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Who is accessing family mental health programs? Demographic differences before and after system reform

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Abstract

Childhood mental health disorders are on the rise in the United States. To ensure equitable access to care, it is important to examine the characteristics of children and families who access services. This study compares the demographic characteristics of two samples of families who participated in National Institute of Mental Health-funded studies of a Multiple Family Group model, entitled the 4Rs and 2Ss Multiple Family Group (4Rs and 2Ss) in New York City. One sample is currently receiving services, and the other received services a decade ago. Significant differences in demographic characteristics were found between the two samples pertaining to child race, child nativity, caregiver age, primary caregiver, caregiver marital status, caregiver race, caregiver education, caregiver employment, and family income. Families currently engaging in the public mental health service system are primarily White, and are less disadvantaged than families a decade ago. These differences are examined in light of changing policy and epidemiological trends, and potential unintended consequences are discussed.

1. Introduction

Approximately one in five children or adolescents are believed to meet criteria for a mental health disorder before adulthood (Grant, 2015). Among children, the prevalence of mental health disorders is estimated to range from 2% (depression) to 7% (Attention Deficit Hyperactivity Disorder; Andersen, Davidson, & Baumeister, 2013). Rates of mental health disorders among adolescents is considerably higher: While accounting for comorbidity rates around 40%, 31.9% of over 10,123 adolescents who participated in the National Comorbidity Survey-Adolescent (NCS-A) Supplement epidemiological study met criteria

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for an anxiety disorder, 19.1% evidenced a behavior disorder, and 14.3% met criteria for a mood disorder (Merikangas et al., 2010).

Of equal concern, the rate of children and adolescents experiencing a psychiatric disorder appears to be increasing. The seminal Great Smoky Mountains Study, which followed 1,420 children from 9 to 13 years of age, found an increase in mood disorders, substance abuse, social anxiety and panic disorder over time, although other disorders, such as ADHD and separation anxiety disorder, decreased (Costello, Mustillo, Keeler, Angold, & Erkanli, 2003). Adolescents who participated in the NCS-A also showed an uptick in the prevalence of anxiety and mood disorders, behavior disorders, and substance abuse/dependence (Merikangas et al., 2010). Other national studies such as the National Survey of Children's Health (Perou et al., 2013), also show an increase over time in child mental health disorders between 1994-2011.

Collectively, these findings suggest that an alarming proportion of the United States population will experience serious mental health problems before reaching adulthood (Saloner, Carson, & Cook, 2014), to the detriment of the child and family. Indeed, youth psychiatric disorders are associated with considerable burden (Saloner, Carson, & Cook, 2014), and many have lasting, adverse effects that extend well into adulthood (Saloner et al., 2014). As a case in point, Disruptive Behavior Disorders, a category of chronic and impairing disorders characterized by impulsivity, aggression, violence, and criminal acts (Acri, Gopalan, Chacko, & McKay, in press) are correlated with impairments in academic and social functioning, interferes with the parent/child relationship, and are linked to future difficulties including school drop-out, substance use/abuse, delinquency, incarceration, criminal behaviors, and premature death (Loeber, Burke, Winters, Zera, & Lahey, 2000; Loeber, Green, Lahey, Frick, & McBurnett, 2000).

Further, although the number of youth who are recipients of mental health treatment is far lower than estimated need (Anderson, Chen, Perrin, & Cleave, 2015; Costello, Egger, & Angold, 2005), more children and adolescents are using mental health services. In one study, an analysis of insurance claims from the US population found a 26% increase in children's health expenditures at outpatient facilities between 2007 and 2010 (Health Care Cost Institute, 2012). Moreover, Olfson, Druss and Marcus' (2015) analysis of the Medical Expenditure Panel Surveys of over 50,000 children between 6-17 years of age found that a greater number of children received treatment between 2010 and 2012 (13.3%) in comparison to 1996 and 1998 (9.2%).

