Mental Health in Ohio: 2019 Update

May 2021

OMAS
Ohio Medicaid Assessment Survey

Ohio Department of Medicaid

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MedTAPP
Medicaid Technical Assistance and Policy Program

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EXECUTIVE SUMMARY

Mental health is vital to overall health and wellbeing in every stage of life. This chart book describes mental health and associated factors among Ohio adults and children, and uses the term “mental health” as a holistic term to capture the social and emotional well being of an individual. The chart book examines the prevalence of mental health-related impairment and identifies stressors related to mental health, including comorbid physical health conditions, gaps in access to care and health insurance coverage, and other socioeconomic factors. It describes populations disproportionately effected by mental health including racial and ethnic minorities and children. The findings are based on results of the 2019 Ohio Medicaid Assessment Survey (OMAS) and the Ohio COVID-19 Survey series.

Key Findings

- 3.6% of children ages 5 to 11, and 4.9% of children ages 12 to 18 experienced *frequent mental distress* (FMD), defined as a mental health condition or emotional problem that prevented participation in school, social relationships, or other daily activities for at least 7 or the past 30 days.
- 8.8% of adults ages 19-64 years reported *mental health impairment* (MHI) defined as impairment in routine work or other usual activities for at least 14 of the past 30 days due to mental or emotional problems.
- The prevalence of MHI was highest among young adult women, affecting 15.7% of women between 19 and 24 years of age.
- Mental Health was lowest among men between ages 55 and 64 years, affecting 5.7% of men in this age group.
- Black and Hispanic adults with MHI were disproportionately affected by comorbid health conditions and socioeconomic stress.
- A variety of comorbid health conditions were more prevalent among children with FMD and adults with MHI.
- FMD and MHI was associated with a variety of socioeconomic stressors including adverse childhood experiences (ACEs) among children, financial stress, housing and food insecurity, and social isolation in adults.
- Adults with MHI experienced gaps in access to care, and barriers to care including cost, transportation, and finding available health care providers.

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EXECUTIVE SUMMARY

Key Findings (*cont.*)

- Medicaid was the most common source of health insurance coverage among adults and children with MHI.

Impact of COVID-19 on Mental Health

Though data collection for the 2019 OMAS was conducted before the start of the COVID-19 pandemic, preliminary findings from the Ohio COVID-19 Survey (OCS) suggest that the prevalence of major mood disorder symptoms has increased as a result of the COVID-19 pandemic. This finding is consistent with prior iterations of the OMAS that suggest the prevalence of mental health challenges increased during times of economic stress. Further, there is evidence that individuals with mental or emotional distress are more vulnerable to health and socioeconomic stressors as the pandemic lingers. Strengthening health and safety services may lessen the pandemic's impact on MHI.

Visit **grc.osu.edu/OMAS** for additional information about OMAS, including public use files, codebooks, and methods

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BACKGROUND

The population of interest in this report includes children and adults with mental illness. Understanding the prevalence and impact of mental illness is important because it affects quality of life and health in almost every life domain, from education and career development to physical health to the formation of healthy relationships[1-6]. In turn, difficulties in these areas reduce one's ability to recover from mental illness and lead a healthy life.

The impact of mental illness may be observed at a young age and becomes more prevalent during adolescence and early adulthood. Adverse childhood experiences and family instability have been identified as contributing factors along with biological factors. The transition from adolescents to adulthood is a particularly troubling time in that it is marked by declines in mental health treatment utilization and adherence.[7] A range of factors contribute to these declines including system barriers and avoidance of treatment.[7]

For many individuals, recovery from mental illness can be complicated by comorbid conditions,[8,9] which require access to a range of health services, including screening and treatment for chronic disease and substance misuse. From a cost perspective, treatment expenditures associated with most chronic medical conditions are two-to-three times greater when there is a co-occurring diagnosis of depression[11,12] and exceed those associated with cardiovascular disease and cancer.[10] The discrepancy is attributed to a variety of factors including lack of access to care and a lack of providers with sufficient training integrate behavioral health and general medicine. Psychiatric symptoms also contribute to a lack of adherence to medical treatment due to poor self-management.[11]

Mental health services can prevent or reduce the impact of mental illness on community functioning[13] and physical health if they are evidence-based and designed to meet individual needs, preferences, and cultural perspectives. Yet mental illness often goes untreated.[14] When left untreated, its impact can be devastating, including social isolation and substance use disorders, which are common among individuals with mental illness and are also a leading risk factors for suicide and self-harm.[15–17]

Efforts to reduce the negative impact of mental illness may focus on three broad areas: (1) prevention and early intervention for children and families, (2) reducing gaps in access to evidence-based care; (3) addressing socioeconomic factors that can increase resilience; and (4) acknowledging individual differences and reducing stigma.[18–19] Several subpopulations are disproportionately affected by mental health conditions.

Racial & Ethnic Disparities

Racial disparities in mental health care are greater than in other areas of health care.[20]

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BACKGROUND

Racial & Ethnic Disparities *(cont.)*
Members of racial/ethnic minority groups in the United States have inadequate access and utilization of mental health services, and lower quality of care. These factors contribute to increased likelihood of poor mental and physical health outcomes. Furthermore, the impact of mental illness is exacerbated by financial stress, which is more common among people of diverse racial and ethnic groups. Children who experience unfair treatment due to race are at increased risk of mental and physical health concerns later in life.[21] Estimates based on the Youth Risk Behavior Survey conducted in 2019 suggest that Black or African American high school students in Ohio were more than twice as likely to attempt suicide compared to other high school students (15.8% versus 6.8%).[22]

Health Policy Perspective

From a health policy perspective, considerations include access to evidence-based care, behavioral health and primary care providers with sufficient training to address both behavioral health and co-occurring medical conditions, and provide access to ancillary supports for self-management, such as housing.[10]

Access and quality of care for mental illness and comorbid chronic conditions have improved in recent years, due, in part to the integration of mental and physical health care in behavioral health and primary care provider settings. Additionally, federal legislation[23] has enabled state reforms that aim to increase access to treatment. The Mental Health Parity Act of 2008 prohibited differential coverage for mental health conditions;[24] and the Affordable Care Act (ACA) of 2010 established mental health treatment as an essential benefit and prohibited exclusions based on preexisting conditions.

In 2014, Ohio expanded Medicaid coverage for adults with incomes up to 138% of the Federal Poverty Level (FPL) ($29,974 in annual income for a family of three in 2020), which benefited individuals with behavioral health conditions who met the income eligibility criteria. Prior to these reforms, lack of adequate insurance coverage for those with mental illness was much more widespread and often led to financial hardship and bankruptcy.

Between 2016 and 2018, Ohio Medicaid redesigned its behavioral health benefit by: (1) Integrating payments for mental health and general medical services to Medicaid managed care plans; (2) covering basic primary care within behavioral health settings; and (3) covering a variety of evidence-based practices and care coordination strategies for individuals with mental illness. Additionally, a variety of payment reforms and federal demonstration projects, such as comprehensive primary care, paved the way for integration of behavioral health treatment in primary care settings, and expansion of services that address socioeconomic stressors, providing ancillary supports for housing and…

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BACKGROUND

Health Policy Perspective *(cont.)*
employment. Despite these efforts, workforce shortages and competency gaps continue to limit access to care for individuals with mental health challenges, particularly in rural areas of Ohio.[3]

COVID-19

The 2019 OMAS was completed prior to the novel coronavirus (known as COVID-19) pandemic, thus the findings only describe the impact of MHI prior to the pandemic. A sample of OMAS survey participants were engaged to participate in the Ohio COVID-19 Survey, sponsored by the Ohio Department of Health and the Ohio Department of Medicaid. This survey provided preliminary evidence of the impact of the pandemic on mental health.

OBJECTIVES

The 2019 OMAS Mental Health Chart Book is intended to support the development of state policies that affect Medicaid enrollees with mental health conditions. It focuses on the following six objectives:

1. Describe the prevalence of frequent mental distress (FMD) among children and mental health impairment (MHI) among adults, including differences related to race, and ethnicity.

2. Describe the relationship between mental health conditions and comorbid physical health conditions that underscore the need for coordination of services for individuals with FMD and MHI.

3. Examine modifiable social determinants of health that may have an impact of the ability of individuals with MHI to recover from mental illness.

4. Describe access to care and health insurance to cover the cost of care for individuals with FMD and MHI.

METHODS

Description of Data Sources

- The primary source of data for this chart book is the 2019 Ohio Medicaid Assessment Survey (OMAS), and earlier OMAS surveys from 2008, 2010, 2012, 2015, and 2017.
- Data from the 2020 Ohio COVID-19 Survey (OCS).

Further Details on the 2019 OMAS & 2020 OCS

- The 2019 Ohio Medicaid Assessment Survey (OMAS) is a random sample telephone survey that assesses Ohio residents' access to health care, health care status, health care use, health risk behaviors, and health demographics.
- The 2019 OMAS includes interview data from 31,558 Ohio adults, 19 -64 years, and 7,404 adult proxy interviews of Ohio children, 5-18 years. The 2019 OMAS is the 8th iteration of the survey.
- Participants include Ohioans on Medicaid, potentially eligible for Medicaid based on family income, and those who are not enrolled in Medicaid.
- Data from the 2008, 2010, 2012, 2015, 2017, and 2019 OMAS iterations were examined to identify trends over time in the prevalence of individuals with mental health impairment and their needs and access to care.
- Beginning in April, 2020, the 2019 OMAS sample frame and respondents were engaged to assist Ohio's health and human service agencies evaluate the challenges presented by COVID-19 pandemic. The Ohio COVID-19 Survey (OCS) employed a weekly sampling strategy to track trends over time.
- More information on the findings and methodology of the survey is accessible at: https://grc.osu.edu/OMAS/2019Survey.

Variable Definitions

- Mental Health Impairment (MHI): Among adults, MHI was assessed by asking the number of days in the past 30 days prior to being interviewed that a mental health condition or emotional problem kept the respondent from participating in work or other usual activities. Those respondents who reported 14 days of functional impairment due to mental health or distress were classified as having MHI. The 14-day threshold aligns with the Centers for Disease Control and Prevention's recommendations for measurement classification.[23]

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METHODS

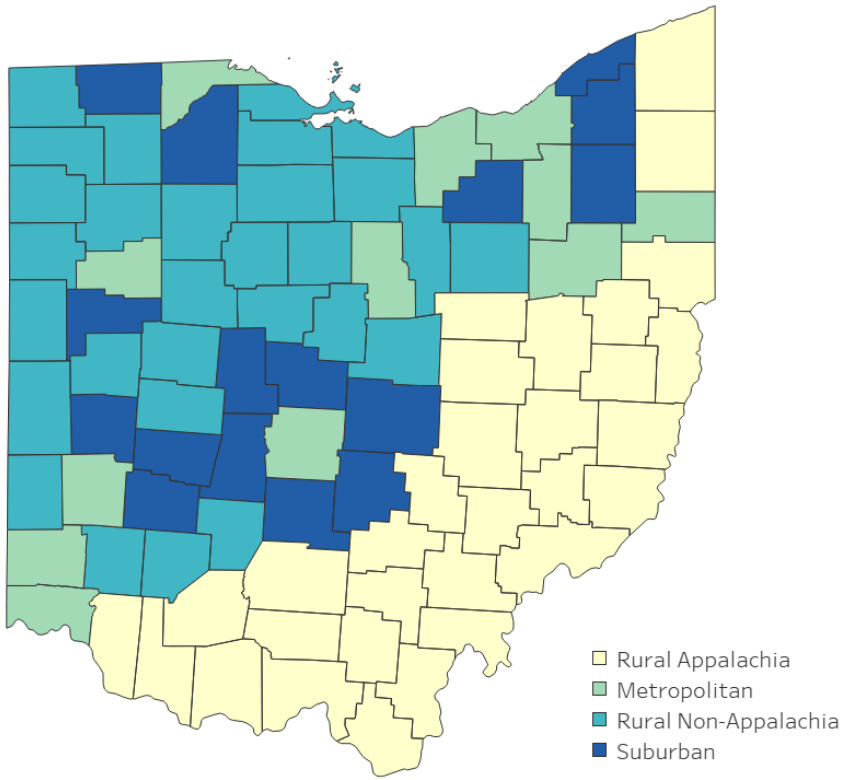
Variable Definitions *(cont.)*

- Frequent Mental Distress (FMD) *(cont.)*: The number of days of mental distress were assessed and factors associated with 7 or more days of impairment during the past 30 days were identified to understand the impact of FMD among children. The 7-day threshold was selected in collaboration with senior staff from the Ohio Department of Mental Health and Addiction Services.
- Depression Screen: Possible depression among adults was assessed following the COVID-19 pandemic using the 2-item form of the Patient Health Questionnaire (PHQ-2), which is a well-validated screening instrument for symptoms of major depression. Note. While there is an association between major depression and MHI, functional impairment may be due to mental distress without depression. Similarly, individuals with depression do not necessarily experience impaired functioning that meets the definition of MHI,

Analyses

- Analyses in this chart book adjusts for survey design, weights, and complex design to be representative of Ohio's non-institutionalized residential adults and children.
- Logistic regression and Pearson's Chi-square were applied to analyses of binomial and categorical outcomes, respectively. All group differences and temporal trends that are described in the results are within .95 precision (.95 confidence bounds), unless otherwise noted.

OMAS County Types



This chartbook contains analyses that refer to county types, which are Ohio counties grouped into demographic characteristics. OMAS defines these county types in accordance with federal definitions, as follows: (1) Appalachian is defined using the Appalachian Regional Commission (ARC) standard; (2) metropolitan is defined using US Census Bureau definitions incorporating urban areas and urban cluster parameters; (3) rural is defined by the Federal Office of Rural Health Policy at the Health Resources and Services Administration (HRSA), excluding Appalachian counties; and (4) suburban is defined by the US Census Bureau and is characterized as a mixed-use or predominantly residential area within commuting distance of a city or metropolitan area. These designations were originally set by the Ohio Department of Health in 1997 for the 1998 Ohio Family Health Survey (OFHS) and were slightly adjusted in 2004 and again adjusted in 2010 to include Ashtabula and Trumbull counties as Appalachian, in accordance with a federal re-designation. Guidance for these categories was provided by National Research Council's Committee on Population and Demography staff – for original designations and revisions.

RESULTS: PREVALENCE OF FMD AMONG CHILDREN AND MHI AMONG ADULTS

The following section provides an overview of prevalence and trends in frequent mental distress (FMD) among children and mental health impairment (MHI) among adults in Ohio across different demographic characteristics and Medicaid status.

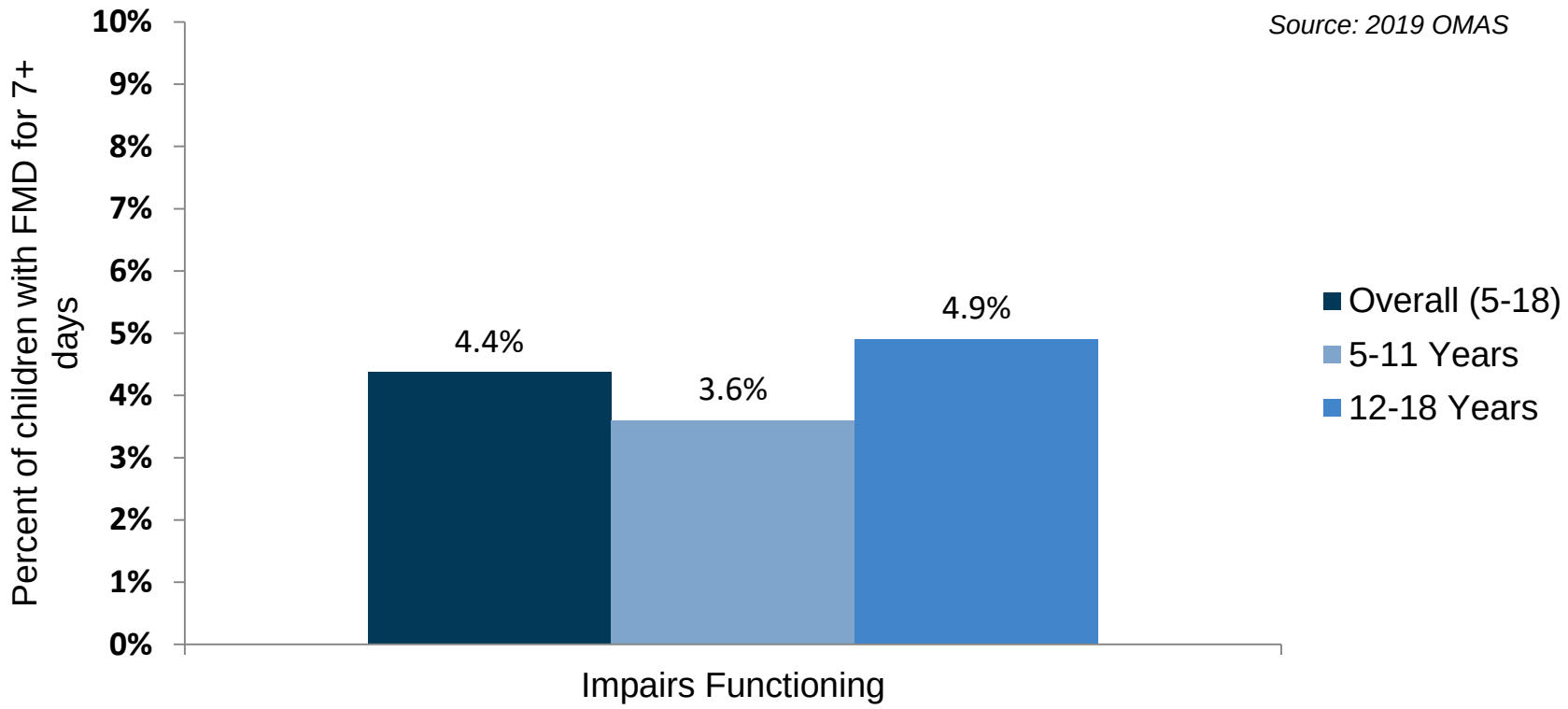
Key Findings: Prevalence of Childhood FMD & Adult MHI

- 4.4% of Ohio children experienced frequent mental distress (FMD), defined as mental health problems that kept them from school, social relationships, and other usual activities for at least 7 of the past 30 days.
  - The proportion of children with FMD increased during adolescence (4.9% among ages 12-18).
  - FMD was greatest among Hispanic adolescents (7.1%).
- 8.8% of Ohio adults, 19-64 years of age, reported having mental health impairment (MHI) in 2019 – an increase of 31% from a low of 6.1% in 2015.
  - The prevalence of MHI was highest (15.7%) among younger women, 19-24 years, and lowest (5.7%) among men, 55-64 years.

Key Findings: Prevalence of Childhood FMD & Adult MHI

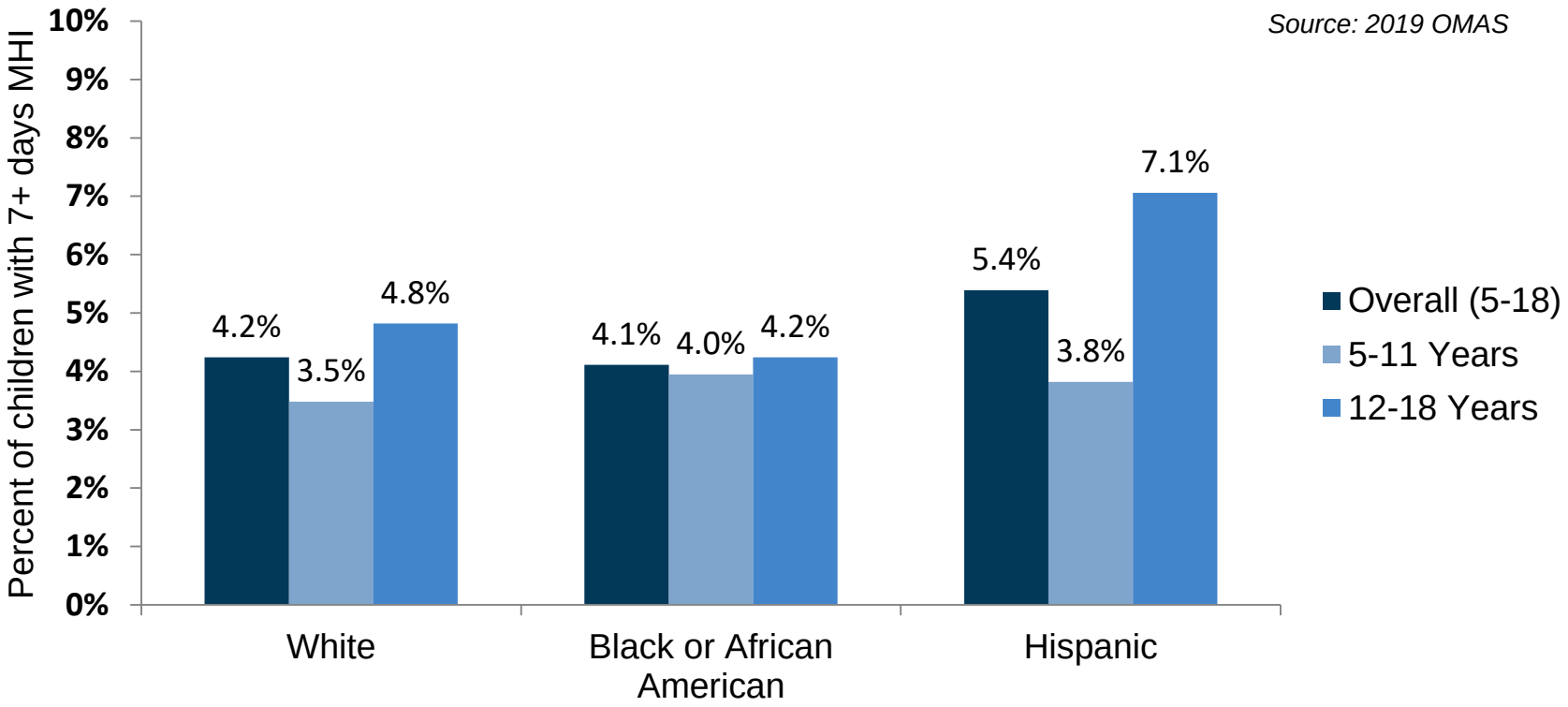
- Racial and ethnic differences in the prevalence of mental health impairment (MHI) were related to income.
  - Among low income adults, the prevalence of MHI was greater among white (19%) than Black, African American (13.2%), or Hispanic (11.2%) respondents.
  - Among higher income adults, the prevalence of MHI was greater among Hispanic adults (10.6%) than white (6.6%), Black or African American adults (6.4%).
- Medicaid was the primary source of insurance for children with FMD and adults MHI.
- Following the start of the pandemic (April through August 2020), between 11.1% and 18.2% of Ohio adults screened positive for depressive symptoms; higher than national estimates of 7.1% prior to the pandemic.

