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Mental Health Status and Use of Mental Health Services by California Adults

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SUMMARY: In 2005, nearly one in five adults in California, about 4.9 million people, said they needed help for a mental or emotional health problem. Approximately one in 25, or over one million Californians, reported symptoms associated with serious psychological distress (SPD).¹ Of those adults with either perceived need or SPD, only one in three reported visiting a mental health professional for treatment. This policy brief, based on data from the 2005

California Health Interview Survey (CHIS 2005), presents the first comprehensive overview of mental health status and service use in California, and highlights differences by age, gender, race/ethnicity, income and insurance status. It also demonstrates the critical need for continued efforts to expand mental health services and threats to such services caused by the ongoing state budget crisis.

Poor mental health exacts a substantial toll not only on affected individuals but also on their families and loved ones, the communities in which they live and society at large.² In the United States, mental illness accounts for approximately 25% of disability and is a leading cause of premature death.³ Aside from reducing overall years and quality of life, untreated mental illness has been associated with suicide, substance abuse, homicide, heart disease and other medical conditions, work or school problems, family conflicts, relationship difficulties, social isolation, poverty and homelessness.^{4,5} Although these complications may be severe, effective treatment can improve the life and well-being of most people with mental illness. This policy brief looks at the prevalence of both serious psychological distress and perceived need among adults in California. (For definitions, see page 2.)

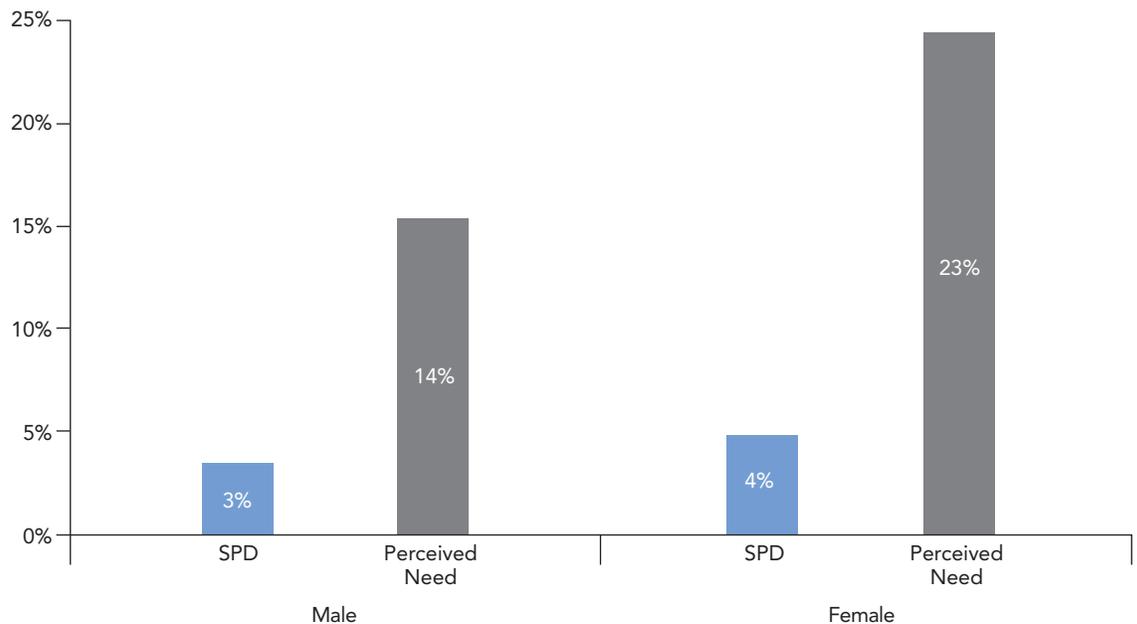
Serious Psychological Distress and Perceived Need Higher Among Women, Middle-Aged and Low-Income Adults

Women in California were nearly 1.5 times as likely as men to report symptoms associated with serious psychological distress (4.5% vs. 3.1%), and more than 1.5 times as likely to say they needed help for a mental or emotional health problem, such as feeling sad, anxious or nervous (22.7% vs. 14.3%; Exhibit 1). Moreover, adults ages 46-64 (5%) were more likely to experience SPD than all other age groups (3-4%), while perceived need was twice as high in adults under age 65 than in adults age 65 and older (20.2% vs. 9.2%).

