Does Race Matter?

A Summary of AHCI Reports

April 2005, Revised August 2006

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AHCI Publishes Two Reports on Mental Health Treatment for Children

In the United States, African-Americans are less likely than Caucasians to access mental health care. African-Americans are also less likely to receive high-quality mental health treatment. These *disparities* are not because African-Americans are less likely to need mental health treatment. In fact, African-Americans may have greater needs for mental health treatment because of poverty and other issues.

Allegheny HealthChoices, Inc. (AHCI) has done several studies to learn if there are racial differences in mental health care for children in the HealthChoices program. This newsletter describes the results of these studies.

AHCI's goal for these reports is to provide data on access and service use for children by race. We hope this data is used to identify possible problems in the system and start discussing solutions.

AHCI's analysis was done in three parts:

1. A study of all children 0-20 years who were enrolled in HealthChoices during 2002. This report was published in November 2004.

2. A supplemental report on those children with a history of involvement with the child welfare and/or juvenile justice systems. This report was published in April 2005.

3. A comparison of 2002 to 2003 data. These results are shared in the article on pages 5-6.

Age, gender, diagnosis, and insurance coverage are all important factors to consider when measuring mental health treatment. Whether or not children are involved with child welfare and/or juvenile justice is also important. All of these factors were included in our reports.

More African-American Children are Involved with Social Services

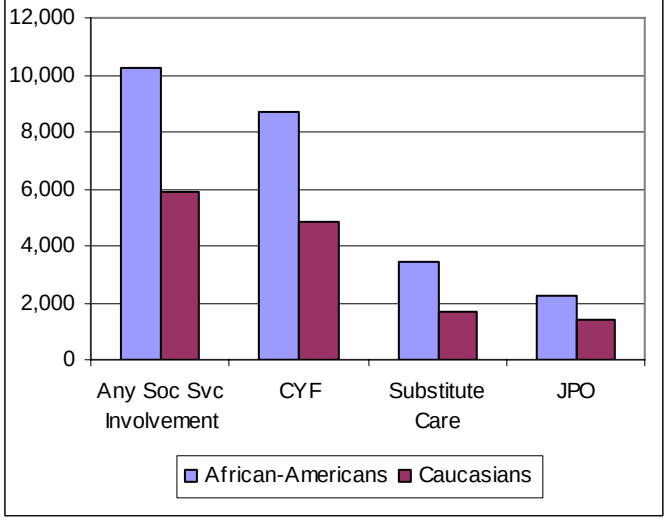
In the United States, African-American children are more likely to be involved with child welfare (CYF) or juvenile justice (JPO) services. They are also more likely to be placed outside of their home in foster care, group homes or other treatment facilities (substitute care).

This is true for Allegheny County (see Chart 1). About half of all children (0-20 years) in the HealthChoices program in 2002 were African-American. African-Americans were more likely to have had involvement with each social service.

Children involved with these services are more likely to need mental health treatment. For example, children can become involved with CYF when neglect or abuse is an issue. These children, especially children who are placed outside of their home, are more likely to need mental health treatment than the general population.

Because of these higher treatment needs, AHCI completed another report for children involved with these social services. See the article on pages 4-5 for our findings.

Chart 1. Number of Children in the HealthChoices Program (2002) with Histories of Social Service Involvement, by Race



Fewer African-American Children Accessed Mental Health Services

The odds that children will have a mental health diagnosis that needs treatment depends on their age and gender. For example, boys are more likely than girls to have autism, and children at very young ages can be diagnosed with autism. On the other hand, females are more likely to have major depression, a disorder that becomes more common in the late teen years. Also, children do not usually develop substance abuse disorders until their mid to late teen years.

