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On the Relationship Between Stakeholder Affiliation and Attitudes Toward Behavioral Health Reform in Kansas

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ABSTRACT

Introduction. The lack of access to behavioral health care, trends in behavioral health issues, and the impact of social determinants of health underlie the need for behavioral health reform in Kansas. However, stakeholders may affect progress toward behavioral health reform. This study examined stakeholders' attitudes toward behavioral health reform.

Methods. The authors analyzed data from a survey administered to elected officials, members of health advocacy groups, state employees, and payers in Kansas. Main outcome measures included attitudes toward the perceived benefit of certain behavioral health and social determinants of health policies and the perceived performance of the primary care and behavioral health care systems in Kansas.

Results. Payers perceived legislation to improve insurance coverage for behavioral health issues as less beneficial than state employees and members of health advocacy groups. Elected officials perceived legislation to address various social determinants of health as less beneficial than health advocates. Members of health advocacy groups rated the behavioral health care system more poorly than elected officials did.

Conclusions. Preliminary findings reflected both the barriers and facilitators to behavioral health reform in Kansas. However, several limitations undermined the generalizability of these findings. Future studies should consider more representative sample sizes, additional variables in behavioral health and social determinants of health policies, and more comprehensive, validated measures. ***Kans J Med 2023;16:28-34***

INTRODUCTION

The sheer scope of challenges facing Kansans with behavioral health issues and the behavioral health care system at large has demonstrated a need to improve access to behavioral health services and treatment outcomes effectively; expand the capacity and sustainability of the behavioral health care system; and address racial/ethnic, socioeconomic, and geographical disparities in behavioral health issues and access to behavioral health services. Through the Special Committee on Kansas Mental Health Modernization and Reform,[1,2] the Governor's Behavioral Health Services Planning Council (GBHSPC) and its Subcommittees,[3,4] the Kansas Mental Health Coalition,[5] and other behavioral health services stakeholders, a broad array of policies have been recommended to reform the behavioral health care system in Kansas. The efforts of various stakeholders in Kansas toward behavioral health reform resulted in the establishment of and funding for certified community behavioral health clinics (CCBHCs) through passage of Senate Substitute for House Bill 2208 in 2021,[6-9] as well as the implementation of a 988 suicide prevention and mental health crisis hotline in 2022.[10,11]

Other behavioral health reform efforts in Kansas have faltered. The Kristi L. Bennett Mental Health Parity Act was introduced in the 2020-2021 Kansas state legislative session to address mental health and substance use parity issues.[12,13] Although lauded by consumers of behavioral health services, their family members and caregivers, and behavioral health professionals in its potential to improve health insurance coverage for behavioral health issues in Kansas,[14-16] efforts to pass the Kristi L. Bennett Mental Health Parity Act have died in committee.[12,13,17,18] In testimony on the Kristi L. Bennett Mental Health Parity Act, business interest groups such as the Kansas Chamber of Commerce and payers such as Blue Cross/Blue Shield, Cigna, and Medica expressed opposition.[19] Efforts to expand Medicaid in Kansas, which has been associated with improvements in behavioral health outcomes and access to behavioral health services,[20-28] have also faltered.[29-31] The support for or opposition to various behavioral health reform strategies between stakeholders underlies the need to examine behavioral health politics and policy further.

Previous studies have examined the attitudes of specific stakeholders in the behavioral health care system, notably elected officials, toward behavioral health issues and behavioral health reform. In a study which assessed predictors of support for or opposition to comprehensive state behavioral health parity legislation (C-SBHPL) among state legislators, beliefs that C-SBHPL increases access to behavioral health services and does not increase health insurance premiums were the strongest predictors for state legislators' support of C-SBHPL, more so than political party affiliation or ideology.[32] Inversely, the strongest predictor for state legislators' opposition to C-SBHPL was stigma against people with mental illness.

