



Who is accessing family mental health programs? Demographic differences before and after system reform



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A B S T R A C T

Childhood mental health disorders are on the rise in the United States. To ensure equitable access to care, it is important to examine the characteristics of children and families who access services. This study compares the demographic characteristics of two samples of families who participated in National Institute of Mental Health-funded studies of a Multiple Family Group model, entitled the 4Rs and 2Ss Multiple Family Group (4Rs and 2Ss) in New York City. One sample is currently receiving services, and the other received services a decade ago. Significant differences in demographic characteristics were found between the two samples pertaining to child race, child nativity, caregiver age, primary caregiver, caregiver marital status, caregiver race, caregiver education, caregiver employment, and family income. Families currently engaging in the public mental health service system are primarily White, and are less disadvantaged than families a decade ago. These differences are examined in light of changing policy and epidemiological trends, and potential unintended consequences are discussed.

1. Introduction

Approximately one in five children or adolescents are believed to meet criteria for a mental health disorder before adulthood (Grant, 2015). Among children, the prevalence of mental health disorders is estimated to range from 2% (depression) to 7% (Attention Deficit Hyperactivity Disorder; Andersen, Davidson, & Baumeister, 2013). Rates of mental health disorders among adolescents is considerably higher: While accounting for comorbidity rates around 40%, 31.9% of over 10,123 adolescents who participated in the National Comorbidity Survey-Adolescent (NCS-A) Supplement epidemiological study met criteria for an anxiety disorder, 19.1% evidenced a behavior disorder, and 14.3% met criteria for a mood disorder (Merikangas et al., 2010).

Of equal concern, the rate of children and adolescents experiencing a psychiatric disorder appears to be increasing. The seminal Great Smoky Mountains Study, which followed 1420 children from 9 to 13 years of age, found an increase in mood disorders, substance abuse, social anxiety and panic disorder over time, although other disorders, such as ADHD and separation anxiety disorder, decreased (Costello, Mustillo, Keeler, Angold, & Erkanli, 2003). Adolescents who participated in the NCS-A also showed an uptick in the prevalence of anxiety and mood disorders, behavior disorders, and substance abuse/dependence (Merikangas et al., 2010). Other national studies such as the National Survey of Children's Health (Perou et al., 2013), also show an

increase over time in child mental health disorders between 1994 and 2011.

Collectively, these findings suggest that an alarming proportion of the United States population will experience serious mental health problems before reaching adulthood (Saloner, Carson, & Cook, 2014), to the detriment of the child and family. Indeed, youth psychiatric disorders are associated with considerable burden (Saloner et al., 2014), and many have lasting, adverse effects that extend well into adulthood (Saloner et al., 2014). As a case in point, Disruptive Behavior Disorders, a category of chronic and impairing disorders characterized by impulsivity, aggression, violence, and criminal acts (Acri, Gopalan, Chacko, and McKay, in press) are correlated with impairments in academic and social functioning, interferes with the parent/child relationship, and are linked to future difficulties including school dropout, substance use/abuse, delinquency, incarceration, criminal behaviors, and premature death (Loeber, Burke, Winters, Zera, & Lahey, 2000; Loeber, Green, Lahey, Frick, & McBurnett, 2000).

Further, although the number of youth who are recipients of mental health treatment is far lower than estimated need (Anderson, Chen, Perrin, & Cleave, 2015; Costello, Egger, & Angold, 2005), more children and adolescents are using mental health services. In one study, an analysis of insurance claims from the US population found a 26% increase in children's health expenditures at outpatient facilities between 2007 and 2010 (Health Care Cost Institute, 2012). Moreover, Olsson,

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Druss, and Marcus' (2015) analysis of the Medical Expenditure Panel Surveys of over 50,000 children between 6 and 17 years of age found that a greater number of children received treatment between 2010 and 2012 (13.3%) in comparison to 1996 and 1998 (9.2%).

An ongoing endeavor in services research is to understand the characteristics of families who access care. Andersen's (1995) theoretical framework of service use for children suggests access can be predicted, in part, by predisposing factors such as the demographics of the child and family. Over the years, research on family level factors associated with engagement in mental health services has pointed to family poverty, parent and family stress, single parent status, effectiveness of parental discipline, whether parents actually receive the type of child mental health services they prefer, and family cohesion and organization, among other factors (Gopalan, Fuss, & Wisdom, 2015). However, there is often conflicting evidence as to the demographic characteristics of families initiating services. Several studies suggest that African American youth are the least likely to access services (Lê Cook, McGuire, Lock, & Zaslavsky, 2010; Saloner et al., 2014; Snowden, Wallace, Cordell, & Graaf, 2016), while others find the opposite (Chow, Jaffee, & Snowden, 2003; Costello et al., 2005; Swartz et al., 1998). Similarly, low-income status is associated with service underuse in some studies (Saloner et al., 2014), but interestingly, Burns et al. (1995) found that in addition to being male, poverty status was predictive of service use among children in the Great Smoky Mountains Study.

