

October 2021

Missed Opportunities: Up to 9 in 10 Women Eligible for Public Health Services in California Have Unmet Mental Health Need

Safa Salem, D. Imelda Padilla-Frausto, Hin Wing Tse, Firooz Kabir, Nicolás E. Barceló, and Blanche Wright

“Medi-Cal managed care programs have a chance to intervene early and prevent mental health problems from becoming more severe and disabling.”

SUMMARY: A public health approach that focuses on prevention and early intervention can inform policies, programs, and services that address socioeconomic inequities and issues of access and unmet need for mental health care services. Prior analyses on psychological distress in California have shown that women are more likely than men to experience serious psychological distress (SPD). This policy brief presents pooled 2018 and 2019 California Health Interview Survey data on the unmet need among women who are eligible for public health services by level of psychological distress and by social status indicators (race, ethnicity, citizenship status, language, age, and family type) and economic status indicators (education and employment). Nearly 9 in 10 women with mild psychological

distress who are eligible for public health services had unmet need, as did 7 in 10 similar women with moderate psychological distress and 5 in 10 women with serious psychological distress. This study underscores the need to increase use of and improve access to mental health services, especially among women of color and women with mild and moderate psychological distress whose symptoms could become progressively more severe and disabling. Policy recommendations that can improve the mental well-being of women in California include increasing equity in mental health service use, promoting mental health literacy and outreach, increasing mental health screening and awareness, and reducing socioeconomic inequities among women.

For the past two decades, the World Health Organization (WHO) has advocated a public health approach to mental health that includes three tiers of prevention.^{1,2} Primary prevention aims to limit the incidence of disease and disability in the population. Secondary prevention aims to prevent the progression of disease and disability. Tertiary prevention aims to reduce the consequences of established disease and disability. While tertiary prevention is provided by county mental health plans to help individuals who are most in need

of specialty mental health services, Medi-Cal managed care programs have a chance to intervene early and prevent mental health problems from becoming severe and disabling, thus preventing more intensive and costly care. In previous analyses, individuals reporting serious psychological distress were more likely to report severe impairment at work and in daily life than individuals reporting moderate psychological distress, who were more likely to report moderate impairment.^{3,4}

“Women eligible for public health services have higher rates of mental health distress compared with those who have private insurance.”

DEFINITIONS

Eligible for Public Health Services

People who in the past year lacked insurance or were covered by public insurance programs such as Medi-Cal.

Serious Psychological Distress (SPD)

Serious, diagnosable mental health challenges that warrant mental health treatment and tertiary mental health prevention within a population.⁵

Moderate Psychological Distress (MPD)

Moderate mental distress that is clinically relevant and warrants mental health intervention and secondary mental health prevention within a population.⁶

Mild Psychological Distress (MdpD)

Mild psychological distress that may be clinically relevant and may warrant primary mental health prevention within a population.⁴

Need for mental health services

Defines serious, moderate, or mild psychological distress in a person who may benefit from mental health treatment or intervention.⁷

Unmet need for mental health services

An identified need for mental health services in a person who has not seen a professional in the medical or mental health sectors in the past year for their mental health problems.⁸

Using data from the 2018 and 2019 California Health Interview Surveys (CHIS), this study examines unmet need for mental health services among women ages 18 and over who are eligible for public health services and who report serious, moderate, or mild psychological distress. A previous study found that women and men were equally likely to have mild or moderate psychological distress; however, women were more likely than men to have serious psychological distress.³ These findings suggest a missed opportunity to prevent symptoms of distress among women with

mild or moderate psychological distress from progressing to serious psychological distress.

WHO's framework of social determinants of health inequities (SDHI) shows how the social and political context produces a set of social and economic conditions that disproportionately impact the health and well-being of certain populations, depending on where they happen to be in the structural hierarchy. For this paper, the effects of the sociopolitical context can be seen in social status indicators such as race, ethnicity, citizenship status, language, age, and family type, and in the resulting economic status indicators, such as education and employment. These indicators, combined, are considered the structural determinants of mental health inequities.

Qualification for public health coverage shows socioeconomic inequities among women in California

More than one-third (34%) of women ages 18 and over are eligible for public health services, based on lack of insurance and low income. However, some groups of women are disproportionately eligible.