In another study which assessed the attitudes of state legislators on whether different adverse childhood experiences (ACEs) increase the risk of behavioral health issues in adulthood found that Democrat, liberal, and female state legislators were significantly more likely to view ACEs as risk factors for adult behavioral health issues than Republican, conservative, and male state legislators.[33] State legislators who were female, Democrat, or have liberal ideology also were significantly more likely to support opioid use disorder (OUD) parity than state legislators who were male, Republican, or had conservative ideology.[34] Furthermore, in a study which compared state legislators' support for parity laws for four mental illnesses, anorexia/bulimia was found to have the lowest support in parity (40%) when compared to other mental illnesses such as major depression (53%), post-traumatic stress disorder (PTSD; 55%), and schizophrenia (57%).[35]

Fewer studies have compared the attitudes of different stakeholders toward behavioral health issues and behavioral health reform. Nevertheless, mayors were less likely than health commissioners to strongly agree that health disparities exist within their cities, and they were more

likely than health commissioners to believe that city policies would have little to no impact on addressing health disparities.[36] In a study conducted in 2003, a majority of state legislators and county commissioners in Kansas rated affordable mental health services as an example of a public health activity, and rated affordable mental health services as important, but almost none rated mental health or substance use issues as the main public health concern for their jurisdiction.[37] No other studies were identified on attitudes of different types of elected officials in Kansas toward behavioral health politics and policy, and in general, no other studies were identified on differences in attitudes between behavioral health services stakeholders toward behavioral health reform in Kansas.

Given the need for Kansas-specific research on similarities and differences between stakeholders on their attitudes toward behavioral health issues and behavioral health reform, the purposes of this research study were to assess whether there were significant differences between stakeholders in Kansas among their attitudes toward policies that affect behavioral health and behavioral health care and policies that affect social determinants of health.

METHODS

Participants. Four types of stakeholders were included in this research study: (1) elected officials; (2) employees of state government agencies and entities whose work pertains to behavioral health; (3) payers; and (4) members of health advocacy groups. Given the expectation that inclusion of consumers of behavioral health services as a fifth stakeholder category would have necessitated full Institutional Review Board (IRB) review, and the fact that consumers were likely to be represented in the four stakeholder categories (particularly as members of health advocacy groups), consumers of behavioral health services were not categorized as a separate stakeholder group. The study was approved by the Wichita State University Institutional Review Board. Through purposive sampling and snowball sampling, participants were contacted through email or phone call to provide informed consent and fill out the survey. Survey data were collected from April 2021 to June 2021.

There was a total of 249 survey participants. The survey included the following demographic items: stakeholder group, race/ethnicity, political party, age, gender, sexual orientation, geographic location of residence, and education level. A total of 183 participants indicated their stakeholder group: 42 participants were elected officials (23%); 25 participants were state employees (13.7%); 7 participants were payers (3.8%); and 109 participants were members of health advocacy groups (59.6%). Table 1 provides further information on the demographics of survey participants.

Materials. Surveys were administered through Qualtrics. Informed consent forms contained information about the purpose of the research study, procedure, known benefits and risks, voluntary participation, confidentiality/privacy, and contact information. The survey consisted of a modified version of the Behavioral Health Integration Survey Module (BHISM),[38] a modified version of a mental health care survey from the American Psychiatric Association,[39] demographic information, and a free-response question. The full survey can be found in Appendix A (available online only at journals.ku.edu/KJM).

Table 1. Demographic information of survey participants.

Variable	n	%
Stakeholder		
Health Advocate	109	59.6
Elected Official	42	23.0
State Employee	25	13.7
Payer	7	3.8
Political Affiliation		
Democratic	106	54
Republican	48	24
Libertarian	7	4
Preferred Not to Answer	36	18
Gender		
Female	118	61
Male	74	38
Non-binary	1	1
Race/Ethnicity		
White	170	79
Person of Color	45	21
Sexual Orientation		
Heterosexual	174	88
Sexual Minority	24	12
Geographic Description of Residence		
A Suburban Area	72	37
An Urban, Non-Inner-City Area	52	26
An Urban, Inner-City Area	41	21
A Rural Area	32	16
Age		
18-22	13	7
23-30	16	8
31-45	58	29
45-63	63	31
64+	51	25
Highest Level of Education Completed		
Some High School	1	1
High School or GED	10	5
Associate Degree or Trade School	30	15
Bachelor's Degree	52	26
Master's Degree	82	41
PhD, MD, DO, or Other Doctorate Level of Education	23	12

American Psychiatric Association Mental Health Care Survey (APA MHCS). The American Psychiatric Association Mental Health Care Survey (APA MHCS)[39] was modified for this study to measure the perceived benefit of certain legislation to address (1) behavioral health and behavioral health care issues and (2) to address social determinants

of health on a scale of 1 to 5, with 1 being extremely important and 5 being not at all important. The behavioral health policy items included (1) the reduction of costs of behavioral health care, (2) improvements in insurance coverage for behavioral health issues, (3) reduction in suicide rates, (4) increases in the number of behavioral health professionals, and (5) reduction in underage substance use. The social determinants of health policy items included (1) access to affordable housing, (2) access to green spaces, (3) access to healthy foods, (4) employment opportunities, (5) reduction of gun violence, and (6) reduction of homelessness. The modified APA MHCS assessed a greater variety of behavioral health and behavioral health care policies and social determinants of health policies than the original APA MHCS.