“More than one million Californian adults report severe psychological distress.”

Exhibit 1

Prevalence of Serious Psychological Distress and Perceived Need by Gender, California Adults, 2005



Source: 2005 California Interview Survey

Perceived Need (PN)

A measure of mental health assessed by asking survey participants if they felt they needed to see a mental health professional in the past year.

Serious Psychological Distress (SPD)

An estimate of serious, diagnosable mental health disorders within a population based on the number and frequency of symptoms reported.

With support from the California Department of Mental Health, the 2005 California Health Interview Survey (CHIS 2005) included a series of questions to

examine mental health status and use of mental health services among adults age 18 and older in California. To assess perceived need for mental health services, CHIS 2005 asked respondents, "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" To measure serious psychological distress, CHIS 2005 used the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population.⁶ Use of mental health services was based on self-reported visits during the past 12 months to a psychiatrist, psychologist, social worker or counselor.⁷



This publication contains data from the California Health Interview Survey (CHIS), the nation's largest state health survey.

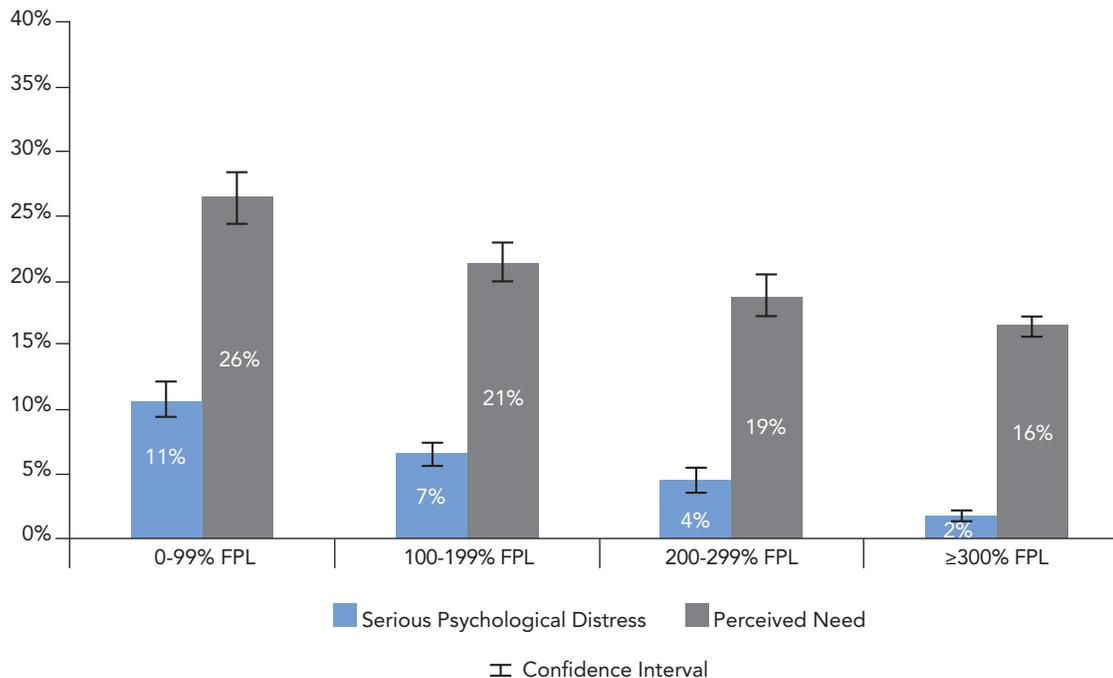
Conducted by the UCLA Center for Health Policy Research, CHIS data gives a detailed picture of the health and health care needs of California's large and diverse population.

