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PUBLIC OUTPATIENT MENTAL HEALTH SERVICES: Use and Outcome Among Asian Americans

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Use of public outpatient mental health services and treatment outcomes were studied among Chinese, Japanese, Filipino, Korean, and Southeast-Asian Americans in Los Angeles County. Filipinos were underrepresented in the system, whereas Southeast Asians were overrepresented and had higher utilization rates, but showed less improvement, than did the other groups. The influence of therapist-client ethnic match and of clinicians' professional status were assessed, and recommendations are made for further research based on present findings.

Meeting the mental health needs of the diverse population of the United States continues to be a major challenge to mental health policy makers and providers. A recent assessment of service use and outcome among Asian, African, Mexican, and white Americans *(Sue, Fujino, Hu, Takeuchi, & Zane, 1991)* found that Asian Americans underutilized mental health services. The present investigation seeks to examine that finding more closely by comparing use and treatment outcomes across major Asian groups in the Los Angeles public mental health system.

The size of the Asian-American population is increasing rapidly. In Los Angeles County, it more than doubled between 1980 and 1990 *(U.S. Bureau of Census, 1982, 1992)*. Although Asians are generally viewed as a single group, they are not homogeneous; they differ in cultural background, history, and time of migration, as well as in acculturation level *(Takaki, 1989; Wong, 1982)*.

A recent status report by the U.S. General Accounting Office *(1990)*, based on government documents and community-based data, demonstrated the diversity of Asian Americans. As shown in TABLE 1, Japanese Americans were found to speak English better than all other Asian Americans except Filipinos, to be more likely to have been born in the United States and to have graduated from high school (all of which mediate greater acculturation), and to have higher per capita income than other Asians. In contrast, Southeast Asians (including Vietnamese, Cambodians, Laotians, and the Hmong) were the least acculturated, having arrived in the U.S. during the last two decades as a consequence of the wars in Southeast Asia; many came from rural settings and have experienced severe culture shock *(Strand & Jones,*

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Table 1

DEMOGRAPHIC CHARACTERISTICS OF MAJOR ASIAN GROUPS IN THE U.S.[a]

CHARACTERISTIC	CHINESE	JAPANESE	KOREAN	FILIPINO	SE ASIAN
Speaks English well (%)	76	90	75	91	53
American born (%)	37	72	18	35	9
Graduated high school (%)	71	82	78	74	56
Per capita income	$7,500	$7,800	$5,200	$6,700	$2,900

[a]U.S. General Accounting Office *(1990)*.

1985; Williams & Westermeyer, 1986). Among Filipinos, Chinese, and Koreans, a significant proportion are immigrants who must thus confront the challenges of adjusting to a new country.

Demographic differences among Asian Americans are likely to hold implications for help-seeking behavior, for level of mental health service use, and for treatment outcome. Those who are American born, speak better English, and are better educated are more likely to utilize and benefit from mental health services, since their view of treatment is likely to be more congruent with that of Western-trained clinicians *(Lin & Lin, 1978; White & Marsella, 1982; Ying & Miller, 1992)*. In contrast, Asian Americans who are foreign born are more apt to regard Western treatment methods as strange and thus are less likely to make use of mental health services and to benefit from them. Of particular interest in this regard are the Southeast Asians, who are the least acculturated but also have the greatest mental health needs as a consequence of war and escape traumas.

The aim of the present investigation was to *1)* assess the rate of service use, *2)* compare and contrast use and outcome, and *3)* identify variables that predict service use and positive outcome in five major Asian-American subgroups—Chinese, Japanese, Filipino, Korean, and Southeast Asian. In addition to client ethnicity, the contribution of therapist characteristics to service use and outcome was of interest to this investigation. Specifically, the contribution of the therapist's professional status and the role of therapist-client ethnic and gender match were assessed. It was hypothesized that greater professional status and expertise would engender greater credibility *(Sue & Zane, 1987)* and mediate greater service use and superior outcome *(Baekeland & Lundwall, 1975; Garfield, 1963; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975)* and that therapist-client ethnic and gender match would elicit greater affinity and empathy. In particular, in the case of ethnic match, it was expected that the therapist would be more aware of the client's beliefs, better able to provide assistance congruent with these beliefs, and thus viewed as effective by the client. Previous research supports the importance of empathy and similarity in problem conceptualization as factors in service use and outcome *(Bryson & Cody, 1973; Flaskerud, 1986; Krebs, 1971; Lambert, Shapiro, & Bergin, 1986; Sue et al., 1991; White & Marsella, 1982)*.