Design and Procedure. Data were analyzed using the software IBM SPSS Statistics (Version 26). Kruskal-Wallis tests were conducted to determine whether there were significant differences between stakeholders on the perceived benefits of behavioral health policies, social determinants of health policies, as well as letter grade ratings of the primary care and behavioral health care systems. Bonferroni-corrected Dunn's tests were conducted in post-hoc analyses to identify which stakeholders had significant differences from each other and to correct for potential Type 1 errors from the Kruskal-Wallis tests.

RESULTS

Stakeholders' Perceived Benefit of Behavioral Health Policies. Kruskal-Wallis tests were conducted to compare stakeholders' perceived benefits of the following policies to improve behavioral health and behavioral health care: (1) the reduction of costs of behavioral health care, (2) improvements in insurance coverage for behavioral health issues, (3) reduction in suicide rates, (4) increases in the number of behavioral health professionals, and (5) reduction in underage substance use. No significant differences were observed between stakeholders on the perceived benefit of legislation to reduce costs of behavioral health care, reduce suicide rates, reduce underage substance use, or increase the number of behavioral health professionals.

Significant differences were observed only on the perceived benefit of legislation to improve insurance coverage for behavioral health issues. Elected officials perceived that legislation to improve insurance coverage for behavioral health issues would be less beneficial than state employees and members of health advocacy groups. Payers also perceived that legislation to improve insurance coverage for behavioral health issues would be less beneficial than state employees and members of health advocacy groups. Bonferroni-corrected Dunn's tests revealed that only the differences between payers with state employees and payers with members of health advocacy groups were statistically significant. Table 2 provides additional information on stakeholders' perceived benefit of various behavioral health reform policies.

Stakeholders' Perceived Benefit of Social Determinants of Health Policies. Kruskal-Wallis tests were conducted to compare stakeholders' perceived benefits of the following policies to improve behavioral health and behavioral health care: (1) access to affordable housing, (2) access to green spaces, (3) access to healthy foods, (4) employment opportunities, (5) reduction of gun violence, and (6) reduction of homelessness.

Significant differences were observed between stakeholders on the perceived benefit of policies to improve access to affordable housing. Bonferroni-corrected Dunn's tests revealed significant differences between elected officials and members of health advocacy groups. Elected officials perceived that legislation to improve access to affordable housing would be less beneficial than members of health advocacy groups.

Significant differences were observed between stakeholders on the perceived benefit of policies to improve access to green spaces. Bonferroni-corrected Dunn's tests revealed significant differences between elected officials and members of health advocacy groups. Elected officials perceived that legislation to improve access would be less beneficial than members of health advocacy groups.

Significant differences were observed between stakeholders on the perceived benefit of policies to improve access to healthy foods. Bonferroni-corrected Dunn's tests revealed significant differences between elected officials and members of health advocacy groups. However, both elected officials and members of health advocacy groups had the same median score on the perceived benefit of policies to improve access to healthy foods.

No significant differences were observed between stakeholders on the perceived benefit of policies to improve employment opportunities. All stakeholder types had the same median score for perceived benefit of policies to improve employment opportunities.

Significant differences were observed between stakeholders on the perceived benefit of policies to reduce gun violence. Elected officials perceived that legislation to reduce gun violence would be less beneficial than payers, state employees, and members of health advocacy groups. Bonferroni-corrected Dunn's tests revealed that only the difference between elected officials and members of health advocacy groups remained statistically significant.

Significant differences were observed between stakeholders on the perceived benefit of policies to reduce homelessness. Elected officials perceived that legislation to reduce homelessness would be less beneficial than payers and members of health advocacy groups. Bonferroni-corrected Dunn's tests revealed that only the difference between elected officials and members of health advocacy groups remained statistically significant. Table 3 provides further information on stakeholders' perceived benefit of policies to address social determinants of health.

Table 2. Summary of Kruskal-Wallis Tests on stakeholders' perceived benefit of behavioral health policies.