Given the body of evidence emphasizing the important role of families in addressing child and adolescent mental health problems (Gopalan et al., 2015), it is important to flesh out conditions and demographic predictors of families who access the system, so that services can be tailored accordingly.

Political and legislative changes, and shifts in funding streams, regulations, and billing practices may account for fluctuations in the characteristics of families accessing child mental health services. Although the overall research is relatively thin, Snowden et al.'s (2016) study of the impact of funding within the California public mental health service system, for example, found that the new funds without cost-sharing regulations, in addition to the amount of pre-funding expenditures towards specific demographics, reduced the racial disparity gap in access (e.g., clinics that spent more on Caucasian youth prior to the influx of new funds then directed money towards engaging African American youth in services).

Over the past several years, New York State has made a series of policy decisions.

based upon the principles and goals articulated in the Affordable Care Act, and created a local version of priorities, which are summarized in the New York State Medicaid Redesign Team's Behavioral Health Workgroup report. Key components of this report include a shift of Medicaid beneficiaries with serious mental illness from fee-for-service to managed Medicaid, and the provision of integrated care management for all Medicaid beneficiaries with complex needs (New York State Medicaid Redesign Team's Behavioral Health Workgroup Report, 2013). Additionally, the fiscal structure was overhauled, moving from a volume-based system of care to a value-based payer model, which requires managed care organizations to move away from care models that incentivize the number of services delivered (volume) towards those that incentivize quality of services delivered (value) (Acri et al., in press). The goal of these reforms were to lower unnecessary Medicaid expenditures, enhance the quality of services, and increase access to care (New York State Medicaid Redesign Team's Behavioral Health Workgroup Report, 2013).

However, it is not clear how changes in services and billing structures may have impacted service utilization, particularly in a shrinking public mental health service system; indeed, available data from three boroughs in New York City found that the public mental health system can only accommodate 1% of children between 0 and 4 years of age with a behavioral problem, and 12% of children between 5 and 17 with a mental health disorder (Citizens' Committee for Children of New

York, 2012). Accordingly, the purpose of this study is to examine variations in the demographic characteristics of families utilizing services in the public mental health system at two points in time, with one prior to and the other following a set of major reforms undertaken across New York State. Specifically, this study will explore demographic data from two cohorts of families who sought treatment in the public mental health system, a decade apart, to better understand the potential influence of large-scale reforms in the mental health care system upon service access.

2. Methods

This study aimed to explore differences in demographic characteristics of families served by the public mental health service system among caregivers who participated in one of two National Institute of Mental Health-funded studies of a Multiple Family Group model, entitled the 4Rs and 2Ss for Strengthening Families (4R2S). The 4R2S is a manualized, time-limited (16 weeks, 90–120 min per session) mental health intervention that targets school-age, urban youth meeting diagnostic criteria for ODD and their families. The intervention integrates essential practices of behavioral parent training and family therapy, including 6 core components known as the 4Rs and 2Ss: Roles, Responsibilities, Relationships, Respectful communication, Social support, and Stress. This family group intervention model in practice aims to decrease problem behaviors, strengthen families, and increase engagement in treatment (Gopalan et al., 2014; Gopalan et al., 2015). Study 1 of the 4R2S was conducted between 2006 and 2010 within mental health clinics of New York City, and Study 2 is currently underway within mental health clinics of New York City. Institutional Review Board approval was obtained for both studies. Participants included English or Spanish-speaking adult caregivers (18 years or older) of a child between 7 and 11 years of age who met eligibility criteria for Oppositional Defiant Disorder (ODD) based upon the Disruptive Behavior Disorders Rating Scale Oppositional Defiant subscale (Pelham, Gnagy, Greenslade, & Milich, 1992). Study 1 consisted of 320 caregivers of children who met criteria for ODD and Study 2 consists of 212 caregivers of children who met criteria for ODD to date. Thus, the total sample analyzed for this paper included 532 caregivers combined from Study 1 and Study 2.

2.1. Measurement

Demographic variables were collected using general socio-demographic questionnaire that assessed familial factors examined in this study: child age, child gender, child race, child ethnicity, child nativity, child primary language, primary caregiver, caregiver age, caregiver marital status, caregiver race, caregiver ethnicity, caregiver education, caregiver employment, and family income. All variables were measured with a self-report survey in which caregivers completed all questions related to self and their child of focus. Response categories for child variables include: male or female (gender), White/Caucasian, Black/African American, Native American, or Asian/Pacific Islander (race), Hispanic/Latino or Non-Hispanic/Latino (ethnicity), US born or Non-US born (nativity), and only English, mostly English/some native, half English/half native, mostly native/some English, or only native (primary language).

As for caregiver variables, response categories for primary caregiver, marital status, race, and ethnicity include: mother, father, grandparents, mother and father, or other (primary caregiver), single, married/common law/domestic partner, divorced, separated, or widowed (marital status), White/Caucasian, Black/African American, Native American, or Asian/Pacific Islander (race), and Hispanic/Latino or Non-Hispanic/Latino (ethnicity). Additionally, response categories for education, employment, and family income include: 8th grade or less, completed high school/GED, some college, or completed college/some grad/completed grad school (education), full time, part time,

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