Learn more at:

www.chis.ucla.edu

Prevalence of Serious Psychological Distress and Perceived Need by Income as Percent of Federal Poverty Level, California Adults, 2005

Exhibit 2



Source: 2005 California Interview Survey

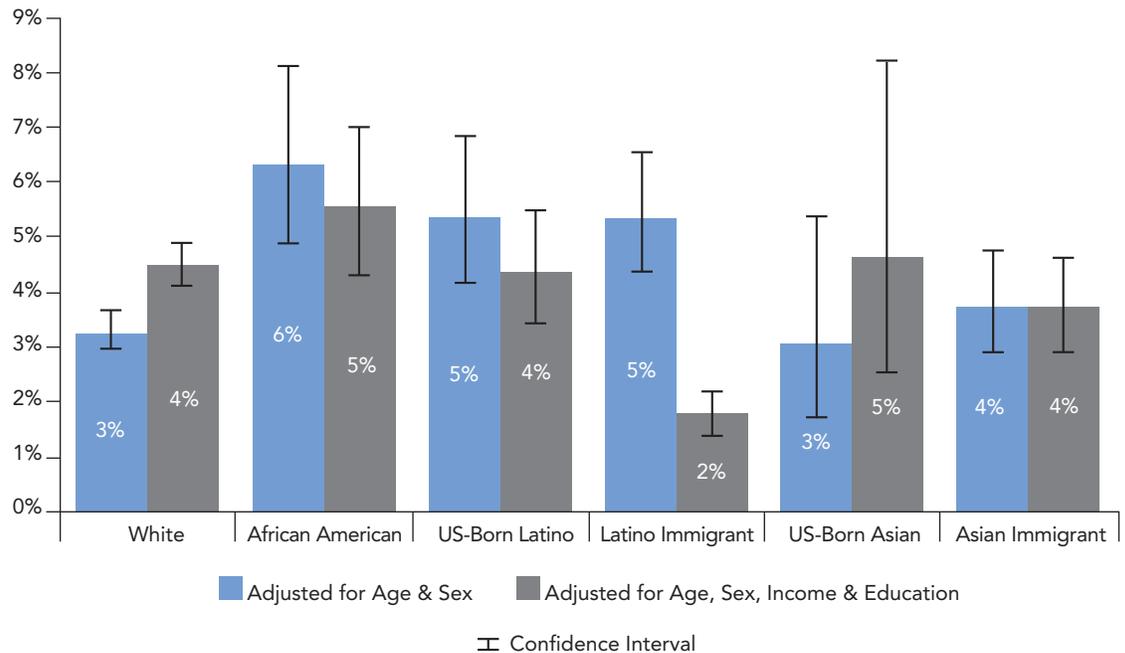
There were also considerable income disparities in the rates of serious psychological distress and perceived need. As shown in Exhibit 2, adults living below 100% of the federal poverty level (FPL) were significantly more likely to report symptoms associated with SPD than those with incomes between 100-199% FPL or 200-299% FPL, and more than five times as likely as those living at or above 300% FPL. Similarly, more than one in four adults living below 100% FPL said they needed help for a mental or emotional health problem (perceived need), whereas only one in five adults living at 100-299% FPL and less than one in six adults living at or above 300% FPL perceived such a need. Further analysis indicated that these findings are independent of differences in income by age or gender.

Racial/Ethnic Differences Rooted in Income Disparities

Although variations in mental health status were observed by race/ethnicity, these variations were mostly explained by differences in income (Exhibit 3). For example, when looking at race/ethnicity adjusted only for age and gender, African Americans (6.3%) were significantly more likely to report symptoms associated with serious psychological distress than Whites (3.3%) and Asian immigrants (3.7%). When the effects of income and education were removed through statistical adjustment, racial/ethnic differences were notably diminished, suggesting that disparities in SPD by race/ethnicity are largely a reflection of differences in income.

Exhibit 3

Partially and Fully Adjusted Prevalence of Serious Psychological Distress by Race/Ethnicity and Nativity, California Adults, 2005



Source: 2005 California Interview Survey

“Latino immigrants were the least likely of all racial/ethnic groups to report symptoms associated with SPD.”

