THE UNIVERSITY of TENNESSEE CHATTANOOGA

Study ID:

Internal Use

SOCIAL WORK DEPARTMENT FIELD-BASED RESEARCH PROPOSAL FORM

Please carefully read the instructions you received as part of this packet. **To complete this form electronically, click on the § icon (it will appear §) and simply type in the information.** Include all items (a)-(e) with your submission (see the instructions for details on these items):

(a) This completed form with original signatures (no copies) in an envelope; also submit an electronic copy of this form via the Blackboard drop box.
(b) Attach the "Informed Consent" form(s) you will use for the study.
(c) Attach the certificate verifying completion of required IRB training
(d) Attach annotated bibliography of references
(e) One sample of each data collection instrument you plan to use for the study. E-mail scanned electronic copies if possible.

Submit all materials to:

Valerie L. Radu, Ph.D. **Social Work Department Head** **Dept. #3133**	Telephone: 423-425-4266 Facsimile: 423-425-5564 E-mail: Valerie-Radu@utc.edu

Date of First Draft : § 9/27/07

Part I. Overview

A. Principal Investigator Information

Name: § Misty Collins Date Submitted: § 9/27/07

Email: § Misty-Collins@utc.edu Phone: § 423-503-4919

B. Field Agency Information

Agency: § Moccasin Bend Mental Health Institution

Address: § 100 Moccasin Bend Road

§ Chattanooga, TN 37405

Field Instructor Name/E-Mail Address: § Michelle Kaufman , michelle.kaufman@state.tn.us

Telephone: § 423-785-3391 Fax: § 423-785-3456

Can you receive confidential information on the fax number and E-mail address provided above? § No

Part II. Information About the Study

Study Overview

Study Title:	§ Relationship of access to health care and the hospitalization rate of an individual with a mental illness.
Area of Study:	§ Mental Health
Specific Topic:	§ The number of hospitalizations at a mental health center of an individual diagnosed with a severe psychiatric diagnosis is directly related to their individual access to health care.

If "cut-and-pasting" text to complete the items below, make sure the text appears as Arial 10pt, line spacing 1.5.

1. **Abstract—including (but not limited to) the nature and rationale of the study, its primary supporting references in the literature, its need and expected applied or theoretical value (attach annotated bibliography of references):**

   § The objective of the studies included in the attached abstracts was to determine how health care insurance correlates to a patient's rate of hospitalization. The effect of insurance coverage on an individual with a mental illness will determine their access to medical care (Mcalpine, 2000). The studies in the abstracts have shown that lack of health care insurance directly affects a patient's access to resources such as mental health centers (Druss, 1998). If an individual with a mental illness is able to receive the appropriate services required for them to function in society they must have access to sufficient resources in order to do so. This study will look at the relationship between health care insurance and how it affects the access to mental health care for individuals with severe psychiatric diagnosis. Research will also prove if there is a relationship between an individual with a severe psychiatric diagnosis at an inpatient mental health facility that has private insurance versus state issued insurance.

2. **Major hypotheses/questions to be investigated:**

   § What is the relationship between access to health care insurance and the hospitalization rate of an individual with a severe psychiatric diagnosis at an inpatient mental facility?

   What is the relationship between an individual with a severe psychiatric diagnosis at an inpatient mental health facility that has private insurance in relation to state issued insurance?

3. **Population(s) or data desired (describe in detail):**

   § The population sampling frame used to conduct the research will be chosen from 1500 patients at Moccasin Bend Mental Health Institution. Using systematic random sampling the individuals selected will be based out of 250 patients a month and the data will be collected from a six month time period. This will be done by collecting a five percent sample of the sampling frame. The selected sample will consist of every 20th patient until 75 have been selected.

4. Titles of instruments (forms, questionnaires, tests, etc.) to be used for data collection; include reference page citing empirical support for instruments:

§ A code book has been developed and the variables will be collected. See code book at end of proposal.

5. Procedures planned for administering instruments, and/or collecting data (be as specific as possible):

§ I will go to the records department at Moccasin Bend Mental Health Institution, sign a confidentiality form, and fill out my approved data collection form.

