utah department of human services

IGP: Division of Substance Abuse and Mental Health

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ABSTRACT

The number and percent of people identified in Utah's 2012 public behavioral health system matched to the Utah Department of Workforce Services (DWS) Intergenerational Poverty (IGP) population is relatively small to both populations. Those matched to the public system appear to hold little difference to the others in the public system, principally less when compared to the public Medicaid funded population.

Of the 56,824 people served in Utah's public behavior health system in 2012, a total of 7,418 matched to the 74,764 people identified as being in IGP by DWS. This accounts for 13.8% of Utah's 2012 public behavioral health system and 9.9% of the IGP population. Within this matched population, 5,961 people received mental health (MH) services (13.4% of 2012 clients served) which accounts for 7.9% of the IGP population. Additionally, 1,099 people matched to substance use disorder (SUD) treatment (6.5% of 2012 clients served) and accounting for 1.4% of the IGP population.

A stigma that financial insecurity is partly or entirely an indicator for need of behavioral health treatment is not substantiated in research review. Socioeconomic adversity can be a significant risk factor for behavioral health concerns but is not the sole causal factor for a person needing behavioral health treatment. Indeed, the source of serious mental illnesses are not entirely known and substance use disorders crosses all economic strata. Within the small matched data reviewed, it remains unconfirmed that the IGP population is different than the general low financial security population already identified and in public behavioral health treatment.

THE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

The Utah Division of Substance Abuse and Mental Health (DSAMH) was created as Utah's public substance abuse and mental health authority. DSAMH contracts with local county governments statutorily designated as local substance abuse and local mental health authorities.

The Division of Substance Abuse and Mental Health by Utah Statue focuses on intervention, prevention, and identification early as these steps can control or mitigate future behavioral risks. As the public behavior health system is largely funded by Medicaid, low income clients benefit from the removal of cost barriers to treatment access through their income eligibility to Medicaid.

As an artifact of legislative authority over the State's public system and Medicaid funding, low income and/or Medicaid clients are a large portion of those in public services. Low income individuals will have an oversized presence in Utah's public system. This may not reflect need due to income. DSAMH publishes need estimates within the State using nationally recognized methodologies, but these estimates do not account for income.

DSAMH collects data from the Local Authority system for federal reporting. Clients who receive services for mental health or substance use at private providers may not be included in the public system.

INTRODUCTION

Research clearly establishes socioeconomic adversity can have a causal effect on increasing behavioral and physical health burdens.[1] This causal relationship does not provide formulated correlates for levels of poverty and psychological harm. Additionally, a stigma that specific people in financial insecurity are party or entirely in need of behavioral health treatment is not substantiated in research literature.[2] Research does not support that mental health interventions alone are a panacea to raise people out of poverty.[3]

Where research does attribute financial insecurity to behavioral health harm, it falls short of identifying cohorts in intergenerational poverty (IGP) rigorously studied measured against a less narrowly defined two generation comparison population experience socioeconomic adversity.[4] When looking at the Utah public behavioral system data in 2012 against the Utah IGP population, it remains unclear if a difference exists between IGP populations and the general population served with economic instability. When accounting for income and/or Medicaid funding, it becomes less clear a policy actionable difference exists.

Within the public system, analysis on differences by socioeconomic status defined as IGP is confounded by the proxy to the low income Medicaid funded clients. Within the IGP population, a high level of Medicaid funding is present, but this is also true of the public system. This relationship cannot be understated has having a confounding effect on analyzing population differences. The public system is composed of a large low income Medicaid population and identifying meaning and significant attributes based on the small IGP population, a subset of the low income population, risks assumptions caused by general variability in the data.

Comparisons in the 2012 data between the total served population, the identified IGP population, and the low income/Medicaid population show similarities between the groups. Analysis looked at the demographics served, Medicaid Funding, classification of Serious Mental Illness (SED/SPMI), Urban/Rural Authority locations, and events and use of federally mandated services.

MATCH: MENTAL HEALTH

A total of 5,961 people identified in IGP were matched to the 2012 public mental health system.