Other variables included in the study, primarily as covariates, are age, sex, and marital status, which have been found to have no effect on service use and outcome *(Garfield, 1986; Leaf et al., 1985)*. Available information on education, employment, and income is unreliable. In addition to extensive missing data, those with no income cannot be distinguished from those for whom this was not assessed. Instead, Medi-Cal eligibility, which reflects disadvantaged socioeconomic status and has been found to mediate premature termination *(Berrigan & Garfield, 1981; Weighill, Hodge, & Peck, 1983)*, was used as an indirect measure of financial status. The number of sessions allotted to Medi-Cal clients is usually limited to two per month, with additional sessions subject to review. Such clients are rarely seen more than the stan-

dard two sessions and are likely to make less use of services than do non-Medi-Cal clients.

Additional covariates were extent and nature of dysfunction as measured by the Global Assessment Scale (GAS) *(Endicott, Spitzer, Fleiss, & Cohen, 1976)* and *DSM-III* diagnosis *(American Psychiatric Association, 1980)*. The GAS assesses overall functioning at time of entry into treatment. Psychiatric diagnosis reflects the nature of the problem. It was hypothesized that patients with a poorer initial level of functioning and more severe diagnoses would need and use more service but would show less improvement at outcome *(Fairweather et al., 1960; Horwitz, 1974; Mintz, Luborsky, & Christoph, 1979)*. Finally, increased use was postulated to hold a positive relationship with outcome *(Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971)*.

METHOD

Data were drawn from files of the Los Angeles County Department of Mental Health for 1983–1988, based on its Automated Information System (AIS), which compiles records on system management, revenue collection, clinical management, and research. Client, therapist, and treatment information are entered on standardized forms by the therapist and transferred to a computerized file. All data are entered into AIS through a fixed format screen. Out-of-range values and certain logical and substantive inconsistencies are denied entry. In addition, state and county mental health departments also monitor and reviewed AIS operations and data entry. In 1985, the county AIS system was recognized by the National Association of Counties with an award for excellence.

The Department of Mental Health also conducts training sessions on the use of GAS, the measure obtained to assess level of functioning at the start and termination of treatment. The GAS is scored on a 100-point scale, with higher numbers reflecting superior functioning *(Endicott et al., 1976)*. An internal study by Los Angeles County found interrater reliability for the GAS to be .72. Level of use is measured by number of sessions attended by the client. Diagnostic categories include adjustment disorder, anxiety disorder, affective disorder, schizophrenia and other psychoses, and nonpsychiatric diagnoses.

RESULTS

Data were gathered on 1,731 Asian-American adults (18 years and older) in the Los Angeles County Public Mental Health System. Only their first episode between 1983 and 1988 was included in the analy-

Table 2

SAMPLE CHARACTERISTICS (*N*=1,731)

CHARACTERISTIC	CHINESE (*N*=414)	JAPANESE (*N*=309)	FILIPINO (*N*=326)	KOREAN (*N*=277)	SE ASIAN (*N*=405)	ETHNIC DIFF.*
Male (%)	40.1	36.9	35.6	36.8	42.0	
Married (%)	35.0	30.1	33.7	46.2	41.7	K>C,J,F
Age (*SD*)	37(14)	38(15)	36(14)	36(12)	35(11)	
Medi-Cal (%)	70.8	63.4	68.7	67.1	82.2	SE>C,J,F,K
Entry GAS (*SD*)	45(14)	46(14)	46(14)	45(14)	46(11)	
Schizophrenia/other psychosis (%)	21.7	18.8	19.3	23.8	16.3	
Affective disorder (%)	31.2	28.5	27.9	33.2	27.7	
Anxiety disorder (%)	6.3	5.5	4.6	9.7	13.1	SE>C,J,F
Adjustment disorder (%)	29.5	31.7	26.1	15.9	24.9	K<C,J,F,SE
Nonpsychiatric disorder (%)	11.4	15.5	22.1	17.3	18.0	F>C
Professional (%)	90.3	87.4	85.9	96.8	72.1	SE<C,J,F,K
Ethnic match (%)	57.5	38.8	33.1	57.8	53.1	J,F<C,K,SE
Sex match (%)	54.6	57.0	56.1	53.4	50.9	
Number of sessions (*SD*)	7(3)	7(3)	6(3)	7(3)	9(3)	SE>C,J,F,K
Exit GAS (*SD*)	50(15)	51(16)	51(16)	51(16)	48(14)	