Behavioral Health Policies	Kruskal-Wallis Tests	Probability Value of Bonferroni-Corrected Dunn's Tests	Median			
			Health Advocates (n = 109)	Elected Officials (n = 42)	State Employees (n = 25)	Payers (n = 7)
Reduce costs of behavioral health care	$H(3) = 2.99$, $p = 0.394$, $\varepsilon^2 = 0.017$		1.0	2.0	1.0	2.0
Improve insurance coverage for behavioral health issues*	$H(3) = .953$, $p = 0.030$, $\varepsilon^2 = 0.051$	0.011 - 0.012	1.0	2.0	1.0	2.0
Reduce suicide rates	$H(3) = 3.67$, $p = 0.300$, $\varepsilon^2 = 0.021$		1.0	2.0	1.0	1.0
Reduce underage substance use	$H(3) = 5.63$, $p = 0.088$, $\varepsilon^2 = 0.032$		1.0	1.0	2.0	1.0

*Indicates statistical significance at $p < 0.05$.

Table 3. Summary of Kruskal-Wallis Tests on stakeholders' perceived benefit of social determinants of health policies.

Social Determinants of Health Policies	Kruskal-Wallis Tests	Probability Value of Bonferroni-Corrected Dunn's Tests	Median			
			Health Advocates (n = 109)	Elected Officials (n = 42)	State Employees (n = 25)	Payers (n = 7)
Improve access to affordable housing*	$H(3) = 10.24$, $p = 0.017$, $\varepsilon^2 = 0.057$	0.012	1.0	2.0	2.0	1.0
Improve access to green spaces*	$H(3) = 8.953$, $p = 0.030$, $\varepsilon^2 = 0.051$	0.021	2.0	3.0	2.0	2.0
Improve access to healthy foods*	$H(3) = 7.96$, p = p.047, $\varepsilon^2 = .045$	0.033	1.0	2.0	2.0	2.0
Improve employment opportunities	$H(3) = 2.50$, $p = 0.476$, $\varepsilon^2 = 0.015$		2.0	2.0	2.0	1.0
Reduce gun violence**	$H(3) = 13.44$, $p = 0.004$, $\varepsilon^2 = 0.075$	0.005	1.0	3.0	1.0	1.0
Reduce homelessness*	$H(3) = 11.04$, $p = 0.012$, $\varepsilon^2 = 0.062$	0.011	1.0	2.0	2.0	1.0

*Indicates statistical significance at $p < 0.05$. **Indicates statistical significance at $p < 0.01$.

Table 4. Summary of Kruskal-Wallis Tests on stakeholders' letter grade ratings of the primary care and behavioral health care systems in Kansas.

System	Kruskal-Wallis Tests	Probability Value of Bonferroni-Corrected Dunn's Tests	Letter Grade Rating Based on Median Score				
			Health Advocates (n = 109)	Elected Officials (n = 42)	State Employees (n = 25)	Payers (n = 7)	Total
Primary Care System	$H(3) = 9.032$, $p = 0.029$, $\varepsilon^2 = 0.050$	0.198 - 0.218	C	B	C	B	C
Behavioral Health Care System***	$H(3) = 10.817$, $p = 0.013$, $\varepsilon^2 = 0.060$	0.003	D	C	C	C	D

***Indicates statistical significance at $p < 0.005$.

Stakeholders' Letter Grade Ratings of the Primary Care System in Kansas. Kruskal-Wallis tests were conducted to compare stakeholders' letter grade rating of the primary care system in Kansas on an ordinal scale from A (which was assigned a value of 1) to F (which was assigned a value of 5). Significant differences were observed between stakeholders on how they rated the primary care system in Kansas. Members of health advocacy groups rated the primary care system in Kansas more poorly than elected officials and payers. State employees also rated the primary care system in Kansas more poorly than payers. However, Bonferroni-corrected Dunn's tests revealed no significant differences between members of health advocacy groups with payers, members of health advocacy groups with elected officials, and state employees with payers on their letter grade ratings for the primary care system in Kansas. Table 4 provides further information on stakeholders' letter grade ratings of the primary care system in Kansas.

Stakeholders' Letter Grade Ratings of the Behavioral Health Care System in Kansas. Similarly, Kruskal-Wallis tests were conducted to compare stakeholders' letter grade rating of the behavioral health care system in Kansas on an ordinal scale from A to F. Significant differences were observed between stakeholders on how they rated the behavioral health care system in Kansas. Members of health advocacy groups rated the behavioral health care system in Kansas more poorly than elected officials. Significant differences between members of health advocacy groups and elected officials remained following Bonferroni-corrected Dunn's tests. Table 4 provides further information on stakeholders' letter grade ratings of the behavioral health care system in Kansas.