Figure 1. Percent of Ohio Youth with Frequent Mental Distress (FMD)



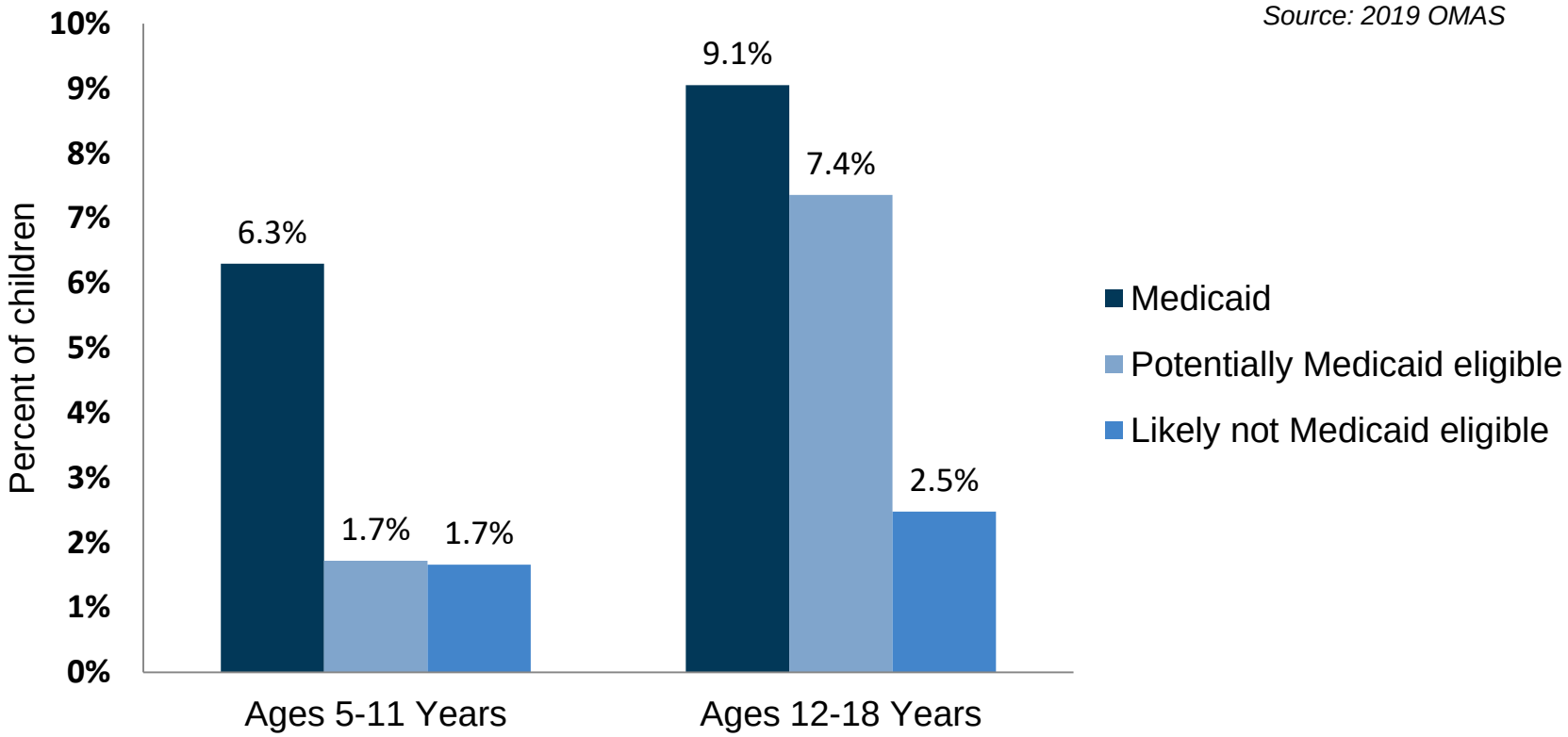
The proportion of children with mental or emotional problems that kept them from school, social relationships, and other usual activities for at least 7 of the past 30 days (frequent mental distress, FMD) increased from 3.6% among children 5-11 years of age, to 4.9% among adolescents 12 – 18 years of age.

Figure 2. Percent of Ohio Youth with FMD, by Race



The percent of children with mental or emotional problems that kept them from school, social relationships, and other usual activities for at least 7 of the past 30 days (frequent mental distress, FMD) was lowest of among white children ages 5-11 years (3.5%) and highest among Hispanic children ages 12 – 18 years (7.1%).

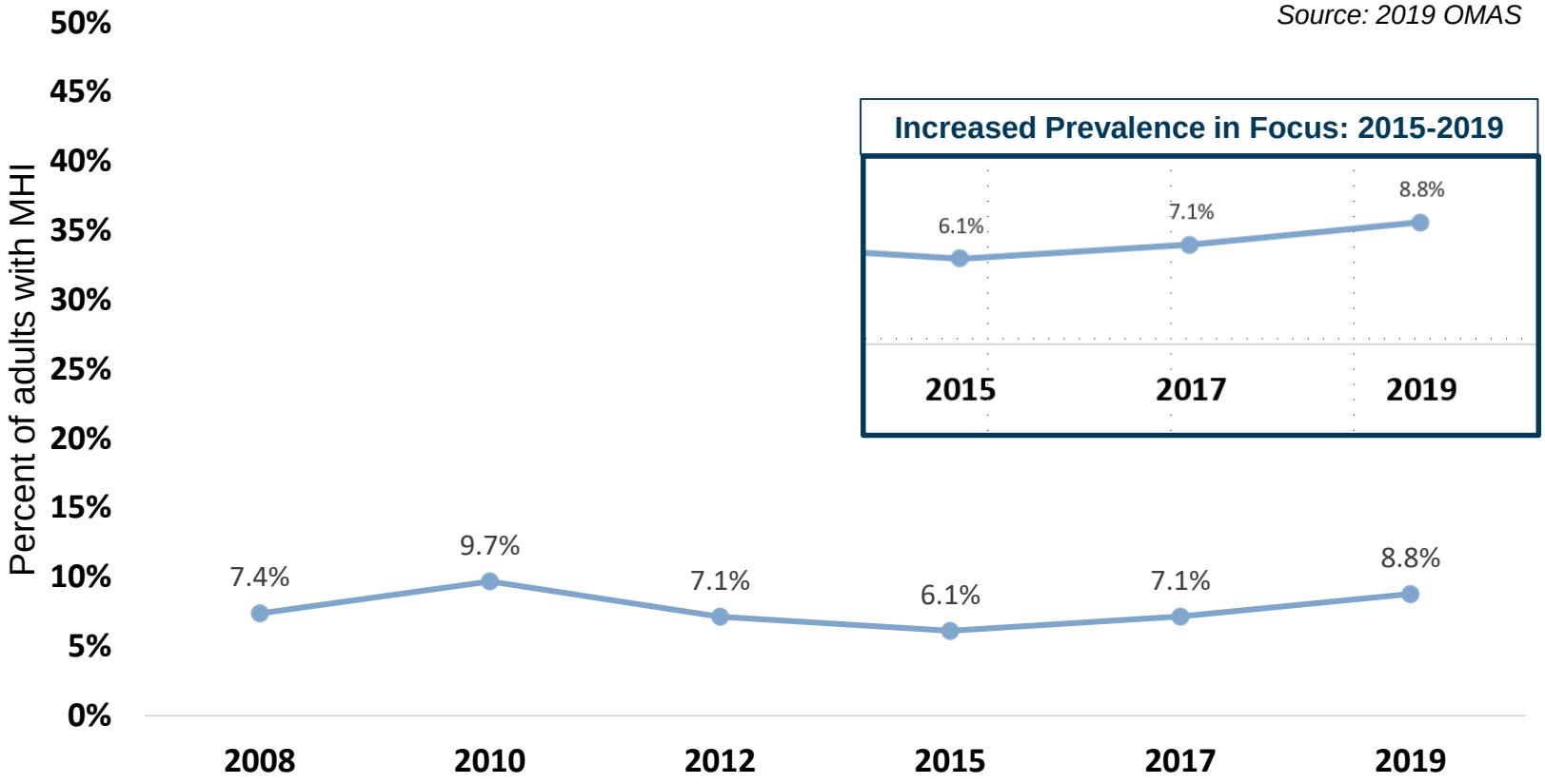
Figure 3. Prevalence of FMD among Children by Medicaid Status



The prevalence of frequent mental distress (FMD) was greater among children enrolled in Medicaid and those who were potentially eligible for Medicaid or likely not eligible for Medicaid based on family income. Note that over 80% of children with FMD were enrolled in Medicaid.

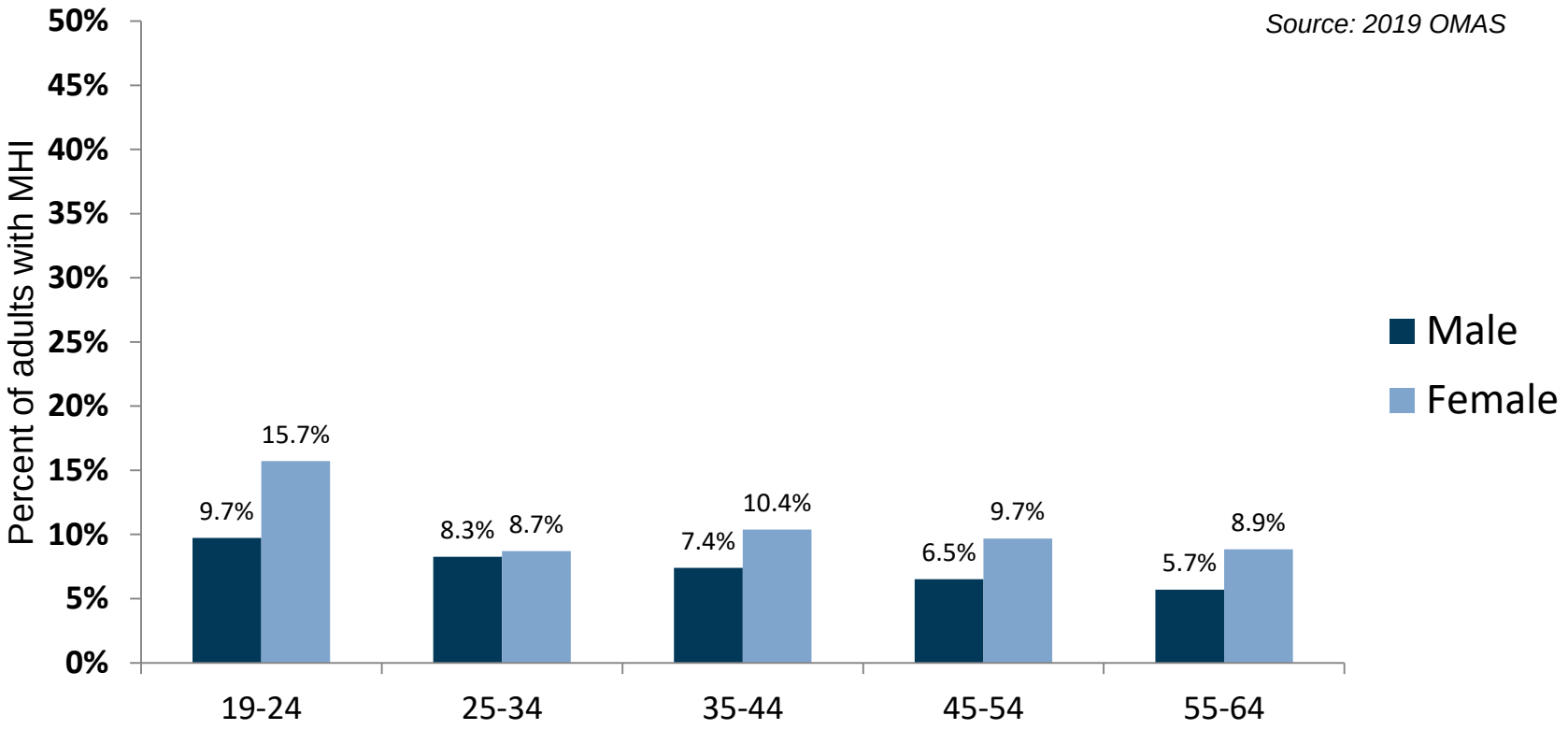
Figure 4. Prevalence of MHI among Ohio Adults Ages 19 – 64 Years

Source: 2019 OMAS



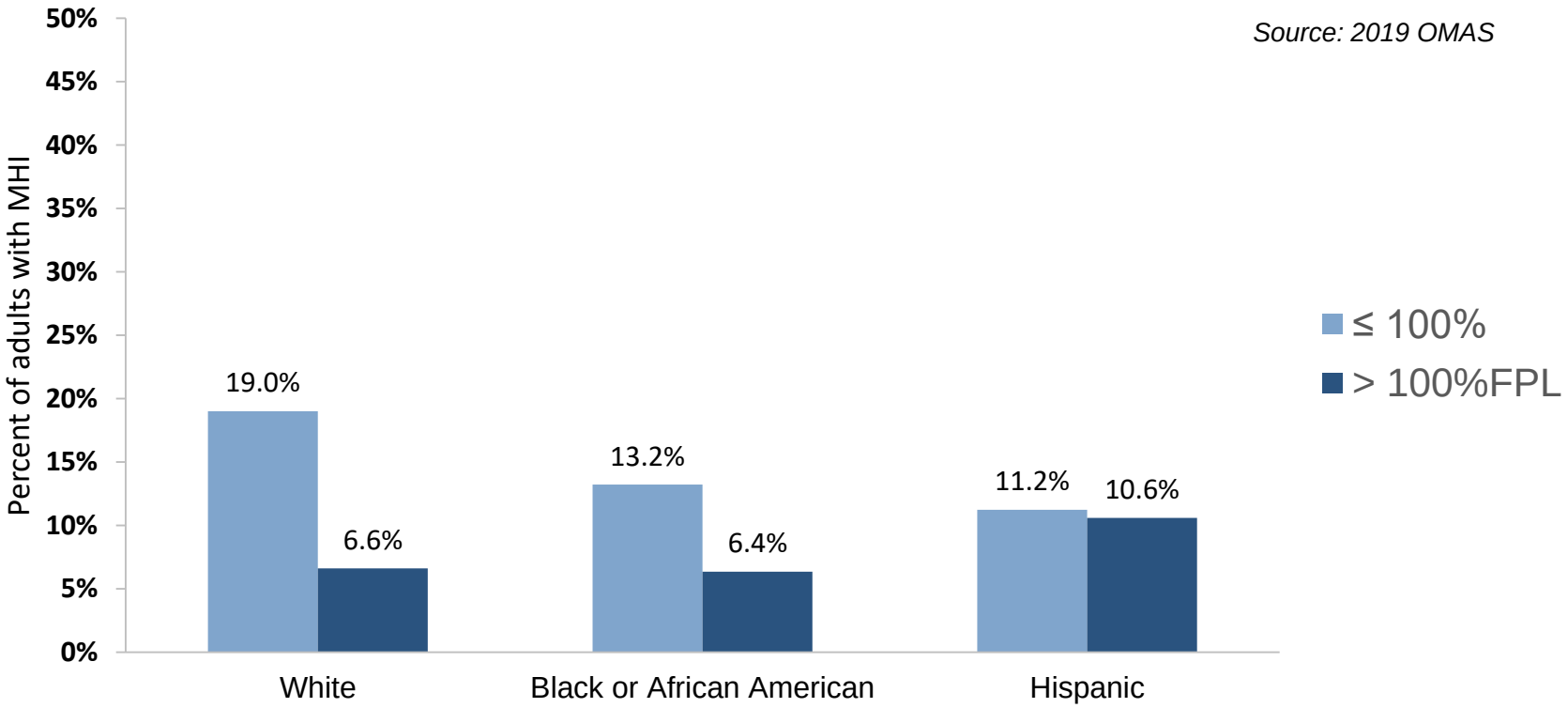
A higher proportion of respondents reported mental health impairment (MHI) in 2010 and 2019 compared to other years of the survey.

Figure 5. Prevalence of MHI among Adults by Sex & Age



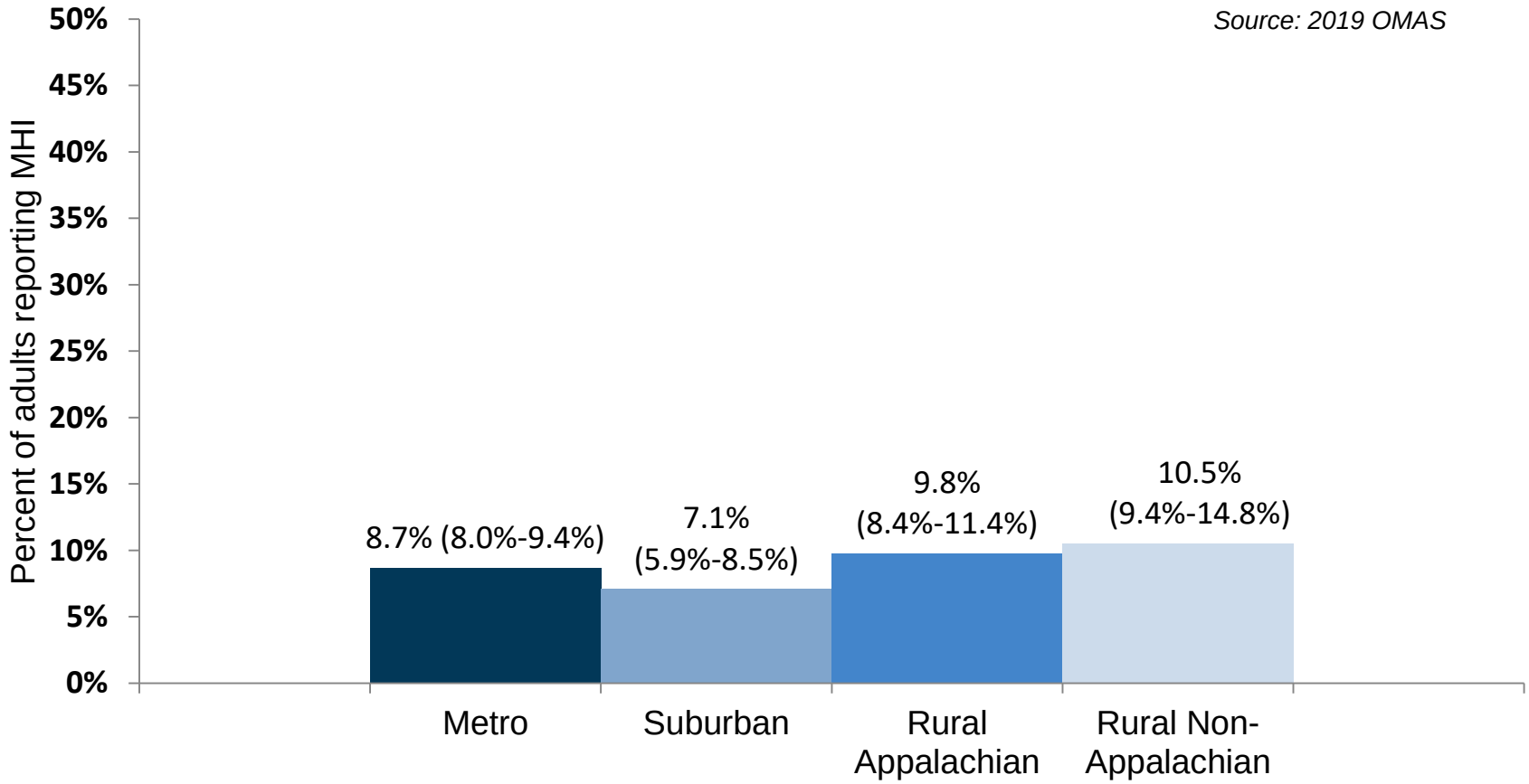
The prevalence of mental health impairment (MHI) was greatest among younger women, 19-24 years, and lowest among older man, 55-64 years.