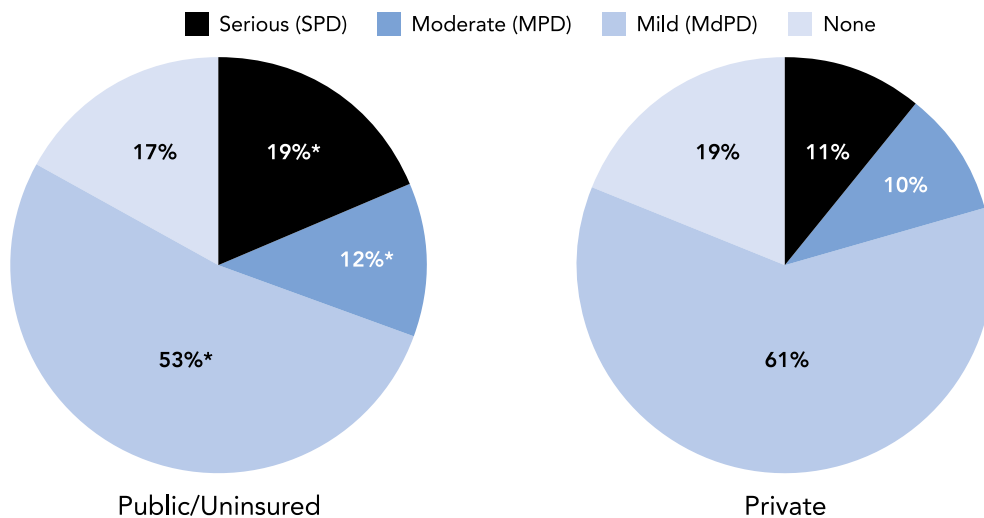
Race and ethnicity. Women of color are from two to nearly four times more likely to be eligible for public health services than their non-Latino white counterparts. Specifically, 66% of American Indian or Alaska Native women, 52% of Latina women, 39% of African American women, and 33% of Asian women are eligible, compared to 18% of women who identify as non-Latino white.

U.S. citizenship status. Compared to women who are U.S.-born citizens (28%), women who are noncitizens without a green card are nearly three times as likely to be eligible for public health services (78%), and women who are noncitizens with a green card are nearly twice as likely (54%).

Language. Women who speak only Spanish are more than three times as likely as English-only speakers to be eligible for public health services (72% vs. 22%). Women who speak

Psychological Distress Among Women Ages 18 and Over, by Insurance Type, California, 2018–2019

Exhibit 1



Source: Pooled 2018 and 2019 California Health Interview Surveys

* Differences in estimates between women covered by private insurance (including Medicare coverage) and women who are

covered by public insurance or who are uninsured by each psychological distress level are statistically significant at a minimum of $p < .05$.

only an Asian language (52%) and those who are bilingual in English and Spanish (50%) are more than twice as likely as English-only speakers to be eligible.

Family type and age. Single women with children are nearly six times more likely to be eligible for public health services than their married counterparts without children (63% vs. 18%, respectively). Most women ages 65 and over should be covered by Medicare; however, nearly one-quarter (23%) of these women are eligible for public health services. Compared to the oldest age group, the youngest women—those ages 18–25—are more than twice as likely to be eligible (52%).

Education and employment status. Women with less than a high school education are more than four times as likely as women with a graduate degree (68% vs. 15%) to be eligible for public health services. Women who are unemployed and looking for work are nearly three times as likely as women who have full-time employment (65% vs. 24%) to rely on public health services.

Women eligible for public health services have higher rates of mental health distress compared with those who have private insurance

Women who are eligible for public health services are more than 1.5 times more likely to report serious psychological distress (19%) than women who have private insurance coverage (11%) (Exhibit 1). They are also more likely to report moderate psychological distress than their privately insured counterparts. These data show a higher burden of mental health need among women who are eligible for public health services.