Adjusting for income and educational attainment had a particularly influential effect among Latino immigrants who, compared to all other groups, were the least likely of all racial/ethnic groups to report symptoms associated with SPD (3.7-5.5% vs. 1.8%). It also implies that the rate of SPD among Latino immigrants is more closely related to their socioeconomic status than their ethnicity or place of birth.

In reviewing the rates of perceived need by race/ethnicity (adjusted for age and sex), relatively minor differences were observed by group (data not shown). After further adjusting for income and educational attainment, PN was significantly more likely among Whites (20.9%) than among African Americans (17.2%), Latino immigrants (15.6%), US-born Asians (15.3%), and Asian immigrants (14.2%).

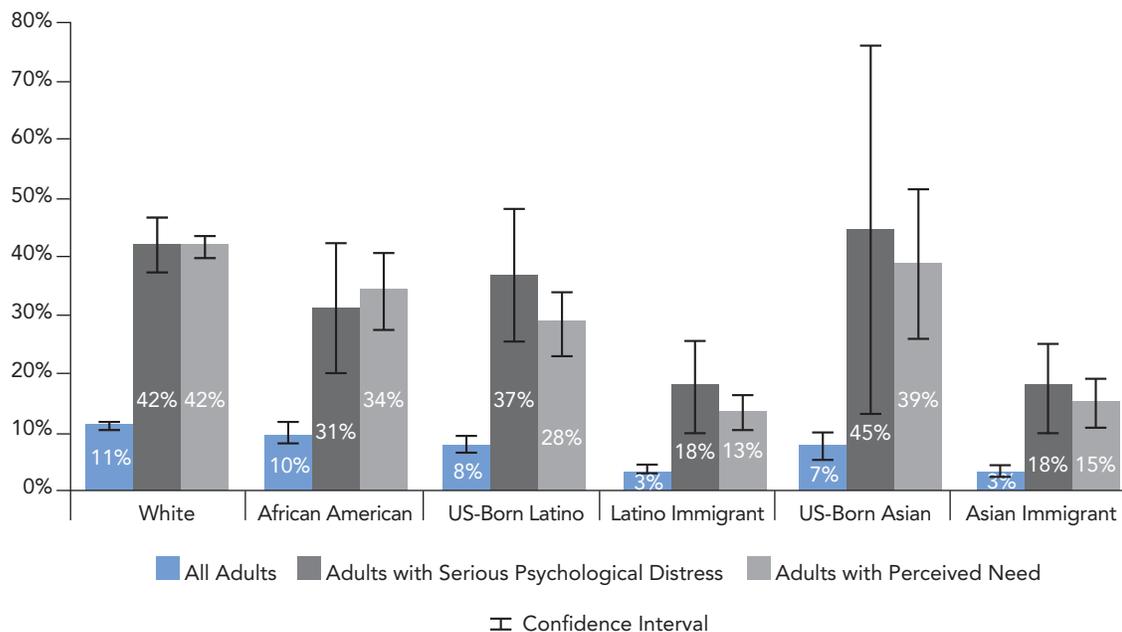
Most Adults with Serious Psychological Distress or Perceived Need Do Not Receive Treatment

Mental health services are often effective, though there are numerous challenges to connect those in need with appropriate care. Overall, men (6.5%) and adults age 65 or older (3.8%) are significantly less likely than women (10.1%) and younger adults (7.5-9.6%) to report visiting a mental health professional for treatment during the past 12 months.⁸

The differences in self-reported service use by race/ethnicity are striking (Exhibit 4). Self-reported visits to a mental health professional were significantly lower among Latino and Asian immigrants (3%) than among all other racial/ethnic groups (7-11%). Among only those adults with serious psychological distress, Latino and Asian immigrants also reported significantly lower rates of service use (18%) than US-born Latinos (37%) and Whites (42%).⁹ Similarly, among only those adults with perceived need, Latino and Asian

Prevalence of Self-Reported Visits to a Mental Health Professional by Race/Ethnicity, Nativity and Mental Health Status, California Adults, 2005

Exhibit 4



Source: 2005 California Interview Survey

immigrants were significantly less likely to report visiting a mental health professional for treatment (13% and 15%, respectively) than all other groups (28-42%), and US-born Latinos reported significantly lower rates of service use than Whites (28% vs. 42%).