Figure 6. Prevalence of MHI among Ohio Adults, by Income & Race/Ethnicity



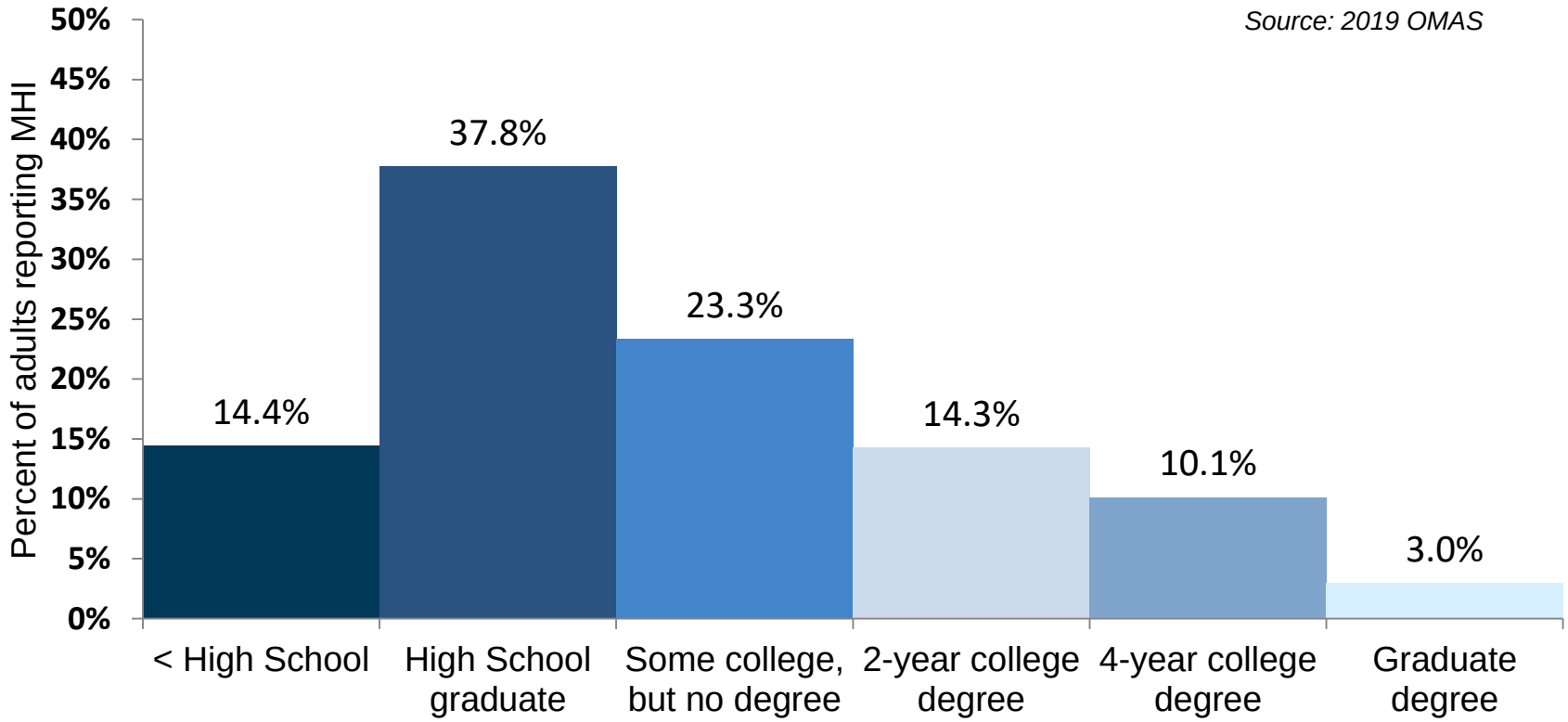
Among lower income groups (≤ 100% FPL), the prevalence of MHI was higher among white adults than among Black, African American or Hispanic adults. Among higher income groups (> 100% FPL), the prevalence of MHI was higher among Hispanic adults than white, Black or African American adults.

Figure 7. Prevalence of MHI among Adults by County Type



There were no substantial regional differences in the prevalence of mental health impairment (MHI).

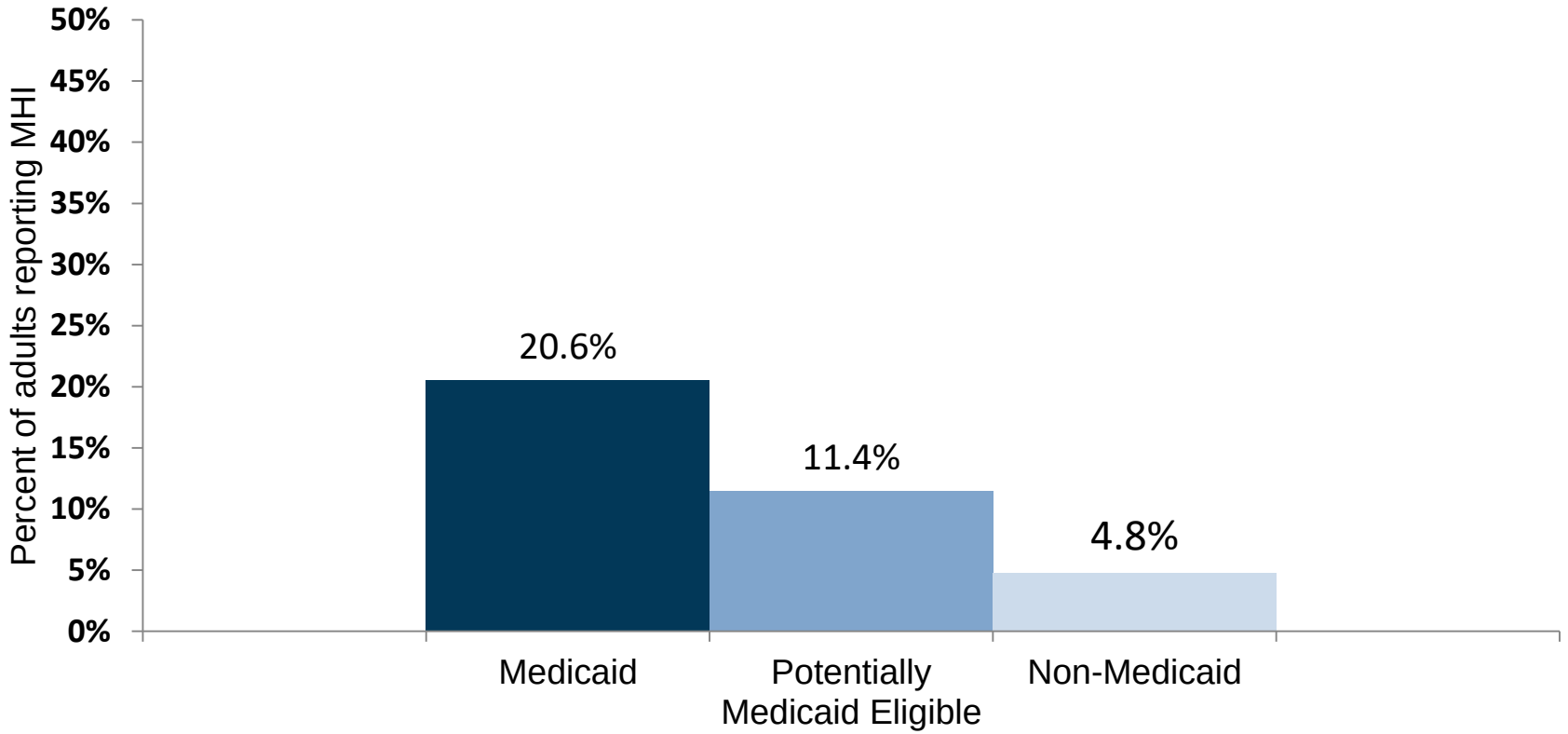
Figure 8. Prevalence of MHI among Adults by Education



Among those with more than a high school education, there was an inverse relationship between level of education and prevalence of MHI. The low prevalence of MHI among those with less than a high school education may be attributed to age; those with less than high school education were significantly older than those who completed high school.

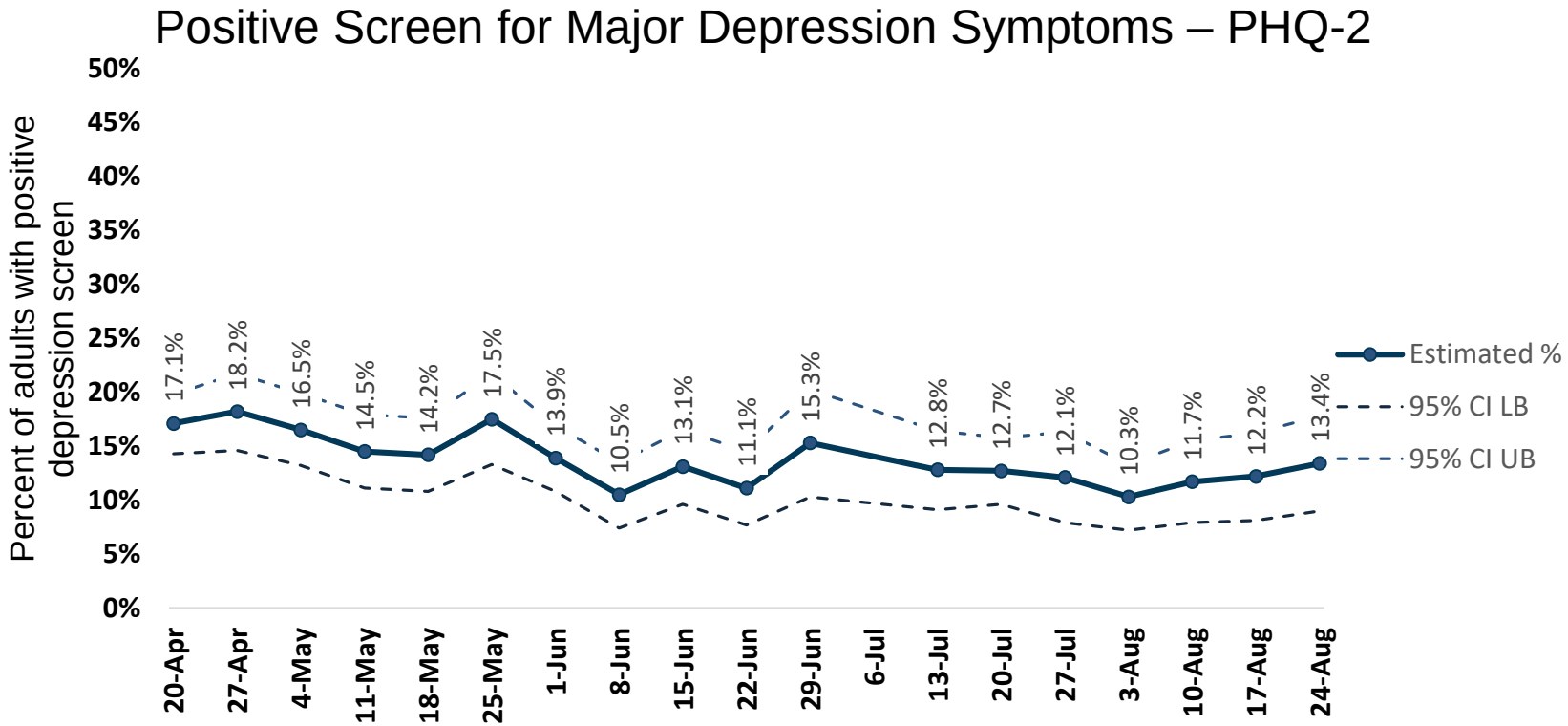
Figure 9. Prevalence of MHI among Adults by Medicaid Status

Source: 2019 OMAS

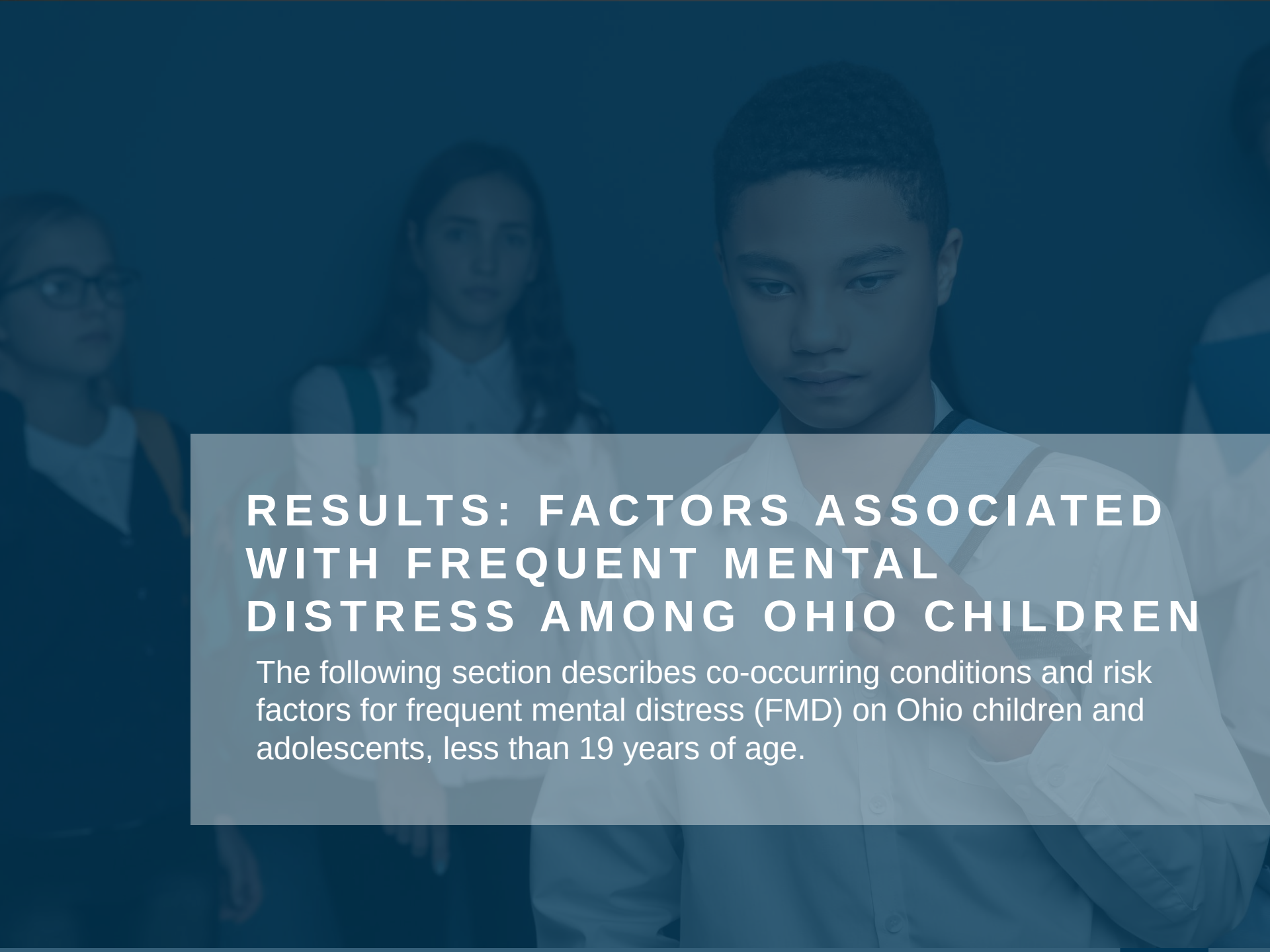


The prevalence of mental health impairment (MHI) is higher among respondents who were enrolled in Medicaid than respondents who were not enrolled in Medicaid.

Figure 10. Estimated Prevalence of Major Depression among Adults Ages 19-64 During the COVID-19 Pandemic



The proportion of respondents who screened positive for depression was between 14.2% and 17.5% in the weeks following the start of COVID-19 and dropped to between 10.3% and 15.3% in June through August, 2020. By comparison, the estimated prevalence of major depression in the United States prior to the health crisis (7.1%). In addition, 25.8% of respondents reported negative mental health or substance use effects and 28.1% of reported negative social effects due to the health care crisis.



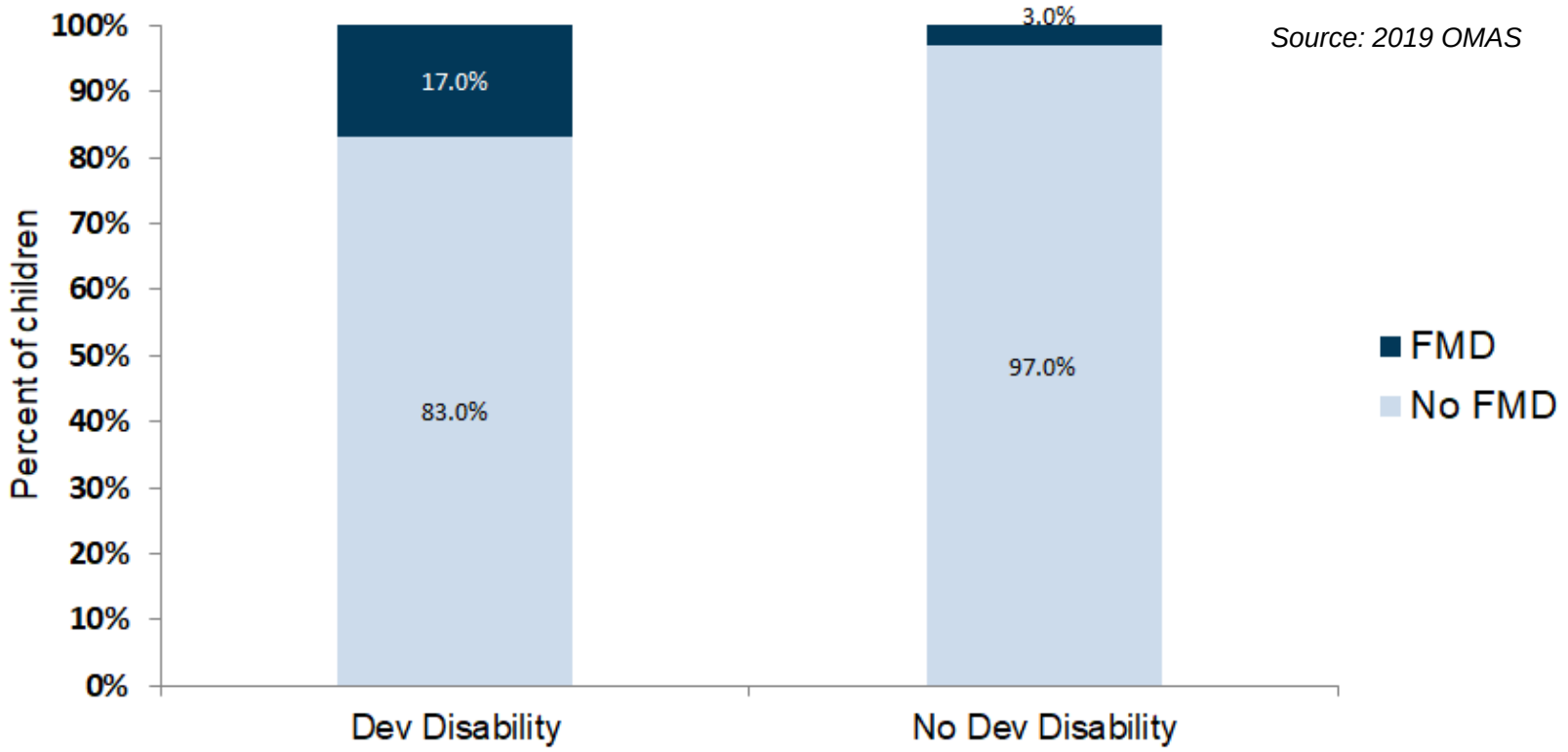
RESULTS: FACTORS ASSOCIATED WITH FREQUENT MENTAL DISTRESS AMONG OHIO CHILDREN

The following section describes co-occurring conditions and risk factors for frequent mental distress (FMD) on Ohio children and adolescents, less than 19 years of age.

Key Findings: Impact of Frequent Mental Distress (FMD) on Children

- An association was observed between FMD and developmental disabilities.
  - Children with developmental disabilities were six times as likely to experience FMD (17% versus 2.6%).
- FMD among children was associated with an increased prevalence of asthma (28.4% vs. 17.7%).
- FMD among children was associated with adverse childhood experiences. Children with FMD were more likely than children without FMD to have experienced unfair treatment due to race and live in a household in which one or more adults had a mental illness or substance use disorder.

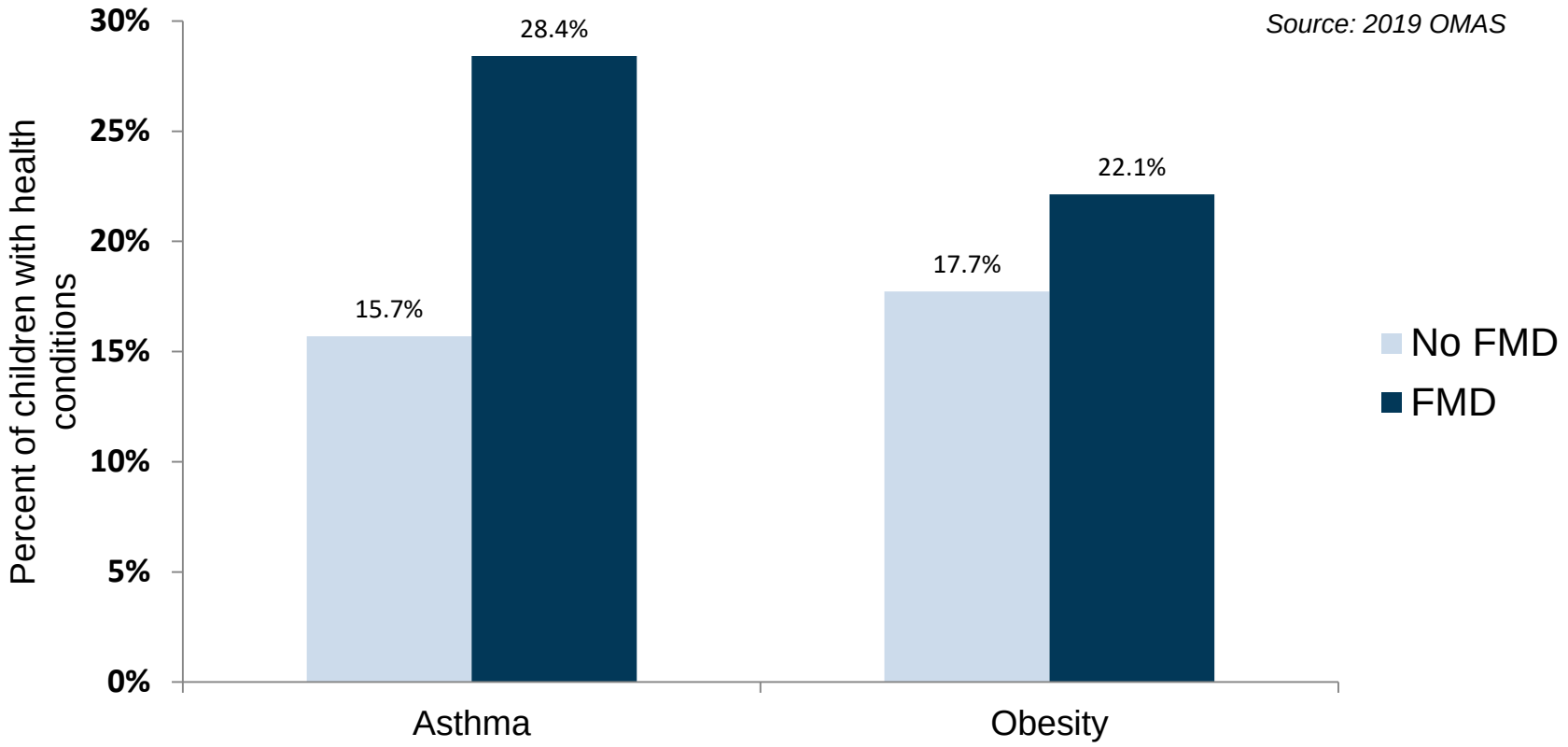
Figure 11. Prevalence of Frequent Mental Distress (FMD) among Children (5-18) with Developmental Disabilities



