



Examining the Mental Health Trends and Service Utilization of Biracial Youth

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BACKGROUND

Between 1970 and 2000, the population of Biracial or multiracial children in the United States grew from approximately 500,000 to more than 6.8 million youth (Hobbs & Stoops, 2002). The dramatic increase in this population, combined with the role of culture, race and ethnicity in mental health (SG Report, 2001), has created a demographic imperative for mental health services that are diversified and flexible.

Findings from existing research regarding the rates of mental health problems and service utilization among Biracial youth are limited and inconsistent. For example, Milan and Keiley (2000) found that Biracial adolescents displayed more depressive symptoms compared to monoracial minority adolescents, while Shih and Sanchez (2005) reported opposite findings. These conflicting results suggest that more research is needed to discern if Biracial youth are particularly at-risk for depression.

Regarding service utilization, one study found that Biracial youth were more likely to receive some form of therapy compared to Caucasian or monoracial minority youth (Milan & Keiley, 2000). Findings, however, did not address possible within-group differences among Biracial youth and did not include the setting in which mental health services were utilized, indicating that specific information on this population is still needed. The present study aims to examine the levels of depressive symptomatology between Biracial and monoracial minority youth and provide descriptive information on the mental health service utilization of these populations.

METHODS

Procedures This study is a secondary analysis of data collected for the National Survey on Drug Use and Health (NSDUH). The NSDUH is conducted through the Substance Abuse and Mental Health Services Administration (SAMHSA) annually and is a primary source of national data on health and substance use. Data is collected from approximately 70,000 individuals ages 12 and older each year through a computer-assisted household interview.

Sample. Participants were from the 2002 to 2006 Surveys and from the 2004 to 2006 surveys. The first cohort included 15,526 monoracial African American youth and 800 Biracial youth ages 12-17. The second cohort included 9,265 monoracial African American youth and 544 Biracial youth ages 12-17. The Biracial sample includes youth who are African American and Caucasian.

Measures. The current study focused on items from the “Adolescent Depression” and “Youth Mental Health Service Utilization” sections of the NSDUH. Items measuring adolescent depression asked for participants to report depressive symptomatology (e.g., feeling sad, empty, losing interest) through their lifetime, along with length of time symptoms occurred and specific outcomes of their symptoms (e.g. weight gain, sleep deprivation). Items measuring service utilization asked for youth to report if they had received mental health services in the past year and if so, which setting they had received those services (outpatient, inpatient, school, physician). Although the service utilization scale did ask questions relating to why youth received treatment, the sample size for Biracial youth responding to these questions was not large enough to conduct this analysis.

ANALYSES

T-tests were conducted to test the difference between monoracial and Biracial youth on depressive symptoms and mental health service utilization. Analyses on depressive symptoms were conducted using the 2004 to 2006 sample while analyses on service utilization were conducted using the 2002 to 2006 sample.

RESULTS

Results indicated that there were no significant differences between groups on average scale score for lifetime Major Depressive Episode (MDE) (See Table 1). In addition, there were no significant differences between groups in the percentage reporting symptoms of MDE. (See Table 2).

Results, however, did show a difference in the source of mental health service utilization in the past year between monoracial and Biracial youth (See Table 3). Specifically, significant differences were found between groups for overall mental health service utilization ($t = -2.25, p = .05$) in specialty mental health ($t = -2.10, p = .05$) including outpatient treatment ($t = -2.25, p = 0.05$) and foster care/therapeutic foster care ($t = 2.86, p = .01$), and in school settings ($t = -2.88, p = .01$) including meeting with a school counselor, psychologist, or teacher ($t = -2.52, p = .05$).