Of those people IGP matched, 2,474 were youth (17 and younger) and 3,487 were adults. Youth makes up a larger percent of IGP people to the public youth/adult served population. However, the IGP group is defined low income, youth IGP matches were younger, the IGP demographics are younger, and Medicaid funding has a percent is highest at the youngest years, it is not unexpected compared to the total mental health youth population. This product of a larger population of younger IGP Medicaid clients is confirmed in Table 4.

MH Counts

	Distinct Clients	% of Total MH Clients
MH IGP Clients	5,961	13.8%
MH Clients - Non IGP	37,106	86.2%

MH Youth/Adult Counts

		Distinct Clients	% of IGP/ Non Clients
MH IGP Clients	Youth	2,474	41.5%
	Adult	3,487	58.5%
MH Clients - Non IGP	Youth	12,922	34.8%
	Adult	24,184	65.2%

MH Medicaid Count

		Distinct Clients	% of IGP/ Non IGP Clients
MH IGP Clients	Medicaid	4,411	74%
	Non Medicaid	659	11%
	Both	934	16%
MH Clients - Not IGP	Medicaid	19,635	54%
	Non Medicaid	11,255	31%
	Both	5,778	16%

MATCH: SUBSTANCE USE

A total of 1,999 people identified in IGP were matched to the 2012 public substance abuse treatment system. Of those people IGP matched, the group was a predominately adult population with 94.9% 18 years and above.

SUD IGP and non IGP

	Distinct Clients	% of Total SUD Clients
SUD IGP	1,999	12.51%
SUD Not IGP	13,974	87.49%

SUD % of Youth and Adult

		Distinct Clients	% of IGP/Non IGP Clients
SUD IGP	Youth	102	5.1%
	Adult	1,897	94.9%
SUD Not IGP	Youth	1,618	11.6%
	Adult	12,356	88.4%

MEDICAL FUNDING

Mental Health Medicaid Funding: The 2012 public mental health system population is heavily Medicaid funded. As an artifact of Medicaid income eligibility, the majority of low income IGP and non IGP clients are Medicaid funded. The difference in Table 2 between a the percentage points between the youth totals of the IGP and non IGP total can be explained in the greater Medicaid funding within IGP, where IGP would be assumed to be served more by Medicaid funding as shown in Table 4.

			Distinct Clients	% of IGP/ Non IGP Clients
MH IGP Clients	Medicaid	Youth	2,109	85%
		Adult	2,302	66%
MH Clients - Not IGP	Medicaid	Youth	9,152	71%
		Adult	10,483	45%

SUBSTANCE ABUSE MEDICAID FUNDING

Similar to the IGP match mental health population, a large portion of the SUD IGP group consists of Medicaid clients. This is atypical of the general SUD population which is predominately Non-Medicaid clients.

SUD Medicaid / Non Medicaid

		Distinct Clients	% of IGP/Non IGP Clients
SUD IGP	Medicaid	854	42.7%
	non Medicaid	1,145	57.3%
SUD Not IGP	Medicaid	2,577	18.4%
	non Medicaid	11,397	81.6%

SERIOUS ILLNESS MENTAL HEALTH

Serious and Persistent Mental Illness: The percent of SED/SPMI clients are nearly identical between the IGP population and the general public system. Even when comparing across gender, percentages are still nearly identical.

MH Serious Illness

		Youth	Adult
MH IGP Clients	SMI	1,884 76%	2,424 70%
	Not SMI	600 24%	1,092 31%
MH Clients - Not IGP	SMI	9,658 75%	15,887 68%
	Not SMI	3,309 26%	7,758 33%

Urban/Rural Mental Health: With Utah's population largely spread across a condensed urban corridor and spanning physical rural and frontier areas, access to treatment is always a concern for the behavioral health system in Utah. Urban and rural settings provide different threats to behavioral health. However, barriers to access and utilization and limited services is an established issue for rural communities where treatment providers can be limited, far away, or entirely unavailable.[5] Many social-ecological levels barriers exist to healthcare access,[6] but rural areas can be particularly unique.[7] The IGP population appears as distributed across urban and rural Local Authorities as the general public system population and the IGP base dataset.