*p<.001.

ses (23.5% of clients had more than one episode during this period). Sample characteristics by ethnicity are presented in TABLE 2. Given the wide range of sessions utilized (1 to 539), log transformation was used in this and other analyses. Chi-square analyses and ANOVA tests were utilized to assess ethnic differences (given the numerous comparisons, a significance level of $p<.001$ was used).

Korean Americans were significantly more likely to be married than were Chinese, Japanese, and Filipinos. Southeast Asians were more likely to be on Medi-Cal than were members of the other groups. In terms of diagnostic differences, Southeast Asians were significantly more likely to suffer from anxiety than were Chinese, Japanese, and Filipinos; Koreans were less likely to suffer from an adjustment disorder than the others; and Chinese were less likely to suffer from nonpsychiatric illness than were Filipinos. Southeast Asians were less likely to be seen by a professional; Japanese and Filipinos were less likely to see a therapist of their own ethnic background; and Southeast Asians were likely to use more sessions than the others. The mean number of sessions used by the various ethnic groups (between 6 and 9) is comparable to that reported in the literature *(Berrigan & Garfield, 1981; Billings & Moos, 1984)*.

Utilization Rate

Using available census data for 1980 and 1990, the Asian population in Los Angeles County for 1985 was estimated to be 624,218, of whom 27% were Chinese, 20% Japanese, 26% Filipino, 16% Korean, and 11% Southeast Asian (including Vietnamese, Cambodian, and Laotian) *(U.S. Bureau of Census, 1982, 1992)*. Of the Asians in the Los Angeles Public Mental Health System during 1983–1988, 24% were Chinese, 18% were Japanese, 19% were Filipinos, 16% were Koreans, and 23% were Southeast Asians. Filipinos were thus considerably underrepresented, and Southeast Asians overrepresented in the mental health system.

Service Use and Outcome

To assess ethnic variation in service use and outcome, five regression analyses per question were conducted, varying the ethnic group deleted in each analysis. For instance, Chinese Americans were compared to all other groups, then Japanese Americans were compared to all others, and so on. Other variables controlled for in the service-use model were clinician's professional status, therapist-client ethnic and gender match, and client's entry GAS score, *DSM-III* diagnosis, age, sex, marital status, and Medi-Cal eligibility. In the outcome model, number of sessions was also controlled for. Southeast Asians were found to use significantly more service but reported poorer outcome than did all other Asians ($p<.05$). Other groups did not differ significantly from one another.

Predictors of Use and Outcome

Service use and outcome for each ethnic group were examined. In all models, the comparison group consisted of female, unmarried, non-Medi-Cal-eligible clients with an affective disorder (the most common diagnosis) who were seeing nonprofessional, and also non-ethnic and non-sex-matched, clinicians.

Therapist-client ethnic match significantly predicted increased service use for all groups but Southeast Asians (TABLE 3). Sex-match was a positive predictor only for Japanese Americans. Professional status significantly predicted service use positively for Filipino and Chinese clients, but negatively for Southeast Asians. Medi-Cal eligibility mediated significantly less service use for all groups other than the Japanese. Those with less severe diagnoses, such as nonpsychiatric diagnosis or adjustment disorder, generally used less service than did those suffering from an affective disorder. Older Southeast Asians were found to use more service.