6. Design and statistical techniques planned for data analysis (each data analysis step must be stated):

My design study is a nonexperimental secondary data collection.

§ 1. Data will be collected and entered into SPSS.

2. Descriptive statistics will be run to check for data distribution and skewness.

3. For the first research question, descriptions will be summed to create a total score. T-tests will be run to look for differences between the groups. A correlation analysis will be run to examine the relationship between health care insurance and the hospitalization rate of an individual with a severe psychiatric diagnosis.

4. For the second research question, T-tests will be run to look for the differences between the groups. A correlation analysis will be run to examine the relationship between individuals with a severe psychiatric diagnosis receiving heath care insurance through private insurance and those that have state issued insurance.

7. Expected beginning date and completion date of study:

§ The study will begin on November 1, 2007 and will end on April 1, 2008.

8. Form in which findings will be reported:

§ The findings will be reported in a graph and on the research paper. The findings will also be put into an electronic poster.

University of TN at Chattanooga
SOCIAL WORK DEPARTMENT

REQUEST FOR USE OF SECONDARY DATA FOR FIELD RESEARCH PROJECT

Requestor's Name: Misty Collins **Date of Request:** 10/17/07

Source of dataset requested: Secondary data from Moccasin Bend Mental Health Institution's patients is requested.

Description of how data will be used (be as specific as possible): Data will be used to determine if insurance coverage has a direct effect on the number of hospitalizations an individual with a severe psychiatric diagnosis is entitled to.

Detailed list of variables to be used (all variables must be listed):
The participant's gender, race, age, income, living environment, prescribed medications, type of insurance coverage, mental illness diagnosis, and length of stay at mental health center will be used.

Describe how the data will be analyzed including how identifying information will be addressed during analysis: Data will be analyzed by examining the variables needed to conduct the research to determine if they have an effect on the individual's treatment at mental health facilities. Identifying information will be addressed aggregately to portray the population being researched.

How will results be reported? The findings will be reported in a research paper. Data will also be used for an electronic poster for a class presentation. The agency may also use the findings for an annual report.

How will data be stored and confidentiality ensured? Data will be stored on a travel drive that belongs to the student. Confidentiality will be ensured by not concealing and identifying information of the client and by the data file being deleted after the project is complete.

List names/title of individuals who will have access to data and for what purpose: Misty Collins – BSW student – for purpose of research and to complete a research project. Valerie Radu, PhD, Research Instructor for the purpose of assisting the student with data analysis.

Additional comments:

Question Number	*Variable Description*	*Variable Name*	*Value Label*
Q1	Participant's marital status	MARITAL STATUS	1. Married 2. Divorced 3. Single 4. Widowed 5. Separated 0. Missing Data
Q2	Participant's gender	GENDER	1. Male 2. Female 3. Other 0. Missing Data
Q3	Participant's Race	RACE	1. Caucasian 2. African American 3. Hispanic 4. Other 0. Missing Data
Q4	Age at last birthday	AGE	Continuous Data
Q5	Participant's Income	INCOME	1. $20,000 and Below 2. $20,000 - $30,000 3. $30,000 - $40,000 4. $40,000 - $50,000 5. $50,000 and Above 0. Missing Data
Q6	Participant's Living Environment	LIVING ENVIRONMENT	1. Mental Health Facility 2. Group Home 3. Jail 4. Nursing Home 5. Homeless 6. Other 0. Missing Data
Q7	Prescribed Medication(s)	MEDICATION	1. Yes 2. No 0. Missing Data
Q8	Insurance Coverage	INSURANCE	1. Private 2. TN Care 3. Medicaid 4. Medicare 5. None 6. Other 0. Missing Data
Q9	Axis I	AXIS I	1. Self Coded 0. Missing Data

Q10	Axis II	AXIS II	1. Self Coded 0. Missing Data
Q11	Participant's Mental Illness	DIAGNOSIS	1. Bi-polar 2. Schizophrenic 3. Depression 4. Other 0. Missing Data
Q12	Number of hospitalizations	HOSPITALIZATIONS	Continuous Data
Q13	Length of stay at MHC	LENGTH OF STAY	Continuous Data

ANNOTATED BIBLIOGRAPHY

N.A. (2000). Are people with mental illness getting the help they need? *RAND Health*. Retrieved on September 18, 2007. (http://www.rand.org/health).