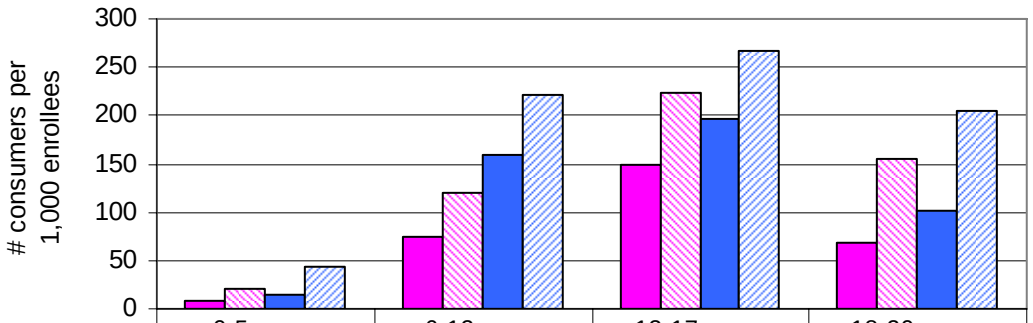
The odds that children will have a mental illness that needs treatment also depends on factors related to their environment, like poverty, or involvement with social services.

However, there is no strong evidence that the odds of having a mental illness that needs treatment is different by race, when these other factors (age, gender, poverty, involvement with social services) are the same. When these other factors are the same, differences, or *disparities*, in access to treatment should be investigated. These differences probably mean that fewer African-Americans than Caucasians access mental health treatment when they could benefit from it.

Access rates, also called penetration rates, are the standard way to measure access to health care. The number of consumers (those who used a mental health service) is divided by the number of children enrolled in the HealthChoices program. This result is shown as the number of consumers per 1,000 enrollees. Each group (male, female, etc.) has a different number of enrollees. Using a rate per 1,000 enrollees lets us compare different groups.

Chart 2 below shows access rates for different age and gender groups, by race.

Chart 2. Access Rates by Age, Gender and Race, 2002



	0-5 years	6-12 years	13-17 years	18-20 years
African-American Females	7.66	74.55	148.49	69.28
Caucasian Females	21.05	120.37	224.05	154.64
African-American Males	14.69	159.74	195.67	102.35
Caucasian Males	43.84	220.46	267.89	204.11

Children 0-5 Years

The youngest children (0-5 years) were least likely to access mental health treatment. This is not a surprise, since few children this young are expected to need mental health treatment. However, both African-American females and males accessed treatment at a lower rate than their Caucasian peers.

Children 6-12 Years

In this age group, males of either race were more likely than females to access mental health treatment. Again, both African-American females and males accessed treatment at a lower rate than their Caucasian peers.

Adolescents 13-17 Years

In this age group, Caucasians of either gender were more likely to access mental health treatment.

Adolescents 18-20 Years

Fewer of older adolescents accessed treatment. Also, the differences by race for both males and females were larger when compared to 6-17 year olds.

Recommendations

Outreach and assessment practices for the youngest group (0-5 years) and the oldest group (18-20) should be evaluated. For these two groups, the gaps between African-Americans and Caucasians were the largest.

Treatment Patterns Vary by Race for both Service Types and Amounts

Access to Service Types

AHCI looked at access rates for specific services by race to see if there were differences. These results can be discussed with providers and families to learn what might cause these differences.

Chart 3 includes the most common mental health services children use. This chart shows how many children *accessed* each service. It does not show *how much* of each service children used. Quantity of services is discussed below.

Chart 3 shows that outpatient mental health services are the most commonly used service for children, followed by medication checks and behavioral health rehabilitation services (BHRS). Residential treatment, crisis services, family-based services, and inpatient services are accessed at lower rates