MH Urban/Rural

	Rural	Urban
MH IGP Clients	1,680 28.18%	4,348 72.94%
MH Clients - Not IGP	11,597 31.83%	25,180 69.12%

Urban/Rural Substance Use:

SUD Urban/Rural

	Rural	Urban
SUD IGP	487	1,540
	24.4%	77.0%
SUD Not IGP	4,662	9,455
	33.4%	67.7%

Frequency of Utilization Mental Health:
Analysis took the IGP and non IGP 2012 population and tracked each person to their discharge or up to 2019. Review of the federally reported mandated services events and duration showed little difference in the IGP population to the general public health system.

For Medicaid clients and IGP clients, the median count of years in services were the same between Youth/Adult:

	Youth/Adult	
IGP/ non IGP	Adult	Youth
MH IGP Clients	3.0	2.0
MH Clients - Non IGP	3.0	2.0

More precisely is the event counts of services. For example, the number of events of mandated Assessments shows little meaningful difference between IGP and the total public populations, with equal similarities when account for income.

Youth/Adult	IGP/ non IGP	Assessment Events	
Youth	MH IGP Clients	0	23.32%
		1-5	75.83%
		6-15	1.78%
	MH Clients - Non IGP	0	26.95%
		1-5	71.72%
		6-15	2.11%
Adult	MH IGP Clients	0	29.88%
		1-5	66.02%
		6-15	5.42%
	MH Clients - Non IGP	0	29.73%
		1-5	64.17%
		6-15	6.91%

The number of events of mandated Case Management events shows little difference between IGP and the total Public system.

Youth/Adult	IGP/ non IGP	Case Mgmt Events	
Youth	MH IGP Clients	0	69.60%
		1-5	18.03%
		6-15	6.71%
		16+	6.75%
	MH Clients - Non IGP	0	67.51%
		1-5	19.73%
		6-15	6.49%
		16+	7.00%
Adult	MH IGP Clients	0	64.07%
		1-5	16.75%
		6-15	6.54%
		16+	13.99%
	MH Clients - Non IGP	0	64.88%
		1-5	16.65%
		6-15	5.96%
		16+	13.50%

SUBSTANCE USE OUTCOMES:

Overall, there wasn't a significant difference in outcome measurements between the SUD IGP group and the SUD Non-IGP group.

- Both groups were similar in 90 day retention in treatment with the IGP group at 59.4% retained 90n days or more and 60.1% for the Non-IGP group.
- Treatment completion percentages were also similar with 39.8% of the IGP group and 47.8% of the Non-IGP group completing treatment successfully.

There were slight differences in a few Outcome measurements between the two groups.

- The SUD IGP group showed a drug abstinence increase of 152.9% from admit to discharge compared to an increase of 111.6% in the Non-IGP Group.
- The increase in Employment from admit to discharge for the IGP group was 36.4%, which was almost double the Non-IGP rate of 19.3%

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CONCLUSION

It remains unclear if there is a meaningful difference between the matched IGP population and the population in services, particularly the low income Medicaid population receiving services. through the Utah public behavioral health data matched to the 2012 intergenerational poverty cohort that a difference exists between this low income population and the general system with regards to access, utilization, and outcomes.

Questions remain if:

- Significant and policy actionable differences exist between the IGP population and the low income Medicaid population. Future research should be cautious that the IGP family unit is itself a proxy to Medicaid eligibility through definition of income,
- DSAMH published need estimates for the Utah population without regard to income. If being defined IGP by DWS wholly accounts for that population, future research would have to balance and weight the unaccounted for low income not utilizing services.
- A range of economic insecurity exists within IGP and non IGP low income Medicaid clients. As such, it remains unclear if policy efforts targeting the IGP population beyond Medicaid access would be appropriate. For example, there is a larger total of lower income clients with in the public system than the matched IGP clients.

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