Mental health made headlines throughout the 1990s. The U. S. Congress declared those years the Decade of the Brain, prompting research that has led to a better understanding of how the brain works as well as improved drug treatments and therapies for mental illness. The decade closed with the 1999 White House Conference on Mental Health and the Surgeon General's first-ever Report on Mental Health in America. Clearly, mental health issues are becoming important to policymakers, but a major stumbling block in policy debates has been the lack of reliable data about the rapidly changing health care system and how it affects those with mental health problems. *Health Care for Communities* (HCC) is a new fact-gathering tool designed to fill this information gap and provide the data needed for informed debates, specifically about mental health issues. It is part of the innovative Health Tracking Initiative funded by the Robert Wood Johnson Foundation. The main component of HCC is a national household survey that will be repeated at two-year intervals to track changes over time (Sturm et al., 1999). Results from the first years of HCC are now becoming available. Several RAND studies have used the HCC data to investigate how parity legislation is affecting insurance coverage and access to care for people with mental illness.

Andersen, R. & Newman, J. (2005) Societal and individual determinants of medical care utilization in the United States. *The Milbank Quarterly, 83.*

A theoretical framework for viewing health services utilization is presented, emphasizing the importance of the (1) characteristics of the health services delivery system, (2) changes in medical technology and social norms relating to the definition and treatment of illness, and (3) individual determinants of utilization. These three factors are specified within the context of their impact on the health care system. Empirical findings are discussed which demonstrate how the framework might be employed to explain some key patterns and trends in utilization. In addition, a method is suggested for evaluating the utility of various individual determinants of health services utilization used in the framework for achieving a situation of equitable distribution of health services in the United States.

Cooper-Patrick, L., Gallo, J.J., Powe, N.R., Steinwachs, D.M., Eaton, W.W. & Ford, D.E. (1999). Mental health service utilization by african americans and whites: the baltimore epidemiologic catchment are follow-up. *Medical care,* 37*,* 1034-1045.

OBJECTIVE. To compare mental health service utilization and its associated factors between African Americans and whites in the 1980s and 1990s. DESIGN. Household-based longitudinal study with baseline interviews in 1981 and follow-up interviews from 1993 to 1996. SETTING. The Baltimore Epidemiologic Catchment Area (ECA) Follow-Up. SUBJECTS. Subjects included 1,662 adults (590 African Americans and 1,072 whites). MAIN OUTCOME. Use of mental health Variable. Services, defined as talking to any health professional about emotional or nervous problems or alcohol or drug-related problems within the 6 months preceding each interview. RESULTS. In 1981, crude rates of mental health service use in general medical (GM) settings and specialty mental health settings were similar for African Americans and whites (11.7%). However, after adjustment for predisposing, need, and enabling factors, individuals receiving mental health services were less likely to be African American. Mental health service use increased by 6.5% over follow-up, and African Americans were no longer less likely to report receiving any mental health services in the 1990s. African Americans were more likely than whites to report discussing mental health problems in GM settings without having seen a mental health specialist. They were less likely than whites to report use of specialty mental health services, but this finding was

not statistically significant, possibly because of low rates of specialty mental health use by both race groups. Psychiatric distress was the strongest predictor of mental health service use. Attitudes positively associated with use of mental health services were more prevalent among African Americans than whites. Conclusion. Mental health service use increased in the past decade, with the greatest increase among African Americans in GM settings. Although it is possible that the racial disparity in use of specialty mental health services remains, the GM setting may offer a safety net for some mental health concerns of African Americans.

Dixon, L., Postrado, L., Delahanty, J., Fischer, P., & Lehman, A., (1999) The association of medical comorbidity in schizophrenia with poor physical and mental health. *Journal of Nervous & Mental Disease,* 187, 496-502.