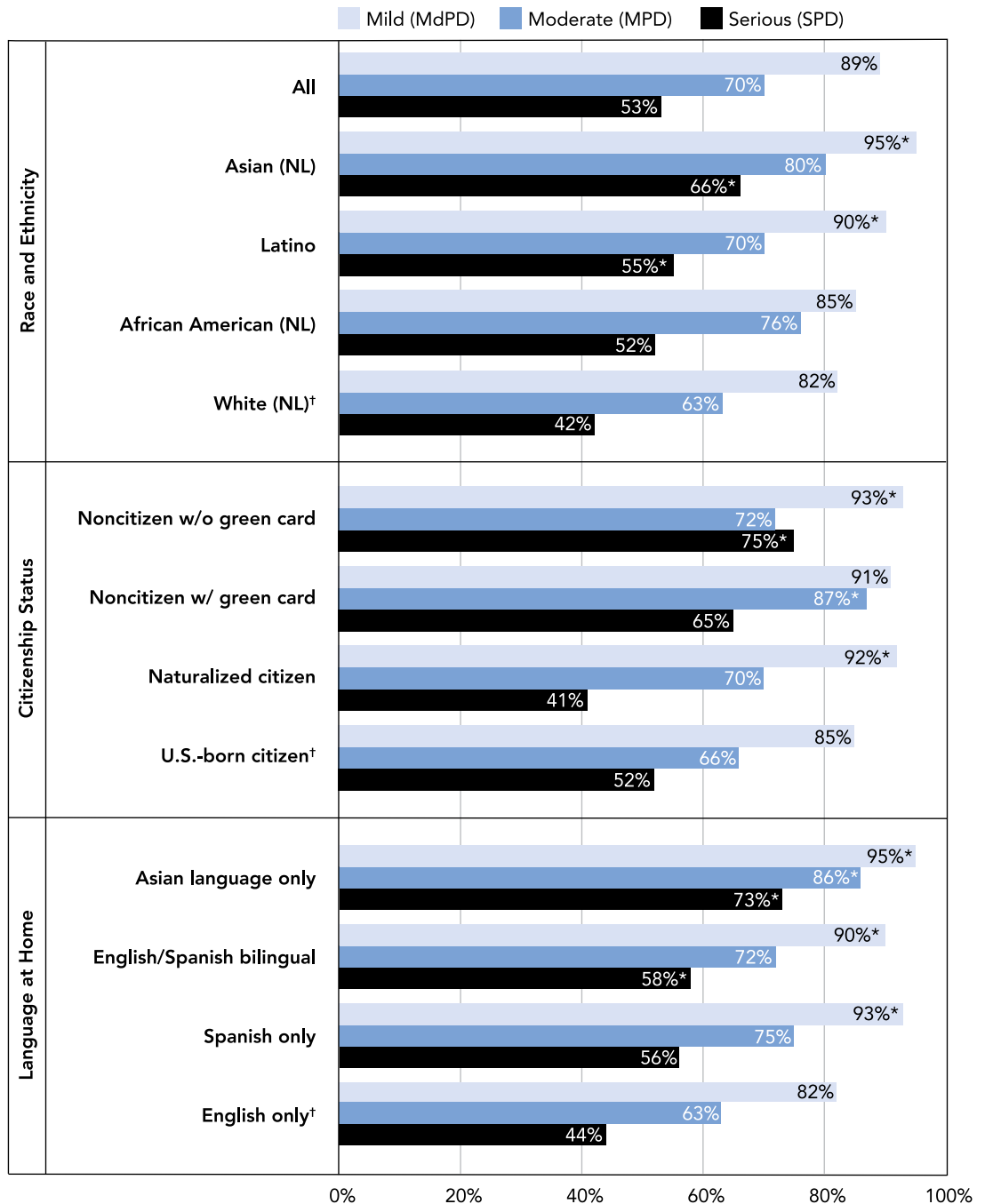
Structural determinants and unmet need for mental health services

The structural determinants of mental health inequities, which more strongly impact women who are eligible for public health services, highlight why some populations may be much more vulnerable to poor mental health outcomes. The remainder of this policy brief examines differences in unmet mental health need among women who are eligible for public health services across social status indicators (race, ethnicity, nativity and citizenship status, language, age, and family type) and economic status indicators (education and employment status).

“Women who are eligible for public health services are more than 1.5 times more likely to report serious psychological distress than women who have private insurance coverage.”

Exhibit 2

Percentage of Women With Unmet Need for Mental Health Services by Level of Psychological Distress and by Race, Ethnicity, Citizenship Status, and Language, Ages 18 and Over, California, 2018–2019



Source: Pooled 2018 and 2019 California Health Interview Surveys

Note: NL = Non-Latino

† Reference group

* Differences in estimates between reference group and other groups by each psychological distress level are statistically significant at a minimum of $p < .05$.