Source: 2019 OMAS

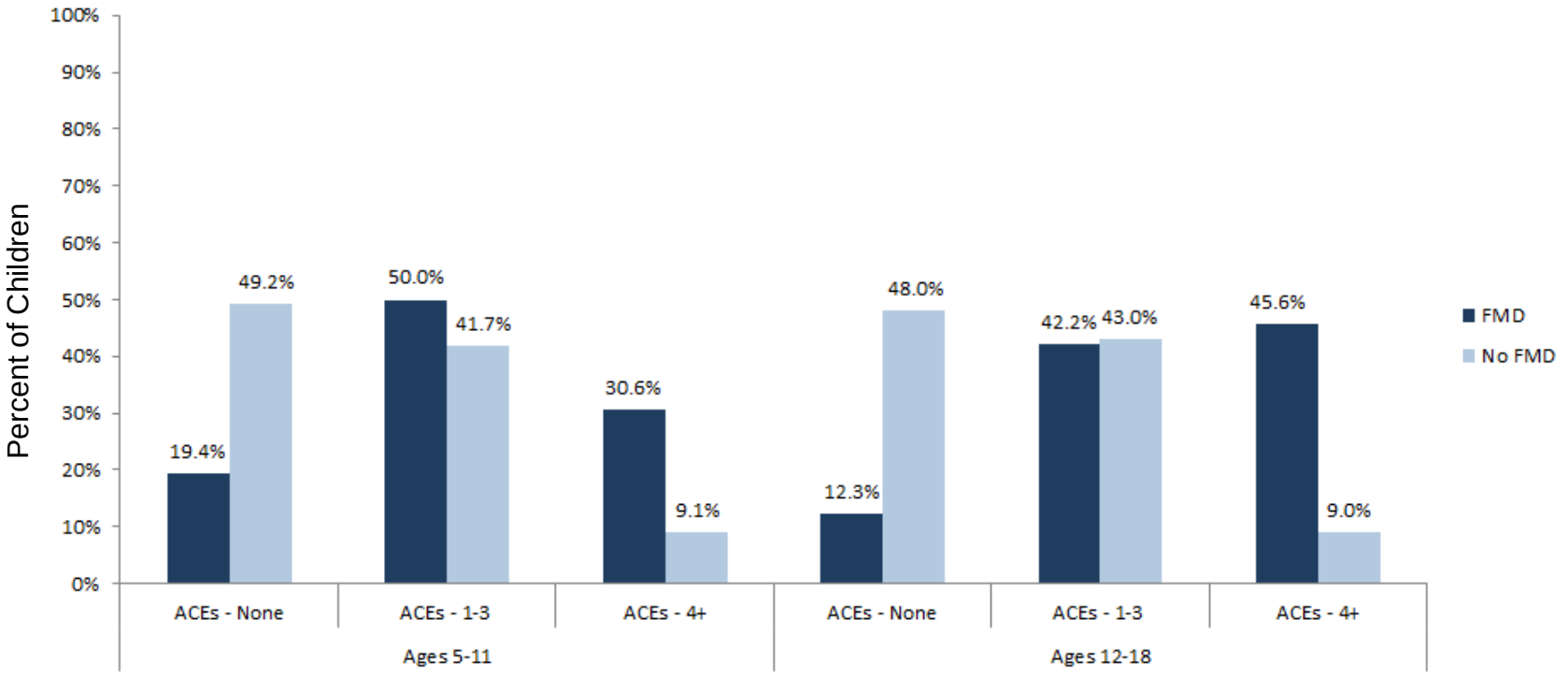
Children with developmental disabilities are nearly six times as likely to experience frequent mental distress (FMD) as children without developmental disabilities (17% versus 3%). Among children with FMD, 41% have a co-occurring developmental disability.

Figure 12. Co-occurring Health Conditions among Children (5-18) by FMD Status



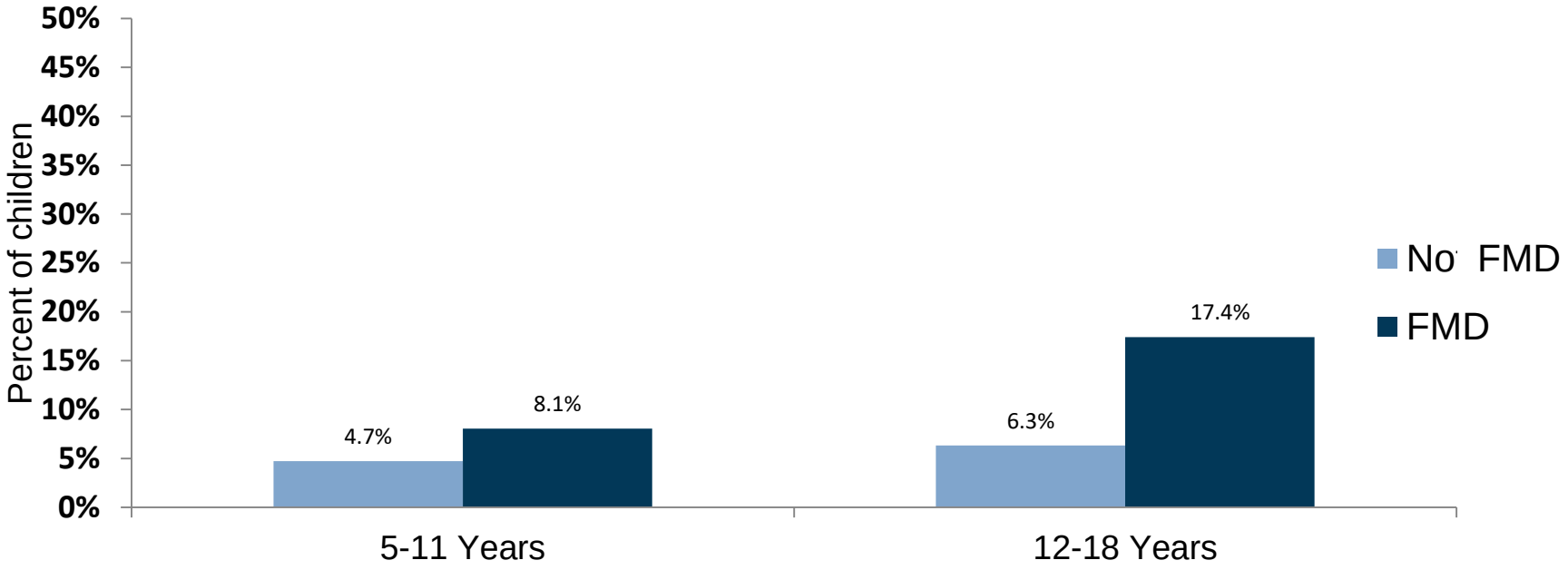
Asthma was more common among children with frequent mental distress (FMD).

Figure 14. Percent of Children with MHI by Adverse Childhood Event Categories



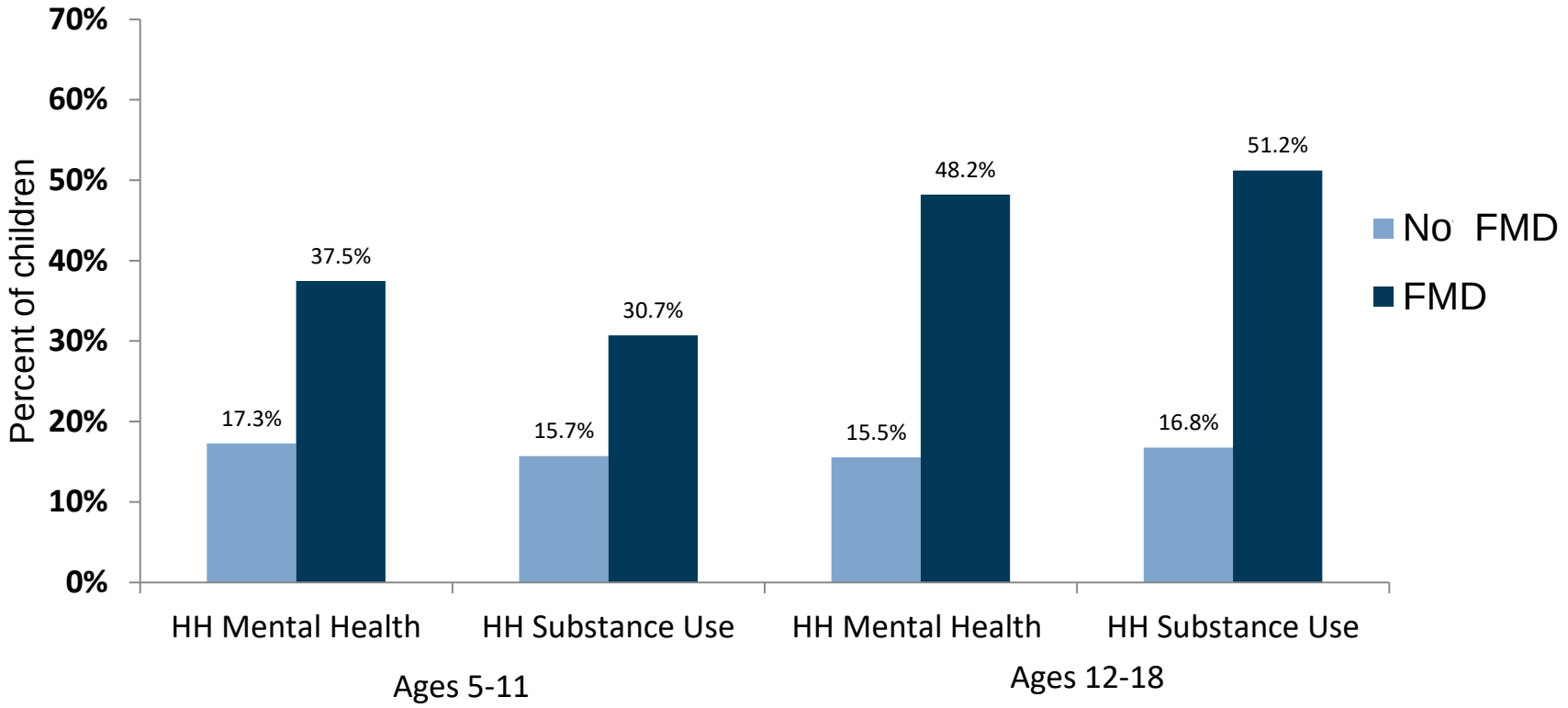
Children with frequent mental distress (FMD) were more likely than children without FMD to experience four or more adverse childhood experiences (ACEs) which are associated with an increased risk of poor outcomes such as parent divorce/separation, parent incarceration, parent death, neighborhood violence, and mental illness/substance use by an adult in household, and unfair treatment due to their race.

Figure 15. Association Between Childhood Mental Distress & Unfair Treatment Due to Race



Frequent mental distress (FMD) was associated with past experience of unfair treatment due to race. The experience of unfair treatment due to race was nearly twice as likely among young children (5-11 years) with FMD and three times as likely among adolescents (12-18 years) with FMD compared to children in the same age groups without FMD.

Figure 16. Association Between Childhood Mental Distress & Mental Health of Adults in Household



Children with Frequent Mental Distress (FMD) were more likely than children without FMD to have lived in a household with an adult with mental illness or substance use disorder. By adolescence, approximately half of children with FMD had lived in a household with an adult with mental illness or substance use disorders.

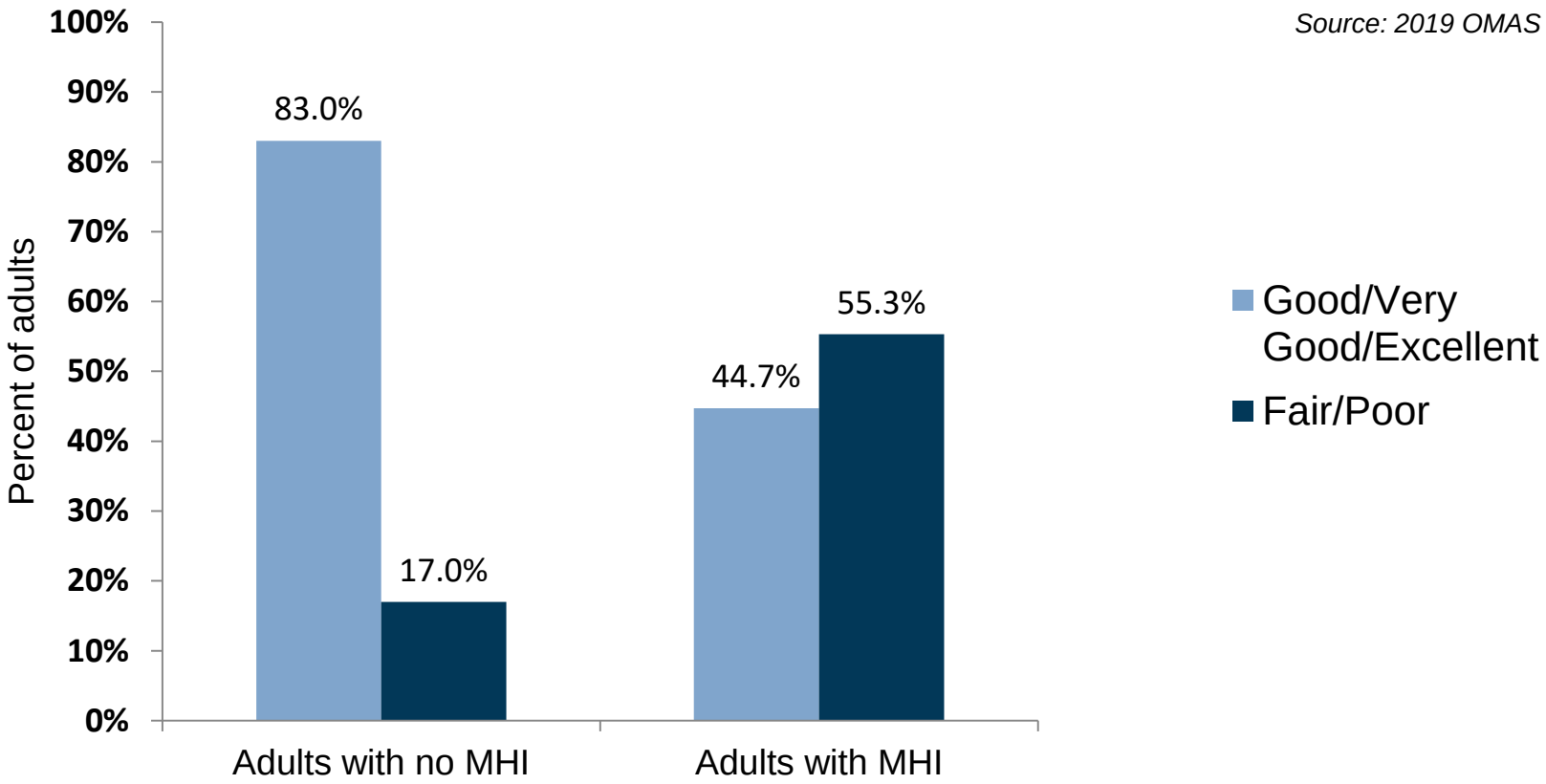
RESULTS: COMORBID CHRONIC CONDITIONS AMONG ADULT OHIOANS WITH MHI

The following section describes the prevalence of comorbid health conditions by mental health impairment (MHI) status, including hypertension, high cholesterol, diabetes, asthma, arthritis, and related conditions.

Key Findings: Comorbid Physical Health Conditions among Ohio Adults with MHI

- Among Ohio adults, mental health impairment (MHI) was associated with a higher prevalence of self-rated fair/poor health and chronic physical health conditions including:
  - Hypertension (40.2% vs. 27.2%)
  - High cholesterol (31.7% vs. 19%)
  - Diabetes (17.9% vs. 9.5%)
  - Asthma (31.9% vs. 17.3%)
  - Arthritis (68.6% vs. 38.7%)
- There were racial and ethnic differences in comorbid physical health and socioeconomic stress regardless of MHI status. However, racial disparities in diabetes and asthma were greater among racial and ethnic minority groups with MHI compared to those without MHI.

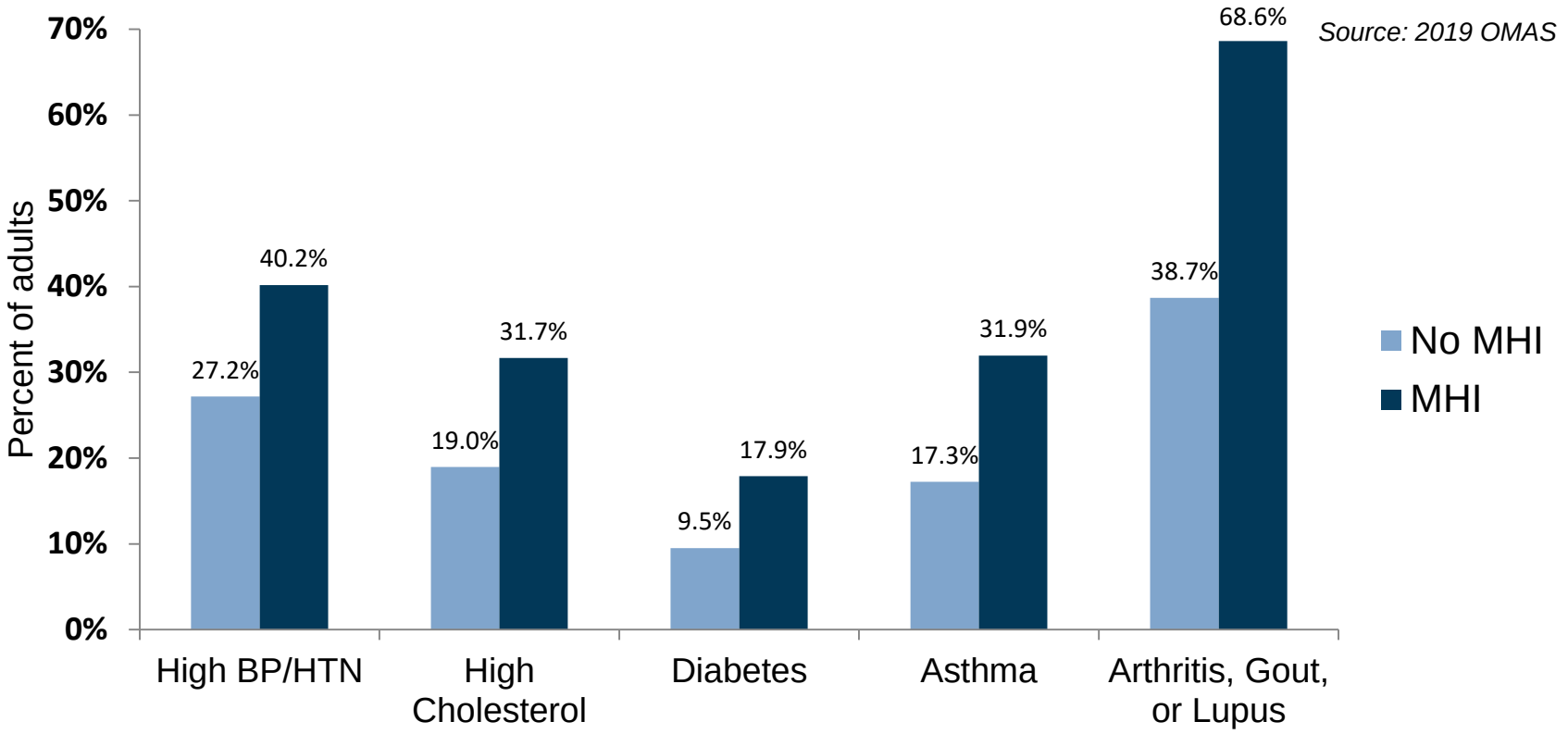
Figure 17. Self-reported Health Status among Ohio Adults, by MHI status



Source: 2019 OMAS

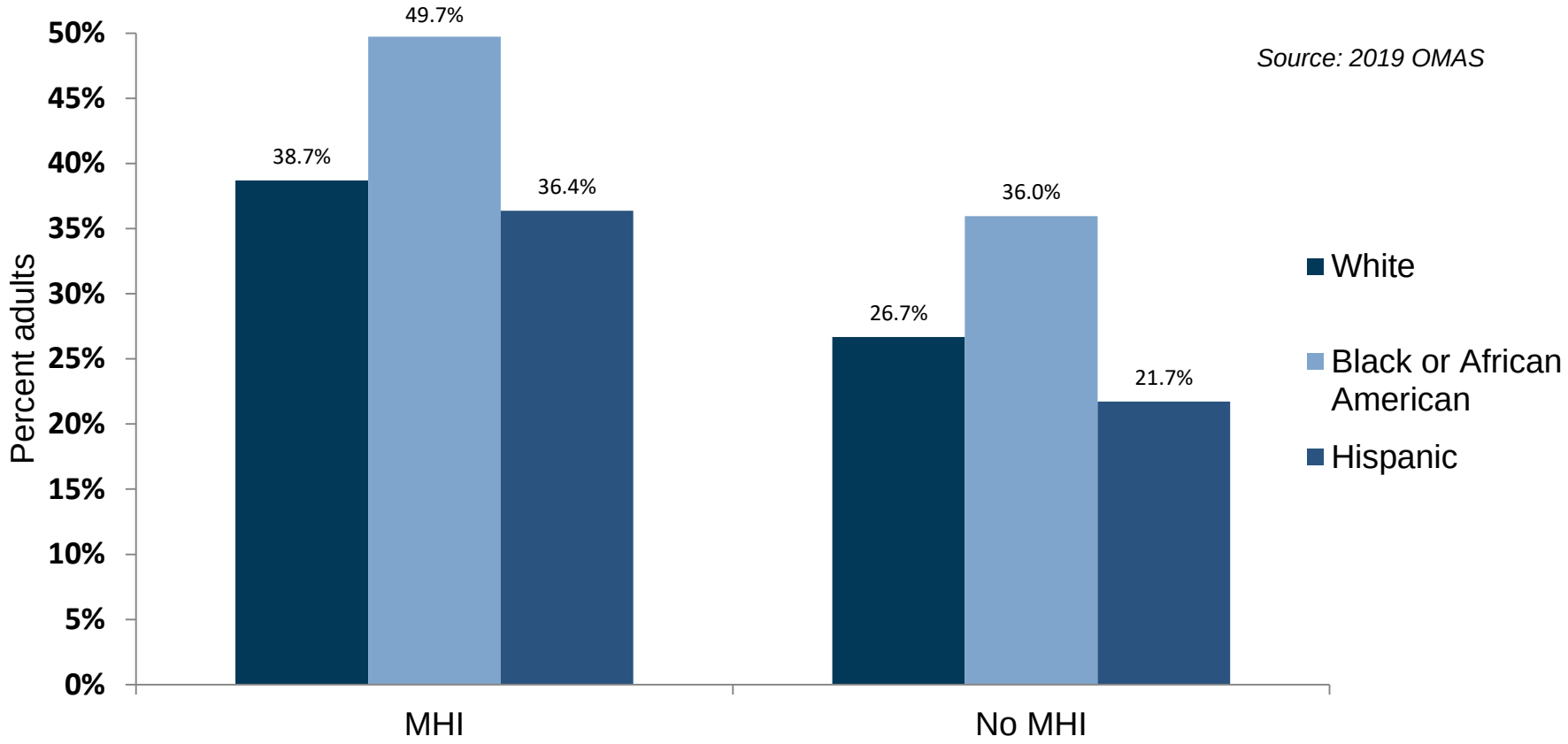
Adults with mental health impairment (MHI) were more likely that those without MHI to rate their health as fair or poor.