This study determined the prevalence of medical comorbidities in a cohort of persons receiving treatment for schizophrenia and the association of medical comorbidity with physical and mental health status. A total of 719 persons with schizophrenia sampled from a variety of community and treatment settings as part of the schizophrenia Patient Outcomes Research Team (PORT) participated in a survey interview. Multiple regression analyses were used to assess sociodemographic factors associated with the number of current medical comorbidities and the association of medical comorbidity count with patient ratings of physical health, mental health, symptoms, and quality of life. The majority of patients reported at least one medical problem. Problems with eyesight, teeth, and high blood pressure were most common. A greater number of current medical problems independently contributed to worse perceived physical health status, more severe psychosis and depression, and greater likelihood of a history of a suicide attempt. This study underscores the need to attend to somatic health care for persons with schizophrenia as well as the linkage of physical and mental health status.

Druss, B.G., & Rosenheck, R.A. (1998). Mental disorders and access to medical care in the United States. *American Journal of Psychiatry,* 155*,* 1775-1777.

Objective**:** The authors examined the barriers to receipt of medical services among people reporting mental disorders in a representative sample of U.S. adults. Method**:** The sample was drawn from adults who responded to the 1994 National Health Interview Survey (N=77,183). The authors studied the association between report of a mental disorder and 1) access to health insurance and a primary provider, and 2) actual receipt of medical care. Multivariate techniques were used to model problems with access as a function of mental disorders, controlling for demographic, insurance, and health variables. Results**:** While people who reported mental disorders showed no difference from those without mental disorders in likelihood of being uninsured or of having a primary care provider, they were twice as likely to report having been denied insurance because of a preexisting condition or having stayed in their job for fear of losing their health benefits. Among respondents with insurance, those who reported mental illness were no less likely to have a primary care provider but were about two times more likely to report having delayed seeking needed medical care because of cost or having been unable to obtain needed medical care. **Conclusions:** People who reported mental disorders experienced significant barriers to receipt of medical care. Efforts to measure and improve access to health care for this population may need to go beyond simply providing insurance benefits or access to general medical providers.

Edwards, D.J. (2006). A soft landing after benefit cuts: a Tennessee provider aims to ease the transition for beneficiaries with severe and persistent mental illness. *Behavioral Healthcare,* 26*,* 401.

In 1994, Tennessee tried a bold experiment. With special waivers from the federal government, the state expanded its Medicaid program, and any Tennessean who lacked healthcare coverage could buy into the program--renamed TennCare. At one point TennCare provided coverage for 23% of the state's population--more than any other state. But as the economy soured, the state's budget tightened, and Tennessee--which has no income tax and is obligated to balance its budget--had to make painful decisions about the popular program. "It was clear that the growth rate of TennCare could not be sustained by the tax structure in Tennessee," says David C. Guth, Jr., CEO of Centerstone, Tennessee's largest behavioral healthcare provider and one of the largest in the nation. "The governor, as well as the legislature, was under tremendous pressure to bring the growth of TennCare under control." As in other states, the cost of pharmaceuticals was a rapidly growing line-item for TennCare. Guth

