



Research paper

Ethnic and racial differences in mental health service utilization for suicidal ideation and behavior in a nationally representative sample of adolescents



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ABSTRACT

Background: This study examined racial/ethnic differences in mental health treatment utilization for suicidal ideation and behavior in a nationally representative sample of adolescents.

Method: Data were drawn from the National Survey on Drug Use and Health. Participants included 4176 depressed adolescents with suicidal ideation and behavior in the previous year. Weighted logistic regressions were estimated to examine whether adolescent racial/ethnic minorities had lower rates of past-year treatment for suicidal ideation and behavior in inpatient or outpatient settings, while adjusting for age, depressive symptom severity, family income, and health insurance status.

Results: Among adolescents with any suicidal ideation and behavior, and suicide attempts specifically, non-Hispanic blacks and Native Americans were less likely than whites to receive outpatient treatment, and multiracial adolescents were less likely to be admitted to inpatient facilities. Apart from Hispanics, racial/ethnic minorities were generally less likely to receive mental health care for suicidal ideation, particularly within psychiatric outpatient settings. A pattern emerged with racial/ethnic differences in treatment receipt being greatest for adolescents with the least severe suicidal ideation and behavior.

Limitations: The cross-sectional data limits our ability to form causal inferences.

Conclusion: Strikingly low rates of treatment utilization for suicidal ideation and behavior were observed across all racial/ethnic groups. Certain racial/ethnic minorities may be less likely to seek treatment for suicidal ideation and behavior when symptoms are less severe, with this gap in treatment use narrowing as symptom severity increases. Native Americans were among the racial/ethnic groups with lowest treatment utilization, but also among the highest for rates of suicide attempts, highlighting the pressing need for strategies to increase mental health service use in this particularly vulnerable population.

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1. Introduction

Suicide is the third leading cause of death for children and adolescents aged 10–24, and as of 2015, it accounts for approximately 4600 deaths each year in the United States (Centers for Disease Control and Prevention, 2015). The risk of first onset for suicidal ideation and behavior increases dramatically at the beginning of adolescence and remains high into young adulthood, with a peak in suicidal behavior at age 16 (Nock et al., 2008; Skegg, 2005). This spike in suicidal ideation and behavior in adolescence makes it a critical developmental period for intervention and treatment efforts. More generally, the grave and irreversible nature

of death by suicide makes adolescent suicidal behavior an important clinical and public health issue.

Previous findings in adult research have shown that as many as 56% of suicidal ideators and 39% of suicide attempters do not seek specialty mental health treatment in the past 12 months (Kessler et al., 2005). Additionally, consistent with the adult literature, 67.3% of adolescent suicidal ideators and 56.9% of adolescent suicide attempters have not received specialty mental health treatment in the past 12 months (Husky et al., 2012). These findings showcase a significant lack of treatment utilization for suicidal thoughts and behavior.

In adults, an important predictor of failure to receive care for suicidal ideation and behavior is race/ethnicity. Particularly, racial and ethnic minorities are least likely to seek out specialty mental health treatment, with one recent study finding that 59.7% of black, non-Hispanic suicidal ideators, 61.6% of Hispanic suicidal ideators, and 84.1% of Asian or Pacific Islander suicidal ideators do

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not receive treatment (Ahmedani et al., 2012). Yet, for adolescents, much less is known about treatment use differences among racial/ethnic groups. Past research has, however, documented racial/ethnic differences in rates of suicidal behavior among these groups. In particular, suicide attempt and death rates are highest among Native American youth (Miller et al., 2012). Additionally, Hispanic youths show higher rates of suicidal ideation and attempted suicide than non-Hispanic youths, and suicide rates for African-American youths have increased in recent years (Cash and Bridge, 2009; Bridge et al., 2006).

The current study examined racial/ethnic differences in mental health treatment utilization for suicidal ideation and behavior in a nationally representative sample of adolescents. Several recent studies utilizing the same data set have similarly examined racial/ethnic differences in treatment utilization for other psychiatric conditions, but none to date have investigated such trends with respect to suicidal ideation and behavior in this age group (Alegria et al., 2011, 2012; Cummings et al., 2011, 2014; Cummings & Druss, 2011). We also assessed whether racial/ethnic patterns of disparity in mental health service utilization differed at different severities of suicidal ideation and behavior (i.e., suicidal ideation versus suicide attempts). This study further adds to the existing literature by providing an analysis of treatment receipt specifically for suicidal ideation and behavior across a variety of mental health settings, including both inpatient and outpatient. By focusing specifically on treatment use for suicidal ideation and behavior in the context of racial/ethnic groups, this study adds to the limited literature on cultural considerations for treatment specifically for suicidal ideation and behavior in youths (Goldston et al., 2008). Additionally, the current study's focus on treatment use specific to suicidal ideation and behavior holds critical clinical importance. Given the very high-risk nature of adolescent suicidal ideation and behavior, as well as its high comorbidity with other manifestations of psychopathology (Nock et al., 2013), it is particularly clinically important to determine if suicidal ideation and behavior, rather than comorbid presentations, end up being the primary focus of treatment. The size of the sample in the current study provides a unique opportunity and sufficient power to detect differences in service use across a wide range of racial/ethnic groups (i.e., non-Hispanic whites, Hispanics, non-Hispanic blacks, Asians and Pacific Islanders, Native Americans, and multiracial adolescents).