An ongoing endeavor in services research is to understand the characteristics of families who access care. Andersen's (1995) theoretical framework of service use for children suggests access can be predicted, in part, by predisposing factors such as the demographics of the child and family. Over the years, research on family level factors associated with engagement in mental health services has pointed to family poverty, parent and family stress, single parent status, effectiveness of parental discipline, whether parents actually receive the type of child mental health services they prefer, and family cohesion and organization, amongst other factors (Gopalan et al., 2010). However, there is often conflicting evidence as to the demographic characteristics of families initiating services. Several studies suggest that

African American youth are the least likely to access services (Lê Cook, McGuire, Lock, & Zaslavsky, 2010; Saloner et al., 2014; Snowden, Wallace, Cordell, & Graaf, 2016), while others find the opposite (Chow, Jaffee, & Snowden, 2003; Costello et al., 2005; Swartz et al., 1998). Similarly, low-income status is associated with service underuse in some studies (Saloner et al., 2014), but interestingly, Burns and colleagues (1995) found that in addition to being male, poverty status was predictive of service use among children in the Great Smoky Mountains Study.

Given the body of evidence emphasizing the important role of families in addressing child and adolescent mental health problems (Gopalan et al., 2010), it is important to flesh out conditions and demographic predictors of families who access the system, so that services can be tailored accordingly.

Political and legislative changes, and shifts in funding streams, regulations, and billing practices may account for fluctuations in the characteristics of families accessing child mental health services. Although the overall research is relatively thin, Snowden et al.'s (2016) study of the impact of funding within the California public mental health service system, for example, found that the new funds without cost-sharing regulations, in addition to the amount of pre-funding expenditures towards specific demographics, reduced the racial disparity gap in access (e.g., clinics that spent more on Caucasian youth prior to the influx of new funds then directed money towards engaging African American youth in services).

Over the past several years, New York State has made a series of policy decisions based upon the principles and goals articulated in the Affordable Care Act, and created a local version of priorities, which are summarized in the New York State Medicaid Redesign Team's Behavioral Health Workgroup report. Key components of this report include a shift of Medicaid beneficiaries with serious mental illness from fee-for-service to managed Medicaid, and the provision of integrated care management for all Medicaid beneficiaries with complex needs (New York State Medicaid Redesign Team's Behavioral Health Workgroup Report, 2013). Additionally, the fiscal structure was overhauled, moving from a volume-based system of care to a value-based payer model, which requires managed care organizations to move away from care models that incentivize the number of services delivered (volume) towards those that incentivize quality of services delivered (value) (Acri et al., in press). The goal of these reforms were to lower unnecessary Medicaid expenditures, enhance the quality of services, and increase access to care (New York State Medicaid Redesign Team's Behavioral Health Workgroup Report, 2013).

However, it is not clear how changes in services and billing structures may have impacted service utilization, particularly in a shrinking public mental health service system; indeed, available data from three boroughs in New York City found that the public mental health system can only accommodate 1% of children between 0-4 years of age with a behavioral problem, and 12% of children between 5-17 with a mental health disorder (Citizens' Committee for Children of New York, 2012). Accordingly, the purpose of this study is to examine variations in the demographic characteristics of families utilizing services in the public mental health system at two points in time, with one prior to and the other following a set of major reforms undertaken across New York State. Specifically, this study will explore

demographic data from two cohorts of families who sought treatment in the public mental health system, a decade apart, to better understand the potential influence of large-scale reforms in the mental health care system upon service access.

2. Methods

This study aimed to explore differences in demographic characteristics of families served by the public mental health service system amongst caregivers who participated in one of two National Institute of Mental Health-funded studies of a Multiple Family Group model, entitled the 4Rs and 2Ss for Strengthening Families (4R2S). The 4R2S is a manualized, time-limited (16 weeks, 90-120 minutes per session) mental health intervention that targets school-age, urban youth meeting diagnostic criteria for ODD and their families. The intervention integrates essential practices of behavioral parent training and family therapy, including 6 core components known as the 4Rs and 2Ss: Roles, Responsibilities, Relationships, Respectful communication, Social support, and Stress. This family group intervention model in practice aims to decrease problem behaviors, strengthen families, and increase engagement in treatment (G Gopalan et al., 2014; G. Gopalan, Fuss, & Wisdom, 2015). Study 1 of the 4R2S was conducted between 2006-2010 within mental health clinics of New York City, and Study 2 is currently underway within mental health clinics of New York City. Institutional Review Board approval was obtained for both studies. Participants included English or Spanish-speaking adult caregivers (18 years or older) of a child between 7 and 11 years of age who met eligibility criteria for Oppositional Defiant Disorder (ODD) based upon the Disruptive Behavior Disorders Rating Scale Oppositional Defiant subscale (Pelham, Gnagy, Greenslade, & Milich, 1992). Study 1 consisted of 320 caregivers of children who met criteria for ODD and Study 2 consists of 212 caregivers of children who met criteria for ODD to date. Thus, the total sample analyzed for this paper included 532 caregivers combined from Study 1 and Study 2.