points out that TennCare's costs for pharmaceuticals for behavioral health conditions grew from $100 million to $600 million between 1994 and 2005; in contrast, the costs of behavioral health services provided through TennCare grew from $320 million in 1994 to $400 million in 2005. Although many of the newer--and more expensive--antipsychotics debuted during this time, Guth doesn't believe the rise in pharmaceutical costs can be tied to one factor. The state's reaction to overall growing costs in TennCare was the usual approach: place limits on eligibility and reduce benefits. But policymakers knew they just couldn't cut off people with severe and persistent mental illnesses from vital services, so they created the Mental Health Care Safety Net, an ongoing program (subject to funding review) providing a limited formulary and services to people who no longer qualify for full TennCare benefits, Guth explains. These benefits are available only to beneficiaries who were receiving TennCare benefits before the recent eligibility changes. For many beneficiaries, however, this could have been a jarring change from the type of care they were used to receiving. "Centerstone was very concerned about the possible impact on folks moving from the TennCare program to the safety net," says Guth. So Centerstone identified $800,000 in one-time funds it could use to create a "soft landing," to ease the transition between traditional TennCare services and those provided under the safety net. In its soft landing program, Centerstone assists clients with transitioning from the TennCare formulary to the more limited one offered through the safety net. Centerstone funded case management services that would not be available through the safety net so patients could complete their treatment goals (Fortunately, the state later restored case management services to the safety net program). Most behavioral health providers don't have hundreds of thousands of dollars available to help patients when payers change benefit structures. But Centerstone had been preparing for changes in TennCare from the beginning. Says Guth: "We knew that when TennCare was first introduced, that was not the first and last major change we would see." Subsequently, Centerstone's board and management have been continuously setting aside resources. As pressures on the state budget have eased, so have pressures on TennCare to limit eligibility and benefits. Guth notes that the state is expanding eligibility for safety net services, and advocates are hoping the cost savings generated through the cuts eventually will lead to expanded benefits. And despite TennCare's ups and downs, Guth is not pessimistic about the program: "It was a good plan. TennCare has had its problems, but it was the right thing to do, and still is the right thing to do."

Hodgkin, D., Merrick, E.L., Horgan, C.M., Garnick, D.W. & McLaughlin, T.J. (2007). Does type of gatekeeping model affect access to outpatient specialty mental health services? *Health Services Research,* 42, 104-120.

Objective. To measure how a change in gatekeeping model affects utilization of specialty mental health services. Data Sources/Study Setting. Secondary data from health insurance claims for services during 1996-1999. The setting is a managed care organization that changed gatekeeping model in one of its divisions, from in-person evaluation to the use of a call-center. Study Design. We evaluate the impact of the change in gatekeeping model by comparing utilization during the 2 years before and 2 years after the change, both in the affected division and in another division where gatekeeping model did not change. The design is thus a controlled quasi experimental one. Subjects were not randomized. Key dependent variables are whether each individual had any specialty mental health visits in a year; the number of visits; and the proportion of users exceeding eight visits in a year. Key explanatory variables include demographic variables and indicators for patient diagnoses and their intervention stares (time-period, study group). Data Collection/Extraction Methods. Claims data were aggregated to create analytic files with one record per member per year, with variables reporting demographic characteristics and mental health service use. Principal Findings. After controlling for secular trends at the other division, the division which changed gatekeeping model eventually experienced an increase in the proportion of enrollees receiving specialty mental health treatment, of 0.5 percentage point. Similarly, there was an increase of about 0.6 annual visits per user, concentrated at the low end of the distribution. These changes occurred only in the second year after the gatekeeping changes. Conclusions. The results of this study suggest that the gatekeeping changes did lead to increases in utilization of mental health care, as hypothesized. At the same time, the magnitude of the increase in access and mean number of visits that we found was relatively modest. This suggests that while the change from face-to-face specialty gatekeeping to call-center intake does increase utilization, it is unlikely to overwhelm a system with new demand or create huge cost increases.

Leslie, D.L. & Rosenheck, R. (1999). Changes in inpatient mental health utilization and costs in a privately insured population. *Medical Care,* 37, 457-468.

BACKGROUND. Concerns over rising health care costs have led to pressure on health care providers to reduce inpatient costs. METHODS. Inpatient claims data were analyzed for adult users of mental health services (n = 45,579) from a national sample of over 3.8 million privately insured individuals between 1993 and 1995 from the ~ a r k e t S c a n ~ ~ database. Costs and annual hospital days per treated patient were compared across diagnostic groups and plan types. RESULTS. Inpatient mental health costs fell 30.5% over the period, driven primarily by decreases in the number of hospital days per treated patient per year (-20.0%), with smaller changes in the proportion of enrollees who received care (-0.2%), and per diem costs (-13.l0/0). Patients whose primary diagnosis was mild-moderate depression saw the largest decrease in costs per treated patient (44.5%), and those diagnosed with schizophrenia experienced the smallest decrease (23.5%). There was no evidence of substitution of medical for psychiatric care. CONCLUSIONS. Inpatient cost reductions have been substantial and are primarily caused by reductions in the number of inpatient mental health treatment days per treated patient. Further research is needed to evaluate the impact of these changes on outcome, quality of care, and patient satisfaction.