Figure 18. Prevalence of Comorbid Conditions Among Adults, by MHI Status



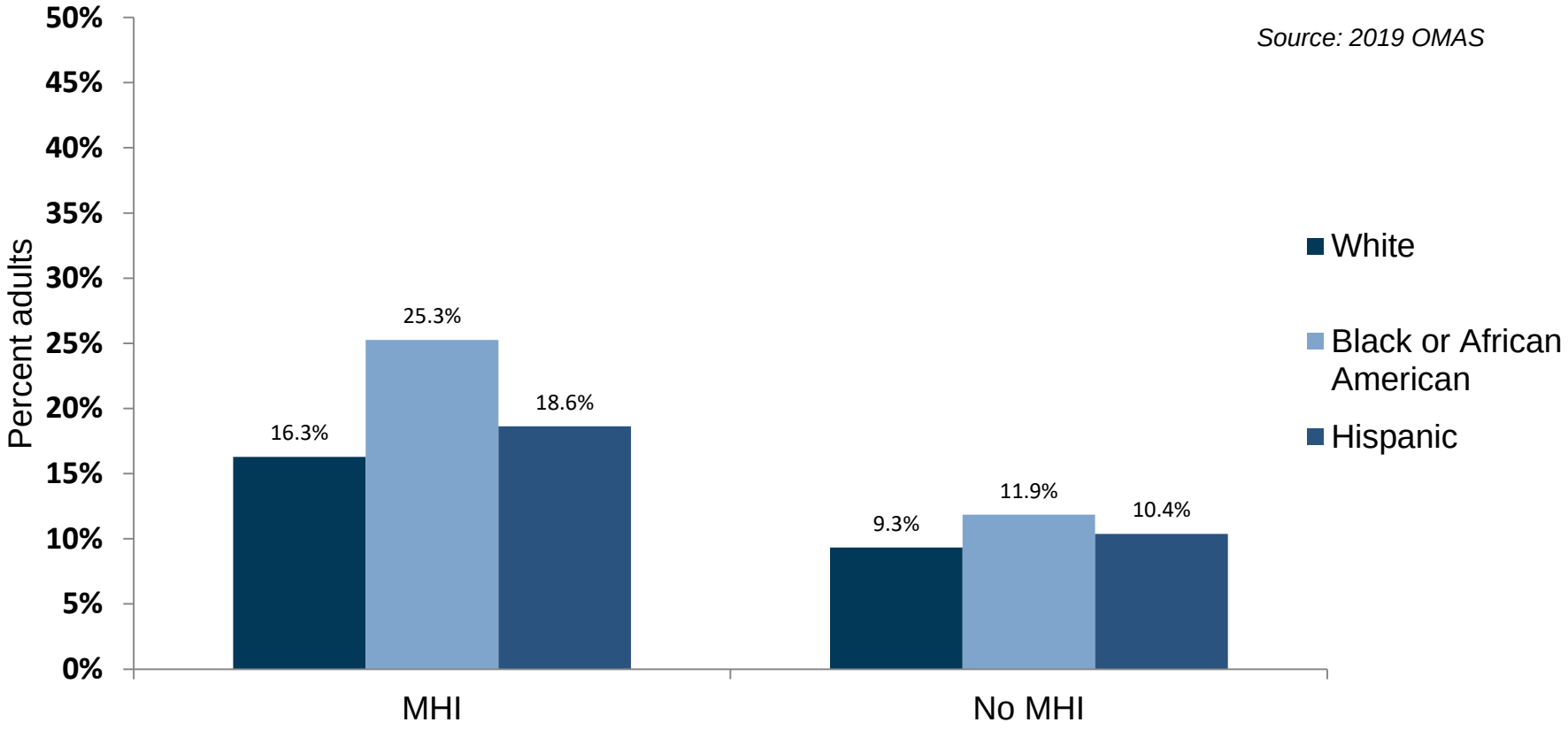
The prevalence of chronic health conditions, including hypertension (HTN), high blood pressure (BP), high cholesterol, diabetes, asthma, arthritis, gout, and lupus, was higher among individuals with mental health impairment (MHI).

Figure 19. Hypertension among Ohio Adults by MHI Status & Race/Ethnicity



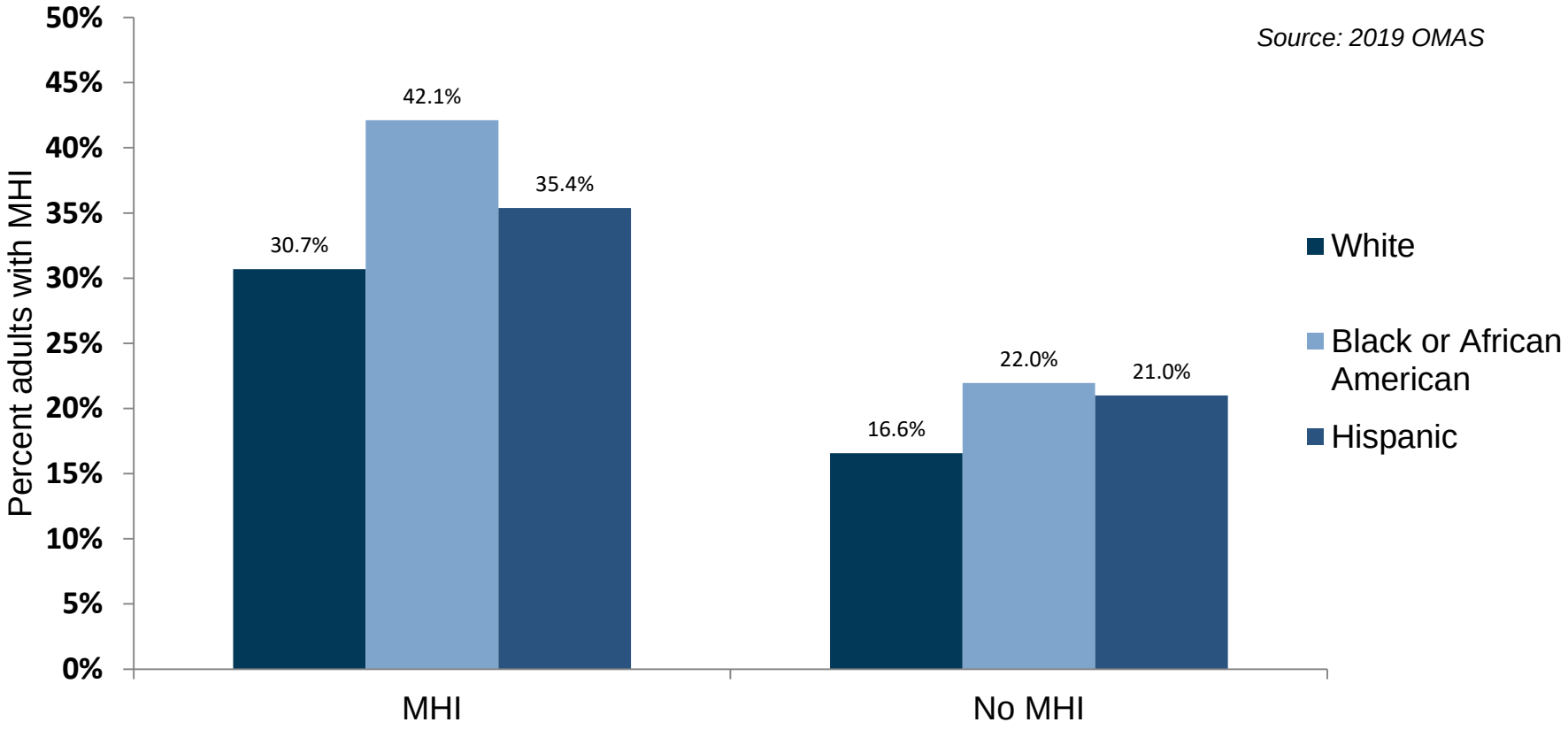
There were racial disparities in hypertension regardless of mental health impairment (MHI) status. Black and African American adults with MHI had the highest rate of hypertension (49.7%).

Figure 20. Diabetes among Ohio Adults by MHI Status & Race/Ethnicity



There were racial disparities in diabetes regardless of mental health impairment (MHI) status. However, disparities were greater among racial and ethnic groups with MHI. Black and African American adults with MHI had the highest rate of diabetes (25.3%).

Figure 21. Asthma among Ohio Adults by MHI Status & Race/Ethnicity



Disparities in the prevalence of asthma were observed between white and Black and African American adults. The disparity between Black and African American adults versus white and Hispanic adults was greater among those with MHI.

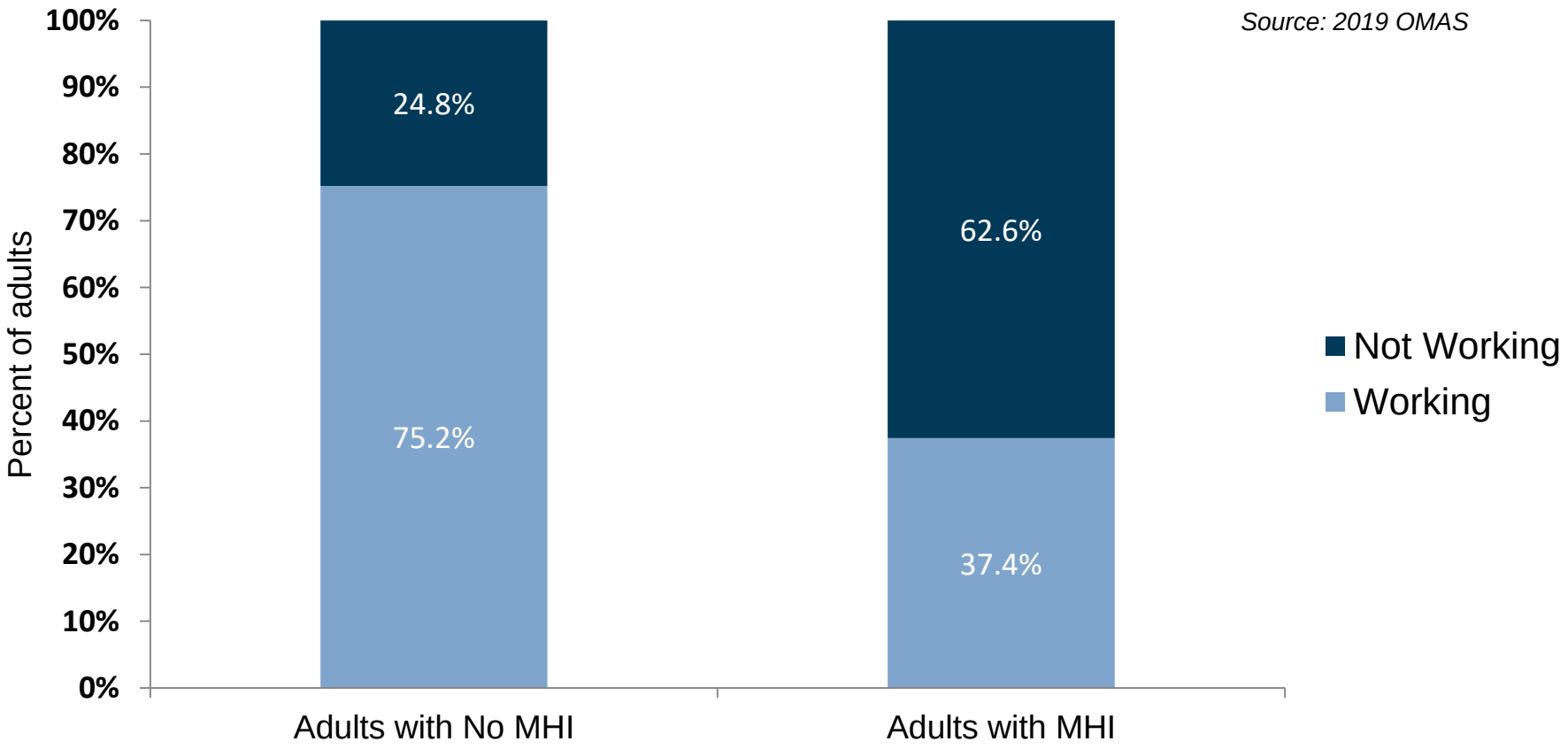
RESULTS: SOCIAL AND ECONOMIC STRESSORS AMONG OHIO ADULTS WITH MHI

The following section describes employment, income, housing, food security, and social isolation experienced by adults with mental health impairment (MHI).

Key Findings: Social & Economic Stressors among Ohio Adults with MHI

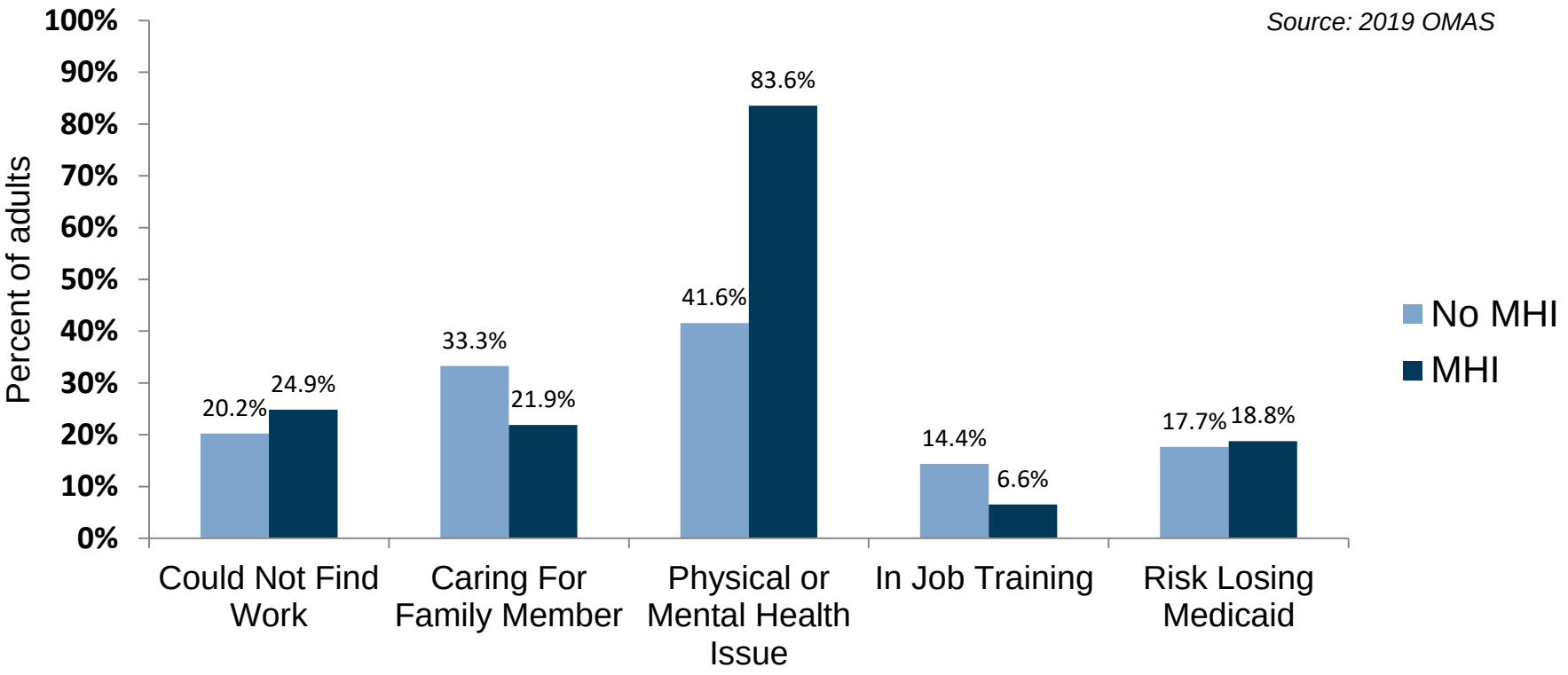
- Adults with mental health impairment (MHI) were twice as likely as those without MHI to be unemployed (62.6% vs 24.8%); most attribute unemployment to physical and/or mental health limitations.
- Adults with MHI reported more economic stressors than adults without MHI. They reported lower income, more housing and food insecurity, and more difficulty paying medical bills. Over half (56.1%) reported worrying that food will run out and nearly half (47.3%) reported experiencing food shortages.
- Adults with MHI were at least three times as likely to report social isolation as adults without MHI (64.4% vs 15.9%).

Figure 22. Employment among Ohio Adults: Full or Part-Time Job Last Week, by MHI Status



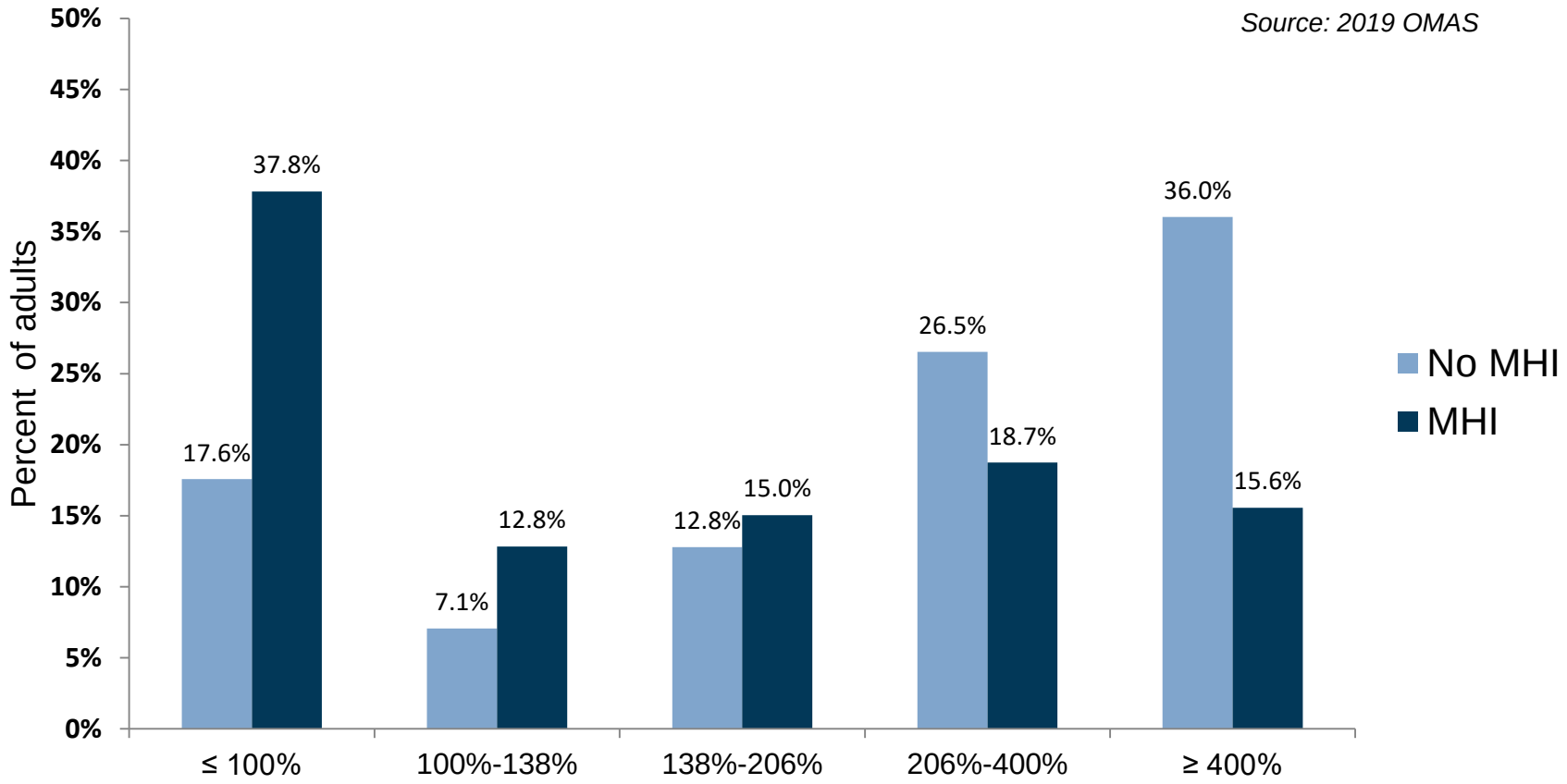
Adults with mental health impairment (MHI) were employed at half the rate of those without MHI.

