 12214795]
20. Stockdale SE, Lagomasino IT, Siddique J, et al. Racial and ethnic disparities in detection and treatment of depression and anxiety among psychiatric and primary health care visits, 1995–2005. Med Care. 2008; 46:668–677. [PubMed: 18580385]
21. Jang Y, Chiriboga DA, Herrera JR, et al. Attitudes toward mental health services in Hispanic older adults: The role of misconceptions and personal beliefs. Community Ment Health J. 2011; 47:164–170. [PubMed: 20091227]
22. Alegría M, Canino G, Ríos R, et al. Mental health care for Latinos: Inequalities in use of specialty mental health services among Latinos, African Americans, and Non-Latino whites. Psychiatr Serv. 2002; 53:1547–1555. [PubMed: 12461214]
23. Fiscella K, Franks P, Doescher MP, et al. Disparities in health care by race, ethnicity, and language among the insured: Findings from a national sample. Med Care. 2002; 40:52–59. [PubMed: 11748426]
24. Cook BL, Doksum T, Chen CN, et al. The role of provider supply and organization in reducing racial/ethnic disparities in mental health care in the U.S. Soc Sci Med. 2013; 84:102–109. [PubMed: 23466259]
25. August KJ, Nguyen H, Ngo-Metzger Q, et al. Language concordance and patient-physician communication regarding mental health needs. J Am Geriatr Soc. 2011; 59:2356–2362. [PubMed: 22091992]

26. Ward EC, Wiltshire JC, Detry MA, et al. African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. Nurs Res. 2013; 62:185–194. [PubMed: 23328705]

27. Conner KO, Lee B, Mayers V, et al. Attitudes and beliefs about mental health among African American older adults suffering from depression. J Aging Stud. 2010; 24:266–277. [PubMed: 21423819]

28. Neighbors HW, Musick MA, Williams DR. The African American minister as a source of help for serious personal crises: Bridge or barrier to mental health care? Health Educ Behav. 1998; 25:759–777. [PubMed: 9813746]

29. Diala CC, Muntaner C, Walrath C, et al. Racial/ethnic differences in attitudes toward seeking professional mental health services. Am J Public Health. 2001; 91:805–807. [PubMed: 11344893]

30. Sorkin DH, Nguyen H, Ngo-Metzger Q. Assessing the mental health needs and barriers to care among a diverse sample of Asian American older adults. J Gen Intern Med. 2011; 26:595–602. [PubMed: 21321793]

Table 1

Sociodemographic Characteristics of Respondents Aged 55 and Older According to Ethnicity and Race (N = 93,938)

Characteristic	Non-Hispanic White, n = 75,324	Black, n = 4,319	Asian or Pacific Islander, n = 7,695	Hispanic, n = 6,600
Age, mean	67.4	66.3	66.7	64.6
Female, %	53.8	58.3	57.3	50.0
Education, some college or more, %	68.9	62.0	63.2	21.7
Married, %	63.0	41.9	70.8	62.9
Insured, %	94.5	91.9	89.8	79.1
Born in United States, %	91.3	92.4	16.3	32.9

Table 2

Reasons for Not Seeking Treatment According to Ethnicity and Race

Reason	Unadjusted %, Adjusted Odds Ratio (95% Confidence Interval)			
	Non-Hispanic White, n = 2,702 (Reference)	Black, n = 164	Asian or Pacific Islander, n = 123	Hispanic, n = 294
Cost	36.2	40.4, 0.9 (0.5–1.7)	39.6, 0.9 (0.4–2.1)	54.4, 1.2 (0.7–2.3)
Not comfortable talking to professional	20.6[ab]	23.5, 1.2 (0.6–2.2)	38.6, 2.8 (1.2–6.4)[a]	31.6, 2.2 (1.2–4.2)[b]
Concerned about someone finding out	11.0[ab]	27.0, 3.5 (1.6–7.6)[a]	44.5, 5.5 (2.2–13.6)[bc]	20.7, 1.2 (0.5–2.9)[c]
Had hard time getting appointment	7.3[a]	11.7, 1.5 (0.8–2.9)	8.8, 0.8 (0.2–2.8)	22.8, 2.3 (1.1–4.7)[a]

Logistic regression analyses included the covariates age, sex, marital status, education level, English language proficiency, nativity status, number of chronic conditions, and level of mental health need.

"Same-letter superscripts[abc]" in the same row indicate that the two parameter estimates are significantly different from one another, $P < .05$. For example, Asian respondents were 2.8 times as likely to report not feeling comfortable talking to a professional about their mental health as non-Hispanic white respondents.

Table 3

Barriers to Receiving Mental Health Treatment According to Ethnicity and Race

Barrier	Non-Hispanic White (Reference)	Black	Asian or Pacific Islander	Hispanic
Still receiving treatment for problem				
n (%)	8,007 (66.0)	419 (71.2)	326 (62.6)	613 (61.2)
OR (95% CI)		1.2 (0.8–1.9)	1.1 (0.6–1.9)	0.8 (0.5–1.2)
Completed recommended full course				
n (%)	2,595 (73.6)	129 (67.3)	111 (59.4)	241 (72.0)
OR (95% CI)		0.8 (0.4–1.6)	0.8 (0.3–2.0)	1.7 (0.9–3.3)
Reason no longer receiving treatment, n[e]	782	44	47	77
No longer needed, got better				
%	41.0	36.4	44.7	40.3
OR (95% CI)		1.0 (0.5–2.2)	0.7 (0.3–1.5)	0.9 (0.5–1.7)
Not getting better				
%	7.0[ab]	<5	8.5	5.2
OR (95% CI)		0.2 (0.1–0.8)[a,d]	0.2 (0.1–0.6)[b,d]	0.5 (0.1–2.0)
Wanted to handle problem on own				
%	10.2	15.9	10.6	10.4
OR (95% CI)		1.0 (0.4–2.7)	0.2 (0.4–0.8)	0.4 (0.1–1.9)
Bad experiences with treatment				
%	6.0	9.1	0 —	6.5
OR (95% CI)		0.3 (0.1–1.8)		1.4 (1.2–11.3)
Lack of time or transportation				
%	<5[a]	<5	<5	<5
OR (95% CI)		0.3(0.1–1.2)	0.1(0.1–1.4)	0.1 (0.1–1.0)[a]
Too expensive				
%	7.4	6.8	8.5	9.1
OR (95% CI)		0.2 (0.1–0.8)	1.3 (0.3–5.9)	1.3 (0.1–15.9)
Insurance does not cover				
%	5.0[a]	9.1	8.5	3.9
OR (95% CI)		2.9 (0.1–106.2)	3.5 (1.1–11.4)[ab]	0.2 (0.1–1.1)[b]

Logistic regression analyses included the covariates age, sex, marital status, education level, English language proficiency, nativity status, number of chronic conditions, and level of mental health need.

OR = odds ratio; CI = confidence interval.

"Same-letter superscripts[abc]" in the same row indicate that the two parameter estimates are significantly different from one another, $P < 0.05$.

[d] Because of small cell sizes, the exact percentage within these cells cannot be reported.

[e] Columns do not sum to 100% because a small percentage of respondents indicated another barrier or did not answer the question.