Access to Care for Youth in a State Mental Health System: A Simulated Patient Approach

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Objective: To examine access to psychiatric care for adolescents with depression in outpatient specialty clinics within a state mental health system, using a simulated patient approach.

Method: Trained callers posed as the mother of a 14-year-old girl with depression, following a script. A stratified random sample (n = 264) of 340 state-licensed outpatient mental health clinics that serve youth was selected. Clinics were randomly assigned to season and insurance condition. We examined whether access varied by season, clinic characteristics, and caller insurance type. Weighted logistic and linear mixed effects regression models were fitted to examine associations with appointment availability and wait times.

Results: Among clinics at which a treatment appointment could be scheduled, appointment availability differed by season. Clinics that had participated in state-sponsored trainings targeting access were more available. Wait times for treatment appointments varied by season and region. Wait times in New York City were shorter than in some other regions. Although callers were 4.1 times more likely to be able to schedule a psychiatry appointment in the spring, wait times for psychiatry appointments were significantly longer in the spring than in the summer (49.9 vs. 36.7 days). Wait times for therapy appointments were significantly shorter in community than in hospital clinics (19.1 days vs. 35.3 days).

Conclusion: Access to psychiatric care for youth with depression was found to be variable in a state system. State-sponsored trainings on strategies to reduce wait times appear to improve care access. The simulated patient approach has promise for monitoring the impact of health care policy reforms on care quality measures.

Key words: simulated patient, access to psychiatric care, appointment availability, wait times, outpatient mental health clinics

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Access to timely mental health care is an important issue, given the well-documented disparities in psychiatric care access and wide-ranging changes in health care delivery underway as a result of the Affordable Care Act (ACA). Ensuring that youth with mental health needs are offered timely access and access to quality services is especially important, given the potential lifelong effects of childhood psychiatric problems and societal costs generated by untreated mental health needs.[1] Accountability expectations set forth by the ACA have increased attention to issues of equitable access to effective mental health care and establishment of measureable standards.[2-4] State mental health systems are experiencing massive changes consequent to the 2008 recession, followed by the Mental Health Parity Act and, more recently, the ACA.[5] Altogether, the recession and these major policies have led states to be increasingly concerned about service costs, quality, and outcomes. As states and health plans are restructured to contain costs, ensuring appropriate access for the populations for whom they are responsible is of paramount importance. Disparities in access to specialty psychiatric care, especially for youth, have been well documented. Variations in insurance coverage and geographic location are among the most commonly reported contributors to differences in access, independent of population characteristics or level of need.[6-10]

Despite increased national attention to issues of access, few empirical studies have examined access to mental health care using rigorous research methodology. Defining access adequacy varies by state and health plan. The most widely used methods to track access include complaint tracking, surveys of patients and providers, and data provided by health plans (such as numbers of providers in a geographical area). However, these estimates are limited: they are global and may not reflect actual access or address the experience of individuals who actually attempt to access services.[11] Actual experiences are critical because individuals who seek services vary greatly in their need for services, the persistence with which they seek them, and their ability to navigate complex health systems. Moreover, existing data are subject to numerous problems. Patient surveys may suffer from nonrepresentative samples and recall bias. Social desirability may bias the data from providers or health plans. Rigorous and practical strategies to assess service access are needed to understand the impact of the changing health care landscape on youth psychiatric services.

This article is discussed in an editorial by Dr. Bonnie T. Zima on page 355.

One such rigorous methodology that has gained recent attention is the use of simulated patients or "mystery shoppers." Mystery shopping originally referred to private investigators hired by banks and retail stores to assess for employee theft or fraud. It has evolved into "a form of research whereby individuals measure any type of customer service process by acting as actual or potential customers."[12] "Simulated patient" is the term most often used in medical settings where actors are trained to play patients for the purpose of training and evaluation of medical services.[13] In contrast to more conventional approaches, the simulated patient approach confers some benefits. Simulated patients/caregivers provide accurate, real-time estimates of appointment availability and wait times. When incorporated into a well-designed empirical study, these approaches allow assessment of additional variables that may affect access, such as time of year, type of insurance, and caller persistence.[8,11,14]

Three recent studies have used a simulated patient methodology to examine access to care for depression. In a study of adult patients, those presenting with depression were able to make an appointment significantly less often than patients calling for a medical complaint, and only 12% of calls for depression resulted in an appointment within 2 weeks (compared with 40% for a medical complaint).[8] In 2 studies evaluating specialty psychiatric care for adolescents with depression, significant disparities in appointment availability and wait time by insurance status were evident, and overall less than 30% of appointments for routine medication management could be scheduled within 30 days.[11,14] However, neither study examined the range of available community mental health services or examined clinic characteristics or regional differences that could influence appointment availability and wait times.

Through a partnership with the Office of Mental Health (OMH) of New York State (NYS), we designed a study to examine access to mental health care for adolescents with depression in all OMH-licensed outpatient clinics serving youth and to test the usefulness of a simulated patient methodology for state systems. We used adolescent depression as a tracer condition because depression is common among adolescents, with up to 12% meeting full diagnostic criteria for depression.[15-17] Although the sequelae of depression may be life threatening and although effective treatments exist, data suggest that 60% to 80% of symptomatic adolescents do not receive appropriate care.[18] Barriers to care are numerous, including scarcity of mental health providers, limited access to appropriate care, and attitudinal and practical barriers even when care is available.[19-21] This study measured appointment availability and wait times for psychiatry and therapy appointments, as well as availability of cognitive-behavioral therapy (CBT), an evidence-based psychotherapy that is often used for adolescents with depression. We also examined variation in appointment availability and wait time for appointments by clinic characteristics (e.g., affiliation, payer mix, client mix, geographic region, urbanicity), caller insurance type (Medicaid or private), and season contacted (spring or summer).

METHOD

Study Sample

The focus of this study was the 340 NYS outpatient mental health clinics licensed by OMH to serve children and adolescents that were in operation since October 2012 and at the time of data collection (spring/summer 2014). As hospitals and state-operated facilities represented a small percentage of the population (17% and 5%, respectively), these clinics, as well as all community clinics on Long Island (8.5%), were included in the study. Approximately 70% of the remaining 265 community-based clinics were selected via stratified random sampling by region (New York City [NYC], Hudson, Central, and Western) and urbanicity (i.e., metropolitan vs. nonmetropolitan county). Clinics were randomly assigned to season (first call attempt in the spring [April/May] or summer [July/August]) and insurance condition (Medicaid/private insurance) (Figure 1). Because time of year likely influences demands for youth psychiatric services, we elected to call clinics during a more academically demanding and hence stressful spring season and during the

FIGURE 1 Study recruitment.