Figure 23. Reasons for Lack of Employment Among Ohio Adults, by MHI Status



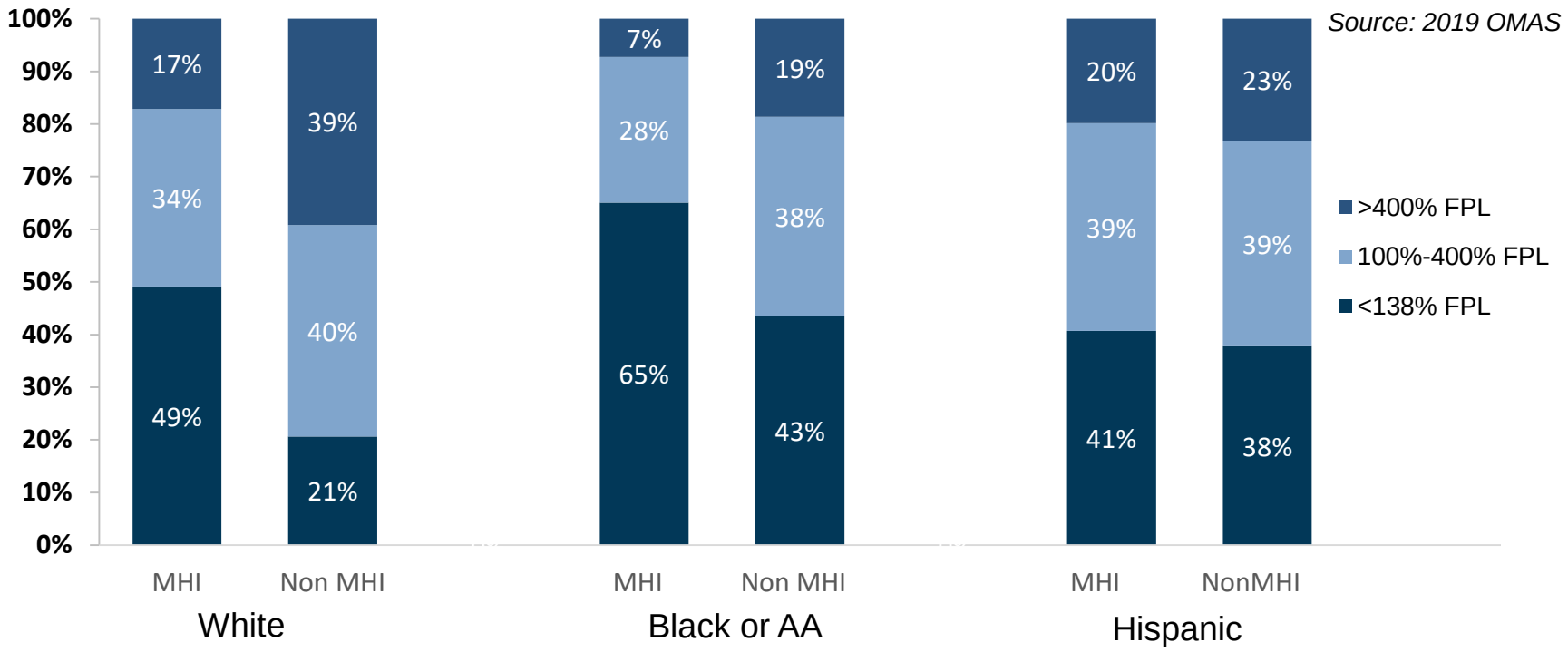
Among respondents who reported not working, the most common reason was physical or mental health. Respondents with mental health impairment (MHI) were twice as likely to identify physical or mental health barriers to employment and less likely to identify caring for family members as a barrier to employment.

Figure 24. Distribution of Income among Ohio Adults, by Percentage of Federal Poverty Level (FPL) and MHI Status



Respondents with mental health impairment (MHI) were more likely to experience poverty than respondents without MHI. *Note that the FPL for Medicaid eligibility is < 138% for adults and <206% for children*.

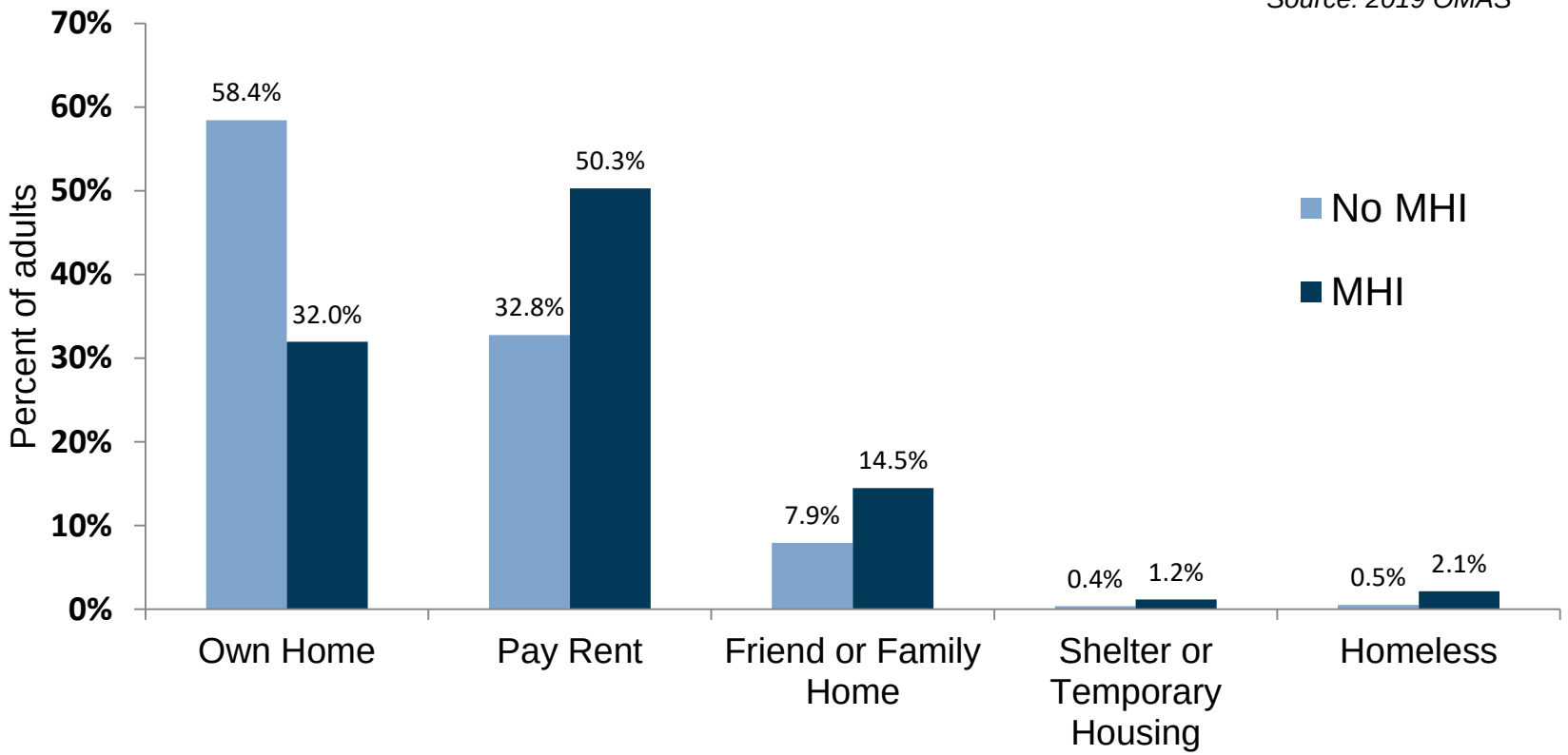
Figure 25. Distribution of Income among Ohio Adults by MHI Status & Race/Ethnicity



Black or African American adults with MHI experience higher levels of poverty than white and Hispanic adults and adults without MHI. There is an association between MHI and low income among White, Black and African American Adults, but not Hispanic adults.

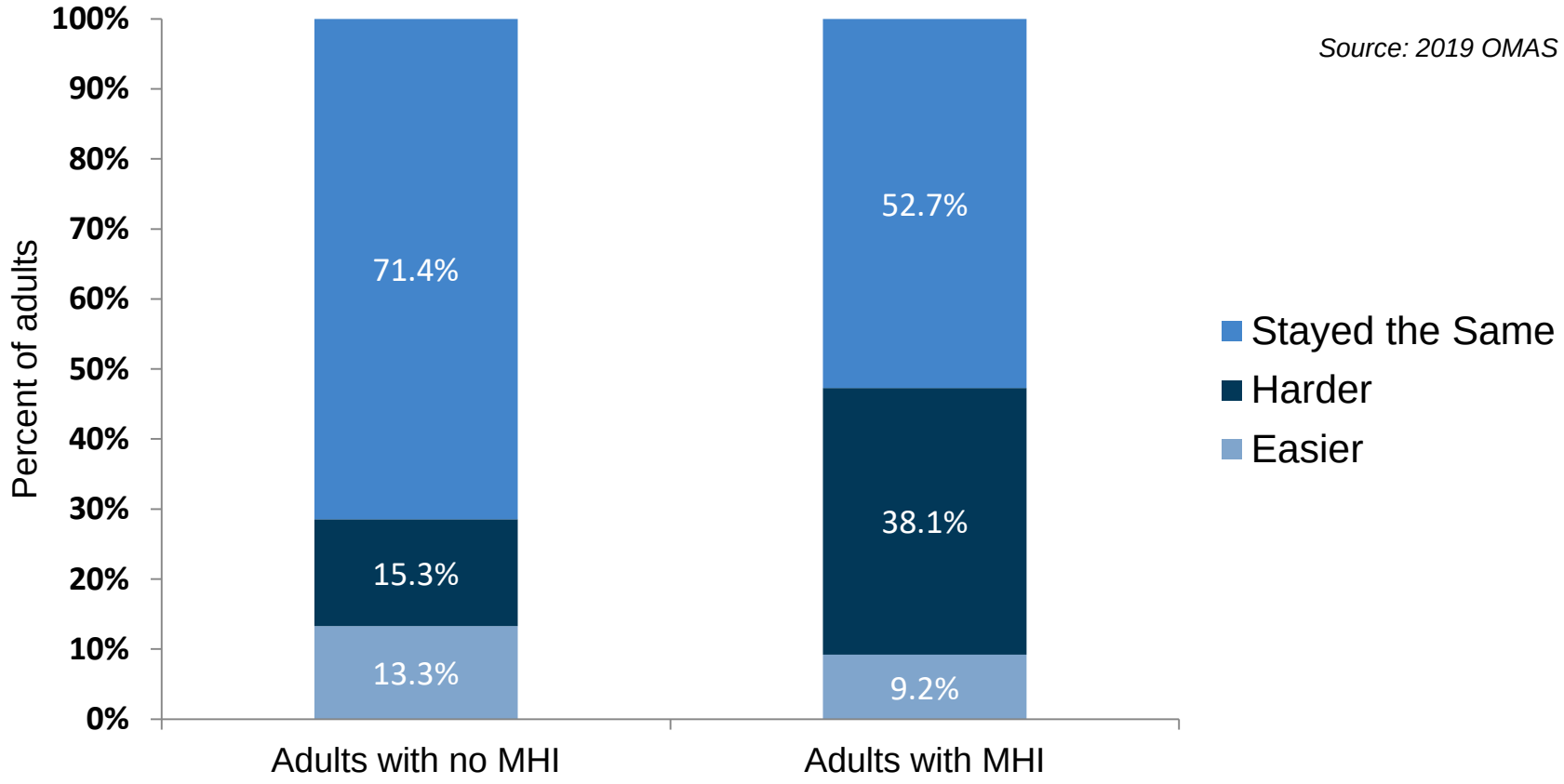
Figure 26. Current Housing Situation among Ohio Adults, by MHI Status

Source: 2019 OMAS



Respondents with mental health impairment (MHI) were less like to own a home or pay rent and more likely to stay with friend or family or to be homeless than respondents without MHI.

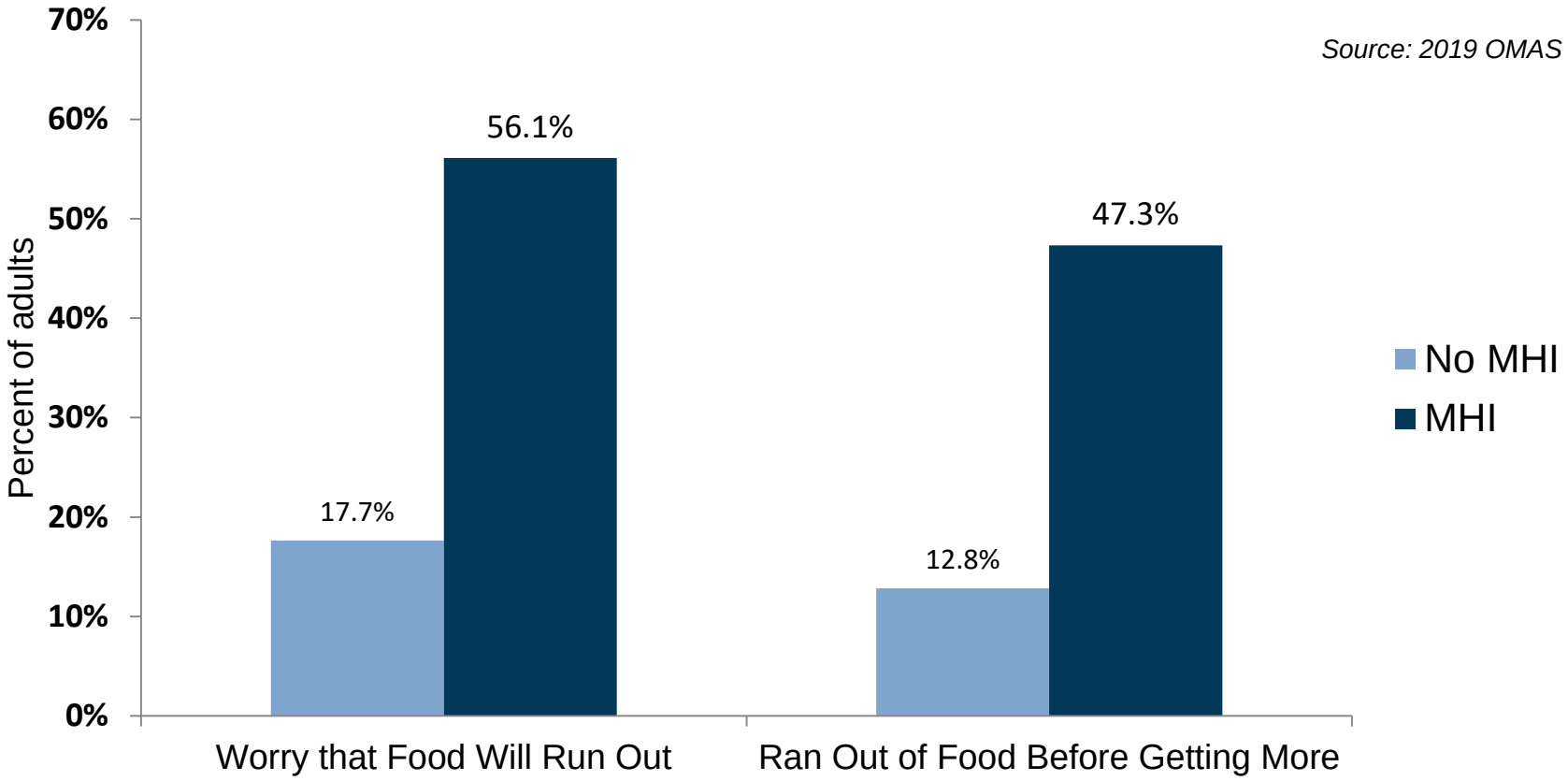
Figure 27. Financial Stress – Ease of Paying Rent in Past Year among Ohio Adults, by MHI Status



Source: 2019 OMAS

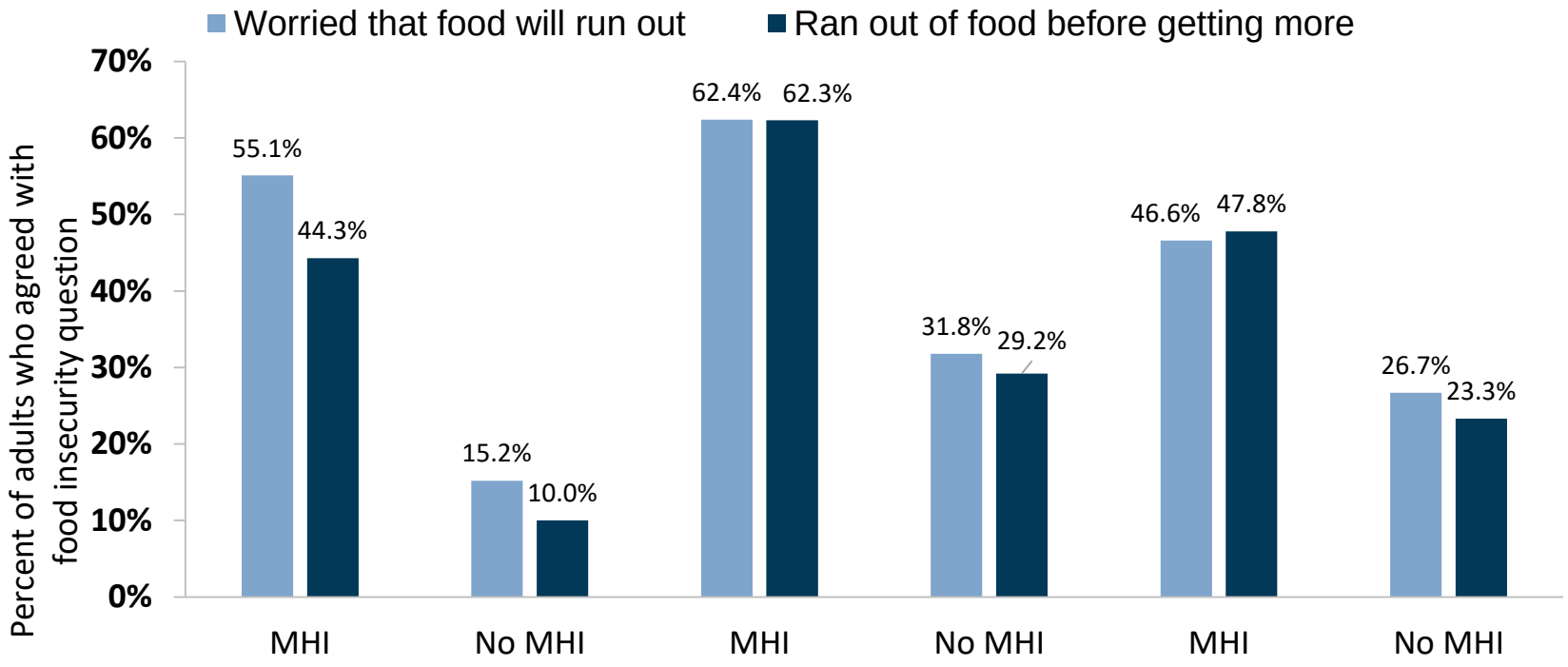
Respondents with mental health impairment (MHI) were more likely than respondents without MHI to report that that paying rent had become harder over the past 12 months.

Figure 28. Financial Stress among Ohio Adults – Food Insecurity, by MHI Status



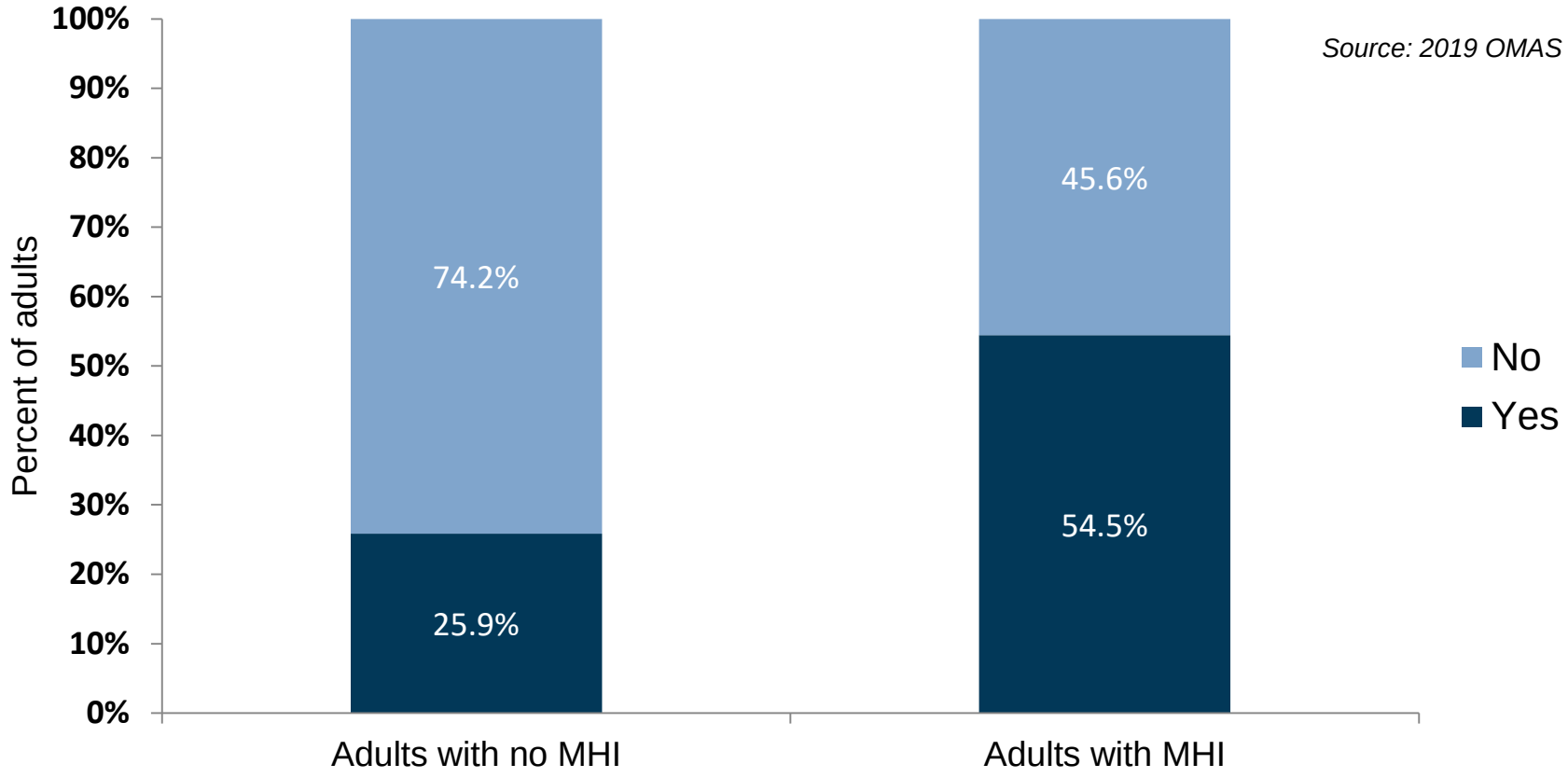
Respondents with mental health impairment (MHI) were more than twice as likely than respondents without MHI to report food insecurity.