“Nearly 9 in 10 women with MdPD who are eligible for public health services had unmet need, as did 7 in 10 similar women with MPD and 5 in 10 women with SPD.”

Nearly 9 in 10 women with MdPD who are eligible for public health services had unmet need, as did 7 in 10 similar women with MPD and 5 in 10 women with SPD (Exhibit 2).

Unmet need by social status indicators

Race and Ethnicity: Two-thirds of Asian women and more than half of Latina women with SPD had unmet need, compared to less than half of white women with SPD (Exhibit 2).

Citizenship Status: Three-quarters of women without a green card who had SPD had unmet need, compared to more than half of corresponding U.S.-born women (Exhibit 2).

Language: For women with SPD, 7 in 10 who speak only an Asian language had unmet need, compared to 4 in 10 women who speak only English (Exhibit 2).

Age: Among women with SPD, women ages 18–25 were almost twice as likely to have unmet need compared to women ages 55–64 (60% vs. 37%) (Exhibit 3).

Family Type: Among women with MPD, 85% of married women with no children had unmet need, compared to 65% of their single counterparts (Exhibit 3).

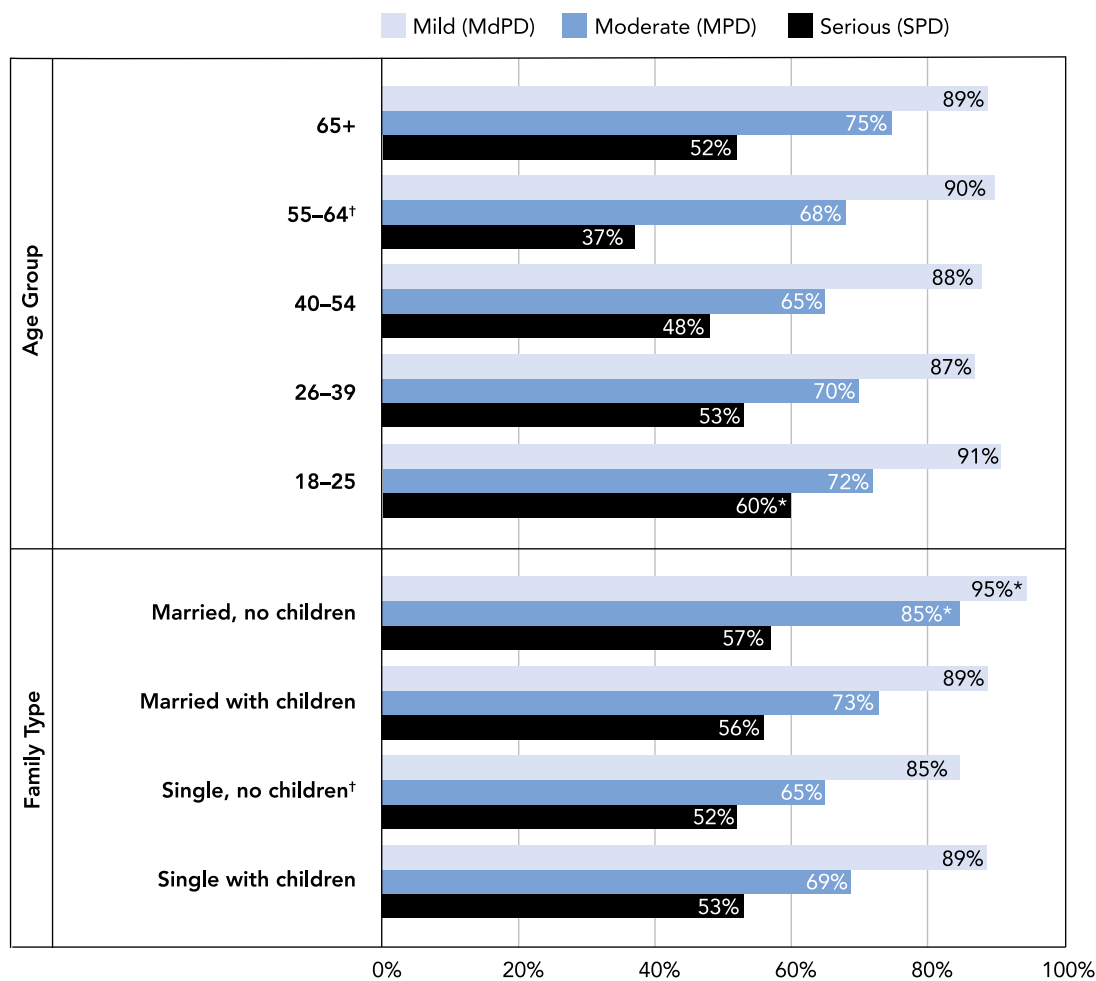
Unmet need by economic status indicators