2. Methods

2.1. Data Source and study sample

Data were drawn from National Survey on Drug Use and Health (NSDUH) for the years 2004–2013. The NSDUH is a nationally representative survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) annually to assess the prevalence of substance use and disorders. The sample uses a multi-stage area probability sampling design with participants aged 12 and older within all 50 states and the District of Columbia. In order to increase precision estimates of youth participants, African-Americans and Hispanics, these groups were intentionally oversampled. Participants include individuals living in households, shelters, half-way houses, group homes, rooming or boarding houses, college dormitories, and military bases. The sample in the current study was restricted to adolescents aged 12–17 who met DSM-IV criteria (American Psychiatric Association, 2000) for major depressive disorder and suicidal ideation and behavior in the past 12 months (unweighted $n=4176$).

2.2. Procedure

Interviewers administered all study items using computer assisted personal interviewing (CAPI) and audio computer-assisted self-interviewing (ACSSI), which provides participants with privacy to answer potentially sensitive questions (e.g. those related to suicidal ideation and behavior) and those regarding illegal behaviors (e.g. illicit substance use). This method of data collection has been associated with increased openness in responses regarding sensitive topics (Turner et al., 1998).

2.3. Study variables

Major depressive episodes (MDEs) in the past 12 months were assessed using items drawn from the depression section of the National Comorbidity Survey-Replication Adolescent Supplement (NCS-A) (Kessler et al., 2009). Suicidal ideation, plans, and attempts were assessed within the context of the past-year MDE. The instrument assessed suicidal ideation ("Did you think about killing yourself?"), suicide plans ("Did you make a plan to kill yourself"), and suicide attempts ("Did you make a suicide attempt or try to kill yourself"). The adolescents were instructed to answer these questions in reference to the time of their past-year depressive episode. These items were adapted from the World Health Organization Composite International Diagnostic Interview-Short Form (CIDI-SF) (Kessler et al., 1998). This instrument has been found to demonstrate adequate validity (Kessler et al., 2009). Specifically, the CIDI and the Schedule for Affective Disorders and Schizophrenia of School-Age Children (K-SADS; Kaufman et al., 1997) have been found to yield comparable lifetime prevalence rates for major depression in the NCS-A (17.7% in the CIDI and 17.5% in the K-SADS), and the concordance rate between the two instruments is high ($\kappa=0.74$).

Mental health treatment utilization for suicidal ideation and behavior in the past 12 months was assessed across a variety of treatment settings. In particular, psychiatric inpatient treatment was defined by two items inquiring about staying overnight or longer in a hospital and/or residential treatment center for suicidal ideation and/or behavior. Psychiatric outpatient treatment was ascertained with four items regarding receipt of service from a partial day hospital or day treatment program, mental health clinic or center and/or a therapist, psychologist, social worker, or counselor for suicidal ideation and/or behavior.

2.4. Data analysis

A series of multivariate logistic regression analyses were conducted to assess racial/ethnic differences in mental health treatment utilization for suicidal ideation and behavior. Specifically, these analyses were conducted in among suicidal ideators and suicide attempters, separately, with inpatient and outpatient treatment, respectively, as the criterion variables. To avoid potentially confounding milder forms with more severe forms of suicidal ideation and behavior (e.g., the possibility that an observed effect for suicidal ideation is better accounted for by the presence of suicide attempters in the analysis), adolescents who attempted suicide have been excluded from the analyses involving suicidal ideators, leaving a subsample of "pure" ideators (i.e., ideators who did not attempt suicide). Health insurance status (private insurance, Medicaid, other insurance, uninsured), family income (<\$20,000, \$20,000 to \$50,000, \$50,000 to \$75,000, >\$75,000), age, sex, and depressive symptom severity were included as covariates in all analyses. All analyses were conducted using weighting procedures to accommodate the complex sampling frame of the survey (Substance Abuse and Mental Health Services Administration, 2014).

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