

**Characteristics of the Medicaid Population of Iowa Who Receive Mental Health Services:
A Managed Mental Health Care Pre-Implementation Survey (Child Summary July, 1995)**

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Survey Results: Child

Description of Survey Sample. The targeted goal was the receipt of 500 responses from the parent or guardian of children who had received mental health services in FY 1993. As in adults, a 25% response rate among the “high severity group” and a 40% response rate among the “low severity group” was anticipated. A total of 1700 surveys were to be sent in order to reach the intended goal of 500 completed surveys. However, in reviewing the list of study subject supplied by the state, 19 children were less than 4 years of age and parents of these subjects were not sent a survey instrument. Therefore, the total number of surveys sent was 1681. The distribution of the intended sample is described below.

	Rural	Urban
High Severity		
(hospitalized)		
sampled	600	600
expected	150	150
Low Severity		
(not hospitalized)		
sampled	250	250
expected	100	100

Demographic characteristics of 378 respondents to the child survey instrument are summarized below.

Analysis of Survey Data. Data from the child survey was evaluated in order to identify factors that contributed to service satisfaction, service ease, and quality of life of Medicaid mental health service recipients and their parent or caretaker.

Demographic Characteristics of Adult Survey Respondents (parent or caretaker)

Diagnostic Classification

percent schizophrenia	36.8
percent schizoaffective disorder	3.7
percent bipolar affective disorder	6.5
percent major depressive disorder	25.0
percent anxiety disorder	3.8
percent panic disorder	7.6
percent adjustment disorder	16.6

Mean Age (years) 37.0

Percent Female 72.0

Percent Rural 44.8

Marital Status

percent never married	39.3
percent separated	6.1
percent spouse deceased	2.7
percent married	16.9
percent divorced	31.3
percent common law/living together	3.7

Educational Status

percent never attended school	0.6
percent eighth grade or less	7.1
percent some high school	16.8
percent high school or equivalent	36.6
percent some college/junior college	26.7
percent college graduate	5.6
percent some graduate school	2.5
percent graduate or professional school	4.1

Diagnoses

The distribution of respondents by age and age at first use of mental health services for children with diagnoses of major depressive disorder, conduct disorder, oppositional defiant disorder and adjustment disorder was assessed. Children with depression were older than children in the other diagnostic categories and encountered mental health services at an older age. Children with ADHD received services earlier in their development.

Assessment of service need differed among respondents according to diagnostic group. Parents of children with major depression and conduct disorder perceived a need for the services of a psychiatrist more often than the parents of children with other diagnoses. Children with conduct disorder and major depression were most likely to have a history of hospitalization. Children with adjustment disorder were less likely to have been hospitalized as were children with ODD. The children who were hospitalized were significantly older in age.

Children with conduct disorder and major depression appeared most likely to be placed out of the birth-parent home. Children with adjustment disorder lived in 'other situations' (foster care, possibly secondary to abuse). The age distribution implied that children in institutions are older than children at home or in foster care. Peak ages of children in foster home settings included ages 6, 9, and 17.

The distribution of diagnostic category was not affected by rural versus urban location, but did vary by gender. Depressed and adjustment disorder groups consisted of a relatively greater proportion of females.

The perception of service need, availability and use also varied by gender of the child. According to survey respondents, males more often needed psychiatrists, group homes and residential care. The study discovered boys more often utilized psychiatric care and group homes, while girls used foster care more frequently than boys. More information about the illness and treatment was given when the respondent's child was a boy. There did not appear to be a difference in service satisfaction and service ease according to gender.

Physical Health Status

While most (over 80%) of children were rated as being in good or better than good health by their parent or guardian, 18.3% of the children were perceived by their parents as being in 'poor' or 'fair' health. The perception of physical health status of children by the study respondents is summarized below.

Health Status Perceptions

Health Ratings by Parents	% of Sample
poor	3.4
fair	14.9
good	34.5
very good	29.7
excellent	17.5

Children were perceived as having poorer physical health if the child had been psychiatrically hospitalized. Respondents judged health better if a psychiatrist or non-psychiatric physician was not needed. Furthermore, the study detected better health appraisals if no crisis services were needed or utilized. Respondents who assessed children as having poorer physical health expressed the least satisfaction with service satisfaction and service ease.

Service Need, Availability and Use

Mental health service use by children and by their parents was assessed. Key services for children appear to be appointments with professionals such as psychiatrists, psychologists and social workers. In-home services and DHS caseworkers are also seen as important. Respondents perceived a shortage of non-psychiatrist mental health personal. Coping with raising a child was cited as a service that parents deemed undersupplied.

The survey found service needs highest among institutionalized children and lowest among children in their own homes. Most services were perceived to be more available if the child of the respondent was in an institutional setting. Likewise, the data indicate that services were used more often if the child was living in an institutional setting.

While parents of children who were referred to a residential setting indicated a need for more services by their children, the same parents did not indicate availability and use as often. This suggests that parents of children in residential settings may not have accessed services that could have alleviated the conditions that necessitated placement in a residential setting.

Service use, also, appeared to vary according to characteristics of the parent or caretaker. For example, non-birth parents knew more about the availability of services, which may reflect the greater training and education of foster parents compared with the child's birth parents. Furthermore, non-birth parents indicated utilization of all types of treatment more often than the birth parent group. This may reflect better utilization of services by foster parents, as well as less knowledge of services by the birth parents.