Table 1. Summary of T-test by Race Group: Average scale scores for lifetime depressive episode (MDE) (N = 9,809)

Variable	Single-Race Average Scale Scores (SE)	Biracial Average Scale Scores (SE)	t
MDE in Lifetime	0.9 (0.03)	1.1 (0.19)	-0.77
12-14 yrs.	0.8 (0.04)	1.0 (0.26)	-0.91
15-17 yrs.	1.1 (0.05)	1.2 (0.24)	-0.52

Table 2. Summary of Percentages and T-test by Race Group: MDE and MDE Components in Lifetime (N=9,809)

Variable	Single-Race Percentages (SE)	Biracial Percentages (SE B)	t
MDE in Lifetime	12.4 (0.45)	13.8 (2.48)	-0.54
Depressed Mood	12.2 (0.43)	13.5 (2.44)	-0.54
Diminished Interest/Pleasure in Most Things	14.1 (0.48)	14.1 (2.25)	-0.00
Changes in Appetite or Weight	10.1 (0.40)	10.5 (2.26)	-0.19
Insomnia or Hypersomnia	11.9 (0.44)	14.1 (2.43)	-0.90
Psychomotor Agitation or Retardation	7.5 (0.36)	8.0 (1.98)	-0.26
Fatigue or Loss of Energy	11.0 (0.42)	14.2 (2.44)	-1.29
Feelings of Worthlessness	5.6 (0.33)	9.5 (2.21)	-1.78
Diminished Ability to Think/Concentrate	12.4 (0.45)	14.6 (2.45)	-0.89
Recurrent Suicide Ideation	10.0 (0.40)	11.3 (2.28)	-0.58

Table 3. Summary of Percentages and T-test by Race Group: Source of Mental Health Service in the Past Year (N=16,326)

Variable	Single-Race Percentages (SE)	Biracial Percentages (SE)	t
Any Mental Health Service	5.4 (0.24)	9.5 (1.82)	-2.25*
Specialty Mental Health	12.5 (0.36)	17.0 (2.13)	-2.10*
Outpatient	10.0 (0.31)	15.0 (2.16)	-2.25*
Private Therapist (Psychologist, Psychiatrist, Social Worker, Counselor)	7.3 (0.26)	10.8 (1.73)	-1.96
Mental Health Clinic or Center	2.3 (0.15)	2.7 (0.85)	-0.50
Partial Day Hospital or Day Treatment Program	2.1 (0.14)	2.8 (1.24)	-0.52
In-Home Therapist, Counselor or Family Preservation Worker	3.0 (0.18)	4.1 (1.27)	-0.86
Inpatient or Residential (Overnight or longer)	4.1 (0.22)	4.5 (1.29)	-0.30
Hospital	3.0 (0.18)	2.8 (0.86)	0.22
Residential Treatment Center	1.4 (0.12)	1.9 (0.97)	-0.50
Foster Care/Therapeutic Foster Care Home	1.0 (0.10)	0.4 (0.21)	2.86**
Education	13.8 (0.36)	20.3 (2.22)	-2.88**
School Counselor, School Psychologist or Regular Meetings with Teacher	11.3 (0.32)	16.2 (1.92)	-2.52*
Special Ed. Services, Special Classroom, Special Program or Special School	4.8 (0.22)	7.2 (1.73)	-1.39
Medical			
Pediatrician or Other Family Doctor	2.7 (0.18)	3.6 (1.22)	-0.75

* $p < .05$; ** $p < .01$

CONCLUSIONS

The purpose of the current study was to examine mental health trends, specifically rates of depression, and service utilization of Biracial youth compared to monoracial youth. Although significant differences were not found between groups on rates of depression, the percentage of youth in both groups that have experienced a major depressive episode or symptoms of depression are noteworthy (See Figure 1).

Findings did indicate a significant difference between groups on the type of mental health service utilized. While Biracial youth are utilizing services significantly more than single race youth, the types of services being utilized vary. For instance, Biracial youth tend to obtain services more often from outpatient settings and educational settings, while monoracial African American youth receive help in foster care settings. Although differences in other types of services were not significant, it was found that some services were utilized more by one group than the other (See Figure 2).