The considerable variation in service use by age, gender and race/ethnicity suggests that men, older adults, and Latino and Asian immigrants are less likely to receive mental health treatment. Although mental health problems may be universally painful or shaming, harmful social norms and the stigma surrounding mental disorders may be a particular barrier to seeking treatment among these groups.

Lack of Insurance a Barrier to Mental Health Treatment

Adults with health insurance coverage in California were almost twice as likely to receive mental health services during the past 12 months as adults without health insurance

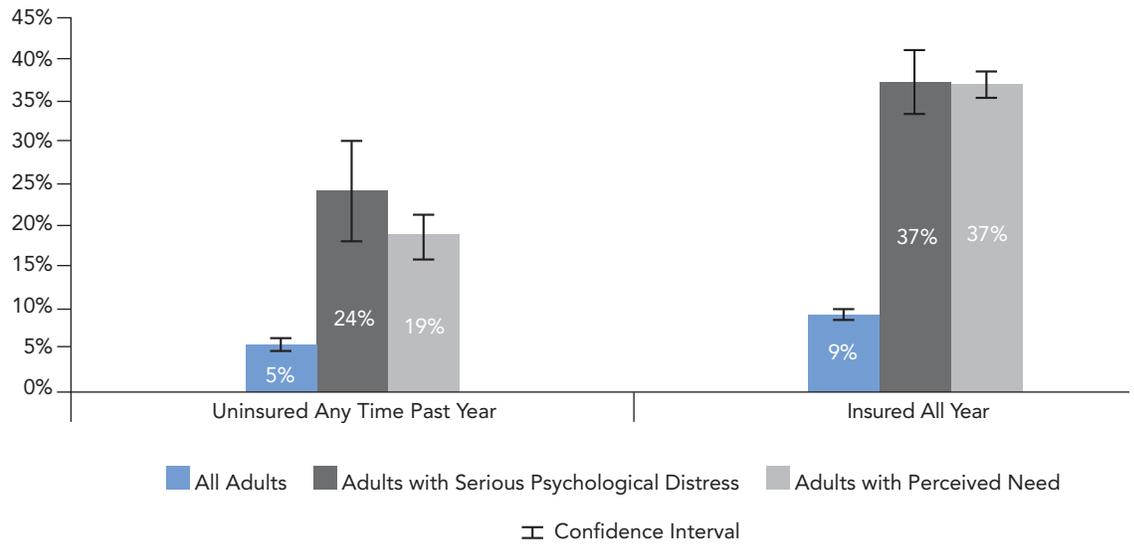
(9% vs. 5%; Exhibit 5). Among those adults with serious psychological distress, service use was significantly higher among insured adults (37%) than among uninsured adults (24%). Similarly, among those with perceived need, insured adults were more than twice as likely to report visiting a mental health professional for treatment than uninsured adults (37% vs. 19%).

In addition to having health insurance, mental health service use also varied by type of insurance coverage. Among adults under age 65, those with public insurance were significantly more likely to report receiving treatment than adults with employer-based or privately-purchased insurance (14% vs. 9%). However, among insured adults with either SPD or PN, there were no significant differences in service use by insurance type.

“Social norms and the stigma surrounding mental disorders may be a particular barrier to seeking treatment.”

Exhibit 5

Prevalence of Self-Reported Visits to a Mental Health Professional by Insurance and Mental Health Status, California Adults, 2005



Source: 2005 California Interview Survey

“Reduced state funding for local mental health programs and public insurance programs could be devastating to hundreds of thousands of Californians.”

Discussion and Policy Implications

In 2005, nearly 19% of California’s adults said they needed help for a mental or emotional health problem (PN) and approximately 3.8% reported symptoms associated with serious psychological distress. The findings of this study suggest that structural (insurance) and cultural (stigma) barriers exist in engaging and treating those in need.