Education: Eighty percent of women with MPD who have a college degree or higher had greater unmet need, as did 73% of their counterparts with a high school education and 72% with less than a high school education, compared to women with some college education (56%) (Appendix, Exhibit A1).

“For women with SPD, 7 in 10 who speak only an Asian language had unmet need, compared to 4 in 10 women who speak only English.”

Percentage of Women With Unmet Need for Mental Health Services by Level of Psychological Distress and by Age and Family Type, Ages 18 and Over, California, 2018–2019

Exhibit 3



Source: Pooled 2018 and 2019 California Health Interview Surveys
 † Reference group

* Differences in estimates between reference group and other groups by each psychological distress level are statistically significant at a minimum of $p < .05$.

“By filling the gaps in care described in this policy brief and increasing socioeconomic equity for women, California can help ensure the mental well-being of all.”

Employment: Six in 10 women who were employed part-time and the same ratio for those employed full-time who had SPD had unmet need, compared to 4 in 10 women with SPD who were unemployed (Appendix, Exhibit A1).

Summary and Policy Recommendations

Using pooled data from the 2018 and 2019 CHIS, we found that women who reported mild psychological distress were the most likely to have unmet need for mental health care, followed by women reporting moderate psychological distress, then by women reporting serious psychological distress. Unmet need for mental health care varied by social and economic factors for women across all levels of distress.

These findings underscore the importance of using the World Health Organization’s social determinants of health inequities (SDHI) framework with a public health prevention approach to improve the reach and efficacy of services for women needing preventive mental health services. Such efforts could save the state from preventable high-cost, high-need care. That, in turn, would unburden the current mental health safety-net system and allow the state to invest more funds in prevention and early intervention programs and in services that could help mitigate the structural determinants of mental health inequities. To this end, the following recommendations are provided for local and state policymakers:

Increase equity in mental health service utilization. The inequities in unmet need by race, ethnicity, and language are consistent with state-level Medi-Cal data.⁹ Additionally, inequities were found among foreign-born women. One way to increase equity is to implement the National Culturally and Linguistically Appropriate Services in Health and Health Care Standards (National CLAS Standards).¹⁰ Another is to bolster efforts to increase the number of mental health providers who participate in public health insurance

plans and ensure it is more representative of California’s diverse population.¹¹

Promote mental health literacy and outreach. Consistent with public health and prevention literature, population mental health and well-being across all prevention levels will be best served by large-scale interventions. Such interventions should be done with multiple modes of communication, with limited or no cost involved and minimal barriers to access.

Increase mental health screening and awareness. Efforts to increase screening and awareness need to recruit and prioritize the multiple sites where people seek help and “where people live their lives.”¹² Such efforts should be aimed at reaching people in both formal health care settings (with emphasis on primary care) and informal, non-health care settings, such as faith-based organizations, beauty salons, gyms, community resource centers, child care organizations, and others.¹³ Mental health providers can establish partnerships with schools, justice systems, primary-care organizations, social services, and local organizations to develop initiatives aimed at increasing accessibility and awareness, reducing stigma, and decreasing costs.

Reduce socioeconomic inequities. Equitable social and economic policies, such as access to citizenship, pathways to higher education, and employment opportunities that pay a living wage, can better address the structural and social determinants that leave some groups of women either disproportionately covered by Medi-Cal or uninsured. Policymakers at the federal, state, and local levels need to work closely with communities of color and immigrant women to continually evaluate equity-based policies and advocate for change as needed. The data presented in this policy brief were collected prior to the COVID-19 pandemic; the socioeconomic inequities seen prior to the pandemic have likely been exacerbated. Policymakers need to promote income equality in ways such as expanding the Families First Coronavirus

Response Act, which has provisions for paid medical leave due to COVID-19. The pandemic has adversely affected income and job opportunities for women,¹⁴ necessitating longer-term structural changes to improve women's income equity and equality in the labor market.