DISCUSSION

Payers' perceptions that legislation to improve health insurance coverage for behavioral health issues would be less beneficial relative to members of health advocacy groups and state employees may be reflected in current legislative barriers in the enactment of C-SBHPL, such as the Kristi L. Bennett Mental Health Parity Act[19] and ongoing challenges with the attainment and enforcement of behavioral health parity in Kansas.[40] In a report which assigned letter grade rankings and points for each state's policies on behavioral health parity, Kansas was assigned a letter grade of D and a score of 65 out of 100 points, underlying the necessity to improve insurance coverage for behavioral health issues in Kansas.[40]

The significant differences between elected officials and members of health advocacy groups on the perceived benefit of legislation to address social determinants of health could be reflective of broader attitudes by elected officials toward social determinants of health and policy setbacks in addressing social determinants of health, despite the impact social determinants of health within this study, such as housing instability,[41-44] green spaces,[44-48] food insecurity,[49-52] gun violence,[53-55] and homelessness,[41,56,57] can have on behavioral health. Several studies have examined the attitudes of elected officials toward social determinants of health.[33,36,58] Notably, per Purtle et al.[36], a smaller proportion of mayors strongly agreed that health disparities exist in their city and that city policies could impact health disparities when compared to health commissioners. Other studies generally have found that among elected officials, factors such as gender, political party affiliation, and political ideology can influence attitudes toward social determinants of health.[33,36,58] These studies may explain why significant differences were observed between elected officials and members of health advocacy groups on the perceived benefit of social determinants of health policies.

Members of health advocacy groups' lower ranking of the behavioral health care system in Kansas relative to elected officials' ranking demonstrated a gap between members of health advocacy groups and elected officials on the performance and status of the behavioral health care system in Kansas, thus, a need for elected officials to be more aligned with the perspectives of members of health advocacy groups on behavioral health reform.

Study Limitations. There were several major limitations in this study. There existed a non-response bias such that stakeholders who were more receptive to behavioral health reform may have been more likely to take this survey than stakeholders who were more so ambivalent or opposed to behavioral health reform, despite the notable influence these stakeholders also may have on shaping public policy. The implications of the non-response bias in the survey follow that stakeholders' support for various behavioral health reform strategies may be over-represented.

Statistical analyses did not take into consideration confounding and extraneous variables to stakeholder affiliation. In Kansas, a plurality of registered voters and a majority of elected officials across all levels of governments are affiliated with the Republican Party.[59–61] However, most stakeholders in this study's sample were affiliated with the Democratic Party. The significant differences between elected officials and members of health advocacy groups on the perceived benefit of behavioral health and social determinants of health policies, as well as the perceived performance of the behavioral health care system, may be mediated by other factors such as political party affiliation and ideology rather than stakeholder affiliation alone. Based on the literature, other notable variables which may have affected the results from the statistical analyses include lived experiences of behavioral health issues, stigmatizing attitudes toward behavioral health or people with behavioral health issues, familiarity with behavioral health reform, and demographic factors.

Another major limitation of the study design for the survey entailed the utilization of only four stakeholder types, despite the critical role other stakeholders have in the behavioral health care system. Moreover, there likely exists a considerable overlap between patients and consumers of behavioral health services with the four stakeholder types categorized in this study, chiefly, the members of health advocacy groups.

Directions for Future Research. Future studies on stakeholder attitudes toward behavioral health reform should utilize more comprehensive statistical analyses such as regressions or analysis of variance to account for the multiple variables that can influence stakeholders' attitudes toward political and policy-level factors that affect behavioral health and behavioral health care. Future studies also should consider the

usage of larger, more representative sample sizes, address non-response biases, and increase the types of stakeholders to improve generalizability. Given that the APA MHCS[39] was modified for this study, future studies should assess the reliability and validity of the modified versions to improve its psychometric properties, as well as consider the usage of measures assessing attitudes toward behavioral health reform and related concepts that have already been validated in the literature. Finally, future studies on assessing stakeholder attitudes toward behavioral health reform should examine the extent to which they are predictive of real-life policy-level decisions, and more specifically, how different stakeholders' support for and prioritization of behavioral health reform are reflected in their advocacy, policymaking, and/or campaigns.

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