Table 3

STANDARDIZED BETA WEIGHTS OF MODEL VARIABLES PREDICTING SERVICE USE BY ETHNICITY

VARIABLE	ETHNICITY				
	CHINESE	JAPANESE	FILIPINO	KOREAN	SE ASIAN
Male[a]	-0.02	-0.06	-0.03	-0.09	0.07
Married[a]	0.02	-0.10	-0.03	-0.12	0.04
Age	0.02	-0.06	0.03	-0.10	0.19***
Medi-Cal eligible[a]	-0.11*	-0.11	-0.14**	-0.20***	-0.10*
Entry GAS	0.05	0.15*	-0.03	0.06	0.08
Schizophrenia/other psychosis[a]	0.04	-0.08	-0.04	0.01	0.09
Anxiety disorder[a]	-0.13**	-0.06	0.01	-0.02	-0.02
Adjustment disorder[a]	-0.03	-0.16*	-0.06	-0.29***	-0.11
Nonpsychiatric disorder[a]	-0.03	-0.13*	-0.15*	-0.17**	-0.25***
Professional clinician[a]	0.12*	0.04	0.16**	0.10	-0.17***
Ethnic match[a]	0.18***	0.18**	0.33***	0.14*	0.08
Sex match[a]	0.01	0.12*	0.08	0.07	0.08

[a]Female, unmarried, non-Medi-Cal-eligible clients with an affective disorder seeing nonprofessional, non-ethnic, and non-sex-matched clinicians make up the deleted comparison group.

*$p<.05$; **$p<.01$; ***$p<.001$.

In terms of service outcome, TABLE 4 shows that a higher level of functioning at entry into treatment (higher entry GAS score) mediated better outcome across all ethnic groups. In addition, for Chinese, Filipinos, and Koreans, attending a greater number of sessions also mediated a more positive outcome. In terms of therapist variables, ethnic match was a significant mediator for better outcome in Chinese Americans, and professional status was a significant mediator for Filipinos. For Southeast Asians, a less severe diagnosis (i.e., nonpsychiatric or adjustment disorder) predicted better outcome than a diagnosis of affective disorder. This was only partially true for Chinese and Filipinos. Medi-Cal eligibility predicted poorer outcome for Filipinos. Married Southeast Asians showed poorer outcome.

DISCUSSION

Among these Asian subgroups, Filipinos were underrepresented and Southeast Asians overrepresented in the Los Angeles Public Mental Health System. The relatively light use of the public mental health system by Filipinos may be due to their greater likelihood of being employed, based on their proficiency in English, giving them greater access to private health insurance.

The overrepresentation of Southeast Asians probably reflects the greater mental health needs of this population as a result of severe war and migration traumas. Compared to the other groups, a higher proportion of Southeast Asians suffered from anxiety disorder, likely to be post-traumatic stress disorder. Southeast Asians are also the most recently arrived among the groups, with the least exposure to Western industrialized society and thus the greatest likelihood of experiencing serious adjustment difficulties. Although this translated into greater service use, their outcome was poorer than that of other Asian groups, even when diagnosis and initial level of functioning were controlled for. This was likely due not only to the persistence of their problems but also to current intervention methods, which may be less effective in treating this population. It appears that current treatment models for trauma need to be made more culturally congruent for Southeast Asians.

Southeast Asians also differed from the other groups studied in being more likely to continue treatment when the service provider was a paraprofessional. This finding is particularly important, since Southeast Asians were significantly more likely to be seen by paraprofessionals than were

Table 4

STANDARDIZED BETA WEIGHTS OF MODEL VARIABLES PREDICTING SERVICE OUTCOME BY ETHNICITY

VARIABLE	ETHNICITY				
	CHINESE	JAPANESE	FILIPINO	KOREAN	SE ASIAN
Male[a]	0.05	0.01	0.05	0.01	0.01
Married[a]	0.02	0.05	-0.03	-0.03	-0.09*
Age	-0.04	-0.05	0.03	-0.01	0.04
Medi-Cal eligible[a]	-0.01	-0.01	-0.09**	-0.04	-0.03
Entry GAS	0.67***	0.69***	0.61***	0.67***	0.64***
Schizophrenia/other psychosis[a]	-0.04	-0.07	-0.14**	-0.06	-0.03
Anxiety disorder[a]	0.06	-0.01	0.03	0.01	0.06
Adjustment disorder[a]	0.06	0.08	0.01	0.01	0.11**
Nonpsychiatric disorder[a]	0.09*	0.04	0.10*	0.08	0.14**
Professional clinician[a]	-0.01	0.05	0.10**	0.05	0.03
Ethnic match[a]	0.10**	-0.01	0.03	0.06	0.01
Sex match[a]	0.01	-0.01	-0.03	-0.04	0.02
Number of sessions	0.11***	0.05	0.11**	0.10*	-0.01