By filling the gaps in care described in this policy brief and increasing socioeconomic equity for women, California can help ensure the mental well-being of all.

Data Sources and Methods

This policy brief presents data from the 2018 and 2019 California Health Interview Survey (CHIS), conducted by the UCLA Center for Health Policy Research. We used data collected in interviews with 23,791 self-identifying female adults, ages 18 and over, sampled from every county in the state. All analyses presented in this brief include replicate weights to provide corrected confidence interval estimates and statistical tests.

Serious psychological distress in the past year (SPD) was measured by using a cutoff score of 13 to 24 on the Kessler-6 (K6), a validated measure designed to estimate the prevalence of diagnosable mental disorders within a population.⁵ Moderate psychological distress (MPD) in the past year was measured by using a K6 score of 9 through 12—a conservative cutoff on the lower score, as one validation study found a cutoff of 5 or 6 to be a clinically relevant level.⁶ Mild psychological distress (MdPD) in the past year was measured using a K6 score of 1 through 8. A K6 score of 1 through 24 was used as an objective measure of need for mental health services.^{5,6}

Among those with MdPD, MPD, and SPD, unmet need for mental health services was measured with this question: “In the past 12 months, have you seen your primary care physician or mental health professional for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?” A “no” response was coded as the individual's having an unmet need for mental health services. To measure eligibility for public health services, adults who were uninsured or who were covered by Medi-Cal or other public insurance (not including Medicare) in the past year were coded as eligible, and adults with private insurance or Medicare were coded as not eligible.

Author Information

Safa Salem is an MD candidate at Ohio State University and a UCLA CDC public health scholar alumna. D. Imelda Padilla-Frausto, PhD, MPH, is a research scientist at the UCLA Center for Health Policy Research. Hin Wing Tse is a CHIS researcher and data dissemination coordinator at the UCLA Center for Health Policy Research. Firooz Kabir is a master's student at the UCLA Fielding School of Public Health. Nicolás E. Barceló, MD, is a postdoctoral scholar in health services research at the UCLA National Clinician Scholars Program. Blanche Wright, MA, C.Phil, is a doctoral candidate in the UCLA clinical psychology program, a National Institute of Mental Health NRSA Fellow, and a Robert Wood Johnson Foundation Health Policy Research Scholar.

Funder Information

This policy brief was funded by the California Department of Health Care Services – Community Services Division. The content is solely the responsibility of the authors and does not necessarily represent the official views of the funder.

Acknowledgments

The authors truly appreciate the UCLA CHPR communications team for their support in copy editing, designing, and disseminating this policy brief. In addition, the authors would like to thank the California Department of Health Care Services – Community Services Division, Kathryn Kietzman and Riti Shimkhada of the UCLA Center for Health Policy Research, and Kali Patterson of the Mental Health Services Oversight and Accountability Commission for their thoughtful and thorough reviews.

Suggested Citation

Salem S, Padilla-Frausto DI, Tse HW, Kabir F, Barceló NE, Wright B. 2021. *Missed Opportunities: Up to 9 in 10 Women Eligible for Public Health Services Have Unmet Mental Health Need*. Los Angeles, CA: UCLA Center for Health Policy Research.



The California Health Interview Survey covers a wide array of health-related topics, including health insurance coverage, health status and behaviors, and access to health care. It is based on interviews conducted continuously throughout the year with respondents from more than 20,000 California households. CHIS interviews were offered in English, Spanish, Chinese (both Mandarin and Cantonese), Vietnamese, Korean, and Tagalog. CHIS is designed with complex survey methods requiring analysts to use complex survey weights in order to provide accurate variance estimates and statistical testing. CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Public Health, the California Department of Health Care Services, and the Public Health Institute. For funders and other information on CHIS, visit chis.ucla.edu.

10960 Wilshire Blvd., Suite 1550
Los Angeles, California 90024



The UCLA Center
for Health Policy Research
is part of the
UCLA Fielding School of Public Health.

**UCLA
FIELDING
SCHOOL OF
PUBLIC HEALTH**

The analyses, interpretations, conclusions,
and views expressed in this policy brief are
those of the authors and do not necessarily
represent the UCLA Center for Health Policy
Research, the Regents of the University
of California, or collaborating
organizations or funders.