Mcalpine, D.D. & Mechanic, D. (2000). Utilization of specialty mental health care among persons with severe mental illness: the roles of demographics, need, insurance, and risk. *The Global Journal for Improving Health Care Delivery and Policy,* 35*,* 277-292.

OBJECTIVE: To examine the sociodemographic, need, risk, and insurance characteristics of persons with severe mental illness and the importance of these characteristics for predicting specialty mental health utilization among this group. DATA SOURCE: The Healthcare for Communities survey, a national study that tracks alcohol, drug, and mental health services utilization. Data come from a telephone survey of adults from 60 communities across the United States, and from a supplemental geographically dispersed sample. STUDY DESIGN: Respondents were categorized as having a severe mental disorder, other mental disorder, or no measured mental disorder. Differences among groups in sociodemographics (gender, marital status, race, education, and income), insurance coverage, need for mental health care (symptoms and perceived need), and risk indicators (suicide ideation, criminal involvement, and aggressive behavior) are examined. Measures of service use for mental health care include emergency room, inpatient, and specialty outpatient care. The importance of sociodemographics, need, insurance status, and risk indicators for specialty mental health care utilization are examined through logistic regression. PRINCIPAL FINDINGS: The severely mentally ill in this study are disproportionately African American, unmarried, male, less educated, and have lower family incomes than those with other disorders and those with no measured mental disorders. In a 12-month period almost three-fifths of persons with severe mental illness did not receive specialty mental health care. One in five persons with severe mental illness are uninsured, and Medicare or Medicaid insures 37 percent. Persons covered by these public programs are over six times more likely to have access to specialty care than the uninsured are. Involvement in the criminal justice system also increases the probability that a person will receive care by a factor of about four, independent of level of need. The average number of outpatient visits for specialty care varies little across type of disorder, and the median number of visits (ten) is equivalent for those with a severe mental illness and those with other disorders. CONCLUSIONS: Persons with severe mental illness have a high level of economic and social disadvantage. Barriers to care, including lack of insurance, are substantial and many do not receive specialty care. Public insurance programs are the major points of leverage for improving access, and policy interventions should be targeted to these programs. Problems of adequate care for the severely mentally ill may be exacerbated by the managed care trend to reductions in intensity of treatment.

McLaughlin, C. (2004). Delays in treatment for mental disorders and health insurance coverage. *Health Services Research,* 39, 221.

Wang et al. (2004) present interesting information about the frequent and lengthy delays in receiving treatment experienced by many individuals after the onset of a mental disorder. They estimate a median delay of 10 years after onset until the first contact with a general medical doctor and 11 years until the first contact with a psychiatrist. Even though more severe mental disorders were associated with shorter delays, the average delay between onset and first treatment contact for even the most severe disorders was 5 years. As noted by these authors, there is evidence that delays in treatment can lead to increased morbidity and mortality, including the development of various psychiatric and physical comorbidities and the adoption of life-threatening and life-altering

self-treatments (e.g., licit and illicit substance abuse). Beyond appealing to some sense of obligation or desire to provide adequate and timely medical care to individuals suffering from mental disorders, it is also in the nation's financial self-interest to find out the factors influencing the length of the delay. Wang et al. tested the effect of various individual characteristics, including age, gender, education, and race, on increases or decreases in the length of time before initial contact. Data limitations did not permit them to test for the effect of two other factors likely to be determinants of the timing of contact with a medical professional: income and health insurance coverage. Although education and race are usually correlated with both of these characteristics and therefore may be jointly capturing the effects of income and insurance, the question of the net effect of these two factors remains unanswered. Because affordability of care is one of the few factors private and public policymakers can alter, this is a question worth pursuing.

McLellan, T.A., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). Drug dependence, a chronic mental illness:

implications for treatment, insurance, and outcomes evaluation. *JAMA,* 284, 1689-1695.