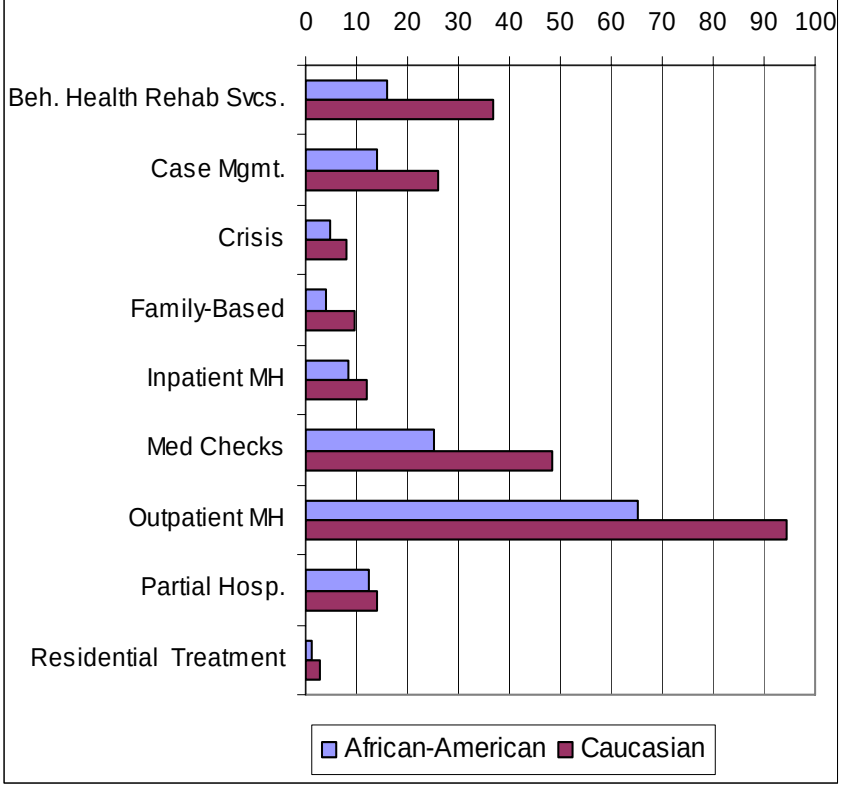
Chart 3 shows that African-Americans accessed each service less than Caucasians.

The largest gaps in access rates between African-Americans and Caucasians were in family-based services, BHRS, and residential treatment. These services are generally provided in the child's home. Both require a special evaluation before services are provided. Both the evaluation process and families' thoughts about services in the home should be looked at to investigate the differences by race.

Medication checks and case management services, which are usually used along with other services, also had large gaps between the two races. For these two services, access rates for African-Americans were about half the access rates for Caucasians.

Access rates by race were most alike for partial hospitalization. Most partial services are school-based programs. School districts usually recommend children for school-based partial programs. The role of schools in referring children for this service needs to be better understood.

Chart 3. Children's Access Rates (consumers per 1,000 enrollees) by Race for Most Commonly Used Services, 2002



Amounts of Services Used

AHCI also compared the amounts of these services children used. Amounts of services used varied a great deal from child to child. Other research has found that African-Americans often leave treatment early. Even though we cannot tell if children stopped treatment earlier than recommended from our data, we can show differences by race in the amounts of services used. Differences should be investigated.

- Caucasians tended to use more BHRS than African-Americans. This is *partly* related to the larger number of Caucasians diagnosed with autism. Children with autism tend to need high levels of BHRS treatment.
- African-Americans tended to use more partial hospitalization services than Caucasians. This could be related to family choice, treatment needs, or because school districts resist taking these students back.
- About one third of both races only had one hour (or less) of outpatient mental health services. This may mean that children have one visit and do not return.

Important Racial Differences Found in Diagnosis

Diagnosis helps guide the types of treatment and services children receive. For children to be treated effectively, they need to be diagnosed appropriately. When the two races were compared by diagnosis, the patterns were similar in many respects.

- Stress and adjustment disorders and ADHD were the most common diagnoses for children under 20 years.
- A smaller percent were diagnosed with conduct disorders, oppositional defiant disorders, and major depression and neurotic disorders.

The data used for diagnosis comes from the claims forms providers submit to get paid after they have provided a service. Because the data comes from claims and not clinical records, it is not completely reliable. However, there are several differences by race that are important to explore:

Chart 4. Diagnostic Patterns for 2002 Consumers, 0-20 Years

	% of AA	% of C
ADHD	25%	19%
Autism Spectrum Disorders	3%	11%
Conduct Disorders	8%	4%
Drug and Alcohol Disorders	4%	5%
Oppositional Defiant Disorders	12%	7%
Major Depression (and affective disorders)	8%	11%
Neurotic and Other Disorders	11%	14%
Stress & Adjustment Reactions	25%	24%
Other Diagnoses	5%	4%

Green rows show disorders where African-Americans may be over-represented. Orange rows show where African-Americans may be under-represented.

EARLY IDENTIFICATION AND TREATMENT OF AUTISM CAN RESULT IN BETTER LONG TERM OUTCOMES FOR CHILDREN. ARE AFRICAN-AMERICAN CHILDREN IDENTIFIED AS EARLY AS CAUCASIAN CHILDREN?