2.1 Measurement

Demographic variables were collected using general sociodemographic questionnaire that assessed familial factors examined in this study: child age, child gender, child race, child ethnicity, child nativity, child primary language, primary caregiver, caregiver age, caregiver marital status, caregiver race, caregiver ethnicity, caregiver education, caregiver employment, and family income. All variables were measured with a self-report survey in which caregivers completed all questions related to self and their child of focus. Response categories for child variables include: male or female (gender), White/Caucasian, Black/African American, Native American, or Asian/Pacific Islander (race), Hispanic/Latino or Non-Hispanic/Latino (ethnicity), US born or Non-US born (nativity), and only English, mostly English/some native, half English/half native, mostly native/some English, or only native (primary language).

As for caregiver variables, response categories for primary caregiver, marital status, race, and ethnicity include: mother, father, grandparents, mother and father, or other (primary caregiver), single, married/common law/domestic partner, divorced, separated, or widowed (marital status), White/Caucasian, Black/African American, Native American, or Asian/

Pacific Islander (race), and Hispanic/Latino or Non-Hispanic/Latino (ethnicity). Additionally, response categories for education, employment, and family income include: 8th grade or less, completed high school/GED, some college, or completed college/some grad/completed grad school (education), full time, part time, unemployed, or student/retired/disabled (employment), and less than \$9,999, \$10,000 – \$19,999, \$20,000 – \$29,999, \$30,000 – \$39,999, \$40,000 – \$49,999, or over \$50,000 (annual family income).

2.2 Data Analysis

Baseline data from both Study 1 and 2 were analyzed using SPSS 24. Univariate and bivariate explorations of demographic characteristics were performed for both study samples along with analyses to examine differences by sample groups (Study 1 participants vs. Study 2 participants). Specifically, differences by sample groups were explored using Independent Samples T-Tests for continuous and Chi-Square tests for categorical variables.

3. Results

Table 1 presents the demographic characteristics of the sample in the completed and current studies. In Study 1, the majority of children were male (68%) and identified as Black/African-American (30%) and Non-Hispanic/Latino (51%). On average, caregivers were 36.46 years of age (SD = 8.73) and children were 8.87 years of age (SD = 1.42). Most often, caregivers identified as Black/African-American (30%), the child's mother (79%), single (43%), and reported an income of less than \$9,999 a year (39%). In Study 2, the majority of children were male (68%) and identified as either Black/African-American (36%) or White/Caucasian (22%) and Hispanic/Latino (52%). On average, caregivers were 40.83 years of age (SD = 11.58) and children were 8.8 years of age (SD = 1.49). Most often, caregivers identified as Black/African-American (34%), the child's mother (63%), single (41%), and reported an income of \$10,000 to \$19,999 a year (24%).

Significant differences between Study 1 and Study 2 participants were found regarding child race, child nativity, caregiver age, primary caregiver, caregiver marital status, caregiver race, caregiver education, caregiver employment, and family income (see Table 1 significance column). The proportion of children who were identified as White/Caucasian in Study 2 was greater than children who were identified as White/Caucasian in Study 1 ($\chi^2(3) = 13.61$, $p < .01$). The proportion of children who were foreign born ($\chi^2(1) = 54.60$, $p < .001$) was greater in Study 1 than children who were foreign born in Study 2.

Caregivers in Study 2 were significantly older ($M = 40.83$, $SD = 11.58$) than caregivers in Study 1 ($M = 36.46$, $SD = 8.73$; $t(506) = -4.83$, $p < .001$). The proportion of caregivers who identified as Black/African American in Study 1 was greater than caregivers who identified as Black/African American in Study 2, while the proportion of caregivers who identified as White/Caucasian in Study 2 was greater than caregivers who identified as White/Caucasian in Study 1 ($\chi^2(4) = 11.91$, $p < .05$). The proportion of caregivers who identified as being the child's mother ($\chi^2(4) = 25.66$, $p < .001$), single ($\chi^2(4) = 9.97$, $p < .05$), unemployed ($\chi^2(3) = 14.14$, $p < .01$), and having attended some HS/completed HS/obtained a GED ($\chi^2(3) = 14.61$, $p < .01$), independently, were greater in Study 1 than caregivers who identified as the child's mother, single, unemployed, and having attended some HS/completed HS/obtained a GED

in Study 2. Lastly, the proportion of families with an income of less than \$9,999 a year in Study 1 was greater than families with an income of less than \$9,999 in Study 2, while the proportion of families with an income of over \$50,000 a year in Study 2 was greater than families with an income of over \$50,000 a year in Study 1 ($\chi^2(5) = 36.83, p < .001$).