[a]Female, unmarried, non-Medi-Cal-eligible clients with an affective disorder seeing nonprofessional, non-ethnic, and non-sex-matched clinicians make up the deleted comparison group.

*$p<.05$; **$p<.01$; ***$p<.001$.

members of any other group. The paraprofessionals treating Southeast Asians tended to be bilingual Southeast Asians who had often suffered war and migration traumas similar to those of their clients and who therefore may have more easily achieved a level of empathy and understanding. Although this empathy facilitated the client's wish to continue treatment, it did not mediate improved outcome, suggesting that paraprofessionals may lack the full range of skills needed to assist these clients.

Across all groups, therapist characteristics (i.e., professional status, ethnic and gender match with the client) affected level of service. Ethnic match mediated greater service use for all groups other than Southeast Asians, among whom ethnic match may be confounded with the therapist's paraprofessional status; when the latter significantly accounted for the variance in use, it diminished the power of the former to do so.

Japanese and Filipinos were less likely to see an ethnically matched therapist. Perhaps because of their English-language facility, an ethnic- and language-matched therapist was deemed to be less important. However, having an ethnically matched therapist did increase service use among Japanese and Filipinos, suggesting its utility. Chinese and Filipinos seen by professionals reported greater service use. Japanese clients seeing a sex-matched therapist also reported greater use.

Better outcome was found for ethnically matched than for non-ethnically matched Chinese clients, and for Filipinos seeing professionals than for those seeing nonprofessionals. In addition, number of sessions contributed positively to outcome for Chinese, Filipinos, and Koreans. For Filipinos and Koreans, it is likely that therapist-client ethnic match may have indirectly mediated better outcome through its effect on increased service use.

The most powerful variables mediating service outcome were the mental health status variables, with entry GAS being the most significant predictor of exit GAS, the measure of outcome. Severity of diagnosis was also quite important in predicting outcome.

Medi-Cal-eligible Chinese, Filipino, Korean, and Southeast Asian clients used less service, but among these only the Filipino clients showed less improvement than did non-Medi-Cal-eligible clients. It is unclear whether the differential use pattern was due to a problem of demand (i.e., as a result

of being unemployed and having a less stable and structured life, they had greater difficulty staying in treatment) or supply (their being offered fewer sessions due to Medi-Cal's rigorous review). The issue merits further study. It is also unclear why Medi-Cal eligibility mediated poorer outcome only for Filipino clients.

CONCLUSIONS

This article provides an initial examination of the heterogeneity in service use and outcome across Asian ethnic groups. Although limited sample size precluded separate study of each of these Southeast Asian subgroups, it would be valuable to do so in future investigations.

Of the major Southeast Asian groups, Vietnamese are the most likely to have been exposed to Western life prior to migration, while Cambodians have suffered the most severe trauma under the Pol Pot regime, and many Laotians, especially the highland tribal people, are from strictly agricultural and nonliterate societies. These differences are likely to mediate differential mental health needs, service use, and outcome patterns.

The use of aggregate computerized records allowed for an overview of how Asian Americans are faring in the public mental health system. However, these data are limiting in that it was not possible to assess the process of treatment and more closely examine how and why some clients benefit more and some less from treatment despite similarities in client and therapist characteristics.

Finally, it should be noted that, since a public mental health system data set was utilized, these findings are likely to be generalizable only to Asians in such a public system. There is no reliable information as to how many Asians seek managed or private mental health service and whether their patterns of use and outcome differ from those in the public system. It is also not clear whether therapist characteristics and therapist-client ethnic and gender match play similar roles in nonpublic mental health service. These questions deserve further investigation.

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