By comparison to Caucasians, a smaller percent of African-Americans were diagnosed with autism spectrum disorders. On the other hand, more African-Americans were diagnosed with ADHD. There is some concern that some African-American children with autism may be misdiagnosed with ADHD.

Also, Caucasian children diagnosed with autism were younger than African-American children. This may mean that African-American children diagnosed with autism have not been identified as early as Caucasian children. Because early identification and treatment of autism can result in better long-term outcomes for children, the age of children in treatment for autism is very important.

AHCI's findings also suggest that African-Americans are more likely to be diagnosed with conduct or oppositional defiant disorders. They are less likely to be diagnosed with major depression or neurotic disorders. Conversations with clinicians are very important for diagnosis. When children and their families are different from providers in their cultural backgrounds, there may be misunderstandings that affect the clinician's ideas for diagnosis. This is a difficult issue to measure and address, but the data suggests some misdiagnosis of African-American children might be occurring.

Mental Health Treatment for Children Involved in Social Services

Children involved with social services are more likely to need mental health treatment. African-Americans are more likely to have been involved with social services (see page 1). Because of these two facts, AHCI completed a specific analysis to see if there are differences by race in mental health treatment for children with past involvement with social services. Social services included child welfare, juvenile justice, and children placed out of their homes (substitute care).

Children who had been involved in any of these social services in the past were more likely to access mental health treatment than the general population. See Chart 5 on page 5. This is to be expected for two reasons. First, children involved with social services are more likely to need mental health treatment. Second, these children, if involved with social services during the reporting year of 2002, are connected to child welfare/juvenile justice professionals who can recommend behavioral health evaluations and make referrals.

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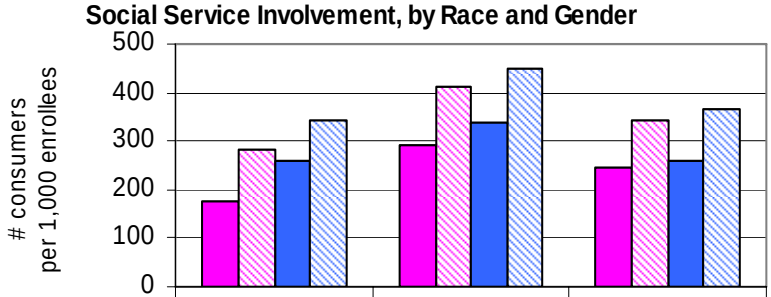
Because of this second reason, we expected that African-American children involved with social services would access mental health services at the same or similar rates as Caucasians. However, we found that African-Americans were still less likely to access treatment than Caucasians. For each of the three social service categories, African-American females were less likely to access mental health treatment than Caucasian females. Males showed the same racial difference. See Chart 5.

Chart 5. 2002 Access Rates for Children with Histories of Social Service Involvement, by Race and Gender



	CYF	Substitute Care	JPO
AA Female	176.2	293.7	245.5
C Female	280.7	413.4	341.7
AA Male	257.2	335.8	259.5
C Male	340.9	448.8	365.4

Racial differences were also found in access rates for specific services, amounts of services used, and diagnoses. Overall, the same *patterns* explained in the articles on pages 2-4 applied to children with histories of involvement with social services.

African-Americans consistently accessed individual services at lower rates than Caucasians. Gaps between races varied by the type of service. Large gaps between African-Americans and Caucasians occurred in family-based services, BHRS, drug and alcohol services, case management, and medication checks. Again, African-American and Caucasian access rates were most similar for partial hospitalization services.

Overall, diagnoses were very similar by race for children with histories of involvement with social services. However, some diagnostic differences require investigation. The data suggests that African-Americans were more likely to be diagnosed with ADHD, conduct disorder, or oppositional defiant disorder, and less likely to be diagnosed with a mood disorder or substance abuse disorder.

Because the diagnostic process relies heavily on conversations, differences between the clinicians' and consumers' cultural backgrounds can result in misunderstanding and unintentional bias.

These findings suggest that there are opportunities to reduce racial differences in access to mental health treatment, and to better coordinate care between systems. Sharing findings with the behavioral health, education, child welfare and juvenile justice systems is the first step in improving mental health treatment for these high-need groups of children.