4. Discussion

The purpose of this study was to examine demographic characteristics associated with caregivers and their children who accessed services for DBDs 10 years ago (Study 1), compared to caregivers and children seeking the same services today (Study 2). This examination is noteworthy for understanding the larger political, legislative, and structural factors that potentially influence mental health service utilization.

Consistent with studies conducted a decade ago by Chow et al. (2003) and Swartz et al. (1998), identifying as Black/African American and living in families characterized by poverty (e.g., reared by a single caregiver, who was unemployed, and who had a family income of less than \$9,999 annually) was predictive of service use in the first study. Yet, families who attended treatment in the second study were significantly more likely to be White/Caucasian; their caregivers also evidenced higher levels of education, employment and family income. Both the mother and father were more likely to be the primary caregiver in the current sample as compared to a decade ago. A higher percentage of children in the recent study were White and identified as being of Hispanic ethnicity.

On the face of it, these findings suggest that the demographic profile of families currently accessing the public mental health service system is made up of those who are less disadvantaged than families a decade ago. Reasons for these differences can only be speculated on at this point, but given the increasing numbers of children and families seeking mental health services (Olfson et al., 2015), it is possible that the overburdened system has enabled easier access for more privileged, less marginalized groups.

It has become clear that the number of children and families accessing public mental health services has been rising dramatically. Research by Olfson and colleagues (2015) reveals that between 1996-1998 and 2010-2012, an increasing percentage of U.S. children and adolescents received outpatient mental health care even as the number of young people with more severe mental health impairment declined. This increase in access to mental health services for families and children may be closely related to changes in health policy that have been implemented in recent years. Indeed, there is abundant research demonstrating the impact of legislative and funding shifts on access to health care services (Smith-Campbell, 2000). Policy changes associated with the Affordable Care Act (ACA) have contributed to greater availability and access to services, enabling more people to seek and receive public health care, and to be diagnosed with these disorders. Previous to the ACA's implementation, US citizens experienced high rates of being uninsured and incomplete coverage of mental health and substance use treatment (Beronio, Glied, & Frank, 2014). The ACA's enactment, and the reforms undertaken by New York State may have improved access to behavioral health treatment, thus enabling many more children and their families to access mental health services.

The rising number of people accessing mental health services may also be related to the decrease in stigma towards mental health problems over the last decade. Research has found that factors such as prejudice and expectations of discrimination against people who have a mental illness increased the likelihood of treatment avoidance, delays to care, and discontinuing services (Henderson, Evans-Lacko, & Thornicroft, 2013). Fortunately, over the past decade, efforts have focused on decreasing stigma towards mental illness (Parcesepe & Cabassa, 2013) and have subsequently led to increases in help-seeking for mental health disorders, including among children. A review of the recent literature on stigma and help-seeking for psychiatric disorders (Schomerus & Angermeyer, 2008) found that public attitudes toward help-seeking have improved over the last decade, resulting in an increased demand for mental health services.

A further reason for increasing numbers of children accessing services is that greater recognition of children's mental health problems has led to more mental health screening and opportunities for help seeking in schools (Adelman & Taylor, 2010). During the past decade, school systems throughout the country have incorporated mental health education, assessments and interventions into their educational networks (Byers & Petaccio, 2016). For many children, schools have served as the main or only providers of mental health services (Adelman & Taylor, 2010). A literature search on mental health awareness interventions in schools in the US found that such programs were associated with improvements in mental health knowledge, attitudes and help-seeking among students, suggesting that school-based mental health awareness programs are able to contribute to positive outcomes related to mental health care seeking and adherence (Salerno, 2016).

Finally, changes in the primary care system have enabled more people to be identified, referred and treated for mental health problems. Improved collaborative care between primary and mental health providers have enhanced screening and expanded access to mental health care. The emergence of the Affordable Care Act not only improved health care access and coverage, it also emphasized the integration of primary care and mental health services for people with co-occurring disorders. For example, it called for reimbursement for general health care delivered in behavioral health settings and the co-location of primary care and behavioral health services (Croft & Parish, 2013). Some state Medicaid plans have adopted statewide programs to facilitate access to child mental health consultants by primary care practitioners, and others have invested in training primary care providers in screening, diagnosis and treatment tools to enhance their functioning as mental health providers (Alegria, Vallas, & Pumariega, 2010).