Specifically, these findings suggest that having any type of insurance makes service use more likely. Moreover, among lower-income adults, for whom private insurance may not be an option, public insurance – which usually includes coverage for mental health services – may be a particularly important avenue in which to address mental health needs.

The strong connections among mental health status, service use, income and insurance coverage demonstrate the importance of parity in treatment of mental disorders. The findings also demonstrate the critical need for

continued efforts to expand mental health services and threats to such services caused by the ongoing state budget crisis in Sacramento; reduced state funding for local mental health programs and public insurance programs could be devastating to hundreds of thousands of Californians with mental health needs.

Broader awareness and support is also needed for efforts to reduce the stigma attached to mental illness, especially among groups with low rates of service utilization. Overall, approaches to stigma reduction involve integrated programs of advocacy, public education and social marketing campaigns. Ongoing research that continues to yield increasingly effective treatments for mental disorders is an additional way to reduce stigma and improve mental health status in California.

Continued mental health surveillance in California will provide the opportunity to track trends in the prevalence of SPD,

PN, and the use of mental health services. Forthcoming analyses will explore additional characteristics of persons with mental health disorders and factors associated with treatment quality and effectiveness.

About CHIS/Data Source

The California Health Interview Survey is a collaboration of the UCLA Center for Health Policy Research, the California Department of Public Health, the Department of Health Care Services and the Public Health Institute. Funding for the CHIS 2005 statewide survey was provided by the California Department of Health Services, The California Endowment, the National Cancer Institute, the Robert Wood Johnson Foundation, the California Children and Families Commission, the California Office of the Patient Advocate, the California Department of Mental Health, the Centers for Disease Control and Prevention (CDC), and Kaiser Permanente. For local funders and additional information on CHIS, visit www.chis.ucla.edu

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Funder Information

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Endnotes

- 1 Findings are based on data from the 2005 California Health Interview Survey (CHIS 2005).
- 2 Dhingra SS, Strine TW, Holt JB, Berry JT, Mokdad AH. Rural-urban variations in psychological distress: findings from the behavioral risk factor surveillance system. *International Journal of Public Health* 2009;54:16-22.
- 3 Marshall Williams S, Chapman D, Lando J. The role of public health in mental health promotion. *Morbidity & Mortality Weekly Report*, Sept 2, 2005;54(34):841-842. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a1.htm>
- 4 <http://www.mayoclinic.com/print/mental-illness/DS01104/METHOD=print&DSECTION=all>
- 5 Although research supports some public safety concerns about people with mental illness, the overall contribution of mental disorders to the total level of violence in society is exceptionally small (Swanson, 1994).
- 6 The K6 asks about the frequency of six symptoms of nonspecific psychological distress (e.g., feeling so sad that nothing could cheer you up) during the past 30 days. Responses are assessed on a 5-point Likert scale (4=all of the time, 3=most of the time, 2=some of the time, 1=a little of the time, and 0=none of the time) and summed to yield a total score between 0 and 24. A score of 13 or above is used to indicate serious psychological distress (SPD).
- 7 This study has several limitations worth noting. Firstly, many people with the most severe mental health problems are either homeless or institutionalized, and because CHIS is a household telephone survey, such people are not included. Secondly, CHIS is based on self-reported data which may be subject to recall as well as social desirability biases. Thirdly, since the K6 only reflects self-reported symptoms experienced during the past 30 days, it likely underestimates the annual prevalence of SPD in the population. Fourthly, the question regarding service use did not specify the type of treatment received or whether the person received medication. Lastly, as is true of all symptom-count and self-reported measures, people who are being treated successfully will not be captured by the symptoms-based indicators used in this study.
- 8 Although service utilization varied by age and sex among all adults in California, when only those adults with either SPD or perceived need were considered, no significant differences were observed by sex.
- 9 Although the rates of service utilization among African Americans and US-born Asians with SPD were higher than among Latino and Asian immigrants with SPD, they were not statistically different from the other racial/ethnic groups.

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