The effects of drug dependence on social systems has helped shape the generally held view that drug dependence is primarily a social problem, not a health problem. In turn, medical approaches to prevention and treatment are lacking. We examined evidence that drug (including alcohol) dependence is a chronic medical illness. A literature review compared the diagnoses, heritability, etiology (genetic and environmental factors), pathophysiology, and response to treatments (adherence and relapse) of drug dependence vs type 2 diabetes mellitus, hypertension, and asthma. Genetic heritability, personal choice, and environmental factors are comparably involved in the etiology and course of all of these disorders. Drug dependence produces significant and lasting changes in brain chemistry and function. Effective medications are available for treating nicotine, alcohol, and opiate dependence but not stimulant or marijuana dependence. Medication adherence and relapse rates are similar across these illnesses. Drug dependence generally has been treated as if it were an acute illness. Review results suggest that long-term care strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated, and evaluated like other chronic illnesses.

Rosenheck, R. & Stolar, M. (1998). Access to public mental health services: determinants of population

coverage. *Medical Care,* 36, 503-512.

OBJECTIVES. This study examined factors that affect access to Veterans Administration mental health services. METHODS**.** Data from national Veterans Affairs databases and the 1990 Decennial Census were used to estimate rates of Veterans Affairs mental health service use in each US county ***(n***= 3,156) among all US veterans and in three subpopulations defined by eligibility and clinical status. Independent variables examined in standard multivariate analyses and using hierarchical linear modeling techniques included county-level sociodemographic characteristics (age, race, and income); "unmanaged" service system characteristics (those not directly controlled by Veterans Affairs program managers, eg, per capita Veterans Affairs funding level and the efficiency of Veterans Affairs service delivery). RESULTS. Altogether, 2.0% of US veterans used Veterans Affairs mental health services. More than one third (36%) of the variance in utilization was explained by sociodemographic factors; 8% was explained by unmanaged service system factors and 7% was explained by managed service system factors, with variations among subgroups. Substitution effects were demonstrated between Veterans Affairs and non-veterans Affairs systems and appeared to be diagnosis-specific. CONCLUSIONS. Both per capita funding levels and efficient service delivery were significantly associated with increased access to mental health services. Implications for health system performance assessment and management are discussed.

Sturm, R. & Wells, K. (2000). Health insurance may be improving—but not for individuals with mental illness.

The Global Journal for Improving Health Care Delivery and Policy, 35, 253-262.

OBJECTIVE: To explore the question of how insurance coverage has changed among individuals with mental problems compared to the general population in the last two years. DATA SOURCES: HealthCare for Communities, a national survey to track health system changes. PRINCIPAL FINDINGS: The percentage of uninsured persons in the general population has not changed very much, and more respondents believe that

health insurance coverage has improved rather than deteriorated over the years 1996 to 1998. However, among individuals with probable mental health disorders, more have lost insurance in those two years than have gained it and more report decreases in health benefits. Individuals with worse mental health consistently report a deterioration of access to care compared to individuals with better mental health. CONCLUSIONS: Substantial activity has taken place in state and federal legislation to increase the mental health benefits offered by health insurance. Although this activity could have improved health insurance especially for individuals with mental illness, such persons continue to fare significantly worse than the general population.

Takeuchi, D.T. & Kim, K.T. (2000). Enhancing mental health services delivery for diverse populations.

Contemporary Sociology, 29*,* 74-83.

Goffman (1971) suggested that people with a serious mental illness lose contact with the rituals and interactions of daily life. When they seek treatment, the mental hospital or clinic only serves to reinforce the individual's disconnect with the established order. Detachment from one's environment is often associated with alienation, demoralization, and distress (Mirowsky and Ross 1986). We have used this premise in thinking about some modest solutions to enhance the lives of people with mental illness. Special attention has been given to how race and ethnicity affect the entry and treatment of people with such problems. The solutions we have proposed are intended to eliminate structural barriers and to help develop stronger social networks. These proposals should provide greater opportunities for individuals to participate more completely in their communities, and to rediscover the lost place that Goffman so aptly described.