In sum, improved access to mental health services may be the result of numerous social, policy and health system delivery changes over the past decade. The increased numbers of children and families engaging in mental health services may be a reflection of the current climate of decreasing stigma, improved coverage, better screening and identification of mental health needs and more choice in where services may be sought. The demographic shifts reported in this paper may be a reflection of more people accessing public mental health services for these reasons. While these developments leading to greater access are largely seen as progress, there are some implications and potential unintended consequences that must be considered at the same time. The question of whether improved access for all

means that low-income individuals or those belonging to minority groups may be shifted out of the mental health system must be considered. While policy and attitudinal shifts have removed barriers to access, the availability of services has not kept up with demand, and there remains a chronic lack of resources and a continuing shortage of mental health providers (Butryn, Bryant, Marchionni & Sholevar, 2017). A recent study that conducted interviews with several mental health agencies found that over 50% of them had waitlists greater than two weeks, and a fifth had wait lists of at least three months (McDonald & Acri, in press). In light of such capacity limitations, it is likely that, as more people access the public mental health service system, greater numbers of youth, and likely the most vulnerable groups will not have their mental health needs met. Indeed, the same study found that despite a high need, there was a limited number of Spanish-speaking clinicians, and thus agencies offering bilingual services have extensive waitlists (McDonald & Acri, in press), suggesting that those with less facility in the dominant language and culture experienced greater difficulty accessing services. While it is possible that more lower income and marginalized youth are now being served in settings such as schools, substantial variations has been found to exist in the number and type of mental health resources that schools provide (Green et al., 2013). Future research must continue to closely monitor changing demographics of people seeking and receiving services in order to address new barriers that may be developing as unintended consequences of policy shifts designed to improve access for all.

5. Implications for Practice

Ensuring access for all requires that mental health agencies carefully examine how societal shifts translate into service delivery processes and procedures. Penchansky and Thomas (1981) suggest that access entails not only availability of services but also the ease with which people can use them (clinic hours, waiting time, and length of waiting time for an appointment); and acceptability, or the attitudes of the users of health care toward the providers, and vice versa. The results of this study call for attention to these issues that may restrict service access for some people as the social and political landscape evolves. This call is particularly salient as the recently passed American Health Care Act is being hotly debated. It has the potential to mark a major shift in national policy for mental health, and particular vigilance is needed. Public mental health services aimed at children and families must attend to the structure of their programs to determine whether low income, minority and vulnerable groups can use them with ease; for example they may consider whether service usage requires time away from work, whether translation services are available, and whether waiting lists are so long that people give up on seeking the help they need. Acceptability as an additional dimension of access should also be addressed. Careful examination of program policies, staff attitudes and practices may reveal hidden or unintentional stigmatizing approaches to minority or low income clients, as research suggests (Allen, Wright, Harding, & Broffman, 2014). Ongoing staff training, supervision and professional development in this area may be warranted. Furthermore, programs may incorporate active outreach as a means of extending services to minority groups who are not well represented within their caseload, to ensure that they are advocating for the people who may be most in need. Finally, the experiences of those being served, as well as those who are

not, must inform continued efforts to creating an accessible and equitable mental health service delivery system. Future research must continue to closely monitor changing demographics of people seeking and receiving mental health services in order to address new barriers that may be developing in the system. The higher numbers of White, educated, American-born individuals and families in the present sample is testament to this possibility.

6. Limitations

Several limitations in this study are noteworthy. First, categories of race and ethnicity were merged in the first study and represented as one item, while they were separated in the second and represented as two distinct items. This categorization may have been problematic as participants were only given the opportunity to select one race or one ethnicity, and not both a race and ethnicity if desired. For example, one who selects 'Hispanic/Latino' would not be able to then select a race, or vice versa. For purposes of analyses in this study, the race/ethnicity item from Study 1 was subsequently separated into 2 items (race and ethnicity) to be more comparable to Study 2. While the Study 1 items ultimately mirrored Study 2, it is important to note this as a limitation since the representation of race and ethnicity still differs and, as a result of the item separation in Study 1, there is missing data. Second, while several of the study sites were the same for both studies, there were also some different sites used. However, all study sites are within the same city, OMH-licensed clinics, and serve the same population. Despite these similarities, it is possible that some differences found from Study 1 to Study 2 could be a function of differences in individuals served by these clinics.