Figure 29. Food Insecurity among Adults with MHI by Race/Ethnicity



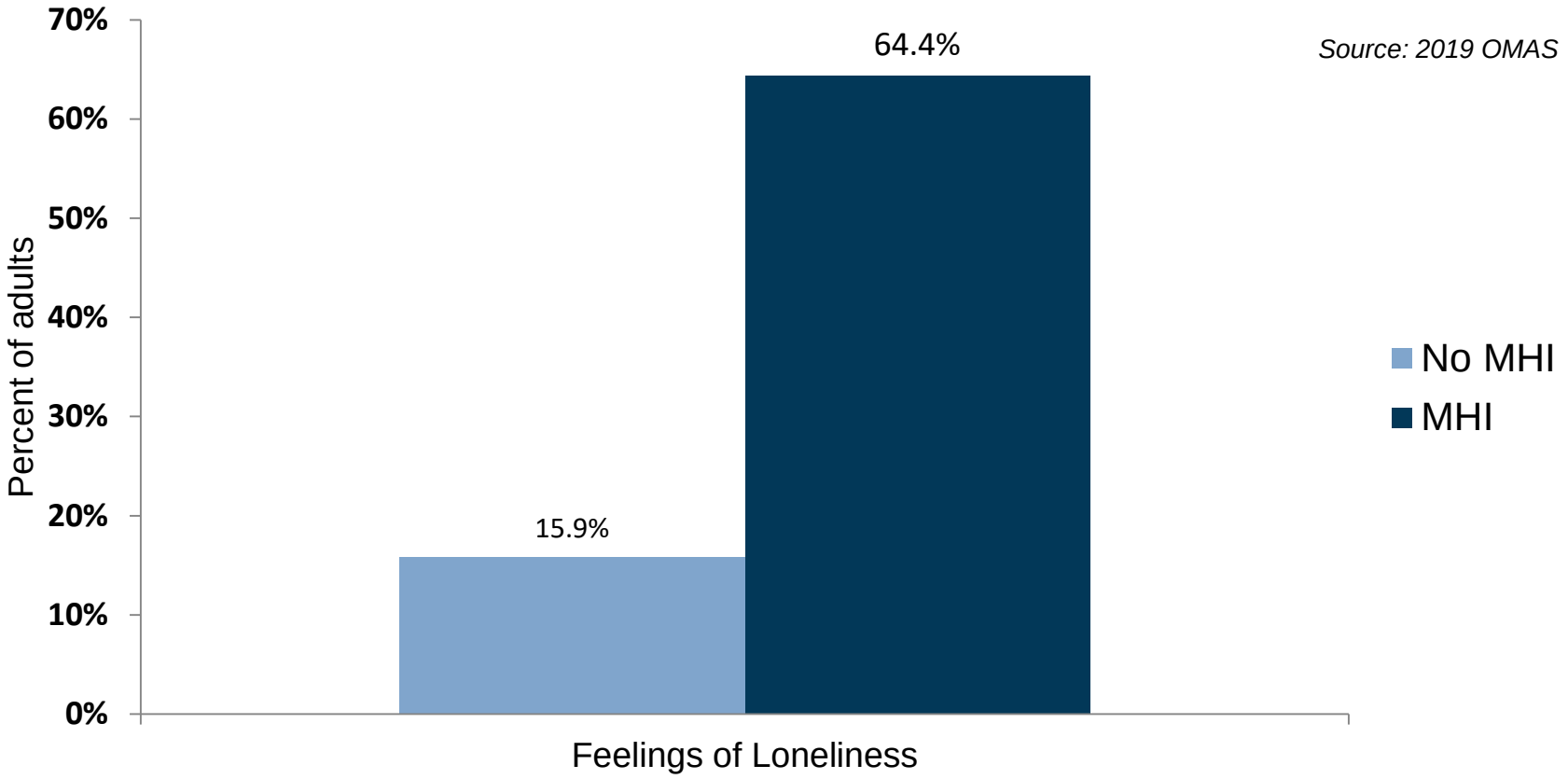
For different race/ethnic groups, adults with MHI were more likely than adults with no MHI to report they were worried that food would run out, or than they had ran out of food before getting more. The association of food insecurity with MHI was greatest among White adults. For example, compared to those with no MHI, White adults with MHI were more than 4 times as likely to have run out of food (10.0% vs. 44.3%).

Figure 30. Financial Stress among Ohio Adults: Difficulty Paying Medical Bills, by MHI Status

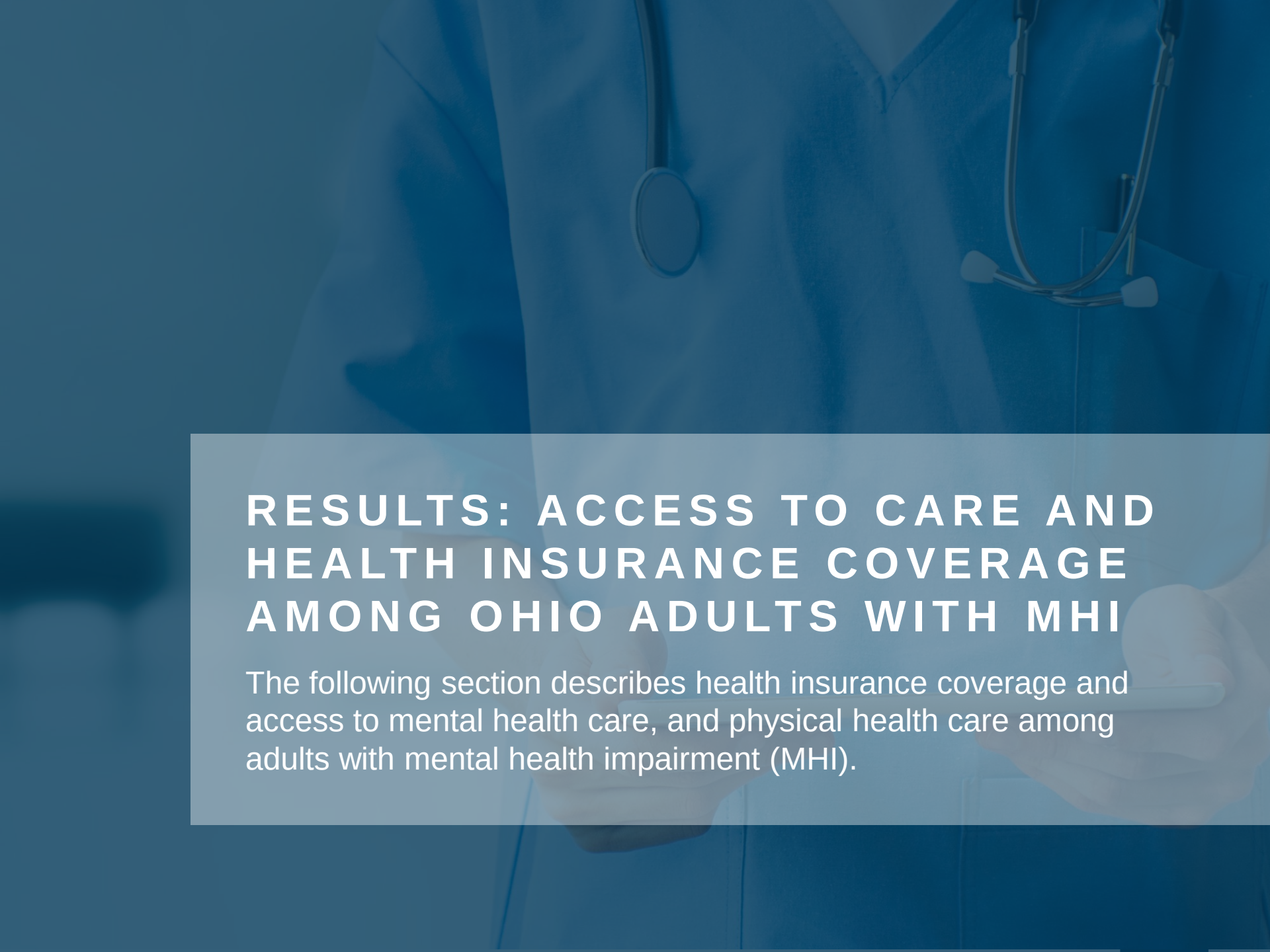


Respondents with mental health impairment (MHI) were twice as likely as respondents without MHI to report difficulty paying medical bills.

Figure 31. Loneliness by MHI Status



Respondents with mental health impairment (MHI) reported had higher rates of loneliness than respondents without MHI, including lack of companionship, feeling left out, and feeling isolated from others.



RESULTS: ACCESS TO CARE AND HEALTH INSURANCE COVERAGE AMONG OHIO ADULTS WITH MHI

The following section describes health insurance coverage and access to mental health care, and physical health care among adults with mental health impairment (MHI).

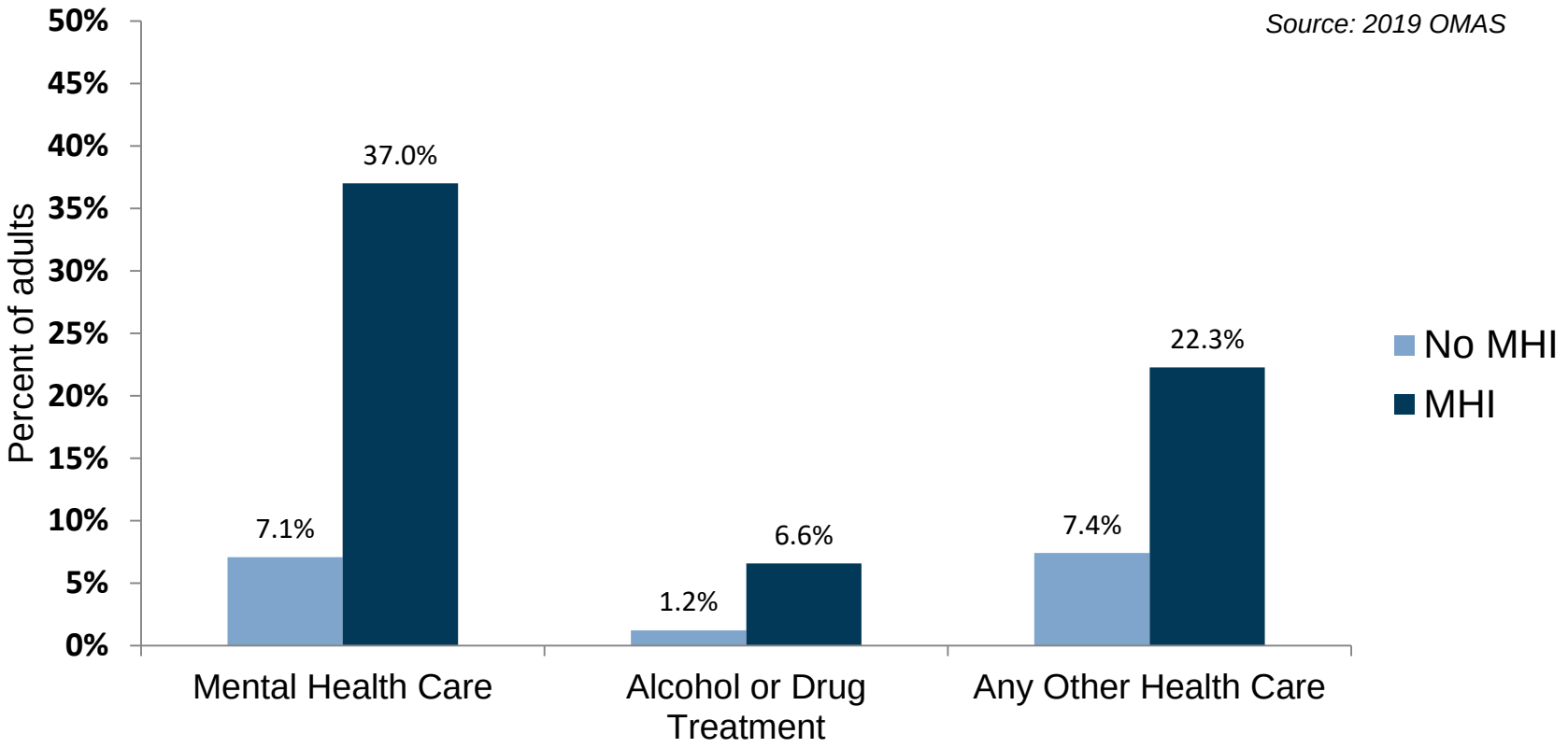
Key Findings: Access to Care & Health Insurance by MHI Status

- Adults with mental health impairment (MHI) more likely to report difficulty getting mental and physical health care than those without MHI (37% vs. 7.1% for mental health care; 22.3% vs. 7.4% for other health care).
    - They were also more likely to experience an increase in difficulty getting medical care over the past three years (35.6% vs. 19.7%).
- Nearly 15% of individuals with MHI were uninsured.
    - Among those with insurance, Medicaid was the most common source of insurance for adults with MHI (55.9%), while employer-sponsored insurance (ESI) was the most common insurance for adults without MHI (62%).

Key Findings: Access to Care & Health Insurance by MHI Status

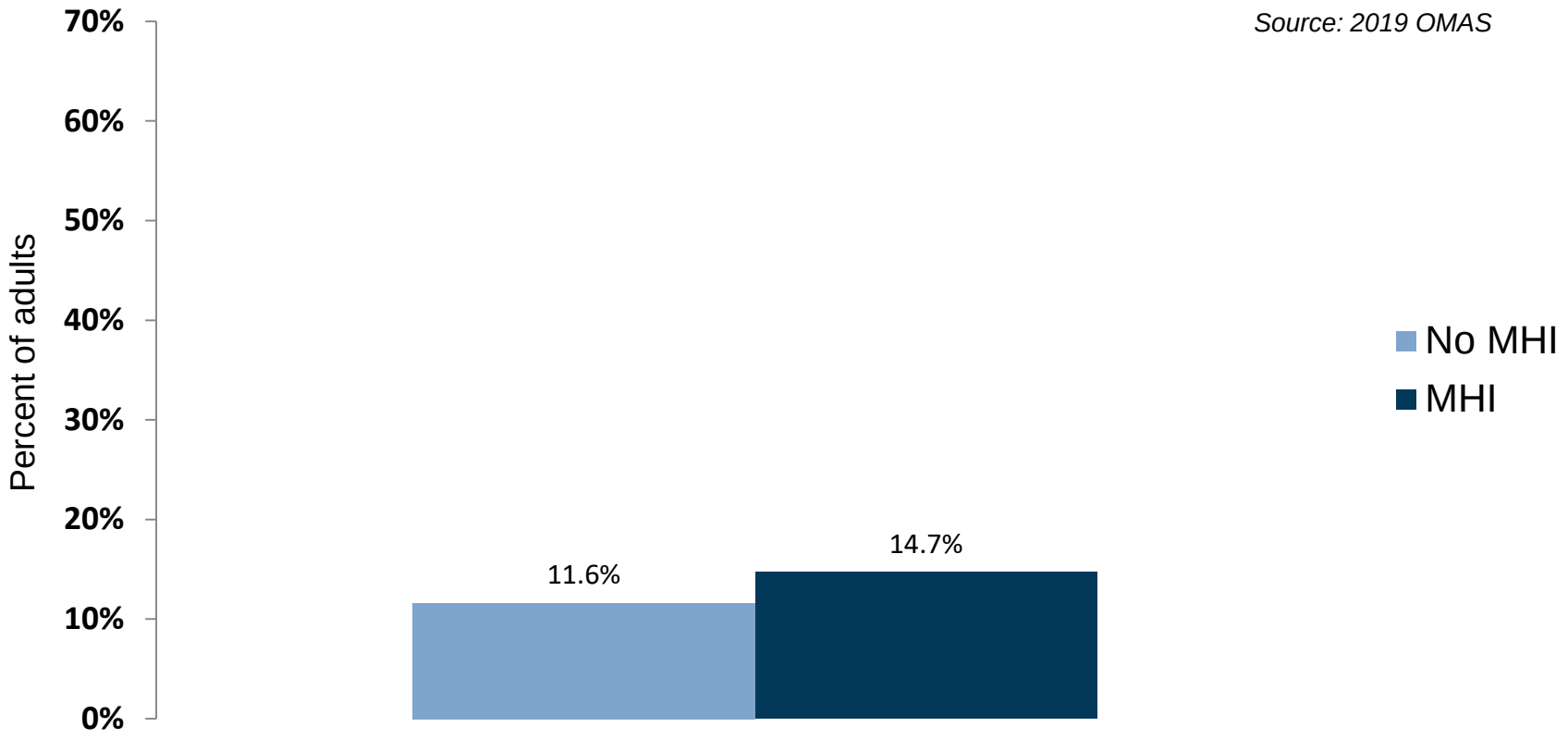
- Adults with MHI were more likely than those without MHI to report delaying or avoiding care (69.5% vs. 37.4%).
  - Common barriers to care included cost, transportation, difficulty finding providers, and lack of available providers.
- Among adults with MHI, those enrolled in Medicaid were more likely to report improved access to care in the past three years than those with other insurance
  - 25.4% for Medicaid enrollees vs. 12.2% and 10.3% for non-Medicaid and potentially Medicaid eligible adults.

Figure 32. Difficulty Getting Health Care During the Past Year among Ohio Adults, by Type of Care and MHI Status



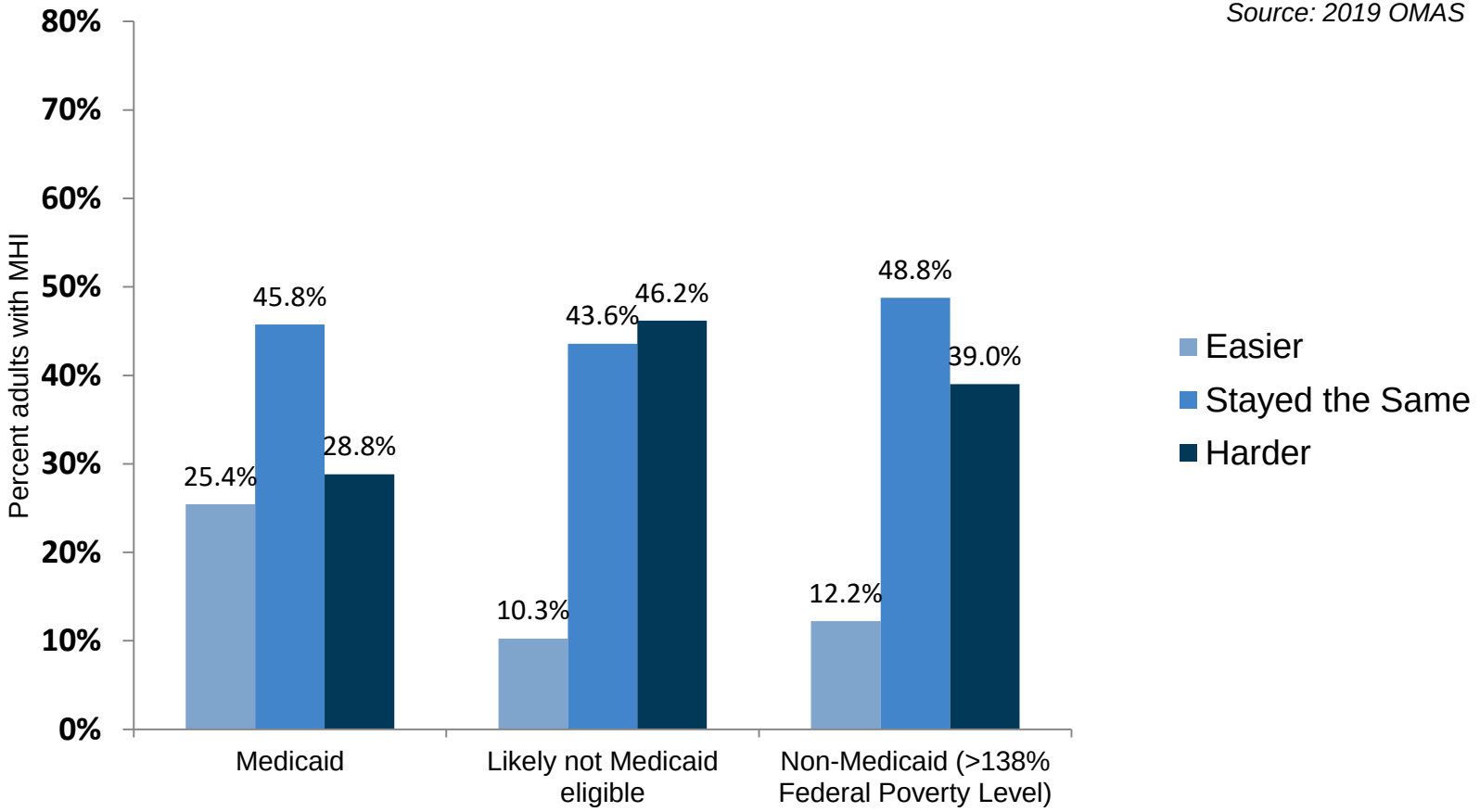
Individuals with mental health impairment (MHI) were more likely than those without MHI to report being unable to get needed mental health care, substance use treatment, and other health care at least once during the previous 12 months.