Findings from this study serve as a first step in identifying patterns of depressive symptoms and service use between mono- and Biracial youth. Comparisons between these two groups do highlight that Biracial youth who are African American and Caucasian utilize significantly different mental health services than single race African Americans. What is unknown, however, is *why* there is a difference in the utilization of these services. For example, results from this study indicating the utilization of more outpatient services by Biracial youth is interesting in light of past findings that African Americans are less likely than Caucasians to seek outpatient treatment for mental health problems (Snowden, 2001). Future research should seek to examine: (1) where Biracial youth seek services and (2) what they seek services for. This will aid in improving the field's understanding of the kinds of settings that might be most important for serving the mental health needs of this growing population. Furthermore these findings should address within-group differences in Biracial youth as this is most likely a heterogenous population.

Figure 1. Percentages of Lifetime MDE and symptoms of MDE

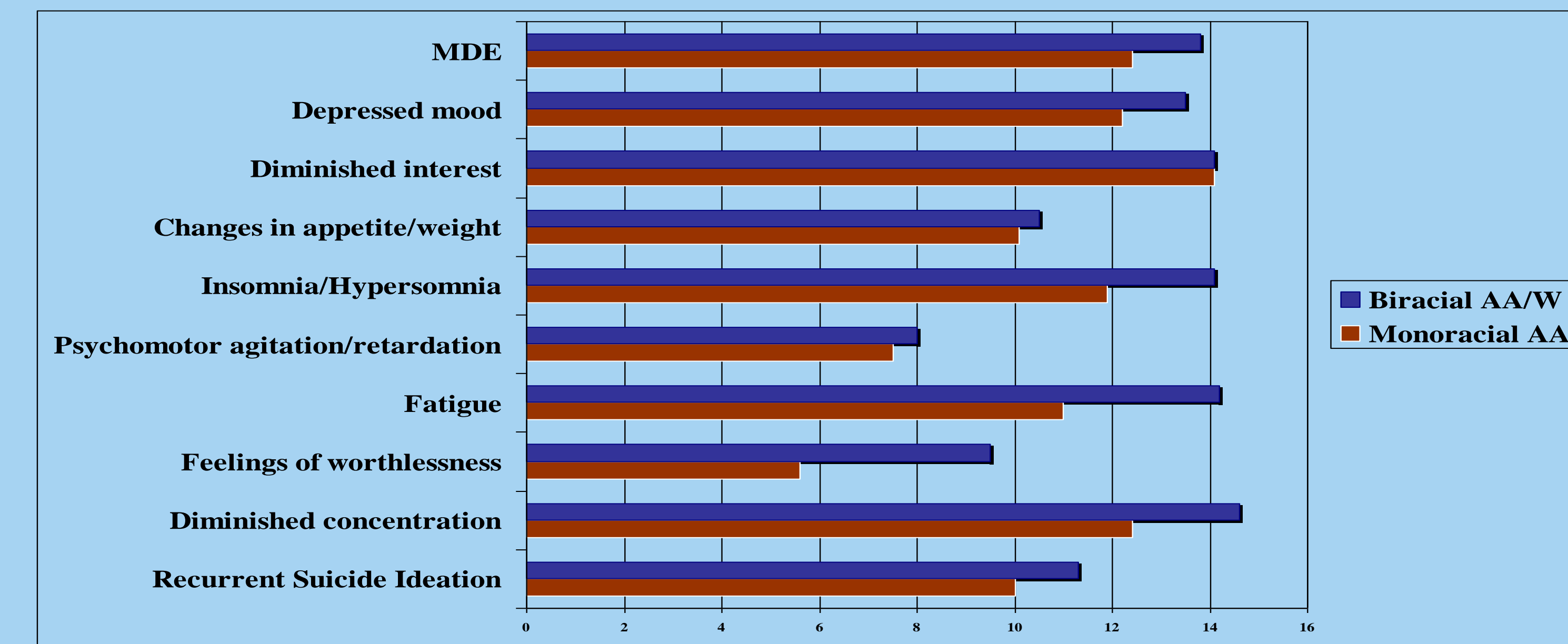


Figure 2. Past Year Mental Health Service Utilization