Limitations notwithstanding, this study serves to enhance understanding of changing demographics of families seeking mental health services as a result of a set of major reforms undertaken by New York State. A deeper understanding of such can lead to continuous monitoring of those accessing the mental health system to ensure access for all.

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Highlights

- This study compares the demographics of two samples of families who participated in National Institute of Mental Health-funded studies of a Multiple Family Group model, entitled the 4Rs and 2Ss Multiple Family Group (4Rs and 2Ss) in New York City. One sample is currently receiving services, and the other received services a decade ago.
- Compared to ten years ago, caregivers seeking services in the mental health system presently are significantly older, and have higher levels of education, employment and family income, and the proportion of
- Compared to ten years ago, the proportion of both caregivers and children who identified as white in the current study is greater than the proportion of children and caregivers who identified as white ten years ago
- Future research must continue to closely monitor changing demographics of people seeking and receiving services in order to address new barriers that may be developing as unintended consequences of policy shifts designed to improve access for all.

Table 1

Demographic Characteristics by Study Sample

Characteristic	Study 1 n = 320		Study 2 n = 212		Sig. ¹
	n	%	n	%	
Child age (M ± SD)	302	8.87 ± 1.42	202	8.80 ± 1.49	
Caregiver Age (M ± SD)	310	36.46 ± 8.73	198	40.83 ± 11.58	***
Child Gender					
Male	217	69.6	145	68.4	
Female	95	30.4	67	31.6	
Child Race					**
White/Caucasian	25	7.8	46	21.7	
Black/African American	95	29.7	76	35.8	
Native American	8	2.5	7	3.3	
Asian/Pacific Islander	1	0.3	8	3.8	
Child Ethnicity					
Hispanic/Latino	156	48.8	111	52.4	
Non-Hispanic/Latino	164	51.3	93	43.9	***
Child Nativity					
US Born	213	66.6	196	92.5	
Non-US Born	100	31.3	10	4.7	
Child Primary Language					
Only English	210	65.6	134	63.2	
Mostly English/Some Native	41	12.8	40	18.9	
Half English/Half Native	36	11.3	25	11.8	
Mostly Native/Some English	15	4.7	9	4.2	
Only Native	9	2.8	4	1.9	
Primary Caregiver					***
Mother	252	78.8	133	62.7	
Father	6	1.9	5	2.4	
Grandparents	14	4.4	14	6.6	

Characteristic	Study 1 n = 320		Study 2 n = 212		Sig
	n	%	n	%	
Mother and father	24	7.5	46	21.7	
Other	14	4.4	12	5.7	
Caregiver Marital Status					*
Single	137	42.8	87	42.4	
Married/Common Law/Domestic Partner	105	32.8	78	38.0	
Divorced	14	4.4	18	8.8	
Separated	44	13.8	15	7.3	
Widowed	7	2.2	7	3.4	
Caregiver Race					*
White/Caucasian	30	9.4	50	23.6	
Black/African American	96	30.0	72	34.0	
Native American	3	0.9	2	0.9	
Asian/Pacific Islander	2	0.6	7	3.3	
Caregiver Ethnicity					
Hispanic/Latino	168	52.5	95	44.8	
Non-Hispanic/Latino	152	47.5	98	46.2	
Caregiver Education					**
8 th Grade or Less	32	10.0	22	10.4	
Completed HS/GED	168	52.5	77	36.3	
Some College	70	21.9	67	31.6	
Completed College/Some Grad School or Completed Grad School	41	12.8	39	18.4	
Caregiver Employment					**
Full Time	75	23.4	79	37.3	
Part Time	54	16.9	25	11.9	
Unemployed	104	32.5	42	19.8	
Student/Retired/Disabled	62	19.4	50	23.6	
Family Income					***
Less than \$9,999	125	39.1	44	20.8	
\$10,000 to \$19,999	81	25.3	50	23.6	

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Characteristic	Study 1 n = 320		Study 2 n = 212		Sig
	n	%	n	%	
\$20,000 to \$29,999	47	14.7	33	15.6	
\$30,000 to \$39,999	23	7.2	23	10.8	
\$40,000 to \$49,000	4	1.3	14	6.6	
Over \$50,000	18	5.6	30	14.2	

*
p < .05,
**
p < .01,

p < .001

Significance examined with Independent Samples T-Tests and Chi-Square tests