Figure 33. Proportion of Ohio Adults Without Health Insurance, by MHI Status



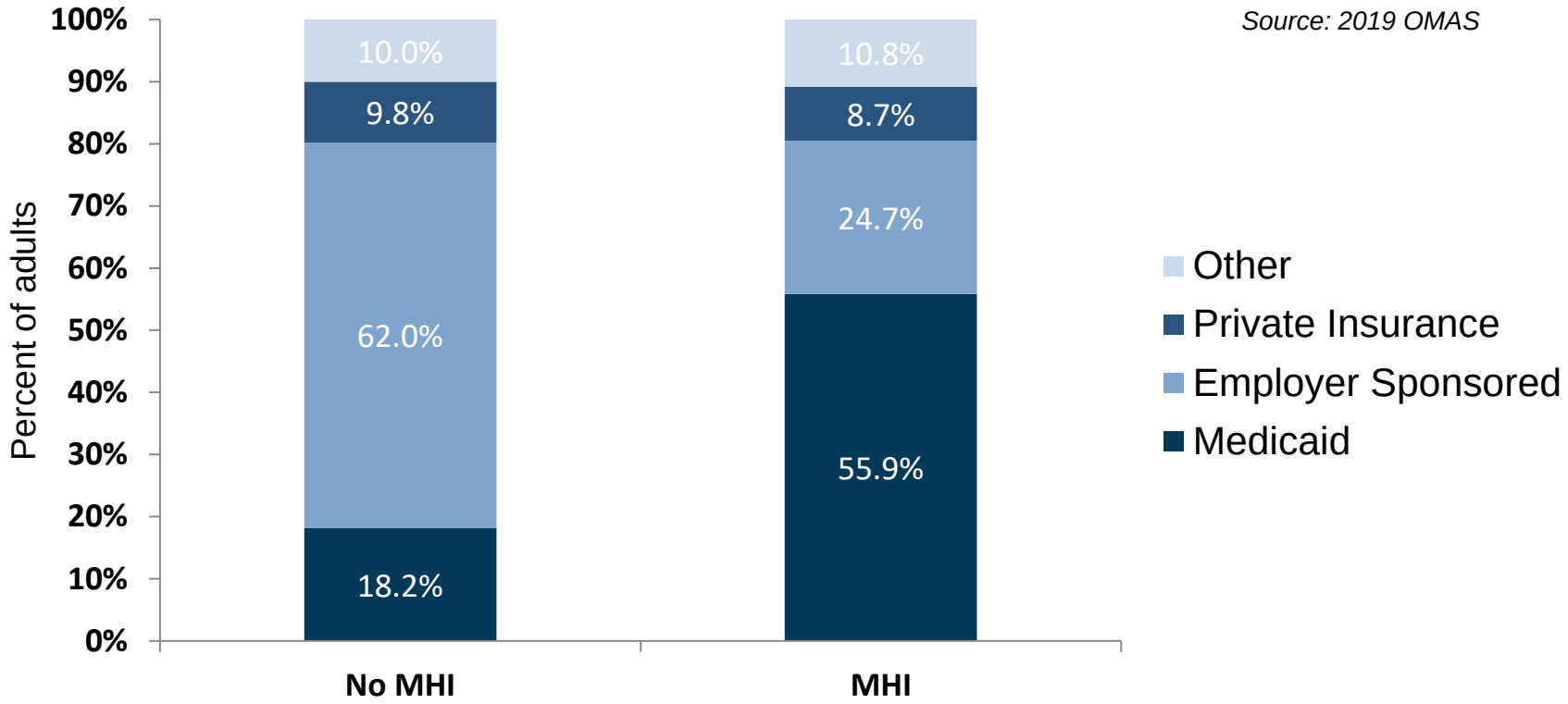
Nearly 15% of adults with mental health impairment (MHI) reported having no health insurance.

Figure 34. Access Medical Care Now Compared to 3 Years Ago among Adults with MHI by Medicaid Status



Respondents with MHI who were enrolled in Medicaid were more likely than those without Medicaid coverage to report that access to care had become easier over the previous 3 years.

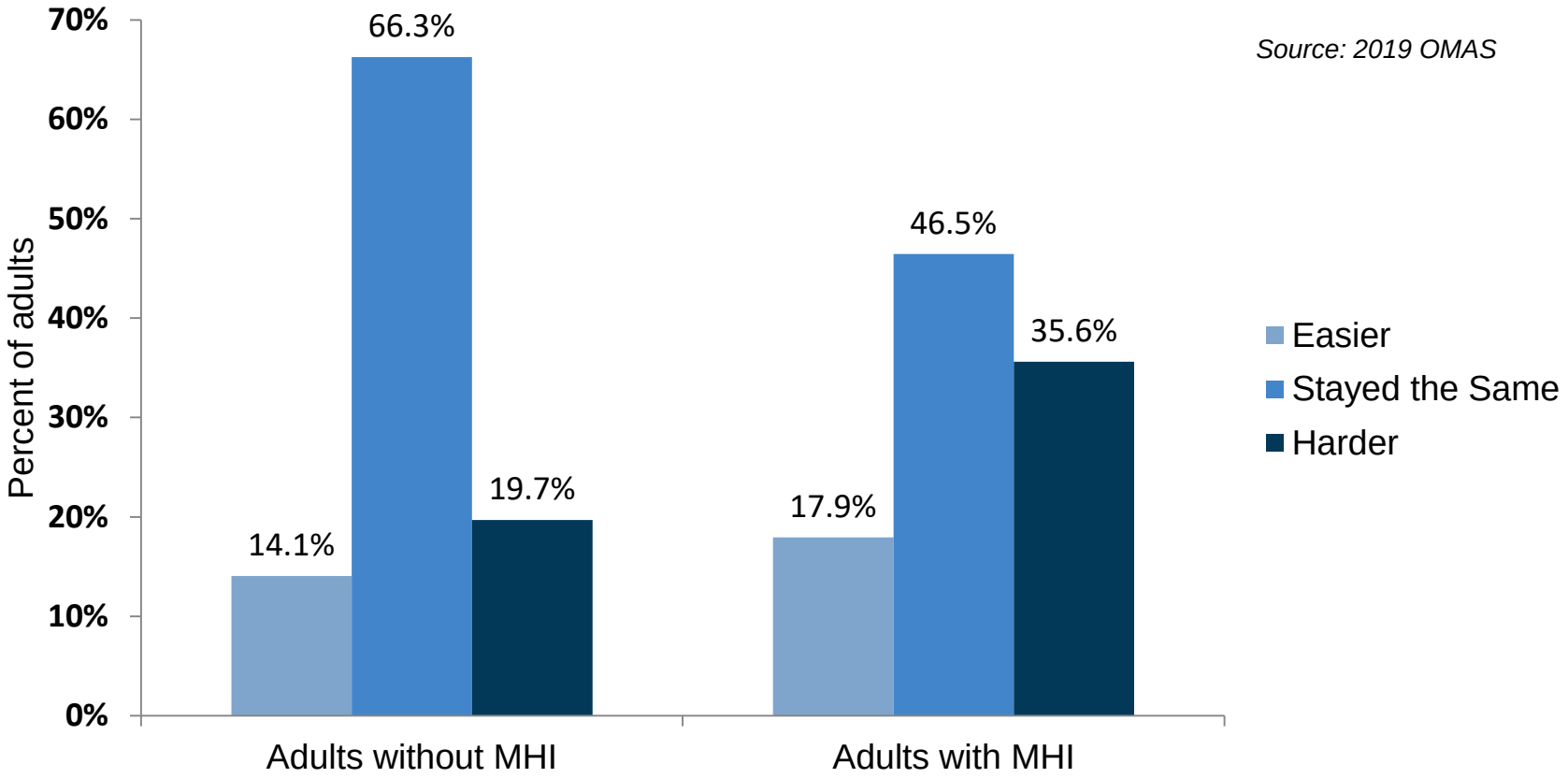
Figure 35. Type of Insurance among Ohio Adults, 19 to 64 Years of Age, by MHI Status



Source: 2019 OMAS

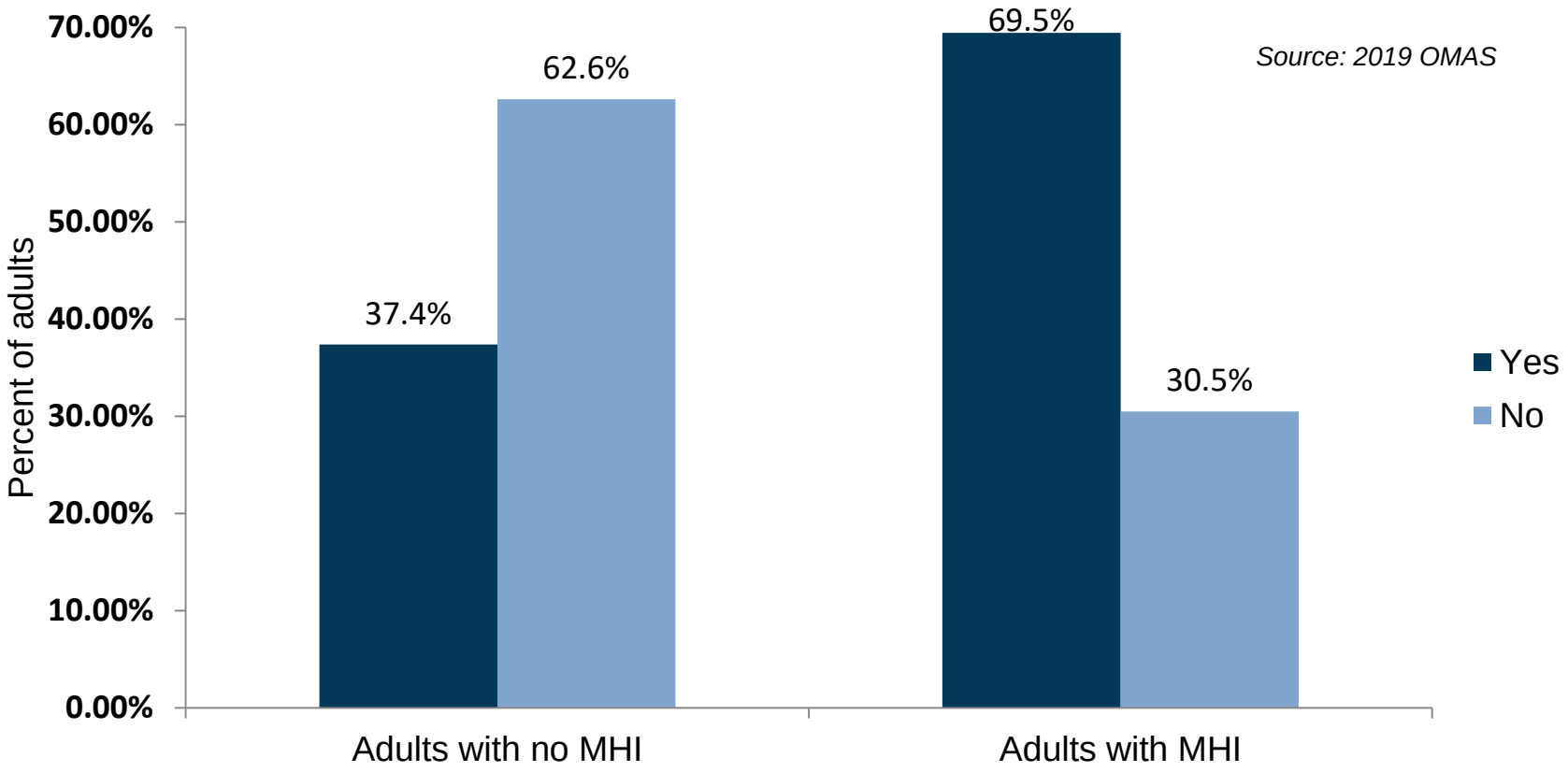
Among adults with health insurance (ages 19-64), Medicaid was the most common form of insurance for those with MHI, while employer sponsored insurance was the most common source of insurance for those without MHI.

Figure 36. Ohio Adults' Ability to Access Medical Care Now Compared to 3 Years Ago, by MHI Status



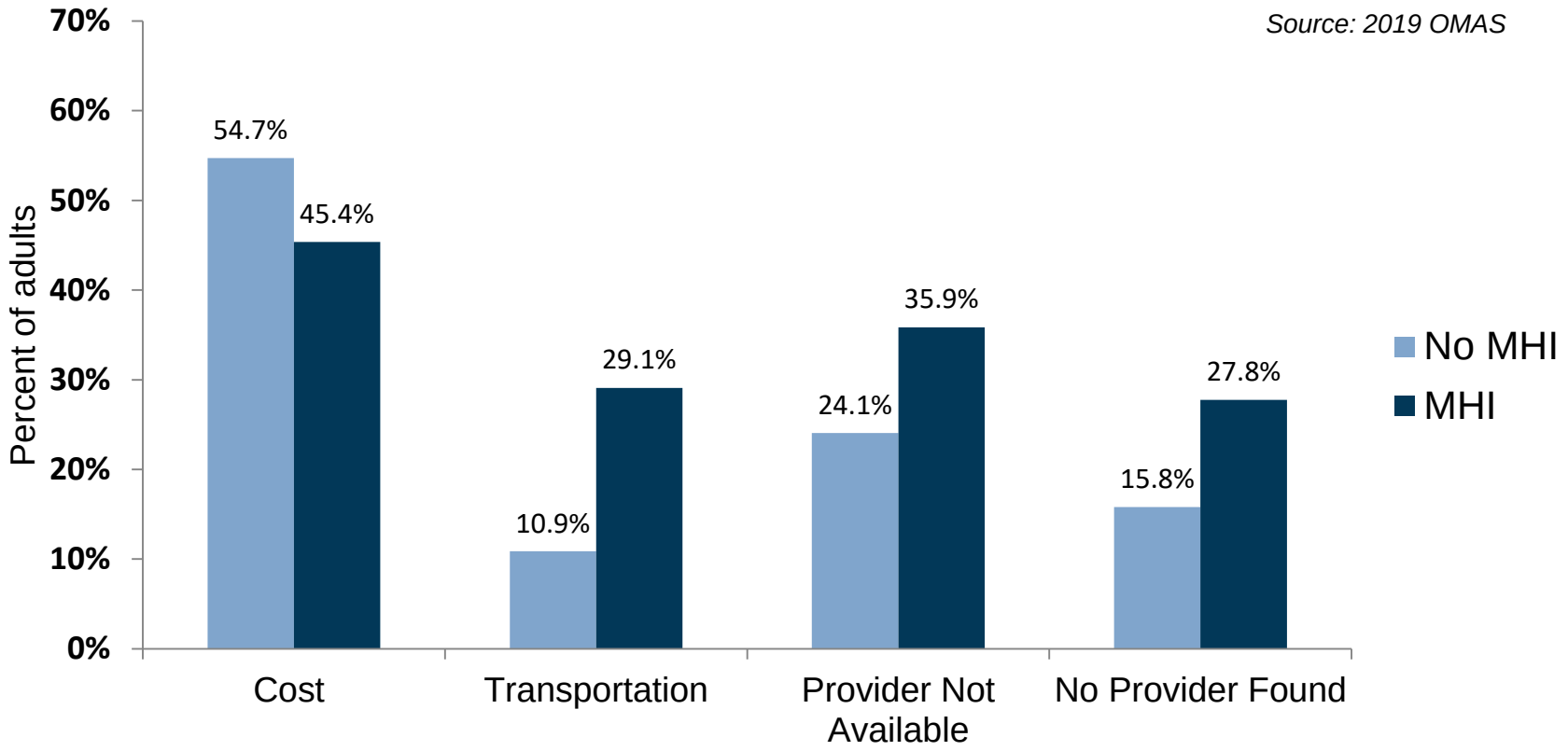
Ohio adults with mental health impairment (MHI) were more likely than those without MHI to report that getting medical care became harder over the past three years. Respondents without MHI were more likely to report no change in access.

Figure 37. Percent of Ohio Adults who Delayed or Avoided Care in Past Year, by MHI Status



Respondents with mental health impairment (MHI) were more likely than those without MHI to report that they delayed or avoided care at least once during the past 12 months.

Figure 38. Among Ohio Adults who Avoided Care, the Most Common Reasons for Avoiding Care, by MHI Status



Respondents with mental health impairment (MHI) were more likely than those without MHI to report that transportation barriers and difficulty finding available providers were common reasons for delaying or avoiding care. Some regional differences were observed, with "provider not available" more common in Metro, Rural Appalachian and Suburban counties than Rural non-Appalachian counties and "provider not found" more common in Rural Appalachian and Rural non-Appalachian counties.

SUMMARY OF RESULTS

Prevalence. 4.4% of children between 5 and 18 years of age experienced frequent mental distress (FMD) that impaired functioning in school and relationships for at least seven of the past 30 days. Among adults ages 18-64, the prevalence of mental health impairment (MHI) varied from 7.4% (2008) to 9.7% (2010) to 6.1% (2015) to 8.8% (2019). Prevalence was related to both age and sex, with higher rates observed in late childhood and early adulthood ages 19-24. Younger women between ages 18 and 24 had the highest rate of MHI (19.7%). From April through August 2020, between 11.1% and 18.2% of Ohio adults screened positive for depressive symptoms.

Factors Associated with FMD among Children. Youth with seven or more day of FMD had a higher prevalence of asthma and developmental disabilities and adverse childhood experiences (ACEs) compared to children with less than seven days of MHI.

Comorbid conditions. MHI was associated with fair/poor self-ratings of health and a higher prevalence of chronic disease including hypertension, high cholesterol, diabetes, asthma, and arthritis.

Social and economic stressors. Adults with MHI had twice the rate of unemployment and experienced more social and financial stress than adults without MHI. Over half of adults with MHI reported incomes at or below 138% of FPL, twice the rate reported by adults without MHI. MHI was also associated with difficulty paying for housing, less secure housing conditions (e.g., less permanent housing), and food insecurity. Finally, over a third of adults with MHI reported loneliness.

Racial disparities. While health and economic disparities exist in the general population, racial disparities among adults with MHI are sometimes greater than those without MHI. Black and African American individuals with MHI experienced higher rates of physical health comorbidity, poverty, and food insecurity than white and Hispanic adults with MHI.

Access to care. Adults with MHI had more difficulty getting mental and physical health care than adults without MHI. They were also more likely to experience increased difficulty getting medical care over the past three years. Common barriers to health care were transportation and finding available providers.

Health insurance coverage. Adults with MHI were less likely to have health insurance coverage and had more difficulty getting mental and physical health care. Among those who had coverage, Medicaid was their primary source of insurance.

POLICY CONSIDERATIONS

Fluctuations in the prevalence of mental health impairment (MHI) in Ohio have coincided with historic events that reshaped Ohio's mental health system. The prevalence of MHI peaked following the "Great Recession" and dropped following the Affordable Care Act and Ohio's Medicaid expansion. The prevalence of MHI in 2019 was 31% greater than the prevalence observed immediately following Ohio's Medicaid expansion. The OMAS-19 points to a variety of important policy pathways to reduce the prevalence and burden of MHI in Ohio.

Comorbid conditions. Ohioans with MHI reported more chronic medical conditions and more difficulty in accessing care over the past three years. Efforts to improve care for chronic conditions have focused on integration of mental and physical health care through system redesign and other payment reform efforts. Additional strategies to manage medical needs may focus on the health care workforce, consumer health literacy, and socioeconomic factors such as housing and food. In particular, improvement efforts could focus on addressing racial disparities in comorbid physical health conditions that affect quality of life impede recovery from mental illness.

Ancillary supports, such as supported housing, employment, and social support. MHI is often associated with a loss of housing and food security, social connectedness, and employment. These factors are barriers to recovery from mental illness and can prevent people from regaining their capacity to function independently. These needs may be addressed through ancillary support service and community collaborative models that integrate services across local systems of care. Health systems can address social supports as a health management strategy. Programs such as Meals-on-Wheels support both food security and social connectedness.

Medicaid. Medicaid is the primary source of insurance for Ohioans with MHI. Thus, it plays a critical role in shaping Ohio's mental health system, preventing MHI, and reducing the negative impact of MHI. Results of the 2019 OMAS demonstrated that Medicaid improves access to care more than any other sources of insurance coverage. While Medicaid policies have been implemented to address many of the gaps identified in this chart book, a disproportionate number of Ohioans with MHI are uninsured even though they are eligible for Medicaid coverage. The human and economic burden of MHI in Ohio may be reduced by facilitating enrollment in Medicaid for individuals with MHI who are eligible.

Access to care. The findings revealed gaps in access and insurance coverage for mental health care among Ohioans with MHI. Efforts to improve access may include training the workforce to implement evidence-based practices, adding new types of providers such as peers, and collaborating with insurance plans to ensure sufficient service capacity in all regions of the state.

Addressing the needs of adolescents and young adults. The findings were consistent with prior research indicating that mental and emotional distress increases in adolescence and early adulthood. The prevalence of MHI was greatest among young adult women between 19 and 24 years of age within the Medicaid program; these are women of reproductive age.

Continued on next page →

POLICY CONSIDERATIONS

Addressing the needs of adolescents and young adults *(cont.)*

Another worrisome trend among adolescents and young adults is a lack of access to care and avoidance of treatment, which increase the risk of negative outcomes. Access to treatment can improve by integrating mental health care in educational and medical settings for young adults. Avoidance of treatment may be reduced by expanding access to practitioners who specialize in the treatment of youth, culturally appropriate services, and increasing mental health literacy among youth and families.

The impact of trauma on children is well established. The findings demonstrate a strong association between MHI and adverse childhood experiences. Communities and states may implement strategies put forth by the CDC, SAMHSA, and other mental health authorities to prevent and reduce the harm of adverse childhood experiences to strengthen economic supports for families, promote social norms that protect against violence and adversity, and build resilience for managing challenges.[25]

Response to COVID-19. The economic and health impact of the current COVID-19 health care crisis is likely to produce another increase in the prevalence of mental health impairment (MHI) among Ohioans and may require additional behavioral health services and supports. Recent evidence points to an increase in the prevalence of psychological distress linked to COVID-19, consistent with trends observed after other large-scale disasters, including epidemics.[26] Preliminary findings from the Ohio COVID-19 Survey suggest that many Ohioans experienced psychological symptoms of depression after the start of the pandemic in March 2020.

Additional attention is required to address the needs of Ohioans with MHI because they have fewer resources to deal with the economic and social stress associated with this health care crisis. Black or African American Ohioans with MHI may be particularly vulnerable to the psychological impact because they have more medical and economic stressors. There also is evidence that adolescents and young adults are especially hard hit because the crisis is likely to affect education and career development.[27] In preparation for the expected consequences of COVID-19, experts recommend developing approaches to strengthening our mental health system and improve access to safety net services. Results of Ohio COVID-19 Survey are likely to prompt additional guidance to minimize the mental health impact of COVID-19.

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