Tommasini, N. (1994) Private insurance coverage for the treatment of mental illness versus general medical

care: a policy of inequity. *Journal of Psychiatric Nursing,* 1, 9-13.

Private insurance coverage has historically been and continues to be discriminatory toward patients requiring treatment for mental illness and substance abuse disorders in comparison with those in need of general medical care. Factors contributing to this disparity include stigma, relatively low overt consumer demand for psychiatric care, lack of knowledge about psychiatric illness and treatment on the part of insurers, a historical reliance on public sector psychiatry, and the assumption that more liberal psychiatric benefits result in unnecessary and excessive use. Strategies aimed at eliminating discriminatory insurance practices against those in need of mental health care must be implemented. Recommended approaches include further research on the cost effectiveness of mental health care, public education regarding the nature of mental illness and its treatment, patient/family advocacy, and the marketing of services by mental health professionals.

Wang, P.S., Berglund, P., & Kessler, R. (2000). Recent care of common mental disorders in the United States.

Society of general Internal Medicine, 5*,* 284-292.

To relate the presence of recent mental disorders to use of mental health services.
DESIGN Cross-sectional survey. STUDY POPULATION The study population was 3,032 respondents to the Midlife Development in the United States (MIDUS) survey, a nationally representative telephone-and-mail survey conducted in 1996. Twelve-month diagnoses according to the *Diagnostic and Statistical Manual of Mental Disorders*, *Revised*, *Third Edition*, of major depressive episode, panic disorder, generalized anxiety disorder, and serious mental illness were made using a structured assessment. Information was obtained on 12-month treatment for mental health problems in the general medical, mental health specialty, human services, and self-help sectors. Definitions of treatments consistent with evidence-based recommendations were developed using available practice guidelines. MEASUREMENTS AND MAIN RESULTS Crude and adjusted likelihoods of receiving any mental health care and guideline-concordant care were measured. Although 53.8% of respondents with at least one 12-month mental disorder received any mental health care in the previous year, only 14.3% received care that could be considered consistent with evidence-based treatment recommendations. Even among those with the most serious and impairing mental illness, only 25% received guideline-concordant treatment. Predictors of receiving guideline-concordant care included being white, female, severely ill, and having mental health insurance coverage. CONCLUSIONS An epidemic of untreated and poorly treated mental disorders exists

in the United States, especially among vulnerable groups such as African Americans and the underinsured. Cost-effective interventions are needed to improve both access to and quality of treatment.

Weiss, R. (2005, June). Study: U.S. leads in mental illness, lags in treatment. *Washington Post,* A3.

One-quarter of all Americans met the criteria for having a mental illness within the past year, and fully a quarter of those had a "serious" disorder that significantly disrupted their ability to function day to day, according to the largest and most detailed survey of the nation's mental health, published yesterday. Although parallel studies in 27 other countries are not yet complete, the new numbers suggest that the United States is poised to rank No. 1 globally for mental illness, researchers said.

Part III. Signatures

(For electronic submission, this page with the original signatures must be sent also by regular mail.)

Applicant

I, the applicant, do hereby agree that I will abide by the policies and regulations of the UTC Social Work Program and will furnish a copy of the abstract and report describing the findings of the study to my field placement agency.

_____ § 9/27/07

Signature of Applicant Date

Field Instructor Approval

I am familiar with the proposed study and feel that the student researcher submitting this proposal is professionally qualified to undertake the investigation. I also believe the research design to be valid and appropriate. By signing this form I agree that my agency will assist the student in obtaining the necessary sample and data required to complete this research project.

_____

Signature of Field Instructor

§ Forensic Coordinator

Position or Title

§ Moccasin Bend Mental Health Institution

Name of Agency

Field Instructor Comments:

FOR INTERNALUSE ONLY	
Approved: ☐	Denied/Resubmit: ☐
Comments: §	Reason for denial: §
_____ UTC Social Work Program Department Head Signature	
_____ UTC Social Work Program Field Education Coord. Signature	
ASSIGNED STUDY ID: §	
Attached Proposal Approval Form (date of approval/denial) : §	