PB2021-9

Copyright © 2021 by the Regents of the
University of California. All Rights Reserved.

Editor-in-Chief: Ninez A. Ponce, PhD

Phone: 310-794-0909
Fax: 310-794-2686
Email: chpr@ucla.edu
healthpolicy.ucla.edu

Endnotes

- 1 World Health Organization. "A Public Health Approach to Mental Health," chap. 1 in *The World Health Report 2001 – Mental Health: New Understanding, New Hope*. <https://apps.who.int/iris/handle/10665/42390>
- 2 These terms are overlapping and complementary to the prevention terms used in WHO's report on the prevention and promotion of mental health. World Health Organization. January 2002. *Prevention and Promotion in Mental Health*. https://www.who.int/mental_health/media/en/545.pdf
- 3 Padilla-Frausto DI, Ponce, NP. 2019. *Identifying Mental Health Needs in California: A Public Health Approach*. Seminar. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/publications/Documents/PDF/2019/MentalHealthNeed_slides_final.pdf
- 4 Please note: Individuals scoring less than 9 on the Kessler-6 were not asked about work and life impairment. However, based on the findings for those with moderate and serious psychological distress, it is plausible that individuals reporting mild psychological distress would be more likely to report mild impairment.
- 5 Kessler RC, Green JG, Gruber MJ, Sampson NA, Bromet E, Cuitan M, Furukawa TA, Gureje O, Hinkov H, Hu CY, Lara C, Lee S, Mneimneh Z, Myer L, Oakley-Browne M, Posada-Villa J, Sagar R, Viana MC, Zaslavsky AM. 2010. Screening for Serious Mental Illness in the General Population With the K6 Screening Scale: Results From the WHO World Mental Health (WMH) Survey Initiative. *International Journal of Methods in Psychiatric Research* 19(S1): 4-22. *Erratum in: 2011. International Journal of Methods in Psychiatric Research* 20(1):62. <https://doi.org/10.1002/mpr.310>
- 6 Prochaska JJ, Sung HY, Max W, Shi Y, Ong M. 2012. Validity Study of the K6 Scale as a Measure of Moderate Mental Distress Based on Mental Health Treatment Need and Utilization. *International Journal of Methods in Psychiatric Research* 21: 88-97. <http://dx.doi.org/10.1002/mpr.1349>
- 7 This is distinct from a subjective measurement of the need for mental health services, in which individuals self-report that they need mental health services.
- 8 This definition of unmet need has limitations, as it does not include all of the important mental health programming that is provided by laypeople, peers, and nonprofessionals; for some, these services may be all that they need.
- 9 California Health Care Foundation. 2020. *Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal*. Accessed September 10, 2021. <https://www.chcf.org/publication/mental-health-disparities-race-ethnicity-adults-medi-cal>
- 10 U.S. Department of Health and Human Services, Office of Minority Health. The National CLAS Standards. Retrieved from <https://minorityhealth.hhs.gov/omb/browse.aspx?lvl=2&lvlid=53>.
- 11 Coffman J, Bates T, Geyn I, Spetz J. 2018. California's Current and Future Behavioral Health Workforce. San Francisco, CA: Healthforce Center at UCSE. <https://healthforce.ucsf.edu/publications/california-current-and-future-behavioral-health-workforce>
- 12 Thornton RLJ, Glover CM, Cené CW, Glik DC, Henderson JA, Williams DR. 2016. Evaluating Strategies for Reducing Health Disparities by Addressing the Social Determinants of Health. *Health Affairs* 35(8): 1416-1423. <http://dx.doi.org/10.1377/bltbaff.2015.1357>
- 13 Wells KB, Jones L, Chung B, et al. 2013. Community-Partnered Cluster-Randomized Comparative Effectiveness Trial of Community Engagement and Planning or Resources for Services to Address Depression Disparities. *Journal of General Internal Medicine* 28(10): 1268-1278. <https://link.springer.com/article/10.1007%2Fs11606-013-2484-3>
- 14 Shalal A. March 8, 2021. Reuters news article on U.S. Treasury Secretary Janet Yellen: "Yellen says COVID-19 having 'extremely unfair' impact on women's income, jobs." <https://www.reuters.com/article/us-usa-treasury-yellen-women/yellen-says-covid-19-having-extremely-unfair-impact-on-womens-income-jobs-idUSKBN2B01UP>

