
THE IMPORTANCE OF OPEN ACCESS TO MENTAL HEALTH
MEDICATIONS IN THE ASIAN AMERICAN COMMUNITY

Facts on Open Access to Medications

- A *Health Affairs* article noted that restrictions on access to medicines could “reduce appropriate care, adversely affect health status, and cause shifts to more costly types of care. For example, [access restrictions] in New Hampshire in 1990 resulted in reductions in the use of psychiatric medications but led to large increases in the use of emergency mental health services and partial hospitalization for people with schizophrenia. The average increase in service costs per patient was estimated to exceed the savings by a factor of 17.”¹
- Time consuming barriers to appropriate treatment, such as prior authorization, can cause physicians and patients to avoid the non-preferred medications. Some physicians even refuse to fill out prior authorization forms because of this added time burden.²
- Prescription drugs used to treat mental illness are not interchangeable. Doctors who treat mental illness often struggle for months or years to find the right medication for each individual patient – the medication that provides the most effective control of symptoms, limits side effects and delays relapse.³
 - About 30 percent of individuals do not respond to the antidepressant initially prescribed to them, while 70 percent of patients who initially respond to a particular antidepressant relapse and require a different medication.⁴
 - 44 percent of American caregivers who say their relative is satisfied with their current medication say it took two years or more for their relative to find a medication that works; 90 percent say that their relative tried more than two different medications before finding the one that works and 35 percent say their relative had to try more than five medications.⁵
- Research in the past few decades has uncovered significant differences among racial and ethnic groups in the metabolism, clinical effectiveness and side-effect profiles of many clinically important drugs.⁶
 - 47 percent to 70 percent of Asian Americans and African Americans may be slow metabolizers of some drugs.⁷
 - Preliminary studies suggest that Asian Americans respond clinically to psychotropic medicines in a manner similar to Caucasians but at lower average dosages.⁸

Facts on Mental Health in the Asian American Community

- Asian Americans show higher levels of depressive symptoms than their Caucasian counterparts.⁸

- Suicide rates among Asian Americans are substantially lower than the rates of Caucasians.⁸
- Asian Americans have extremely low utilization of mental health services relative to other U.S. populations; one study found that only 17% of those experiencing problems sought care.⁸
 - Asian Americans are only 25 percent as likely as Caucasians and 50 percent likely as African Americans and Hispanics to seek outpatient care and are less likely than Caucasians to receive inpatient care.⁹
 - Those who do seek care are more likely to be misdiagnosed as "problem-free."⁹
- One study found that severity of disturbance tends to be high for Asian Americans, possibly because they tend to delay seeking treatment until symptoms reach crisis proportions.¹⁰
- Age at immigration appears to affect the onset of mental disorders in Asian Americans.¹¹
 - Asian Americans who immigrated during childhood, as well as U.S. born Asians, were much more likely to have a mental disorder in their lifetimes than other immigrant generations.¹¹
 - Asian Americans who arrived at age 12 or younger had a greater risk for psychiatric disorders during childhood than their U.S. born counterparts; this risk increased during adolescence.¹¹
 - Asian Americans who arrived before age 41 had a greater risk of onset for mood disorders during or shortly after immigration.¹¹

¹Chris Koyanagi, Sandra Forquer, and Elaine Alfano. *Medicaid Policies to Contain Psychiatric Drug Costs*. *Health Affairs*. March/April 2005; 24(2): 536-544.

²Mackinnon N. J., Kumar R. *Prior authorization programs: a critical review of the literature*. *J Managed Care Pharm* 2001;7;297-302

³Fenton W.S, Blyer CR, Heinssen PK, *Determinants of Medication Compliance in Schizophrenia; empirical and clinical findings*; *Schizophrenia Bull*. 1997 234:637-51.

⁴Kaiser Commission on Medicaid and the Uninsured, "Case Study: Michigan's Medicaid Prescription Drug Benefit," Washington, D.C., January 2003.

⁵2006 *Keeping Care Complete*, survey of U.S. family caregivers developed by the World Federation for Mental Health and Eli Lilly and Company and conducted by Independent market research companies Ipsos-Insight and All Global Ltd.

⁶*Journal of the National Medical Association, Racial and Ethnic Differences in Response to Medications: Towards Individualized Pharmaceutical Treatment*, 2002; Oct. 2002.

⁷*Ethnicity & Psychopharmacology, Review of Psychiatry Series, American, Vol. 19, No.4.*

⁸SAMHSA Surgeon General's Report: *Mental Health Fact Sheet African Americans*.

<http://mentalhealth.samhsa.gov/cre/fact2.asp>.

⁹David Satcher, M.D., Ph.D., *Mental Health: A Report of the Surgeon General*, 1999, as cited on CDC Office of Minority Health Fact Sheet. <http://www.cdc.gov/omh/AMH/factsheets/mental.htm>.

¹⁰SAMHSA Surgeon General's Report: *Mental Health Fact Sheet African Americans*.

<http://mentalhealth.samhsa.gov/cre/fact2.asp>.

¹¹Boyce CA, Fuligni AJ. *Issues for Developmental Research Among Racial/Ethnic Minority and Immigrant Families*. *Res Hum Dev*. 2007 Jun;4(1&2):1-17, as cited on NIMH Science Update <http://www.nimh.nih.gov/press/new-insights-mental-health-culture-immigration.cfm>.