SHARING FINDINGS WITH OTHER CHILD-SERVING SYSTEMS IS AN IMPORTANT FIRST STEP FOR ADDRESSING RACIAL DISPARITIES IN ACCESS TO TREATMENT.

Was 2003 Different from 2002?

In the last several years, some mental health treatment providers in Allegheny County have focused outreach efforts on African-Americans. Also, the County and Community Care Behavioral Health have funded outreach and treatment efforts specifically for African-Americans.

The findings explained in this newsletter so far have used data from 2002. To see if the gaps between the races changed, AHCI did a follow-up analysis with 2003 data. The mental health treatment access rate for African-American children increased by 5% from 2002 to 2003. The access rate for Caucasians increased 2%. For African-Americans, the largest percent increase was in the youngest age group (0-5 years).

For children with histories of involvement with social services, the gaps between the two races in access rates to mental health treatment were about the same as in 2002. One decrease was concerning: a smaller proportion of African-Americans with past or current juvenile justice involvement accessed mental health treatment in 2003 when compared to 2002.

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Allegheny HealthChoices, Inc. (AHCI) is a contract agency for the Allegheny County Department of Human Services' HealthChoices Program.

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INTERESTED IN MORE INFORMATION?

CONTACT US BY PHONE, E-MAIL, OR DOWNLOAD OUR FULL REPORTS FROM WWW.AHCI.ORG.

AHCI is a private, not-for-profit organization formed when the HealthChoices program began. Our mission is to assure equitable access to quality, cost-effective behavioral health care that promotes positive clinical outcomes, recovery, and resiliency.

AHCI's services include the following:

Information Systems: Providing data warehouse, data integration, and report development services

Compliance Monitoring and Oversight: Ensuring contractually required activities are performed

Analysis: Providing data-driven statistical analysis and trending of utilization and service data

Training and Technical Assistance: Providing the necessary tools to institutional and community-based providers

Ombudsman Services: Serving as a problem solver to HealthChoices stakeholders

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About the same percent of children in both years had just one treatment visit (one billed unit), and the difference by race was not large (10% of African-Americans compared to 8% of Caucasians).

For both races, access rates for nearly all services were higher in 2003 than 2002. While access rates were higher, the gaps between the races for specific services seen in 2002 generally continued in 2003. African-Americans made small gains in access rates for BHRS, case management, family-based and outpatient mental health services. However, these gains were not large enough to close the gaps between the races. Change from 2002 to 2003, while small, was in the right direction. Partial hospitalization services were the exception; access rates for partial hospitalization services were the same for both races in 2003.

We also compared the amounts of these individual services children used. As in 2002, amounts of services used varied a great deal from child to child in 2003.

Even though more children accessed BHRS services in 2003, children who used these services in 2003 used less BHRS than children in 2002. African-Americans still tended to use much less BHRS than Caucasians.

Children of both races also used less partial hospitalization services in 2003 than 2002. African-Americans continued to use more of this service than Caucasians.

About one quarter of both races had one hour (or less) of outpatient mental health services in 2003. This may mean that fewer children in 2003 than 2002 had just one visit and did not return.

OVERALL, 2003 AND 2002 SHOWED SIMILAR PATTERNS BY RACE IN ACCESS TO TREATMENT, AMOUNTS OF SERVICES USED, AND DIAGNOSIS. GENERALLY, CHANGES IN 2003 WERE SMALL BUT IN A POSITIVE DIRECTION.

The diagnostic patterns explained on page 4 were similar in 2003. Stress and adjustment reactions and ADHD were the most common diagnoses. Children were diagnosed with conduct disorder, oppositional defiant disorder, and major depression in similar patterns to 2002. Overall, the same differences by race were seen in 2003 and 2002. AHCI observed two important differences from 2002 to 2003:

- Fewer children of either race were diagnosed with a neurotic disorder.
- In 2003, Caucasian children diagnosed with autism were still younger than African-American children, but the age differences were not as great. This may mean that more African-American children with autism receiving behavioral health treatment in 2003 were diagnosed at an earlier age.

Overall, 2003 and 2002 showed similar patterns by race in access to treatment, amounts of services used, and diagnosis. Generally, changes between 2002 and 2003 were small but in a positive direction.