Service need, availability and use also appeared to be influenced by the marital status of the parents. Compared with married parents, all others responded with fewer perceptions of service needs, availability and usage in mental health services.

Service Satisfaction and Ease

Most respondents (75%) answered positively to queries of service satisfaction and service ease. Analysis of responses to questions regarding service satisfaction, service ease, or quality of life study revealed no statistically significant differences between persons who lived in an urban versus rural county.

Assessment of service satisfaction and service ease varied by birth versus non-birth parents with non-birth parents rating *service ease* and *service satisfaction* significantly higher than the birth parents. Similarly, *service satisfaction* and *service ease* questions appeared to vary according to marital status with separated parents being the least satisfied and widowed parents the most satisfied with services. Married and common-law families also tended to be satisfied. *Service ease* reflected the same trend: separated parents were less contented with the convenience of mental health services.

Assessment of Life Quality

The quality of life and outcome measures used in the study consisted of the Achenbach competency scores, and the Child and Adolescent Scale of Temperament and Life Enhancement (CASTLE). The Achenbach competency measures a child's activities in three domains including: 1) activities; 2) social; and 3) school. The CASTLE attempts to quantify 'quality of life' by measuring 4 domains which are: 1) home; 2) school; 3) social; and 4) mood. This scale offered 40 items, 10 in each category. Each item had 5 responses: 1) never; 2) rarely; 3) sometimes; 4) often; and 5) always. After tallying the responses, an overall CASTLE score was scaled from 0 (least often) to 1 (most often).

Quality of life and outcome measures varied by child gender. Females in the sample scored higher than males in the Achenbach social scale and in the total scale score. Furthermore, girls scored higher on the CASTLE home, social, school and total scales.

Quality of Life Measures by Gender

Measure	Female Sample	Male Sample
Achenbach Activities	5.50	5.23
Achenbach Social	4.70***	3.59***
Achenbach School	3.39	3.22
Achenbach Total	13.56*	12.23*
CASTLE Home	0.54	0.53
CASTLE School	0.59**	0.53**
CASTLE Social	0.68***	0.60***
CASTLE Mood	0.60	0.57
CASTLE Total	0.60*	0.56*

* = $p < 0.05$, chi-square

** = $p < 0.01$, chi-square

*** = $p < 0.001$, chi-square

Quality of life and outcome measures also varied by diagnoses. The Achenbach competence scales were the poorest for ADHD and the best for adjustment disorder. The CASTLE quality of life scales also revealed differences according to diagnostic category. Major depression and ODD rated worst on the home subscale whereas children with conduct disorder scored the worst on the social subscale. Respondents with adjustment disorder scored best on the mood and total scales by measures of parental report.

Residence outside of the home appeared to be associated with poorer parental perception of life quality and in total competency measures. In contrast, non-birth parents (essentially foster parents) rated the children and adolescents as healthier and happier in almost all areas.

Recommendations Based on the Analysis

1. Improved access to mental health services may be particularly important for separated parents. While most parental groups expressed satisfaction with the mental health services offered in Iowa, separated parents showed clear concerns about the availability of mental health services. Separated parents expressed significantly lower ratings of mental health services on service satisfaction and service ease. In view of the paucity of data in about the separated parents situation - income, marital problems, financial problems, and skills in family life - definite conclusions concerning the reasons for their unhappiness cannot be made. However, separated parents may need particular help in navigating the mental health services system in order to address accommodation and availability.

2. Comprehensive child and adolescent health care systems should be developed. Very high associations of perceived general physical health with mental health outcome and quality of life attests to a firm alliance between physical and mental health. Therefore, mental health services should not exist in isolation, but should be integrated into a cohesive total health care system.

3. Follow-up or follow-back studies should be conducted. Ways in which outcomes could systematically monitored include: 1) following children entering into the system over several years; 2) determining variables leading to a favorable versus adverse outcome; and 3) monitoring of *quality of life* measures.

4. Comprehensive oversight of the provision and outcome of mental health services might best be accomplished by appointing a special child and adolescent multidisciplinary board. The makeup of the board should consist of members from three areas: 1) mental health government administration (e.g., DHS administration, the juvenile system and public educators); 2) medical and other professional providers (e.g., psychiatrists, psychologists, social workers and nurses); and 3) consumers (e.g., members of advocacy groups such as Children with Attention Deficit Disorder, Tourettes Syndrome Association and the Alliance for the Mentally Ill).

The board should review regularly the provision of mental health services to children and adolescents. Economic and clinical data performance indicators of the delivery system may include service utilization and satisfaction, hospital and residential readmission rates, hospital length of stays.

The impact of mental health service effectiveness on other service systems should also be considered including foster care, residential facilities and long term care, juvenile crime, truancy rate and graduation rates, child abuse and neglect reports, and reports from educational specialists.

5. To evaluate the effectiveness of treatment interventions, a comprehensive statewide database should be developed. The data base should include basic child and parental demographics, diagnosis, treatments, standard assessment of symptoms, and outcome measurements of functional and clinical status. Systematic collection of data will allow for more accurate inferences about the performance of the mental health care delivery system under managed mental health care.