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Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders

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ABSTRACT

Language barriers pose problems in mental health care for foreign-born individuals in the United States. Immigrants with psychiatric disorders may be at particular risk but are currently understudied. The purpose of this study was to examine the effect of limited English proficiency (LEP) on mental health service use among immigrant adults with psychiatric disorders. Drawn from the National Latino and Asian American Study (NLAAS), Latino and Asian immigrant adults aged 18–86 with any instrument-determined mood, anxiety, and substance use disorder (n = 372) were included in the present analysis. Results from hierarchical logistic regression analyses showed that having health insurance, poor self-rated mental health, and more psychiatric disorders were independently associated with higher probability of mental health service use in the Latino group. After controlling for all background characteristics and mental health need factors, LEP significantly decreased odds of mental health service use among Latino immigrants. None of the factors including LEP predicted mental health service use among Asian immigrants, who were also the least likely to access such services. LEP was a barrier to mental health service use among Latino immigrants with psychiatric disorders. This study suggests that future approaches to interventions might be well advised to include not only enhancing the availability of bilingual service providers and interpretation services but also increasing awareness of such options for at least Latino immigrants. In addition, further investigation is needed to identify factors that can enhance access to mental health care services among Asians.

1. Introduction

The growth of the immigrant population in recent years has been phenomenal: current statistics shows that more than one in every eight U.S. residents are immigrants (U.S. Census Bureau, 2004). In 2007, 54.6 percent of foreign-born people in the U.S. were from Central and Latin America, 23.1 percent were from Asia, and the remaining 20.3 percent were from Europe and other regions of the world (Camarota, 2007). The United States grew not only racially and ethnically but also linguistically diverse. According to a recent U.S. Census Bureau (n.d.), over 54 million (19.5 percent of the U.S. population) reported that they spoke a language other than English at home and 8.6 percent of the U.S. population reported they spoke English less than "very well." Additionally, more than half (51.0%) of the U.S. immigrant population appeared to have less than "very well" English-speaking ability (U.S. Census Bureau, 2005), referred to as limited English proficiency (LEP) population.

LEP exerts a pervasive impact. Language barriers not only can lead to miscommunication with health care providers but also can have deleterious effects on navigating the health care system and on understanding health information and treatment (DuBard and Gizice, 2008; Flores, 2006; Ponce et al., 2006). Given that mental health treatment relies on direct verbal communication rather than objective tests as for physical illness, language barriers may be especially important in mental health care settings (Sentell et al., 2007). Previous studies have reported that LEP is associated with lower use of general health care services (Abe-Kim et al., 2007; DuBard and Gizice, 2008; Jacobs et al., 2005; Ponce et al., 2006). With respect to mental health care services there is less evidence. However, a recent study using the 2001 California Health Interview Survey found that LEP Latinos and Asians were less likely to receive

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mental health services compared to those with English proficiency (Sentell et al., 2007). This study was limited in that the investigators used self-reported mental health problems rather than diagnosed mental health problems when they identified people with a mental health need.

Previous studies with immigrants reported that mental health service use varied by immigration-related characteristics such as nativity status, English proficiency, years lived in the U.S., and age at time of immigration (e.g., Abe-Kim et al., 2007; Le Meyer et al., 2009). A recent investigation on mental health service use among Asian Americans found that the most important indicators of within-group differences in service use were nativity status (US-born vs. foreign-born) and generation status (first vs. second vs. third or more) (Abe-Kim et al., 2007). Immigrants were less likely than US-born individuals to use mental health services (6.19% vs. 2.17%) and rates of mental health service use among third-generation Asians were more than three times higher than those of second- or first-generation Asians (10.10% vs. 3.51% vs. 2.17). In the same study, English-speaking ability (excellent/good vs. fair/poor) was also associated differently with use of mental health services among Asians. The English proficient were more likely than those with LEP to use mental health services (3.50% vs. 2.25%).

While LEP has received considerable attention, its particular relevance to immigrant populations remains relatively understudied. The stresses and strains generally associated with the immigrant experience have been well-documented and may last for extended periods of time (e.g., Beiser, 1999; Birman and Taylor-Ritzler, 2007; Chiriboga et al., 2002). There is also some evidence that immigrants with LEP have relatively high levels of emotional distress, and are less likely than native-borns to access mental health services (e.g., Abe-Kim et al., 2007; Chiriboga et al., 2002). Since these individuals with LEP are primarily concentrated among racial/ethnic minorities, studying the health care of Latino and Asian immigrants without paying attention to English proficiency may carry the potential of overlooking racial/ethnic disparities.

For these reasons, and because previous studies of mental health and service utilization among immigrants have rarely evaluated evidence for specific disorders, the current study focused on Latino and Asian immigrants who have instrument-determined diagnoses for psychiatric disorders. The latter individuals represent a population with an identified need for mental health care services. Due to the lack of appropriate national data, it has proved difficult to adequately address access barriers to mental health services faced by Latino and Asian immigrants with mental health problems.

Our underlying hypothesis was that immigrant adults with LEP would be less likely to use mental health services compared to those with good English proficiency. Using a national dataset, findings from this study will help to explain whether LEP is a barrier to mental health service use among immigrants with psychiatric disorders.

2. Materials and methods

2.1. Sample

Data were drawn from the National Latino and Asian American Study (NLAAS), which is a national survey of household residents (18 and older) in the non-institutionalized Latino and Asian populations residing in the contiguous United States. A total of 4649 Latino and Asian Americans were recruited between 2002 and 2003 for the NLAAS survey. All participants were interviewed by trained bilingual interviewers. Interviews were conducted face-to-face, unless the respondent specifically requested a telephone interview or if a face-to-face interview was not feasible. Detailed information on the NLAAS dataset is available elsewhere (Alegría et al., 2004a,b; Heeringa et al., 2004). Languages used for interview in NLAAS were English, Spanish, Vietnamese, Mandarin, Cantonese, and Tagalog. Since immigrant populations with psychiatric disorders were of particular interest for the current analysis, participants ($n = 372$) who were born outside the U.S. and who had any type of mood, anxiety, or substance use disorder indicated by a diagnostic tool were selected. The final sample consisted of 249 Latinos and 123 Asians. Latino immigrants included 82 Cubans, 45 Puerto Ricans, 58 Mexicans, and 64 other Hispanics and Asian immigrants included 34 Vietnamese, 25 Filipinos, 38 Chinese, and 26 other Asians. Despite the heterogeneity of Latino and Asian subgroups, subjects were aggregated into the more inclusive Latino and Asian groups in order to make broad comparisons and establish baselines for further comparisons (Sue et al., 1995).

2.2. Measures

2.2.1. Limited English Proficiency

English-speaking ability was assessed using a single question "How well do you speak English?" Responses were dichotomized into "excellent/good (coded as 1)" or "fair/poor (coded as 0)." Those who reported their English-speaking ability as fair/poor were deemed to have LEP.

2.2.2. Psychiatric disorders

Research-diagnosed psychiatric disorders (i.e., mood, anxiety, and substance disorders) were identified with the World Health Organization's Composite International Diagnostic Interview (WHO-CIDI) (Kessler and Usturn, 2004), a fully structured diagnostic instrument administered by trained lay interviewers that has high concordance with actual psychiatric diagnoses (Haro et al., 2006; Kessler et al., 2004). In order to ensure both adequate translation and cultural relevance of the instruments, the NLAAS developers used an altered version of the CIDI that was based on cross-cultural equivalency in semantic, content, technical, and criterion/conceptual equivalence (see Alegría et al., 2004a). Three categories of psychiatric disorders were covered in the following analyses: (1) mood disorders (major depressive disorder or dysthymia); (2) anxiety disorders (panic disorder, agoraphobia without panic, social phobia, generalized anxiety disorder, or posttraumatic stress disorder); and (3) substance use disorders (alcohol abuse, alcohol dependence, substance abuse, or substance dependence). One category of psychiatric disorders covered in the NLAAS, that involved with impulse control, was not included in the analyses since several of these disorders were not fully measured (e.g., conduct, attention deficit, and oppositional-defiant disorders). Immigrant adults with the presence of any probable mood, anxiety, and substance disorders during the 12-month period were selected for the present study. The maximum possible number of research-diagnosed psychiatric disorders was 11 and psychiatric comorbidities were also assessed.

2.2.3. Self-rated mental health

In addition to diagnoses for psychiatric disorders, self-rated mental health was included as a need variable for mental health treatment because it captures the individual's perception of mental health. Self-rated mental health was assessed with a single item "How would you rate your mental health?" Response categories were 1 (excellent)–5 (poor).

2.2.4. Use of mental health services

Mental health service use was assessed with the question "In the past 12 months, did you go to see [provider on furnished list] for problems with your emotions or nerves?" Four types of specialty